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From the Director

Judith S. Beck, Ph.D.

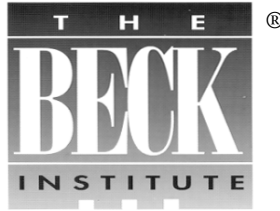
Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work

What do you do when standard cognitive therapy just does not seem to help a patient enough? I've spent the last seven or eight years trying to write a book to help therapists answer this question. After five years (literally) of false starts, I finally figured it out. After another two years, I finished the book.

Here is what I struggled with. There are a host of factors involved with patients' lack of progress in treatment. Where should therapists start? How do they determine whether difficulties have arisen due to factors beyond their (and sometimes their patients') control? How do they know whether they themselves have made mistakes, that is, they have been implementing the basics incorrectly? And/or has a given difficulty arisen because of patients' dysfunctional beliefs? For example, a patient consistently misses sessions or shows up late. Is this a practical problem, e.g., lack of transportation? Is the patient literally too anxious to leave the house? Is the patient unsocialized to treatment? Has the therapist failed to address a problem in the therapeutic alliance? Does the patient doubt that treatment can help? Or actually fear getting better?

I have found that as many difficulties arise from inadequate treatment as from patients' pathology. Therapists may not recognize, for example, how treatment must be varied for each diagnosis. They may assign homework that is much too difficult for a particular patient. They may lack basic counseling skills of conveying empathy, caring, and accurate

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For Cognitive Therapy and Research

From the President

Aaron T. Beck, M.D.

Reflections on my Public Dialog with the Dalai Lama

Judy Beck and I met with the Dalai Lama initially in his private drawing room in the hotel for an informal discussion a couple of hours prior to the actual public dialog. Also attending were Paul Salkovskis, Astrid Beskow, and a number of his own representatives, including his long-time interpreter. Initially, I presented His Holiness with a copy of *Life* magazine from 1959, which had a cover picture of him receiving bouquets from his American supporters after his escape from Tibet to the United States. He seemed pleased to see this much younger picture of himself. I also presented him with a hard copy of *Prisoners of Hate*. He seemed taken by the title, which epitomized his own view that hatred imprisons the people who experience it. He then remarked that there must be six billion prisoners in the world!

On a personal level, I found him charismatic, warm, engaging, and very attentive to what I had to say. At the same time, he seemed to maintain an objective detachment not only with me but also with the members of the entourage. He also impressed me with his wit and wisdom and his ability to capture the nuances of very complex issues.

The dialog was held at the Göteborg Convention Center with about 1400 attendees at the International Congress of Cognitive Psychotherapy. In keeping with his expressed wish, I started the dialog. I began to recite the dozen or so main points of similarity between

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Cognitive Therapy for Challenging Problems— *Continued*

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understanding. They may not focus on key cognitions, problems, and behaviors. On the other hand, therapists may be doing everything right—but the patient is still not progressing.

How can a therapist sort this all out? The first step is to specify problems in behavioral terms. It is too difficult to work on a global problem like a patient's "resistance," or "lack of motivation." It is far easier to solve specific problems (which may have arisen in session or between sessions) such as patients not doing homework, constantly changing the subject in session, becoming angry at the therapist, engaging in self-harm, making too many crisis calls, and so on.

Next therapists need to conceptualize why problems have arisen. This is sometimes a difficult task but therapists can examine a hierarchy of common causes. First they should first determine whether there are relevant factors extraneous to treatment. Next they need to examine what they have been doing and ensure that their treatment has been based on a sound cognitive formulation of patients' specific disorder(s) and an accurate cognitive conceptualization of the individual patient. Following this, they need to examine the therapeutic alliance. They also need to assess patients' goals and their motivation to achieve them. Next they need to determine whether they are using inappropriate or ineffective techniques in structuring sessions, focusing patients on solving problems and making behavioral change, assigning homework, or identifying and modifying key cognitions. Finally they need to discover whether patients' dysfunctional beliefs become activated in treatment and whether patients are therefore employing their characteristic dysfunctional coping strategies in session.

The first step in this hierarchy is examining whether there are important factors extraneous to what is happening in session. For example, patients may have an organic problem masquerading as a psychological disorder. The medication they are taking may be ineffective (or even counter-productive if they become too sedated). Their environment may be too deleterious for treatment to be effective. The format of treatment may be inappropriate (e.g., rather than be in individual therapy, the patient should be in couples, family, or group therapy). They may need adjunctive treatment (e.g., medication, pastoral counseling, vocational counseling) in addition to cognitive therapy. Finally, they may need a different dose of therapy (more frequent or less frequent sessions) or a higher level of care. If any of these problems exist, even the most effective psychological treatment may just not work, or not work well enough.

Assuming that there are no relevant extraneous factors, the next step is for therapists to ensure they have an accurate diagnosis and an accurate formulation of the patient's disorder. Patients with obsessive compulsive disorder may fail to improve if their therapists are providing them with standard treatment for generalized anxiety disorder, for example. Therapists also need to examine their conceptualization of the individual patient and ensure that they have identified patients' most centrally important cognitions and behaviors. Then they must assess whether they have been planning and delivering treatment based on this formulation and conceptualization. It is especially important to understand the cognitive formulation for each Axis II disorder since many problems in treatment can be traced to characterological pathology. Armed with an accurate formulation of a patient's disorder(s) and accurate conceptualizations of individual patients, the therapist can more easily understand why certain problems have arisen and what to do about them.

Since patients tend to progress poorly when the alliance is not strong enough, therapists next need to assess whether there are difficulties in the therapeutic relationship. They need to look at patients' reactions to them and their reactions to patients. If there are problems, patients may resist the standard elements of treatment, such as setting agendas, revealing or focusing on their problems, doing homework, providing feedback, or even coming to treatment regularly.

If there is a reasonably strong alliance, therapists should assess whether patients have clearly defined behavioral goals that are under their control, that are reasonable, and that they really want to achieve. Therapists also need to help patients understand how it is that they will reach these goals, that is, the concrete steps patients will need to take. Failure to set goals appropriately or to address beliefs that interfere with patients' willingness to work toward these goals is another prime factor involved with patients' lack of progress.

If none of the problems in the hierarchy above exist, therapists most likely need to use advanced strategies in order to structure sessions, focus patients on problem solving and implementing solutions for homework, and change key cognitions. It is also especially important to identify patients' dysfunctional beliefs and dysfunctional coping strategies that have interfered with treatment. I will describe the necessary techniques to overcome these problems in a later column.

Reference

Beck, Judith. (2005) *Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work*. New York: Guilford Publications.

Cognitive Theory of Anxiety Disorders: Core Theoretical and Empirical Developments

by Amy Wenzel, Ph.D., University of Pennsylvania

The past two decades have witnessed a wealth of work designed to advance our cognitive understanding of anxiety disorders and provide empirical support for theoretical claims, many of which were proposed in Beck and Emery's seminal 1985 book, *Anxiety Disorders and Phobias: A Cognitive Perspective*. Although Beck and Emery's theory was based primarily on clinical observation, their tenets are remarkably supported in the empirical literature. At present, it is accepted as a truism that individuals with anxiety disorders are characterized by cognitive biases toward threat, such that they are hypervigilant for danger in their environment and interpret ambiguity as though it were threatening. The purpose of this article is to describe the theoretical and empirical accounts that have stemmed from Beck and Emery's work and evaluate the manner in which these accounts support their original claims.

One notable advance is the development of intricate cognitive models of each of the specific anxiety disorders. Although Beck and Emery (1985) outlined the cognitive features of several individuals anxiety disorders, anxiety researchers have extended these models further and increased their specificity. For example, David M. Clark elaborated on their cognitive model of panic by introducing the term, "catastrophic misinterpretation of bodily sensations" (Clark, 1986). Cognitive models of social phobia (e.g., Rapee & Heimberg, 1997; Clark & Wells, 1995) extend Beck and Emery's notion of the "vicious cycle" to suggest that socially anxious individuals narrow their attention on their own anxiety symptoms during evaluative situations, which causes them to miss important social cues and experience an objective

decrement in their social performance. Wells (1995) distinguished between two types of worry in his cognitive model of generalized anxiety disorder (GAD)—Type I worry refers to worry about external events, whereas Type II worry refers to negative appraisals about their own worry activity. Specific cognitive models have been proposed for other anxiety-related pathologies not considered in Beck and Emery's book, such as compulsive checking (Rachman, 2002) and posttraumatic stress disorder (Ehlers & Clark, 2000). Moreover, Beck and Clark (1997) extended the Beck and Emery (1985) model by proposing a three-stage sequence of information processing, such that processing moves from being automatic to being strategic and driven by the activation of cognitive schemas.

Several empirical lines of research have been designed to validate aspects of these cognitive theories. For example, Beck and Emery (1985) described the manner in which anxious individuals narrow their attention on threat at the expense of safety cues. Studies using Emotional Stroop and probe detection tasks have found that anxious individuals selectively attend to threatening semantic and pictorial stimuli (e.g., MacLeod, Mathews, & Tata, 1986; Mogg & Bradley, 2002). Moreover, studies employing masked stimuli of threatening and neutral contents have revealed that attentional biases occur outside of awareness (e.g., Mogg, Bradley, Williams, & Mathews, 1993), confirming Beck and Emery's notion that these biases are automatic and often not under one's volition. In addition, Beck and Emery (1985) indicated that anxious individuals inaccurately appraise situations as

dangerous. Many studies have confirmed that when anxious individuals are presented with ambiguous scenarios that involve potential harm, they rate negative or catastrophic explanation for the events as being more likely than nonanxious individuals (e.g., Amir, Foa, & Coles, 1998).

In contrast, results from other empirical works raise the possibility that certain aspects of cognitive theories of anxiety should be refined. For example, Beck and Emery's (1985) theory suggested that the activation of a maladaptive cognitive set should bias the entire sequence of information processing, from perception to retrieval from long-term memory. Researchers who examined the intentional recall of threat-relevant information generally have failed to find a memory bias this information, relative to neutral information, in anxious individuals, although a few studies have uncovered such a bias (e.g., Greenberg & Beck, 1989), particularly when using samples of patients with panic disorder or posttraumatic stress disorder (Coles & Heimberg, 2002). Other researchers have examined implicit memory, or instances in which previously presented stimuli influence a person's behavior when he or she is not consciously trying to retrieve that information. In one typical implicit memory task, participants are presented with a series of words and asked to rate a characteristic of the word, such as its pleasantness. Later in the experiment, they are presented with a series of word stems, some of which formed the beginnings of words used in the rating task, and they are instructed to complete the stem with the first word that comes to mind. Implicit memory is demonstrated when participants complete the stems with the previously rated words at a higher rate than would be expected by chance, and research

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Tibetan Buddhism and cognitive therapy (listed below). After I recited four or five similarities, he interrupted with the statement that they were as many items as he could absorb at one time.

My main challenge in the dialog was to inform him about the cognitive approach to human problems without in any way taking away from the broad philosophy and psychology of Buddhism. My strategy was to find appropriate points in his discourse where I could introduce cognitive concepts that were relevant in some way to his train of thought. I tried to represent the cognitive approach as a valid system or discipline in its own right that overlapped but also was complimentary to Buddhism. I also had to be conscious of my choice of words. Although His Holiness is quite fluent in speaking English, he is not familiar with more technical words, especially those for which there are no Tibetan equivalents. For example, he used the term “negative thoughts,” which I repeated in preference to the more technical (and precise) cognitive terms, such as self-defeating thoughts or dysfunctional cognitions.

Among the points that I brought up, which he then expanded on from his own vantage point, were that both systems use the mind to understand and cure the mind. Acceptance and compassion were key similarities. Also, in both systems, we try to help people with their overattachment to material things and symbols (of success, etc., something we call “addiction”). I gave a case example of a depressed scientist who was so attached to success (in this case, specifically winning a Nobel Prize) that he excluded everything else in his life, including his family. I had used a typical cognitive strategy to give the patient perspective. In the course of a single session, he changed his beliefs and got over his depression (at least temporarily). The Dalai Lama’s response to this anecdote was, “You should get the Nobel Prize for Peace.”

Another point that I brought up was our distinction between pain and suffering. I suggested that much of people’s suffering is based on the fact that they identify themselves with the pain. People who are able to separate (“distance”) themselves from the pain and view it more objectively had significantly less distress (as pointed out by Tom Sensky’s group in London). His Holiness seemed taken with this concept and then said in an amusing way that maybe he could use this notion to help himself with his chronic itch. (This half-serious comment, of course, evoked a large amount of laughter from the audience.) He later referred to cognitive therapy as similar to “analytical meditation.”

I asked His Holiness how he thought that his message could really take root in the world. He then expanded on his ideas that education had to be the answer. He also expressed his own philosophy, which he described as secular ethics. Although people of different faiths could embrace the values that he expressed, such as total acceptance of all living things, he did not feel that religion was a necessary instrument for this. He appeared to echo what is also the essence of the cognitive approach, namely self-responsibility rather than depending on some external force to inspire ethical standards. Since I believe that CT also regards unethical and morally destructive behavior as a cognitive problem and thus would advocate a “cognitive morality,” I later was able to get this point across but in different words. When he asked me for my view of human nature, I responded that I agreed that people were intrinsically good but that the core of goodness was so overlaid with layer after layer of “negative thoughts” that one had to remove the layers for the goodness to emerge. He expressed the belief that positive thinking (focusing on positive and good things) was the way to neutralize the negative in human nature. My position was that the best way to reach this goal was to pinpoint the

thinking errors and correct them. After we concluded the dialog, Paul Salkovskis gave an outstanding summation of the topics that we had covered.

Since Astrid Beskow (the prodigious organizer of the event) discovered that by coincidence this was his birthday, there was a short birthday celebration during which he was then given a large bouquet. He then gave Astrid, Paul, and myself a Buddhist prayer shawl. I later learned from an intermediary that he enjoyed the dialog and that he would think about several points that I raised.

All in all, it was a thrilling experience for me and, from what I heard from several of the attendees, also for the audience.

From my readings and discussions with His Holiness and other Buddhists, I am struck with the notion that Buddhism is the philosophy and psychology closest to cognitive therapy and vice versa. Below is a list of similarities that I suggested to the Dalai Lama in our private meeting. Of course, there are many strategies we use such as testing beliefs in experiments and formulating the case that are not part of the Buddhist approach.

SIMILARITIES BETWEEN COGNITIVE THERAPY AND BUDDHISM

- I. **Goals** Serenity, Peace of Mind, Relief of Suffering
- II. **Values**
 - (1) Importance of Acceptance, Compassion, Knowledge, Understanding
 - (2) Altruism vs. Egoism
 - (3) Universalism vs. Groupism: “We are one with all humankind.”
 - (4) Science vs. Superstition
 - (5) Self-responsibility
- III. **Causes of Distress:**
 - (1) Egocentric biases leading to excessive or inappropriate anger, envy, cravings, etc. (the “toxins”) and false beliefs (“delusions”)
 - (2) Underlying self-defeating beliefs that reinforce biases.
 - (3) Attaching negative meanings to events.

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demonstrates that anxious individuals do so particularly when they are completing stems of threat-relevant words (Mathews, Mogg, May, & Eysenck, 1989).

In their cognitive model of emotional disorders, Williams, Watts, MacLeod, and Mathews (1997) proposed that anxious individuals demonstrate memory biases for information that is accessible, as in implicit memory tasks, but not necessarily readily available, as in explicit memory tasks. They suggested that this pattern of information processing is adaptive from an evolutionary standpoint because the purpose of anxiety is to detect danger and implant a course of action to deal with it. The Williams et al. model deviates from Beck and Emery's model in that they imply that certain types of cognitive biases, such as attentional biases, are more central to understanding anxiety pathology than other cognitive biases, such as memory biases.

In sum, Beck and Emery's (1985) cognitive perspective on anxiety disorder and phobias spawned twenty years of theoretical and empirical work. Newer cognitive models of anxiety disorders share many central features that Beck and Emery had originally proposed, such as a schema or cognitive set that predisposes individuals to process information in a biased manner, attentional biases toward threat, and catastrophic misinterpretations of ambiguous stimuli. Their model has generated numerous testable hypotheses, and its longevity speaks to its significant explanatory power in accounting for the phenomenology of anxiety and anxiety disorders. In the second article in this series, specific programs of empirical research that advance the cognitive theory of anxiety in new directions will be discussed.

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Reflections— *Continued from page 4*

IV. **Methods:**

- (1) Focus on the Immediate (here and now)
- (2) Targeting the biased thinking through (a) Introspection, (b) Reflectiveness, (c) Perspective-taking, (d) Identification of "toxic" beliefs, (e) Distancing, (f) Constructive experiences, (g) Nurturing "positive beliefs"
 - (3) Use of Imagery
 - (4) Separating distress from pain

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Academy of Cognitive Therapy
Membership Office
One Belmont Avenue, Suite 700
Bala Cynwyd, PA 19004
Tel: 610-664-1273
Fax: 610-664-5137

SPEAKING ENGAGEMENTS

November 1-3, 2005. Ontario, Canada. Algoma Family Services. Cognitive Therapy Workshop.
Speaker: Leslie Sokol, Ph.D. Tel: 705-945-5050 x2044; Fax: 705-942-9273; Email: rlarocque@algomafamilyservices.org

November 4, 2005. Atlanta, GA. Institute for the Advancement of Human Behavior. Cognitive Therapy for Personality Disorders. Speaker: Judith S. Beck, Ph.D. Tel: 800-258-8411; Website: www.iahb.org

November 11, 2005. Allentown, PA. Psychological Association of the Lehigh Valley. Cognitive Therapy for Personality Disorders. Speaker: Judith S. Beck, Ph.D. Contact: Edward Lundeen, Ph.D. Email: romaedl@juno.com

November 11, 2005. Ionia, MI. Ionia County Community Mental Health Workshop. Cognitive Therapy Basics.
Speaker: Daniel T. Beck, M.S.W. Contact: Laurie Boussom, 375 Apple Tree Lane, Ionia, MI 48846

November 17 – 20, 2005. Washington, D.C. Association for Advancement of Behavior Therapy 39th Annual Conference. Cognitive Therapy for Depression. Speaker: Judith S. Beck, Ph.D. ; Conversational Period with Aaron T. Beck, MD. Tel: 212-647-1890; Fax: 212-647-1865;
Website: www.aabt.org

December 7-11, 2005. Anaheim, CA. 5th Evolution of Psychotherapy Conference. Cognitive Therapy: Basics and Beyond
Topic Panels: Resistance and Homework; How to Supervise in Cognitive Therapy. Speaker: Judith S. Beck, Ph.D.; New Advances in Cognitive Therapy. Speaker: Aaron T. Beck, M.D.; Tel: 651-487-3001; Fax: 651-489-3387; Email: miltonerikson@cmehelp.com Website: <http://www.erickson-foundation.org/>

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One Belmont Avenue, Suite 700
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Telephone: 610.664.3020
Fax: 610.664.4437 Email: beckinst@gim.net
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