2321 Theory & Practice 2: Lecture 7

COGNITIVE THERAPY (CT):Aaron T. Beck (b. 1921)

Dr Ian R. Ridgway

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INTRODUCTION

Aaron T. Beck (who calls himself 'Tim') was initially trained in psychoanalysis (as was Albert Ellis[1]). Beck was researching depression under the psychoanalytical understanding that depression resulted from anger turned against the self and was examining dream content in order to find this 'retroflected anger' (Corey, 1996: 338). However, what caught his attention was that depressed clients had a pronounced negative bias in their interpretations of themselves leading to strong self-disparagement.

He came to believe that systematic errors in logical thinking caused depression. These thoughts were understood to be 'automatic', derived from generalisations of past experience.

Although Beck began his work in the area of depression, latterly he has begun to work with Borderline Personality Disorder and Schizophrenia. In both these cases, therapy aims to gently persuade CT that beliefs cannot be supported by evidence. Interestingly, Beck also accepts that intense feelings sometimes lead to beliefs (American Psychological Association, 2000-2002).

1. THE BEHAVIOURIST BACKGROUND

The early behaviourist, J. B. Watson, believed that only external behaviour could be used for psychological subject matter. For him, psychology was the science of behaviour.[2] Using this understanding, everything done by humans became 'behaviour' if one could operationalise it in external, observable action. (Thinking could be understood in terms of the depth of the concentration lines on one's face![3])

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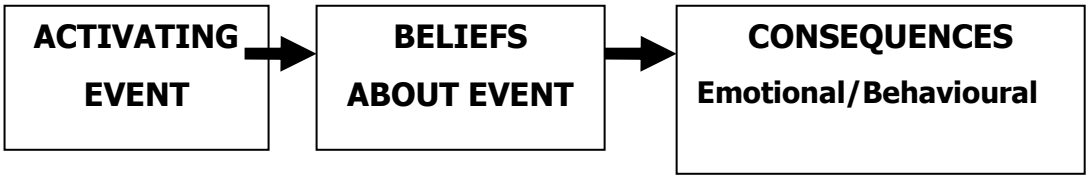
[1] Both Beck and Ellis were also influenced by Karen Horney. Indeed, Ellis used her approach for some time. Horney used to speak of the 'tyranny of the shoulds', which Ellis expressed in his notion of *must-erbating*. Note that this idea stems from Freud's concept of the superego and its 'shoulds'. However, for Freud, the superego is unconscious.

[2] But, B. F. Skinner et al., pointed out that one's own inner states were also behaviour because they could be directly observed.

[3] I'm joking at this point but you get the point I hope.

However, Ellis took the bold step of saying that 'self-talk' was not only a behaviour but a behaviour one could infer[4] from what a person was experiencing following a particular 'activating event'. Ellis had put forward an **ABC** model to explain his ideas where **A** represents an *activating event*. **B** represents his beliefs about the event and **C** represents the emotional and behavioural *consequences* following the beliefs. For Ellis, we are what we think and we disturb ourselves when we tell ourselves repeatedly irrational sentences that we have learned from our backgrounds or devised ourselves.



Even with the coming of the 'cognitive revolution', many behaviourists refused to accept that cognitions could determine emotions/behaviour because to their minds cognitions were simply another class of behaviour and one behaviour could not determine another. For them, what determined behaviours were antecedents and consequences.

Beck was critical of the purely behaviourist approach believing that CTs were helped by behaviourist techniques primarily because their cognitions changed during the procedures. However, behaviourists may argue that this proposition is an unproven supposition. Doubtless, cognitions do change during behavioural techniques but that does not prove that cognitions are the determining factor. Moreover, evidence exists that shows that behaviour therapy alone can significantly improve depressive conditions through a procedure known as 'behavioural activation'.

[4] This process of inference is a weakness in REBT. **A** and **C** are demonstrable but Ellis arrives at B by saying that if A and C have occurred then 'you must have been saying this and this to yourself'. Well, how do we know any such thing?

2. BECK AND ELLIS

In an interview at the American Psychological Association in 2000, Beck and Ellis were interviewed together and asked about any differences they had. They commented that the differences were 'slight' being 'mostly in technique and style, more than in perspective' (American Psychological Association, 2000-2002).

I think it is true that they are 'very close to each other's beliefs about beliefs'. Beck seems to be centrally concerned about particular illogical thought ***processes*** (e.g., all or nothing thinking) that provoke emotional disorder. Ellis seems to be more focussed on ***particular thoughts*** that one should not keep thinking! However, Beck's theory proposes that the processes are derived from core beliefs (American Psychological Association, 2000-2002). Nevertheless, differences are apparent in style with Beck being more of a collaborator than a dictator(!) urging the CT to sit with the therapist and 'reason together' like rational humans. Moreover, Beck is strongly opposed to telling people that a particular irrational belief is the sources of their problems because it is not the belief *per se* but rather that the idea is 'too absolute, broad, and extreme' (Corey, 1996: 340).

In an interview at the American Psychological Association's Conference in 2003, Beck[5] described three attitudes that he believed were at the 'core of many problems' (2003-2005: n. p.):

'If I feel something strongly I should express it.'
'I feel I shouldn't express myself but I have to.'
'If I express myself people will listen to me.'

[5] Ellis was scheduled to be a speaker too but was too sick to attend. He was 90 after all!

Although the report does not elaborate on these three propositions, I understand[6] them to be 3 beliefs that Beck does not accept. (1) Feeling something strongly and then expressing it just because you feel it can get you into much trouble! Feeling needs to be combined with wisdom and knowledge; (2) the belief that I cannot control myself is a dangerous and inaccurate belief; (3) oddly enough, the belief that people will simply listen to me if I 'express myself' which I equate with telling others how I feel, is not true.

3. CT AND DEPRESSION

The study and control of depression has been a major focus of Beck because his early researches were into psychoanalytic explanations of depression. In those studies, he found that depressed clients had a pronounced negative bias in their interpretations of themselves leading to low self-acceptance. Later he found that the negative bias also included the world and the future. Beck called these three aspects the 'cognitive triangle' and understood that negative cognitions about oneself, the world and the future will cause[7] depression (Corey 1996: 344).

Two fundamentals exist for CT (and REBT): first, thoughts and feelings are different phenomena. If our hand accidentally touches a hot stove, we feel a burning sensation or feeling. We may then think, 'That's a hot stove!' or some other expletive! It would make no sense to say to someone you are not really feeling burnt. One cannot argue with feelings according to the cognitivists. One just feels them.[8] However, if this same person were to *think* that he was going to die, we could rightly challenge the soundness of this thought.

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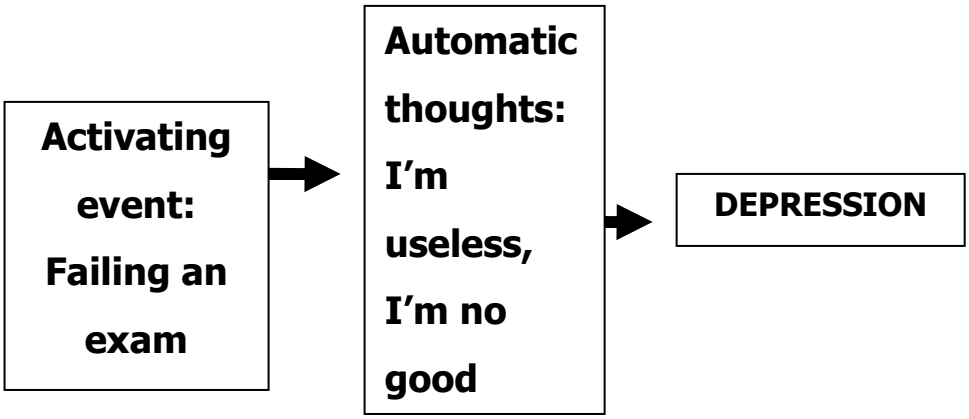
[6] I could, of course, be wrong in my interpretations.
[7] Actually, note that we do not really know whether they cause the depression. All we really know is that they accompany the depressed mood.
[8] However, this proposition is not completely true. If one were to feel pleasure at someone being tortured, we would rightly say that that feeling was wrong or inappropriate.

Second, thoughts create feelings/emotions and behaviour (Leahy, 2003: 9). This fundamental can be used by a CR when faced with a CT who says that he has been sad and crying over the last two weeks. The CR explores with the CT the **why** of the sadness (a depression possibly or one in the making) by having the CT provide information about what he is saying to himself repeatedly as he feels sad. What is he thinking? Beck puts emphasis upon the CT identifying what the automatic repetitious thoughts causing the depression are.

In the example below, a CT presents with a chronic low mood problem. The CR will move quickly to some instruction regarding the connection between thoughts and low mood and to asking the CT the thoughts that are present with the depressed mood. The person may also *feel* that she is useless and no good but what is most important (for CBT) is to establish whether these sentences (in the diagram) are fair representations[9] of what she is thinking.



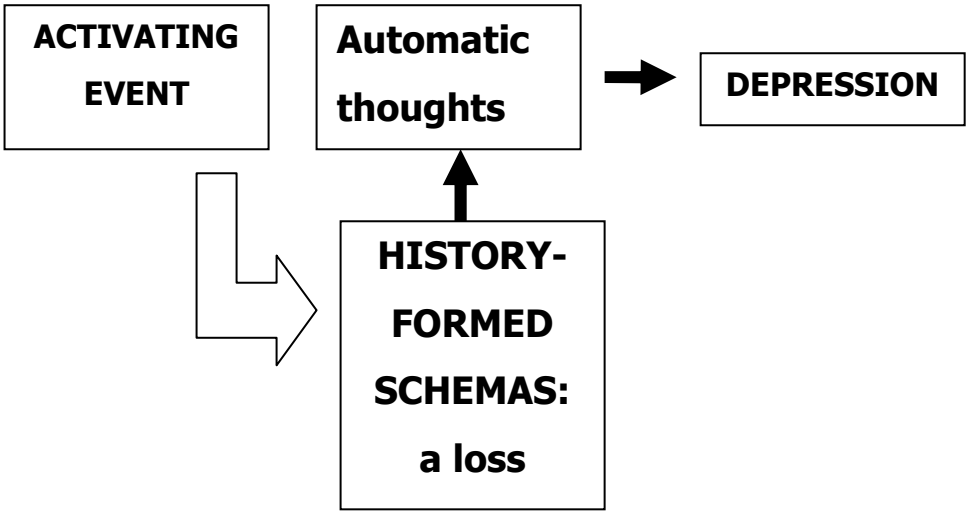
This fundamental can also be demonstrated to a client by having her first think and say to herself, 'I'll never be happy again' and then note the 'feeling of hopelessness' that follows. However, if the client thinks, 'I will be happy

[9] In psychology a lively argument exists between those who say we think in words as opposed to those who say we think wordlessly.

again if I work at it' then the feeling that follows may be relief or a feeling of hope.

a) Depressive schema

However, depression is not quite as simple as that, wouldn't you know it! Like Ellis (and like Freud et al.) before him, Beck is well aware that automatic thoughts by themselves are not the whole answer and that CTs come to therapy with a history of caretaker abuse, poverty, neglect, indifference or instability. This history builds up a depressive schema which is activated whenever certain sensitive happenings take place.



For example, the CT may be very sensitive to losses of all types because at an early age some wounding loss occurred, which may not have been anyone's fault, but left a scar on the child's life. This experience began a history of building a cognitive schema upon that original loss situation which shows itself repeatedly, more intensely, as life goes on. For example, a significant loss of one's parents for young children is a significant anxiety-provoking and mood-depressing occurrence which can lead to the development of a 'loss phobia'. Such a condition cannot be simply treated by challenging surface automatic thoughts.

b) Distortions in thinking

Beck essentially believes that distortions in thinking cause disordered emotional and behavioural consequences. Hence, we need to identify not only the automatic thoughts (e. g., I'm a failure) but the type of distortion that displayed in the automatic thought. Leahy (2003: 19) presents the following helpful table illustrating this relationship between automatic thought and thinking distortion.

AUTOMATIC THOUGHTS	**THINKING DISTORTION**
I'm a failure	Mislabelling
She thinks I'm unattractive	Mind reading
Nothing I do works out	All-or-nothing thinking
Anyone can do this job – it doesn't mean anything	Discounting positives

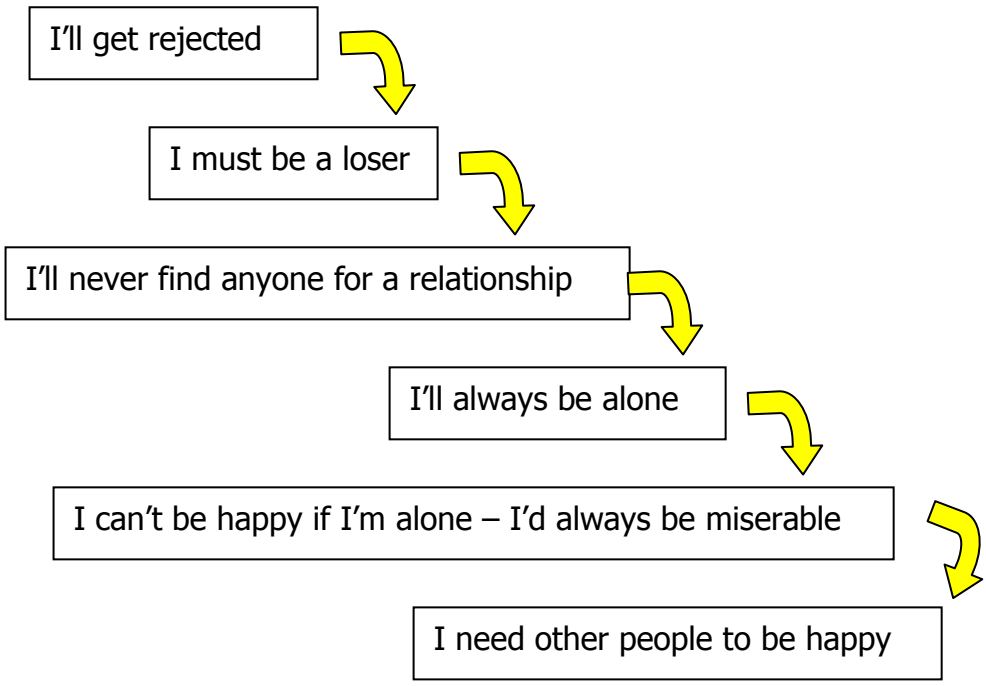
Categorising does not mean refutation or the negating of these thoughts. To be told that one is mind reading does not help me as such. We would have to go further and examine the 'facts' according to Leahy (2003: 19).

4. TECHNIQUES

a) The technique of vertical descent

Some negative thoughts do turn out to be true. If a person were to say that he won't ask a certain young woman at work out because he is afraid she will say no, this may, in fact, be an accurate prediction. It is fortune-telling or mind-reading (?)[10] but she may reject his offer for any number of reasons. However, the therapist is undeterred. What she does is ask, 'What would that mean to you if that happened?' 'What would you think?' 'What would happen next?'

[10] I wonder whether this example is a *logical* error. All rational humanity makes predictions about what others will do. We are not always right or always wrong but we need to make predictions in order to make our way through life.



One of the principles illustrated is that particular thoughts are connected to other thoughts. A web of thoughts and beliefs swirl around the rejection situation.

b) Assigning probabilities in the sequence

With the construction of the diagram above the CT is asked to assign probabilities to each of the items in the descent. She poses the questions: What is the probability that this would happen? What is the likelihood from 0% to 100%?

Most of the above cannot be ranked as either 0% or 100%. So if you ask this woman for a date what is the likelihood that she will say no? If he says 90% then the therapist continues with each thought in the descent until there are six fractions beginning with .90 for the first. Suppose those six fractions are .80, .30, .40, .30, .50, .70.[11] These are multiplied together

[11] I have been fairly bleak in my probabilities!

using a calculator to give 0.01001, that is, 1 chance in 100 of all these thoughts being accurate.

That is a remote probability! However, the CT may say but what if I am that one! The CR needs to ask, 'Are there other areas of your life where you tolerate uncertainty?' 'How come you tolerate it in that area and not in this area?' 'What are the costs and benefits of demanding certainly?'

c) The technique of guessing the thought

Sometimes CTs are not able to identify relevant thoughts. Maybe the emotions are so strong that focussing on thoughts becomes extremely difficult. *One does need to be able to sense or feel that this particular thought fits with the inappropriate feeling/emotion I am experiencing*. Or, maybe the thoughts are not necessarily easy to translate into language as I mentioned earlier in a footnote.

Whatever the case, Leahy recommends the technique of guessing the missing thought. The CR will ask to CT to suggest what might be the thoughts that would go with these feelings. The CR will then say, 'Is it possible you are saying these things to yourself'? What the CT does not do is suggest that she knows what the CT is thinking. [This process contrasts with that of Ellis who will tell a client that if she is feeling this particular way then she ***must*** be saying these types of things to herself!] This procedure is consistent with Beck's collaborative approach.

5. BECK DEPRESSION INVENTORY (BDI)

The 21-item scale takes about 10 minutes to complete and requires a 5^{th}-6^{th} grade reading age (Stinton, 2005: n. p.). It was developed by Beck and associates in 1961 and copyrighted in 1978. Both the older and newer versions have been found to be highly correlated (.94).

a) Reliability

A decent time interval of more than 6 weeks is needed to ensure reliability in scores. With an alternate form, reliabilities have ranged between .89 and .97 (Stinton, 2005).

b) Validity

All tests need to exhibit validity regarding their major construct(s). Some have suggested that the BDI 'is not specific to depression' (Stinton, 2005). Convergent validity is good with the scale showing up depression in Spanish, Persian and Chinese-speaking people. Discriminant validity is also good with the BDI discriminating between psychiatric and non-psychiatric patients.

i) Scoring

With 21 items that can score from zero to three, the highest score obtainable is 63 (21 X 3) while the lowest is zero.

ii) Totals

05-09 considered normal
10-18 mild to moderate depression
19-29 moderate to severe depression
30-63 severe depression

Please note that counsellors are *not* permitted *by law* to administer the BDI because it is considered a psychological test. However, it can be administered by a counsellor if directly supervised by a psychologist.

6. OTHER PSYCHOPATHOLOGY

Beck's investigation of depressive phenomena led to his using his findings for a general theory of psychopathology which he has started to apply to borderline personality disorder and schizophrenia (American Psychological Association, 2003-2005). Others such Freeman and Dattilio (cited in Corey 1996: 343) indicate that CT has been used with:

> generalized anxiety disorder, performance anxiety, social phobia, panic attacks, chronic pain, posttraumatic stress disorders, adjustment disorders, narcissistic personality disorders, marital and family dysfunction and schizophrenic disorders.

7. COGNITIVE THERAPY in the light of 'Dooyeweerd'

Beck's cognitive therapy (CTh) appeals to the connection between the sensitive and the logical aspects. For example, in depression with which Beck has worked extensively, depression appears to be strongly associated with what Beck called negative 'automatic thoughts'.[12] These thoughts come involuntarily and spontaneously when the depression-prone person is plunged into a loss. Beck suggested that these thoughts *caused* the depression.[13] However, after developing his ideas further, he concluded that one cannot simply identify the negative 'automatic thoughts' that depressed people have with a significant loss and seek to remove them. One had to identify the *type* of distortions in thought that were evident: for example, the distortion known as 'mind-reading' is the practice of pretending to know what someone else is thinking about oneself. The counsellee may be accurate in his suspicion but merely holding onto an untested belief that someone has a negative opinion of him is bound to result in diminished self-feeling.

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[12] In Beck's initial research, the presence of such 'automatic thoughts' prompted him to reject Freudian psychotherapy.

[13] Others were to point out that the depression could have caused the thoughts or both could have been caused by something else.

Beck's therapy aims to persuade clients gently that their unhappy feelings are based on beliefs that cannot be supported by evidence (American Psychological Association, 2000-2002). CT appeals to the counsellee's 'sense of logic' but is seeking to awaken the counsellee to his, as yet, limited sense of logic, believing that a more developed 'sense of logic' will be foundational to ridding the person of his emotional distress (Leahy, 2003: n. p.).

REFERENCES

American Psychological Association. (2000-2002). *APA 108th Convention Washington DC, August 4-8, 2000. Asynchonously live from APA 2000*. Available Internet: (http://fenichel.com/Beck-Ellis.shtml) (11th July 2007).

American Psychological Association. (2003-2005). *Getting it right - legend Aaron Beck in conversation with Frank Farley*. Available Internet: (http://fenichel.com/Beck2003.shtml) (December 25th 2006).

Corey, G. (1996). *Theory and practice of counseling and psychotherapy.* (5th ed.). Pacific Grove, CA: Brooks/Cole Publishing Co.

Leahy, R. L. (2003). Eliciting thoughts and assumptions. In *Cognitive therapy techniques: A practitioner's guide*. Available Internet: (http://www.guilford.com/excerpts/leahy3.pdf) (14th July 2006).

Stinton, L. (2005). *Beck Depression Inventory (BDI)*. Available Internet: (http://www.swin.edu.au/victims/resources/assessment/affect/bdi.html) (Accessed 11th July 2007).