Depressive Disorders

Cognitive Therapy of Affective Disorders

Cory F. Newman, PhD and Aaron T. Beck, MD

Cognitive Therapy of Affective Disorders

Cory F. Newman, PhD and Aaron T. Beck, MD

e-Book 2015 International Psychotherapy Institute
freepsychotherapybooks.org

From *Depressive Disorders* edited by Benjamin Wolberg & George Stricker

Copyright © 1990 by John Wiley & Sons, Inc.

All Rights Reserved

Created in the United States of America

Table of Contents

MAJOR PREMISES AND HISTORICAL FOUNDATIONS

CHARACTERISTICS AND COMPONENTS OF COGNITIVE THERAPY

SPECIAL ISSUES IN ADAPTING COGNITIVE THERAPY TO DYSTHYMIC AND BIPOLAR DISORDERS

SUMMARY

REFERENCES

Cognitive Therapy of Affective Disorders

Of all the psychological ailments that plague modern humans, perhaps the most pervasive are the affective disorders. These mood syndromes, including major depression, dysthymia, and bipolar disorder, exact a great toll—diminished quality of life, disturbances of physical well-being, disrupted relationships, interference with academic and vocational performance, and threats to life itself. Traditionally, pharmacotherapy has been the treatment of choice; however, in the past 20 years we have witnessed the rise of short-term psychotherapies for the affective disorders, with special emphasis on unipolar depression.

The cognitive theory of depression (Beck, 1967, 1976; Beck, Rush, Shaw, & Emery, 1979) is at the forefront of such psychotherapeutic approaches, with substantial outcome data supporting its efficacy in both relieving symptomatology (Beck, Hollon, Young, Bedrosian, & Budenz, 1985; Blackburn, Bishop, Glen, Whalley, & Christie, 1981; Dobson, in press; Gallagher & Thompson, 1982; Hollon et al., 1986; Murphy, Simons, Wetzel, & Lustman, 1984; Rush, Beck, Kovacs, & Hollon, 1977; Shaw, 1977; Taylor & Marshall, 1977), and preventing subsequent relapse (Blackburn, Eunson, & Bishop, 1986; Evans et al., 1986; Kovacs, Rush, Beck, & Hollon, 1981; Simons, Murphy, Levine, & Wetzel, 1986). Furthermore, Dobson's (in press) meta-analysis of 21 outcome studies provided compelling evidence for the efficacy of cognitive therapy relative to other therapeutic modalities in the treatment of depression. Specifically, Dobson found that

cognitive therapy produced a significantly greater magnitude of positive change than did wait-list conditions, no-treatment controls, pharmacotherapy, behavior therapy, and other psychotherapies.

In this chapter we will outline the standard course of cognitive therapy for the affective disorders, highlighting the theoretical and empirical rationales for each component and providing illustrative examples. Our attention will focus primarily on unipolar depression, because the cognitive theory and therapy data are most plentiful in this domain; however, we will endeavor to demonstrate the application of cognitive therapy to dysthymic (the so-called "depressive personality") and bipolar disorders as well, by noting special issues that arise in treating these populations.

MAJOR PREMISES AND HISTORICAL FOUNDATIONS

Cognitive therapy posits that an individual's affective state is highly influenced by the manner in which the individual perceives and structures his or her experiences (Beck, 1963, 1967, 1976). Depressed persons tend to bias negatively the information that they process, and they do so across three domains —the self, the personal world, and the future, the *cognitive triad.* Depressed individuals therefore are prone to conclude incorrectly or prematurely that they are failures or bad persons, or deserve some other unshakable pejorative label (bias against the self); that their life situation is intolerably harsh, joyless, unfair, and painful (bias toward the personal world); and that these conditions will never find remediation (bias toward the future). This bleak expectation of unremitting suffering puts depressed individuals at risk for suicidal ideation, intention, or action.

Clinical and empirical evidence has shown that depressed patients consistently and systematically distort their interpretations of events so as to conform to their negative, hopeless beliefs (Beck, 1974; Hamilton & Abramson, 1983; Karoly & Ruehlman, 1983; Krantz & Hammen, 1979; Lewinsohn, Larson, & Muiioz, 1982; Rogers & Forehand, 1983; Roth & Rehm, 1980; Teasdale & Fennell, 1982; Weissman & Beck, 1978). This depressive mindset locks the patients into a closed system of perceptual processing, so that more positive, disconfirming information is minimized or ignored. As a result, their misery is perpetuated, even

when there may be little objective reason to continue to feel negative and hopeless.

As a clinical response to these phenomena, cognitive therapy is a collaborative process of investigation, reality testing, and problem solving between therapist and patient (Weishaar & Beck, 1986). The patient's negative views of the self, life, and the future are treated not as established facts but as hypotheses to be tested. The patient is taught how to evaluate objectively the evidence for and against depressive cognitions via a number of structured techniques, both verbal and behavioral in format. These may include behavioral experiments, logical discourse, imagery restructuring, problem solving, role playing, and so on. As the patient learns to generate alternative interpretations for experiences and to actively solve problems, his or her fundamental depressive beliefs are relinquished and therapeutic change is effected. Furthermore, the active role that the patient takes in his or her treatment provides the necessary tools to continue to cope with difficulties and setbacks after therapy has ended.

There are a number of notable theoretical precursors to Beck's cognitive therapy, dating back as far as the Greek Stoic philosophers, whose phenomenological approach posited that an individual's views of self and world determined his or her feelings and actions. In the twentieth century, emphasis on the importance of conscious subjective experience can be found in the works of ego-oriented theorists such as Adler (1936), Horney (1950), and Sullivan (1953).

Kelly (1955) went a conceptual step further by writing that a person's *construal* of his or her environment is the primary determinant of his or her emotional and behavioral reactions. Additionally, Ellis (1962) advanced the notion of the causal relation between thoughts and emotions by emphasizing the role of "irrational beliefs" in dysphoria.

Beck's formulation of cognitive theory and therapy resulted from his clinical and experimental findings that depressed individuals were prone to idiosyncratic cognitive distortions centering around themes of loss and deprivation (Beck, 1961,1963; Beck &Hurvich, 1959; Beck & Ward, 1961). These consistent results forced Beck to reformulate his view of depression, which originally had been more in line with his psychoanalytic training, to incorporate the negative bias in cognitive processing as being fundamental to the disorder (Weishaar & Beck, 1986). This theory, while primarily attending to the patient's cognitions, does not by fiat downplay the significance of the patient's feelings, behaviors, or biochemistry. Each of these components is seen as a legitimate point of intervention. However, ". . . experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression" (Beck & Young, 1985, p. 207).

The influence of behavior therapy is quite apparent in cognitive therapy as well. In addition to heavily emphasizing an empirical approach, the structure and process of cognitive therapy include such elements as agenda setting, goal setting,

concretizing and solving problems, formulating and testing hypotheses, and assigning self-help homework for the patient to complete between therapy sessions.

While sharing some aspects with other orientations, cognitive therapy is unique in a number of ways. Unlike analytic psychotherapies, cognitive therapy involves an ongoing collaboration between therapist and patient, complete with two-way feedback. Additionally, cognitive therapy posits that important subjective data are readily accessible to consciousness without the need for analytic interpretation. Unlike behavior therapy, cognitive therapy utilizes behavioral change processes not as ends unto themselves but rather as means to achieving cognitive change (Beck et al., 1979). In contrast to Ellis's (1962) Rational Emotive Therapy, the cognitive therapist examines the unique and idiosyncratic cognitions of the patient instead of trying to "fit the patient to the irrational belief." Furthermore, the cognitive therapist uses subtle, Socratic questioning, not dramatic persuasion. The goal is to lead the patient to draw upon his or her own conclusions.

CHARACTERISTICS AND COMPONENTS OF COGNITIVE THERAPY

Cognitive therapy is an active, structured, psychoeducational treatment. Patients are taught that their emotional distress is mediated by the content and the process of their thinking styles, that they can learn to monitor and identify such cognitive patterns, and that modification of their thoughts to make them more objective and scientifically systematic (cf. Evans & Hollon, 1988) can lead to therapeutic changes in affect and behavior. From the outset of therapy, the cognitive therapist endeavors to highlight the intimate interrelations among the patient's thoughts, feelings, actions, and physiology and collaboratively engages the patient in evaluating and making changes in these areas of functioning. These activities proceed best when the cognitive therapist communicates the basic therapeutic characteristics of warmth, genuineness, and openness (cf. Truax & Mitchell, 1971) and is adept at empathically listening to and understanding the patient's unique phenomenology. These ideal characteristics of cognitive therapists should highlight the fact that, although they need to be critical thinkers, they do *not* merely engage the patient in arid intellectual debate, nor do they exhort or harangue patients into "accepting" the therapists' points of view. A friendly, trusting, mutually respectful therapeutic relationship is a necessary foundation on which to build the specific techniques of cognitive therapy.

Prior to the beginning of treatment, it is strongly recommended that patients be given a comprehensive diagnostic evaluation (Sacco & Beck, 1985). This is

important for a number of reasons. First, the complaint of depressed affect may actually be secondary to another, perhaps more primary psychological disorder (e.g., obsessive-compulsive disorder or borderline personality disorder). Additionally, the patient's dysphoria may be related to an organic disorder, such as hypothyroidism, hypoglycemia, diabetes, epilepsy, or postconcussive syndrome (Hall, Gardner, Stickney, LeCany, & Popkin, 1980). Furthermore, the severity of the depression, along with the degree of suicidality, should be assessed as soon as possible. In serious cases, medication (e.g., lithium for bipolar depressives) and/or hospitalization may be indicated. Moreover, it makes good clinical sense to gather as much background information as possible about the patient prior to starting treatment. This would include information on current life situation, as well as historical information on the patient's upbringing, schooling, vocations, and significant relationships.

This latter point calls to mind a common myth about cognitive therapy—that it ignores the patient's past experiences. Quite to the contrary, a complete cognitive conceptualization of the patient's problems requires the assessment of past learning experiences. For example, it is frequently found that some of the patients' most dysfunctional beliefs about themselves have their roots in early-life (and presenttime) negative feedback from the family of origin. Although the cognitive therapist attempts to deal with such beliefs as they pertain to the patient in the here and now, a conscious, rational exploration of the past is an important part of this process of cognitive reevaluation.

Socializing the Patient into the Cognitive Therapy Model

During the initial session, the therapist attempts to begin at least three important processes: (a) establishing therapeutic rapport, (b) defining the problem and setting goals of treatment, and (c) educating the patient in the cognitive therapy model. In order to set these processes into motion, the therapist establishes an important precedent by asking the patient to suggest items for an *agenda* for the session. The therapist may suggest some items, elicit others, and then ask for feedback on the overall plan for the session. A prototypical "opening statement" for the first cognitive therapy session is as follows:

> [Introductions and establishing rapport, followed by . . .] One of the things we do in cognitive therapy is to set an agenda for each session. This helps to make certain that we cover all the points that are important to you, and to make the best use of our time together. I have some ideas for agenda items for today's session, and then I'd like to hear what *you'd* like to focus on, and then maybe we can come to some agreement [checks for understanding and acknowledgment]. For starters, I'd like to check on how you're feeling today, and see if there are any pressing issues that you'd prefer to discuss right away. Then we could summarize your general life concerns that are bringing you to therapy, and perhaps establish a problem list to begin work on. In addition, I'd like to tell you a bit about cognitive therapy, so you'll have a better understanding about what to expect in this model of treatment. How do these ideas sound to you?

The agenda items suggested in the above example usually serve as appropriate starting points, except in cases where the patient is feeling particularly hopeless and/or suicidal. In such instances, it is imperative for the therapist to attend to the patient's immediate state of mind, to make every effort

to offer realistic hope for relief from suffering, and to ask direct questions about suicidal ideation and/or intent. Formulating a verbal antisuicide contract, along with giving the patient the therapist's home phone number, may suffice. For some patients, hospitalization may need to be suggested and encouraged. In any event, the therapist can naturally begin to take note of the kinds of thoughts that are contributing to the patient's feelings of hopelessness, as reflected by the patient's spontaneous discourse or revealed in the patient's answers to therapeutic questions directly aimed at what is on the patient's mind.

In a typical first session where there is no suicidal crisis, more time can be spent in clarifying presenting problems and in setting general therapeutic goals. It is important that the therapist refrain from jumping in and challenging the patient's thinking before the patient even has a chance to comprehend what the therapy is about. Instead, it is wise to simply listen, reflect, be attentive, and give summary feedback and suggestions. Such summary feedback can be used to highlight for the patient the connection between his or her thoughts and feelings, thus subtly initiating the education process. If time permits, the therapist may choose, with the patient's consent, to present a more direct and comprehensive preview of cognitive therapy, in the form of a short monologue. For example, the therapist might say:

> Mr. X, I'd like to tell you a bit about what you can expect to be doing in cognitive therapy. Is that OK with you? OK. One of the fundamental principles of cognitive therapy is that a person's thoughts are very much responsible for how he feels. That's not to say that he has no "real"

> problems in life, or that his problem "is all in his head." Not at all. But we know from years of clinical experience and experimental research that depressed people tend unwittingly to add to their own burdens by having certain negative biases in their thinking, and that these biases are dysfunctional because they make people even more depressed, and interfere with their ability to help them solve their own problems. So, what we'll be doing here will involve trying to identify the thoughts that *you* have that may be making *you* more depressed, and then talking about ways to make your thinking more objective, even-handed, and constructive, so that you learn how to deal effectively with the kinds of life stresses that would otherwise get you down.

Note that the therapist implicitly presents cognitive theory as a diathesis-stress model (Abramson, Alloy, & Metalsky, 1988; Beck & Young, 1985; Evans & Hollon, 1988; Sacco & Beck, 1985; Weishaar & Beck, 1986), according to which maladaptive thinking patterns interact with real life events to create a depressive episode. The therapist may then proceed with the following:

> Cognitive therapy is a very active treatment. By that I mean that we work together quite intensively to help you to learn to help yourself. For example, we'll set agendas to make the best use of our sessions, we'll work on a number of antidepression techniques, and we'll give each other ongoing feedback and suggestions. Perhaps most importantly, you'll be asked to practically apply the things you learn in these sessions to your everyday life, in the form of self-help homework assignments. We've found that patients who apply therapeutic skills between sessions recover more rapidly, and learn valuable coping skills that can be effectively used long after therapy is done. Let me emphasize that throughout this process you will have the final say on what courses of action are chosen. Your opinions and requests will be respected, and we'll try at all times to maintain a spirit of teamwork. Do you have any questions or concerns about what I've just said? Could you give me some feedback on the main points you've heard me make just now? I want to make certain that I've been clear.

Sometimes a depressed person may feel a bit overwhelmed by the prospects of an active treatment, especially if inertia and low motivation are part of the clinical picture. By asking for the patient's concerns about the course of therapy, the therapist sets the tone for a collaborative relationship and provides fertile ground for eliciting the patient's "hot cognitions." This enables the therapist once again to highlight the interrelation of thoughts and emotions.

Identifying Automatic Thoughts and Underlying Assumptions

Early in therapy, patients are taught about the phenomena that Beck (1963) called "automatic thoughts," the thoughts that mediate between environmental events and a person's emotional reactions to those events. These thoughts often go unnoticed because they are habitual and take place very quickly (hence, the term "automatic"). Because these thoughts are often not attended to, people will generally conclude that a particular external stressor directly "causes" their emotional upset, as if the negative emotion were reflexive and completely out of voluntary control. For example, Mr. X might say that a job interview "caused" him to be anxious, while not taking into account the cognitive *appraisals* of the job interview that were mediating such anxiety. He may have been covertly saying to himself: "I know I'm going to slip up somewhere in this interview and I won't get the job. I'll probably make a fool of myself in the process. Everyone will think I'm a real loser. Maybe I really am a loser." Such thinking may be commonplace for a person with low self-esteem, but he may not realize that these thoughts do not

necessarily represent objective reality, and that he therefore may be subjecting himself to needless distress and may be interfering with his actual abilities to perform well on the interview. The therapist can help the patient to understand this concept by saying:

> One of the most important aspects of cognitive therapy will be for you to become more aware of your thoughts when you become upset, and to learn how to be a "healthy skeptic" with regard to your own viewpoints. In other words, if you catch yourself saying self-defeating things to yourself, you need not accept these thoughts as 100 percent true. There will usually be at least one other plausible way to look at the situation, one that may be less upsetting and more constructive.

In order to assist patients in noticing such automatic thinking, therapists instruct them to use their emotional upset (e.g., sadness, hopelessness, or anger) as a *cue* to ask themselves the following question: "What am I saying to myself right now that could be causing me to feel so badly?" Patients are encouraged to jot their thoughts down on paper, thus concretizing the upsetting notion and starting the process of finding alternative, more adaptive responses.

Another important means by which to ascertain patients' automatic thoughts is to ask, whenever an affective shift takes place in the session, "What was going through your mind just now?" For those patients who have difficulty in articulating their thoughts, the therapist may use *imagery* by asking them to picture the upsetting situations in detail (Beck & Young, 1985) and then to give a running account of what they're thinking and feeling and what it all means to

them. If the upsetting event is in the interpersonal sphere, the therapist can role-play the situation with the patient, so as to elicit the automatic thoughts that might actually occur in the heat of the moment (hence the term “hot cognitions”).

Beck (1967) identified several common systematic errors in the way depressed patients process information, and these errors are often quite evident in their automatic thoughts. It is often helpful to describe and review these types of distortions with patients, and to instruct them to match their own automatic thoughts to the corresponding depressogenic style as it occurs. The goal is not to teach patients to denigrate themselves for their “irrational thinking,” but rather to help them gain a valuable self-help skill. The systematic errors in logic that Beck (1967) discussed are:

1. All-or-none thinking. The tendency to see things in black-and-white terms; anything less than perfect is seen as utterly terrible. For example, a less than idyllic but basically solid marriage may be viewed as a total failure.

2. Overgeneralization. Drawing broad-sweeping conclusions on the basis of isolated incidents. For example, a woman who argues with her mother and then sees her cry concludes, “I always hurt everyone I care about.”

3. Arbitrary inference. Jumping to conclusions, fortune-telling, mindreading, and/or mistaking emotion for fact. For instance, a woman doesn’t receive a phone call from her boyfriend on a given day, and erroneously concludes that he no longer cares for

her.

4. Selective abstraction. Focusing on one negative detail of a situation out of context, thereby missing the bigger picture, which may be more hopeful. For example, a man receives a job evaluation which is 90 percent positive and 10 percent critical. He dwells on the critical 10 percent and becomes convinced that his job is in danger.

5. Magnification and minimization. Overestimating the importance of undesirable events, and downplaying the significance of positive events. As an example, a woman may feel terribly guilty as she magnifies the fact that she lost her temper with her son on one occasion, while she systematically forgets or diminishes the importance of the numerous times she has been patient, attentive, and loving.

6. Personalization. Taking responsibility for negative happenstances that are realistically out of the person's direct control. A teenager may blame herself for her father's drinking, believing that it would never happen if she were truly a good daughter.

Patients frequently find that their automatic thoughts fall into a number of the categories listed above. It is clearly a positive therapeutic step when a patient is able to say something along these lines: "Oops. There I go again, jumping to conclusions. I guess that things might not necessarily turn out as badly as I expect."

As treatment progresses, the cognitive therapist begins to help the patient to

attend to the basic underlying beliefs, assumptions, or life rules that predispose him or her to depressogenic thinking. These underlying assumptions typically represent themes that tie together the various automatic thoughts that the patient is prone to have. These assumptions often take shape during the primary socialization period of a person's life (childhood and adolescence) and, like religious or cultural rules, are extremely fundamental to the way a person views the self, the world, and the future. Because they are so basic (deep cognitive structure), the patient's particular *maladaptive* assumptions are more difficult to ascertain than are the more transient automatic thoughts (surface structure). Careful observation on the part of both patient and therapist is needed to consolidate a seemingly disparate set of automatic thoughts into the themes that represent the patient's specific areas of vulnerability. For example, Ms. W had the following automatic thoughts when she began treatment with one of us (CFN):

> "He [the therapist] probably thinks I'm stupid."
>
> "I'll bet he laughs at me behind my back."
>
> "I don't want to tell him anything personal that he'll use against me."
>
> "I really don't want to be here. This is a mistake."

These thoughts were elicited when the therapist noticed that Ms. W was growing more and more irritable as the session progressed. (This highlights the importance of dealing with the patient's thoughts about the therapeutic relationship, not only to help avert resistance and/or premature termination but

to shed light on the patient's habitual automatic thoughts and assumptions about other important relationships.) After these thoughts were gently addressed, a couple of basic themes emerged:

1. People who are more educated than I am will harshly and unfairly judge me to be inferior.

2. I desperately need approval. I'm nothing without it.

Discovery of these themes ultimately led to fruitful exploration of her expectations for exploitation in relationships and of her regrets about never having gone to college. By the end of treatment, she no longer automatically assumed that others would look down on her; she was far more assertive and confident, and had begun to take college courses.

Rationally Responding to Automatic Thoughts and Assumptions

An integral component of cognitive therapy is teaching patients to reevaluate their automatic thoughts and to generate new and more adaptive responses. One method involves instructing patients to ask themselves a series of four questions whenever they catch themselves having thoughts that are upsetting them. The first of these questions is, "What is the *evidence* that supports and/or refutes this thought?" This helps the patient to steer clear of faulty inference-making that is based primarily on hunches, intuition, "gut feelings," and other forms of illogical thinking. Of course, it is important to teach the patient the

kinds of information that qualify as true objective evidence (Newman, 1989), so as to avoid the same pitfalls that occur when depressogenic assumptions are made in the first place.

A second question is, “How else could I view this situation?” This asks the patient to make a conscious effort in trying to see things in a different light. For instance, the cognitive therapist can prompt answers to this question by asking, “How could this situation turn out to be a blessing in disguise?” It is important to keep an open mind when answering this question, and it is often advisable to brainstorm possible alternatives.

The third question asks, “Realistically, what is the worst thing that could happen in this situation, and what implications would it have for my life?” This question provokes an earnest analysis of the degree of seriousness of the situation or feeling and has as its goal the task of helping patients to “de-catastrophize” their thinking.

The final question is quite pragmatic and constructive: “Even if there is reason to believe that my depressing viewpoint is warranted, what can I *do* to help remedy this situation?” This question sets the stage for constructive problem solving, which is especially important in helping patients to decrease their sense of helplessness and hopelessness and to learn to engage in rational self-help behaviors.

One particularly useful format for organizing, concretizing, and recording the self-help process described above is the Daily Thought Record (DTR) (see Table 17.1). Once patients have become familiar with the methods of identifying automatic thoughts, they are asked to use DTRs to articulate upsetting thoughts, and their concomitant situations and emotions, that occur *between sessions.* Additionally, the DTR requires that patients generate and record more objective, functional thoughts, and then notice and write down any improvement in mood that they perceive. The DTR often serves as an excellent cognitive self-help assignment and may also be used collaboratively by patient and therapist *during* the session, especially if the patient needs extra instruction in learning to use this tool or if emotional upsets occur. In any case, a review of the patient's work on the DTR is a typical agenda item for each session. (For a more complete description of use of the DTR, see Beck et al., 1979; Sacco & Beck, 1985).

Table 17.1 depicts an actual DTR completed by one of our patients (with certain details altered to protect confidentiality). Mr. A, already feeling quite depressed and thinking of suicide, suffered a severe blow when his beloved dog was killed by a car. Admirably, he was able to help himself get through this ordeal without an increased risk of suicide via a most skillful use of the DTR. (Note the dramatic reduction in the patient's report of feelings of suicidality.)

The DTR is by no means the only method by which to reevaluate dysfunctional thinking. Another method involves reverse role playing: the

therapist plays “devil’s advocate” (Goldfried & Davison, 1976) and argues in favor of the patient’s negative automatic thoughts and assumptions; the patient has the responsibility to counter these arguments with rational responses. This process can be accentuated if the patient is asked to imagine that a “best friend’s” automatic thoughts are being challenged. Frequently, depressed patients are far more understanding and even-handed when looking at their friends’ problems than when looking at their own. Assuming that the patient is successful in rationally responding to the “friend’s” or the “devil’s advocate’s” stated concerns, the patient can be asked whether those same responses could be self-applied. If the answer is “yes,” the technique has been helpful. If the answer is “no,” the therapist can then engage the patient in a discussion of the issues surrounding a double standard—the patient is selectively tougher on himself or herself than on anyone else. The rationality of this cognitive pattern can then be challenged in its own right.

Table 17.1 Mr. A’s Daily Record of Dsyfunctional Thoughts

Date	Situation	Emotion(s)	Automatic Thoughts)	Rational Response	Outcome
	Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of	1. Specify sad/ anxious/angry, etc. 2. Rate degree of emotion, 1-100.	1. Write automatic thoughts) that preceded emotion(s). 2. Rate belief in	3. Write rational response to automatic thoughts). 4. Rate belief in rational response, 0-100%.	1. Re-rate belief in automatic thought(s), 0-100%. 2. Specify and rate subsequent

thoughts, daydream, or recollection, leading to unpleasant emotion.		automatic thoughts), 0-100%.		emotions, 0-100.
I found Bucky dead by the side of the road. He was hit in the head by a car.	unbearable pain and anguish (100) devastated (100) crushed (100) suicidal (100)	1. You were my best friend and now you're gone and you didn't even say goodbye. Why did you have to leave me. (No rating) 2. I might as well be dead too. (80)	1. Don't hurt yourself more by saying he left you. He didn't leave you. He may have been on his way home when he was hit. (No rating) In his heart, Bucky was always thinking about you. He didn't want to get hit any more than the driver wanted to hit him. But these things happen and it does little good to try and find an answer to why he died. He's at peace. At least you don't have to wonder where he is or whether he's alive or dead. (No rating) 2. I'm very, very upset that Bucky is dead. Now think about yourself and how others close to you would feel if out of the blue you were no longer alive. Probably the same	pain (80) anguish (80) devastated (70) crushed (80) suicidal (10)

way. Is that what you want to do to them? You would have accepted Bucky back under any circumstances, blind, lame . . . and others would rather see you alive with a few problems than not at all. (100)

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

Another technique involves the use of imagery. Weishaar and Beck (1986) presented a number of applications of imagery, including:

1. Time projection. Having the patient imagine his or her life months or years in the future, so as to gain some detachment and perspective about the current upsetting event.

2. Goal rehearsal. Covertly imagining solving a current problem, so as to increase a sense of self-efficacy.

3. Coping imagery. Imagining: changing the features of a situation to make it less threatening, dealing with a range of possible outcomes (from best to worst), and/or how someone else would cope in the same circumstances.

Behavioral experiments represent yet another way to test and challenge depressive expectations. For example, if a patient is convinced that her situation is hopeless, she may systematically avoid doing anything to help herself. She may think that “nothing will work anyway . . . I’ll just fail again and be even more miserable.” In this case, the therapist asks her to treat the above thought as a hypothesis to be behaviorally tested. The patient is asked to generate a proposed self-help behavior (e.g., getting up at 8 a.m. so as not to sleep too much and then feel that the day has been wasted) and then to predict the outcome if she puts it into action (e.g., “I’ll feel sick, I’ll stay in bed, and wind up not only wasting a day but loathing myself for being a lazy good-for-nothing”). The patient is then asked if she would go forth with the self-help behavior and see if her prediction is confirmed or discontinued.

If the negative prediction is disconfirmed, the patient has had an important corrective experience that dispels the hopeless assumption and demonstrates how thinking patterns alone, rather than an actual lack of capacity for change, may be hindering her recovery. If the prediction is borne out, all is not lost, because the patient can be instructed to monitor her automatic thoughts at the time the experiment is carried out, thus helping the therapist and patient to gain access to key hot cognitions that are hampering progress.

The above description does not represent an exhaustive review of potential strategies for identifying and changing dysfunctional thoughts and beliefs. Any

ethical, mutually agreed-upon technique that serves to deal constructively with depressive thinking is consistent with cognitive therapy. Although a number of tried-and-true methods for cognitive restructuring have been found to be consistently helpful, the notion that cognitive therapy represents a cookbook application of a specified number of rigid techniques is simply a myth.

Behavioral Techniques

Cognitive therapy incorporates behavioral procedures in order to alter depressogenic belief systems and to facilitate problem solving (Beck et al., 1979; Evans & Hollon, 1988). Although they are employed throughout the course of therapy, they are generally concentrated in the earlier stages of treatment, especially with more severely depressed patients who may be suffering from lethargy, inertia, and a sense of helplessness and hopelessness (Beck & Young, 1985; Sacco & Beck, 1985). The immediate goal is to counteract the patient's avoidance and/or withdrawal, and to begin to engage him or her in constructive activity. The long-range goals are to decrease discouragement that is born of inactivity and therefore to positively alter the patient's negative views of the self, the world, and the future.

The most frequently utilized behavioral techniques include: (a) scheduling of activities, (b) mastery and pleasure ratings, (c) graded task assignments, (d) assertiveness practice, and (e) problem solving, to name a few. The scheduling of

activities usually goes hand-in-hand with mastery and pleasure ratings. For example, in order to combat low motivation, hopelessness, and excessive rumination, the therapist and patient may generate and plan a daily schedule for the patient to follow. Furthermore, the patient may be asked to rate each activity on a 1-10 scale of pleasure (“How much did I *enjoy* this activity?”), and a separate 1-10 scale of mastery (“How much did I accomplish, and how well did I perform and cope with this activity?”).

Each scale is important in its own right. The pleasure scale serves to contradict the patient’s assertion that nothing can be enjoyable anymore; the mastery scale focuses the patient’s attention on the ability to act constructively on the environment. The mastery scale is also useful in that it may increase the patient’s sense of self-efficacy (thus lifting mood and hopefulness), even as the patient engages in some relatively unenjoyable tasks that are necessary in successful day-to-day responsible living. Again, if the patient’s self-ratings are consistently low in both pleasure and mastery, the therapist can assist in identifying the various dysfunctional cognitions that are responsible for such negative feelings and impressions and are therefore important to cognitive assessment.

When the patient endeavors to achieve a given goal that seems overwhelmingly difficult (e.g., finding appropriate employment), a graded task assignment can be introduced. Here, the overall goal is subdivided into easier

stages that are more concrete and less formidable to achieve (e.g., revising a resume, scanning the classified section of the newspaper, and so on). The patient then performs the tasks one by one, focuses on the success and productivity generated by each task, and counters negative thoughts that may interfere with the appreciation of each accomplished task or with expectations for the next task. Ultimately, the patient learns that by breaking down a major goal into more manageable components, difficulties that previously seemed insurmountable can be overcome.

When the patient's depressive symptoms are exacerbated by social withdrawal and/or a lack of assertiveness in social encounters, role playing can be used in the session to practice new, adaptive behaviors in this realm. After identifying problematic situations, the therapist and patient work together to brainstorm possible verbal and behavioral responses and then put them into simulated action by role playing. The patient is encouraged to try these new, assertive responses in actual situations between sessions and to monitor the results. Cognitions that might inhibit the patient from following through on such an assignment should be assessed and dealt with in the session.

Another integral cognitive-behavioral component of cognitive therapy is problem solving. This general strategy is comprised of (a) defining the problem, (b) brainstorming the potential solutions, (c) examining the pros and cons of each proposed solution, (d) choosing and implementing the chosen course of action,

and (e) evaluating the results. (For a comprehensive explication of problem solving, see D'Zurilla & Nezu, 1982). The third step (examining pros and cons) has alternative applications in cognitive therapy. For example, when a patient staunchly persists in holding on to a dysfunctional thought, belief, and/or behavior in spite of rational responses to the contrary, the patient can be asked what is gained by maintaining that position and what is lost by doing so. Conversely, the patient is asked to consider what is gained or lost by *changing* the belief and/or actions. This approach serves at least two functions: (a) to elucidate idiosyncratic or "secondary" gains that the patient may be deriving from the seemingly maladaptive stance, and (b) to highlight the patient's self-defeating thoughts and behaviors and demonstrate that there *are* viable, more adaptive alternatives that would clearly benefit the patient more in the long run.

Homework Assignments

Consistent with cognitive therapy's emphasis on teaching patients to become their own "therapists," homework assignments are included as a vital part of treatment. We have found that when patients systematically apply what they have learned in the session to their everyday lives between sessions, they make more rapid and more lasting progress. Homework assignments help patients solidify and generalize their new skills and foster a sense of therapeutic self-reliance.

Homework assignments are not given in a gratuitous manner, just to keep the patient busy. Rather, each assignment should be directly related to the content of the therapy session and should be explained so that the patient understands its rationale. For example, if a depressed patient states that she is lonely but is avoiding making contact with a particular long-distance friend because she assumes that “she won’t really want to talk to me . . . I’d just be bothering her,” the therapist may suggest an assignment whereby the patient is to call or write to this friend and then compare the outcome of this communication to her original negative expectations. This assignment would serve to counteract the patient’s inclination to socially isolate herself, would potentially highlight the erroneous and self-defeating nature of her original expectations, and/or could provoke the uncovering of other inhibitory cognitions that need to be addressed.

In the spirit of collaboration that is one of the hallmarks of cognitive therapy, it is important that the therapist not merely “order” the patient to follow through on a given assignment, without first checking to see if the patient agrees that it could be important and useful to do. Qualms about doing homework assignments should be respected and, at the same time, looked at as automatic thoughts subject to the same rational evaluation as any other automatic thoughts that may be contributing to the patient’s condition. If a patient steadfastly declines to do a particular assignment, he or she can be asked to generate an assignment. In fact, as therapy progresses it is a good idea to encourage patients to develop their own assignments, as yet another step toward self-sufficiency. If the patient refuses to

do any assignments at all and/or does not seem responsive to the therapist's sincere rationales behind the homework, it is important that the therapist not assume that the patient is "resistant" or "passive-aggressive." Otherwise, the therapist runs the risk of engaging in dysfunctional, nonobjective thinking as well, for example, by *labeling* a patient and *jumping to conclusions* about his or her character. (This example brings up the fact that therapists, as human beings, are subject to their own erroneous thinking at times, and need to be willing to look at their *own* automatic thoughts and beliefs when therapy is not going smoothly and frustrations build.) When such difficulties arise, the therapist can model appropriate problem-solving behavior by working with the patient to identify the sources of the difficulties and by collaboratively attempting to overcome them.

Additionally, the therapist would do well to explain that homework assignments are a "no-lose" proposition. They cannot be failed; doing an assignment partially is better than not doing it at all, and even if the outcome of the assignment seems less than helpful, it may serve to highlight problems that still need to be worked on. In any event, valuable therapeutic information is gained, and the patient has taken a step toward self-help in the long run (if not in the short run).

SPECIAL ISSUES IN ADAPTING COGNITIVE THERAPY TO DYSTHYMIC AND BIPOLAR DISORDERS

The affective disorders, in spite of being described by a rather consistent set of phenotypic symptoms, are quite heterogeneous in terms of etiology and response to treatment (Hollon & Beck, 1978, 1979). Although cognitive therapy was originally developed as a treatment for unipolar depression, the reality is that many patients who come to therapy complaining of depressed mood may be better diagnosed as suffering from dysthymia, bipolar disorder (depressed phase), major unipolar depression superimposed on a long-standing dysthymia (the so-called "double-depression"), or an atypical depression (e.g., secondary to a borderline personality disorder). While some of the above subclasses of the affective disorders seem to beg for a pharmacological approach to treatment, we have found that cognitive therapy is still an efficacious element of the treatment plan, in much the same way that a treatment package of cognitive therapy and pharmacotherapy has been found to effect clinically significant treatment and maintenance gains in certain unipolar-depressed populations (Blackburn et al., 1981; Hollon et al., 1986; Hollon & Beck, 1978).

Although the empirical literature is sparse in this area, the following is a brief overview of issues that are pertinent to the application of cognitive therapy to dysthymic and bipolar disorder populations.

Dysthymic Disorder and "Double Depression"

Dysthymic disorder, a chronic subtype of depression, is characterized by "low-level" dysphoria, anhedonia, low self-esteem, low energy, and a fairly rigid pessimistic outlook on life (Kocsis & Frances, 1987; Yee & Miller, 1988). Dysthymia, especially the early-onset variety, seems to render individuals at increased risk for developing full-blown major depression (Yee & Miller, 1988). This resultant "major depression on top of dysthymia" condition has been observed to hinder the patient's recovery from the major depressive episode, when compared to patients who do not suffer from underlying dysthymia in the first place (Miller, Norman, & Dow, 1986). Furthermore, the continuance of dysthymia after a major depression remits has been found to increase a patient's risk for subsequent major depressive relapse (Keller, Lavori, Endicott, Coryell, & Klerman, 1983). Interestingly, the data are still very unclear as to whether dysthymia and major depression lie on a continuum of severity or constitute qualitatively different disorders (Keller et al., 1983).

Cognitive therapy is known for, among other things, being a shortterm therapy. Most outcome studies involving cognitive therapy specify an average of 12 to 16 sessions before termination (Beck et al., 1985; Evans et al., 1986; Hollon et al., 1986; Kovacs et al., 1981; Rush et al., 1977), and many therapists and patients alike have come to expect that treatment will be no longer than this. However, the chronic nature of dysthymia dictates the treatment will run a longer course. Cognitive therapists must be aware of their own and their patients' expectations regarding length of treatment and be prepared to deal with thoughts

and feelings of hopelessness in both parties as therapy goes beyond three or four months. In fact, assuming that the patient has been properly diagnosed at intake, the cognitive therapist would do well to exercise a psychoeducational role by explaining to the patient what is known about the disorder and what to expect in terms of course and length of treatment. A conservative estimate, leaving room for wide patient variability, would be six months to two years.

A patient who is suffering from “double-depression” may seek treatment for the major depressive episode but be relatively resigned to a usual low-level dysphoric condition. Indeed, the patient may not be aware of having a chronic mood disorder at all, not having known anything different. The patient may therefore be prone to leave therapy prematurely, once the major depression has been treated, unaware that further improvement is possible and that he or she is at risk for subsequent major depressive relapse (Keller et al., 1983; Miller et al., 1986; Yee & Miller, 1988).

At the Center for Cognitive Therapy in Philadelphia, it is standard practice that when a patient’s depression remains at a high level for a prolonged period (e.g., even after 12 to 16 sessions), a medication consultation is suggested. Many of the patients who become candidates for antidepressant medication are diagnosed as having dysthymic disorder. While there are numerous studies demonstrating the efficacy of a combination of cognitive therapy and pharmacotherapy for unipolar depression (e.g., Blackburn et al., 1981, Blackburn et al., 1986; Hollon et

al., 1986; Hollon & Beck, 1978), more data are needed to make this same assertion for the treatment of dysthymia. One clue that this may be so was provided by Kocsis and Frances (1987), who concluded that antidepressants are an effective treatment for dysthymia but added that cognitive factors are very important and must be addressed as part of therapy as well.

For those dysthymic patients who report having “always been a sad person,” a truly successful treatment would need to focus on enhancing the patient’s capacity for experiencing joy, rather than solely “taking the edge off” the dysphoria (cf. Lutz, 1985; Menzel, 1987). Often, such patients operate on the implicit assumption that it is “wrong” to feel good (especially those who have been raised with religious guilt) or have fears about “jinxing” themselves into a disaster if they let their guard down and allow themselves to be happy or hopeful. These beliefs, and others related to them, would need to be identified and challenged in order to combat the patient’s habitual anhedonia. Imagery, facilitated by a relaxation induction, can be utilized to remember times when the patient felt happiness or love, or to imagine joyous life events in the future. Behaviorally, dysthymic patients can be encouraged to engage in pleasant events (Lewinsohn, 1975), to initiate social contact with others, and to more freely accept positive attention from others.

Therapists must recognize that dysthymic patients are often low in motivation and may also represent mild chronic suicide risks. Therefore, it is

important to regularly monitor suicidal ideation and intention and to be prepared to deal with the patient's (and one's own) hopelessness and frustration.

Bipolar Disorder

Patients who are experiencing a manic episode rarely feel that they are in need of therapy. However, it is not uncommon for a bipolar disordered patient to seek treatment when in the throes of the depressive phase. When treating these patients, cognitive therapists may find themselves in a bind. The bipolar depressive's rapid lifting of mood, unlike that of the unipolar patient, does not necessarily portend a positive therapeutic effect. Indeed, the therapist may need to help the patient to recognize and reevaluate dysfunctional *hyperpositive* thinking, including dangerously inflated ideas about invulnerability, excessively optimistic expectations for success in various life ventures, and denial of all problems. (This point highlights the fact that cognitive therapy is *not* equivalent to "the power of positive thinking" approach. The goal of cognitive therapy is to teach *adaptive, constructive, functional* thinking, whether it be positive, conservative, or cautionary in tone.)

Lithium carbonate is a well-documented treatment of choice for bipolar disorder (Chor, Mercier, & Halper, 1988; Cochran, 1984). However, noncompliance in taking medication is a prevalent problem with this population. Cochran (1984) demonstrated the effectiveness of cognitive therapy in improving

patients' compliance in taking their prescribed dosages of lithium, both during adjunctive cognitive therapy and at six-month follow-up. She noted that a thorough assessment of patients' beliefs and attitudes toward their illness and toward medication can successfully predict risk for noncompliance, and that high-risk beliefs can then become targets for cognitive therapy. Table 17.2 presents the DTR of Ms. J, one of our patients suffering from bipolar disorder. She had been given the assignment of completing a thought record each time she noticed that she missed taking her medication, so as to catch the thoughts that might be hindering her from complying with treatment. Her successful completion of this DTR, which led to the revelation that she worried about being labeled as a "psychotic" if she were to be seen taking the lithium, represented a significant breakthrough in treatment. She is currently still in cognitive therapy, takes her lithium routinely, and maintains a stable enough mood to rationally address problematic issues in her life with some success.

Table 17.2 Ms. J's Daily Record of Dsyfunctional Thoughts

Date	Situation	Emotion(s)	Automatic Thought(s)	Rational Response	Outcome
	Describe: 1. Actual event leading to unpleasant emotion, or 2. Stream of	1. Specify sad/ anxious/angry, etc. 2. Rate degree of emotion, 1-100.	1. Write automatic thoughts) that preceded emotion(s). 2. Rate belief in	1. Write rational response to automatic thoughts). 2. Rate belief in rational response, 0-100%.	1. Re-rate belief in automatic thoughts), 0-100%. 2. Specify and rate subsequent

thoughts, daydream, or recollection, leading to unpleasant emotion.		automatic thoughts), 0-100%.		emotions, 0-100.
It's early Sunday morning and I realize I forgot to take my midday and nightly dosage of Lithium the day before.	annoyed (85) apathetic (50)	1. Oh well. It isn't going to kill me if I miss a few times. (100) 2. I probably don't need Lithium anyway. (90) 3. I don't want people to think I'm a freak or psychotic or something. I want to be regarded as a normal person!!!!	1. Well, should I suddenly plummet into a depression I might very well feel suicidal again. So it might actually kill me if I skip a few times. (90) 2. Most signs show that I do need Lithium. It's to my advantage to take the medication. It isn't painful and I have few side effects. And it isn't worth going off the medication and taking the risk of going through all that pain and craziness again. (90) 3. I'm not crazy. I have a treatable disorder that many successful and creative and important people have had. If someone does, by chance, regard me as abnormal, it's not worth my time to have them as friends. People who really care	annoyed (20) apathetic (0)

about me won't
stop being my
friend because I
take Lithium.
(100)

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

Cognitive therapy is also useful in treating the depressive aftereffects of a manic episode (Jacobs, 1982) and serves as a viable replacement treatment when there are significant medical contraindications to taking lithium (e.g., when the patient is pregnant; see Chor et al., 1988). Chor et al. (1988) noted several important components to a cognitive therapy for bipolar disorder, including: (a) mood monitoring, with predetermined precautions to be implemented when the patient's mood would get too high or too low, (b) anticipatory problem solving, (c) stimulus control (e.g., avoiding risky situations such as bars, drugs, and driving, when in a manic state), (d) planning more activities when mood is low and fewer activities when mood is high, and (e) challenging of hyperpositive cognitions (e.g., "assuming superiority," "I can do no wrong" statements, jumping to conclusions based on impulsive emotional desires, and inclinations toward overaggression). Again, the data are quite limited in this area, but one can readily hypothesize that a combination of cognitive therapy and lithium would create a positive synergistic therapeutic effect and would lead to greater maintenance of gains that either

treatment alone or alternative treatments. This remains to be empirically tested.

SUMMARY

There is considerable evidence that cognitive therapy is an effective short-term therapy for unipolar depression. Clinical evidence suggests that cognitive therapy may also be efficacious in the treatment of dysthymic disorder and as part of a package treatment for bipolar disorder.

Cognitive therapy teaches patients to become skilled reality testers via monitoring thoughts and basic assumptions about the self, the world, and the future and then putting these cognitions to empirical tests. These tests include examining evidence for one's beliefs, setting up behavioral experiments and graded tasks, weighing the pros and cons of maintaining or changing certain cognitive and behavioral patterns, and a host of additional interventions. Through this process, learned in session and applied between sessions, patients begin to take a more constructive, hopeful view of themselves and their problems, learn to take steps to help themselves, and therefore feel happier.

The cognitive therapist's role is one of teacher and collaborative facilitator, actively helping the patient to gain new perspectives, behaviors, and skills that can help toward better functioning now and in the future, long after therapy is completed.

Cognitive theory of the affective disorders is parsimonious, has heuristic value, and is testable. The corresponding therapy is eminently teachable and has

an excellent track record in outcome studies in the treatment of depression. Demonstrating the utility of cognitive therapy for other subtypes of the affective disorders (e.g., dysthymia, bipolar disorder) will be an important future direction in the ongoing study of this therapeutic approach.

REFERENCES

Abramson, L. Y., Alloy, L. B., & Metalsky, G. I. (1988). The cognitive diathesis-stress theories of depression: Toward an adequate evaluation of the theories' validities. In L. B. Alloy (Ed.), *Cognitive processes in depression* (pp. 3-30). New York: Guilford.

Adler, A. (1936). The neurotic's picture of the world. *International Journal of Individual Psychology, 2,* 3-10.

Beck, A. T. (1961). A systematic investigation of depression. *Comprehensive Psychiatry, 2,* 163-170.

Beck, A. T. (1963). Thinking and depression: 1. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9,* 324-333.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects.* New York: Harper & Row.

Beck, A. T. (1974). The development of depression: A cognitive model. In R. Friedman & M. Katz (Eds.), *Psychology of depression: Contemporary theory and research* (pp. 3-28). Washington, DC: Winston/Wiley.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Beck, A. T., Hollon, S. D., Young, J., Bedrosian, R. C., & Budenz, D. (1985). Treatment of depression with cognitive therapy and amitriptyline. *Archives of General Psychiatry, 42,* 142-148.

Beck, A. T., & Hurvich, M. S. (1959). Psychological correlates of depression. Frequency of "masochistic" dream content in a private practice sample. *Psychosomatic Medicine, 21,* 50-55.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression: A treatment manual.* New York: Guilford.

Beck, A. T., & Ward, C. H. (1961). Dreams of depressed patients: Characteristic themes in manifest content. *Archives of General Psychiatry, 5,* 462-471.

Beck, A. T., & Young, J. E. (1985). Cognitive therapy of depression. In D. Barlow (Ed.), *Clinical handbook*

of psychological disorders: A step-by-step treatment manual (pp. 206-244). New York: Guilford.

Blackburn, I. M., Bishop, S., Glen, A. I. M., Whalley, L. J., & Christie, J. E. (1981). The efficacy of cognitive therapy in depression: A treatment trial using cognitive therapy and pharmacotherapy, each alone and in combination. *British Journal of Psychiatry, 139,* 181-189.

Blackburn, I. M., Eunson, K. M., & Bishop, S. (1986). A two-year naturalistic follow-up of depressed patients treated with cognitive therapy, pharmacotherapy, and a combination of both. *Journal of Affective Disorders, 10,* 67-75.

Chor, P. N., Mercier, M. A., & Halper, I. S. (1988). Use of cognitive therapy for treatment of a patient suffering from a bipolar affective disorder. *Journal of Cognitive Psychotherapy: An International Quarterly, 2,* 51-58.

Cochran, S. D. (1984). Preventing medical non-compliance in the outpatient treatment of bipolar affective disorders. *Journal of Consulting and Clinical Psychology, 52,* 873-878.

Dobson, K. S. (in press). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology.*

D'Zurilla, T. J., & Nezu, A. (1982). Social problem-solving in adults. In P. C. Kendall (Ed.), *Advances in cognitive-behavioral research and therapy* (Vol. 1, pp. 201-274). New York: Academic Press.

Ellis, A. (1962). *Reason and emotion in psychotherapy.* New York: Lyle Stuart.

Evans, M. D., & Hollon, S. D. (1988). Patterns of personal and causal inference: Implications for the cognitive therapy of depression. In L. B. Alloy (Ed.), *Cognitive processes in depression* (pp. 344-377). New York: Guilford.

Evans, M. D., Hollon, S. D., DeRubeis, R. J., Piasecki, J., Tuason, V. B., & Garvey, M. J. (1986). *Relapse/recurrence following cognitive therapy and pharmacotherapy for depression: 4. Two-year follow-up in the CPT project.* Unpublished manuscript, University of Minnesota and St. Paul-Ramsey Medical Center, Minneapolis-St. Paul.

Gallagher, D. E., & Thompson, L. W. (1982). Treatment of major depressive disorder in older adult outpatients with brief psychotherapies. *Psychotherapy: Theory, Research and Practice, 19,* 482-490.

Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy.* New York: Holt.

Hall, R. C. W., Gardner, E. R., Stickney, S. K., LeCany, A. F., & Popkin, M. K. (1980). Physical illness manifested as psychiatric disease (Analysis of a state hospital inpatient population). *Archives of General Psychiatry, 37,* 989-995.

Hamilton, E. W., & Abramson, L. Y. (1983). Cognitive patterns and major depressive disorder: A longitudinal study in a hospital setting. *Journal of Abnormal Psychology, 92,* 173-184.

Hollon, S. D., & Beck, A. T. (1978). Psychotherapy and drug therapy: Comparisons and combinations. In S. L. Garfield & A. E. Bergin (Eds.), *The handbook of psychotherapy and behavior change* (2nd ed., pp. 437-490). New York: Wiley.

Hollon, S. D., & Beck, A. T. (1979). Cognitive therapy of depression. In P. C. Kendall & S. D. Hollon (Eds.), *Cognitive-behavioral interventions: Theory, research, and procedures* (pp. 153-203). New York: Academic Press.

Hollon, S. D., DeRubeis, R. J., Evans, M, D., Tuason, V. B., Wiemer, M. J., & Garvey, M. (1986). *Cognitive therapy, pharmacotherapy, and combined cognitive therapy-pharmacotherapy in the treatment of depression: 1. Differential outcome.* Unpublished manuscript, University of Minnesota and St. Paul-Ramsey Medical Center, Minneapolis-St. Paul.

Horney, K. (1950). *Neurosis and human growth: The struggle toward self-realization.* New York: Norton.

Jacobs, L. I. (1982). Cognitive therapy of postmanic and postdepressive dysphoria in bipolar illness. *American Journal of Psychotherapy, 36,* 450-458.

Karoly, P., & Ruehlman, L. (1983). Affective meaning and depression: A semantic differential analysis. *Cognitive Therapy and Research,* 7, 41-50.

Keller, M. B., Lavori, P. W., Endicott, J., Coryell, W., & Klerman, G. L. (1983). Double depression: Two-year follow-up. *American Journal of Psychiatry, 140,* 689-694.

Kelly, G. (1955). *The psychology of personal constructs.* New York: Norton.

Kocsis, J. H., & Frances, A. J. (1987). A critical discussion of DSM-III dysthymic disorder. *American Journal of Psychiatry, 144,* 1534-1542.

Kovacs, M., Rush, A. J., Beck, A. T., & Hollon, S. D. (1981). Depressed outpatients treated with cognitive therapy or pharmacotherapy: A one-year follow-up. *Archives of General Psychiatry, 38,* 33-39.

Krantz, S., & Hammen, C. (1979). Assessment of cognitive bias in depression. *Journal of Abnormal Psychology, 88,* 611-619.

Lewinsohn, P. M. (1975). Engagement in pleasant activities and depression level. *Journal of Abnormal Psychology, 84,* 729-731.

Lewinsohn, P. M., Larson, D. W., & Mufloz, R. F. (1982). The measurement of expectancies and other cognitions in depressed individuals. *Cognitive Therapy and Research, 6,* 437-446.

Lutz, R. (1985). *Zum Konzept euthymer Behandlungsstrategien.* Unveroeffentlichter Vortrag, Philipps-Universitaet Marburg.

Menzel, S. J. (1987). *Therapieprogramm zum Aufbau von positivem Verhalten und Erleben bei Depression.* Unveroeffentlichter Diplomarbeit Westfaelische Wilhelm-Universitaet Muenster.

Miller, I. W., Norman, W. H., & Dow, M. G. (1986). Psychosocial characteristics of “double depression.” *American Journal of Psychiatry, 143,* 1042-1044.

Murphy, G. E., Simons, A. D., Wetzel, R. D., & Lustman, P. J. (1984). Cognitive therapy and pharmacotherapy: Singly and together in the treatment of depression*. Archives of General Psychiatry, 41,* 33-41.

Newman, C. F. (1989). “Where’s the evidence?” Helping patients to rationally respond to their automatic thoughts. *International Cognitive Therapy Newsletter, 5,* 4-8.

Rogers, T. R., & Forehand, R. (1983). The role of parent depression in interactions between mothers

and their clinic-referred children. *Cognitive Therapy and Research,* 7, 315-324.

Roth, D., & Rehm, L. P. (1980). Relationships among self-monitoring processes, memory, and depression. *Cognitive Therapy and Research, 4,* 149-158.

Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S. D. (1977). Comparative efficacy of cognitive therapy versus pharmacotherapy in outpatient depressives. *Cognitive Therapy and Research, 1,* 17-37.

Sacco, W. P., & Beck, A. T. (1985). Cognitive therapy of depression. In E. E. Beckham & W. Leber (Eds.), *Depression: Treatment, assessment, and research.* New York: Dow Jones-Irwin.

Shaw, B. F. (1977). Comparison of cognitive therapy and behavior therapy in the treatment of depression. *Journal of Consulting and Clinical Psychology, 45,* 543-551.

Simons, A. D., Murphy, G. E., Levine, J. L., & Wetzel, R. D. (1986). Cognitive therapy and pharmacotherapy for depression: Sustained improvement over one year. *Archives of General Psychiatry, 43,* 43-48.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Taylor, F. G., & Marshall, W. L. (1977). Experimental analysis of a cognitive-behavioral therapy for depression. *Cognitive Therapy and Research, 1,* 59-72.

Teasdale, J. D., & Fennell, M. J. V. (1982). Immediate effects on depression of cognitive therapy interventions. *Cognitive Therapy and Research, 6,* 343-352.

Truax, C. B., & Mitchell, K. M. (1971). Research on certain therapist skills in relation to process and outcome. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis.* New York: Wiley.

Weishaar, M. E., & Beck, A. T. (1986). Cognitive therapy. In W. Dryden & W. Golden (Eds.), *Cognitive-behavioral approaches to psychotherapy* (pp. 61-91). London: Harper & Row.

Weissman, A., & Beck, A. T. (1978). *Development and validation of the dysfunctional attitude scale.* Paper presented at the meeting of the Association for the Advancement of Behavior Therapy,

Chicago.

Yee, C. M., & Miller, G. A. (1988). Emotional information processing: Modulation of fear in normal and dysthymic subjects. *Journal of Abnormal Psychology, 97,* 54-63.