Aaron Beck and Cognitive Behavioral Therapy

Historical Background and Key Figure

Although Aaron Beck’s system has many similarities to that of Albert Ellis, Beck offers a more detailed cognitive theory of neurotic disorders. His work differs from Ellis’ Rational Emotive Behavioral Therapy (REBT) in more fully utilizing cognitive and behavioral methods, in being less doctrinaire in what he regards as rational and irrational (using instead the terms “adaptive” and “maladaptive” beliefs), and more importantly in encouraging a therapeutic style less combative and rigid than Ellis’ in favor of a gentler though direct Socratic questioning style. He has made similar analyses of cognitive distortions responsible for a number of other neurotic and psychotic disorders.

At about the same time that Albert Ellis was publishing his first papers on RE(B)T, Aaron Beck, a psychiatrist on the faculty of the department of psychiatry at the University of Pennsylvania, was taking his first steps along a similar route. Beck practiced psychoanalysis, but in his own life, he had earlier used behavioral and rational techniques on himself to conquer his own phobias.

Until his late thirties, Beck believed in and used psychoanalytic therapy with his patients. He was particularly interested in treating depression. He developed a theory but Beck was troubled that his theory was not well accepted by many psychiatrists and psychologists, and he set out to gather data from his own clinical experience to validate it. Through numerous clinical experiments, Beck realized that “The neurotic is not only emotionally sick - he is cognitively wrong” quoting humanistic psychologist Abraham Maslow. This concept is the basis of his cognitive therapy.
For several years, Beck’s ideas were ignored and he was considered something of a pariah in the profession. But by the 1970s, as cognitivism began to pervade psychology and, to some extent, psychiatry, his ideas were absorbed into the major theories of personality and behavior. A growing number of clinicians began relying on his methods, especially when dealing with depressed patients, and over the years some of these clinicians have modified or added to Beck’s formulations and developed their own versions. Beck is generally acknowledged within psychology and psychiatry as the creator of cognitive therapy. By the 1980s, cognitive psychotherapy had become part of the mainstream. In his version of cognitive therapy and in other variations, it is now one of the leading treatments used in the United States. In addition to the one third of all psychotherapists who are primarily cognitive-behavioral, about another third are eclectic, most of them using cognitive-behavior therapy at times. It is widely considered the treatment of choice for certain problems, particularly depression and low self-esteem (Corsini & Wedding, 2000).

Cognitive therapy typically proceeds in three stages: 1) the presentation of the therapeutic rationale; 2) the development of awareness of dysfunctional thoughts on the part of the client; and 3) the actual alteration of the dysfunctional thoughts and the substitution of more functional thinking. In a direct fashion, reflective of the Socratic philosophical tradition, Beck uses persistent but gentle logic and persuasion to alter the person’s thinking. He employs a variety of cognitive and behavioral techniques, as well as assigning homework between therapy sessions to speed up recovery.

The central insight of cognitive therapy, as originally formulated, is that thoughts mediate between stimuli, such as external events, and emotions. A stimulus elicits a
thought - which might be an evaluative judgment of some kind - which in turn gives rise to an emotion. In other words, it is not the stimulus itself which somehow elicits an emotional response directly, but our evaluation of or thought about that stimulus.

Two ancillary assumptions underpin the approach of the cognitive therapist: 1) the client is capable of becoming aware of his or her own thoughts and of changing them, and 2) sometimes the thoughts elicited by stimuli distort or otherwise fail to reflect reality accurately.

Cognitive therapy suggests that psychological distress is caused by distorted thoughts about stimuli giving rise to distressed emotions. The theory is particularly well developed (and empirically supported) in the case of depression, where clients frequently experience unduly negative thoughts which arise automatically even in response to stimuli which might otherwise be experienced as positive. Any thoughts could lead to feelings of hopelessness or reduced self-esteem, maintaining or worsening the individual’s depression.

Usually cognitive therapeutic work is informed by an awareness of the role of the client’s behavior as well (therefore the term ‘cognitive behavioral therapy’, or CBT). The task of cognitive therapy or CBT is partly to understand how the three components of emotions, behaviors and thoughts interrelate, and how they may be influenced by external stimuli - including events, which may have occurred early in the client’s life.

Cognitive therapy aims to help the client to become aware of thought distortions, which are causing psychological distress, and of behavioral patterns, which are reinforcing it, and to correct them. The objective is not to correct every distortion in a client’s entire outlook (and after all, virtually everyone distorts reality in many ways) just
those which may be at the root of distress. The therapist will make every effort to understand experiences from the client’s point of view, and the client and therapist will work collaboratively with an empirical spirit, like scientists, exploring the client’s thoughts, assumptions and inferences. The therapist helps the client learn to test these by checking them against reality and against other assumptions.

Because of the interrelationship between thoughts, feelings and behaviors, therapeutic interventions frequently involve the client’s behavior. For instance, a client with a strong fear may go to great lengths to avoid the situation that causes anxiety. This behavior will prevent the client from acquiring information that contradicts their thought or perhaps their mental image. The therapist may help the client to overcome this avoidance as part of the process of correcting the distorted thought.

Evaluation

On first hearing of the basic cognitive therapeutic approach, many people will observe that simply being told that a view does not accurately reflect reality does not actually make them feel any better. They might say, “I know that my fear is groundless, but I can’t help worrying about it anyway”. But to suggest that a cognitive therapist merely tells the client something is wrong is to caricature the approach (and, in fact, few cognitive therapists would actually tell a client some view doesn’t reflect reality anyway but would rather help the client to explore whether it reflects reality).

A more salient criticism for some clients may be that the therapist initially may appear in an authority role, in the sense that s/he provides problem solving experience or
experts in cognitive psychology. Some people may also feel that the therapist can be ‘leading’ in questioning and directive in terms of their recommendations.

Cognitive behavioral therapy in clinical practice tends to be characterized by shorter-term interventions targeted at specifically defined problems. These problems are attacked as directly as possible, in a manner some belittle as “symptom reduction.” Cognitive-behavioral therapy emphasizes empirical documentation of effectiveness, so it is no coincidence that cognitive behavioral therapy techniques have been mostly developed for the treatment of problems, which are easier to measure directly, such as depression, stress, anxiety or academic underachievement. Problems characterized by more vague complaints tend to be ignored by this approach.

Although the cognitive therapist is straightforward and looks for simple rather than complex solutions, this does not imply that the practice of cognitive therapy is simple. Cognitive therapists do not put weight on exploring the unconscious or underlying conflicts. Instead, they work with the clients in the present to bring about schematic changes. Emotions are played down in cognitive therapy treatment.

Corey (1996), summarizes some of the criticisms of Beck’s cognitive therapy as: 1) it focuses too much on the power of positive thinking, 2) it is too superficial and simplistic, 3) it denies the importance of the client’s past, 4) it is too technique oriented, 5) it fails to use the therapeutic relationship, 6) it works only eliminating symptoms, but failing to explore the underlying causes or difficulties, 7) it ignores the role of unconscious factors, and 8) it neglects the role of feelings.

Clients who are comfortable with introspection, who readily adopt the scientific method for exploring their own psychology, and who place credence in the basic
theoretical approach of cognitive therapy, may find this approach a good match. Clients who are less comfortable with any of these, or whose distress is of a more general interpersonal nature, such that it cannot easily be framed in terms of interplay between thoughts, emotions and behaviors within a given environment, may be less well served by cognitive therapy. Cognitive and cognitive-behavioral therapies have often proved especially helpful to clients suffering from depression, anxiety, panic and obsessive-compulsive disorder.
References
