

think of rational responses more readily with practice.

Another problem deriving from the misapplication of cognitive therapy techniques occurs when the therapist uses a particular technique inflexibly. It is often necessary for the therapist to try out several behavioral or cognitive techniques before finding an approach to which a patient responds well. The cognitive therapist must stay with a particular technique for a while to see whether it works, but he or she must also be willing to try an alternative technique when it becomes apparent that the patient is not improving. To give a specific example, behavioral homework assignments are sometimes more helpful with particular patients, even though the therapist has every reason to predict in advance that cognitive assignments will be more effective.

In some instances in which it appears that little progress is being made in therapy, it turns out that the therapist has selected a tangential problem. The cognitive therapist should be alert to this possibility, especially during the early stages of therapy. When there appears to be little or no significant change in depression level, even when the patient seems to have made considerable progress in a problem area, the therapist should consider the possibility that the most distressing problem has not yet been uncovered. A typical example of this kind of difficulty is the patient who presents difficulty at work as the major problem, when it turns out that couple problems are contributing significantly to the work difficulties. The real issue may be withheld by the patient because it seems too threatening.

Finally, cognitive therapy is not for everyone. If the therapist has tried all available approaches to the problem and has consulted with other cognitive therapists, it may be best to refer the patient to another therapist with either the same or a different orientation.

Regardless of why therapy is not progressing satisfactorily, cognitive therapists should attend to their own affect and cognitions. They must maintain a disciplined, problem-solving stance. If the cognitive therapist finds him- or herself unduly influenced by a patient's despair or begins to notice that his or her own schemas are triggered by therapeutic interactions, he or she should seek supervision. Hopelessness in patients or therapists is an obstacle to problem solving. If therapists can effectively counteract their own negative self-assessments and other

dysfunctional thoughts, they will be better able to concentrate on helping patients find solutions to their problems.

Case Study of Denise: Nonchronic Depression

In the case study that follows, we describe the course of treatment for a nonchronically depressed woman seen at our center. Through the case study, we illustrate many of the concepts described earlier in this chapter, including elicitation of automatic thoughts, the cognitive triad of depression, collaborative empiricism, structuring a session, and feedback.

Assessment and Presenting Problems

At the initial evaluation, Denise reported that she was a 59-year-old widow, who had been living alone for the last year. Denise's husband had been diagnosed with brain cancer three years prior and died approximately one year ago. She had two grown unmarried children (27 and 25 years old) who were pursuing careers in other parts of the country. Denise had an undergraduate degree and had worked until age 30 but stopped after marrying. Denise described her major problems as depression (over the last year and a half), difficulty coping with daily life, and loneliness. She reported one prior episode of major depression around age 25, following the death of her father.

Denise said she had become increasingly socially isolated with the onset of her husband's illness (brain cancer). She reported having had normal friendships as a child, teenager, and young adult. She and her husband had led a relatively quiet life together, mostly focused on raising their children and respective work. When they had free time, they had enjoyed intellectual and cultural activities together (museums, lectures, concerts, and fine restaurants). They had a few close friends with whom they socialized but those friends had retired in Florida and Arizona during the time of the husband's illness.

Denise was diagnosed with a major depressive disorder, recurrent, on Axis I. Her test scores verified the diagnosis of depression. Denise's Beck Depression Inventory (BDI) score was 28, placing her in the moderate to severe range of depression. Her most prominent depressive symptoms included loss of pleasure, irritability, social withdrawal, inability to make

decisions, fatigue, guilt, difficulty motivating herself to perform daily functions, and loneliness.

Session I

The session began with Denise describing the “sad feelings” she was having. The therapist almost immediately started to elicit Denise’s automatic thoughts during these periods.

THERAPIST: What kind of thoughts go through your mind when you’ve had these sad feelings this past week?

DENISE: Well, I guess I’m thinking what’s the point of all this. My life is over. It’s just not the same. I have thoughts like, “What am I going to do? Sometimes I feel mad at him, you know, my husband. How could he leave me? . . . Isn’t that terrible of me? What’s wrong with me? How can I be mad at him? He didn’t want to die a horrible death. I should have done more. I should have made him go to the doctor when he first started getting headaches. . . . Oh, what’s the use?”

THERAPIST: It sounds like you are feeling quite bad right now. Is that right?

DENISE: Yes.

THERAPIST: Keep telling me what’s going through your mind right now?

DENISE: I can’t change anything. It’s over. I don’t know. . . . It all seems so bleak and hopeless. What do I have to look forward to . . . sickness and then death?

THERAPIST: So one of the thoughts is that you can’t change things, and that it’s not going to get any better?

DENISE: Yes.

THERAPIST: And sometimes you believe that completely?

DENISE: Yeah, I believe it, sometimes.

THERAPIST: Right now do you believe it?

DENISE: I believe it—yes.

THERAPIST: Right now you believe that you can’t change things and it’s not going to get better?

DENISE: Well, there is a glimmer of hope, but it’s mostly . . .

THERAPIST: Is there anything that you kind of look forward to in terms of your own life from here on?

DENISE: Well, what I look forward to . . . I enjoy seeing my kids, but they are so busy right now. My son is a lawyer and my daughter is in medical school. So, they are very busy. They don’t have time to spend with me.

By inquiring about Denise’s automatic thoughts, the therapist began to understand her perspective—that she would go on forever, mostly alone. This illustrates the hopelessness about the future that is characteristic of most depressed patients. A second advantage to this line of inquiry is that the therapist introduced Denise to the idea of looking at her own thoughts, which is central to cognitive therapy.

As the session continued, the therapist probed Denise’s perspective regarding her daily life. The therapist chose to focus on her inactivity and withdrawal. This is frequently the first therapeutic goal in working with a severely depressed patient.

In the sequence that follows, the therapist guided Denise to examine the advantages and disadvantages of staying in her house all day.

DENISE: Usually I don’t want to leave my house. I want to stay there and just keep the shades closed; you know, I don’t want to do anything. I just want to keep everything out, keep everything away from me.

THERAPIST: Now do you feel better when you stay in the house all day trying to shut everything out?

DENISE: Sort of . . .

THERAPIST: What do you mean?

DENISE: Well, I can watch TV all day and just lose myself in these silly shows. I feel better when I see other people and their problems on these shows. It makes me feel less lonely and like my problems aren’t so bad.

THERAPIST: And so how much time do you spend doing that?

DENISE: Now, lately? . . . Most of the time. Staying inside and watching TV feels safe, sort of secure, everything . . . like my loneliness, feels more distant.

THERAPIST: Now after you have spent some time like this, how do you feel about yourself?

DENISE: Afterwards? I usually try not to pay much attention to how I’m feeling.

THERAPIST: But when you do, how do you feel?

DENISE: I feel bad. I feel bad for wasting the day. I don't get to things that I need to take care of . . . like my bills, like cleaning, like taking a shower. I usually end up feeling kind of pathetic . . . and guilty.

THERAPIST: On the one hand you seem to feel soothed and on the other hand, afterwards, you're a bit critical of yourself?

Note that the therapist did not try to debate or exhort Denise to get out of the house or become involved with necessary daily tasks. Rather, through questioning, the therapist encouraged her to examine more closely her assumption that she was really better off watching TV all day in her house. This is the process we call "collaborative empiricism." By the second session, Denise had reexamined her hypothesis about watching TV and remaining in the house all day.

DENISE: About watching TV in the house versus getting out, I thought about that the other day. I remember telling you that it made me feel better to stay there. When I paid attention to what I really felt, it didn't make me feel better. It just kind of blocked out feeling bad, but I didn't feel better.

THERAPIST: It is funny then that when you talked about it, your recollection of the experience was more positive than it actually was, but that sometimes happens with people. It happens to me too. I think that something is good that's not so hot when I actually check it out.

We now return to the first session. After some probing by the therapist, Denise mentioned that it sometimes feels like cognitive therapy "is my last hope." The therapist used this as an opportunity to explore her hopelessness and suicidal thinking.

THERAPIST: What was going through your mind when you said, "This is my last hope"? Did you have some kind of vision in your mind?

DENISE: Yeah, that if this doesn't work, I feel like I couldn't take living like this the rest of my life.

THERAPIST: If it doesn't work out, then what?

DENISE: Well, I don't really care what happens to me . . .

THERAPIST: Did you have something more concrete in mind?

DENISE: Well, right this minute I don't think I could commit suicide, but if I keep feeling this way for a long time, maybe I could. I don't know, though—I've thought about suicide before, but I have never really thought about how I would do it. I know certain things stop me, like my kids. I think it would really hurt them and some other people too, like my mother. My mom is in good health now, but she may need me some day. . . . Yeah, those are the two things that stop me, my children and my mother.

THERAPIST: Now those are the reasons for not committing suicide. Now what are some of the reasons why you might want to, do you think?

DENISE: Because sometimes it just feels so empty and hopeless. There's nothing to look forward to—every day is the same. My life is such a waste, so why not just end it?

The therapist wanted Denise to feel as free as possible to discuss suicidal thoughts; thus, he tried hard to understand both the reasons for her hopelessness and the deterrents to suicide. After determining that she had no imminent plans to make an attempt, the therapist said that he would work with her to make some changes. He then asked her to select a small problem that they could work on together.

THERAPIST: Now are there any small things that you could do that would affect your life right away?

DENISE: I don't know. Well, I guess just calling my friend Diane in Florida. She called about a month ago and then again last week. Both times I told her I was busy and would call her back, but I haven't. I've felt so down. I have nothing to say to her.

THERAPIST: Well, when she lived in the area, what kinds of things did you talk about?

DENISE: We have kids about the same age, so we would talk about our kids. We both like to read and we used to go to a book club together—so we would talk about the books we were reading. Both of us liked art. We used to attend lectures at the museum during the week, so we would talk about art and the lectures. We would spend time making plans to do things together in our free time. It al-

- ways was very interesting when I spent time and with her. We had so much in common. I do miss her.
- THERAPIST: It sounds like you used to be involved in a number of interesting activities. What about now?
- DENISE: After my husband got sick and then my friends moved, I just stopped. I haven't done any of those things in quite a while.
- THERAPIST: What do you think about attending a lecture series now?
- DENISE: I don't know.
- THERAPIST: Well, what do you think about that idea?
- DENISE: It's an OK idea, but it just seems like too much. I don't think I'll enjoy it . . . the way I feel . . . I don't know.
- THERAPIST: Would you be willing to test out that thought that you won't be able to enjoy it now?
- DENISE: I don't know . . . I guess so.
- THERAPIST: Is that a "yes"?
- DENISE: Yes, but I don't see how I'm going to get myself to do it.
- THERAPIST: Well, how would you go about finding out about a lecture series?
- DENISE: You look online at the museum's website to see what's available.
- THERAPIST: OK. Do you have a computer?
- DENISE: Yes.
- THERAPIST: Is it working?
- DENISE: Yes.
- THERAPIST: How do you feel about doing that?
- DENISE: I guess I could do that. . . . I'm so pathetic, I know what to do. I don't need you to spell it out for me. Why didn't I just do this before?
- THERAPIST: Well, you probably had good reasons for not doing it before. Probably you were just so caught up in the hopelessness.
- DENISE: I guess so.
- THERAPIST: When you are hopeless you tend to deny, as it were, or cut off possible options or solutions.
- DENISE: Right.
- THERAPIST: When you get caught up in hopelessness then, there is nothing you can do. Is that what you think?
- DENISE: Yeah.
- THERAPIST: So, then, rather than be down on yourself because you haven't looked this up online before, why don't we carry you right through?
- This excerpt illustrates the process of graded tasks that is so important in the early stages of therapy with a depressed patient. The therapist asked the patient a series of questions to break down the process of attending a lecture series into smaller steps. Denise realized that she had known all along what to do, but, as the therapist pointed out, her hopelessness prevented her from seeing the options.
- DENISE: Taking this step is going to be hard for me.
- THERAPIST: First steps are harder for everybody, but that's why there is an old expression: "A journey of a thousand miles starts with the first step."
- DENISE: That's very true.
- THERAPIST: It's the first step that is so very important, and then you can ready yourself for the second step, and then the third step, and so on. Eventually, you build up some momentum, and each step begins to follow more naturally. But first, all you have to do is take one small step. You don't have to take giant steps.
- DENISE: Well, yeah, I can see that. I guess I was thinking every step was just as hard as the first. Maybe it will get easier.
- In the second session, Denise reported success.
- DENISE: I checked online about the lecture series and I surprised myself. One actually sounded interesting, and I'm thinking that I might just register for it online. I really didn't think any of those feelings were still there. I'm kind of looking forward to that next step.
- At the end of the first session, the therapist helped Denise fill out the Weekly Activity Schedule for the coming week. The activities were quite simple, such as getting up and taking a shower, fixing meals, going out shopping, and checking out the lecture series online. Finally, the therapist asked Denise for feedback about the session and about her hopelessness.

THERAPIST: Do you have any reactions?

DENISE: I'm still feeling down, but I'm also feeling a little better. It's interesting that just the idea of looking at what lecture's might be available is making me feel a little lighter. I even had the thought of calling Diane to talk over the options. . . . Is this a sign of better things to come?

THERAPIST: What do you think?

DENISE: Maybe.

Session 2

In the second session, the therapist began by collaborating with Denise to set an agenda. Denise wanted to discuss the fact that she had not been attending to her bills or to her housework and was still spending a good part of the day alone in front of the TV; the therapist utilized this as an opportunity to discuss the issue of activity versus inactivity on the agenda. They then reviewed the previous homework. Denise had carried out all the scheduled activities and had also listed some of her negative thoughts in between sessions. Her BDI score had dropped somewhat. (Patients routinely fill out the BDI before each session, so that both the patient and the therapist can monitor the progress of treatment.)

Denise then shared her list of negative thoughts with the therapist. One concern was that she had expressed angry feelings about her husband during the first session.

DENISE: I don't like revealing things about myself, but you told me to write down my thoughts. So here it is. When I went to bed the night after of our first session, I thought about what I said to you, you know, about being angry at my husband. I was thinking that you probably think I am this really harsh and cold person. I mean, here my husband died this horrible death and I have this hard, insensitive reaction. I started thinking that now you probably feel really negatively toward me because of that statement and that you don't want to work with me.

THERAPIST: I'm really glad you're telling me these thoughts. Let me start by asking you who is having these negative thoughts?

DENISE: You? Well, no. Actually, it's me.

THERAPIST: Right. Do you think that someone

like me might have another reaction to what you said?

DENISE: I don't know. I mean it is pretty harsh being angry at someone who had no control over what was happening.

The therapist then offered Denise an alternative perspective:

THERAPIST: Do you think that someone might react to your statements with empathy?

DENISE: How could they?

THERAPIST: I imagine it would be very upsetting and annoying to have lost both your husband and your friends—all around the same time. Even though you love and care about all of them, feeling angry is understandable. It sounds like a basic human reaction to some very difficult life events.

DENISE: Yeah, I guess that does make sense. Thanks.

This illustrates how a cognitive therapist can utilize events during the session to teach a patient to identify automatic thoughts and to consider alternative interpretations. In addition, the therapist provided a summary of a key theme he had identified from listening to Denise's automatic thoughts about her husband and about therapy. The theme was her fear of being harshly judged and potentially punished for her statement (punitiveness schema). Cognitive therapists often identify and begin to correct EMSs during the first phase of treatment. More intensive work on changing schemas in a later phase of treatment may be required to inoculate against relapse. We elaborate on this process in the next section of this chapter. In the segment that follows, the therapist explained how he arrived at the conclusion that punitiveness was an important schema for Denise.

THERAPIST: When you said that you thought I would have a negative opinion about you and not want to work with you because you said you felt angry at your husband, it sounded as though you were really concerned that you would be harshly judged and punished for your statements.

DENISE: Yes, that's right.

THERAPIST: I don't want to make too much out of this at the moment, but you also said that

after your friends had moved, you felt angry at them and judgmental of their decision. Even though you knew that each set of friends had to move for specific financial or health reasons and they had been in the process of completing their moves over several years, part of you still felt very angry with them. You mentioned that you strongly believe that friends should be there for each other, especially in times of great need, and if a friend lets another friend down, that relationship should end. Is that right?

DENISE: Right.

THERAPIST: So here, you largely have withdrawn from these important relationships and now you're feeling quite lonely. The thought of talking to these friends again brings fears that they will now be angry and punitive with you for your reaction to them. You're caught in a no-win situation. Is that right?

DENISE: Yes, that sounds right.

THERAPIST: So one of the things that can really grab hold of you—and make you feel terrible—is this notion that people, including yourself, should behave in specific ways, and if they or you don't behave the "right" way, then harsh punishment should result. Is that correct?

DENISE: Yes, that sounds right. But hearing you say it makes me realize that it doesn't really sound right.

THERAPIST: What do you mean?

DENISE: It's too extreme. It's too harsh. People are human and they have limitations and they make mistakes sometimes.

THERAPIST: It's good that you are starting to notice and evaluate these thoughts rather than just responding to them automatically. What this tells us is that you have to be alert for whenever you have the sense that either you or others should be strongly punished for not behaving in a specified way. The idea that people should not be cut a break, even under very difficult circumstances, may not work very well in real life with real people. You mentioned that both friends told you they felt terrible about leaving you at this time, and both have called you regularly since leaving the area. Do you think that if you begin to respond to and return their calls, they might react differently—in the

same way that I reacted differently from what you expected?

DENISE: Yes, that is very likely.

About halfway through the session, the therapist asked the patient for feedback thus far:

THERAPIST: Now at this point, is there anything that we have discussed today that bothered you?

DENISE: That bothered me?

THERAPIST: Yeah.

DENISE: I feel like I'm a bit of a freak.

THERAPIST: That is important. Can you . . .

DENISE: Well, I'm trying not to feel that way, but I do.

THERAPIST: Well, if you are, you are. Why don't you just let yourself feel like a freak and tell me about it?

DENISE: Well, I'm feeling like I'm just so different from everyone else. Other people don't seem to have my problems. They're still happily married and carrying on with life. I just feel so different from everyone.

This comment led to identification of a third theme, the social isolation/alienation schema. Denise had been viewing herself as increasingly different for the past couple of years. By this point, however, she was beginning to catch on to the idea of answering her thoughts more rationally. After the therapist pointed out the negative thought in the preceding excerpt, the patient volunteered:

DENISE: I know what to do with the thought "I'm a freak."

THERAPIST: What are you going to do with it right this minute?

DENISE: I am going to say to myself, "I'm not so different from other people. Other people have lost their mates. I'm not the only one. I'm just the first one in my group of friends. Eventually, they will all have the same situation as me. It's just a part of life." Seeing you for help doesn't mean I'm a freak. You probably see lots of people and help them with problems like mine.

THERAPIST: Right.

The same automatic thoughts arose later in the session, when Denise noticed the therapist's

wedding ring. In the extended excerpt below, the therapist helped her set up an experiment to test the thought “I’m so different from him.”

THERAPIST: OK, now let’s just do an experiment and see if you yourself can respond to the automatic thought, and let’s see what happens to your feeling. See if responding rationally makes you feel worse or better.

DENISE: OK.

THERAPIST: OK. “I’m so different from him.” What is the rational answer to that? A realistic answer?

DENISE: You are wearing a wedding ring and that is different from me, because I’m alone, without a mate.

THERAPIST: Yes. And?

DENISE: And? . . . I don’t really know much about you, other than you’re married. I guess from what I do know, that information could also be viewed as a similarity. We both have gotten married and know what it’s like to be married. I assume that you’ve never lost a mate, but maybe that is not true. You may have lost a mate as well.

THERAPIST: So, is it that you’re different or that I’m different? Or is it that we just have different situations with respect to our mates at this point in time?

DENISE: We just have different situations right now.

The preceding exchange demonstrates the use of reattribution. At first, Denise interpreted the therapist’s ring as evidence that they were very different. As a result of the guided discovery approach, she reattributed the difference to one of two factors: Either she or the therapist was different or that the situation with respect to mates was different for each. At the end of the experiment, Denise expressed satisfaction that she was finally recognizing this tendency to distort her appraisals.

DENISE: Right now I feel glad. I’m feeling a little better that at least somebody is pointing these things out to me. I never realized I was so judgmental of myself and other people and that I’m assuming I’m so different from everyone.

THERAPIST: So you feel good that you have made this observation about yourself?

DENISE: Yes.

After summarizing the main points of the second session, the therapist assigned homework for the coming week: to fill out the Daily Record of Dysfunctional Thoughts (see Figure 6.4) and the Weekly Activity Schedule (with mastery and pleasure ratings; see Figure 6.3).

Session 3

By the beginning of the third session, Denise’s mood had visibly improved. She had registered for a lecture series at the museum and was looking forward to attending the first lecture. She also had called her friend Diane with very positive results. She was catching negative and punitive thoughts toward others and herself and was challenging these thoughts. The primary agenda item Denise chose to work on was “how I back away from other people,” an aspect of her unrelenting standards, punitiveness, and social isolation/alienation schemas.

DENISE: I want to stop withdrawing from people. I want to be more accepting and engaged with others.

THERAPIST: What holds you back?

DENISE: I guess I believe that I have to be a bit removed and strict in relation to others or they’ll just behave in whatever way they want. People have to know my rules and abide by them if they want to have a relationship with me.

The therapist continued probing to understand why Denise believed she had to have others adhere to such a strict set of rules to have a relationship. As the discussion progressed, it became obvious that, in the abstract, she could see that such hard and fast rules were not necessarily conducive to having a good relationship—in fact, such rules sometimes put others off. But in real-life situations, Denise never felt she was wrong. The therapist’s next task was to help Denise bring her rational thinking to bear on her distorted thinking *in the context of a concrete event*. At the therapist’s request, Denise then described a conversation with her friend Diane, and how her intolerance for Diane’s deviation from her rules created distance. Denise had wanted Diane and her husband to come for a visit the following summer. Diane, however, told her that their

dog had been quite sick, and that if the dog was still alive she could not leave it. Denise thought this was ridiculous. She believed a relationship with a pet should never take precedence over a human relationship. This occurred when Denise actually had wanted and hoped to get closer to Diane again. The therapist helped her use logic to evaluate her maladaptive schema.

THERAPIST: You had the thought “I’m right to set the record straight with her. She can’t put me in second place to her dog. She can’t do that without consequence.” It seems likely that you believed that thought, and that you believed the thought was right. And since you believed that thought was right, you then felt you had to withdraw your affection from her if she didn’t abide by your wishes.

DENISE: Right.

THERAPIST: Now, let’s look at it. Do you think that thought is correct?

DENISE: Well, yes, it’s insulting.

THERAPIST: What’s insulting?

DENISE: She’s putting her dog in a higher priority position.

THERAPIST: Have you ever had a pet?

DENISE: No.

THERAPIST: Do you think that maybe Diane feels like her dog is a part of her family?

DENISE: I never thought of it that way.

THERAPIST: If you look at the situation from that perspective, how do you feel?

DENISE: I feel like I’m being a little insensitive. . . . That’s not right. I’m not allowing for any other perspective. I’ve never had a pet, so I don’t really know what it’s like to have a pet. It’s not right for me to be so judgmental of Diane. I need to be more understanding. I wasn’t very caring. I am actually behaving in a way that goes directly against my deepest values.

THERAPIST: So, according to your own values, was this right?

DENISE: No, it’s not right. I wasn’t respecting her feelings. I was just demanding that she respect mine. That wasn’t right.

THERAPIST: OK, now this is one of the problems. If you want to get over this sense that you should never give in or bend your rules for others, one of the things you can do is look for this thought, “I’m right and you

should have a negative consequence for your ‘wrong’ decision”—and refer back to this conversation we are having now and decide for yourself whether, indeed, you were right. Now, if every time you approach a conflict in a relationship and allow for the possibility that you might not fully understand, but really think underneath, “But I know I’m right,” you are going to feel put out, and then you are not going to want to engage with that person. Is that right?

DENISE: Yeah, that sounds right.

THERAPIST: So we have to decide here and now.

Do you indeed think that you are right to suspend your initial negative judgment to leave open the possibility of reevaluating your reaction to her behavior?

DENISE: Yes.

THERAPIST: Now, the next time you get the thought, “I’m right and I’m going to make sure this other person knows it,” how are you going to answer that thought?

DENISE: If I’m right? But I’m not necessarily right. I need to consider the other person’s perspective. I need to try to understand them and then see if what I’m thinking fits.

THERAPIST: Now are you saying that because that is the correct answer, or because you really believe it?

DENISE: No, I really believe it.

The therapist followed this discussion with a technique called “point-counterpoint” to help Denise practice rational responses to her automatic thoughts even more intensively. In this excerpt, the therapist expressed Denise’s own negative thinking as Denise tried to defend herself more rationally.

THERAPIST: Now I am going to be like the prosecuting attorney, and I’ll say, “Now I understand you let your friend violate one of your rules of friendship. Is that true?”

DENISE: Yes.

THERAPIST: “Now it seems to me that that was a very bad thing for you to do.”

DENISE: No, it wasn’t.

THERAPIST: “You don’t think it was?”

DENISE: No, I should try to understand her perspective.

THERAPIST: “Well, you can sit there and say you

should be more understanding, but I thought you said before that you wanted people to respect you.”

DENISE: I do, but I also need to respect others.

THERAPIST: “I know, but now you are saying that you are going to let her get away with this. What’s next?”

DENISE: What’s next can only be a better understanding of one another. We’ll feel closer.

THERAPIST: “But how can you feel closer if she’s not respecting your rules of friendship?”

DENISE: Maybe my rules are not appropriate in this situation. I need to learn to be more understanding, flexible, and tolerant of some deviations from my rules.

THERAPIST: “But then you’ll lose control of the situation.”

DENISE: No, that’s an exaggeration. I don’t need to control the whole situation. I can still decide what makes sense. I am still in control of what’s important.

THERAPIST: “How can that be?”

DENISE: Because I can respect myself and respect my friend, as well. I don’t have to turn everything into an either–or situation to try to make her see and do it my way. That just makes it difficult for her to get along with me, and I’ll lose out on the relationship in the long run if I keep on insisting that she either do it my way or we do nothing.

Finally, the therapist returned to the schema and asked the patient how much she believed the new perspective.

THERAPIST: If you’re flexible, you’ll lose control. Now do you believe that?

DENISE: No.

THERAPIST: Do you believe it partially?

DENISE: No. In fact, I’m more likely to lose control of any possibility of getting what I want if I’m so inflexible. It’s like I lose sight of the importance of the relationship when I get so stuck on thinking that I have to be in control and that the other person has to do it my way.

THERAPIST: OK, so right now, how much do you believe that?

DENISE: Completely.

THERAPIST: 100%?

DENISE: Yes.

THERAPIST: You are sure 100%, not 90 or 80%?

DENISE: No, 100%.

For the remainder of Session 3, Denise and the therapist reviewed other instances in which she noticed that her standards were not flexible and felt the urge to be punitive when her rules were not met. The session ended with a summary of the main issues raised in the first three sessions.

Summary of Initial Sessions

In the first three sessions, the therapist laid the groundwork for the remainder of treatment. He began immediately by teaching Denise to identify her negative automatic thoughts. By doing this, the therapist began to understand her feelings of hopelessness and to explore her isolation. By identifying her thoughts in a variety of specific situations, he was able to deduce several key schemas that later proved central to Denise’s thinking: (1) unrelenting standards, (2) punitiveness, and (3) social isolation/alienation. All appeared to be contributing to Denise’s social isolation and depression. The therapist made especially skillful use of Denise’s thoughts during the second therapy session to help her see that she was distorting evidence about the therapeutic interaction and coming to the inaccurate conclusion that the therapist would be judgmental and punitive with her and withdraw positive feelings for her, in the same way that Denise tends to respond to others.

Beyond identifying thoughts and distortions, the therapist guided Denise to take concrete steps to overcome her inactivity and withdrawal. He asked her to weigh the advantages and disadvantages of staying in the house all day watching TV; he broke down the task of attending a lecture series at the museum into small, manageable steps; and he worked with her to develop an activity schedule to follow during the week.

Finally, the therapist employed a variety of strategies to demonstrate to Denise that she could test the validity of her thoughts, develop rational responses, and feel better. For example, during the course of the three sessions the therapist set up an experiment, used reattribution, offered alternative perspectives, and practiced the point–counterpoint technique.

One final point we want to emphasize is that the primary therapeutic mode was questioning. Most of the therapist's comments were in the form of questions. This helped Denise to evaluate her own thoughts outside of the session and prevented her from feeling attacked by the therapist.

By the end of these initial sessions, Denise reported being more optimistic that her life could change.

Later Sessions

Denise continued to fill out the Daily Record of Dysfunctional Thoughts and gathered evidence that she could relax her standards and be more tolerant of others' viewpoints and foibles. She discovered that she felt happier, both with herself and others, as a result.

The therapist set up several experiments with Denise to test a series of beliefs: that her friends would become punitive with her when she did not behave perfectly, and that her relationships would become unpleasant and undesirable if she relaxed any of her rigid standards regarding how others should behave in relationships. Through graded tasks, Denise counteracted her tendency to withdraw by gradually approaching new and sometimes unfamiliar situations. When she noticed herself imposing her standards of behavior on others, or noticed in herself the urge to become punitive, Denise practiced more open and accepting behaviors (by asking open-ended questions that reflected back her understanding of others' responses, and by inhibiting harsh and judgmental statements). She practiced tolerating the discomfort associated with these new behaviors until they began to feel more comfortable and natural.

When Denise terminated therapy, her BDI score was in the normal range. The symptom reduction phase of treatment was successfully completed in 20 sessions.

The next section describes and illustrates a case example of schema-focused therapy for chronic depression.

SCHEMA THERAPY FOR CHRONIC DEPRESSION

Schema therapy, developed by Young (1990/1999; Young et al., 2003), can be used with patients who present with recurrent depressive episodes, an early age of onset (before age 20)

of depression, early life trauma or adverse family relations (loss of parent in childhood, sexual, physical and/or verbal abuse, neglect, and overprotection), comorbid personality disorder(s), and a large number of EMSs (identified with the Young Schema Questionnaire; Young & Brown, 1990/1994), particularly in the domains of Impaired Autonomy and Overvigilance. Young (1990/1999; Young et al., 2003) has written extensively about the schema therapy approach. Young and Klosko (1994) have published a self-help book for patients to guide them.

Beck and colleagues (1990) have noted that

schemas are difficult to alter. They are held firmly in place by behavioral, cognitive, and affective elements. The therapeutic approach must take a tripartite approach. To take a strictly cognitive approach and try to argue patients out of their distortions will not work. Having the patients abreact within the session to fantasies or recollections will not be successful by itself. A therapeutic program that addresses all three areas is essential. A patient's cognitive distortions serve as signposts that point to the schema. (p. 10)

As a result, schema therapy is significantly different from traditional CBT. It places more emphasis on early developmental patterns and origins, long-term interpersonal difficulties, the patient-therapist relationship, and emotive or experiential exercises.

Case Study of Barbara

The second case study demonstrates the use of schema therapy with a chronically depressed patient. We shifted to schema therapy because Barbara's depression was not lifting with standard cognitive therapy. Although Barbara had learned how to challenge automatic thoughts with rational responses and had followed through on graded behavioral assignments to test her thoughts, she never believed the rational responses. Barbara had remained convinced that she was worthless, useless, and hopeless. Additionally, many of the behavioral assignments presented "catch-22" scenarios within her current life situation. It was necessary to add various emotive and experiential techniques that are part of schema therapy to access Barbara's core beliefs. Core beliefs are the cognitive components of schemas. Schemas are deeply held emotionally based beliefs or EMSs that are unquestioningly experienced as