Psychologist Dr. Garamoni answers FAQs about Cognitive Therapy.

FAQ: FREQUENTLY ASKED QUESTIONS ABOUT COGNITIVE THERAPY

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FAQ: FREQUENTLY ASKED QUESTIONS ABOUT COGNITIVE THERAPY

What is cognitive therapy?

Cognitive Therapy (CT) is a system of psychotherapy designed to help a client identify and challenge negative patterns of thinking in order to alter distressing and/or dysfunctional emotions and behaviors. CT is one of the main therapeutic approaches within the larger group of **Cognitive Behavioral Therapies** (CBT). CT was first expounded in the 1960s by American psychiatrist Aaron T. Beck after he had become disillusioned with long-term **Psychodynamic Therapy**, which is based on gaining insight into unconscious conflicts. He devoted himself to developing an effective, short-term therapy that targeted the largely conscious streams of negative thoughts associated with depression, anxiety, and other problems. During this period, Albert Ellis was working independently on similar ideas and developed the other main type of CBT, **Rational Emotive Behavior Therapy** (REBT).

Dr. Beck's work is distinguished not only by his contributions to the theoretical and technical development of CT, but also (and I think most especially) by his organized efforts to research the effectiveness of CT in treating depression, anxiety, and a host of other behavioral and emotional problems. Largely to his credit, CT is distinguished from all other forms of therapy (including other forms of CBT) by the fact that it has received the most scientific support in the history of psychotherapy.

On a personal note: Dr. Robert M. Schwartz and I had the honor of being invited by Dr. Beck to deliver a lecture on our "States of Mind Model" to his students at the University of Pennsylvania. An illness prevented us from delivering the prepared lecture, but we had the opportunity to meet Dr. Beck at his home and discuss our theory with him over lunch. I was very flattered by his interest in our theory of balanced thinking. I was also quite impressed with the depth and breadth of his knowledge of the whole field of psychotherapy. As a life-long student of philosophy, I admired his grasp of the philosophical underpinnings of the science of psychology.

What is the theory on which cognitive therapy is based?

Cognitive therapy is based on the **cognitive model of emotions**. The central idea behind the cognitive model of emotions can be traced back to Ancient Greek and Roman philosophers: The way we perceive situations influences how we feel in these situations. It is common knowledge that same event will evoke different emotional reactions in different people. Consider the wide range of emotional reactions to a movie in a crowd of people exiting a movie theater. It is also common knowledge that similar events will evoke different emotional reactions in the same person at different times. Consider how your own feelings have changed over time about something--a book, a person, etc.

Cognitive therapy has strong appeal to most clients because the cognitive model of emotions appeals to common sense. With a little coaching, clients can personally test and confirm the theory through introspection. By monitoring their thoughts and feelings in various situations, they can see the connections between them. A client can be led to see that anyone who thinks what the client was thinking in a specific situation would of necessity feel what the client felt in that situation.

Here is a personal example from an experience I had on an African safari. I was in a Range Rover with other people when we slowly approached and quietly parked next to a pride of lions sprawled under a shady tree. One woman said she was thinking that the lions might somehow get in the vehicle and maul her: She felt scared. A man said he always wanted to see lions in the wild, but this was even better than he ever imagined: He was in awe. A teenager said he had seen lions the other day and wanted to see something new and different: He was feeling boredom. Another young fellow expressed the idea that it wasn't right to be disturbing the lions in their natural habitat: He was angry. The woman sitting next to him put her hands over her mouth, widened her eyes, and said she accepted her personal responsibility for disturbing these lions: She felt guilty. How do we explain so many different emotions in response to the same situation? It is not the situation itself that directly affects how anyone feels, but rather, one's thoughts in that situation.

When we are distressed, we often do not think clearly and our thoughts are biased or distorted in some way. We are not wired like Dr. Spock who seems to think clearly and logically all the time. We can and do jump to conclusions. We can and do take things personally when we shouldn't. We can and do make mountains out of molehills. We can and do read someone's mind as if we know what that person is thinking when in fact we really don't.

The bad news is here is that we are all too prone to biases and errors in our thinking. The good news is that we usually can catch ourselves when we make these mistakes and fix them before we get into too much trouble. And the best news of all is that we can be trained to do this and become even better at it.

Cognitive therapists help clients identify their distressing thoughts and evaluate how realistic these thoughts are. Clients learn to identify and correct distortion and biases in their thinking. When clients think in more realistic and balanced ways, they usually feel better. This emotional improvement is rewarding and provides the motivational fuel to power reality-testing in other distressing situations.

An under-appreciated strength of cognitive therapy is the fact that there is now a large and rapidly growing body of theory and research to support the cognitive model of emotions. As a scientist-practioner, I'm heartened to know that these advances have been made by independent researchers who study cognitive appraisal processes in emotion but have little if anything to do with cognitive therapy. That makes the case for the cognitive model and cognitive therapy even stronger in my mind.

How does cognitive therapy differ from other forms of psychotherapy?

"Psychotherapy" is an umbrella term that refers to a large number of treatment methods, each rooted in different theories about the causes of psychological heath and illness. There are more than 250 kinds of psychotherapy, but only a few have found mainstream acceptance. Many kinds of psychotherapy are variations on well-known approaches of earlier theorists. Most therapies can be classified as (1) psychodynamic, (2) humanistic, (3) behavioral, (4) cognitive, or (5) eclectic.

Cognitive therapy differs from other forms of psychotherapy in the following ways:

1. Cognitive therapy is one of the few forms of psychotherapy that has been **scientifically tested** in over four hundred clinical trials and found to be effective for many different disorders. No other form of therapy has been researched as thoroughly as cognitive therapy.

2. Cognitive therapy is usually **focused more on the present than the past**. This emphasis on the present stands in contrast with traditional psychodynamic therapies, which are in some way based on the work of Sigmund Freud, the founder of psychoanalysis. In general, psychodynamic therapists stress the importance exploring one's childhood and past experiences. There is a place in cognitive therapy for identifying and modifying dysfunctional core beliefs, rules, and assumptions that clients often acquire during childhood. However, the emphasis is more on solving present problems and preventing future ones.

3. Cognitive therapy is usually **concerned more with conscious experience than unconscious material or observable behavior.** The cognitive therapist emphasizes the connections among components of conscious experience: thoughts, feelings, and behavior. This contrasts with the psychoanalyst's emphasis on unconscious material (drives, motives) that needs to be illuminated and interpreted to resolve intrapsychic conflicts. The cognitive therapist's emphasis on subjective thoughts and feelings also differs from behavioral therapist's focus on objective, observable behavior.

4. Cognitive therapy is usually **more time-limited than open-ended**, as is the case with some systems of therapy. This is especially true of classical psychoanalysis, which can take several years before an analysis is considered complete. In contemporary psychoanalysis, the duration of therapy is often between one and four years and sessions may take place one or two times a week. Some psychoanalytically oriented therapists treat patients in 30 sessions or less.

5. Cognitive therapy is usually **more problem-solving oriented** than some other therapies. Much of what the client does in cognitive therapy is solve current problems. This emphasis on problem-solving stands in contrast to the use of free association in classical and contemporary psychoanalysis. The cognitive therapist's explicit focus on problem-solving also contrasts with the humanistic therapist's focus on guiding clients toward personal realizations and insights by creating a caring, supportive atmosphere in which clients are encouraged to take responsibility for their lives, accept themselves, and recognize their own potential for growth and change.

6. Cognitive therapy is usually **more structured** than many other therapies. Throughout therapy, most sessions have a predictable and prescribed structure:

- Getting a brief update since the last session, including a rating of mood and medication check, if necessary;
- Bridging from the last to the present session;
- Setting the agenda;
- Reviewing homework;

- Discussion of issue(s) with relevant therapeutic goals in mind;
- Setting new homework;
- Providing a summary; and
- Eliciting feedback.

7. An overarching and explicit goal of cognitive therapy is to use sessions as opportunities to **teach the client to become his or her own cognitive therapist**. Clients are educated in the **cognitive model of emotions**--the basic idea that what we feel is determined by what we think. Clients learn specific skills in cognitive therapy that they can use for the rest of their lives. These skills involve:

- Identifying and correcting distortions and biases in their thinking;
- Modifying core beliefs, rules, and assumptions that give rise to these dysfunctional thinking patterns;
- Relating to others in more effective ways; and
- Identifying and changing dysfunctional behaviors.

8. Cognitive therapy deliberately fosters an **explicit collaborative relationship** between the therapist and the client. The therapist models this relationship from the very first session and continues to foster a collaborative working relationship throughout therapy. One useful analogy that I use is the relationship between a pilot and a navigator. The client is the pilot who is in charge of choosing where he or she wants to go--the goals of treatment. The therapist is the navigator who charts a course that will most likely take the client to these destinations as quickly as possible with the least amount of turbulence--the treatment plan. Both the therapist and the client have responsibility to provide input to the treatment plan, set the agendas for each session, and determine when to terminate therapy.

Does cognitive therapy work?

The simple answer to this question is this: "Cognitive therapy is one of the few forms of psychotherapy that has been scientifically tested and found to be effective in over four hundred clinical trials for many different disorders." (Beck, 2009).

No other form of therapy has been researched and supported as thoroughly as cognitive therapy. The short-term and long-term benefits of cognitive therapy have been strongly supported by an abundance of research.

Now it is quite easy to ask the question, "Does cognitive therapy work?" But it is quite another thing to answer this question with scientific research.

Several years ago, psychologists A. Butler and J. Beck (2000) reviewed the available scientific literature on cognitive therapy to answer a more focused and refined question:

How effective is cognitive therapy, for which disorders, and compared to what?

Butler and Beck reviewed 14 meta-analyses that had investigated the efficacy of cognitive therapy with a total of 9,138 subjects in 325 studies involving 465 specific comparisons regarding 14 disorders or populations. (That is a lot of data!) **Meta-analysis** is a statistical approach that allows researchers to pool the results of multiple studies and describe these results in a standard unit known as an **effect size**. In their review, they examined how cognitive therapy outcomes compared

to the outcomes of various control groups in terms of their effect sizes. Without getting into the statistical details, here are the main conclusions of their study:

1. Compared to no-treatment, wait list, and placebo controls, cognitive therapy is substantially superior for adult and adolescent unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, and childhood depressive and anxiety disorders.

2. Compared to no-treatment, wait list, and placebo controls, cognitive therapy is moderately superior for marital distress, anger, childhood somatic disorders, and chronic pain.

3. Cognitive therapy is somewhat superior to antidepressant medications in the treatment of adult unipolar depression.

4. One year after treatment discontinuation, depressed patients who had been treated with cognitive therapy had half the relapse rate of depressed patients who had been treated with antidepressant medication (30% versus 60%).

5. In the small number of direct study comparisons, cognitive therapy is moderately superior to supportive/nondirective therapies for adolescent depression and generalized anxiety disorder.

6. Cognitive therapy is equally effective as behavior therapy in the treatment of adult depression and obsessive-compulsive disorder.

As a scientist-practitioner in an evidence-based practice, I generally select and use therapies that have the most empirical support and are backed by well-developed theories. The research summarized here is pretty impressive. That is why I specialize in cognitive therapy for depression and cognitive therapy for anxiety.

What is your training and experience in cognitive therapy?

As an undergraduate majoring in philosophy at the University of Wisconsin, I was convinced that ideas make a difference in the lives of individuals and in the course of history. I learned to recognize that the life of each individual human being depends on what that individual knows, values, and does: Our beliefs, values, and actions determine whether we live or die, flourish or flounder, and experience happiness or misery along the way. I also learned to appreciate that the rise and fall of civilizations can be explained by the fundamental beliefs and values that guided the actions of influential figures in the history these civilizations.

As a student of philosophy, I was also exposed to ancient and modern philosophical theories of emotion, especially as emotions have moral implications through their influence on our judgments, choices, and decisions. I came away from these philosophical reflections on human nature with a working model of the relationship between thoughts, emotions, and behavior: What we think in any given situation influences but does not necessarily determine what we feel in that situation, and what we feel in that situation influences but does not necessarily determine what we do in that situation, and what we do in that situation influences but does not necessarily determine what we

get out of that situation. We can change what we feel in a situation by choosing to question and change our thoughts about that situation, and whatever our emotional impulses are to act in that situation, we can override them by choosing to focus on the foreseeable consequences of our actions in that situation.

The fundamental philosophical insight here is that we have the freedom and the consequent responsibility to think about our thinking as it affects our emotions and behavior--to reflect constantly upon whether our thoughts need to be more realistic so that what we feel, what we do, and what we get out of life is aligned as fully as possible with the facts of reality.

During the late 1960's, I was introduced to three very similar cognitive theories of emotion independently developed by three intellectual giants in the psychology of emotion: Magda Arnold, Nathaniel Branden, and Albert Ellis. Their theories, albeit thinly supported by any research at the time, convinced me more than ever that what we feel must be caused (largely) by what we think.

The point of all of this is this: I have been reflecting on the connections between thoughts and emotions for a long time now, and I have years of experience using cognitive models of emotions to help people understand and overcome emotional problems.

With my philosophical background in the rear view mirror, I now want to answer the specific question about my training and experience in cognitive therapy.

I have been practicing various forms of cognitive behavioral therapy since the early days of my training in 1983. I have used these techniques to help people suffering from a wide range of problems, including major depression and other mood disorders; generalized anxiety, panic, phobias, PTSD, and other anxiety disorders; anger control and stress management problems; marital and family relationship problems; and sexual difficulties.

I have been specifically practicing Beck's Cognitive Therapy for over 20 years. I went through a three-year training program in the Cognitive Therapy Clinic at the University of Pittsburgh School of Medicine from 1988-1991. This program was specifically designed to ensure that therapists were highly trained to provide the quality of cognitive therapy necessary to research the effectiveness of cognitive therapy. During that period, I met these standards and managed a three-year study of clinically depressed patients treated with Cognitive Therapy. Based on this study, I co-authored several peer-reviewed articles on cognitive therapy and depression.

What is the initial evaluation? How does this differ from therapy sessions that follow?

I conduct an **initial evaluation interview** to gather comprehensive information about each client, including:

- presenting problems, issues, and symptoms;
- history of these complaints and any other behavioral health problems;
- history of any treatments (self-help or professional; effective and ineffective);
- history of marital and family relationships;
- educational history;
- employment history;
- health history;
- family behavioral health history;
- sources of stress and support;
- personal strengths and limitations; and
- treatment goals.

Clients should expect to spend between two to four hours in the interview process, often across two or more visits. There are clear benefits to this process:

- The intake gives me a great deal of clinical information, so therapy can get off to a faster start with a preliminary diagnosis and treatment plan.
- Individualized decisions can be made for clients more quickly.
- The client has enough time to ask me questions to determine if the course of treatment offered is a good fit and we are "in sync" with one another.
- I can determine whether other forms of care are required and whether referrals elsewhere are indicated.

How long are the sessions in cognitive therapy?

Typically, clients in cognitive therapy meet with me for 45-60 minutes. Clients usually spend 5-10 minutes filling out short questionnaires that help me (a) monitor how they are feeling and (b) get feedback on how well the sessions are progressing. Clients typically spend about an hour on the session and the paperwork.

How often are sessions held?

Most clients attend one session per week. Sessions are usually held on the same day and time each week. Sometimes, however, the session times may vary to accomodate the client's work or travel schedule.

If a client's problems are urgent and warrant more frequent sessions, as is often the case at the beginning of treatment, it is usually possible to meet with me twice per week. On the other hand, if we think it is time to taper off the sessions toward the end of therapy, sessions may be scheduled every other week.

Some clients may want to meet less frequently for financial reasons. I usually advise against a diluted course of treatment because in my experience it is not as effective. A lot can happen in a client's life over a two week period. The time spent in a session getting caught up on this and and getting back "in sync" is that much less time available for therapy. In these situations, I instruct my office manager to make financial arrangements (credit cards, payments plans) so the client can receive an affordable and adequate course of therapy.

What is a session of cognitive therapy like?

I will typically have you fill out forms to assess your mood before each session begins. I have patients in cognitive therapy complete the Beck Depression Inventory, the Beck Anxiety Inventory, and other questionnaires repeatedly over the course of treatment to help give both of us an objective way of assessing your progress. One of the first things I usually do in a therapy session is to look at these questionnaires to determine how you've been feeling this week, compared to other weeks. This is what I call a "mood check." Just like a nurse checks your physical "vital signs"-- your weight, temperature, and blood pressure--I check your psychological "vital signs"--depression, anxiety, and other symptoms.

Early in each session, I will ask you what problem you'd like to put on the agenda for that session, what happened during the previous week that was important, and what might happen during the upcoming week that might also be important. I will also suggest items to be put on the agenda. Then I will make a bridge between the previous session and this week's session by asking you what seemed important that we discussed during the past session, what homework assignments you were able (or unable) to complete during the week, and whether there is anything about your

therapy that you would like us to change.

Most of the session will be spent discussing the problems we put on the agenda. I will help you engage in problem-solving and reality-checking your thoughts in problematic situations. I will help you learn these skills and other techniques for feeling better by getting more control over your thinking and behavior patterns. I will usually point out how to make best use of what you've learned during the session in the coming week.

Toward the end of the session, we will work together to summarize the "take-away" points of the session. I often will ask you questions to get feedback on our work during the session, such as:

- What was helpful?
- What was not helpful?
- Did anything bothersome happen?
- Did I misunderstood you?
- Is there anything you'd like to see changed?

You will come to see that we need to be very active in cognitive therapy sessions.

How long does a course of cognitive therapy take?

The client and I make a joint decision about the planned length of therapy based on the client's goals, values, needs, and other personal considerations. Some clients remain in therapy for a brief time period, completing a course of six to eight sessions. Other clients with long-standing problems and numerous treatment goals choose to remain in therapy for many months. The length of therapy varies widely from client to client. The typical treatment plan for cognitive therapy usually calls for 12-24 sessions spread over three to six months.

After a few sessions with a client, I usually have a good idea of how long it will take to achieve the client's goals. During therapy, goals may be added to or deleted from the treatment plan, requiring adjustments to the estimate length of treatment.

Regardless of the length of treatment, the **final session** should be planned so that we can review the progress you have made in therapy, discuss any remaining work that needs to be done, arrange for a follow-up visit, and, most importantly, say "good-bye." Some clients really need to go through and benefit from a positive experience in terminating a therapeutic relationship because they have never learned to end any relationship without unhealthy consequences. A well-managed termination of therapy brings a much-needed sense of closure to a personal relationship and yields a better long-term outcome for clients than an abrupt or unannounced termination.

I recommend to many clients that they have "booster sessions" three, six, and twelve months after therapy is ended. Let's say, for example, that a client completes a 16 week course of therapy sessions, and we decide that sufficient progress has been made to bring therapy to a close. At that point, the client can schedule one or more follow-up sessions. These booster sessions serve as a “tune-up” to help clients stay on track, address any residual problems, refresh the skills they learned in therapy, and maintain their long-term gains from therapy.

What are self-help assignments in cognitive therapy?

The progress you make during therapy is best measured by the progress you make outside of my office. I will help you select and carry-out "homework" assignments that help you make progress in the "real world." These assignments will show you how to apply ideas and skills between sessions. This process is designed to equip you to become your own therapist after your work with me is

complete.

I assign many different types of homework. Some self-help assignments include learning how to observe your own thoughts, feelings, and actions in various situations so you can become more aware of the connections among these aspects of your experience. Other assignments ask you to change your ways of thinking about certain matters so that you feel more positive. Some projects involve reading to gain insight into your difficulties and learn how to improve your life.

I often ask clients to conduct what are called “behavioral experiments.’ Here the client is prompted to consider new approaches to an old problem. The client then evaluates options and select one to put into action. The client predicts the outcome and then documents the results. As a result of behavioral experiments, clients often learn that doing new, challenging, or uncomfortable things brings dramatic and positive changes in their lives.

Homework is highly recommended because it will help your progress in therapy if you really give it a try. Research on cognitive therapy homework shows that clients who wholeheartedly complete these assignments make faster, more long-lasting progress than those clients who, for whatever reason, elect not to involve themselves with the homework.

I do my best to create an environment in which my clients feel free to explore and learn without worrying about being criticized by me. I will not be finding fault with you if you are unwilling or unable to do any of these assignments.

How will we know whether cognitive therapy is working?

In my experience, most clients experience noticeable relief from their symptoms within four weeks of cognitive therapy--if and when they have been regularly attending sessions and completing the prescribed homework assignments on a daily basis between sessions.

Clients also see their improvement objectively reflected in the scores on the symptom inventories they complete on a regular basis: These scores typically begin to drop within several weeks.

Does cognitive therapy involve medications?

Research shows that cognitive therapy in most cases can be very effective without taking medications. Most of my depressed and anxious clients are treated without any medication at all. My results with cognitive therapy seem comparable to what is published in the scientific literature. The majority of clients achieve full remission (60-70% "responders"); a minority feel significantly better but still experience some bothersome residual symptoms (15-20% "partial responders"); and a smaller minority feel little improvement (10-15% "non-responders').

Some research suggests that a combination of cognitive therapy and an appropriate medication can be effective. In my experience, some people with mood and anxiety disorders do respond better to a combination of medication and cognitive therapy. If you are taking medication, or would like to be on medication, I would be happy to discuss whether you should have a consultation with your physician or a specialist (a psychiatrist) to make sure you are taking the right medication at the right dosage.

If you are not taking medication and do not want medication, I may nevertheless advise you that we should assess, after five to six weeks, how much you've progressed in cognitive therapy. At that time, we can discuss whether you might do well to have a psychiatric consultation to obtain more information about the advantages and disadvantages of medication. I can help you consider the

plusses and minuses of adding medication to the treatment plan. If you wish to start medications along with cognitive therapy, I can help arrange a medical evaluation by your physician or a psychiatrist. I can also help by communicating with them about your response to medication and any side-effects.

Do you offer cognitive therapy for children and adolescents?

Yes, I provide individual cognitive therapy for older adolescents on a case-by-case basis. I often uses cognitive therapy techniques in family therapy with children and youth while one or both parents are present. The idea here is to "teach the teacher"-- meaning that I coach parents on how to coach their children to discover and correct dysfunctional thinking patterns and conduct behavioral experiments.

Do you offer cognitive therapy for couples or families?

I use cognitive therapy to conceptualize and treat a wide spectrum of problems presented by couples and families. However, my approach to treating these issues is usually **eclectic** -- meaning that I draw on multiple perspectives in conducting couples counseling or family therapy. Another way of saying this is that I view problems through a **biopsychosocial** framework because I need to be on the look-out for any biological, psychological, and social/cultural factors that contribute to a problem--and the solution to a problem.

Do you offer cognitive therapy for groups?

I have conducted group cognitive therapy for people suffering from mood disorders. This service is not being offered at this time.

Will you provide cognitive therapy while I am receiving treatment elsewhere?

As a rule, I advise against being in more than one ongoing course of individual therapy: Therapists often have different orientations to therapy and therefore there is a foreseeable risk that a client will receive conflicting advice, which can be confusing and cause more harm than good. Clients need consistent feedback and direction to get the most out of treatment. Depending on two or more therapists at the same time can undermine the ultimate goal of having the client depend on himself or herself. Cognitive therapy works well, in part, because cognitive therapists teach their clients the skills they need to have confidence in themselves. Depending on multiple therapists does not foster this sense of self-sufficiency.

In some cases, clients do need additional health care professionals to perform a role other than that of an individual therapist. If you need medications, you would see a physician who prescribes and monitors whatever psychiatric medications you need to take. In this situation, you would want to give me and your prescribing physician permission to talk to each other, so they can discuss your treatment needs and coordinate plans for your care.

Clients may also benefit from a different modality of therapy while receiving cognitive therapy. For example, while seeing me for cognitive therapy, a client may benefit from group therapy, family therapy, marriage counseling/couples therapy, or even some support group (e.g., Al-Anon).

What if I want to get therapeutic help for someone else?

People sometimes call me to seek treatment for a friend or relative. If you are calling to schedule an appointment for someone over the age of 18, I will not be able to make an appointment for anyone

other than yourself. I will, of course, be willing to listen to your concerns, but the person you are concerned about must be the one to call and schedule an appointment. Once the appointment is scheduled, I cannot share any further information with you unless the client gives written permission. Information about therapy is private, and the confidentiality of this information is protected by law.

I appreciate that you may be frustrated because someone you love or care about refuses to call for an appointment or seek treatment. Your options are limited. First, you can arrange a "consultative appointment" with me to seek advice on how you might deal more effectively with this person. Alternatively, you can begin therapy yourself if your life has been adversely affected by this person, and you are exploring ways to change your situation. Finally, you can try to get the individual's cooperation to enter treatment by offering to go to therapy together.

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