CHAPTER 1

Overview

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

—EPICTETUS

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

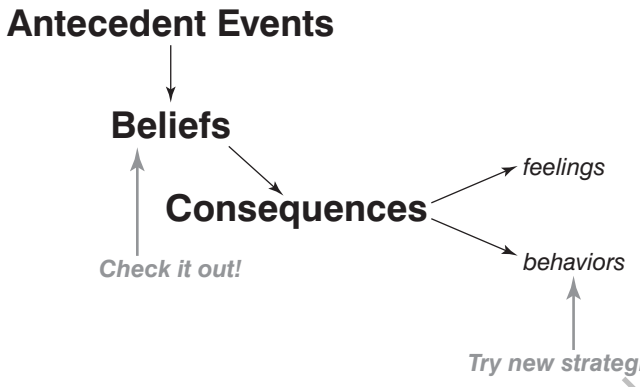

FIGURE 1.1. The original cognitive model.

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 (Joorman 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.

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