training policemen). The notion of providing individuals with a prospective defense against stress is in some respect analogous to immunization against attitude change (McGuire, 1964; Tannenbaum, 1967) and, of course, medical inoculation against biological disease. The general underlying principle in these two analogous situations is that a person's resistance is enhanced by exposure to a stimulus that is strong enough to arouse the defenses without being so powerful as to overcome them. An examination of the way in which this principle is applied by both social psychologists and physicians may suggest methods for refining and improving stress-inoculation. For instance, it may prove helpful to expose a client to a variety of graded stressors (e.g., cold pressor test, stress-inducing films, fear-inducing imagery, deprivation conditions, fatigue). Presumably, the more varied and extensive the application training, the greater the likelihood the client will develop a general learning set, a general way of talking to himself in order to cope. Cognitive coping modeling films can also be used to facilitate learning.

Several investigators have pointed to the potential of preventive intervention approaches, especially with high-risk populations (Henderson, Montgomery, & Williams, 1972; Poser, 1970; Seligman, 1973). The possibility of explicitly teaching even nonclinical populations to cognitively cope by such diverse techniques as information-seeking, anticipatory problem-solving, imagery rehearsal, task organization, altering attributions and self-labels, shifting attention, and using abstraction and relaxation seems to hold much promise. An explicit training program that would teach coping skills and then provide application training in handling a variety of stressors is in marked contrast to the haphazard and chance manner in which people now learn to cope with stress. The research on stress seems to indicate the necessary skills required to cope, and the method of cognitive-behavior modification seems to provide a promising means for teaching such skills.

IN MIECHENBAUM (1977)

6

Cognitive Restructuring Techniques

Man is disturbed not by things but the views he takes of them.

—EPICTETUS[26]

The only feature common to all mental disorders is the loss of common sense (sensus communis) and the compensatory development of a unique private sense (sensus privatus) of reasoning.

—IMMANUEL KANT

If we wish to change the sentiments it is necessary before all to modify the idea which has produced [them], and to recognize either that it is not correct in itself, or that it does not touch our interests.

—PAUL DUBOIS

It is very obvious that we are influenced not by "facts" but by our interpretation of facts.

—ALFRED ADLER

Cognitive restructuring therapy and semantic therapy are generic terms that refer to a variety of therapeutic approaches whose major mode of action is modifying the pa-

[26] Since Epictetus' statement appears in several books by cognitive therapists, as a sort of rallying cry, it may be of interest to note the context in which Epictetus made his infamous remarks. "Men are disturbed not by things which happen,

tient's thinking and the premises, assumptions, and attitudes underlying his cognitions. The focus of therapy is on the ideational content involved in the symptom, namely, the irrational inferences and premises. Thus, the semantic or cognitive therapist attempts to familiarize himself with his patient's thought content, style of thinking, feelings, and behaviors, in order to understand their interrelationships.

For the semantic therapist, mental illness is fundamentally a disorder of thinking—the patient consistently distorts reality in an idiosyncratic manner and/or reaches unreasonable conclusions concerning his ability to cope with his environment. The patient's distorted thought processes adversely affect his view of the world and lead to unpleasant emotions and behavioral difficulties. The cognitive therapist helps the patient to identify specific misconceptions, distortions, and maladaptive attributions and to test their validity and reasonableness.

Ellis noted that several Greek and Roman philosophers (including Epictetus), as well as ancient Buddhist thinkers, perceived the close connection among reason, emotion, and behavior and offered advice for changing behavior by altering thinking patterns (1962). In this century, a number of therapists, including Dubois (1905), Coué (1922), Korzybski (1933), Johnson (1946), Low (1950), Kelley (1955), Phillips (1957), Frank, (1961), Ellis (1962), Blumenthal (1969), Beck (1976), and Lazarus (1972), have emphasized the role of cognitive factors in contributing to mental illness and have focused on altering the client's maladaptive self-verbalizations. Shaffer, for example, defined therapy as a "learning process through which a person acquires an

but by the opinions about the things: for example, death is nothing terrible, for if it were, it would have seemed so to Socrates; for the opinion about death, that it is terrible, is the terrible thing. When then we are impeded or disturbed or grieved, let us never blame others, but ourselves, that is, our opinions. It is the act of an ill-instructed man to blame others for his own bad condition; it is the act of one who has begun to be instructed, to lay the blame on himself; and of one whose instruction is completed, neither to blame another, nor himself" (Epictetus, *The Enchiridion*).

ability to speak to himself in appropriate ways so as to control his own conduct" (1947, p. 463).

Miller further underscored this tradition when he highlighted the potential importance of language in directing behavior:

> My major interest in psychology has been in research on psychological aspects of language and communication. Because our uniquely human capacity for speech is continually in my mind, I can never approach questions of behavior control without remembering that the most precise technique we have for behavior control is human language. This "technique" can cause you to do things you would never think of doing otherwise. It can change your opinions and beliefs. It can be used to deceive you. It can make you happy or sad. It can put new ideas in your head. It can make you want things you do not have. *You can even use it to control yourself.* (Miller, 1970, p. 999, emphasis added)

In a critical examination of cognitive restructuring approaches to therapy, it is well to avoid an error that has commonly been made in therapy outcome research. This pitfall can be illustrated by reference to an important doctoral dissertation entitled *Insight vs. Desensitization in Psychotherapy: An Experiment in Anxiety Reduction* that was conducted by Paul while I was a graduate student at the University of Illinois (1962–1966). Indeed, the dissertation was published as a book (Paul, 1966) and Paul received the award that year for the most creative doctoral dissertation in North America. Many people then considered it a landmark study, which documented the relative superiority of the behavior therapy procedure of desensitization over "insight" therapy. Paul deserved his kudos, for the study provided a prototype for therapy outcome studies. There was only one shortcoming: One of the independent variables, namely, "insight," was not operationally defined to permit ready replication. In describing the treatments in his study, Paul presented an explicit therapist manual of the desensitization treatment; but in describing the insight-oriented psychotherapy he said only,

> This treatment consisted of the traditional interview procedures used by the respective therapists [there were five therapists] in their daily work. With this approach, the therapist attempts to reduce anxiety by helping the client gain "insight" into the bases and interrelationships of his problem. (1966, p. 18)

The only hint of the therapists' techniques was given by their scores on a self-report Therapist Orientation Sheet. The explicit treatment techniques used by the therapists to effect "insight" and their respective definitions of "insight" were not indicated by Paul.

The reason I mention the Paul study is that it falls victim to what Kieslar calls the "therapist uniformity myth" (1966). When applied to psychotherapy research, the uniformity myth assumes that findings from most procedures labeled "insight-oriented therapy" or what I am here calling cognitive restructuring therapy will be equivalent since the treatment methods are assumed to be equivalent. However, there are many different ways to conceptualize "insight" and many ways to conduct insight-oriented therapy. I will argue that, given the present state of cognitive restructuring *therapies*, we should not subsume them under one umbrella term or impose a "uniformity" myth. Let us examine some of the similarities and differences that characterize semantic or cognitive therapies.

Reconsider the assessment procedure described in the last chapter on stress-inoculation training, in which the client was asked to close his eyes and replay in his mind's eye a movie of his problem situation, reporting the thoughts and feelings that preceded, accompanied, and followed the maladaptive act. For a moment let's leave the "head" of the client and shift our focus to what the therapist may be thinking (in some sense, saying to himself) as he listens to the client's description. Put yourself in the place of the therapist. How do you view your client's thoughts and images? Are they seen as reflections of irrational belief systems and faulty thinking styles, *or* as instances of

problem-solving ability and coping skills, *or* as instances of behavior *per se*, part of the client's complex response chain? Each of these conceptualizations (and others are possible) gives rise to different treatment interventions. Indeed, the host of different therapy procedures may be distinguished by the therapists' conceptualizations of their clients' cognitions. What a therapist says to himself about his client's thoughts and images, the way he views his client's internal dialogue will influence the questions he will ask the client, the tests he will administer, the nature of the homework assignments he will give, and how he will conduct therapy. We will explore therapists' self-statements concerning the therapy process by examining the different conceptualizations that have guided cognitive restructuring therapies.

Cognitions as Instances of Irrational Belief Systems

The semantic therapy that has received the most attention in recent years is Ellis' rational-emotive therapy (RET). The basic premise of rational-emotive therapy is that much, if not all, emotional suffering is due to the irrational ways people construe the world and to the assumptions they make. The assumptions lead to self-defeating internal dialogue or self-statements that exert an adverse effect on behavior. Thus, the task for the RET therapist is threefold. He must first determine precipitating external events that upset his patient. Then he must determine the specific thought patterns and underlying beliefs that constitute the internal response to these events and give rise to negative emotions. Third, he must assist the client in altering these beliefs and thought patterns. Ellis proposed that a major core of emotional disturbances has to do with the client's preoccupation with what others think of him (1962). Ellis encouraged the clinician to note the themes, the irrational premises, that underlie our patient's self-statements, images, and cognitions. He attempts to have

clients examine the ideas, such as the following, that give rise to misperceptions: (1) I must be loved or approved of by practically every significant person in my life, and if I'm not it's awful; (2) I must not make errors or do poorly, and if I do it's terrible; (3) people and events should always be the way I want them to be.

Ideas that are based, as these are, on the belief that a person's self-worth is basically determined by others represent an irrational extrapolation of the consequences of personal actions. The extrapolation is irrational because it does not reflect realistically the events that the client has experienced in the past.

In order to counteract such beliefs, the rational-emotive therapist encourages, goads, challenges, educates by means of a Socratic dialogue, provides information, conducts rational analyses, assigns behavioral homework assignments, and so on, in order to have the client entertain the notion that his maladaptive behavior and emotional disturbance are a reflection of a commitment to irrational beliefs.

As a result of such therapeutic interventions, it is hoped that the client will replace the beliefs described above with the following: (1) It's definitely nice to have people's love and approval, but even without it, I can still accept and enjoy myself; (2) doing things well is satisfying, but it's human to make mistakes; (3) people are going to act the way they want, not the way I want.

It should be stressed that a client, before semantic therapy (including RET), is unlikely to "tell himself" various things consciously or deliberately when he is confronted with real-life situations. Rather, because of the habitual nature of one's expectations or beliefs, it is likely that such thinking processes become automatic and seemingly involuntary, like most overlearned sets. Moreover, the patient's maladaptive cognitions may take a pictorial form instead of or in addition to the verbal form (Beck, 1970). For example, a woman with a fear of walking alone

found that her spells of anxiety followed images of her having a heart attack and being left helpless. A college student discovered that her anxiety at leaving the dormitory was triggered by visual fantasies of being attacked. Such idiosyncratic cognitions (whether pictorial or verbal) are usually very rapid and often contain an elaborate idea compressed in a few seconds or less. Beck points out that these cognitions are experienced as though they were automatic and involuntary and that they usually possess the quality of appearing plausible, rather than unrealistic.

The semantic therapist attempts to make his client aware of negative self-statements and images and of the anxiety-engendering, self-defeating, and self-fulfilling-prophecy aspects of such thinking. The first goal of therapy is to have the patient entertain the possibility that his maladaptive behaviors and emotional upset are contributed to by what he says to himself. The therapist, after initially listening to the patient's complaints, may give the patient the assignment of listening to himself over the course of the week and conducting a situational analysis of the times at which he experiences behavioral and affective upsets and engages in negative self-statements. Through careful questioning by the therapist, the patient begins to accept a cognitive conceptualization of his problem, one that is shared by the therapist. When the patient returns with examples of his negative self-statements, the therapist may ask, with some tact and skill, "Are you telling me that these kinds of thoughts are part of your problem? How do they cause you to become upset?" At this point the patient begins to provide evidence that negative self-statements are contributing to his problem. Once the patient entertains the possibility that his maladaptive behaviors result from what he tells himself, then a whole set of therapeutic assignments makes sense to him. *Whether the patient did or did not actually talk to himself prior to therapy is less important than that he is willing to view his behavior as if it were affected by self-statements and modifiable by them.* The semantic

therapist usually employs homework assignments to engender the patient's acceptance of this viewpoint. The patient is asked to engage in graduated performance tasks to help him identify the ways in which his cognitions contribute to maladaptive behavior.

Ellis, in a rather forceful manner, has the client adopt the point of view that maladaptive behaviors and feelings derive from his belief system.[27] However, one must clearly distinguish between (a) the intentional use of such a belief-system analysis in RET, which leads to change, and (b) the natural occurrence of such belief systems, which contributes to maladaptive behavior in the first place. We may find that having the client view his behavior from Ellis' perspective leads to change but it does not follow that the existence of such self-negating beliefs is the key characteristic that distinguishes clients from nonclients. Elsewhere, I have argued that it may not be the *incidence* of irrational beliefs that is the distinguishing characteristic

[27] As you may recall, Ellis was instrumental in setting forth my journey of cognitive-behavior modification. Dr. Ellis' own therapy style must be distinguished from the rational-emotive therapy (RET) approach. This distinction will be particularly relevant for those readers who have seen Dr. Ellis conduct therapy in person, in films, or heard him on audiotapes. His approach is forcefully didactic—so forceful, that on one occasion I was moved to suggest, rather tongue-in-cheek, that RET as conducted by Ellis would only be successful with New Yorkers. (Ellis practices therapy in New York.) And I went on to suggest that wherever else in the world RET was successfully conducted, it would be with a patient who had moved from New York. In fantasy I began to consider at what point one of Dr. Ellis' patients might terminate therapy: One of Ellis' patients gets into a taxi on Forty-Second Street in New York and says, "You have to hurry, I'm going to be late for my therapy hour." After a slight pause, the taxi-driver turns and says, "Don't rush me, Mister. Why are you so hung-up about what your therapist will think of you if you're late?" etc. When the patient arrives at Dr. Ellis' office, the patient begins to describe his run-in with the taxi-driver, at which point Dr. Ellis says, "Why are you so upset with your concern about what the taxi-driver thinks of you? Your self-worth. . . ." The similarity in the advice offered by Ellis and the taxi-driver dawns on the patient and therapy ends. End of fantasy!

The point of these anecdotes is not to detract from the pioneer contributions of Ellis, for they are immeasurable, but rather to underscore the importance of distinguishing therapist style from therapy content. Perhaps this point could be most simply underscored by having the reader conjure-up the image of Carl Rogers conducting RET.

between normal and abnormal populations, as Ellis suggests (Meichenbaum, 1976b). Nonclinical populations may also hold many of the unreasonable premises that characterize clinical populations. But what the nonclinical subjects say to themselves about the irrational beliefs, the coping mechanisms they employ, may be what distinguishes clinical from nonclinical populations. In other words, it may *not* be the absence of irrational thoughts *per se* but rather the set of management techniques employed to cope with such thoughts and feelings that characterizes the nonpatient population or determines the "recovery" time from emotional upsets. The *nonpatient* may be more capable of "compartmentalizing" such events and be more able to use coping techniques such as humor, rationality, or what I have come to call "creative repression."

Although therapeutic procedures such as Ellis' rational-emotive therapy (RET) have been available and professionally visible for well over a decade, there is a paucity of controlled experimental data bearing on their efficacy. A few encouraging studies of the efficacy of RET have been offered (Baker, 1966; DiLoreto, 1971; Karst & Trexler, 1970; Meichenbaum, Gilmore, & Fedoravicius, 1971; Trexler & Karst, 1972; Wolfe & Fodor, 1975).[28] However, after reviewing the outcome literature for RET and cognitive restructuring therapy in general, Mahoney concludes, and my own assessment of the literature is in full accord, "the clinical efficacy of Ellis' rational-emotive therapy has yet to be adequately demonstrated" (1974, p. 182). However, a similar assessment could be made of other therapies and the studies reviewed in this book are grounds for encouragement.

Cognitions as Instances of Faulty Thinking Styles

Closely akin to Ellis' rational-emotive approach is Beck's analysis of the stylistic qualities of our client's cog-

[28] The interested reader should see a bibliography of outcome RET studies by Murphy and Ellis (1976).

nitions, especially those of depressives (Beck, 1976; Braff & Beck, 1974). Beck attempts to have clients become aware of the distortions in their thought patterns (1970). These distortions include: (1) arbitrary inference—the drawing of a conclusion when evidence is lacking or actually supports the contrary conclusion; (2) magnification—exaggeration of the meaning of an event; (3) cognitive deficiency—disregard for an important aspect of a life situation; (4) dichotomous reasoning—overly simplified and rigid perception of events as good or bad, right or wrong; (5) overgeneralization—taking a single incident such as failure as a sign of total personal incompetence and in this way generating a fallacious rule. Such cognitive distortions result in the client's selectively attending to and inaccurately anticipating consequences. Beck's therapy is directed toward the client's identifying such stylistic qualities so that he can come to understand that his affective experiences and maladaptive behaviors are a result of his particular thinking processes—thinking processes that he is capable of changing and controlling by himself.

Cognitive therapy that derives from Beck's analysis of the client's cognitions involves helping the patient to evaluate both his attributions and performance more realistically by focusing on his negative self-judgments. Asking the client to engage in a set of graded tasks, homework assignments, and maintain activity lists provides the therapist with the behavioral data around which to examine the client's thinking style. Although individual treatment strategies may vary with the severity of the patient's problem and his ability and readiness to conceptualize in a certain manner, the process of the cognitive-behavioral therapy developed by Beck and his colleagues has a common pattern. The patient is taught to recognize and monitor his cognitions as well as to test and validate the relationship between cognition and affect. Both semantic and behavioral techniques are used to question the validity of or basis for the negative cognitions and misconceptions. After

the patient recognizes the distortions in his cognitive set, the belief system or "silent assumptions" that support his attitudes and conceptions are then challenged. The therapist demonstrates to the patient that his interpretation of daily experiences is unrealistic. The patient, in a collaborative fashion with the therapist, discovers his cognitive distortions by his own data collection. For instance, a patient's assertion, "I had a terrible week," is examined in the context of his list of undertakings that week that he is asked to record. In this way the patient is made aware of how he assigns peculiar and upsetting meanings to experiences. Beck's use of an activity record allows the patient to review his behavior and to examine it in context and in perspective. In doing so, the client's cognitive distortions become more apparent and alternative interpretations can be brought to bear.

The initial results using this therapy approach have been encouraging but, as yet, not definitive. In a review of the literature Beck found ten studies that compared cognitive therapy, behavior therapy, and the combination of the two in the treatment of depression. "The major conclusion which can be drawn from these studies is that treatment procedures which directly change cognitions and/or behaviors are effective in alleviating depression. Furthermore, they are more efficacious than nondirective and supportive [treatments]" (Beck, 1976, p. 95). The studies Beck cited included Shipley and Fazio (1973), Taylor (1974), Shaw (1975), Schmickley (1975), Hodgson and Urban (1975), Fuchs and Rehm (1975), Rehm, Fuchs, Roth, Kornblith, and Roman (1975), Gioe (1975), and Klein and Seligman (1976). Unfortunately, these studies were predominantly dissertations involving college student populations. A few studies have applied Beck's procedures to psychiatric populations but these are the exception (e.g., Rush, Beck, Kovacs, Khatami, Fitzgibbon, and Wolman, 1975a; Rush, Khatami, and Beck, 1975b). For example, Rush *et al.* compared twice weekly cognitive therapy with chemotherapy

for a period of ten weeks in depressed patients (1975b).[29] The results indicated an equivalent efficacy of drug therapy and psychotherapy at an immediate posttest, and at a three-month follow-up. In addition, a lower drop-out rate was noted in the cognitive therapy group compared to the chemotherapy group.

Cognitions as Instances of Problem-Solving Ability and Coping Skills

Whereas the Ellis and Beck cognitive therapy approaches sensitize the therapist to listen for the *presence* of maladaptive self-statements, assumptions, and beliefs, the cognitive therapist with a problem-solving and coping-skills orientation listens for the *absence* of specific, adaptive cognitive skills and responses. D'Zurilla and Goldfried (1971) and Goldfried and Goldfried (1975) suggest that our client's cognitions evidence a deficit in systematic, problem-solving skills. The problem-solving treatment is designed to have the client learn how to identify problems, generate alternative solutions, tentatively select a solution, and then test and verify the efficacy of that solution. The clinical potential of such a problem-solving approach is illustrated in the treatment research reviewed by Hanel (1974), Meichenbaum (1974a), Schneider and Robin (1975), and Spivack and Shure (1974). Each of these investigators highlighted the therapeutic value of teaching clients cognitive problem-solving skills. A number of recent studies further illustrates how a problem-solving training approach can be employed with various clinical populations. The applications have included the use of problem-solving in crisis clinics (McGuire & Sifneos,

[29] It is important to recall the discussion of drug treatment with hyperactive children. Medication not only has pharmacological effects but likely also alters the client's internal dialogue. It would be interesting to take the interview schedule that Whalen and Henker used for studying changes in attribution with hyperactive children who were receiving medication and apply it to depressives who receive medication.

1970), with hospitalized psychiatric patients (Coché & Flick, 1975), in assisting adolescents to handle various conflict situations (Kifer, Lewis, Green, & Phillips, 1973), in helping ex-drug addicts to remain drug-free (Copeman, 1973) and various high school and college students to deal with interpersonal anxiety (Christensen, 1974).

Common to each of these problem-solving approaches is an attempt to teach the client to engage in covert problem solving, entailing symbolic stimulus-transformation, cognitive rehearsal, and tests of alternate solutions. The problem-solving training usually includes: (1) cognitive reappraisal, which is based on training in discrimination among observation, inference, and evaluation—the individual learns to reappraise the evaluation that he places on the stimuli; and (2) behavioral experimentation—the individual learns to generate and experiment with a range of alternative behaviors in response to identified interfering social stimuli. The approach is a broad social competence training model, unrestricted in its application to various populations.

Whereas some cognitive restructuring therapists emphasize problem-solving, others are more concerned with coping skills. The problem-solving approach teaches the client to stand back and systematically analyze a problem situation in the absence of any acute stress; the coping-skills approach concentrates on what the client must do when immediately confronted with an acute stressful situation. Indeed, the problem-solving process may include rehearsal of coping skills, as clients imagine dealing with stressful events. The research reviewed in the last chapter on stress-inoculation training illustrates how a coping-skills orientation can be employed in therapy.

Cognitive Restructuring Therapies—Some Differences

Ellis, Beck, D'Zurilla and Goldfried, Meichenbaum—what are the differences? Irrational beliefs,

faulty thinking styles, inadequate problem-solving skills and coping skills—what difference does it make? They are all cognitive restructuring therapies.[30] How important are the nuances? Once again, the answer is that we don't know. However, a logical analysis of the various therapy approaches may help direct our search for the answers.

The therapist manuals that have been written by these various cognitive restructuring therapists vary in several respects. Most notably, they vary in terms of the relative emphasis placed on formal logical analysis (i.e., isolation and evaluation of premises), the directiveness with which the therapeutic rationale and procedures are presented and the relative reliance on adjunctive behavior therapy procedures.

A major distinction among the various cognitive restructuring therapy approaches is the differential emphasis placed on the rational analysis of the client's belief system. Ellis, and to a lesser extent Beck, highlights the implicit assumptions and premises that give rise to negative self-statements and emotional disturbance. In examining the client's maladaptive behaviors Ellis has the client "become aware of" or "entertain the notion" that certain irrational beliefs guide faulty thinking and contribute to maladaptive

[30] A number of different therapy approaches using various procedures have the clients become aware of and alter their internal dialogues. For example, in Moreno's psychodramatic method the therapist encourages the client through dramatic interplay to make his private fantasies public, to play out his internal dialogue in a safe setting. By means of role reversal the client can then gain the viewpoint of significant others. In Gestalt therapy the client becomes aware of his internal dialogue by identifying with two opposing parts of his conflict in an exercise called "topdog-bottomdog." The client plays the role of each side of the conflict, usually locating each side in a separate chair, and then proceeds to have a dialogue or encounter between them (e.g., "I want to, but I can't," "I wish I could, but what would people think," "I feel like crying, but I'm holding back"). In Berne's transactional analysis the client is made aware of his internal script. Note, that it is not as if clients actually have scripts or conflict polarities but rather each of these therapy procedures provide a plausible way for the client to conceptualize their problems—a conceptualization that will lead to particular therapy interventions.

behavior. The task for the patient is to challenge these faulty beliefs. Ellis states:

> Cognitively, RET teaches clients the A-B-C's of personality formation and disturbance-creation. Thus, it shows people that their emotional *C*onsequences do *not* directly stem from the *A*ctivating events in their lives, but from their *B*elief Systems *about* these Activating events. Their Belief systems, when they feel disturbed, consist of, first, a set of empirically-based, rational Beliefs. For example, when they fail at a job or are rejected by a love partner they rationally convince themselves, "How unfortunate it is for me to fail! I would much rather succeed or be accepted." If they stick rigorously to these rational Beliefs, they feel appropriately sorry, regretful, frustrated, or irritated; but they do *not* feel emotionally upset or destroyed. To make themselves feel inappropriately or neurotically, they add the nonempirically-based, irrational Beliefs "How *awful* it is for me to fail! I *must* succeed. I am a thoroughly *worthless person* for failing or for being rejected!" *Then* they feel anxious, depressed, or worthless. In RET, the therapist or teacher shows people how to vigorously challenge, question, and *D*ispute their irrational Beliefs. Thus, they are shown how to ask themselves: "*Why* is it awful that I failed? Who says I *must* succeed? Where is the evidence that I am a *worthless person* if I fail or get rejected?" If people persistently and forcefully *D*ispute their insane ideas, they acquire a new cognitive *E*ffect, namely, the Beliefs that: (1) "It is not awful but only very inconvenient if I fail"; (2) "I don't *have* to succeed, though there are several good reasons why I'd *like* to"; (3) "I am never a *worthless person* for failing or being rejected. I am merely a person who has done poorly, for the present, in these areas, but who probably can do better later. And if I never succeed or get accepted, I can *still* enjoy myself in *some* ways and refrain from downing myself. (Ellis, 1971, p. 19)

In Ellis' form of cognitive therapy the client views his behavior as influenced by maladaptive beliefs and the challenging of these beliefs is the central task of therapy.

Beck's focus on irrational beliefs is in the context of a host of cognitive therapeutic tactics such as reality testing, authenticating observations, validating conclusions, and

distancing (i.e., regarding thoughts objectively). Patients are systematically taught such skills as self-observation in order to note the relationship between thoughts and emotions and then taught to regard such thoughts as hypotheses rather than facts. Beck's focus is more on the specific self-statements that occur in particular situations (usually graded task assignments) and how the client can test the validity of these self-statements. Finally, the assumptions and beliefs that underlie and generate the client's hypotheses are examined. The rational analysis of the client's belief system follows from the client's own behavioral data.

My own approach is closer to that of Beck than to Ellis, as I attempt to have clients increase their awareness of the negative self-statements and images they emit but without formally doing a rational analysis of the so-called irrational belief system. Instead, the focus is on the client's learning to employ specific problem-solving and coping skills. There is a clear need to compare the importance of using different cognitive interventions.

The present discussion of the variety of different cognitive restructuring therapy techniques presents a dilemma for the cognitive-behavior therapist in choosing among the different therapeutic approaches. This dilemma is magnified when we consider the host of different ways behavior therapy procedures such as modeling and imagery rehearsal and so on can be employed to alter the client's cognitions (as described in Chapter 4). The use of imagery in psychotherapy nicely illustrates this dilemma. Desensitization, emotive imagery, aversive images, implosive images, symbolic modeling, "depth" images, psychosynthesis, guided affective images, etc.—one could go on and on generating over twenty different ways images alone can be employed in psychotherapy. It is almost as if we had asked psychotherapists to take Guilford's creativity test and asked them to answer the item "What are all the unusual uses of . . . imagery in psychotherapy?" When we add to this list the many other ways cognitions can be employed in

therapy the list becomes overwhelming. Such a lengthy list of alternative therapy procedures leads to a technical eclecticism, a trial-and-error clinical approach. From a research viewpoint the host of therapy techniques leads to what I have come to call a preoccupation with "engineering" questions. As phrased by Paul:

> What treatment, by whom, is most effective for this individual, with what specific problem, under what set of circumstances? (1969, p. 162).

Engineering questions are not unimportant but the question of "why" and "how does change come about" is often not considered. Instead, we are offered numerous comparative studies all addressed to answering "engineering" questions. Perhaps we can short-circuit some tedious and expensive comparisons by engaging in theory construction. It seems that the field of behavior therapy and for that matter, psychotherapy in general, has adopted an atheoretical stance. Whether it is London (1972) appropriately calling for an "end of ideology" or Lazarus (1972, 1976) counseling us to use "what works" we have become overly concerned with "engineering" questions. The next two chapters are designed to provide a beginning toward filling the vacuum by providing a theory of behavior change and attempting to address the "why" and "how" questions.