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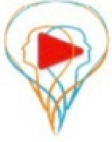

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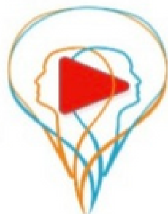

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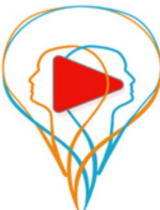

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Instructor's Manual

for

AARON BECK ON COGNITIVE THERAPY

with

AARON T. BECK, M.D

Manual by

Ali Miller, MFT

The *Instructor's Manual* accompanies the DVD *Aaron Beck on Cognitive Therapy with Aaron T. Beck, M.D.*(Institutional/Instructor's Version). Video available at www.psychotherapy.net.

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150 Shoreline Highway, Building A, Suite 1
Mill Valley, CA 94941
Email: contact@psychotherapy.net
Phone: (800) 577-4762 (US & Canada)/(415) 332-3232

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Miller, Ali, MFT

Instructor's Manual for Aaron Beck on Cognitive Therapy with Aaron T. Beck, M.D.

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Instructor's Manual for

AARON BECK ON COGNITIVE THERAPY WITH AARON T. BECK, M.D.

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the concepts presented. The **Discussion Questions** section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions. What are viewers' impressions of what is presented in the interview?

4. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from **Related Websites, Videos and Further Reading** prior to or after viewing.

5. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

Cognitive Therapy in Historical Context*

The early years

Psychotherapy began with the practice of psychoanalysis, the “talking cure” developed by Sigmund Freud in the 1890s. Soon afterward, theorists such as Alfred Adler and Carl Jung began to introduce new conceptions about psychological functioning and change. These and many other theorists helped to develop the general orientation now called psychodynamic therapy, which includes the various therapies based on Freud’s essential principle of making the unconscious conscious.

In the 1920s, behaviorism became the dominant paradigm, and remained so until the 1950s. Behaviorism used techniques based on theories of operant conditioning, classical conditioning and social learning theory. Major contributors included Joseph Wolpe, Hans Eysenck, and B.F. Skinner. In the 1930s, Wilhelm Reich began to develop body-oriented psychotherapy, and in 1956 Alexander Lowen expanded on Reich’s beliefs and founded Bioenergetic Analysis, also a form of mind-body psychotherapy.

Starting in the 1950s, two main orientations evolved independently in response to behaviorism—cognitivism and existential-humanistic therapy. The humanistic movement largely developed from both the existential theories of writers like Rollo May and Viktor Frankl and the person-centered psychotherapy of Carl Rogers. These orientations all focused less on the unconscious and more on promoting positive, holistic change through the development of a supportive, genuine, and empathic therapeutic relationship.

Also during the 1950s, Albert Ellis developed what was originally called rational therapy, which was then revised to Rational Emotive Therapy in 1959, and finally changed to its current name in 1992, Rational Emotive Behavior Therapy (REBT).

Beck develops Cognitive Therapy

In 1954 Beck took a position at the University of Pennsylvania in the psychiatry department, which is where he developed the depression research clinic. After years of practicing psychoanalysis, Beck became

disillusioned with long-term psychodynamic approaches based on gaining insight into unconscious emotions and drives, and came to the conclusion that the way in which people perceived, interpreted and attributed meaning in their daily lives—a process known as cognition—was key to therapy. Ironically, it was Beck's explorations into psychoanalytic concepts of depression while working at University of Pennsylvania that led to his development of Cognitive Therapy. Beck began to work more intensely on his cognitive approach to depression, and in 1961, he developed the Beck Depression Inventory (BDI), one of the most widely used and referenced scales of depression.

In 1967 Beck outlined his innovative approach in his first book, *Depression: Clinical Experimental and Theoretical Aspects* (republished in 1970 as *Depression: Causes and Treatment*). Initially Beck's new cognitive approach came into conflict with the behaviorism popular at the time, which focused on assessing stimuli and behavioral responses and did not pay attention to cognitions. However, in the early 1970s, a period known as the "cognitive revolution" occurred in the field of psychology. Beck was suddenly invited to give lectures on his research in cognitive psychology across Pennsylvania and New York. Behavioral modification techniques and cognitive therapy techniques became joined together, giving rise to Cognitive Behavioral Therapy. By the mid-1970s Beck expanded his focus on depression to include anxiety and other psychiatric disorders, and in 1976 published *Cognitive Therapy and the Emotional Disorders*. To date, Beck has produced more than 550 scholarly articles and 18 books on subjects ranging from depression, suicide, relationships, anxiety, and many other topics. Although cognitive therapy has always included some behavioral components, advocates of Beck's particular approach seek to maintain and establish its integrity as a distinct, clearly standardized kind of cognitive behavioral therapy.

*Adapted from:
http://en.wikipedia.org/wiki/History_of_psychotherapy
http://pabook.libraries.psu.edu/palitmap/bios/Beck__Aaron_Temkin.html
http://en.wikipedia.org/wiki/Cognitive_therapy
http://en.wikipedia.org/wiki/Rational_emotive_behavior_therapy

Summary of the Cognitive Therapy Approach*

Developed by Dr. Aaron T. Beck, Cognitive Therapy (CT), or Cognitive Behavior Therapy (CBT), is a form of psychotherapy in which the therapist and the client work together as a team to identify and solve problems. Therapists help clients to overcome their difficulties by changing their thinking, behavior, and emotional responses. For more information about training in CBT, visit www.beckinstitute.org.

A System of Psychotherapy

Cognitive therapy is a comprehensive system of psychotherapy, and treatment is based on an elaborated and empirically supported theory of psychopathology and personality. It has been found to be effective in more than 400 outcome studies for a myriad of psychiatric disorders, including depression, anxiety disorders, eating disorders, and substance abuse, among others, and it is currently being tested for personality disorders.

In the mid-1960s, Dr. Aaron T. Beck developed cognitive therapy as a time-sensitive, structured therapy that uses an information-processing model to understand and treat psychopathological conditions. The theory is based, in part, on a phenomenological approach to psychology, as proposed by Epictetus and other Greek Stoic philosophers and more contemporary theorists such as Adler, Alexander, Horney, and Sullivan. The approach emphasizes the role of individuals' views of themselves and their personal worlds as being central to their behavioral reactions, as espoused by Kelly, Arnold, and Lazarus. Cognitive therapy was also influenced by theorists such as Ellis, Bandura, Lewinsohn, Mahoney, and Meichenbaum.

The Cognitive Model

Cognitive therapy is based on a cognitive theory of psychopathology. The cognitive model describes how people's perceptions of, or spontaneous thoughts about, situations influence their emotional, behavioral (and often physiological) reactions. Individuals' perceptions are often distorted and dysfunctional when they are distressed. They can

learn to identify and evaluate their "automatic thoughts" (spontaneously occurring verbal or imaginal cognitions), and to correct their thinking so that it more closely resembles reality. When they do so, their distress usually decreases, they are able to behave more functionally, and (especially with anxiety) their physiological arousal abates.

Individuals also learn to identify and modify their distorted beliefs: their basic understanding of themselves, their worlds, and other people. These distorted beliefs influence their processing of information, and give rise to their distorted thoughts. Thus, the cognitive model explains individuals' emotional, physiological, and behavioral responses as mediated by their perceptions of experience, which are influenced by their beliefs and by their characteristic ways of interacting with the world, as well as by the experiences themselves. Therapists use a gentle Socratic questioning process to help patients evaluate and respond to their automatic thoughts and beliefs—and they also teach them to engage in this evaluation process themselves. Therapists may also help patients design behavioral experiments to carry out between sessions to test cognitions that are in the form of predictions. When patients' thoughts are valid, therapists do problem solving, evaluate patients' conclusions, and work with them to accept their difficulties.

The Goal of Cognitive Therapy

The goals of cognitive therapy are to help individuals achieve a remission of their disorder and to prevent relapse. Much of the work in sessions involves aiding individuals in solving their real-life problems and teaching them to modify their distorted thinking, dysfunctional behavior, and distressing affect. Therapists plan treatment on the basis of a cognitive formulation of patients' disorders and an ongoing individualized cognitive conceptualization of patients and their difficulties. A developmental framework is used to understand how life events and experiences led to the development of core beliefs, underlying assumptions, and coping strategies, particularly in patients with personality disorders.

A strong therapeutic alliance is a key feature of cognitive therapy.

Therapists are collaborative and function as a team with patients. They provide rationales and seek patients' agreement when undertaking interventions. They make mutual decisions about how time will be spent

in a session, which problems will be discussed, and which homework assignments patients believe will be helpful. They engage patients in a process of collaborative empiricism to investigate the validity of the patient's thoughts and beliefs.

Cognitive therapy is educative, and patients are taught cognitive, behavioral, and emotional-regulation skills so they can, in essence, become their own therapists. This allows cognitive therapy to be time-limited for many patients; those with straightforward cases of anxiety or depression often need only six to twelve sessions. Patients with personality disorders, comorbidity, or chronic or severe mental illness usually need longer courses of treatment (six months to one year or more) with additional periodic booster sessions.

Cognitive therapists elicit patients' goals at the beginning of treatment.

They explain their treatment plan and interventions to help patients understand how they will be able to reach their goals and feel better. At every session, they elicit and help patients solve problems that are of greatest distress. They do so through a structure that seeks to maximize efficiency, learning, and therapeutic change. Important parts of each session include a mood check, a bridge between sessions, prioritizing an agenda, discussing specific problems and teaching skills in the context of solving these problems, setting of self-help assignments, summary, and feedback.

Cognitive Therapy Techniques

Therapists use a wide variety of techniques to help patients change their cognitions, behavior, mood, and physiology. Techniques may be cognitive, behavioral, environmental, biological, supportive, interpersonal, or experiential. Therapists select techniques based on their ongoing conceptualization of the patient and his or her problems and their specific goals for the session. They continually ask themselves, "How can I help this patient feel better by the end of the session and how can I help the patient have a better week?" These questions also guide clinicians in planning strategy.

There is no one typical client for this approach, as cognitive therapy

has been demonstrated in numerous research studies to be effective for depression, anxiety disorders, substance abuse, eating disorders; for bipolar disorder and schizophrenia (as an adjunct to medication); and

for a variety of medical problems with psychological components. Of course, treatment has to be varied for each disorder and therapists must not only understand the cognitive formulation of a specific disorder but also be able to conceptualize individual clients accurately and devise a treatment plan based on this formulation and conceptualization. Cognitive therapy interventions must also be adapted for older adults, children, and adolescents and for group, couples, and family treatment.

* Adapted from http://www.beckinstituteblog.org/cognitive-behavioral-therapy/

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. **Cognitive Therapy:** What do you think of Cognitive Therapy? Do you agree with Beck that the basic problem clients face has to do with the way they think, and that the way to solve their problems is to focus on their cognitions? Do you help your clients examine their thinking? Why or why not?

2. **Evolution:** What reactions did you have as Beck spoke about his evolution from psychoanalyst to cognitive therapist? Were you surprised to learn that Beck was originally a psychoanalyst and that his original motivation for research was to prove to skeptics that psychoanalysis really had the "pipeline to truth"? Have you had the experience of converting from one school of thought to another, whether in the field of psychotherapy or elsewhere? How has your thinking about therapy evolved since you initially became interested in the field?

3. **Length of therapy:** Beck spoke about how psychoanalysis would typically take several years, whereas when he began using cognitive therapy, clients would show improvement after the first session. What are your thoughts on how long therapy should take? How many sessions do you typically have with clients before you begin to see improvement? What is the average length of time for which you treat clients? What do you think about insurance companies dictating the length of treatment?

4. **Mystique:** What are your thoughts on why psychodynamic therapy has persisted despite outcome studies that favor cognitive therapy? Do you agree with Beck that psychoanalysis might continue to have appeal because there is a certain mystique to psychoanalysis which attracts loyal followers? Do you agree with Beck that there is a cultural time lag?

5. **Hodge-podge:** What reactions did you have to Beck's thoughts on the integration of therapeutic modalities? Do you share his

concern that there is a certain "hodge-podge" when you try to bring together a lot of very diverse techniques, unless there is a unifying principle? What are your thoughts on integrating various techniques and schools of therapy? What are the benefits and risks of an eclectic approach to psychotherapy? Do you stick to one orientation or are you more integrative in your approach?

6. **Outcome studies:** How did you react when Beck spoke about his concern that there is a trend away from outcome studies? What are your thoughts on the importance of outcome studies for psychotherapy? What do you think are some of the benefits and risks of psychotherapy research? What do you think are some of the limitations of focusing too much on empirical data? If trusting your intuition and trusting empirical data were on two ends of a spectrum, where would you place yourself and why?

7. **Mentors:** What mentors, teachers, authors, events, or associations have been influential in your approach to psychotherapy? What are some of the key lessons you have learned from these sources? Whose opinions have you rejected in order to clarify your own views?

8. **Depression:** Were you surprised, like the interviewer was, that Beck said, "Cognition doesn't cause depression"? Do you agree with Beck that depression has various causes, but once a person is depressed, then they tend to process information in a negative way? Do you think of depression as having a thinking disorder in it like Beck does? How do you tend to think about depression when working with depressed clients? How do your thoughts about depression influence your therapeutic approach and treatment plans?

9. **Evolutionary friction rub:** What do you think of Beck's theory about depression's evolutionary origins: that depression might be a way people in previous eras conserved energy when they had no resources? Do you find it useful to consider the functional role of depression (or any other psychiatric disorder) and how it might have had some adaptive purpose at some point in the distant or immediate past? Why or why not? What reactions do you have

to Beck's theory about what he called the "evolutionary friction rub" and his belief that biological evolution lags behind cultural evolution?

10. **Cognitive profiles:** What do you think of the development of cognitive profiles for each of the psychiatric disorders? If you reflect on clients you have worked with or are currently working with, what might their cognitive profiles be?

11. **Panic disorder:** Do you agree with Beck that people who have a panic disorder are misinterpreting various internal sensations? What do you think of his approach of reproducing the panic attack in the patient in session and then inviting the patient to become aware of their internal sensations? What are some ways you might go about reproducing a panic reaction for a patient? Do you think this is an effective way to get people to re-label their sensations as something normal and not catastrophic? Does this sound like a technique you can see yourself using to help clients with panic attacks? Why or why not? How do you tend to work with people who suffer from panic disorder?

12. **Good training:** Beck and Kendall agreed that the primary basis for good training for therapists should focus primarily on a well-rounded education in psychology and evolutionary biology, and that supervised practicum is less important. What are your thoughts on this? What do you think the key ingredient is for training good therapists? What has been most essential in your own training?

13. **Predictions:** What reactions did you have to Beck's predictions for the future of psychotherapy? In particular, what do you think of his hypothesis that patients with more severe disorders will be treated by the most experienced therapists and patients with less severe disorders will be treated by less experienced therapists? From your perspective, has this prediction panned out? Do you think this is an effective way to offer treatment? Why or why not?

14. **Transportability:** What do you think of the idea of transporting a therapy model from one setting to another? What are the pros and cons of manualized treatment? Have you ever conducted

therapy using a treatment manual? If so, what was that experience like? Have you ever been evaluated as a therapist? How were you evaluated and what was that like for you? If you were to create an evaluation tool for therapists, what would you include in it? How do you evaluate your own competence as a therapist?

15. **Cross cultural appeal:** Beck was surprised to find that cognitive therapy had a universal appeal across various cultures. Why do you think he was surprised by this? Have you noticed this universal appeal when using cognitive therapy with clients from different cultures? Do you think cognitive therapy might appeal to some people more than others? If so, for whom do you think it might have the greatest and least appeal? Why?

16. **The approach:** What are your overall thoughts about Aaron Beck's Cognitive Therapy approach? What aspects of his approach can you see yourself incorporating into your work? Are there some components of his approach that seem incompatible with how you work?

17. **Personal Reaction:** How would you feel about having Beck as your therapist? Do you think he could build a solid therapeutic alliance with you? Would he be effective with you? Why or why not?

Reaction Paper for Classes and Training

Video: *Aaron Beck on Cognitive Therapy with Aaron T. Beck, M.D.*

• **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.

• **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about Cognitive Therapy? What stands out to you about how Beck approaches psychotherapy?

2. What I found most helpful: As a therapist, what was most beneficial to you about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What principles/techniques/ interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4**. How I would do it differently:** What might you do differently from Beck when working with clients? Be specific about what different approaches, interventions and techniques you would apply.

5. Other Questions/Reactions: What questions or reactions did you have as you viewed the interview with Beck? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

Aaron Beck's website at University of Pennsylvania

www.med.upenn.edu/suicide/beck/index.html

Beck Institute for Cognitive Behavior Therapy: Offering CBT training, workshops, and other professional resources

www.beckinstitute.org

Academy of Cognitive Therapy

www.academyofct.org

The Association for Behavioral and Cognitive Therapies

www.abct.org

International Association for Cognitive Psychotherapy

www.the-iacp.com

National Association of Cognitive-Behavioral Therapists

www.nacbt.org

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Cognitive Therapy for Weight Loss with Judith Beck
Cognitive-Behavioral Therapy with Donald Meichenbaum
Mixed Anxiety and Depression: A Cognitive-Behavioral Approach with Don- ald Meichenbaum
Depression: A Cognitive Therapy Approach with Arthur Freeman
Cognitive Therapy for Addictions with Bruce S. Liese
Rational Emotive Behavior Therapy for Addictions with Albert Ellis
Cognitive-Behavioral Child Therapy with Bruce Masek
Couples Therapy for Addictions: A Cognitive-Behavioral Approach with Barbara S. McCrady
Cognitive-Behavioral Therapy with John Krumboltz

Behavioral Couples Therapy with Richard Stuart Arnold Lazarus: Live Case Consultation

RECOMMENDED READINGS

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Complete Transcript of *Aaron Beck on Cognitive Therapy*

THE EVOLUTION OF COGNITIVE THERAPY

Kendall: Good morning, hello, my name is Phil Kendall. I'm a Professor of Psychology and Director of the Doctoral Training program in clinical psychology here at Temple University. And it's my very special pleasure and good fortune to have this opportunity to talk with Dr. Aaron T. Beck, University Professor of Psychiatry at the University of Pennsylvania. Dr. Beck is the founder of cognitive therapy and it's very nice of him to take this time to speak with us today for these archives for the Association for the Advancement of Behavior Therapy. Good morning, Tim nice to see you.

Beck: Pleasure really to be here and be able to chat with you and share some of my recollections and ideas with you, Phil.

Kendall: Great. We have quite a few questions, Tim. I don't know that we'll have a chance to get to all of them, but I'll try to go over the ones I think are most important. We'll get them in first. I think one question that most people would really like to know from your vantage point, from your prospective: Cognitive therapy has been very influential—what are some of the things that you notice about its evolution? How did it come about?

Beck: Well, to answer that I really have to go back into the misty fogs of my earliest professional beginnings. I started off my career in medical school thinking that psychiatry was a lot of bunk. And I eventually got into a career in neurology. At one point, it was it was determined that neurology residents had to spend time in psychiatry. I fought that as much as I could, but I ended up in psychiatry.

And when I was there I had my first real exposure to psychoanalysis. And I was finally sold on the idea that psychoanalysis really had the pipeline to truth. And so, I spent the next several years trotting down the yellow brick road trying to find truth. And indeed, I got trained as a psychoanalyst and graduated from The Philadelphia Psychoanalytic Institute in 1956.

At that point I noticed that many of my colleagues, particularly those in the academic psychology departments were, very skeptical about psychoanalysis. So, I felt that it was incumbent on me to try to show them the real truth. And so I start to do some research. In the very beginning, I researched dreams and it looked as though my research in dreams actually did hold up some of the psychoanalytic beliefs regarding depression.

Typically in the dream of a depressed person the individual saw himself as the victim of some unpleasant circumstances. And it seemed to me that this really showed that the individual had a need to suffer and the person's—the patient's—hostility was inverted against himself and therefore produced all of the symptoms, including the slowing down, sense of rejection, suicidal wishes and so on.

I then felt that in order to really prove this out I had to use some of the experiments that have been developed by cognitive psychologists, other psychologists, and that did a whole series of studies to test the hypothesis that depressed people had a need to suffer. Well much to my surprise it turned out that far from having a need to suffer, depressed people had a very strong need to receive approval and some type of justification for themselves.

At this point, I started to rethink everything that I had done before. And as I looked at it, it seemed to me that a very commonsensical approach to these depressive dreams was that depressed people saw themselves in their dreams as being victims of circumstances, being losers and so on because that was their basic perception of themselves.

00:05:00

In other words, what we were seeing here was not a motivational process—mainly the wish to suffer—but was a cognitive process. The individual's perception of himself as defeated, derelict, diseased, dishonored and so on.

Now, at the same time I was treating patients in psychoanalysis. And after the patients had returned sometimes for a booster shot a year or two later, I'd ask them, "What did you get out of the psychoanalysis that you went through?" And they'd say, "You know, Doctor, what helped the most was when you sat me down one day and said: 'You're

really not solving this problem properly. You got to really look at what are the pros and what are the cons and then reach a decision.'" I said, "Did I say that?" and they say, "Yeah."

And then another patient would say, "Wait, you told me one day that my thinking was all fouled up." And what I had to do was to start to compare a realistic evaluation of the situation with my emotional evaluation. And then I thought to myself, "Well, if the basic problem has to do with the way people think, then perhaps the way to solve the problem is to just focus on that level." And rather than thinking about the need to suffer, what I ought to do is try to get people to examine their thinking.

At that particular point, I changed my tactics clinically and I asked patients to try to test out their various beliefs. And as they started to test them out, it turned out that they discovered that their thinking was askew in many ways; for example, they would catastrophize and see things much more negatively than they really were. They would tend to see only the negative side of things and not the positive.

And the interesting thing was, once I started focusing on that the patients started to get better. So it no longer took one to two years to get a patient better, but they were starting to show improvement after the very first visit and by the tenth or twelfth visit they'd say, "Doctor, you've helped me a lot, but it's time to say goodbye."

And that's, in a way, the way that I evolved my present notion of cognitive therapy.

Kendall: It's really interesting for me to hear that because there's a nice blend between your research causing you to think a certain way and your clinical experience also causing you to think a certain way. And they happen to go together and it's a nice scientist-practitioner evolution.

Beck: That's right.

Kendall: I really like to hear that. One of the things that's happened in this evolution, of course, is that many of your current books are very influential. People read them and conduct studies of some of the hypotheses that you present. But I think the books came out—some

of your earlier books—came out a long time ago. How were they first received? What was the initial impact?

Beck: Well, my first book actually was on depression. When I started to do research on depression, I realized that I did not have total mastery of this particular area. And so I reviewed the literature very thoroughly and I decided if I was going to do research I had to really try to categorize all of these phenomena and different biological and psychological findings. As I did that, it seemed to be a natural for a book. At that particular time I was approached by Harper and Rowe and they said, "Why don't you write a book on depression?" There hadn't been any really definitive books up until that time.

And so my very first book was received quite well because it covered the entire literature on depression. And I managed to sneak in the chapter there on psychotherapy, which I called "Insight Therapy (Cognitive Therapy)." And the book did well, but only on the basis that it was a text of depression, not because it was an introduction to the cognitive model or to cognitive therapy.

I got off to a good start and then when I finally did write my second book, which was Cognitive Therapy and the Emotional Disorders, I thought I could trade on the reputation of my first book and find a publisher very easily. Well it didn't happen that way. In fact, I think I was rejected by about 12 or 15 publishers before I finally found a publisher who was willing to do it.

And my second book then, Cognitive Therapy and the Emotional

Disorders, was published by a fairly small publisher, International Universities Press, which predominantly published psychoanalytic books. But the person who told them about this said, "Well, Beck's a psychoanalyst and this is simply new psychoanalysis that—

Kendall: [Laughs]—

Beck:—we're getting. And so the book then got published. However, once it did get published and got out into the public domain, then the book did sell fairly well. After that, after the success of the

second
book it wasn't too much of a problem to find a publisher for my third book, which was Cognitive Therapy of Depression.

Kendall: And of course that one has been very, very successful, I know.

Beck: Yeah.

Kendall: Almost every time I travel and visit people in different countries and across the universities, one book that's on the shelf is that one. You can pick it right out.

Beck: Yeah, that book has done very well and it's still selling today. That was 1969 and now 20 years later it's still selling very well.

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A COMPREHENSIVE APPROACH

Kendall: One thing that I'd like to ask about because there is in the history of ... in the evolution of cognitive therapy there's something about psychodynamic and there's currently some influence from the behavioral camps. And I'd be curious how you would describe, Tim, how you see cognitive therapy different from the other schools? What are some of the perhaps distinctive ...

Beck: Well, many years ago, Phil, I thought to myself—if I want to really produce something that's worthwhile, I ought to set up criteria for this therapy. And I thought that I didn't want to just present cognitive therapy as just one other set of techniques, not just a toolbox, but as a broad comprehensive approach. And so I set up certain criteria for what I would call the system of psychotherapy. And I thought the system of psychotherapy, first of all, should have a good theory of personality.

Kendall: Mm-hmm.

Beck: Secondly, it should be a theory of psychopathology and third, there should be a set of principles and strategies for the application of both of these theories to help people with their various problems. So that was one set of criteria for the system. And our mature system should not only have these three major criteria, but should have empirical data to support each of them. So, there should be empirical data to support the theory of personality, empirical data to support the theory of psychopathology and also to support outcome studies to support the therapy itself.

And indeed, one of the requirements I set for myself was that the therapy should be easily interlocked with the particular theory so that you could derive from the theory a particular set of therapeutic devices—that they should not be totally separate. Now once I had set that for myself, then I have spent many years trying to fulfill these different criterion and much of this has been has done, most of it has been done, by people who have been interested in this field and even more by people who have actually been trained with me.

Now, of all of the other systems of psychotherapy, the one that comes closest to fulfilling the first set of criteria is psychoanalysis—there is a therapy of personality, psychopathology and there are a set of procedures. The one system that comes closest to supplying the empirical data is actually behavioral therapy. So in cognitive therapy I tried to merge both of these two things, the theoretical and the empirical.

Kendall: That's a really laudable goal and I think you've done quite well in promoting that nationally and internationally. It's nice to see it happen. In these days, we have a concern about provision of services; we have a concern about their cost and about the time it takes. And the data seem to be directing people to use procedures like cognitive, cognitive behavior approaches to therapy.

And yet, I believe it's fair to say that you and I and others would certainly expect that these data would cause some turnover in the types of treatments that are provided. Yet in spite of a lot of somewhat compelling and convincing data, psychodynamic, for example, treatments still continue. They're often still provided in some settings. So in spite of the great success of cognitive therapy, there's a persistence for people to apply procedures for perhaps other reasons. I'm curious what your thoughts are about that.

Beck: Well, I've thought a lot about this, Phil, and I really have wondered why cognitive therapy has not had any more pervasive influence or cognitive and behavior therapy, both of which have a very strong empirical basis. And actually our first outcome study showing that cognitive therapy was an effective treatment for depression was published in the very early '70s. And since then, cognitive therapy

has been applied to over 25 or 30 conditions where there's very strong empirical evidence to support its efficacy.

However, this has not been reflected in any wide scale adoption of cognitive therapy by the practitioners of the various therapies. One of the factors that has to do with the appeal of psychoanalysis is that there's a certain mystique to psychoanalysis which originally captivated my interest and, in fact, captured my heart and soul, which has attracted and maintained the loyalty of everybody—almost everybody—who's been really exposed to it. So, cognitive ... say psychoanalysis, in my own of way thinking, provides mysterious solutions to relatively simple problems.

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Cognitive therapy, I think, provides simple solutions to rather mysterious problems. But it therefore, by being sort of commonsensical, doesn't have quite the intriguing aspect that psychoanalysis has. A second factor is that even if the graduate programs in clinical psychology are heavily imbued with cognitive behavioral principles, the actual supervision of the fledgling psychotherapist is done largely by people who are psychodynamic.

And why are they psychodynamic? Because they were trained in the psychodynamic therapies back in the '50s and '60s and '70s. And so, when the students are exposed to this type of supervision that's what they tend to carry on and when they become supervisors themselves, their supervisees again are imbued with the psychodynamic approach.

The third element is that there is a cultural time lag. I was looking at an article which reviewed cohorts from various decades. And way back in the '70s and '60s actually, a vast majority of the people who were trained then still subscribed to a psychodynamic viewpoint. But as you go decade by decade, the newer graduates of the schools are much more likely to be attracted to the cognitive behavioral and the rational emotive therapies.

Kendall: Yeah, it's a trend I've observed and seen at conventions and association meetings over time. I think that's quite accurate. Another topic that's of interest to me to hear you talk about, Tim, would be the topic of integration. As you know, there's a society that talks about the

integrating of different schools of therapy. There's a journal focused on that. And independent of those two efforts there are also other journals, like Cognitive Therapy in Research or Behavior Therapy, where even though they have titles which suggest a uni-dimensional focus, they're actual multi-dimensional in focus.

Conventions have taken as their theme integrating or applying and building bridges across things. What do you think are some of the important ideas about the impact cognitive therapy could have—and to a degree behavior therapy or cognitive behavior therapy, if you will—could have on other schools? What would be some of things you might suggest for integration?

Beck: Well integration, of course, is a very hot topic. And what it brings about is a sense of sharing, ecumenisism, fellowship, open-mindedness and so on, all of which are qualities that I applaud very much. One of the things that I'm concerned about is that there's a certain hodge-podge when you try to bring together a lot of very diverse techniques, unless there's some unifying principle behind them. And actually, I had a paper published in the Journal of Psychotherapy Integration which I titled "Cognitive Therapy: The Integrative Therapy."

Now, in order to have a true integration, you have to have some kind of conceptual framework that the various techniques can be fitted into. One of the problems is if there is no integration of that type, if there's no theoretical integration, then we really don't know what the patient is receiving. And there's a tendency for therapists to jump from one technique to another. So that's one problem is the lack of unity, the lack of uniformity.

Another problem is that the integration of these various therapies has not been tested. For example, in panic attacks we already get close to a 90, to 100 percent improvement rate and the question then is how is adding new therapies going to improve on that? But quite aside from improving on what we've already shown, the question is with this big movement I have not seen a single paper based on an integration of a variety of techniques which has shown any empirical power.

And what I'm really very much concerned about is that there actually

is a trend away from outcome studies. There's a lot of talk nowadays about outcome studies not really captioning the clinical reality. And what we have to do is go much more on the hunches and the sense and the feelings of the therapist and not pay so much attention to what's been discovered in empirical work. And I think this is probably an unfortunate trend.

Kendall: Yeah, it's interesting the way you described it because when eclecticism is mentioned on the international circuit, of course you have to translate it into another language. And in several cases, eclecticism translates into something like a hodge-podge, a messy conglomerate rather than an integrated approach and I think people find it distasteful to think of therapy as just a pick-and-choose without any guiding integrative theory.

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INTELLECTUAL INFLUENCES

Let's move on to another topic, a topic that when I wrote the question I found myself thinking back on my own answers, you know, "Gee who influenced me? How did I get into this field and what teachers sparked certain perceptions and thoughts?" So I'd like to ask you that, Tim, if you could. Tell me a little bit about some of the teachers in your career, some of the people whose work you've read, some of the experiences you've had in the classroom or in the clinic that have had an impact on how you've gotten to this point.

Beck: Well, you know, I really wish I could say there was some mentor or a teacher or professor who had a real impact on me. Unfortunately, I think whatever impacts they had I quickly diluted when I moved away from psychoanalysis. So, that most of the effect that any of my teachers had was during my psychoanalytic training. And there were people, such as Leon Saw, who had some effect, Barnes Alexander, a few other psychoanalytic teachers had an effect.

But, to a large extent, when I started working this stuff out on the laboratory, I found I had to pretty much reject what they had to say. So the question still is where did the influence come from? Well, one of the early people who influenced me was Karen Horney. And I found that her book, which was kind of an upgrading of psychoanalysis, was

very appealing.

[Cough]

Horney's writings then led to Adler; and I think that Adler was probably the first cognitive therapist, although that's not the term that he uses. But much of what Adler wrote later on when I was more involved in cognitive therapy, I found very simpatico with my way of thinking.

However, one of the persons who really helped me along through his writings was George Kelly. At the time I was making my shift over from the motivational model and the whole idea of unconscious and id, ego, super ego. I was looking for some kind of vocabulary, some way of conceptualizing my new way of thinking and it was at that time that I came across George Kelly's massive tomes—two volume tomes—on personal construct theory and therapy. And at that particular time I was able to get some sort of vocabulary from him.

And I thought first, in terms of describing these various conceptual categories using his term of personal constructs. Ultimately, I went back to Piagetian ideas of schemas and from there on I was able to draw as much as I could on cognitive social psychology, cognitive psychology and so on. So that most of the influence then has come through reading rather than through any direct preceptorship or mentorship.

Kendall: That's interesting. An anecdote, if you don't mind my sharing here—

Beck: Sure.

Kendall: You were influenced so greatly by Kelly. And earlier, when you're talking about the publications of your books you mentioned that there was an initial success and then a second one had a bumpy road. I had the opportunity to talk with Kenneth MacCorquodale years back—

Beck: Yeah.

Kendall:—and he pointed out that Kelly's book had circulated many publishers and had been rejected many times. And he was the one

who came out pushing and pushing for it and eventually, of course, it did get published and a number of people have found it very, very influential. It's an interesting parallel.

Beck: That is interesting.

Kendall: You know, that his book did the same. What about, in addition to teachers, as you've nicely told us, what about some societies or associations or events? Anything like that that's had an influence on you?

Beck: Well, it was really very important and there's a bit of an anecdote in this—originally, when I was evolving my cognitive therapy, I really did not have anybody, no professional to share this with. In fact, one of my best audiences was my daughter, Judy, who is now Director of the Institute for Cognitive Therapy in Philadelphia. And when she was teenager I used to tell her about my theories and she said, "Well that really makes a lot of good sense."

CT MEETS BEHAVIORAL THERAPY

Somewhere back in the '60s, in the mid '60s, I became aware of the behavior therapy movement and there I thought, "This is really very valuable," because the behavior therapist not only have a very interesting theory, but they have certain criteria for setting up therapies which I found very congenial to me. For example, in behavior therapy, one sets goals not only for the entire therapy but for each session.

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One provides structure for the session, one operationalizes the various strategies and techniques and one assesses the patient both before, during and after the sessions. And I found this a very scientific approach and a very rigorous and highly structured approach. And indeed, I adopted this approach to cognitive therapy [in] which I would use behavioral strategies, but, also in line with my whole idea of the cognitive map, I would use a variety of interventions which were designed ultimately not to just change behavior, but to change the person's beliefs and the way they interpreted and processed their experiences.

And so, I found this was a very useful approach. And it occurred to me that maybe the behavior therapist might be interested in what I had to say. And I remember I was at a meeting in Miami at one time and I wandered around at this behavior therapy meeting, one of the early A.A.B.T. meetings. I was wandering lonely as a cloud and I didn't know anybody there.

Kendall: [Laughs]—That's changed hasn't it?

Beck: And I could go all around without anybody even being aware of my existence. And then I met a chap who had been doing some obesity research, Hagen, and he introduced to me a group from Penn State—and Ed Craighead particularly. And Ed then invited me to go out to dinner and they thought that some of my ideas were of some interest to them.

And then, the following year Ed invited me to come to the A.A.B.T. and do a panel. And from there on I found here was a group that was very congenial, were very open-minded and were willing to listen to my ideas, as well as to share their ideas with me.

Kendall: Yeah.

Beck: And it was there that I made contact with Craighead and Meichenbaum and Mahoney and David Barlow and then later yourself and so on.

Kendall: It's a nice family. It's a good group. I like the description you used "open-minded." I think that's been a real strength of the association is being able to bring ideas and put them to the test. That's a nice feature. One time at a conference also, this I think was in Toronto. I think it was the World Congress of Cognitive Therapy in Toronto and you were presenting, I believe, the first slide was something, like, "Cognition doesn't cause depression."

Beck: Yeah.

Kendall: And I looked at it and I went, "Wait a minute. How's he going to work that in?" And I had read and knew, I thought, where you were going to go with it, but I wasn't sure. And I thought to myself as you spoke that they're probably a lot of people who would be surprised at that. I thought of that as an interesting and perhaps even

provocative way to introduce the topic of your new thoughts about psychopathology.

THE EVOLUTIONARY ORIGINS OF DEPRESSION

Kendall: What would be some things you'd want to tell people about your new thoughts on psychopathology?

Beck: Well, first of all, just to pick up the old thoughts. I never really thought that cognition caused depression or that it caused anything else. As thinking human beings, as total human beings we think and we feel and we act. And one very important part of what we do, which influences our feelings and so on, is the way we process information. And my point was once a person is depressed they tend to process information in a negative way. What causes the depression, of course, is something totally different. It can be caused by biochemical factors. It can be caused ultimately by defeats or desertions, losses and so on and so forth.

So, my major contention was that depression had a thinking disorder in it. Now what I've puzzled about in recent years is how has depression evolved through the eons? Why is it that people today are still stuck with depression, which seems to serve minimal purpose, minimal function, unlike anxiety and hostility? For example, you know that anxiety and hostility are emergency reactions. At least in the wild it serves people well to be able to react immediately to a situation that is a threat.

But where is depression of any use or how could it have been of any use back in the evolutionary eras? And as I thought about it, I felt there's one characteristic of depression, par excellence, and that is depression seems to have to do with energy conservation. Everything about the depressed person seems to be directed towards conserving energy—there's the slowing down; there's the loss of appetite, which then enables a person to not go out foraging for food and so on. And so, it seemed to me that depression might be a form of regulation, that the individual somehow finds that his resources have dried up and it's best to wait until such time as the resources become available again. And until that time occurs it's probably best to conserve one's energy.

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The other side of it is the mania partner. Where would mania arise? Well, when there were plenty of resources, then it's to one's advantage to be able to go out and to expend energy and to pile up the resources. Well the question is where does cognition come into it? Well, cognition is the regulator. If you see everything negatively and you think that everything you do is going to have a bad outcome, then you're not going to be motivated to try or to do anything. In fact, the whole body will slow down.

When you see that things are plentiful and the opportunities are there, then it's much better to be optimistic and to go out and grab things. Now why today are we stuck though with such a profound type of reaction, such as depression or mania? One possible explanation is something that I call the evolutionary friction rub. And that is that certain mechanisms—such as even the fight/flight reaction, the anger/anxiety reaction—could have been quite adaptive in a different evolutionary niche. But, today in our highly advanced technological society the fight/flight reaction, for the most part, does not serve us any, at all.

Similarly, we've shifted from the wild to a much more mild and moderate type of situation and we no longer need depression to force us to shut down. Nonetheless, the mechanisms have not kept up with the cultural evolution. So we have biological evolution which has lagged far behind the cultural evolution. And the net result of this time lag is depression and some of the other psychological disorders.

Kendall: That's a very interesting approach. I found myself forgetting to think of the next question because I'm—

Beck: [Laughs]

Kendall:—so interested in your answer. I like the fact, in particular, that you look to its place, it's functional role, and how it might have some adaptive meaning in a less severe way and that perhaps those with severe depression have gone beyond the adaptive role that it could serve. It's really interesting.

I know that you've written about other disorders as well and I

was wondering if you had some thoughts about other forms of psychopathology and some ideas about where cognition plays a role or doesn't play a role or where cognitive or cognitive behavioral therapy plays a role or doesn't play a role in some of the other disorders? Do you have any ideas about that?

Beck: Well I mentioned there have been about 30 orders that have been researched, not by myself primarily, but by various people who have worked with me or who have picked it up on their own. And each of these individuals has produced a cognitive profile or cognitive map for each of these disorders. So, that using this cognitive map they're able to then use a variety of techniques. They could be experiential. They could be insightful. They could be strictly cognitive or behavioral to attack the disorder.

For example, at Oxford there have been about 10 or 12 different disorders that have been tackled: social anxiety, chronic fatigue syndrome, hypochondriasis, panic and so on. Each of these disorders has its own cognitive constellation. And once the cognitive constellation is pinned down, then one can get the various important techniques that are going to be useful in that. And the approach can be quite different judging from one to another.

For example, in panic disorder our basic assumption is that people who have a panic disorder are misinterpreting various internal sensations. Now, when the patient comes into the office, the panicky patient is fairly calm. For one thing, panicky people feel much more reassured when they're in the presence of an authority—of a medical or psychological authority. So they will never feel panicky in your office.

So what we have to do is we have to produce a panic attack or a semi panic attack, get the patient then to become aware of the sensations and at that point, when they're aware of the sensations they can then re-label them as not a threatening disaster, not a catastrophic thing, but as something that's quite explainable in normal biological terms. But since they're in a very high affective state, the sluices for learning have been opened up and they can then take the information in and within a very short period of time they have reconstructed their entire

interpretation of internal sensations.

Now, in contrast, somebody who is depressed doesn't have to have the depression reproduced in the office because they already are depressed. And so what one does there is to see the kind of thinking. But in the thinking of the depression is not focused on internal sensations as it is with the panic, but has to do with their own beliefs about themselves, about their future and about their past.

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And so, one can deal directly with the way they're interpreting their external events at that time.

Kendall: That's a provocative answer and I think it's one that I hope other schools of thought hear about. Because you're essentially saying that the treatment pays attention to the nature of the disorder. And the more we know about the nature of the disorder, the more we'll be able to improve our treatments. And that certainly would suggest that one treatment isn't appropriate for everything and I think that's an important lesson. I'm glad that you chose to focus on that.

When we talk about therapists, cognitive therapists, they're everywhere. They're often from a variety of backgrounds. I'm a clinical psychologist, you're a psychiatrist. There are other schools where people are trained. Do you think there's one road or many roads? What are your thoughts about the proper training that a cognitive therapist should have? What are some of the background experiences, you think, and training experiences that would be most useful and effective?

Beck: Well, I consider psychology the basic science of psychotherapy and I think that the background should be a well-rounded education in psychology, which will include not simply clinical psychology, but it should include abnormal psychology, cognitive psychology, social psychology, child psychology and so on.

And thus, when the patient—the therapist rather—comes to do therapy he's able to bring to bear his learning about the total personality. And I also would throw in evolutionary biology. Because the more perspective one has one how these various, let's say,

dysfunctional mechanisms arose, the more the person's going to be able to pinpoint exactly what the problem is.

Kendall: That's interesting. I had a course by a friend of mine, Dr. Mikulka. It was...Eibelsfelt. It was a book and it was—

Beck: Oh, sure.

Kendall:—evolutionary biology. Very influential because you learn about fixed action patterns and about certain ways that animals, in this case, respond to certain stimuli. And when you see a pattern in humans that's similar, it's interesting.

Beck: Yeah.

Kendall: It's a phenomenon that I think is something that certain times psychologists don't get, you know—

Beck: And I found it really very helpful to look at these things and in a way it de-stigmatizes a person's overreactions to situations. And I can tell a patient, "You know, the way you reacted had great survival value for you in a different situation. Now the situation has changed and we have to adapt these really very laudable lifesaving devices to a different environment.

Kendall: Yeah, it's perhaps a trend, perhaps not. But, there's some training institutions that are drifting a little bit away from the basic psychology courses, more towards therapy training, in general, or supervision as the key ingredient. And I'd like to underscore your point and that's that the basic courses, the basic core content is really the primary basis for good training. Nice comment.

We talked a little bit about this, Tim, already. But, it's a question that I'd like to have you address, perhaps again, maybe in a different light—that's the relationship between cognitive therapy and behavior therapy. Some people talk about cognitive-behavioral therapy, which I think is a reflection of an integration.

But, in fact, you're a cognitive therapy, as you prefer to call it, is also an integration. Do you have any thoughts or ideas you'd like to share about that working relationship?

Beck: Well, I think, first of all, it's valuable to retain the term cognitive

behavioral therapies because there are a variety of—

Kendall: Very true, good.

Beck:—people who will emphasize, say, behavioral methods more than they will cognitive and some cognitive more than behavioral. What I think would be useful for the application of the term cognitive therapy is the cognitive framework that I proposed before—the whole cognitive theory, the idea of having specific cognitive profiles for each of the disorders. And in that way we can get some distinction between the cognitive behavioral therapies—which involve a whole variety of approaches—and what I call cognitive therapy, which is fairly uniform and, therefore, since it's uniform, it's fairly testable. So we can say this is cognitive therapy. It has its own set of principles behind it and it has its own very specific methodologies that are going to be used for a given patient.

Kendall: I sit corrected. I like your notion about it's not cognitive behavioral therapy, but cognitive behavioral therapies or cognitive therapies. Because there are they fine tunings that are done for the nature of the disorder, as you pointed out earlier.

You've had a very distinguished career. There are few people who make it to the top ten list and you certainly have been on the top ten list of influential people in psychotherapy. When you look back on it, when you think about things, the bumpy road to success and the many forks and choices and things, are there any accomplishments that stand out?

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Any events that stand out? Anything that make[s] you feel particularly good? Any accomplishments that you like?

Beck: Well, you know, there's kind of a primacy effect in this and the memories that stick out the most in my mind have to do with the years between say 1960 and 1961. In those particular years I started to re-examine all of psychoanalysis. This was when I finally made my break. And once I came to the conclusion that dreams could be seen as representations of people's particular beliefs, which related to their beliefs in their waking life—once I adopted the cognitive model, in

other words—I started to look at all the other theoretical notions of psychoanalysis and I found that everything fell to the ground or practically everything. There were still a few elements that still made sense. So, the first thing was that I was able to disencumber myself of a lot of beliefs that I had previously held to. This then gave me kind of a tabula rasa to start from scratch.

And so I said let's assume as people before me had assumed, that the big problem with psychopathology is the way we interpret reality. Now, starting with I started to,I began to look at each of the various disorders—depression, anxiety and so on—and I found that I could establish for each of these a cognitive model.

The next exciting thing was knowing what the cognitive model was, I found that using cognitive techniques I could reverse the psychopathology. This all happened between 1960 and 1961. I got my first paper published in 1963 on thinking and depression.

Kendall: I think you've almost answered my next question, but I'll try it just in case. You've published a number of papers. You've published a number of books. And I find myself sometimes looking back and there's one I prefer over another thinking maybe it really was a good piece. Maybe it wasn't even the one most read. When you look back over the papers that you've published and the books and not assuming that one is more important according to others, but to yourself which one—any one or two that stand out that you look back and you go, "Gee, that was a real piece of work. I glad I did that?"

Beck: Well, I guess the book that still appeals to me the most was Cognitive Therapy and the Emotional Disorders. That was the first strong, formal statement that I made regarding my theory and my approach and it covered all of the emotional disorders. That laid the ground work for all of my later books, which have to do with specific disorders: personality disorders, drug abuse, anxiety, phobias, panic and so on. But this was like the first born and this laid the framework for everything that came after.

Kendall: Yeah, nice work, too. I think many people would agree with you on that particular one.

THE FUTURE OF PSYCHOTHERAPY

Kendall: We've looked back. We've look back at your career, at influences, at successes and at trends. Let's look forward a little bit. Let's look in the crystal ball, if there is such a thing. Or let's put it differently. Let's have your very well-educated speculations. What do you think are some important things about the future for psychotherapy, in general?

Beck: Well I think there are very radical changes that I expect will take place, in fact, already are taking place in psychotherapy and the delivery of psychotherapeutic services. For one thing, I think that in the future cognitive therapy will no longer be called cognitive therapy. I think what we will have is psychotherapy, which will consist of really tried and true and tested approaches to psychopathology. And I think the cutting edge—

Kendall: So the empirical validation is crucial

Beck: The empirical, I think, is going to win out in the long run, but we may be talking now 10 or 15 years down the road. Now, as far as whatever therapy is delivered, I think that's what it will be ultimately. That there will be psycho—a psychotherapy, which has been shown to be effective and adapted, of course, to the various disorders.

Now, I think there are going to be radical changes in the delivery of treatment. One of the radical changes that I expect is that probably more and more treatment will done in the primary care physician's offices. I think the family doctors are going to have psychologists, psychotherapists right in their offices and the patients are going to get screened at the time that they make their visits to their family doctor. And the therapy will be provided right on the spot, instead of being farmed out, for the most part, to mental health clinics or to private practitioners they are today.

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So, I think that's one major change. I think another major change, which is an economic one, is I believe there's going to be some kind of a triage that will be set up. That is that patients are going to be classified as either easy to treat, moderately difficult to treat or very difficult to treat, so that the severity of the disorder is going

to be taken into account in the way patients are routed towards psychotherapy.

Very likely the very easy treatment cases, relatively easy treatment cases will be treated not by PhD's or M.D. psychiatrists or psychologists, but might even be treated by Bachelor's level or certainly Master's level psychotherapists. The more difficult patients will be treated by somewhat more expert therapists and the very difficult patients will be treated by the real heavy hitters, the very skilled therapists, the very experienced therapist.

And I think that way there will be a certain containment on medical costs. Another thing that I think, which is in progress right now, is that there will be more or less a set number of visits for each of the conditions. This will be a flexible limit. But we found in our own institute that the average number of case… the average of visits is actually very low when it's not part of an outcome study. The mean number of visits is between three and four.

And it's only when the patients are told that they have to come for a whole course of therapy, such as ten visits or 50 visits or 100 visits that they tend to stay in for a long time. Now we do know that three or four visits is not enough to make a happy warrior out of the patients. But it helps them to get over their problems. Nonetheless, after a few weeks the problems may recur. So we want to pipe in return visits or booster shots.

So patients will get their initial set of visits, which will be time limited, with an escape clause for the cases that don't respond so rapidly. Then, you're going to get your booster shots, which can continue on over the next year or two.

Kendall: That's an interesting idea. One of the themes that I've noticed in our conversation today is that there are treatments that are developed, they focus on the nature of the disorder. These treatments undergo some rigorous evaluations and when found to be effective that it's your recommendation and that of others that they be transported then to other facilities, more service-providing kinds of facilities.

I'm Interested in your speculations about what I'll call this transportability. How do you get a therapy that you've developed with a set of colleagues and how does it transport to another setting? What are some of the issues or some of the things that we need to pay attention to to facilitate that transportation?

Beck: Well transportation, of course, is very important. Now, in each of the studies, the empirical studies, we've always had to prepare treatment manuals. The treatment manuals then become kind of the standard by which we can judge what the therapy is, what the specific—

Kendall: The operationalization.

Beck:—the operationalization is there.

Kendall: Yeah, it's a nice feature.

Beck: Now, not only that, but it forms a basis for evaluating the therapies and the therapists. So, for example, Brian Shaw found out in a large NIMH study that there was actually a surprisingly high correlation between competence as measured by one of these competency scales based on the manual and actual outcome. That the more competent therapist did become more did show greater results.

So, so far we say that the manuals allow the therapy to be transportable to different settings. But, remember, therapy is done by therapists, just like surgery is done by surgeons. And we have to be able to see how well the service is actually provided. And we can do that by using evaluation tools.

Then there's transportation, not only to different settings within our Anglo-Saxon culture—North America and Britain—but there's also the translation into other cultures. And I've been very surprised to speak to therapists, some of whom trained with me, from India and China and Sub-Saharan Africa and the Mid-East, to have them say the following, "You know, your therapy works very well in our culture. It fits very well with our cultural beliefs."

And it's been quite a surprise to me that cognitive therapy seems to have kind of a universal appeal across all of these cultures. But in each case it has to be adapted then to the particular idioms of the culture

we're talking about

00:49:57

Kendall: Yeah, that's again another interesting theme that you raise and that's—we've looked outcomes in terms of what treatment's provided and how long a treatment lasts and a number of variables—individual verses group, whatever. But the notion that the quality of the treatment judged against a standard, how well was this particular treatment actually provided and does that relate to outcome? It's an interesting theme I think should be pursued in other treatments as well. We have a lot we could talk about, Tim. We've really come to the point where we have to close. And it's unfortunate, but perhaps we can do this another time. I want to take this opportunity though to thank you very much for taking time out of your very busy schedule to come over and participate in this and thanks very much.

Beck: It's been a pleasure talking to you.

Announcer: We hope that you have found this video useful and interesting. For a complete list of available titles in this series and our clinical grand round series or for other educational materials and publications, please contact the A.B.C.T. office or look at our website.

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DVD Artwork: Julie Giles

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About the Contributors

VIDEO PARTICIPANTS

Aaron Temkin Beck, M.D. is the father of Cognitive Therapy, having created and refined cognitive therapy over the course of his research and clinical career. He has published more than 550 scholarly articles and 18 books and has developed widely-used assessment scales. He has received many prestigious awards including the 2006 Albert Lasker Clinical Medical Research Award for developing cognitive therapy, which fundamentally changed the way that psychopathology is viewed and its treatment is conducted. He has been listed as one of the “10 individuals who shaped the face of American Psychiatry” and one of the five most influential psychotherapists of all time. Dr. Beck is an emeritus professor in the Department of Psychiatry at the University of Pennsylvania and the director of the Aaron T. Beck Psychopathology Research Center, which is the parent organization of the Center for the Prevention of Suicide. He is also the co-founder and president emeritus of the Beck Institute for Cognitive Behavior Therapy. His current research focuses on cognitive therapy for suicide prevention, dissemination of cognitive therapy into community settings, and cognitive therapy for schizophrenia.

Philip C. Kendall, Ph.D, ABPP, Featured Interviewer, is a professor of psychology and director of the Child and Adolescent Anxiety Disorders Clinic at Temple University. He has written over 400 publications, including over thirty books and over twenty treatment manuals and workbooks. He has been awarded fellow at the Center for Advanced Study in the Behavioral Sciences, inaugural Research Recognition Award from the Anxiety Disorders Association of America, “Great Teacher” award from Temple University, identified as a “top therapist” in the tristate area by Philadelphia Magazine, and the Society of Clinical Psychology 2006 Award for Distinguished Contributions to the Science of Clinical Psychology. He has been president of the Society of Clinical Child and Adolescent Psychology (Division 53) of APA as well as President of the Association for the Advancement of Behavior Therapy (AABT, now ABCT). Dr. Kendall has designed and evaluated treatment programs for youth. His

programs has been identified as empirically-supported, have been translated and implemented in over a dozen countries, and are the focus of numerous federally-funded research initiatives in treatment and prevention across the globe.

MANUAL AUTHORS

Ali Miller, MA, MFT, is a writer for Psychotherapy.net as well as a psychotherapist in private practice in San Francisco and Berkeley, CA. She works with individuals, couples, and families and facilitates therapy groups for women. You can learn more about her practice at www.AliMillerMFT.com.

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ADD/ADHD
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Child Abuse
Culture & Diversity
Death & Dying
Depression
Dissociation
Divorce
Domestic Violence
Grief/Loss
Happiness
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