Among today’s clinical psychologists, cognitive therapy prevails. Surveys indicate a dramatic increase in the popularity of cognitive therapy, especially since the 1980s (e.g., Norcross & Karpak, 2012). In fact, far more contemporary clinical psychologists endorse cognitive therapy as their primary orientation than any other single-school approach. In short, “cognitive therapy clearly has become the prominent approach to psychotherapy in the early part of the 21st century” (K. S. Dobson, 2012, p. 112).

The attraction to the cognitive approach may stem from a variety of factors. Cognitive therapy strikes a balance among some of the other psychotherapeutic options. Like behavioral therapy, it tends to be brief, structured, and targeted. However, like psychodynamic therapy, it focuses on important mental processes. In some ways, cognitive therapy actually represents a reaction against both the behavioral and psychodynamic approaches. Two important historical developments occurred around the same time, beginning in the 1950s and 1960s, contributing to the development of cognitive therapy:

- **Strict applications of behavioral therapy**—techniques based on operant and classical conditioning—didn’t always work. Gradually, behavioral therapists and researchers began to recognize that cognition played a unique and important role in human behavior.
GOAL OF COGNITIVE THERAPY

Simply put, the goal of cognitive therapy is logical thinking. The word *cognition*, after all, is basically synonymous with the word *thought*. Thus, cognitive therapists fundamentally presume that the way we think about events determines the way we respond (Lorenzo-Luaces, German, & DeRubeis, 2015; Onken, 2015). In other words, “individuals’ interpretations and perceptions of current situations, events, and problems influence how they react” (J. S. Beck, 2002, p. 163). Psychological problems arise from illogical cognitions. For example, an illogical (or irrational or unrealistic) interpretation of a life event—a relationship breakup, an F on an exam, a comment from a friend—can cause crippling depression or anxiety. However, psychological wellness stems from logical cognitions. That is, when the cognitions appropriately match the event, they can lead...
to more adaptive, healthy reactions. Therefore, the role of the cognitive therapist is to fix faulty thinking (A. T. Beck & Haigh, 2014; Bermudes, Wright, & Casey, 2009; D. A. Clark, Hollifield, Leahy, & Beck, 2009; D. Dobson & Dobson, 2009; K. S. Dobson, 2012).

The Importance of Cognition

When they refer to cognitions, cognitive therapists use lots of terms interchangeably: thoughts, beliefs, interpretations, and assumptions, to name a few. Whatever we call them, we often overlook their importance in our day-to-day lives. When someone asks, “Why are you so happy?” or “Why are you so sad?” we typically point to a recent event that made us happy. We portray our experience as a two-step model in which things happen and those things directly influence our feelings. The truth, according to cognitive therapists, is that such a two-step model is flawed; specifically, it’s missing an important step in the middle. The three-step model that cognitive therapists endorse goes like this: Things happen, we interpret those things, and those interpretations directly influence our feelings. Thus, “it is not a situation in and of itself that determines what people feel but rather the way in which they construe a situation” (J. S. Beck, 1995, p. 14). In other words, events don’t make us happy or sad. Instead, the way we think about those events does. (See Figure 15.1."

As an example of the power of our cognitions, consider an unexpected overnight snowfall. At the same time, three neighbors wake up, look out their windows, and see the ground covered in 6 inches of white, with more flakes continuing to fall. In the first
house lives a mail carrier who covers her route by foot. For her, the snow causes feelings of dread. It's important to recognize, however, that between seeing the snow and feeling the dread, she has thoughts: “This is going to be a miserable day. I'll be cold and wet, I might slip and fall, and my route will take much longer than usual.” Her next-door neighbor owns a snowplow business. He wakes up, sees the same snow, and feels elated. Like his neighbor, somewhere between the sight of the snow and the resulting feeling, the snowplow driver thinks: “What a great day! I'm going to make a lot of money. Not to mention, I'll be able to help a lot of people.” In the next house, a high school student who didn't study for today's biology exam sees the snow and feels tremendous relief. Between the sight and the feeling, he thinks: “Whew! School's going to be cancelled, and I'll have an extra day to study for that exam. What a lucky break.” The same snowfall caused very different feelings in these three people, illustrating that it's not the events that happen to us but the meaning we assign to those events that shapes our feelings. Even if that process of assigning meaning happens automatically and within a split second, it nonetheless represents a crucial link to our feelings, including feelings characteristic of psychopathology such as depression or anxiety. Thus, these oft-ignored intermediary cognitions are a focal point in cognitive therapy.

Revising Cognitions

Once we accept the idea that cognitions determine feelings, revising them becomes the foremost task. Specifically, the goal is to ensure that the thoughts a person has about particular events rationally and logically correspond to the event itself. If they don't, they can lead to unnecessary and unpleasant feelings (D. Dobson & Dobson, 2009; A. Ellis, 2008; B. F. Grant, Young, & DeRubeis, 2005). For example, let's reconsider the mail carrier described above. It's reasonable for her to feel some degree of dread about the snow; after all, it will certainly make her day more difficult. But if the thoughts underlying her dread are illogical, they can make the dread excessive. That is, if she thinks, “I'll get fired if my route takes longer than usual today” or “I'll definitely fall on wet pavement and end up with a broken bone or a concussion” or “I may freeze to death on my route,” she can cripple herself with anxiety or depression. The goals of the cognitive therapist would not be to make this mail carrier feel unrealistically positive—it would hardly be logical for her to jump for joy about this situation—but to help revise her thoughts so they make realistic sense. At the end of this process, she might be just a bit apprehensive or down, which, in comparison to being devastated by anxiety or depression, represents a significantly improved emotional state.

As we see later in this chapter, there are different methods of revising cognitions. (There are also different terms for it, such as restructuring or modifying cognitions.) In general, these methods follow a common three-stage sequence: Illogical cognitions are first identified, then challenged, and eventually replaced with more logical cognitions (J. S. Beck, 1995; A. Ellis, 2008; Leahy, 2003; C. F. Newman, 2016). The first step—the identification of illogical thoughts—should not be confused with the psychodynamic goal of making the unconscious conscious. Cognitive therapists do not delve into the unconscious depths of the psyche as do psychodynamic therapists. They do, however, acknowledge that some of our cognitions are automatic thoughts—that is, they take place in an instant and without any deliberation. (The student with the surprise snow day described earlier certainly didn't need to pause and ponder, “How do I feel about this snow? Hmm,
Let me mull it over.” The interpretation happened far more immediately.) As such, these cognitions can become so routine and habitual that they are hard to recognize. A primary responsibility of the cognitive therapist, especially early in therapy, is to assist the client in identifying automatic illogical or irrational thoughts.

The second step, in which the illogical cognitions are challenged, also takes a variety of forms. As we see later in this chapter, some therapists rely on the power of verbal persuasion to convince clients to abandon illogical beliefs, whereas others encourage clients to test the accuracy of their beliefs by performing assigned behaviors in the real world. The objective of either of these approaches is to cause clients to doubt the truth of their illogical beliefs and to reach the conclusion that these beliefs should be revised. This revising, the third step in this process, is often difficult for clients to do at first—it can feel foreign, since therapists are asking clients to think in ways opposite to the ways clients may have been thinking for many years (D. A. Roth, Eng, & Heimberg, 2002). The cognitive therapist may, therefore, take the lead in the initial attempts to revise the client’s thoughts. Ultimately, however, the goal is for clients to be able to revise their own thoughts without therapist input.

The process of revising cognitions should always take place in a context of cultural sensitivity. There is no such thing as universally or absolutely logical thinking. A belief that is logical, rational, or adaptive for members of one culture may be illogical, irrational, or maladaptive for members of another culture. Culturally competent cognitive therapists are aware of the influence that their own cultural background has on their view of logical thinking and are careful not to impose their own cultural values on clients in the process of revising or restructuring clients’ cognitions.

Teaching as a Therapy Tool

Cognitive therapists explicitly include in their duties the education of their clients about the cognitive approach. In other words, cognitive therapists often function as teachers with their clients. For example, they might use a combination of minilecture, handouts, and readings to explain to clients the difference between the two-step (events lead directly to feelings) and the preferred three-step (cognitions intervene between events and feelings) models of understanding the sources of our feelings. Moreover, they train clients to recognize illogical thoughts, to assign labels to them, and to track them in a particular written format. And, like any good teacher, cognitive therapists aspire for clients ultimately to be able to use the lessons learned to teach themselves rather than remaining dependent on the teacher (J. S. Beck, 1995; Olatunji & Feldman, 2008).

Homework

Another similarity between cognitive therapists and teachers is the assignment of homework (J. S. Beck, 1995; Kuehlwein, 1993; Olatunji & Feldman, 2008; P. Robinson, 2008).
Cognitive therapists strongly believe that much of the work of therapy is conducted between sessions. Much like the time between class meetings of a college course, the time between therapy sessions is used to explore and confirm the lessons learned during the meetings. In some cases, the homework is written: Clients are asked to keep a record of events, cognitions, feelings, and attempts to revise the cognitions to change the feelings they experience. (Later in this chapter, we examine written formats such as these in more detail.) In other cases, the homework is behavioral: Clients are asked to perform certain behaviors before the next meeting, typically for the purpose of examining the validity of an illogical thought. In either case, discussion of the homework will constitute a significant part of the subsequent session (Kazantzis & Dattilio, 2010).

Considering Culture

Cognitive Therapy With LGBTQ Clients

For many, life as a lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) person today is quite different from what it was a generation or more ago, as society’s attitudes toward members of the LGBTQ community appear to have become more accepting. However, Purcell, Swann, and Herbert (2003) argue that in spite of these social changes, negative attitudes toward LGBTQ individuals persist in our society and that these attitudes are reflected even among members of the LGBTQ community. In fact, these authors make the case that “internalized homophobia”—an aversion to homosexuality applied by gay individuals to themselves—pervades gay and lesbian culture to some extent. That is, gay or lesbian individuals may hold some beliefs that disapprove of their own sexual orientation or lifestyle, such as, “Homosexuality is wrong” or “My family/friends/religion/society will reject me if I come out.” These beliefs could hinder self-respect and self-worth and contribute to depression or other clinically significant problems.

Are such beliefs consistent with contemporary societal values? Or expressed in terms of cognitive therapy, are such beliefs logical? To the extent that they are not, could cognitive therapy be helpful in identifying their logical flaws, challenging them, and replacing them with more logical thoughts? These questions illustrate the need for cultural competence and cultural self-awareness in clinical psychologists. It is essential for the clinical psychologist to understand these beliefs from the perspective of the clients—to see their world through their eyes—to appreciate whether such beliefs are sensible or misguided for them. Clinical psychologists should also be well aware of their own personal views on these issues and stop themselves from equating their own views with the “logical” way to think. What seems adaptive from the perspective of the
clinical psychologist may be maladaptive from the perspective of the client.

Of course, cognitive therapists’ work with LGBTQ clients often focuses on cognitions that have nothing to do with their sexual orientation. Indeed, LGBTQ clients bring the same problems to therapy as heterosexual clients do (Martell, Safren, & Prince, 2004), but in addition, they may be struggling with some cognitions related to internalized homophobia, as described by Purcell et al. (2003).

What other diverse groups might experience similar “internalized” self-critical cognitions as a reflection of broader societal views? How might a culturally competent cognitive therapist address the logical or illogical nature of those cognitions?

A Brief, Structured, Focused Approach

Cognitive therapists strive to achieve a positive therapy outcome quite quickly—typically, in fewer than 15 sessions, but significantly longer in complex or severe cases (J. S. Beck, 1995, 2002; D. A. Roth et al., 2002). For outpatients, sessions typically take place once per week, eventually tapering off in frequency as the client improves. Several factors contribute to the efficiency of cognitive therapy, including its focus on the client’s current problems (rather than extensive exploration of the past); a purposeful, goal-oriented focus on clearly identified symptoms; and structured therapy sessions (Grant et al., 2005; Olatunji & Feldman, 2008).

The structured nature of cognitive therapy sessions differs sharply from the free-flowing, spontaneous style of humanistic therapy (Pretzer & Beck, 2004). Whereas humanistic (or “client-centered”) therapists allow clients to determine the topics to be discussed during a session, the amount of time spent on each, and the like, cognitive therapists set an agenda (J. S. Beck, 1995; A. Freeman, Pretzer, Fleming, & Simon, 1990). Typically, each session is sequentially organized into segments (see Table 15.1), and sometimes each segment is allotted a specific amount of time. Of course, the client has input on the content of the agenda for the session, but cognitive therapists usually shun therapy that lacks predetermined, explicit structure.

TWO APPROACHES TO COGNITIVE THERAPY

There are two widely recognized pioneers of cognitive therapy: Albert Ellis and Aaron Beck. As described earlier, each developed his own version of cognitive therapy at about the same time, and although each was influenced somewhat by the other, their approaches evolved independently for the most part. The two approaches unquestionably overlap in terms of their emphasis on improving clients’ symptoms via correcting illogical thinking, but the terminology and, at times, the techniques they employ distinguish them from each other (DiGiuseppe, David, & Venezia, 2016). Let’s consider each separately.
Table 15.1  Typical Sequential Structure of a Cognitive Therapy Session

1. Check on client’s mood or emotional status and solicit brief updates on recent events.
2. Set and confirm the agenda for the current session.
3. Establish a link to the previous session, often by reviewing previous homework assignment.
4. Progress through the body of the current session, proceeding step-by-step through the agenda.
5. Develop and assign new homework assignment.
6. Summarize current session; solicit client feedback.

Sources: Beck (1995), Freeman et al. (1990), and Pretzer and Beck (2004).

Albert Ellis

For many years, Albert Ellis called his approach to therapy rational emotive therapy (RET), but later in his career, he altered the name to rational emotive behavior therapy (REBT). We'll use the more recent name here, understanding that both refer to Ellis's version of cognitive therapy.

As the first two words of the REBT label indicate, Ellis's therapy approach emphasizes a connection between rationality and emotion (David, Cotet, Matu, Mogoase, & Stefan, 2018; Dryden, 2009, 2015; A. Ellis, 2008; A. Ellis & Ellis, 2011; O’Kelly & Collard, 2016). A. Ellis (1962) argues that if we can make our beliefs less irrational, we can live happier lives:

The central theme of [REBT] is that man is a uniquely rational, as well as uniquely irrational animal; that his emotional or psychological disturbances are largely a result of his thinking illogically or irrationally; and that he can rid himself of most of his emotional or mental unhappiness, ineffectuality, and disturbance if he learns to maximize his rational and minimize his irrational thinking. (p. 36)

The ABCDE Model

One of Ellis's most enduring and clinically useful contributions is his ABCDE model for understanding and recording the impact of cognitions on emotions (also known as the ABC model) (e.g., David, 2015; Dryden, 1995, 2009; A. Ellis, 2008; A. Ellis & Ellis, 2011; A. Ellis & Grieger, 1977; A. Ellis & Harper, 1975). By creating this model, Ellis was able to frame the essential aspects of cognitive therapy into an accessible acronym that enabled its use by thousands of therapists and clients.

In the ABCDE model, A, B, and C represent the three-step model described near the beginning of this chapter: Events lead to thoughts, which in turn lead to feelings. Ellis's model simply replaces these three terms with more easily remembered terms:
Activating event (A), Belief (B), and emotional Consequence (C). According to Ellis, irrational beliefs are toxic because they function as rigid, dogmatic demands that we apply to ourselves—for example, “I must get an A in every class,” “I need to be dating someone,” or “I can’t let my family down.” Although these may be strong preferences, they are not, in fact, “musts” or absolute rules. Moreover, we tend to couple these demands with over-estimations of the consequences of failure—“If I don’t get an A, I’ll flunk out of school and end up on the street”; “If I’m not dating anyone, I’m completely worthless”; or “If I let my family down, their disapproval will destroy me.” Ellis sees flawed logic in all these self-statements and opportunity for therapeutic benefit in correcting them.

To accomplish this correction, Ellis’s model adds two more steps, D and E. In his model, D stands for Dispute, and E stands for Effective new belief. Specifically, the irrational belief (B) is the target of the dispute. The addition of this step is particularly important within Ellis’s model of cognitive therapy. Ellis’s model not only helps clients identify irrational beliefs (B) that may intervene with the events in their lives (A) and their subsequent feelings (C); it urges clients to dispute those beliefs as well. This can be an empowering experience for clients who have been stuck in an ABC sequence that leaves them feeling perpetually unhappy, anxious, and so on. When they realize that their experience need not stop at C (the unwanted feeling), that they have the right to challenge the belief that caused C and replace it with something more rational, therapeutic benefit is in the works. In Ellis’s model, disputing often takes the form of pointed questions or statements that attack the irrational nature of beliefs or labels that can be assigned to irrational beliefs to discredit them. Regardless of the form of the dispute, if it is effective, it affords the client the opportunity to replace the original, irrational belief with an effective new belief (E) that is more rational and leads to less troubling feelings (Dryden, 2009; A. Ellis, 2008).

As a clinical example, consider Keyon, a 24-year-old man who recently earned a degree in accounting. Keyon sought therapy from Dr. Liu, a clinical psychologist with a cognitive orientation, because he was struggling with excessive anxiety. Specifically, Keyon was scheduled to take the Certified Public Accountant (CPA) exam in about 2 months, but his anxiety about the exam was interfering with his preparation. He intended to study for the exam, but when he tried, he was so anxious that he couldn’t concentrate. In fact, just thinking about the CPA exam made Keyon feel panicky. After Dr. Liu educated Keyon about the cognitive model (specifically, Ellis’s ABCDE model), they were able to identify steps A and C right away: The activating event was studying for (or thinking about) the CPA exam, and the emotional consequence was anxiety. With Dr. Liu’s help, Keyon next identified two beliefs (B) that linked his thoughts of the CPA exam to his feelings of anxiety: “I absolutely have to pass the CPA exam on my first attempt” and “If I don’t pass the CPA exam on my first attempt, my career is doomed, and that would destroy me.” In the next step, disputing (D), Dr. Liu made efforts to question the logic of Keyon’s beliefs:

Who says you have to pass the CPA exam on your first attempt? I understand that’s a preference, but is it a life-or-death necessity? Realistically, don’t quite a few accountants fail the CPA exam on their first try? And don’t many of them pass it later and go on to have successful careers? And even if you don’t end up with the career in accounting that you envisioned, does that mean your life is ruined? There are plenty of ways for you to have a rewarding career that don’t involve accounting at all.
In time, Keyon found himself persuaded by the strength of Dr. Liu’s arguments and began to disbelieve his own irrational thoughts. Eventually, he was able to replace his original, irrational beliefs with effective new beliefs (E):

I want to pass the CPA exam on my first attempt, but it’s not an absolute necessity. If I pass it on a later attempt, that will probably work out fine also, and in the big picture, my happiness doesn’t depend entirely on following the career path I’ve envisioned.

These new beliefs greatly reduced Keyon’s anxiety.

The ABCDE model lends itself quite nicely to written format, and cognitive therapists often take advantage of this. It’s likely that Dr. Liu, for example, would have taught Keyon how to view his experiences as ABCDE sequences and chronicle them accordingly. Typically, clients complete forms that are organized into A, B, C, D, and E columns. During sessions or as homework, in retrospect or as an event takes place, clients can sort their experiences into the five-column organizational structure provided by this type of journal form. By doing so, they train themselves to experience life in this sequence. In particular, they become more adept at identifying an irrational belief (B), constructing a dispute (D) in response to the belief, and generating an effective new belief (E). Of course, the goal is not for the clients to depend on this written format for the rest of their lives to feel happier; instead, a five-column ABCDE thought journal can serve as training wheels that stabilize clients while they learn to think more logically, and once they can stabilize themselves, the ABCDE process takes place within the mind, without any outside aids.

Table 15.2 summarizes the full ABCDE acronym, including an applied example from Keyon’s therapy with Dr. Liu.

### Table 15.2 Albert Ellis’s ABCDE Model as Applied to a Clinical Example (Keyon)

<table>
<thead>
<tr>
<th></th>
<th>Activating event</th>
<th>Belief</th>
<th>Consequence (emotional)</th>
<th>Dispute</th>
<th>Effective new belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Activating event</td>
<td>Studying for or thinking about the CPA exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Belief</td>
<td>“I absolutely have to pass the CPA exam on my first attempt. If I don’t pass the CPA exam on my first attempt, my career is doomed, and that would destroy me.”</td>
<td>Anxiety</td>
<td>“Who says you have to pass the CPA exam on your first attempt? I understand that’s a preference, but is it a life-or-death necessity? Realistically, don’t quite a few accountants fail the CPA exam on their first try? And don’t many of them pass it later and go on to have successful careers? And even if you don’t end up with the career in accounting that you envisioned, does that mean your life is ruined? There are plenty of ways for you to have a rewarding career that don’t involve accounting at all.”</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Consequence (emotional)</td>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Dispute</td>
<td>“Who says you have to pass the CPA exam on your first attempt? I understand that’s a preference, but is it a life-or-death necessity? Realistically, don’t quite a few accountants fail the CPA exam on their first try? And don’t many of them pass it later and go on to have successful careers? And even if you don’t end up with the career in accounting that you envisioned, does that mean your life is ruined? There are plenty of ways for you to have a rewarding career that don’t involve accounting at all.”</td>
<td></td>
<td>“I want to pass the CPA exam on my first attempt, but it’s not an absolute necessity. If I pass it on a later attempt, that will probably work out fine also, and in the big picture, my happiness doesn’t depend entirely on following the career path I’ve imagined.”</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Effective new belief</td>
<td>“I want to pass the CPA exam on my first attempt, but it’s not an absolute necessity. If I pass it on a later attempt, that will probably work out fine also, and in the big picture, my happiness doesn’t depend entirely on following the career path I’ve imagined.”</td>
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</tbody>
</table>
Consoliding Culture

Are Some Beliefs Too Sacred to Dispute?

Cody, a 22-year-old college student, grew up in a family with strict religious beliefs. Among them: Premarital sex is sinful, and anyone who engages in it is an immoral person who will spend the afterlife in hell. Last week, Cody and his girlfriend of 2 years had sex for the first time. And his anxiety is through the roof. He seeks the help of a clinical psychologist, Dr. Talia Brown. Dr. Brown holds different religious beliefs than Cody does, and regarding premarital sex, she does not share Cody's beliefs at all. She believes that premarital sex is not necessarily sinful, and she disagrees that it will result in an eternity in hell. In fact, as she applies a cognitive perspective to Cody's case, Dr. Brown sees Cody's beliefs as irrational and distorted. Her plan to help Cody reduce his anxiety is to replace what's in his B column—"Premarital sex is sinful"—with something she believes to be more logical and less anxiety producing—"Premarital sex is OK in some circumstances."

A fundamental task in cognitive therapy is to dispute irrational beliefs, but who decides what's irrational? Moreover, are some client beliefs—religious, cultural, or otherwise—too sacred to dispute, even if the therapist questions their rationality? Is it appropriate for Dr. Brown to critically examine Cody's beliefs about premarital sex, or should she take a "hands-off" approach in the spirit of cultural sensitivity? Her plan to help Cody reduce his anxiety is to replace what's in his B column—"Premarital sex is sinful"—with something she believes to be more logical and less anxiety producing—"Premarital sex is OK in some circumstances."

Often [mental health professionals] assume that counselors should accept without question clients' cultural values. In their thinking, uncritical acceptance reflects an unbiased approach to counseling, especially as it pertains to clients whose cultural backgrounds are radically different from their own. . . . We maintain that in some cases, rigid and extreme adherence to cultural values not only is dysfunctional but also creates a great deal of psychological distress. We suggest that examination of clients' cultural impasses and at times cultural confrontation are essential competencies under the larger domains of multicultural counseling competence. (p. 378)

Indeed, cognitive therapists have long recognized the importance of cultural competence as they work with clients of diverse religious, ethnic, and other groups (e.g., Hays & Iwama, 2006; H. G. Koenig, 2005; Paradis, Cukor, & Friedman, 2006; Pargament, 2007). But the notion of cultural confrontation opposes much of the traditional wisdom about respecting clients' values by declining to challenge them. In your opinion, should Dr. Brown proceed with her plan to challenge Cody's religious beliefs about premarital sex? If she does, will Cody be receptive to her strategy? Will his anxiety decrease? If you were the client, how would you respond? Which beliefs of yours—religious, cultural, political, personal, or otherwise—would you see as too sacred for your psychologist to dispute?
Aaron Beck

Aaron Beck has always used the general term cognitive therapy to describe his technique. He originally developed his approach as a way to conceptualize and treat depression (e.g., A. Beck, 1976; A. Beck, Rush, Shaw, & Emery, 1979), but it has been very broadly applied since shortly after its inception. (In fact, his daughter, Judith Beck, has become a leader of the current generation of cognitive therapists and has spearheaded its application to many new problems.) An important part of Beck's theory of depression is his notion of the cognitive triad, in which he argues that three particular cognitions—thoughts about the self, the external world, and the future—all contribute to our mental health. Beck theorized that when all three of these beliefs are negative, they produce depression (Alford & Beck, 1997; J. S. Beck, 1995).

The essence of Aaron Beck's approach to cognitive therapy, like Ellis's, is to increase the extent to which the client thinks logically. And also like Ellis's, Beck's approach incorporates a way of organizing clients' experiences into columns on a written page. In Beck's brand of cognitive therapy, this form is known as a dysfunctional thought record (e.g., J. S. Beck, 1995, 2002; A. Freeman et al., 1990; Leahy, 2003), and although its headings differ a bit from Ellis's ABCDE acronym, they function similarly. Typically, the dysfunctional thought record includes columns for

- a brief description of the event/situation,
- automatic thoughts about the event/situation (and the extent to which the client believes these thoughts),
- emotions (and their intensity),
- an adaptive response (identifying the distortion in the automatic thought and challenging it), and
- outcome (emotions after the adaptive response has been identified and the extent to which the client still believes the automatic thoughts).

Conceptually, the columns in Beck's dysfunctional thought record correspond quite closely to the columns of Ellis's ABCDE forms. For example, in the fourth column (“adaptive response”) of a dysfunctional thought record, clients perform essentially the same task they would in Column D (“Dispute”) of Ellis's form. For this task, Beck created a vocabulary to identify common ways clients' thoughts can be distorted. This vocabulary has become a vital aspect of cognitive therapy. Let's consider it here in more detail.

Common Thought Distortions

An essential step in cognitive therapy is to discredit illogical automatic thoughts by labeling them. To facilitate this labeling, Beck and his followers have identified and defined a list of common thought distortions (e.g., A. T. Beck et al., 1979; J. S. Beck, 2002; Craighead, Craighead, Kazdin, & Mahoney, 1994; Leahy, 2003; C. F. Newman, 2016). Cognitive therapists teach these terms to clients, often using handouts or take-home
readings, and train them to use the terms when examining their own thoughts. Examples of these common thought distortions include the following:

- **All-or-nothing thinking:** Irrationally evaluating everything as either wonderful or terrible, with no middle ground or “gray area”
- **Catastrophizing:** Expecting the worst in the future, when, realistically, it’s unlikely to occur
- **Magnification/minimization:** For negative events, “making a mountain out of a molehill”; for positive events, playing down their importance
- **Personalization:** Assuming excessive personal responsibility for negative events
- **Overgeneralization:** Applying lessons learned from negative experiences more broadly than is warranted
- **Mental filtering:** Ignoring positive events while focusing excessively on negative events
- **Mind reading:** Presuming to know that others are thinking critically or disapprovingly, when knowing what they think is, in fact, impossible

In Beck’s cognitive therapy, when clients assign these thought distortion labels to illogical thoughts, the illogical thoughts grow weaker. Labeling thoughts as illogical enables the client to dismiss them and replace them with more adaptive and logical thoughts, which ultimately decreases the client’s psychological distress. As a clinical example, consider Olivia, a 30-year-old woman who was recently divorced after a 3-year marriage and currently lives alone. In her first session with Dr. Zimmerman, a clinical psychologist with a cognitive orientation, Olivia explains that she feels depressed about being without a partner. The comments she made to Dr. Zimmerman could be summed up in these three beliefs: “I’m no good at relationships,” “Living alone, even for a short time, is intolerable,” and “A lot of my friends are married, but I’m not, so there must be something wrong with me.” After educating Olivia about Beck’s cognitive approach, including the list of common thought distortions, Dr. Zimmerman and Olivia got to work. Together, they attacked the flawed logic in each of Olivia’s beliefs by labeling them as distortions. For example, when Olivia views herself as “no good at relationships,” she’s overgeneralizing from the recent divorce. Living alone may not be her preference, but to call it “intolerable” constitutes magnification. And to blame the divorce on herself—“there’s something wrong with me”—is personalization that is unfounded and unfair. With repeated practice, Olivia developed the ability to identify and oppose her own illogical thoughts and replace them with more logical alternatives. She never became overjoyed about her divorce or the loneliness in her current life—such a reaction would also be illogical—but she was able to lift herself from a state of despair to a state of contentment and mild hopefulness, which made a tremendous difference in her day-to-day life.

**Beliefs as Hypotheses**

Beck argued that our beliefs are hypotheses, even though we may live our lives as if our beliefs are proven facts. Therefore, a potent way to expose a belief as illogical is
In my practice, I have learned that when I use cognitive therapy, sometimes clients are reluctant to challenge an illogical belief. That seems counterintuitive—after all, shouldn’t they welcome a dispute that helps them think more rationally and improve their emotional state? In some cases, I have found, there’s a second illogical belief lurking behind the first one.

For example, consider Ayana, who was in therapy with me when she was a high school senior. Ayana had a remarkably negative self-image. That self-image was centered on a core belief of hers: “I’m stupid.” Ayana’s belief in her own stupidity was so powerful that it not only caused her great sadness, it also inhibited her from applying to college. As I explored this belief with Ayana, it became clear to me that it was not entirely based on truth. In fact, it seemed way off base. Ayana earned a solid B+ grade point average all the way through high school. She performed well in several honors courses. Her friends often turned to her for help with their homework. Clearly, there was plentiful evidence for Ayana’s intelligence, but she focused only on the negative. She earned a D in a math class during the first semester of ninth grade, she had a couple of friends with better GPAs than hers, and she had recently bombed a physics test. I taught Ayana about the common thought distortions and helped her see that several of them could explain her irrational belief in her own stupidity: She was magnifying her few academic weaknesses and minimizing her many academic strengths; she was overgeneralizing from her worst academic moments to a broad image of herself as stupid; and she was using all-or-nothing thinking rather than giving herself the option of falling somewhere short of sheer genius but far, far above absolute stupidity.

Any of these arguments, I reasoned, should be enough to allow Ayana to escape from her false self-image as a stupid person. But she didn’t escape. We discussed these disputes, and the effective new beliefs she could adopt, for several sessions. But she seemed more motivated to keep her self-image than to change it. Finally, I tactfully and kindly mentioned to Ayana what I was noticing. I asked her if there was a reason why she might be reluctant to see herself as a smart, capable young woman. Through tears, she revealed something important: “If I’m smart, I should apply to college. But if I go to college, my parents will resent me for it. I’ll be the first one from our family to go to college. They will think I’m selfish. I can’t do that to them.” Now it made sense to me why Ayana might cling to the illogical belief that she’s stupid. But was it possible that the belief about her parents’ attitude toward Ayana going to college was itself an illogical belief? Much as Aaron Beck encouraged clients to test their beliefs as if they were hypotheses, I encouraged Ayana to bring up the topic of college with her parents, to see how they responded. To her surprise, they were completely in favor of it. Her parents mentioned nothing about selfishness or resentment and spoke extensively about how proud they would be. After a couple of conversations like this with her parents, Ayana was able to replace her inaccurate belief about her parents’ view of college with the more accurate belief. That alteration, in turn, enabled her to replace her illogical belief that she was stupid with the logical belief that she was bright and capable. Soon, she was working on college applications.
to “put it to the test” in real life, just as scientists empirically test their hypotheses in the lab. Beck’s approach to cognitive therapy often includes such personal “experiments,” frequently in the form of homework, designed to bolster or undermine a client’s beliefs (K. S. Dobson & Hamilton, 2008; Kuehlwein, 1993; D. A. Roth et al., 2002; C. F. Newman, 2016).

As a clinical example, consider Frank, a 45-year-old chain-restaurant manager who has held his job for 15 years but has become increasingly unhappy with it. This professional dissatisfaction is the main contributor to the depression for which he seeks therapy. He mentions to Dr. Morris, his cognitively oriented clinical psychologist, that he would like to look for another job, but adds, “I’m sure I wouldn’t be able to get one,” a belief that leaves Frank feeling dejected about the future. One effective strategy that Dr. Morris might employ would involve challenging the logic of Frank’s belief that he is not employable elsewhere. Using Beck’s dysfunctional thought record (or Ellis’s ABCDE columns), Dr. Morris could try to use words to persuade Frank that his belief is illogical: Perhaps Frank is minimizing his skills and experiences, mind reading when in fact he doesn’t know how prospective employers may evaluate him as an applicant, or engaging in some other cognitive distortion. To accompany this argument, Dr. Morris might also assign Frank some homework that will serve to test his belief. For example, Dr. Morris might ask Frank to create a résumé and highlight the parts of it that would be attractive to an employer (training, years of experience, etc.). Or Dr. Morris might ask Frank actually to test the market—respond to some want ads and see what kind of response he gets from employers. If these homework assignments result in some feedback inconsistent with Frank’s hypothesis—that is, if his résumé actually looks good or if prospective employers show interest—the experience will force Frank to abandon the belief that he’s unemployable. And by replacing that belief with the belief that he is indeed attractive to employers, Frank will be more hopeful and less vulnerable to depressive feelings.

Of course, when cognitive therapists encourage clients to test their hypotheses, they are careful to do so in a way that will effectively refute illogical thoughts (Kuehlwein, 1993). If they assign homework that confirms illogical beliefs, the efforts can backfire.

In practice, the approaches of Ellis and Beck overlap quite a bit. Cognitive therapists often incorporate elements of both styles of therapy into their own techniques. Although the terminology that Beck and Ellis use differs somewhat, their therapeutic goals are essentially the same: to identify and critically evaluate illogical thinking and replace it with more rational alternatives that ultimately alleviate psychological symptoms.

**RECENT APPLICATIONS OF COGNITIVE THERAPY**

Although cognitive therapy was originally targeted toward limited types of psychological symptoms, it is now applied almost universally across the range of psychological problems. In fact, it is increasingly used for problems outside the range of traditional mental disorders as well.
Metaphorically Speaking

If You’ve Seen Attorneys Argue in Court, You Understand How Cognitive Therapists Dispute Thought Distortions

“Objection!” In the courtroom, this is how attorneys protest the unsound tactics of opposing counsel. Usually, the purpose of an objection is to interrupt an illogical argument. In other words, as soon as an attorney notices that the opposition is putting forth a logically flawed argument, the appropriate action is to insist that only logically sound statements be allowed in the argument and that any irrational statement be stricken from the record.

In a way, cognitive therapists teach clients to be their own defense attorneys in the “cognitive courtroom” of the mind. Specifically, cognitive therapists train clients to spot illogical thoughts, object to them, and insist that only logical thoughts be allowed. This process implies that there are two opposing voices in each of our minds, just as there are two opposing attorneys in a courtroom. These two voices are represented by the two columns in the cognitive model in which beliefs are articulated—Columns B (Belief) and E (Effective new belief) in Ellis’s ABCDE model. Between them, Column D (Dispute) serves as an objection to the first, illogical voice (B) and an opportunity for the second, logical voice (E) to make a more logical statement.

To illustrate, let’s consider an illogical belief held by Shannon, a 20-year-old college student: “If I fail an exam, I’m stupid.” Or, stated as an accusation from another person, “If you fail an exam, you’re stupid.” If this accusation goes unopposed, as it would in a courtroom with only the prosecuting attorney in attendance, this case may end with the verdict that Shannon is, in fact, stupid. But if Shannon objects to the flawed logic in this belief—in Ellis’s terms, if she disputes it effectively—Shannon will exonerate herself of the charge of stupidity. In truth, Shannon may be able to use several different disputes to support her objection—perhaps the test was unfair and many students failed it, or perhaps Shannon wasn’t feeling well on the day of the test, or perhaps Shannon has earned As on most of her other tests in college. Any of these objections creates reasonable doubt about the accusation that Shannon is stupid and increases the likelihood that, in her “cognitive courtroom,” she will be found innocent of this charge. As a result, she will avoid a “sentence” of depression. A key to this metaphor, and to cognitive therapy more generally, is that when illogical thoughts cross their minds, individuals feel entitled to defend themselves by objecting and correcting the illogical thoughts rather than simply allowing them to continue unchallenged.
The Third Wave: Mindfulness- and Acceptance-Based Therapies

In recent years, a new brand of therapies based on mindfulness and acceptance have become increasingly popular and empirically supported (S. C. Hayes, Villatte, Levin, & Hildebrandt, 2011; Masuda & Wilson, 2009; L. P. K. Morgan & Roemer, 2015). Collectively, they are often called “third-wave” therapies, referring to the evolution from strict behaviorism (first wave) to cognitive therapy (second wave) to these newer therapies (DiGiuseppe et al., 2016; W. C. Follette, Darrow, & Bonow, 2009; S. C. Hayes, 2004). As such, they should not necessarily be considered cognitive therapies in the strict sense; although they appear in this chapter on cognitive therapy, they also feature behavioral and other elements. We’ll examine three particular forms of these therapies in detail: acceptance and commitment therapy, dialectical behavior therapy, and metacognitive therapy. But first, let’s consider some commonalities among therapies of this kind.

Mindfulness lies at the core of the third-wave therapies (Dimidjian & Linehan, 2009; V. M. Follette & Hazlett-Stevens, 2016; S. C. Hayes et al., 2011; S. L. Shapiro, 2009). Mindfulness can be difficult to define, but its proponents have made attempts:

- Mindfulness “refers to being able to pay attention in the present moment to whatever arises internally or externally, without becoming entangled or ‘hooked’ by judging or wishing things were otherwise” (Roemer & Orsillo, 2009, p. 2).
- Mindfulness is “an innate human capacity to deliberately pay full attention to where we are, to our actual experience, and to learn from it. This can be contrasted with living on automatic pilot and going through our day without really being there” (Hick, 2008, p. 5).
- “The short definition of mindfulness . . . is (1) awareness, (2) of present experience, (3) with acceptance” (Germer, 2005, p. 7).
- Mindfulness is “the awareness that arises out of intentionally attending in an open and discerning way to whatever is arising in the present moment” (S. L. Shapiro, 2009, p. 555).

As the previous descriptions may suggest, mindfulness derives from Buddhist traditions, but it is typically used without any explicit religious ties. (Zen meditation can accompany mindfulness-based therapies, but they are often practiced without any meditation component. In fact, mindfulness is the term that often replaced Zen as Zen practices became more popular in the Western world and became less connected to religion practices or meditation (Lungu & Linehan, 2016).) Mindfulness promotes full engagement with one’s own internal mental processes in a nonconfrontational way. This nonconfrontational approach is a key difference from the more traditional cognitive therapies of Albert Ellis or Aaron Beck. Whereas Ellis and Beck encouraged people to dispute and revise their thoughts, mindfulness-based therapists prefer to change people’s relationships to their thoughts rather than the thoughts themselves (Olatunji & Feldman, 2008). So, rather than relating to thoughts as all-powerful determinants of reality or
truth, clients can learn to understand their thoughts as fleeting suggestions that may not require much of a reaction at all. Once the relationship with thoughts is changed in this way, individuals may find it easier to face unpleasant thoughts (or feelings or sensations) rather than avoiding them. That is, rather than engaging in experiential avoidance, as third-wave therapists call it, the individual can engage in acceptance: allowing these internal experiences to run their course without fighting against them. This can facilitate positive change for clients with a wide range of psychological problems (Dimidjian & Linehan, 2008; Farmer & Chapman, 2008; Niles et al., 2014; Orsillo, Danitz, & Roemer, 2016; Roemer & Orsillo, 2009; Spinhoven, Drost, de Rooij, van Hemert, & Penninx, 2014).

As a specific illustration of a clinical intervention that relies on mindfulness, consider urge surfing. Urge surfing is an approach to the treatment of addictive behaviors such as smoking or drinking, or any other behavior in which clients struggle with unwanted urges, that encourages clients to relate differently to their urges than they have before (S. Bowen & Marlatt, 2009; J. S. Harris, Stewart, & Stanton, 2017; Ostafin & Marlatt, 2008; Rogojanski, Vettese, & Antony, 2011; Shonin & Van Gordon, 2016; N. N. Singh et al., 2018). The goal is not to stop, suppress, or fight the urges, as other forms of therapy might encourage; instead, the goal is to experience them, to “ride” or “surf” them like a wave that will rise and then inevitably subside, and to realize that they are temporary and not all-powerful. As described by Lloyd (2009),

Clients are taught to treat urges as though they were like waves in the ocean. Urges come on, grow in intensity, and eventually subside just like ocean waves. Moreover, like waves, urges tend to be brief. They do not grow and grow until the client has to do something before they will go away. Urges go away on their own. . . . [In this type of treatment,] clients are taught how to fully experience the urge in a different way—that is, to experience the urge for what it is: brief, nonlethal, of relatively predictable course, and most important, defeatable. (p. 669)

As this description illustrates, the critical element of this treatment is not the urge itself but the way the client responds to the urge. As with all third-wave or mindfulness-based therapies, the emphasis is on helping clients experience the urge (or feeling or thought) that arises in the moment and not overestimate its destructive power or underestimate their own ability to withstand it. It may be unpleasant, but it will pass, and the client can accept and survive it.

Mindfulness and acceptance are valuable new components of therapeutic practice, whether these concepts form the foundation of the therapy strategy or merely complement other approaches. That is, mindfulness and acceptance don’t demand an either/or decision. Therapists can practice forms of therapy for which mindfulness and acceptance are core elements—as in the three therapies described in this section—or therapists can enhance other forms of therapy, such as psychodynamic, humanistic, or others, by blending in elements of mindfulness and acceptance (Hick & Bien, 2008). For example, one study found that for clients with OCD who were treated with exposure and response prevention, adding a mindfulness component to the treatment significantly increased their improvement (Key, Rowa, Bieling, McCabe, & Pawluk, 2017).
Acceptance and Commitment Therapy

Steven C. Hayes, a clinical psychologist and professor at the University of Nevada, Reno, is considered a leading figure in acceptance and commitment therapy (ACT). According to Hayes and others, what is “accepted” in ACT is internal psychological experience, such as emotions, thoughts, and sensations (Bach & Moran, 2008; Forman, Juarascio, Martin, & Herbert, 2015; S. C. Hayes, 2004; S. C. Hayes & Strosahl, 2004). Too often, individuals who struggle with psychological problems have not accepted these private events but have dodged and ducked them via distraction. This kind of experiential avoidance can underlie all kinds of psychological problems (Eifert & Forsyth, 2005). It’s a bit like a phobia, but the feared object is within rather than outside the individual. And just like phobias of dogs, snakes, or airplanes, avoidance is a common but ultimately unhelpful coping mechanism. So, in this context, acceptance means facing one’s internal fears.

S. C. Hayes (2004) presents a couple of metaphors that clarify the basic tenets of acceptance within ACT. For one, he asks us to imagine our thoughts as a parade. In this parade, we are spectators, not participants. As our thoughts march by, we notice them, certainly, but how long can we let the parade flow without reacting to them—without joining the parade or trying to stop it or otherwise getting drawn in? The longer we can acknowledge our thoughts without compulsively reacting to them, according to Hayes, the better our chances of psychological well-being will be. In a second metaphor, Hayes compares the process of accepting internal experiences to jumping off a step rather than stepping down from it. Stepping down feels safer, he says, because we maintain control the whole time. Jumping down gives all the control to gravity. Clients, according to Hayes, need to “practice jumping” with regard to their thoughts, feelings, and sensations. That is, little by little, they need to stop battling for control with these experiences and simply trust that wherever the experiences drop them, they will be able to land safely and continue on their way.

The C in ACT refers to a commitment to one’s own personal values. Of course, for many clients, clarification must come before commitment. That is, therapy must first help the client discover exactly what their personal values are. Once this happens, the client is poised to make a commitment to remaining true to these values in terms of their day-to-day decisions and behaviors. And the T in ACT refers to taking action consistent with one’s own personal values; here, we see the behavioral emphasis inherent in ACT that connects the client’s new way of thinking with new ways of living.

Hayes and others (e.g., Eifert & Forsyth, 2005; S. C. Hayes & Strosahl, 2004) describe a pair of acronyms to explain the problematic approach that underlies psychological illness, as well as their strategy for psychological wellness. Essentially, FEAR is replaced by ACT. To explain, FEAR stands for

- **Fusion** with inner experiences such as thoughts, feelings, and sensations that limits flexibility in responding;
- **Evaluation** of self, especially one’s own inner experiences;
- **Avoidance** of unpleasant inner experiences via such means as distracting or numbing oneself; and
- **Reason-giving**, or leaning too heavily on rationalizations that sound legitimate but actually perpetuate unhealthy approaches to life.
ACT, on the other hand, stands for

- **Accepting** one’s own inner experiences for what they are, and nothing more;
- **Choosing** directions in life based on one’s core values, which will enhance life’s meaning and purpose; and
- **Taking action** in matters large and small that are consonant with one’s own values.

### Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) was developed by Marsha Linehan specifically for the treatment of borderline personality disorder (BPD; Koerner, 2012; Koerner & Dimeff, 2007; Linehan, 1993a, 1993b). The treatment has garnered a notable level of empirical support, such that it is now considered a treatment of choice for BPD, and in adapted form it is also used successfully for other disorders, especially those that involve emotion dysregulation (Cameron, 2015; Dimeff & Koerner, 2007; Kliem, Kröger, & Kosfelder, 2010; Lungu & Linehan, 2016; Lynch, Trost, Salsman, & Linehan, 2007; Paris, 2009).

DBT is based on a conceptualization of BPD as a problem of emotional regulation. In other words, across most aspects of their lives, individuals with BPD struggle to control the intensity of their feelings (Linehan, 1993a). Emotional dysregulation is thought to stem from two sources: biological predisposition and environment. Specifically, the environmental component is an invalidating interpersonal environment. That is, individuals who develop BPD often come from families who “communicate that the individual’s characteristic responses to events (particularly their emotional responses) are incorrect, inappropriate, pathological, or not to be taken seriously” (Koerner & Dimeff, 2007, p. 3). Such an environment teaches the individual that only extreme emotional reactions will elicit a response from others, so they often communicate very intense displays of emotion when others might see such displays as excessive or unnecessary. This can explain why individuals with BPD are often very draining to friends and family (not to mention therapists) and why they threaten and attempt suicide at a high rate (Wheelis, 2009).

A few core practices are central to DBT: problem solving, validation, and dialectics. When DBT therapists work with clients on problem solving, they help clients “think through” stressful situations that might otherwise evoke an extreme emotional response. In a pragmatic way, they encourage clients to strategize for the best possible outcome, considering what will happen if they act on emotional impulses versus taking more deliberate actions. Additionally, the problem-solving component of DBT includes some discussion of the factors that might have inhibited effective problem solving in the past and how the client can overcome those factors in the present and the future. The validation component of DBT focuses on the client’s feelings, which (as stated earlier) have typically not been validated in the past. Compared with empathy, which is commonplace among many therapies, validation as practiced in DBT is much stronger. It directly, persuasively communicates to BPD clients that their feelings are both important and a sensible reaction to their situation. The dialectics involved in DBT refer to efforts to resolve simultaneous, contradictory feelings or experiences of the client. For example, clients may express a wish to kill themselves yet not do so. In such a situation, the DBT
therapist, with a balance of respect and confrontation, can point out that the client has a wish to live as well as a wish to die and can discuss with the client ways in which the healthier wishes can be strengthened (Dimeff & Koerner, 2007; Koerner, 2012; Koerner & Dimeff, 2007; Wheelis, 2009). Another example of a dialectic involved in DBT is more broad-based: simultaneous acceptance and change of the client. The therapist should strive to communicate the dual message that they accept clients while at the same time pushing them to change, and to get clients to adopt the same attitude toward themselves. Striking a balance between the two is essential (and difficult), because endorsing acceptance too strongly can make clients feel invalidated regarding their emotional pain, while endorsing change too strongly can make clients feel invalidated regarding their overall acceptability (Lungu & Linehan, 2016).

Linehan (1993b) includes four specific modules of skills training within DBT. Collectively, they relate closely to the core components of DBT described above, but they are best described as problem-solving strategies that therapists teach to clients. The skills include

- emotion regulation, which involves identifying, describing, and accepting rather than avoiding negative emotions;
- distress tolerance, which emphasizes the development of self-soothing techniques and impulse control to help clients with BPD minimize such behaviors as suicide attempts, self-harm, and drug abuse;
- interpersonal effectiveness, which helps clients determine appropriately assertive social skills in order to preserve relationships that might otherwise be damaged by extreme emotional outbursts; and
- mindfulness skills, which encourage clients to engage fully in their present lives, including their internal experiences, such as feelings, thoughts, and sensations, without avoidance or evaluation.

**Metacognitive Therapy**

In traditional cognitive therapy, as practiced by Albert Ellis, the irrational belief is brought on by an “activating event” (A in the ABCDE model). The primary idea in the relatively new practice of metacognitive therapy is that the activating event can be a cognition itself rather than some external occurrence. Simply stated, people can become depressed, anxious, or otherwise psychologically unwell because of reactions to their own thoughts rather than their reactions to the things that happen to them (K. S. Dobson, 2013; P. Fisher & Wells, 2009; Wells, 2009). So the cause of our unhappiness is just as likely to be thoughts about thoughts as thoughts about external events.

Metacognitive therapists frequently refer to the cognitive attentional syndrome (CAS), a term that describes a brooding, ruminative, problematic thinking style that can underlie many psychological problems. The CAS can include two types of specific thoughts about worry, positive and negative—and both cause trouble. Positive beliefs about worry may sound like this: “Worrying helps me prepare for the future. If I don’t worry, I could get blindsided by something. The last thing I want to do is stop worrying.” Negative beliefs about worry may sound like this: “Oh no, I have started worrying. Once
I start, I’ll never be able to stop. It’s gonna be a terrible day now that the worrying is happening. This worry is totally out of control.” Whatever the original, external event may have been—a failed exam, upsetting medical news, a relationship breakup, an unexpected financial expense—the client’s thoughts about the event may pile up rather quickly, such that not just thoughts about the event but thoughts about thoughts about the event can be the most relevant trigger of the anxiety. As such, metacognitive therapists make thinking about the primary focus of their interventions.

Metacognitive therapy has been applied primarily to anxiety disorders, including obsessive-compulsive disorders, posttraumatic stress disorder, and generalized anxiety disorder. Although it is a relatively new treatment, evidence for its effectiveness with these disorders has started to appear (D. A. Clark & Beck, 2010; P. Fisher & Wells, 2008; Wells & King, 2006; Wells et al., 2008). A version of metacognitive therapy has also been used with clients who have schizophrenia, where the goal is to promote thinking about delusional thoughts (rather than immediate acceptance of those delusional thoughts; Moritz et al., 2014).

Cognitive Therapy for Medical Problems

The relationship between mind and body can strongly influence the way an individual deals with a medical problem. Of particular interest to cognitive therapists are the beliefs that medical patients hold regarding their illness, injury, or condition. How will it affect them? How will their family members respond or cope with it? How well will treatment work? What negative effects might treatment have? Irrational answers to these questions could unnecessarily hinder recovery, and, moreover, they could cause excessive worry or despair in the process.

In recent decades, numerous studies have indicated that cognitive therapy can have a significantly beneficial effect on the healing process and the ultimate prognosis of medical patients. For example, Jakes, Hallam, McKenna, and Hinchcliffe (1992) examined the effect of cognitive therapy on patients with tinnitus, an auditory problem involving excessive perception of noises. Some of these patients underwent a brief form of cognitive therapy in which their illogical beliefs about the disease were corrected. Compared with patients who did not receive this cognitive therapy, those who did demonstrated significant improvement regarding their level of distress about tinnitus. Cognitive therapy has been successfully applied to many other medical problems as well, including chronic headache, chronic pain, premenstrual syndrome, sexual disorders, spinal cord injuries, and brain injury (Carter, Forys, & Oswald, 2008; A. Freeman & Greenwood, 1987; Jay, Elliott, Fitzgibbons, Woody, & Siegel, 1995).

As an example of the potential of cognitive therapy to positively influence the lives of medical patients, consider Jackie, a 45-year-old woman recently diagnosed in the very early stages of breast cancer. Understandably, Jackie is distressed by the diagnosis, but some of her initial beliefs about the disease are in fact illogical, and these thoughts make her more distraught than she needs to be. For example, Jackie firmly believes, “I’m going to die,” “I’ll need chemotherapy, which will be so painful and miserable that I won’t be able to live through it,” and “My family and friends will distance themselves from me if they find out.” Although these may be possibilities, Jackie may be overestimating their likelihood and, in the process, convincing herself of a worst-case scenario. In cognitive
therapy with Dr. Richards, her clinical psychologist, Jackie challenges the validity of these beliefs and learns to identify irrational thoughts and replace them with more rational thoughts. By the end of a brief course of therapy, Jackie remains concerned about her breast cancer but not excessively so. She is realistic rather than pessimistic: “I could die, but the odds are low because it was caught very early and I’m getting good care”; “I may not need chemotherapy, and if I do, it will be very unpleasant but tolerable”; and “I can’t be sure how my family and friends will react, but their past behavior leads me to believe that most will be quite supportive.” These new beliefs—free of catastrophizing, magnification, mind reading, or other distortions—produce in Jackie a better psychological state and a better medical prognosis as well.

### Schema Therapy

Schema therapy is a relatively recent variation of cognitive and cognitive-behavioral therapy intended for clients who have borderline personality disorder or other long-standing, complex clinical issues. It is based on the idea that when young children experience poor parenting (such as parents who are rejecting, unloving, abusive, unavailable, etc.), they are likely to develop schemas, or deep-seated cognitions about themselves and their relationships to others, that match their experience but are maladaptive as they move forward in life. For example, a child may adopt schemas centering on abandonment (“People who are important to me will leave me”), mistrust (“People in my life will hurt me”), shame (“I must be a terrible, unlovable person”), or failure (“I’m untalented and will never succeed”). These schemas become the focus of therapy. The therapist not only helps the client see how these schemas may be false, but also uses the therapeutic relationship (in which the client is likely to act out these schemas) as a firsthand way to demonstrate their falsehood. The key difference between schema therapy and most other forms of cognitive therapy is the attention paid to the roots of the problematic cognitions—in other words, the focus on early childhood and how it shaped the cognitions, or schemas, that continue to have a negative effect on the client’s current life (Dozois & Brinker, 2015; van Vreeswijk, Broersen, & Nadort, 2012; J. E. Young, Klosko, & Weishaar, 2003). Schema therapy has a notable and growing amount of evidence in the treatment of borderline and other personality disorders (Bamelis, Evers, Spinhoven, & Arntz, 2014; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Reiss, Lieb, Arntz, Shaw, & Farrell, 2014). It has also been used to treat clients with long-term depression and complex eating disorders (Pugh, 2015; Renner, Arntz, Leeuw, & Huibers, 2013).

### HOW WELL DOES IT WORK?

The efficacy of cognitive therapy is strongly supported by a body of empirical evidence that is enormous and continues to grow. Lists of “treatment that work,” including comprehensive books on the subject and websites (e.g., APA Division 12), mention cognitive therapy many times for many disorders (DiGiuseppe et al., 2016). The range of psychological disorders for which cognitive therapy works is expansive, including depression, anxiety disorders (especially generalized anxiety disorder), bulimia, posttraumatic stress...
disorder, hypochondriasis, numerous personality disorders, and others (J. S. Beck, 2002; Cuijpers et al., 2014; Epp, Dobson, & Cottraux, 2009; Hanrahan et al., 2013; Higa-McMillan, Francis, Rith-Najarain, & Chorpita, 2016; Hofmann, Sawyer, Witt, & Oh, 2013; Querstret & Cropley, 2013; Rees & Pritchard, 2015; D. A. Roth et al., 2002). And the improvements that cognitive (and cognitive-behavioral) therapies provide may extend beyond mere symptom relief: One meta-analysis of 44 studies, covering over 3,300 clients, found that cognitive-behavioral therapy had a significantly positive effect not just on the disorder itself but on overall quality of life, including a broad range of physical and psychological variables (Hofmann, Wu, & Boettcher, 2014). And, as stated earlier, studies support the use of cognitive therapy for some medical problems and some personality disorders as well. Specific components of cognitive therapy have also received empirical support; for example, numerous studies have found that homework enhances therapy outcome in comparison with similar therapies that do not include homework (e.g., Dozois, 2010; Kazantzis, Whittington, & Dattilio, 2010).

Some of the evidence supporting the efficacy of cognitive therapy specifically focuses on REBT. One meta-analysis of dozens of REBT treatment outcome studies over a 50-year period found strong evidence for its ability to reduce irrational beliefs and produce positive outcomes (David et al., 2018). Another meta-analysis found that simply having rational beliefs—the primary aim of the REBT approach—significantly negatively correlates with psychological distress. In other words, as rational beliefs increase, the chances of psychological problems (broadly defined) drop. The most important rational beliefs appeared to be those related to self-acceptance (Oltean & David, 2018).

Evidence is accumulating for the third-wave, mindfulness-based therapies as well (Banks, Newman, & Saleem, 2015; Bos, Mereau, Brink, Sanderman, & Bartels-Velthuis, 2014; Feliu-Soler et al., 2018; Norton, Abbott, Norberg, & Hunt, 2015). A large-scale meta-analysis of over 200 studies of mindfulness-based therapies, covering more than 12,000 clients, found robust effects across a wide range of clinical problems, especially anxiety disorders, depression, and stress (Khoury et al., 2013). Mindfulness-based therapies have also been found to have positive effects in meta-analyses that focus on specific problems like eating disorders, psychosis, and weight loss (Carrière, Khoury, Günak, & Knäuper, 2018; Linardon, Gleeson, Yap, Murphy, & Brennan, 2019; Louise, Fitzpatrick, Strauss, Rossell, & Thomas, 2018). DBT is particularly well established as a treatment that works for borderline personality disorder and an increasingly wide range of additional disorders (Dimeff & Koerner, 2007; Kliem et al., 2010; Koerner, 2012; Lynch et al., 2007; Paris, 2009). ACT has also accumulated an impressive amount of empirical evidence in the treatment of various anxiety and mood disorders and some other disorders as well (D. M. Davis & Hayes, 2011; Hofmann et al., 2010; Olatunji & Feldman, 2008; Roemer & Orsillo, 2009; Swain, Hancock, Hainsworth, & Bowman, 2013). Evidence is also growing for the benefits of schema therapy for borderline personality disorder and perhaps for other disorders such as chronic depression and complex eating disorders (Jacob & Arntz, 2015; Pugh, 2015; Renner et al., 2013).

As a result of this therapy’s roots in the behavioral movement, cognitive therapists typically emphasize aspects of therapy that facilitate empirical evaluation, such as defining problems in terms that can be overtly measured and observed. If these terms are not blatantly behavioral, they may take the form of numerical ratings that clients assign to symptoms’ severity (such as depressed mood or anxiety level) both before and after
cognitive interventions. So, although a client’s anxiety may rate a 90 on a 0 to 100 scale before therapy, it may drop to 60 after a few sessions and to 20 by the time therapy is complete. Such objectivity facilitates empirical outcome research designed to determine how well cognitive therapy works.

**Denise in Cognitive Psychotherapy**

In the first session with Denise, it was evident that her primary symptoms were depressive and that the event that precipitated these depressive symptoms was the change in ownership of the restaurant where she works as a chef. More specifically, the new owner’s policies—implementing a menu over which Denise has no control and prohibiting her from visiting with customers in the dining room—seemed to have triggered Denise’s depressive symptoms.

I proceeded to treat Denise using a style of cognitive therapy that included aspects of both Ellis’s and Beck’s techniques. First, I educated Denise about the cognitive model by explaining that although sometimes we experience life as if events directly cause feelings, there are, in fact, automatic thoughts or beliefs that intervene. I used Ellis’s ABCDE model to further illustrate how Denise could understand her experience, and I provided her with a list of Beck’s cognitive distortions to equip her with the tools she would need to dispute her irrational thoughts in Column D. Denise had no trouble filling in Columns A (activating event) and C (emotional consequence) of this model. The implementation of the new restaurant policies was the activating event, and her depressive symptoms represented the emotional consequence. Our next task was to identify the beliefs (B) that occurred between A and C. This was a bit of a struggle for Denise, but with some exploration and discussion, we identified this powerful thought: “I’m incompetent.” Denise explained that she could think of no other reason why her new boss would bar her from determining the menu or from talking with diners. The boss’s new policies, Denise believed, were motivated by the boss’s desire to prevent Denise’s incompetence from ruining the restaurant’s business.

The next stage in therapy focused on Stage D (dispute), where I encouraged Denise to think critically about her belief (B) that she was incompetent. I asked a number of questions to facilitate this process, such as, “What evidence do you have that you are incompetent?” “What evidence do you have that you are not incompetent?” and “How else might we be able to interpret your new boss’s policies?” At first, the notion of challenging her original (illogical) belief seemed foreign to Denise, and she struggled a bit with this task. But after a few sessions, it became more familiar and comfortable for her. Using homework assignments, I asked Denise to complete a five-column thought journal in which she identified not only activating events, beliefs, and emotional consequences but also disputes and effective new beliefs. These last two columns represented uncharted territory for Denise, but
(Continued)

with time she became quite adept at completing the entire table. Specifically, Denise applied the following thought distortion labels:

- **Personalization** (Maybe the new boss would have implemented these new policies regardless of the chef who held Denise’s position; if so, Denise need not take them personally.)
- **Mental filtering** (Denise had been extremely competent as a chef and in other capacities throughout her life, yet she was focusing exclusively on this presumed slight by her new boss.)
- **All-or-nothing thinking** (Denise may not share her new boss’s preferences, but there were still many things she loved about working as a chef. Just because her job wasn’t perfect, she need not think of it as terrible. Instead, it may fall somewhere in between.)

Individually, any of these disputes was effective enough to negate Denise’s illogical thoughts of incompetence, and in combination they were especially potent. By the end of therapy, Denise was completing Column E (effective new belief) with ease: “I’m not incompetent at all. My new boss’s actions may have little or nothing to do with me personally; I have plenty of evidence that I am a competent person, and even if I don’t like my job as much as I used to, it’s still enjoyable and fulfilling in some ways.” As a result of her disputes and effective new beliefs, Denise’s depressive symptoms improved dramatically.

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**CHAPTER SUMMARY**

The primary goal of cognitive therapy, which has become the most commonly practiced approach to psychotherapy among clinical psychologists, is to promote logical thinking. Cognitive therapists accomplish this goal by helping clients recognize and revise cognitions that are illogical or irrational during a course of therapy that is typically brief, structured, and problem focused. Their techniques involve teaching clients about the cognitive model, in which cognitions intervene between events and feelings, and assigning written or behavioral homework to be completed between sessions. Whether using Albert Ellis’s ABCDE model (highlighted by disputing irrational beliefs and replacing them with effective new beliefs) or Aaron Beck’s list of common thought distortions (e.g., **all-or-nothing thinking**, **personalization**, **magnification/minimization**), cognitive therapists enable clients to overcome psychological and behavioral problems by insisting on a logical response to the events of their lives. Although cognitive therapy originally targeted anxiety and mood disorders, it is now applied to most other psychological disorders, including personality disorders, and to other issues such as medical problems and minor psychological problems that fall short of diagnostic criteria. A large and increasing body of outcome studies suggests that cognitive therapy is highly efficacious for a wide range of psychological disorders, including mood disorders, anxiety disorders, eating disorders, and others.
KEY TERMS AND NAMES

ABCDE model 370
acceptance 380
acceptance and commitment therapy (ACT) 381
activating event 371
all-or-nothing thinking 375
automatic thoughts 366
Aaron Beck 364
Judith Beck 374
belief 371
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personalization 375
rational emotive behavior therapy (REBT) 370
CRITICAL THINKING QUESTIONS

1. To what extent do you agree with the fundamental cognitive assumption that illogical or irrational thinking underlies psychological problems?

2. If you were the client, how would you respond to the assignment of homework by your therapist?

3. If you were a clinical psychologist practicing cognitive therapy, which of Albert Ellis’s ABCDE columns would you expect clients to have the most trouble filling in?

4. In your opinion, do any of the common thought distortions that Aaron Beck and his followers defined seem to predispose individuals to particular types of psychological problems (e.g., anxiety, depression, others)?

5. What are the primary differences between traditional cognitive therapy and the more recently developed metacognitive therapy?

LOOKING TOWARD GRADUATE PROGRAMS

The following table is a list of index entries in the Insider’s Guide to Graduate Programs in Clinical and Counseling Psychology (Sayette & Norcross, 2018) relevant to the topics in this chapter (see page 25 in Chapter 1 for more information about the Insider’s Guide). Keep in mind a few things as you consider these listings: They are current as of the 2018/2019 edition of the Insider’s Guide (which typically revises every two years); they may have changed as faculty members retire, take new jobs, or develop new interests; and a graduate program’s own website may have more extensive or up-to-date information.
## KEY JOURNALS

Links available at edge.sagepub/pomerantz5e

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<th>Cognitive Behaviour Therapy</th>
<th>Cognitive Therapy and Research</th>
<th>International Journal of Cognitive Therapy</th>
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## STUDENT STUDY SITE RESOURCES

Visit the study site at edge.sagepub/pomerantz5e for these additional learning tools:

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- Culture expert interviews
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