Cognitive therapy (CT), a system of psychotherapy with an operationalized treatment, is based on an elaborated theory of psychopathology and personality. The theory has been empirically validated in hundreds of cognitive science studies, and the therapy itself has been demonstrated to be effective in hundreds of randomized controlled trials for a wide variety of psychiatric disorders, psychological problems, and medical conditions with psychological components (Beck, 2005). Research has shown that CT is highly effective in helping patients not only overcome their disorders but also in preventing relapse (Hollon et al., 2005).

CT treatment is goal-oriented, time-sensitive, educative, and collaborative, and it is based on an information-processing model. The cognitive model posits that the way people perceive their experiences influences their emotional, behavioral, and physiological reactions. Correcting misperceptions and modifying unhelpful thinking and behavior brings about improved reactions (Beck, 1964).

CT was developed in the early 1960s by Aaron T. Beck, a psychiatrist. Trained as a psychoanalyst, Beck conducted a series of experiments in the 1950s that he believed would provide scientific validation of the psychoanalytic concepts of depression. When his research failed to validate the notion that depression was a result of retroflected hostility, he began further investigations into the nature of this psychiatric disorder. He discovered that depressed patients displayed a characteristic negative bias in their thinking. They continually had spontaneously occurring negative cognitions (“automatic thoughts” that were verbal or imaginal in nature) about themselves, their worlds, and their future. Beck found that his depressed patients rapidly improved when he moved from free association to a more directive style of treatment in which he and his patients focused on solving current problems and engaged in collaborative empiricism, jointly investigating the accuracy and utility of the patients’ automatic thoughts. When patients solved their problems, modified their dysfunctional behavior, and corrected the distortions in their thinking, they quickly experienced enduring improvement in their mood, symptoms, functioning, and relationships (Beck, 1979).

After developing the cognitive theory and therapy of depression, Beck and colleagues turned their attention to developing cognitive formulations and treatments for other disorders. They found, for example, that anxious patients were pre-occupied with fearful automatic thoughts about danger, risk, vulnerability, and their inability to cope effectively to prevent or handle adverse circumstances. The
thinking of substance-abusing patients was characterized by an underestimation of the risks of using drugs or alcohol and by permission-giving cognitions. By the early years of the twenty-first century, researchers throughout the world had found empirical validation for the theory and treatment of a myriad of disorders, including various forms of depression, the range of anxiety disorders, eating disorders, body dysmorphic disorder, somatization disorder, substance abuse, personality disorders, and, in conjunction with medication, severe mental illnesses such as bipolar disorder and schizophrenia. CT has also been shown to be effective in the treatment of medical conditions such as insomnia, infertility, fibromyalgia, chronic pain, irritable bowel syndrome, erectile dysfunction, obesity, premenstrual syndrome, and migraine headaches. The therapy has been adapted and its efficacy demonstrated in individual and group treatment, for children and adolescents, for adults and older adults, and for couples and families.

The theory of CT was influenced by Greek Stoic philosophers and by a number of contemporary theorists such as Adler, Alexander, Horney, Sullivan, Kelly, Arnold, Ellis, Lazarus, Bandura, Lewinsohn, and Meichenbaum. Breaking with psychoanalytic models of theory and practice, Beck incorporated behavioral approaches as espoused by social learning, stress inoculation training, problem solving training, and self-control therapy, with a primary emphasis on changing cognition as well as behavior.

CT treatment is based on a cognitive formulation that varies from disorder to disorder (Beck, 1967). In panic disorder, for example, therapy focuses on the catastrophic misinterpretation of symptoms and extinction of avoidance behaviors. CT treatment is also based on a specific cognitive conceptualization of the individual. One patient, for example, thought, “I’m having a heart attack,” whenever she perceived that her heart was beating rapidly. Her specific safety behaviors were to avoid physical exertion and to leave situations when she started to feel anxious. The cognitive formulation of avoidant personality disorder involves negative beliefs about the self and others, and cognitive, behavioral, social, and emotional avoidance. One such patient had automatic thoughts such as “No one likes me,” “I can’t stand feeling this way,” and “If I go to the party, people will reject me.” He avoided most social occasions, and, when he did attend an event, he avoided making eye contact, conversing with others, and drawing attention to himself. He tried to avoid even thinking about things that led to his feeling anxious and thereby distracted himself whenever he experienced a negative emotion.

The cognitive formulation of patients’ disorders focuses not only on their most superficial level of thinking (their automatic thoughts), but also on deeper level cognitions (their basic assumptions and core beliefs) and patterns of dysfunctional behavior. A man with paranoia may think, “My neighbors are plotting against me,” which is a specific reflection of his general core beliefs, “I am vulnerable” and “People are likely to hurt me.” He displays characteristic behaviors, or coping strategies, of guardedness and vigilance for interpersonal harm, related to his basic assumptions, “If I trust others, I’ll be harmed” and “If I’m always on guard, I can protect myself.”

The current emotional and behavioral reactions of patients are understandable once their perceptions of situations are elicited; these perceptions make sense once the basic way they view themselves, their worlds, and other people, together with their characteristic ways of coping with their experiences, are identified. The treatment of patients with personality disorders (as compared with symptomatic disorders like depression and anxiety) generally requires a greater emphasis on understanding the meaning to patients of their adverse childhood experiences; how these experiences led to the development and maintenance of extremely strong, rigid, global beliefs about the self, world, and others; how these beliefs shape their interpretations of current experiences; how these beliefs could
be faulty (despite the very strong sense patients have that these ideas are true); and how, over time, these beliefs can be modified (Beck et al, 2004; Beck, 2005).

When conceptualizing and treating individual patients, the therapist is informed by the general cognitive formulation of the patient’s disorder(s) and collects data to develop an individualized cognitive conceptualization. Treatment is modified to suit the individual’s preferences, and the therapist takes into consideration relevant factors such as the patient’s age, gender, developmental level, ethnicity, culture, religious beliefs, and childhood, family, social, educational, vocational, medical, and psychiatric history.

Therapists initially conduct an intensive evaluation to diagnose patients on the five axes of DSM-IV, including an emphasis on current functioning and a review of pertinent aspects of the patient’s history. Based on this evaluation and on the cognitive formulation of patients’ disorder(s), therapists present a general treatment plan. Using examples from patients’ recent distressing experiences, therapists conceptualize and help patients understand how their thinking has influenced their emotions, behavior, and sometimes physiology as well. They emphasize that patients get better by making small, daily changes in their thinking and behavior and that the overall goal of treatment is to teach patients to become their own therapist. Therapists elicit feedback from the patient about the treatment plan and modify it, if needed. They then elicit specific behavioral goals that the patient wishes to accomplish as a result of treatment.

CT sessions are structured to make maximal use of time to help patients solve their problems, feel better by the end of the session, and develop a plan to improve their experience in the coming week(s). At the beginning of sessions, therapists reestablish rapport with patients and collect data to organize the session. They conduct a mood check to ensure that patients’ symptoms are diminishing over time. They elicit important experiences, both negative and positive, from the past week that might bear further discussion, they review homework, and they inquire whether important events or problems might arise in the coming week and should be discussed. To set a collaborative agenda, therapists summarize this information and ask patients which problems they most want help in solving. Together they prioritize the problems and plan how to divide the session time.

In the context of solving specific problems, therapists collect data, plan a strategy, and determine needed techniques. They provide a rationale for their interventions, elicit feedback, and modify their approach as needed. They primarily use Socratic questioning and guided discovery to help patients identify, evaluate, and modify key cognitions. They directly teach patients skills to solve their own problems; to test their thinking through a process of realistic appraisal and/or behavioral experiments; to develop new core beliefs; to alter maladaptive behavior; to improve daily functioning and relationships; and to regulate emotion. They continually elicit feedback to ensure that patients find interventions useful. After discussing a problem and devising a plan of action for patients to carry out at home, therapists ask patients to summarize key points of their discussion, which the therapist or patient then writes down. They also record what the patient has decided to do about the problem in the coming week, for example, by instituting solutions to problems, reading therapy notes, testing the validity and utility of automatic thoughts and beliefs, responding to predicted and novel cognitions, and trying new behavioral skills.

Toward the end of the session, therapists and patients review the follow-up tasks (homework) and, if needed, modify the tasks or the patient’s maladaptive thinking about the tasks, to ensure that the
patient is highly likely to accomplish them. Therapists then elicit feedback on the session as a whole, asking whether patients felt accurately understood, whether they found the session helpful, and whether they would like to make changes in the next treatment session (Beck, 1995).

A number of studies have demonstrated that the degree to which therapists follow these principles of treatment is associated with the degree of improvement their patients display. The Cognitive Therapy Rating Scale (available from http://www.academyofct.org, along with an instructional manual) provides a summary of these skills and is an essential tool to ensure treatment fidelity and efficacy. It measures general therapeutic skills in setting agendas, eliciting feedback, accurate understanding, interpersonal effectiveness, collaboration, and pacing and making efficient use of time. It also emphasizes conceptualization, strategy, and technique, through an assessment of the expertise therapists display in guided discovery, focusing on key cognitions and behaviors, strategy for change, application of techniques, and homework design and review (Young & Beck, 1980).

The field of cognitive therapy is likely to expand as it continues to gain credibility, not only through the overwhelming evidence of outcome research but also newly demonstrated changes in the neurobiology of patients treated with CT (Beck, 2008). The number of cognitive scientists, researchers, and practitioners worldwide continues to grow exponentially, and new discoveries serve to continually help clinicians refine their understanding and treatment of psychiatric disorders, psychological problems, and medical problems with psychological components.

See also
Behavior Modification; Cognitive Behavioral Analysis System of Psychotherapy.

References
APA

Chicago

Harvard

MLA