From Practicing Cognitive Therapy: A Guide to Interventions
Edited by Robert L. Leahy

CHAPTER 1
INTRODUCTION:
FUNDAMENTALS OF COGNITIVE THERAPY

Robert L. Leahy, Ph.D.
Cornell University Medical College
and
The American Institute for Cognitive Therapy, NYC

Twenty years ago cognitive therapy was identified with the treatment of depression. Aaron Beck's seminal work in the 1970's proposed that depression is the consequence of the conscious negative thoughts of the depressive who viewed self, experience and the future as bleak and empty. Beck proposed that specific cognitive content characterized each psychiatric disorder and that the goal of therapy was to identify and modify the patient's distortions or biases in thinking and the patient's idiosyncratic cognitive schemata. The cognitive model suggested that neurotic functioning was maintained and aggravated by the self-fulfilling negative information processing of the patient.

In a similar orientation, Abramson, Seligman and Teasdale (1978) advanced the attributional model of depression which proposed that depression is the consequence of negative explanatory style. Depressive pessimism and low self-esteem were seen as the consequence of attributing negative events to lasting personality traits of the self that led the depressive to generalize failure to other tasks and to future events. Similar to Beck's cognitive model, the attributional model stressed the conscious thought processes of depressed individuals, but focused on the patient's attributions of causality for failure and success and the patient's disposition to generalized negatives across situations and over time.

Beck, Shaw, Rush and Emery (1979) published the treatment manual, ***Cognitive Therapy of Depression***, which not only provided clinicians with detailed guidelines for the treatment of patients, but also provided researchers with a standardized treatment protocol for outcome studies of cognitive therapy of depression. Since the publication of the treatment manual, an overwhelming number of outcome studies have demonstrated that cognitive therapy is as effective as medication in the treatment of depression and may have long-term preventative advantages. In addition to the substantial empirical support for the treatment model, the cognitive model of depression has also received wide empirical support, demonstrating that depression is characterized by the distortions in information processing that Beck and his colleagues had first proposed (Dobson, 1989; Hollon, DeRubeis, & Evans, 1996).

Beck's cognitive model of psychopathology was never limited to a specific diagnostic category. Rather, the cognitive model posits that different psychopathological conditions are characterized by specific cognitive schemata. Thus, depression is associated with negative schemata of failure, loss, and emptiness, anxiety is characterized by threat, imminence, and danger, and

paranoia is marked by themes of distrust and the fear of domination and manipulation. The schematic model of affective and anxiety disorders has been extended by Beck, Freeman and their associates (1990) to the investigation of personality disorders, with each personality disorder characterized by specific schematic content and specific styles of coping.

The implication to draw from this is that there is not *one* cognitive therapy for all psychiatric disorders. For example, the cognitive therapy model and treatment of depression is significantly different from the model and treatment of panic disorder (see Greenberg and Mercier in this volume). Similarly, the cognitive therapy of paranoid delusional disorder is different from the cognitive therapy of narcissistic personality disorder (see Alford, this volume, and Leahy, 1995). Cognitive therapy is not a simplistic, reductionistic approach with one size fitting all. Rather, as will become apparent in this Casebook, there are many versions of cognitive therapy for the wide variety of disorders that are treated.

In the "early days" of cognitive therapy (that is, the 1970's), Beck was cautious in generalizing his model to disorders other than depression. In a systematic and intellectually rigorous and honest manner, Beck would limit his claims to demonstrated results. Today, even to Beck's own surprise, I believe, the cognitive therapy approach has been successfully applied to a wide range of problems. Not only the anxiety disorders have been treated effectively with cognitive therapy, but also substance abuse, borderline personality, paranoid delusional disorder, marital conflict, and anger.

Basic Principles of Cognitive Therapy

The cognitive model emphasizes a number of commonalities. Cognitive therapists generally emphasize current behaviors and thoughts and conscious processing of information. However, we attempt to uncover the patient's underlying assumptions---that is, the patient's rules or values---that predispose him to depression, anxiety or anger. Typical rules are "I should be perfect", "I should be liked by everyone", "My worth depends on others' approval", "I need to be certain", and "My partner should understand and meet my needs without my having to tell him." It is important for the therapist to recognize that each individual has his or her own idiosyncratic rules or assumptions. The process of inquiry and questioning employed by cognitive therapists is useful in uncovering the underlying assumptions of the patient. For example, I was quite surprised to learn that a severely depressed woman believed that if she could make herself still, she could be closer to her father (who had suffered chronic paralysis before he died). We should never assume that we know more than the patient about his underlying beliefs. We only know how to ask the questions that lead to their answers.

Cognitive therapists also focus on the patient's "automatic thoughts" or "cognitive distortions"--- that is, the conscious, spontaneous thoughts that are associated with negative affect. It is customary for us to categorize these distortions into their typical bias or illogic. Examples are the following: "She thinks I'm an idiot" (Mind-reading), "I'll fail the test" (Fortune-telling), "I'm a loser" (Labeling), "I can't stand it--it's awful" (Catastrophizing), "My successes are trivial" (Discounting positives), "I fail at everything" (All-or-nothing thinking), "If I fail at this, I'll fail at other things too" (Overgeneralizing), and "The divorce was all my fault" (Personalizing). It is important to realize that "automatic thoughts" are sometimes true or partly true----maybe that person at the party really does think I'm a loser. Perhaps the use of the word "distortion" is inaccurate---perhaps we should speak of "biases" in thinking. After all, depressed and anxious people are often correct---bad things do happen. Examples of automatic thought distortions are shown in Table 1.

TABLE 1
Cognitive Distortions

1. Mind reading: You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."

2. Fortune telling: You predict the future--that things will get worse or that there is danger ahead. "I'll fail that exam" and "I won't get the job."

3. Catastrophizing: You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. "It would be terrible if I failed."

4. Labeling: You assign global negative traits to yourself and others. "I'm undesirable" or "He's a rotten person."

5. Discounting positives: You claim that the positives that you or others attain are trivial."That's what wives are supposed to do--so it doesn't count when she's nice to me." "Those successes were easy, so they don't matter."

6. Negative filter: You focus almost exclusively on the negatives and seldom notice the positives. "Look at all of the people who don't like me."

7. Overgeneralizing: You perceive a global pattern of negatives on the basis of a single incident. "This generally happens to me. I seem to fail at a lot of things."

8. Dichotomous thinking: You view events, or people, in all-or-nothing terms. "I got rejected by everyone" or "It was a waste of time."

9. Shoulds: You interpret events in terms of how things should be rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."

10. Personalizing: You attribute a disproportionate amount of the blame to yourself for negative events and fail to see that certain events are also caused by others. "The marriage ended because I failed"

11. Blaming: You focus on the other person as the *source of* your negative feelings and you refuse to take responsibility for changing yourself. "She's to blame for the way I feel now" or "My parents caused all my problems."

12. Unfair comparisons: You interpret events in terms of standards that are unrealistic--for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "She's more successful than I am" or "Others did better than I did on the test."

13. Regret orientation: You focus on the idea that you could have done better in the past, rather on what you can do better now. "I could have had a better job if I had tried" or "I shouldn't have said that".

14. What if? You keep asking a series of questions about "What if" something happens and fail to be satisfied with any of the answers. "Yeah, but what if I get anxious? Or what if I can't catch my breath?"

15. Emotional reasoning: You let your feelings guide your interpretation of reality--for example, "I feel depressed, therefore my marriage is not working out."

16. Inability to disconfirm: You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable", you reject as *irrelevant* any evidence that people like you. Consequently, your thought cannot be refuted. "That's not the real issue. There are deeper problems. There are other factors."

17. Judgment Focus: You view yourself, others and events in terms of evaluations of good-bad or superior-inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. "I didn't perform well in college" or "If I take up tennis, I won't do well" or "Look how successful she is. I'm not successful".

[Reprinted from R.. L. Leahy, ***Cognitive Therapy: Basic Principles and Applications.*** Jason Aronson Publishing Co., 1996]

But it is the underlying assumptions and the personal schemas (the patient's vulnerabilities) that lead the individual to become depressed. For example, if I have the automatic thought that Susan does not like me, I probably will not become depressed unless I believe that I need Susan's approval or unless it activates my underlying schema (or belief) that I am a loser and unlovable. The cognitive therapist differs from the behavioral therapist in the sense that the cognitive therapist is interested in "why" negative events have such profound meanings for the patient. For example, although the breakup in a relationship often results in sadness for many people, we differ in the meaning we attach to it. The patient's schemas (or themes of vulnerability) might lead him to ascribe any number of meanings to a breakup, such as abandonment, unworthiness, helplessness, emptiness, or unlovability. It might even activate positive schemas, such as liberation or autonomy. The relationship between schemas, assumptions and automatic thoughts is illustrated in Table 2.

TABLE 2
RELATIONSHIPS AMONG SCHEMAS, ASSUMPTIONS AND AUTOMATIC THOUGHTS

SCHEMA	ASSUMPTION	AUTOMATIC THOUGHTS
Unlovable	If I impress people, they will like me. If people get to know me, they'll think I'm a loser.	He doesn't like me. I'll be rejected. I'm boring
Helpless	If I don't have someone to help me, then I won't survive. I won't be able to support myself.	I can't do anything right. If I make a mistake, things will fall apart.
Abandonment	If I don't get constant reassurance, then I'll be abandoned. It's not possible to be happy on my own.	He's going to leave me. It's awful to be alone. I'll always be alone. I must be a loser.

Throughout the casebook you will notice that a variety of therapists utilize similar techniques. Cognitive therapists draw on behavioral therapy, utilizing exposure to feared stimuli, modeling and behavioral rehearsal, relaxation training, activity scheduling, graded task assignments, assertiveness training, communication and listening skills, and self-reinforcement. The cognitive

therapist has a set of powerful techniques drawn from the cognitive model, including thought monitoring, categorizing the negative thoughts, vertical descent, identifying the underlying assumptions and schemas, the double standard technique, examining the costs and benefits of a belief, role-playing with the therapist, acting in opposition to the thought, and developing coping statements and new adaptive assumptions. Examples of these behavioral and cognitive techniques are shown in Table 1 below.

Table 3
Behavioral and Cognitive Techniques

Behavioral Techniques	Examples
Behavioral Targets	Specific behaviors that the patient wishes to modify. Examples: number of minutes of exercise, checking, hand washing, homework done.
Exposure	Confronting a feared stimulus. Example: The OCD patient is asked to refrain from washing his hands after he places his hands in "dirty" water.
Response/stimulus hierarchy	A list of most to least feared responses or situations to be used in exposure. Example: The patient and therapist make a list of situations or behaviors that the patient fears, ranking them from least to most feared. The patient afraid of elevators ranks "thinking of an elevator" as least feared and "riding on the elevator to the top of the World Trade Center" as most feared.
Modeling	Therapist demonstrates the desired response. Example: The therapist demonstrates in session an appropriate assertive response that the patient then imitates.
Imitation	Patient copies the therapist's response. Example: The patient "copies" and enacts the behavior that he observes in another person.
Behavioral rehearsal	Patient enacts the behavior which he plans to conduct outside of therapy. Example: The patient demonstrates in session how he would assert himself with his boss.
Relaxation training	Relaxing different muscle groups in sequence; imagining relaxing images; practicing slow breathing. Example: The

	therapist guides the patient through progressively tensing and relaxing different mental groups, finishing with an image of a relaxing scene.
Activity scheduling	Tracking activities throughout the day and rating them for pleasure, mastery, anxiety, sadness, fear, or other feelings or sensations. Example: The patient uses an hourly schedule to track his moods and activities.
Graded task assignments	Planning and enacting behaviors that are expected to produce pleasure or mastery. Often these behaviors are chosen from a reward menu that the patient and therapist construct. Example: The patient lists behaviors that he used to engage in before he was depressed and agrees to assign these activities to himself beginning with the least difficult and progressing to more difficult behaviors.
Assertiveness training	Instruction in how to make legitimate requests that will enhance one's pleasure or self-esteem. Example: The therapist instructs the patient in how to make responsible for changes in the behavior in someone else. The patient then practices assertive responses outside of sessions.
Communication training	Instruction in how to use editing and clear "I statements" when speaking to others. Example: The therapist instructs the patient in non-aggressive communication, with the emphasis on editing, non-accusatory speech, "I-statements", and statements of preferences that the patient has.
Active listening training	Instruction in how to use inquiry, rephrasing, empathizing, and validating. Example: The patient learns how to ask others for more information about their feelings and thoughts (inquiry), the patient paraphrases what he hears ("You're saying that..."), the patient indicates the feeling the other person has ("You're feeling angry...") and the patient tries to find some truth in what the other person is saying ("I can see why you would say that because...").
Self-reward	Using self-praise or concrete reinforcements to the self to increase desirable behaviors. Example: The patient may reward himself by tangible positive consequences (food, a

	movie, a present, or a pleasant behavior) or by positive self-statements ("I'm proud of myself for trying").
Cognitive Techniques	
Identify the negative thoughts	The patient monitors the thoughts that are associated with depression, anxiety and anger. Example: The patient self-monitors what he is thinking when he feels worse. "When I felt anxious I was thinking that I was going to fail."
Rate the degree of belief in the thought and the degree of emotion associated with the thought.	After the patient identifies his negative feelings (e.g., sad, angry, frustrated), he indicates which thoughts are associated with each feeling. He then rates (from "0" to "100") how "sad" he feels and how much he believes his negative thought. Example: I felt 85% sad when I thought "I'll never find someone who will love me". I believed that thought 90%"
Categorize the negative thought	The patient classifies the thought according to the thinking (cognitive) distortion exemplified by the thought. Examples of these distortions are fortune telling, mind-reading, mislabeling, catastrophizing, personalizing, all-or-nothing thinking, discounting the positives, and overgeneralizing.
What would it mean if the thought were true? (Vertical descent)	The therapist asks, "If (your thought) is true, what would that mean to you? Why would that be a problem? What would happen?" These questions are asked for each answer given. For example, "If you got rejected at the party, you said that would mean you're not attractive. What would happen if you were not attractive?"
What is the underlying assumption?	The therapist examines the patient's underlying rules. For example, the patient's "if-then" or "should" statements. For example, "If someone doesn't like me, then it means I'm unlovable"
What are the costs and benefits of the thought?	The therapist asks the patient to list all the advantages and disadvantages to himself (herself) of the thought and to divide 100 points between the advantages and disadvantages. This addresses the patient's motivation to change the thought.

What is the evidence?	The patient lists the evidence supporting and refuting his thought. How does the evidence weigh out? What is the quality of the evidence?
Place the event in perspective.	The patient is asked to examine the event along a continuum, from “0" to “100". What will actually happen if the event does occur? What could be worse, better, the same in consequence? What would you still be able to do even if the event does occur?
Double-standard	Therapist asks the patient, “Would you apply the same standard to others? Why (why not)?”
Argue back at the thought	The therapist and the patient take roles in which the patient is asked to argue against his negative thinking. Roles can be switched.
Logical Analysis	Is the patient drawing conclusions that are unwarranted? For example, “If I fail on the exam, then I’m a failure”?
Lack of information	Does the patient have all the information necessary to draw the conclusions? For example, the patient notices a lump on her breast and concludes it is cancer. Can a doctor provide her with more (accurate) information?
Is there an alternative explanation?	The patient is asked to examine as many alternative causes and consequences, especially less negative alternatives.
Is there a problem to be solved?	Can the patient approach his thought as a problem-solver? What is the problem, what would the goal be, what resources, information, skills and actions are relevant? What plans can the patient think of to carry out to solve the problem?
Acceptance	Is there a reality that the patient can learn to accept, rather than trying to fix or struggle with it?

Although most of the chapters in this Casebook are based on derivations of Beck’s work, the authors draw from other cognitive and behavioral models as well as “theoretically integrative” work. Behavioral models include the work of Foa, Lazarus, Lewinsohn, Bandura, O’Leary, Jacobson, and Rehm. Cognitive and cognitive-behavioral models include the work of

Ellis, Burns, Barlow, Linehan, Mahoney, and Meichenbaum. Theoretical integration is reflected in the chapter by Holland on the cognitive and psychoanalytic interface and my chapter on resistance in which I attempt to integrate cognitive theory with social psychology, microeconomic theory and Piagetian structuralism.

The experienced cognitive therapist does not approach every patient with the same bag of tricks. The therapist attempts to develop a case conceptualization, considering the patient's idiosyncratic cognitive schemata, coping style and interpersonal reality (see Tompkins, this volume; Persons, 1990). The early criticisms of cognitive therapy lacking a model of resistance have been addressed by several authors in evaluating personality disorders (Beck, Freeman and associates, 1991) and in examining strategies of self-limitation (Leahy, 1996; also, this volume). Moreover, cognitive therapists integrate behavioral techniques, hypnosis and imagery induction and restructuring in order to activate cognitive schemata and modify thinking and affect (see Riskind, Mercier, Dowd, and Smucker, this volume). In fact, it is difficult to imagine conducting cognitive therapy without employing behavioral techniques, whether to activate the depressed patient (Greenberg), utilize exposure techniques for panic or obsessive-compulsive disorder (Mercier and Holland), or modify interaction, sexual or communication patterns in couples (Epstein and Friedman).

Cognitive therapy is not an easy therapy to employ. The therapist must be active, engaging, informed, and effective. I am often struck by the surprise that some trainees exhibit when they observe me engaging in a cognitive-therapy dialogue. I recall, from my own experience receiving excellent supervision from David Burns, how I wondered how I would ever know "what questions to ask" the patient. Obviously, there is no substitute for extensive supervision and training, but the therapist new to cognitive therapy can quickly learn some of the basic techniques and questions and develop from there. I know that in the first few months when I was doing cognitive therapy, I used Beck's treatment manual on depression as a roadmap for every session. Therapists develop their own style of conducting therapy. I know that the contributors to this volume have different styles and conceptualizations of the therapeutic process. The are all effective and all different. The new therapist will find a style and method that fits his or her personality. I tell trainees that "this is the way that I do it, but there may be other ways that fit you better."

It would be too narrow to think that there is only one cognitive therapy. All of us are indebted---and most of us utilize--- the substantial contributions of other cognitive-behavioral therapists, such as Albert Ellis, David Barlow, Peter Lewinsohn, Arnold Lazarus, and Neil Jacobson. Moreover, many cognitive therapists integrate the work of other psychological models into their work. For example, Guidanno and Liotti have enriched all of our work with difficult patients by helping us understand how Bowlby's work on attachment is so central to understanding the patient's schemata and resistance to change. Cognitive-behavioral therapy advances itself, not through intellectual territoriality or elitism, but by integrating the important work of other theoretical and treatment models. But it is also interesting to note that when psychologists are asked *which* model they try to integrate into their approach, the cognitive model is the most frequently mentioned (Alford & Beck, 1996; Alford & Norcross, 1991).

The contributors to this casebook are some of the leading cognitive therapists in the country. Many of them have been trained directly by Beck or by Beck's students. When I attended a dinner in honor of Beck I was struck by the fact that Beck has had such a lasting

influence on the many people who worked with him. Many of us have been scattered across a variety of continents, but we have also managed to maintain and broaden our contacts with each other over the years.

Many of us are involved in training therapists in the cognitive model. Today, most major cities in the United States and many major cities in the world (e.g., London, Tokyo, Rome) have centers or institutes where people can obtain training. Several authors of this casebook are actively working at either the Center for Cognitive Therapy at the University of Pennsylvania or the American Institute for Cognitive Therapy in New York City. We hope that this casebook, as well as my text, ***Cognitive Therapy: Basic Principles and Applications***, will motivate the reader to integrate cognitive therapy into his or her practice.

References

Abramson, L.Y., Seligman, M.E.P., and Teasdale, J.D. (1978). Learned helplessness in humans: critique and reformulation. *Journal of Abnormal Psychology* 87: 102-109.

Alford, B. A. (1986). Behavioral treatment of schizophrenic delusions: a single-case experimental analysis. *Behavior Therapy* 17: 637-644.

Alford, B. A., and Beck, A. T. (in press). *Cognitive Therapy: An Integration of Current Theory and Therapy.* New York: Guilford.

Alford, B. A., and Norcross, J.C. (1991). Cognitive therapy as integrative therapy. *Journal of Psychotherapy Integration* 1 (3): 175-190.

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Beck, A. T. and Freeman, A. (1990). *Cognitive Therapy of Personality Disorders.* New York: Guilford.

Beck, A.T., Rush, A. J., Shaw, B.F., and Emery, G. (1979). *Cognitive Therapy of Depression.* New York: Guilford.

Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy of depression. JCCP, 57, 414-419

Hollon, S. D., DeRubeis, R.J., & Evans, M.D. Cognitive therapy in the treatment and prevention of depression. Pp. 293-317. In Salkovskis (ed.), *Frontiers of Cognitive Therapy.* New York: Guilford

Leahy, R.L. (1995). Cognitive development and cognitive therapy. *Journal of Cognitive Psychotherapy: An International Quarterly*, 9: 173-184.

Leahy, R.L. (1996) *Cognitive Therapy: Basic Principles and Applications.* Northvale: New Jersey