DEPRESSION

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One of the most important developments in psychosocial approaches to emotional problems has been the success of cognitive therapy for depression. It is now well known that this approach is as good or better than other approaches such as drugs for treating depression, and this chapter presents a very detailed version of the latest rendition of cognitive therapy.

Employing a variety of well-specified cognitive and behavioral techniques, cognitive therapy is also distinguished by the detailed structure of each session with its specific agendas and the very deliberate and obviously effective therapeutic style of interacting with the patient through a series of questions. Finally, the authors underscore very clearly the importance of the collaborative relationship between the therapist and patient, and outline specific techniques to achieve that collaborative state so that the patient and therapist become an investigative team. Many of these concepts and procedures should be very useful to clinicians treating any number of problems in addition to depression.—D. H. B.

OVERVIEW

Depression is the most common presenting problem encountered by mental health professionals. A variety of approaches have been applied to the treatment of depression, and most recently there has been an increasing emphasis on short-term psychotherapies for depression (Rush, 1982). Short-term approaches that have received the greatest attention in outcome research include behavior therapy, interpersonal psychotherapy, brief psychodynamic therapy, and cognitive therapy (Bergin & Lambert, 1978).

Despite the tremendous advances in psychotherapy for depression, pharmacotherapy remains the standard against which other treatments are compared. Recent research suggests that cognitive-behavior therapy is at least as effective as tricyclic antidepressants in the treatment of nonbipolar, depressed outpatients (Rush, Beck, Kovacs, & Hollon, 1977; Beck, Rush, Shaw, & Emery, 1979; Blackburn & Bishop, 1979, 1980; McLean & Hakstian, 1979). The efficacy of the cognitive behavioral approach with depression is especially striking in light of a number of studies in the past showing that traditional psychotherapies

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COGNITIVE MODEL OF DEPRESSION

The cognitive model assumes that cognition, behavior, and biochemistry are all important components of depressive disorders. We do not view them as competing theories of depression, but rather as different levels of analysis. Each treatment approach has its own "focus of convenience." The pharmacotherapist intervenes at the biochemical level; the cognitive therapist intervenes at both the cognitive and behavioral levels. Our experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression.

Our focus in this chapter will be on the cognitive disturbances in depression. According to this theory, negatively biased cognition is a core process in depression. This process is reflected in the "cognitive triad of depression": depressed patients typically have a negative view of themselves, of their environment, and of the future. They view themselves as worthless, inadequate, unlovable, and deficient. Depressed patients view the environment as overwhelming, as presenting insuperable obstacles that cannot be overcome, and as continually resulting in failure or loss. Moreover, they view the future as hopeless; they believe their own efforts will be insufficient to change the unsatisfying course of their lives. This negative view of the future often leads to suicidal ideation and actual attempts.

Depressed patients consistently distort their interpretations of events so that they maintain negative views of themselves, the environment, and the future. These distortions represent deviations from the logical processes of thinking used typically by people. For example, a depressed woman whose husband comes home late one night may conclude that he is having an affair with another woman, even though there is no other evidence supporting this conclusion. This example illustrates an "arbitrary inference"—the patient has reached a conclusion that is not justified by the available evidence. Other distortions include all-or-nothing thinking, overgeneralization, selective abstraction, and magnification (Beck *et al.*, 1979).

According to the cognitive model, an important predisposing factor for many patients with depression is the presence of early negative schemas. The child learns to construct reality through his or her early experiences with the environment, especially with significant others. Sometimes these early experiences lead children to accept attitudes and beliefs that will later prove maladaptive. For example, a child may develop the schema that no matter what he or she does, his or her performance will never be good enough. These schemas are usually out of awareness, and may remain dormant until a life event (such as being fired from a job) stimulates the schema. Once the schema is activated, the patient categorizes, selects, and encodes information in such a way that the failure schema is maintained. Negative schemas, therefore, predispose depressed

patients to distort events in a characteristic fashion, leading to a negative view of themselves, the environment, and the future.

The focus of cognitive therapy is on changing depressive thinking. These changes may be brought about in a variety of ways: through behavioral experiments, logical discourse, examination of evidence, problem solving, role playing, and imagery restructuring, to name just a few. The remainder of this chapter will elaborate on these techniques and their application in clinical practice.

CHARACTERISTICS OF THERAPY

Cognitive therapy with adult depressed outpatients is usually undertaken in the therapist's office. It has most frequently been applied in a one-to-one setting, with just the patient and therapist. Group cognitive therapy has been successful with many depressed outpatients, although we have not yet had enough experience in group settings to know with which patients groups will prove desirable. It is not unusual to involve spouses, parents, and other family members in the course of treatment. They might be used, for example, to provide information that will help patients test the validity of their thinking regarding how others in the family view them. Moreover, "couples therapy" based on the cognitive model is often very effective in relieving depression related to chronic interpersonal problems.

In our clinical experience, a number of therapist characteristics contribute to effective cognitive therapy. First, cognitive therapists should ideally demonstrate the "nonspecific" therapy skills identified by other writers (e.g., Truax & Mitchell, 1971). They should be able to communicate warmth, genuineness, sincerity, and openness. Second, the most effective cognitive therapists seem to be especially skilled at seeing events through the patient's perspective (accurate empathy). They are able to suspend their own personal assumptions and biases while they are listening to depressed patients describe their reactions and interpretations. Third, skilled cognitive therapists can reason logically and plan strategies. They are not "fuzzy" thinkers. In this respect they resemble good trial lawyers, who can spot the sometimes subtle flaws in another individual's reasoning, and skillfully elicit a more convincing interpretation of the same events. Cognitive therapists plan strategies several steps ahead, anticipating the desired outcome. Fourth, the best practitioners of this approach are active. They have to be comfortable taking the lead, providing structure and direction to the therapy process.

We do not yet know which patient characteristics are related to success in cognitive therapy. Our experience suggests that several subtypes of depressives seem less amenable to short-term cognitive therapy. These include patients with hallucinations or delusions; schizoaffective disorders; impaired memory functioning (e.g., organic brain syndromes); borderline personality structures; and severe endogenous depressions. With these patients, cognitive therapy may be helpful over a longer period of time, often in combination with pharmacotherapy, milieu treatment, or extra support from the environment.

Certain patient characteristics are predictive, in our experience, of a more rapid response. Patients who are appropriately introspective; can reason abstractly; are well organized and good planners; are conscientious about carrying out responsibilities; are employed; are not excessively angry, either at themselves or at other people; are less dogmatic and rigid in their thinking; can identify a clear precipitating event for the depressive episode; and have close relationships with others often show faster improvement in depressive symptoms through cognitive therapy.

COLLABORATION

Basic to cognitive therapy is a collaborative relationship between patient and therapist. When the therapist and patient work together, the learning experience is enhanced for both and a cooperative spirit is developed that contributes greatly to the therapeutic process. Equally important, the collaborative approach helps to ensure compatible goals for treatment and to prevent misunderstandings and misinterpretations between patient and therapist. Because of the importance of the collaborative relationship, we place great emphasis on the interpersonal skills of the therapist, the process of joint selection of problems to be worked on, regular feedback, and the investigative process we call collaborative empiricism.

Interpersonal Qualities

Since collaboration requires that the patient trust the therapist, we emphasize those interpersonal qualities that contribute to trust. Warmth, accurate empathy, and genuineness are desirable personal qualities for the cognitive therapist, as for all psychotherapists. It is important that the cognitive therapist not seem to be playing the *role* of therapist. The therapist should be able to communicate, verbally and nonverbally, that he or she is sincere, open, concerned, and direct. It is also important that the therapist not seem to be withholding impressions or information, or evading questions. The therapist should be careful not to seem critical or disapproving of the patient's perspective.

Rapport between patient and therapist is crucial in the treatment of depressed patients. When rapport is optimal, patients perceive the therapist as someone who is tuned in to their feelings and attitudes, is sympathetic and understanding, and is someone with whom they can communicate without having to articulate feelings in detail or qualify statements. When the rapport is good, both patient and therapist feel comfortable and secure.

A confident professional manner is also important in cognitive therapy. Therapists should convey relaxed confidence in their ability to help the depressed patient. Such confidence can help counteract the patient's initial hopelessness about the future. Since the cognitive therapist must sometimes be directive and impose structure, especially in the early stages of treatment, it is helpful to maintain a clear sense of confident professionalism.

Joint Determination of Goals for Therapy

In the collaborative relationship the patient and therapist work together to set therapeutic goals, determine priorities among them, and set an agenda for each session. Problems to be addressed over the course of therapy include specific depressive symptoms (e.g., hopelessness, crying, difficulty concentrating) and external problems (e.g., marital difficulties, career issues, child-rearing concerns). Priorities are then jointly determined in accordance with the amount of distress generated by a particular problem and how amenable to change the particular problem is. During the agenda-setting portion of each therapy session (discussed in detail in the next section), therapist and patient together determine the items to be covered in that session. Through this collaborative process, target problems are selected on a weekly basis.

The process of problem selection often presents difficulties for the new cognitive therapist. These include failure to reach agreement on specific problems to focus on, selection of peripheral concerns, and the tendency to move from problem to problem instead of persistently seeking a satisfactory solution to only one problem at a time. Because the problem selection process entails both structuring and collaboration on the part of the therapist, considerable skill is necessary.

Regular Feedback

Feedback is especially important in therapy with depressed patients; it is a crucial ingredient in developing and maintaining the collaborative therapeutic relationship. The cognitive therapist initiates the feedback component early in therapy by eliciting the patient's thoughts and feelings about many aspects of the therapy, such as the handling of a particular problem, the therapist's manner, and homework assignments. Since many patients misconstrue therapists' statements and questions, it is only through regular feedback that the therapist can ascertain whether he or she and the patient are on the same "wavelength." The therapist must also be alert for verbal and nonverbal clues to convert negative reactions.

As part of the regular feedback process, the cognitive therapist shares the rationale for each intervention mode. This helps to demystify the therapy process and facilitates the patient's questioning the validity of a particular approach. In addition, when the patients understand the connection between a technique or assignment the therapist uses and the solution of a problem, they are more likely to participate conscientiously.

The third element of the feedback process is for the therapist to check regularly to determine whether the patient understands his or her formulations. Patients sometimes agree with a formulation simply out of compliance, and depressed patients frequently exhibit both compliance and reluctance to "talk straight" with the therapist for fear of being rejected, criticized, or of making a mistake. The therapist must therefore make an extra effort to elicit feelings or

wishes relevant to compliance (e.g., anxiety about rejection, wish to please) from the patient and must be alert for verbal and nonverbal clues that the patient may not indeed understand the explanations.

As a regular part of the feedback process, at the close of each session the cognitive therapist provides a concise summary of what has taken place and asks the patient to abstract and write down the main points from the session. The patient keeps this summary for review during the week. In practice, the therapist uses capsule summaries at least three times during a standard therapeutic interview: in preparing the agenda, in a midpoint recapitulation of the material covered up to that point, and in the final summary of the main points of the interview. Patients generally respond favorably to the elicitation of feedback and presentation of capsule summaries. We have observed that the development of empathy and rapport is facilitated by these techniques.

Collaborative Empiricism

When the collaborative therapeutic relationship has been successfully formed, the patient and therapist act as an investigative team. Though we elaborate on the investigative process later, it is appropriate to introduce it in the context of the collaborative relationship. As a team, patient and therapist together approach the patient's maladaptive cognitions and underlying assumptions in the manner that scientists approach questions: Each thought or assumption becomes a hypothesis to be tested and evidence is gathered that supports or refutes the hypothesis. Events in the past, circumstances in the present, and possibilities in the future are the data that constitute evidence, and the conclusion to accept or reject the hypothesis is jointly reached by subjecting the evidence to logical analysis. Experiments may also be devised to test the validity of particular cognitions. The cognitive therapist need not persuade patients of illogicality or inconsistency with reality since patients "discover" their own inconsistencies. This guided discovery process is a widely accepted educational method and is one of the vital components of cognitive therapy.

THE PROCESS OF COGNITIVE THERAPY

We will here attempt to convey a sense of how cognitive therapy sessions are structured and a sense of the course of treatment. Detailed discussion of particular techniques follows this section.

The Initial Sessions

A main therapeutic goal of the first interview is to produce some symptom relief. Relief of symptoms serves the patient's needs by reducing suffering and also helps to increase rapport, collaboration, and confidence in the therapeutic process. Symptom relief should be based on more than rapport, sympathy, and

implied promise of "cure," however, so the cognitive therapist seeks to provide a rational basis for reassurance by attempting to define a set of problems and demonstrating some strategies for dealing with them.

Problem definition continues to be a goal in the early stages of therapy. The therapist works with the patient to define specific problems to focus on during therapy sessions. The cognitive therapist does this by obtaining as complete a picture as possible of the patient's psychological and life situation difficulties. The therapist also seeks details concerning the depth of depression and particular symptomatology. Cognitive therapists are especially concerned with how the patients see their problems.

Once the specific problems have been defined, the patient and the therapist establish priorities among them. Decisions are made on the basis of amenability to therapeutic change and centrality of the life problem or cognition to the patient's emotional distress. In order to help establish priorities effectively, the therapist must see the relationships among particular thoughts, particular life situations, and particular distressing emotions.

Another goal of the initial session is to illustrate the close relationship between cognition and emotion. When the therapist is able to observe the patient's mood change (e.g., crying), he or she points out the alteration in affect and asks for the patient's thoughts just before the mood shift. The therapist then labels the negative thought and points out its relationship to the change in mood. The therapist initially gears homework assignments toward helping the patient see the intimate connection between cognition and emotion.

A frequent requirement in the early stage of therapy is to socialize the patient to cognitive therapy. Particularly if they have previously undertaken analytically oriented or Rogerian therapies, many patients begin cognitive therapy expecting a more insight-oriented, nondirective therapeutic approach. The cognitive therapist can facilitate the transition to a more active and structured one by maintaining a problem-oriented stance, which often entails gently interrupting patients who tend to speculate about the sources of their problems and seek interpretations from the therapist.

Finally, the therapist must communicate the importance of self-help homework assignments during the initial session. Therapists can do this by stressing that doing the homework is actually more important than the therapy session itself. The therapist can also provide incentive by explaining that patients who complete assignments generally improve more quickly. The nature and implementation of self-help homework assignments are considered in further detail in a later section of this chapter.

The Progress of a Typical Therapy Session

Each session begins with the establishment of an agenda for the session. This insures optimal use of time in a relatively short-term, problem-solving therapeutic approach. The agenda generally begins with a short synopsis of the patient's experiences since the last session, including discussion of the homework assignment. The therapist then asks the patient what he or she wants to work on during the session and often offers topics to be included.

When a short list of problems and topics has been completed, the patient and therapist determine the order in which to cover them and, if necessary, the time to be allotted to each topic. There are several issues to be considered in establishing priorities, including stage of therapy, severity of depression, likelihood of making progress in solving the problem, and potential pervasiveness of effect of a particular theme or topic. The cognitive therapist is sensitive to patients' occasional desires to talk about something that seems important to them at the moment, even if such discussion seems not to be productive in terms of other goals. This kind of flexibility characterizes the collaborative therapeutic relationship.

After these preliminary matters have been covered, the patient and therapist move on to the one or two problems to be considered during the session. The therapist begins the discussion of a problem by asking the patient a series of questions designed to clarify the nature of the patient's difficulty. In doing so, the therapist seeks to determine whether maladaptive assumptions, misinterpretations of events, or unrealistic expectations are involved. The therapist also seeks to discover whether the patient had unrealistic expectations, whether the patient's behavior was appropriate and whether all possible solutions to the problem were considered. The patient's responses will suggest to the therapist a cognitive-behavioral conceptualization of why the patient is having difficulty in the area concerned. The therapist will now have discerned the one or two significant thoughts, assumptions, images, or behaviors to be worked on. When this target problem has been selected, the therapist chooses the cognitive or behavioral techniques to apply and shares their rationale with the patient. The specific techniques used in cognitive therapy are explained in the following sections of this chapter.

At the close of the session, the therapist asks the patient for a summary, often in writing, of the major conclusions drawn during the session. The therapist asks for the patient's reactions to the session in order to ascertain whether anything disturbing was said and in order to forestall any delayed negative reactions following the interview. Finally, the therapist gives a homework assignment designed to assist the patient in applying the particular skills and concepts from the session to the problem during the following week.

Middle and Later Sessions

While the structure of cognitive therapy sessions does not change during the course of treatment, the content often changes significantly. Early sessions are aimed to overcoming hopelessness, identifying problems, setting priorities, socializing the patient to cognitive therapy, establishing the collaborative relationship, demonstrating the relationship between cognition and emotion, labeling errors in thinking, and making rapid progress on a target problem. Therapy is initially centered on the patient's symptoms, with attention given to behavioral

and motivational difficulties. Once the patient shows some significant changes in these areas, the emphasis shifts to the content and pattern of the patient's thinking. In the later sessions, the therapist and patient discuss the basic assumptions seen to result in vulnerability to depression.

In contrast to the initial sessions, middle and later sessions center on problems that demand greater probing to understand and change. More specifically, in an early session the therapist might use behavioral techniques to encourage the patient to become more active; in a later session he or she might work with the automatic thought "I'll never be able to advance in my career" or "No one can ever love me." In general, middle sessions focus on more complex problems that often involve several dysfunctional thoughts and behaviors. The therapist works to help the patient integrate concepts learned in earlier sessions. The homework assignments that are given require continual repetition and the application of specific rational responses to dysfunctional thoughts.

In the later sessions, when the patient is feeling less depressed, the therapist and patient turn from specific thoughts about particular problems to more general assumptions about self and life. Such "silent" assumptions as "Unless I perform perfectly I am a failure" and "You never get what you want in life" often underlie many of the patient's problems. These maladaptive assumptions are the rules and formulas by which developing individuals learned to "make sense" of the world, and the assumptions continue to determine how they organized perceptions into cognitions, set goals, evaluated and modified behavior, and understood events in their lives. Cognitive therapy aims at counteracting the effects of maladaptive assumptions and replacing learned techniques and methods with new approaches. If the maladaptive assumptions themselves can be changed, the patient will become less vulnerable to future depressions.

In the later sessions, the patient assumes increased responsibility for identifying problems, coming up with solutions, and implementing the solutions through homework assignments. The therapist increasingly assumes the role of advisor or consultant as the patient learns to implement therapeutic techniques without constant support. As the patient becomes a more effective problem solver, the frequency of sessions is reduced, and therapy is eventually discontinued.

COGNITIVE TECHNIQUES

The specific cognitive techniques provide points of entry into the patient's cognitive organization. The cognitive therapist uses techniques for eliciting automatic thoughts, testing automatic thoughts, identifying maladaptive assumptions, and analyzing the validity of maladaptive assumptions to help both therapist and patient understand the patient's construction of reality. In applying specific cognitive techniques in therapy, it is important that the therapist work within the framework of the cognitive model of depression. Each set of techniques will be discussed in turn.

Eliciting Automatic Thoughts

Automatic thoughts are those thoughts that intervene between outside events and the individual's emotional reactions to them. They often go unnoticed because they are part of a repetitive pattern of thinking and because they occur so often and so quickly. We rarely stop to assess their validity because they are so believable, familiar, and habitual. The patient in cognitive therapy must learn to recognize these automatic thoughts for therapy to proceed effectively. The cognitive therapist and the patient make a joint effort to discover the particular thoughts that precede such emotions as anger, sadness, and anxiety. Therapists use questioning, imagery, and role playing to elicit automatic thoughts.

The simplest method to uncover automatic thoughts is for the therapist to ask patients what thoughts went through their minds in response to particular events. This questioning provides patients with a model for introspective exploration that they can use on their own when the therapist is not present and after the completion of treatment.

Alternatively, when the patient is able to identify those external events and situations that evoke a particular emotional response, the therapist may use imagery by asking the patient to picture the situation in detail. The patient is often able to identify the automatic thoughts connected with actual situations when the image evoked is clear. In this technique, the therapist asks patients to relax, close their eyes, and imagine themselves in the distressing situation. Patients describe in detail what is happening as they relive the event.

If the distressing event is an interpersonal one, cognitive therapists can utilize role playing. The therapist plays the role of the other person in the encounter, while patients play themselves. The automatic thoughts can usually be elicited when patients become sufficiently engaged in the role play.

In attempting to elicit automatic thoughts, the therapist is careful to notice and point out any mood changes that occur during the session and to ask the patient's thoughts just before the shift in mood. Mood changes include any emotional reaction, such as tears or anger. This technique can be especially useful when the patient is first learning to identify automatic thoughts.

Once patients become more familiar with the techniques for identifying automatic thoughts, they are asked to keep a Daily Record of Dysfunctional Thoughts (Beck *et al.*, 1979; see Figure 4-1), in which they record the emotions and automatic thoughts that occur in upsetting situations between therapy sessions. In later sessions they are taught to develop rational responses to their dysfunctional automatic thoughts and to record them in the appropriate column. The therapist and patient generally review the Daily Record from the preceding week near the beginning of the next therapy session.

Eliciting automatic thoughts should be distinguished from the interpretation process of other psychotherapies. In general, the cognitive therapist works only with those automatic thoughts mentioned by patients. Suggesting thoughts to patients may undermine collaboration and might inhibit patients from learning to continue the process on their own. As a last resort, however, when

DATE	SITUATION Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of thoughts, daydream, or recollection, leading to unpleasant emotion.	EMOTION(S) 1. Specify sad/ anxious/ angry, etc. 2. Rate degree of emotion, 1-100.	AUTOMATIC THOUGHT(S) 1. Write automatic thought(s) that preceded emotion(s). 2. Rate belief in automatic thought(s), 0-100%.	RATIONAL RESPONSE 1. Write rational response to automatic thought(s). 2. Rate belief in rational response, 0-100%.	OUTCOME 1. Rerate belief in automatic thought(s), 0-100%. 2. Specify and rate subsequent emotions, 0-100.

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0% = not at all; 100% = completely. In rating degree of emotion: 1 = a trace; 100 = the most intense possible.

FIGURE 4-1. Daily Record of Dysfunctional Thoughts.

nondirective strategies fail, the cognitive therapist may offer several possible automatic thoughts, asking the patient whether any of the choices fit.

Even when many efforts to elicit automatic thoughts have been made by the therapist, sometimes the thought remains unavailable. When this is the case, the cognitive therapist tries to ascertain the particular meaning of the event that evoked the emotional reaction. For example, one patient began to cry whenever she had an argument with her roommate and friend. Efforts to elicit automatic thoughts proved unsuccessful. Only after the therapist asked a series of questions to determine the meaning of the event did it become clear that the patient connected having an argument or fight with the end of a relationship. Through this process, the therapist and patient were able to see the meaning that triggered the crying.

Testing Automatic Thoughts

When the therapist and patient have managed to isolate a key automatic thought, they approach the thought as a testable hypothesis. This "scientific" approach is fundamental to cognitive therapy, in which the patient learns to think in a way that resembles the investigative process. Through the procedures of gathering data, evaluating evidence, and drawing conclusions, the patient learns firsthand that one's view of reality can be quite different from what actually takes place. By designing experiments that subject their automatic thoughts to objective analysis, patients learn how to modify their thinking because they learn the *process* of rational thinking. Patients who learn to think this way during treatment will be better able to continue the empirical approach after the end of formal therapy.

The cognitive therapist approaches the testing of automatic thoughts by asking patients to list evidence from their experience for and against the hypothesis. Sometimes, after considering the evidence, patients will immediately reject the automatic thought, recognizing that it is either distorted or actually false.

When previous experience is not sufficient or appropriate to test a hypothesis, the therapist asks the patient to design an experiment for that purpose. The patient then makes a prediction and proceeds to gather data. When the data contradict the prediction, the patient can reject the automatic thought. The outcome of the experiment may, of course, confirm the patient's prediction. It is therefore very important that the therapist not assume the patient's automatic thought is distorted.

There are some automatic thoughts that do not lend themselves to hypothesis testing through the examination of evidence. In these cases, there are two options available: therapists may produce evidence from their own experience and offer it in the form of a question that reveals the contradiction; or the therapist can ask a question designed to uncover a logical error inherent in the

patient's beliefs. The therapist might say, for example, to a patient who is sure he cannot survive without a close personal relationship, "You were alone last year and you got along fine, what makes you think you can't make it now?"

In testing automatic thoughts, it is sometimes necessary to refine the patient's use of a word. This is particularly true for global labels such as "bad," "stupid," or "selfish." What is needed in this case is an operational definition of the word. To illustrate, a patient at our clinic had the recurring automatic thought, "I'm a failure in math." The therapist and patient had to narrow down the meaning of the word before they could test the thought. They operationalized "failure" in math as being unable to achieve a grade of "C" after investing as much time studying as the average class member. Now they could examine past evidence and test the validity of the hypothesis. This process can help patients to see the all-inclusiveness of their negative self-assessments and the idiosyncratic nature of many automatic thoughts.

• Reattribution is another useful technique for helping the patient to reject an inappropriate self-blaming thought. It is a common cognitive pattern in depression to ascribe blame or responsibility for adverse events to oneself. Reattribution can be used when the patient unrealistically attributes adverse occurrences to a personal deficiency such as lack of ability or effort. The therapist and patient review the relevant events and apply logic to the available information to make a more realistic assignment of responsibility. The aim of reattribution is not to absolve the patient of all responsibility, but to examine the many factors that help contribute to adverse events. Through this process, patients gain objectivity, relieve themselves of the burden of self-reproach, and can then search for ways to solve realistic problems or prevent a recurrence. Another strategy involving reattribution is for the therapist to demonstrate to patients that they use stricter criteria for assigning responsibility to their own unsatisfactory behavior than they use in evaluating the behavior of others. Cognitive therapists also use reattribution to show patients that some of their thinking or behavior problems can be symptoms of depression (e.g., loss of concentration) and not signs of physical decay.

When the patient is accurate in identifying a realistic life problem or skill deficit, the cognitive therapist can use the technique of generating alternatives, in which therapist and patient actively search for alternative solutions. Because the depressed person's reasoning often becomes restricted, an effort to reconceptualize the problem can result in the patient's seeing a viable solution that may previously have been rejected.

It should be noted that the cognitive techniques outlined above all entail the use of questions by the therapist. A common error we observe in new cognitive therapists is an exhortative style. We have found that therapists help patients to change their thinking more effectively by using carefully formed questions. If patients are prompted to work their own way through problems and reach their own conclusions, they will learn an effective problem-solving process. We will elaborate on the use of questioning in cognitive therapy later in the chapter.

Identifying Maladaptive Assumptions

Maladaptive assumptions are the themes connecting the automatic thoughts of patients across situations and over time. They govern, for example, what patients consider right or wrong in judging themselves and others. The therapist can discern these patterns only through careful observation; although some themes can be found in the beliefs of many depressed patients, each individual patient has a unique set of personal rules. Time and effort are required to uncover and modify the specific maladaptive assumptions of a particular patient.

While it is usually fairly easy for most patients to learn to identify their automatic thoughts, it is more difficult for them to identify the underlying assumptions. These assumptions are much less accessible. Some typical unarticulated assumptions include, "In order to be happy, I must be wealthy" and "If I don't have a husband, I'm nobody." While everyone has underlying rules, maladaptive assumptions differ from adaptive ones in being rigid and excessive. They are framed in absolute terms, are unrealistic, and are used too frequently and inappropriately.

Maladaptive assumptions are especially problematic when individual patients have to cope with events that expose their unique vulnerabilities, such as acceptance and rejection, health and sickness, or gain and loss. For example, a patient who held the belief that he had to be perfect placed a high value on career performance. He assessed his own worth on the basis of how well he could accomplish work tasks and how many goals he could achieve. When he was laid off from his job, he believed that he no longer had any value as a person and became severely depressed. In order to identify maladaptive assumptions, cognitive therapists listen for themes that radiate through different situations or problem areas.

When the therapist believes he or she has identified a particular maladaptive assumption, he or she can make a list of several related automatic thoughts that the patient has already expressed and ask the patient to abstract the general rule that underlies the thoughts. If the patient cannot do this, the therapist uses a technique similar to the questioning used in the testing of automatic thoughts: The therapist appeals to the patient's logic by suggesting a plausible assumption, listing the thoughts that follow from it, and asking the patient if the assumption seems to fit. During the questioning process, the therapist is careful not to influence the patient's response. The therapist should be open to the possibility that his or her plausible assumption is not necessarily correct and be ready to join the patient in an effort to find a more accurate statement. Again, it is precisely this kind of flexibility that characterizes optimal collaboration between therapist and patient in cognitive therapy.

A priority in the later stages of cognitive therapy is to help patients identify and challenge those particular maladaptive assumptions that contribute to their vulnerability to depression. For both practical and therapeutic reasons, the pa-

tient must be actively involved in this process. In order to emphasize the importance of altering maladaptive assumptions, the therapist can tell the patient that even though depressive symptoms have abated, vulnerability to depression often remains unless these beliefs are identified and changed.

Analyzing the Validity of Maladaptive Assumptions

Identifying a maladaptive assumption is the first major step toward changing it. Sometimes patients see its absurdity or maladaptiveness immediately once the thought is verbalized and thus no longer hidden. The process of identification itself may be helpful, since many assumptions have never been tested or questioned by patients.

Questioning the patient is generally the most effective approach to modify maladaptive underlying assumptions. While the therapist could offer numerous counterarguments, patients do not seem to change their beliefs based on the number of counterarguments, but because a particular argument makes sense to them. One or two new ways of looking at a situation are often instrumental in changing long-held beliefs.

One approach to modification, once an assumption has been uncovered, is for the therapist to ask the patient if the assumption seems reasonable. If the patient does not see the problems inherent in the assumption, the therapist asks questions designed to reveal them. For example, if a patient believes he or she should put effort into everything, the therapist can disclose, through a series of questions, the problem of putting effort into relaxation.

An effective alternative approach to questioning the logic and consequences of a maladaptive assumption is to have the patient gather evidence against the assumption, either alone or in collaboration with the therapist. The cognitive therapist is careful not to argue with the patient; instead, the therapist seeks to guide and collaborate with the patient in the process of developing evidence. Challenges to the patient's assumptions should be offered in the form of questions and suggestions of alternative assumptions, not in the form of a lecture or argument. When possible, the therapist should work to support the patient's adaptive beliefs since adaptive beliefs can sometimes be effectively used to counter maladaptive ones.

Therapists can also help patients question their assumptions by working with them to make a list of the advantages and disadvantages of modifying the assumption. When the list has been completed, the therapist and patient can discuss the consequences of altering the assumption or weigh the long-term and short-term advantages and disadvantages of particular maladaptive assumptions.

Finally, the behavioral strategy known as "response prevention" can sometimes be used effectively to help patients move beyond their assumptions about what they should ideally do in a given context. Once the rule has been disclosed, an experiment is designed to test what would happen if the patient acted contrary to the "should." The patient predicts the result, carries out the experiment, and discusses the results with the therapist. It is often helpful to subdivide the experiment into discrete graded tasks so the patient can try less threatening changes before more difficult ones.

BEHAVIORAL TECHNIQUES

Behavioral techniques are used throughout the course of cognitive therapy but are generally concentrated in the earlier stages of treatment. Behavioral techniques are especially necessary for those more severely depressed patients who are passive, anhedonic, socially withdrawn, and unable to concentrate for extended periods of time. By engaging the patient's attention and interest, the cognitive therapist tries to induce the patient to counteract withdrawal and become more involved in constructive activity.

The therapist selects from a variety of behavioral techniques those which will help the patient cope more effectively with situational and interpersonal problems. Through homework assignments, patients implement specific procedures for dealing with concrete situations or for using time more adaptively.

The cognitive therapist uses behavioral techniques with the goal of modifying automatic thoughts. For example, a patient who believes "I can't stay with anything anymore" can modify this thought after completing a series of graded tasks designed to increase mastery. The severely depressed patient is caught in a vicious cycle in which a reduced activity level leads to negative self-label which, in turn, results in even further discouragement and consequent inactivity. Intervention with behavioral techniques can enter and change this self-destructive pattern.

The most commonly used behavioral techniques include scheduling activities that include both mastery and pleasure exercises, cognitive rehearsal, self-reliance training, role playing, and diversion techniques. The scheduling of activities is frequently used in the early stages of cognitive therapy to counteract loss of motivation, hopelessness, and excessive rumination. The therapist uses an activity schedule for planning activities hour-by-hour, day-by-day (see Figure 4-2). Patients maintain an hourly record of the activities that they engaged in. Activity scheduling also helps patients obtain more pleasure and a greater sense of accomplishment from activities on a daily basis. The patients rate each completed activity (using a 0–10 scale) for both mastery and pleasure. The ratings usually contradict patients' beliefs that they cannot accomplish or enjoy anything anymore. In order to assist some patients in initiating mastery and pleasure activities, the therapist sometimes finds it necessary to subdivide an activity into segments ranging from the simplest to the most difficult and complex aspects of the activity. We call this the "graded task" approach. The subdivision enables depressed patients to undertake tasks that were initially impossible and thus provides proof of success.

Cognitive rehearsal entails asking the patient to picture or imagine each step involved in the accomplishment of a particular task. This technique can be

Note. Grade activities *M* for mastery and *P* for pleasure 0–10.

		Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Morning	6-7							
	7-8							
	8-9							
	9-10							
	10-11							
	11-12							
Afternoon	12-1							
	1-2							
	2-3							
	3-4							
	4-5							
	5-6							
Evening	6-7							
	7-8							
	8-9							
	9-10							
	10-11							
	11-12							
	12-6							

Remarks:

FIGURE 4-2. Weekly Activity Schedule.

especially helpful with those patients who have difficulty carrying out a task that requires successive steps for its completion. Sometimes impairment in the ability to concentrate creates difficulties for the patient in focusing attention on the specific task. The imagery evoked by the cognitive rehearsal technique helps the patient to focus and helps the therapist to identify obstacles that make the assignment difficult for the particular patient.

Some depressed patients rely on others to take care of most of their daily needs. With self-reliance training, patients learn to assume increased responsibility for routine activities such as showering, making their beds, cleaning the house, cooking their own meals, and shopping. Self-reliance involves gathering increased control over emotional reactions.

Role playing has many uses in cognitive therapy. It may be used to bring out automatic thoughts through the enactment of particular interpersonal situations, such as an encounter with a supervisor at work. Role playing may also be used, through homework assignments, to guide the patient in practicing and attending to new cognitive responses in problematic social encounters. A third use of role playing is to rehearse new behaviors. Thus, role playing may be used as part of assertiveness training and is often accompanied by modeling and coaching.

Role reversal, a variation of role playing, can be very effective in helping patients test how other people might view their behavior. This is well illustrated by a patient who had a "humiliating experience" while buying some clothes in a store. After playing the role of the clerk, the patient had to conclude that she had insufficient data for her previous conclusion that she appeared clumsy and inept. Through role reversal, patients begin to view themselves less harshly as "self-sympathy" responses are elicited.

Finally, the therapist may introduce various diversion techniques to assist the patient in learning to reduce the intensity of painful affects. The patient learns to divert negative thinking through physical activity, social contact, work, play, and visual imagery. Practice with diversion techniques also helps the patient gain further control over emotional reactivity.

QUESTIONING

As we have stressed throughout this chapter, questioning is a major therapeutic device in cognitive therapy. A majority of the therapist's comments during the therapy session are questions. Single questions can serve several purposes at one time, while carefully designed series of questions can help the patient consider a particular issue, decision or opinion. The cognitive therapist seeks through questioning to elicit what patients are thinking; the therapist tries to avoid telling patients what he or she believes they are thinking.

In the beginning of therapy, questions are employed to obtain a full and detailed picture of the patient's particular difficulties. They are used to obtain background and diagnostic data; to evaluate the patient's stress tolerance, capacity for introspection, coping methods, and so on; to obtain information about the patient's external situation and interpersonal context; and to modify vague complaints by working with the patient to arrive at specific target problems to work on.

As therapy progresses, the therapist uses questioning to explore approaches to problems, to help the patient to weigh advantages and disadvantages of possible solutions, to examine the consequences of staying with particular maladaptive behaviors, to elicit automatic thoughts, and to demonstrate maladaptive underlying assumptions and their consequences. In short, the therapist uses questioning in most cognitive therapeutic techniques.

While questioning is itself a powerful means of identifying and changing automatic thoughts and maladaptive assumptions, it is important that the questions be carefully and skillfully posed. If questions are used to "trap" patients into contradicting themselves, patients may come to feel that they are being attacked by the therapist or manipulated. Too many open-ended questions can leave patients wondering what the therapist expects of them. Therapists must carefully time and phrase questions to help patients recognize their thoughts and assumptions and to weigh issues objectively.

SELF-HELP HOMEWORK ASSIGNMENTS

Rationale

Regular homework assignments are very important in cognitive therapy. When patients systematically apply what they have learned during therapy sessions to their outside lives, they are more likely to make significant progress in therapy and to be able to maintain their gains after termination of treatment. Homework assignments are often the means through which patients gather data, test hypotheses, and thus begin to modify maladaptive assumptions. In addition, the data provided through homework assignments help to shift the focus of therapy from the subjective and abstract to more concrete and objective concerns. When the patient and therapist review the previous week's activities during the agenda-setting portion of the interview, they may do so quickly, and the therapist can draw relationships between what takes place in the session and specific tasks, thereby avoiding tangents and side issues. Homework assignments further the patient's self-reliance and provide methods for the patient to continue working on problems after the end of treatment. Cognitive therapists emphasize the importance of homework by sharing with patients their rationale for assigning homework in therapy. They are also careful to explain the particular benefits to be derived from each individual assignment.

Assigning and Reviewing Homework

The cognitive therapist designs each assignment for the particular patient. The assignment should be directly related to the content of the therapy session so that the patient understands its purpose and importance. Each task should be clearly articulated and very specific in nature. Near the end of each session, the assignment is written in duplicate, with one copy going to the therapist and one to the patient.

Some typical homework assignments include reading a book or article about a specific problem, practicing diversion or relaxation techniques, counting automatic thoughts on a wrist counter, rating activities for pleasure and mastery on the activities schedule, maintaining a Daily Record of Dysfunctional Thoughts, and listening to a tape of the therapy session.

During the therapy session, therapists ask for patients' reactions to homework assignments. They ask, for example, whether the assignment is clear and manageable. In order to determine potential impediments, the therapist may ask the patient to imagine taking the steps involved in the assignment. This technique can be especially helpful during the earlier stages of therapy. The patient assumes greater responsibility for developing homework assignments as therapy progresses through the middle and later stages.

It is essential that the patient and therapist review the previous week's homework during the therapy session itself. If they do not do this, the patient may conclude that the homework assignments are not important. During the first part of the therapy session, the therapist and patient discuss the last week's assignment, and the therapist summarizes the results.

Difficulties in Completing Homework

When patients do not complete their homework assignments, or do them without conviction, cognitive therapists elicit automatic thoughts, assumptions, or behavioral problems that may help both therapist and patient understand where the difficulty resides. The therapist does not assume that the patient is being "resistant" or "passive-aggressive." When the difficulties have been successfully identified, the therapist and patient work collaboratively to surmount them. It is, of course, common for patients to have difficulties in completing homework, and we will consider some of the typical problems and ways to counteract them.

When patients do not understand the assignment completely, the therapist should explain it more fully, specifying his or her expectations in detail. Sometimes using the behavioral technique of cognitive rehearsal (described above) can be helpful in such situations.

Some patients believe that they are naturally disorganized and cannot maintain records and follow through on detailed assignments. The therapist can usually help invalidate such general beliefs by asking patients about other circumstances in which they make lists; for example, when planning a vacation or shopping trip. The therapist can also ask these patients whether they could complete the assignment if there were a substantial reward entailed. This kind of question helps make the patient recognize that self-control is not the problem; rather, the patient does not believe that the reward is great enough. When the patient comes to see that the problem is an attitudinal one, the therapist and patient can proceed to enumerate the advantages of completing the assignment.

More severely depressed patients may need assistance to structure their time so that homework becomes a regular activity. This can generally be accomplished by setting a specific time each day for the homework assignment. If necessary, the patient and therapist can set up a reward or punishment system to make sure that the homework gets done. For example, patients can reward themselves for doing the assignment with a special purchase or punish themselves for not doing it by not watching a favorite television program.

Some patients are afraid of failing the assignments or of doing them inadequately. In these cases, the therapist can explain that self-help assignments cannot be failed: Doing an assignment partially is more helpful than not doing it at all, and mistakes provide valuable information about problems that still need to be worked on. In addition, since performance is not evaluated, patients cannot lose if they view the activity from a more adaptive perspective.

Sometimes patients believe their problems are too deeply embedded and complex to be resolved through homework assignments. The therapist can

explain to these patients that even the most complex undertakings begin with and consist of small concrete steps. Some writers, for example, resolve their "writers' blocks" by taking the attitude, "If I can't write a book, I can at least write a paragraph." When enough paragraphs have been written, the result is a book. The therapist and patient can consider the advantages and disadvantages of the patient's believing that problems cannot be solved by doing homework. Or the therapist can ask the patient to experiment before reaching such a conclusion. In those instances where the patient believes that he or she has not made enough progress, and therefore that the homework is not helpful, the therapist can detail the progress the patient has made or can help the patient see that it may take more time before substantial change can be perceived.

When patients seem to resent being given assignments, the therapist can encourage them to develop their own assignments. The therapist might also offer the patient alternative assignments from which to choose, making one of the alternatives noncompliance with homework assignments. If patients choose noncompliance, the therapist can help to examine the consequences of that choice. Still another strategy is to present patients with a consumer model of therapy: Patients have a certain goal (overcoming depression) and the therapist has a means of achievement to offer; patients are free to use or reject the tools, just as they are free to buy or not buy in the marketplace.

When patients believe that improvement can be made just as readily without homework, therapists have two options. They can offer their own clinical experience that most patients who held that opinion were proven wrong and progressed more slowly in therapy. The other option is to set up an experiment for a given period of time, during which patients do not have to complete assignments. At the end of the predetermined period, the therapist and patient can evaluate the patient's progress during that time interval. Once again, it is important that the cognitive therapist keep an open mind: some patients do indeed effect significant change without formally completing homework assignments.

SPECIAL PROBLEMS

The novice cognitive therapist often makes the error of staying with the standard method outlined above even if it is not working very well. The cognitive therapist should be flexible enough to adapt to the needs of patients and to the several special problems that commonly arise in therapy. We have grouped these special problems into two categories: difficulties in the therapist-patient relationship, and problems in which the therapy itself seems not to be working.

Problems in the Therapist-Patient Relationship

The first set of problems concerns the therapist-patient relationship itself. When the therapist first perceives a patient to be dissatisfied, angry, or hostile, it is

imperative that the therapist present the patient with these observations. The therapist can then ask about the accuracy of the observations, the patient's feelings, and thoughts the patient has about the therapist. It is essential that therapists be aware that many interventions can be misinterpreted by depressed patients in a negative way.

With problems of misinterpretation, therapists approach the thought in the same way that they approach other thoughts: They work with the patient to gather data and search for alternative accounts of the evidence. Difficulties in the therapist-patient relationship can generally be resolved through dialogue. There are times when therapists may need to tailor behavior to the particular needs of the individual patient. For instance, therapists may become freer with self-disclosure and personal reactions to meet the needs of patients who persist in seeing the therapist as impersonal. Similarly, therapists can make a point of checking formulations of the patients' thoughts more frequently to meet the needs of patients who continue to believe the therapist does not understand them.

It is imperative in situations like these that the therapist not assume that the patient is being stubbornly resistant or irrational. Cognitive therapists collaborate with patients to achieve a better understanding of patients' responses. The reactions themselves often provide data regarding the kinds of distortions patients make in their other social and personal relationships. The patients' responses therefore give the therapist the opportunity to work with patients on their maladaptive interpretations in relationships.

Problems with the Rate of Progress

A second set of problems occurs when the therapy appears not to be working even when patients conscientiously complete homework assignments and the collaborative relationship seems successful. Sometimes problems stem from inappropriate expectations on the part of the patient—or unrealistic expectations on the part of the therapist—regarding the rapidity and consistency of change. When therapy seems not to be progressing as quickly as it "should," both patient and therapist must remember that ups and downs are to be anticipated in the course of treatment. It is important for therapists to keep in mind that some patients simply progress more slowly than others. The therapist or patient, or both, may be minimizing small changes that have indeed been taking place. In this case the therapist can emphasize the small gains that have been made and remind the patient that large goals are attained through small steps toward them.

At times, patients' hopelessness can lead them to invalidate their gains. Therapists should seek to uncover the thoughts and maladaptive assumptions that contribute to the pervasive hopelessness. In these cases, therapists must work to correct mistaken notions about the process of change and about the nature of depression before further progress in therapy can occur.

In some cases where therapy seems not to be working successfully, it may

be that some of the therapeutic techniques have not been correctly used. Problems often arise when patients do not really believe the rational responses or are not able to remember them in times of emotional distress. It is important that the therapist determine the amount of belief the patient has in the rational responses and help the patient use the new responses as closely as possible to the moment when the automatic thought occurs. To the patient who does not fully believe a rational response, the therapist can ask the patient to take an experimental stance, to take the new belief and "try it on for size." The patient who cannot think of answers because of emotional upset should be told that states of emotional distress make reasoning more difficult and that thoughts such as "If this doesn't work, nothing will" can only aggravate the problem. Patients should be assured that they will be able to think of rational responses more readily with practice.

Another problem deriving from the misapplication of cognitive therapy techniques occurs when the therapist uses a particular technique inflexibly. It is often necessary for the therapist to try out several behavioral or cognitive techniques before finding an approach to which the patient responds well. The cognitive therapist must stay with a particular technique for a while to see if it works, but he or she must also be willing to try an alternative technique when it becomes apparent that the patient is not improving. To give a specific example, behavioral homework assignments are sometimes more helpful with particular patients, even though the therapist has every reason to predict in advance that cognitive assignments will be more effective.

In some instances where it appears that little progress is being made in therapy, it turns out that the therapist has selected a tangential problem. The cognitive therapist should be alert to this possibility, especially during the early stages of therapy. When there appears to be little or no significant change in depression level, even when the patient seems to have made considerable progress in a problem area, the therapist should consider the possibility that the most distressing problem has not yet been uncovered. A typical example of this kind of difficulty is the patient who presents difficulty at work as the major problem when it turns out that marital problems are contributing significantly to the work difficulties. The real issue may be withheld by a patient because it seems too threatening.

Finally, cognitive therapy is not for everyone. If the therapist has tried all available approaches to the problem and has consulted with other cognitive therapists, it may be best to refer the patient to another therapist, either with the same or a different therapeutic orientation.

Regardless of why therapy is not progressing satisfactorily, cognitive therapists should attend to their own cognitions. They must maintain a problem-solving stance and not allow themselves to be influenced by their patients' despair or to see themselves as incompetent. Hopelessness in patient or therapist is an obstacle to problem solving. If therapists can effectively counteract their own negative self-assessments and other dysfunctional thoughts, they will be better able to concentrate on helping patients find solutions to their problems.

CASE STUDY

In the case study that follows, we will describe the course of treatment for a depressed woman seen at our clinic. Through the case study we will illustrate many of the concepts described earlier in this chapter, including the eliciting of automatic thoughts, the cognitive triad of depression, collaborative empiricism, structuring a session, and feedback.

Assessment and Presenting Problems

The patient, whom we will call Irene, phoned the Center for help because she had heard about cognitive therapy on a local radio show. Irene recognized that she was experiencing many of the symptoms of depression described on the program.

She went through the typical assessment procedure at the Center, which consists of 1½ hr of a standard clinical interview and an additional 1½ hr of paper-and-pencil testing.

The intake interviewer reported that Irene was a 29-year-old Caucasian woman, living with her husband and two young children. She was a high school graduate who had stopped work after marrying. Irene described her major problems as depression (for the past few years), difficulty coping with her children, marital conflict, and a sense of "being kept back" by her husband. In terms of her marriage, Irene said she felt stigmatized because her husband had just been released from a drug abuse center. Furthermore, her husband had just been laid off from work and was thus unemployed. He refused to participate in marital counseling with her.

Irene said she had been socially isolated since her marriage, although she reported having had normal friendships as a child and teenager. One factor that she felt made it difficult for her to socialize with other women in the neighborhood was her belief that they looked down on her because she had such poor control over her children and because of her husband's drug record.

The interviewer diagnosed the patient as having major depressive disorder on Axis I and dependent personality on Axis II. Her test scores verified the diagnosis of depression. Irene's Beck Depression Inventory (BDI) score was 29, placing her in the moderate-to-severe range of depression. Her most prominent depressive symptoms included: guilt, self-blame, loss of pleasure, irritability, social withdrawal, inability to make decisions, fatigue, difficulty motivating herself to perform daily functions, and loss of libido. Her Young Loneliness Inventory score (Young, 1982) was 30, indicating an extremely high degree of loneliness. We use this scale because we have observed clinically that depression is often related to lack of satisfaction with interpersonal relationships. The Young Inventory is similar in format to the Beck Depression Inventory and assesses the extent to which patients are distressed by the absence of various types of friendships and intimate ties. Irene also received a high score on the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978). We use the DAS

to assess the most frequently observed maladaptive underlying assumptions. Careful analysis of patient responses to this scale are often useful to the therapist in identifying key assumptions that can later become targets of treatment, as described earlier in this chapter.

First Session

Irene was treated initially by the first author (Beck). Since an intake interview had already been completed by another therapist, Beck did not spend time reviewing symptoms in detail or taking a history. The session began with Irene describing the "sad states" she was having. Beck almost immediately started to elicit her automatic thoughts during these periods[1]:

THERAPIST: What kind of thoughts were you having during these 4 days when you said your thoughts kept coming over and over again?

PATIENT: Well, they were just—mostly, "Why is this happening again"—because, you know, this isn't the first time he's been out of work. You know, "What am I going to do"—like I have all different thoughts. They are all in different things like being mad at him, being mad at myself for being in this position all the time. Like I want to leave him or if I could do anything to make him straighten out and not depend so much on him. There's a lot of thoughts in there.

T: Now can we go back a little bit to the sad states that you have. Do you still have that sad state?

P: Yeah.

T: You have it right now?

P: Yeah, sort of. They were sad thoughts about—I don't know—I get bad thoughts, like a lot of what I'm thinking is bad things. Like not—there is like, ah, it isn't going to get any better, it will stay that way. I don't know. Lots of things go wrong, you know, that's how I think.

T: So one of the thoughts is that it's not going to get any better?

P: Yeah.

T: And sometimes you believe that completely?

P: Yeah, I believe it, sometimes.

T: Right now do you believe it?

P: I believe—yeah, yeah.

T: Right now you believe that things are not going to get better?

P: Well, there is a glimmer of hope but it's mostly . . .

T: What do you kind of look forward to in terms of your own life from here on?

P: Well, what I look forward to—I can tell you but I don't want to tell you. (*Giggles.*) Um, I don't see too much.

1. The case transcript from which this material was excerpted has been copyrighted by the Center for Cognitive Therapy and is reproduced by permission from the Center.

T: You don't want to tell me?

P: No, I'll tell you but it's not sweet and great what I think. I just see me continuing on the way I am, the way I don't want to be, like not doing anything, just being there, like sort of with no use, that like my husband will still be there and he will, you know, he'll go in and out of drugs or whatever he is going to do, and I'll just still be there, just in the same place.

By inquiring about Irene's automatic thoughts, the therapist began to understand her perspective—that she would go on forever, trapped, with her husband in and out of drug centers. This illustrates the hopelessness about the future that is characteristic of most depressed patients. A second advantage to this line of inquiry is that the therapist introduced Irene to the idea of looking at her own thoughts, which is central to cognitive therapy.

As the session continued, the therapist probed the patient's perspective regarding her marital problems. The therapist then made a decision not to focus on the marriage as the first therapeutic target, since it would probably require too much time before providing symptom relief. Instead, the therapist chose to focus on Irene's inactivity and withdrawal. This is frequently the first therapeutic goal in working with a severely depressed patient.

In the sequence that follows, the therapist guides Irene to examine the advantages and disadvantages of staying in bed all day:

PATIENT: Usually I don't want to get out of bed. I want to stay there and just keep the covers up to my head and stay there, you know. I don't want to do anything. I just want to be left alone and just keep everything out, keep everything away from me.

THERAPIST: Now, do you feel better when you get under the covers and try to shut everything out?

P: Yeah.

T: You do feel better?

P: Yeah, I feel better that way.

T: And so how much time do you spend doing that?

P: Now, lately? I don't get to do it too much because I have two kids. I don't ever really get to do it all that much. I would love to do it more. It would help. I mean I feel safe, sort of secure, like they are over on the other side of the wall and they are not near me.

T: Now after you have spent some time in the covers, how do you feel about yourself?

P: If I'm laying there, I don't know.

T: Let's say afterwards?

P: Afterwards? I don't usually have any bad feeling about—oh yeah, I do, I feel like, Oh Christ, you've been laying there doing nothing, you should have been doing this, you should have been doing that, you should have got up and done something, whatever it is I was suppose to do. You know, even when I'm there, I'm not making any solutions to any problems, I'm just there.

T: On the one hand you seem to enjoy and on the other hand afterwards you're a little bit critical of yourself?

Note that the therapist does not try to debate or exhort Irene to get out of bed. Rather, through questioning, he encourages her to examine more closely her assumption that she is really better off in bed. This is the process we call collaborative empiricism. By the second session, Irene had reexamined her hypothesis about remaining in bed:

PATIENT: About staying in bed versus getting up, I thought about that the other day. I thought when I told you—like I said something about like keeping the bad things away from me. Like when I was under the covers or just staying in bed they weren't really kept away from me. Like I always felt like I was always beating them down, I always had to ward them off. I don't know. I thought I told you it made me feel better to stay there, but I don't know if it really did. I don't think it did now that I am thinking about it.

THERAPIST: It is funny then that when you talked about it your recollection was that it actually was comforting, but that sometimes happens with people. It happens to me too. I think that something is really good that's not so hot when I actually check it out.

Returning to the first session, after some probing by the therapist, Irene mentioned that cognitive therapy "is like my last hope." The therapist used this as an opportunity to explore her hopelessness and suicidal thinking:

THERAPIST: What was going through your mind when you said "This is my last hope"? Did you have some kind of a vision in your mind?

PATIENT: Yeah, that if it doesn't work out that I don't think that I could take living like this the rest of my life.

T: If it doesn't work out, then what?

P: Then I wouldn't really care what happened to me.

T: Did you have something more concrete in mind?

P: Well, right this minute I don't think I could commit suicide but maybe if afterwards I thought there was nothing left, I could. I don't know though, I thought about suicide before but I have never been able to bring myself to do it. I've come close but I've never been able to succeed. I know little certain things stop me like my kids, I don't think—even though I sometimes think I'm not as good a mother as I could be—I think they would be a lot worse off with my husband. I think it would destroy some other people, like my mother if I did something like that, you know. That is what I think mainly stops me, my children and my mother. Just that they would—I guess I'm afraid that if I did something like that, maybe my mother would feel that she failed somewhere, which is not true, I don't think, and just about my kids. I couldn't trust my husband with my kids. I think it would really—even though I'm messed up—I think that he would mess them up more.

T: Now these are some of the reasons for not committing suicide, now what are some of the reasons why you wanted to, do you think?

P: Because sometimes it is just hopeless, there are no solutions, there's no—it continues constantly the same way, all the time.

The therapist wants the patient to feel as free as possible to discuss suicidal thoughts; thus, he tries hard to understand both the reasons for her hopelessness and the deterrents. After determining that she had no imminent plans to make an attempt (although she had made an attempt a couple of years earlier), the therapist said he would work with her to solve the problems in her life now and also "work things out inside you own head." He then asked her to select a small problem that they could work on together:

THERAPIST: Now is there any other smaller decisions that you could make that would affect your life right away?

PATIENT: I don't know. Well, I guess just trying—like for a long time I have been wanting to go out and do other things, like I don't know, join something, feel like I'm a part of something, you know, and I haven't been able to do it. I don't know if it's financial why I haven't been able to do it. I mean that is the excuse I come up with but I think sometimes it is not financial, sometimes it's just I don't get up and do it.

T: Well is there some specific group that you have in mind you could join?

P: I don't know. (*Giggles.*) I guess that is another decision I can't make. I think like everything interests me and nothing interests me.

T: Why don't we make a list and see what happens—a mental list? What are some of the things you would be interested in doing?

P: Tennis, I have been wanting to do that for a long time.

T: Now does this involve joining a tennis team?

P: Yeah, well that is what I would want to do.

T: Well, do you know people who belong to it?

P: No, I know other people but they don't belong to it in Philadelphia. Well, they do but I guess . . .

T: How would you go about finding out about a tennis team?

P: You would only have to go down to the nearest tennis court and that's it.

T: What would happen when you went down there?

P: I don't know. I have never been on one.

T: Well, what do you think you could do when you got there?

P: I guess you just—I don't know how many people are in one group. I don't know if you have to have a whole group go down with you and say OK we want to be a team, but I guess there are some people who are short of the whole group and then you could get on that team. You know, I guess.

T: Well, how could you get that information?

P: I guess if I went down there.

T: Do you think you could get the information if you went down there?

P: Yeah.
T: You could find out then whether you join as individuals or groups or how many, if they need somebody to fill in?
P: Yeah, uh-huh.
T: How do you feel about doing that?
P: Kind of stupid. (*Giggles.*)
T: Does it seem so trivial?
P: Yeah, it seems like well why didn't I just do it before.
T: Well, you probably had good reasons for not doing it before. Probably you were just so caught up in the hopelessness.
P: Right, right.
T: When you are hopeless you tend to deny, as it were, or cut off possible solutions. Remember when your husband lost his job, you said that you refused to accept the fact that he would get compensation?
P: Right.
T: When you get caught up in hopelessness then there is nothing you can do, is that what you think?
P: Yeah.
T: So then rather than be down on yourself because you haven't gone over before, why don't we carry you right through?

This excerpt illustrates the process of graded tasks that is so important in the early stages of therapy with a depressed patient. The therapist asked the patient a series of questions to break down the process of joining a tennis league into smaller steps. Irene realized that she had known all along what to do but, as the therapist pointed out, her hopelessness prevented her from seeing possible solutions:

PATIENT: First steps are really hard for me.
THERAPIST: First steps are harder for everybody, but that's why there is an old expression "A journey of a thousand miles starts with the first step."
P: That's very true.
T: Because that step—it's very important to take the first step. Then after taking the first step, and second step, and third step and so on. So all you have to do is take one and you don't have to take giant steps.
P: Well, yeah, I can see that now. I don't think I seen it before. I think before I was thinking every step was just as hard as the first step and maybe it's not that way at all, maybe it's easier.

In the second session, Irene reported success:

PATIENT: I called about the tennis and they said just to come in and give them your name. That's all you had to do, just come in and give them your name, which was really easy to do. It would have been a first step. I was surprised that it was so easy. I guess I thought it was going to be a lot harder, but it wasn't.

At the end of the first session, the therapist helped Irene write out an activity schedule for the coming week. The activities were quite simple, such as taking the children out, visiting her mother, reading a book, going shopping, and checking out the tennis team. Finally, the therapist asked her for feedback about the session and about her hopelessness:

THERAPIST: Do you have any reactions?
PATIENT: I know I went through stages from happy to sad to happy to sad to happy to sad.
T: Where are you at now?
P: Where am I at now? Half-decent.
T: Half-sad/half-happy?
P: No, a little more happier than I am sadder.
T: Now it may be that when you leave you'd be thinking that we haven't really worked on the big problems, and you have to have a way to answer that.
P: I guess I'll just say it will take a little more time.

Second Session

In the second session, the therapist began by collaborating with Irene to set an agenda. She wanted to discuss an argument she had with her husband and to deal with her feelings of inferiority; the therapist added the issue of activity versus inactivity to the agenda. They then reviewed the previous homework. Irene had carried out all the scheduled activities and had also listed some of her negative thoughts in between sessions. Her BDI score had dropped somewhat. (Patients routinely fill out the BDI before each session so that both the patient and the therapist can monitor the progress of treatment.)

Irene then shared her list of negative thoughts with the therapist. One concern was that she had cried during the first session:

PATIENT: Well, I know you are a professional but I felt like I was changed from one mood so easily to another. Like that sort of—when I interpreted it to myself, I felt like I could be manipulated and that was like—I don't know, I don't want to be easily led.
THERAPIST: Well, that's good. You had the thought then that I was manipulating you, that I was somehow pushing the buttons and turning the knobs?
P: Well, yeah.

The therapist offered Irene an alternative perspective:

THERAPIST: I would say just that I wasn't intending to manipulate you, that you yourself are not so gullible that you were easily manipulated. It is just that the way we were going through the interview, we were hitting some points that were sensitive and other points that were not so sensitive and when we

talked about the negatives, you felt worse and when we talked about some positive things, then you felt better or perhaps when you were able to work through some particular problem, get on top of it, made you feel better. Then we go on to another problem, you feel worse. So it was just the nature of the interview rather than having anything to do with you being weak and me being overpowering, manipulative. But that was very good, and going through this explanation again not only to give you the information but to show you how to cope with the negative thoughts.

This is an illustration of how a cognitive therapist can utilize events during the session to teach patients to identity their automatic thoughts and to consider alternative interpretations.

Irene next discussed her argument with her husband, and specifically her thought that maybe she should leave him. She and the therapist agreed that it might be better to wait until her depression lifted a little before trying to make such a major decision. We often recommend that depressed patients postpone major decisions until they are able to regain a realistic perspective on their lives.

The therapist provided a summary of the two key themes he had identified from listening to Irene's automatic thoughts about her husband and about therapy. The first theme was her fear of being controlled by other people (including the therapist); the second was that other people did not care about her. In the segment that follows, the therapist explains how he arrived at the conclusion that caring is an important schema for her:

THERAPIST: Like for instance, when you say the way your husband treats you, it sounded as though you were really bothered about his lack of concern for your feelings and wishes.

PATIENT: Yeah, yeah.

T: I don't want to make too much out of this at the moment, but you also said that after your second baby was born you had the feeling that nobody cared for you, namely, your family.

P: Well, I don't know what happened, I can't remember the circumstances of what happened.

T: But whatever it was, this was the upshot.

P: Yeah.

T: So one of the things that seizes you, can really grab hold and make you feel terrible, is this whole notion that nobody cares, and that even that you are so sensitive in that one area that you thought that we were just using you as a guinea pig here and they were just interested in seeing how I work and not interested in you, the clinic wasn't interested in you, and I wasn't interested in you. So again it seems to be this notion of people who are important not caring. Is that correct?

P: Yeah, in most instances, yeah.

T: In all the instances I have mentioned.

P: Yeah.

T: Well, what this tells us is that you have to be alert to the sense that they don't care because this can really make you feel bad. It may not even be correct. If you found out, for instance, that your mother does care, so that you are wrong in thinking that but still the thought came through very strongly and your current thought is that we don't care, or it was.

About halfway through the session, the therapist asks the patient for feedback thus far:

THERAPIST: Now at this point, is there anything that we have discussed today that bothered you?

PATIENT: That bothered me?

T: Yeah.

P: Uh, I'm feeling stupider and stupider as we go along.

T: That is important, OK. Can you . . .

P: Well, I'm trying not to but I don't know.

T: Well, if you are, you are. Why don't you just let yourself feel stupid and tell me about it.

P: Well, I just feel that I should be recognizing all these things, too.

This comment led to identification of a third key theme: that Irene had been viewing herself as increasingly dumb for the past few years. By this point, however, the patient was beginning to catch on to the idea of answering her thoughts more rationally. After the therapist pointed out the negative thought in the excerpt above, the patient volunteered:

PATIENT: I know what to do with the thought, "I'm stupid for not recognizing these things myself."

THERAPIST: What are you going to do with it right this minute?

P: I am going to say—"Well, you are the professional, you are suppose to see these things."

T: Right, you'd fire me if I didn't see them. Right?

P: I didn't think of that but (*laughs*) . . . no, I wouldn't fire you. I wouldn't fire anybody.

T: So what you are saying is that since I am professionally trained I can see certain things. The other thing is that other people are objective and can often see things in us much more readily than we can in ourselves. It just happens to be a fact of human nature.

P: Yeah.

The same automatic thoughts arose again later in the session, when Irene felt stupid for not knowing the answer to one of the therapist's questions. In the extended excerpt below, the therapist helps her set up an experiment to test the thought, "I look dumb":

THERAPIST: OK, now let's just do an experiment and see if you yourself can respond to the automatic thought and let's see what happens to your feeling. See if responding rationally makes you feel worse or makes you feel better.

PATIENT: OK.

T: OK, why didn't I answer that question right? I look dumb. What is the answer to that? What is the rational answer to that? A realistic answer?

P: Why didn't I answer that question? Because I thought for a second that was what I was suppose to say and then when I heard the question over again, then I realized that was not what I heard. I didn't hear the question right, that is why I didn't answer it right.

T: OK, so that is the fact situation. And so is the fact situation that you look dumb or you just didn't hear the question right?

P: I didn't hear the question right.

T: Or it is possible that I didn't say the question in such a way that it was clear.

P: Possible.

T: Very possible. I'm not perfect so it's very possible that I didn't express the question properly.

P: But instead of saying you made a mistake, I would still say I made a mistake.

T: We'll have to watch the video and see. Whichever. Does it mean if I didn't express the question, if I made the mistake does it make me dumb?

P: No.

T: And if you made the mistake, does it make you dumb?

P: No, not really.

T: But you felt dumb?

P: But I did, yeah.

T: Do you feel dumb still?

P: No.

The preceding exchange demonstrates the use of reattribution. At first, the patient attributed her difficulty answering him as evidence that she was stupid. As a result of the guided discovery approach, she reattributed the problem to one of two factors: either she didn't hear the question right or the therapist did not ask the question clearly enough. At the end of the experiment, Irene expressed satisfaction that she was finally recognizing this tendency to distort her appraisals:

PATIENT: Right now I feel glad. I'm feeling a little better that at least somebody is pointing all these things out to me because I have never seen this before. I never knew that I thought that I was that dumb.

THERAPIST: So you feel good that you have made this observation about yourself?

P: Right.

After summarizing the main points of the second session, the therapist assigned homework for the coming week: to fill out the Daily Record of Dysfunctional Thoughts (see Figure 4-1) and the Weekly Activity Schedule (with mastery and pleasure ratings) (see Figure 4-2).

Third Session

By the beginning of the third session, Irene's mood had visibly improved. She had joined a tennis league with her sister, and had begun to respond more rationally to her automatic thoughts about being dumb. In fact, she was practicing her cognitive therapy skills by helping a friend with a similar problem of self-blame. The primary agenda item Irene chose to work on was "how I back away from other people." She described an incident in which a neighbor was taking advantage of her, but she could not assert herself. In discussing her thoughts, Irene expressed a maladaptive underlying assumption that interfered with her behaving assertively:

PATIENT: I want to be a nice person. I don't want to cause a lot of trouble. I don't want to be fighting with everybody constantly. But I don't like myself when I give in too much too.

THERAPIST: Well, is it possible to be a nice person without giving in all the time?

P: I guess.

The therapist continued probing to understand why the patient believed that a nice person cannot get angry or be assertive. As the discussion progressed, it became obvious that, while in the abstract the patient could see that she was not necessarily bad because she got angry, in real-life situations Irene nevertheless felt she was wrong. The therapist's task next was to help the patient bring her rational thinking to bear on her distorted thinking *in the context of a concrete event*. At the therapist's request, Irene then described an argument in which she yelled at a nieghbor with good justification, yet felt she was bad. The therapist helped her use logic to evaluate her underlying assumption:

THERAPIST: You had the thought "I was wrong to get mad at her, to yell at her." It seems likely that you believe that thought and that the thought was right and that you were wrong. And since you thought that thought was right, you then had to wish to withdraw behind your hat, as it were.

PATIENT: Right.

T: Now, let's look at it. Do you think that thought is correct?

P: No, I don't see how it could have been correct.

T: So according to your own values, you don't think that it is wrong to stick up for your rights?

P: Right.

T: And do you think that you were sticking up for yourself when she called the cops for a car that is blocking her car?

P: Well, the car shouldn't have been blocking her car . . .

T: That wasn't—the question was, should she have called the cops?

P: No, I didn't call the cops when she put her car in the middle of both driveways.

T: Right. So, do you think that it is natural for anybody to get mad at someone who calls the cops over something like that?

P: Wait, what was that?

T: Let me put it again. Do you think it was natural for you to get mad in that situation?

P: Yeah.

T: OK, so you don't see anything wrong in getting mad?

P: No.

T: No. And yet you have the thought right after that that it was wrong to get mad and to yell at her?

P: Yeah, I did have that thought.

T: OK, now this is one of the problems. If you want to get over this sense of giving in all the time, one of the things that you can do is to look for this thought—I was wrong to do such and such a thing—and refer back to this conversation that we are having now and decide for yourself whether, indeed, you were wrong. Now if every time you asserted yourself in that particular way, you think—I was wrong to do that—you are going to feel bad and then you are not going to want to assert yourself again. Is that clear?

P: Uh-huh.

T: So we have to decide here and now, do you indeed think that you were wrong to assert yourself with her?

P: No.

T: Now the next time you get the thought—I was wrong, I shouldn't have said that, I shouldn't have stood up for my rights—how are you going to answer that thought?

P: If I was wrong? I wasn't wrong and I should stick up for my rights.

T: Now are you saying that because that is the answer or because you really believe it?

P: No, I believe it. I did the right thing there, I think. I did the right thing there. I did the right thing.

The therapist followed this discussion with a technique called "Point-Counterpoint" to help Irene practice rational responses to her automatic thoughts even more intensively. In this excerpt the therapist expresses the patient's own negative thinking, while she tries to defend herself more rationally:

THERAPIST: Now I am going to be like the prosecuting attorney and I'll say "Now I understand you were yelling at your neighbor because she called the cops. Is that true?"

PATIENT: Yeah.

T: Now it seems to me that that was a very bad thing for you to do.

P: No, it wasn't.

T: You don't think it was?

P: No, I should have hit her.

T: Well, you can sit there and say you should have hit her. I thought you said before that you wanted to be a nice person.

P: I was a nice person when I didn't call the cops when she blocked the driveway.

T: I know, but now you are saying that you are going to go out and hit her.

P: No, I wouldn't hit her. I wouldn't hit her unless she hit me.

T: Well, but still you yelled at her.

P: I yelled at her, yeah.

T: It doesn't seem to me that nice people yell at other people.

P: Well, I am still a nice person, but she did something wrong and I had to do something wrong.

T: Well, how can you still be a nice person if you yell at people?

P: How can you still be a nice person? You just are. You are a nice person. It is just that a nice person gets mad too.

T: You say a nice person gets mad too?

P: When somebody does something wrong to them.

T: Where did you ever get that idea that nice people get mad when they are wrong?

P: When the other person is wrong? Where did I get that idea? It's true.

T: You really believe that's true?

P: Yeah, nice people are the same as everybody else.

T: So, nice people can get mad?

P: Uh-huh.

Finally, the therapist returns to the underlying assumption and asks the patient how much she believes the new perspective:

THERAPIST: If you get mad, you are not a nice person. How do you believe that?

PATIENT: No.

T: Do you believe it partially?

P: Umm, no. Well, they don't get mad for nothing. They get mad when there is a reason.

T: OK, so right now would you say that you believe—now what about the belief—let's put it the other way, the belief that you can get mad and still be a nice person. How much do you believe that?

P: A hundred.

T: 100%?

P: Yeah.

T: You are sure 100%, not 90% or 80%?
P: No, I think 100%.

For the remainder of the third session, Irene and the therapist reviewed other instances of non-assertiveness to reinforce the main point of the session: that nice people can behave assertively and sometimes even get mad. The session ended with a summary of the main issues raised in the first three sessions.

Summary of the Initial Sessions

In the first three sessions, the therapist laid the groundwork for the remainder of treatment. He began immediately by teaching Irene to identify her negative automatic thoughts. By doing that the therapist began to understand her feelings of hopelessness and explored her suicidal ideation. By identifying her thoughts in a variety of specific situations, he was able to deduce several key themes that later proved central to Irene's thinking: the belief that other people did not care about her, that she could be easily controlled by others, that she was dumb, and that she would not be a nice person if she asserted herself. The therapist made especially skillful use of the patient's thoughts during the therapy session to help Irene see that she was distorting evidence about the therapeutic interaction and coming to the inaccurate conclusion that she was easily manipulated and dumb.

Beyond identifying thoughts and distortions, the therapist guided Irene to take concrete steps to overcome her inactivity and withdrawal: he asked her to weigh the advantages and disadvantages of staying in bed; broke down the task of joining a tennis group into small, manageable steps; and worked with her to develop an activity schedule to follow during the week.

Finally, the therapist employed a variety of strategies to demonstrate to Irene that she could test the validity of her thoughts, develop rational responses, and feel better. For example, during the course of the three sessions, the therapist set up an experiment, used reattribution, offered alternative perspectives, and practiced the Point–Counterpoint technique.

One final point we want to emphasize is that the primary therapeutic mode was questioning. Most of the therapist's comments were in the form of questions. This helped Irene to evaluate her own thoughts outside of the session and prevented her from feeling attacked by the therapist.

By the end of these initial sessions, Irene reported being more optimistic that her life could change. She was then transferred to another cognitive therapist, Dr. Judith Eidelson, for the remainder of treatment. (This transfer had been explained to the patient before she saw Dr. Beck.)

Later Sessions

The first issue Eidelson dealt with was Irene's belief that she was stupid. The patient began to fill out the Daily Record of Dysfunctional Thoughts and

gathered evidence that she was not as stupid as she believed. In fact, Irene brought up the possibility of taking a college course.

There were several obstacles: (1) Her husband had never given her keys to either their car or their house; (2) she did not have enough money to take the course; and (3) she worried that her husband would try to punish her if she tried to become more independent.

Dr. Eidelson set up several experiments with Irene to test a series of beliefs: that her husband would punish her; that she would fail at a job even if she could get one; and that she would fail a college-level course.

Through graded tasks, Irene asked her husband about obtaining keys, joined the tennis league, and began socializing with friends. Although her husband felt rejected and accused her of being stupid, he never took any active steps to stop her, despite her predictions. Irene then got a job as a waitress and again, contrary to her expectations, she was very successful and received a great deal of positive feedback on the job. Soon after getting the job, Irene enrolled in a sociology course and received a grade of A. At each step in the sequence, Irene would identify her automatic thoughts and respond to them, before taking the next step toward independence.

During the final sessions of therapy, the patient raised the issue of leaving her husband. The therapist worked with Irene to evaluate several thoughts and assumptions: (1)"Somehow he'll change and the marriage will work"; (2) "Marriage is a lifetime commitment"; (3) "I can't manage on my own"; and (4) "Leaving him would represent a failure to me." Irene eventually discarded each of these beliefs as invalid or unlikely, and decided to end the marriage. Shortly thereafter, Irene terminated therapy. She felt confident about herself and her decision, and her BDI score was in the normal range. The patient was successfully treated in 20 sessions.

CONCLUSION

There is mounting evidence that cognitive therapy is an effective, short-term treatment for adult outpatients with nonbipolar depressions. Cognitive therapy teaches patients to elicit their automatic thoughts, underlying assumptions, and early schemas. These cognitions are then "put to the test" by examining evidence, setting up *in vivo* experiments, weighing advantages and disadvantages, trying graded tasks, and employing other intervention strategies. Through this process, patients begin to view themselves and their problems more realistically, feel better, change their maladaptive behavior patterns, and take steps to solve real-life difficulties. These changes take place as a direct result of carefully planned, self-help assignments at home.

Throughout the treatment, cognitive therapists maintain a collaborative alliance with their patients. They are very active in structuring the session, yet go to considerable lengths to help patients reach conclusions on their own. The

therapist serves as a guide, helping the patient maneuver through a labyrinth of dysfunctional cognitions that need to be reevaluated.

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ALCOHOLISM

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McCrady cogently notes in this chapter that the treatment of alcoholics is unrewarding enterprise. Not only is treatment a difficult undertaking, but with alcoholics who are often uncooperative, or even disruptive to the clinician, can be frustrating and depressing. Furthermore, treating alcoh quires a broad and deep acquaintance with medical and social aspects of dr well as psychological interventions. On the other hand, there may be n reward than successfully working with a problem drinker who is then able t new life. The development of the techniques described in this chapter, which are very recent in origin, has made this possible in an increasing n cases, and McCrady, a very experienced clinician and clinical researcher, i clearly and in considerable detail how these techniques are administered v context of a typical case. McCrady takes note of the older conditioning an gency management approaches and then, based on the most recent data, a a behavioral-systems model, which emphasizes the importance of the so ronment. Once again, attention to the social context of treatment, partic role of the spouse or a significant other in treatment, is highlighted. In McCrady discusses at some length the variety of setting variables that are i as well as the data available on the desirability of outpatient, partial hospit or inpatient settings depending on the particular client with whom one is The actual components of treatment, consisting of detailed assessment, the tion of skills necessary for abstinence, as well as a discussion of the variet needed to deal with the causes of drinking are outlined in enough detail immediate implementation by a skilled clinician. Finally, as with any addicti ior, the emphasis on maintenance strategies and their description may be o more important parts of the chapter. Clinicians dealing with alcoholics or drinkers should find these step-by-step descriptions, as well as a disc factors that may predict success or failure, invaluable in their practice.—D

Clinicians generally have a negative view of alcoholism, and are pe about its treatment (Knox, 1971). For medical personnel, these attit often shaped by their early experiences in hospitals and inner-city en rooms, where they are exposed to alcoholics with long histories of t and failure and whose condition is complicated by chronic medical p

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