Cognitive Therapy and Research, Vol. 27, No. 1, February 2003 (© 2003), pp. 53–69

Cognitive–Behavior Therapy: Reflections on the Evolution of a Therapeutic Orientation

Marvin R. Goldfried[1]

This article presents an account of the evolution of cognitive–behavior therapy over the past 35 years, which began with the introduction of cognition into behavior therapy in the mid-1960s. As cognitive–behavior therapists became more experienced clinically and recognized that clients did not always engage in clearly reportable internal dialogues, the schema construct was used to understand more about clients' implicit meaning structures. It is noted that self-schemas play a particularly important role in understanding how therapeutic change can be undermined, and clinical guidelines are offered to deal with this dilemma. The distinction between cognitive–behavior therapy and cognitive therapy is discussed, and the importance of activating emotional experiencing in the clinical change process is underscored.

KEY WORDS: behavior therapy; cognitive therapy; cognitive–behavior therapy; schema; emotion; psychotherapy; psychotherapy integration.

It is both an honor and a pleasure to have been asked to contribute to this 25th anniversary issue of *Cognitive Therapy and Research*. As a participant-observer over the past 35 years in the incorporation of cognition into behavior therapy, I was fortunate to have been involved in an important movement that has dramatically advanced the field of psychotherapy. In contrast to the prevailing zeitgeist of the 1970s, we no longer need to make a case for the use of cognitive conceptualizations in the practice of behavior therapy. Indeed, as indicated in a survey by Craighead (1990), more than two thirds of those belonging to the Association for the Advancement of Behavior Therapy (AABT) identify themselves as "cognitive–behavior therapists."

Rather than providing a comprehensive history of the development of cognitive–behavior therapy over the years—excellent reviews of this can be found in Arnkoff and Glass (1992) and Glass and Arnkoff (1992)—my comments focus more on a personal view of the evolution of cognitive–behavior therapy. I begin with the mid-1960s, when a group of behavior therapists came to recognize that cognition might play an important role in understanding and changing human behavior. This eventually

[1]Psychology Department, State University of New York, Stony Brook, New York 11794-2500; e-mail: marvin.goldfried@sunysb.edu.

0147-5916/03/0200-0053/0

developed into a more sophisticated linking of cognitive science with clinical work. Some of the implications of this transition are discussed, including how self-schemas may interfere with the processing of therapeutic change and what can be done to overcome this natural cognitive bias. The distinction between cognitive–behavior therapy and cognitive therapy—which often goes unrecognized—is discussed, and the work on emotional experiencing is presented as providing us with a new challenge for enhancing the effectiveness of cognitive–behavior therapy.

FROM BEHAVIOR THERAPY TO COGNITIVE–BEHAVIOR THERAPY

Behavior therapy was not introduced into the field until the late 1950s, and consequently most of what I learned in graduate school was psychodynamic in nature. I became involved in behavior therapy in the 1960s, when I joined the faculty at Stony Brook and participated in the development of a clinical training program that was to be based on principles of learning. The assumption was that by extrapolating from basic research findings to the clinical situation, our assessment and intervention procedures would be empirically informed, and consequently would be more likely to be effective clinically.

Very soon after arriving at Stony Brook, I came across an article published in the *Psychological Bulletin* that offered a thought-provoking evaluation of behavior therapy, criticizing the fact that the extrapolation of learning principles was based solely on operant and classical conditioning (Breger & McGaugh, 1965). The authors argued that cognitive learning theory and research had been overlooked, causing behavior therapy to be shortsighted in its approach. My own immediate reactions, and those of my colleagues, were quite negative. In re-reading the marginal notes I made at the time in my copy of the article, I viewed this as an attempt to place the work of Tolman on an equal par with that of Pavlov and Skinner—which I learned in graduate school was not at all the case. I later came to recognize that the authors were arguing for the incorporation of the newly emerging field of cognitive psychology into behavior therapy. At the time, however, I lacked the appropriate schema for processing their contradictory information.

Several of us at Stony Brook eventually began to recognize the need to incorporate cognition into behavior therapy, and we organized a symposium that was presented at the 1968 American Psychological Association convention. The participants were Gerald C. Davison, Thomas J. D'Zurilla, Gordon L. Paul, Stuart Valins, and myself. As a counterpoint to the behavioral perspective that was presented, Louis Breger—the senior author of the landmark 1965 article noted above—served as discussant. The purpose of this symposium, which was to argue for the integration of cognitive constructs into behavior therapy, was stated as follows:

> The predominant conceptualization of the "Behavior Therapies" as conditioning techniques involving little or no cognitive influence on behavior change is questioned. It is suggested that current procedures should be modified and new procedures developed to capitalize upon the human organism's unique capacity for cognitive control.

Cognitive psychology was very much in its formative stages in the 1960s, and the primary impetus for the development of cognitive methods in behavior therapy was

based primarily on clinical need and experience, together with the newly emerging contributions to the cognitive literature by Bandura (1969), Mischel (1968), and Peterson (1968).

The introduction of cognitive constructs in behavior therapy represented a major conceptual and methodological shift. Based on the original assumption that behavior therapy had its foundation in classical and operant conditioning, the focus was on that which could be readily observed. Hence it was characterized by a simple stimulus-response (S-R) model for classical conditioning, and a stimulus-response-consequence (S-R-C) model for operant conditioning. Within the shift to a cognitive–behavioral orientation, the model was expanded to that of stimulus-organism-response-consequence—S-O-R-C.

Bergin (1970), in the inaugural issue of the journal *Behavior Therapy*, saw the far-reaching significance in the growing attempts to incorporate cognitive procedures into behavior therapy:

> The sociological and historical importance of the movement should not be underestimated, for it has three important consequences. It significantly reduces barriers to progress due to narrow school allegiances, it brings the energies of a highly talented and experimentally sophisticated group to bear upon the intricate and often baffling problems of objectifying and managing the subjective, and it underscores the notion in that a pure behavior therapy does not exist. (Bergin, 1970, p. 207)

Bergin's insight into the implications of introducing cognitive variables into behavior therapy was most accurate, and many of the behavior therapists involved in the early cognitive–behavioral therapy movement—such as Davison, Goldfried, Lazarus, Mahoney, and Meichenbaum—later developed a more general interest in psychotherapy integration.

FROM SELF-STATEMENTS TO MEANING STRUCTURES

As behavior therapists became more clinically experienced in the use of cognitive procedures, it soon became evident that the early notion of cognition as involving what patients "told themselves" did not always depict what was actually going on. Although there were instances where patients did engage in a clear "internal dialogue," it was often the case that their problematic emotions and behaviors were not so much a function of what they were deliberately saying to themselves, but rather their more implicit *meaning structures* that were associated with events, people, and situations. They might not always be able to report their internal dialogue, but they were reacting emotionally, cognitively, and behaviorally "as if" they were saying certain things to themselves.

In order to understand this phenomenon without making use of the psychodynamic construct of an unconscious, cognitive–behavior therapists adopted the information-processing model used within cognitive psychology. Cognitive science postulated that the processes associated with encoding, storing, and retrieving information may not always be in an individual's awareness. Moreover, these processes may reflect distortions resulting from selective attention, inaccurate classification of events, idiosyncratic storage of information, and/or incorrect retrieval from memory.

It matched what was being observed clinically, and it had its roots in basic research; a perfect fit for behavior therapy.

A construct that was used to understand an individual's meaning structure and the accompanying distortion process was the "schema," which had important implications for assessing and changing problematic functioning (Goldfried & Robins, 1982, 1983; Landau & Goldfried, 1981). A schema has typically been defined as a cognitive representation of individuals' past experiences with other people, situations, and themselves, which helps them construe events within that particular aspect of their life. Much like a template that allows one to detect certain information and ignore others, a schema guides the organization of life events. If one thinks of a schema as providing a roadmap for life, it possesses some definite advantages, such as facilitating recognition, learning, comprehension, and recall of information that is schema-relevant. By organizing information into larger, more meaningful units—meaning structures—we have clear guidelines for navigating the world around us. However, because these meaning structures are based on past experiences, they may no longer be relevant to our current situation. When that happens, problems are likely to arise.

SELF-SCHEMAS AND THE PROCESSING OF THERAPEUTIC CHANGE

Schemas that individuals have about themselves play an important role in the processing of information. When applied to oneself, schemas have been described as "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of the self-related information contained in an individual's social experience" (Markus, 1977, p. 63). As is the case with schemas in general, self-schemas are used to help us to navigate our interactions with the world and others. In organizing and attempting to make sense of the way things are, schemas often lead us to selectively attend to certain information and ignore others. Because self-schemas are based on past experience, and because they function as templates that tend to confirm expectancies based on these past experiences, they are resistant to new information that may be counter-schematic in nature. As suggested earlier, although an individual's self-schema may have served as a useful guideline for past interactions, it may no longer be accurate. Within the clinical context, it often takes the form of a self-deprecatory schema that is associated with such problems as anxiety, depression, unassertiveness, and other problematic aspects of functioning.

A specific aspect of individuals' self-schemas is their sense of self-efficacy. Bandura (1986) has defined self-efficacy as an individual's expectation that he or she is capable of behaving in such a way as to produce certain desired outcomes. It is somewhat similar to the notion of self-confidence, except that it refers to beliefs that occur in the context of specific situations. What is particularly relevant to therapy and the change process is the finding that self-efficacy is a better predictor of future behavior than is past behavior (Bandura, 1986). However, because self-schemas are more likely to process schema-consistent information, clients are likely to have difficulty in encoding, storing, and retrieving their new, counter-schematic therapeutic success experiences. Thus, although symptomatic improvement or behavior change

may temporarily result from therapy, if we hope to produce therapeutic change that is lasting, it becomes particularly important to also change the client's sense of self-efficacy.

In a book entitled *Misunderstandings of the Self*, Raimy (1975) provides a scholarly account of how various forms of therapy have addressed clients' cognitive distortions about themselves and their abilities. Quite consistent with the work of Beck and his associates (Beck, Rush, Shaw, & Emery, 1979), Raimy maintains that an important function of the therapist is to "present evidence" to help clients change the misconceptions they have of themselves. This may be accomplished in a number of different ways, including explanation by the therapist (e.g., confrontation, interpretation), self-examination (e.g., introspection, self-monitoring), modeling (e.g., observing a model who achieves positive consequences for behaving differently), and direct experience (e.g., homework, risk-taking). Regardless of the method that is used, explains Raimy, clients need a "cognitive review" to process this new information. Thus, "For an individual to change a concept of any kind, he must ordinarily be afforded opportunities to examine and reexamine all available evidence that is relevant to the concept . . .. Complex misconceptions in psychotherapy rarely yield to a single examination of the pertinent evidence" (Raimy, 1975, p. 61).

In order to override the natural tendency to maintain negative self-schemas in the face of contradictory evidence—and thereby eventually update self-schemas so that change will be maintained over time—Goldfried and Robins (1983) have offered the following therapeutic guidelines: (1) facilitate new behaviors/experiences; (2) assist clients in discriminating between present and past functioning; (3) encourage clients to view their changes from both an objective and subjective vantage point; (4) help clients retrieve their recent success experiences; and (5) align clients' expectancies, anticipatory feelings, behaviors, consequences, and subsequent self-evaluations. Depending on the particular case at hand, these different strategies will need to receive more or less emphasis.

Facilitating New Behaviors/Experiences

From within a cognitive–behavioral orientation, one of the key components of therapeutic change involves the facilitation of new behaviors. Indeed, this is true of other orientations, which have described the encouragement of new experiences as being central to the change process. In the results of a survey of therapists representing different schools of thought that was published in special issue of *Cognitive Therapy and Research*, new experiences were described as being "critical," "basic," "crucial," and "essential" to therapeutic change (Brady et al., 1980). In order to facilitate these novel experiences, such behavioral procedures as contracting, therapist encouragement of exposure and risk-taking, behavior rehearsal, modeling, relaxation, and the use of coping self-statements have been shown to be effective (Goldfried & Davison, 1976, 1994).

Discriminating Between Present and Past

As noted above, because clients are more likely to detect information that is schema-consistent (e.g., doing badly in a given situation), new and more effective

ways of functioning are likely to go unnoticed. Clients may not fully notice that they are behaving more effectively, may "yes-but" away their improvements, and/or may forget them at a later time. So as to ensure that clients actually "use" these corrective experiences to update their self-schemas, therapists need to highlight the fact that a therapeutic step—however small—has been taken. One way to accomplish this is by having clients compare how they currently reacted with how they would have reacted in the past. Comparing present to past is particularly useful, in that clients' "yes-buts" often refer to the fact a change is only a small step (e.g., "Yes, but I have so much more to do"); that change occurred in only one aspect of their life ("Yes, but I can't do that in other situations"); and that they still do not compare favorably with others ("Yes, but I can't do it as well as some other people"). This metric of acknowledging change by comparing their new reaction with how they would have reacted to comparable situations in the past is illustrated in the following transcript:

Client: I was able to tell my boss that I didn't want to work late on Thursday. It worked out fine and I really felt I handled the situation nicely.

Therapist: I'm glad to hear that. What was the situation and how did you handle it?

Client: It was pretty much the same as always. She asked me Thursday after lunch if I could stay late and finish up some work that had to be ready by the end of the week. I told her that I really couldn't do it, because I had some things that I had to do after work.

Therapist: How did you say it?

Client: In a very matter-of-fact way. I really didn't feel annoyed, so it really wasn't all that hard for me.

Therapist: Sounds good. I think it would be important if we compared how you handled this particular situation with how you typically responded in the past—say, 6 months ago.

Client: Oh, I handled it much better.

Therapist: It certainly seems so. What specifically might you have said in the past?

Client: I would have agreed to stay late, and then felt real angry at myself for doing so.

Therapist: So when this situation occurred in the past, you wouldn't say what you really wanted to say, and then would have felt badly, whereas now you spoke up, and felt good about it.

Client: That's right. And you know something . . . it really worked out okay. I mean, she didn't get angry or anything, and I told her that if I wasn't able to finish the work by Friday, I would stay a little bit later. As it turned out, I got it done in plenty of time (Goldfried & Robins, 1983, p. 80).

Adding an Objective Vantage Point to the Client's Subjective Outlook

Inasmuch as clients' views of themselves (and others) are often schema-based and at times inaccurate, it is important to help them become observers as well as participants in their lives. This is especially the case when they are in the process of undergoing change, where there exists a discrepancy between the way they view

their functioning (i.e., schema-based and often general) as compared to the way they are actually functioning (i.e., data-based and specific). There are a number of different ways in which clients can be helped to see this discrepancy, such as through the therapist's efforts (e.g., pointing out the disparity) or helping them to recognize it themselves (e.g., through self-monitoring). The following transcript, which is a continuation of the one presented above, illustrates how this may be done:

Client: I just feel that I'm always being taken advantage of, and get caught up in things that I really dislike.

Therapist: Such as?

Client: Like at work, I always seem to end up with the dirty work. When I look at other people, they don't seem to have the same problems. Like Lisa, for example . . . she handles herself much better than I ever can.

Therapist: What can she do that you can't?

Client: Well, she's not overburdened the way I am. She doesn't let other people take advantage of her.

Therapist: Can you give me some examples?

Client: If the boss comes in and there's extra work to be done, and she feels she's too busy with what she has to do, she's able to say something about it. I always go along with it.

Therapist: So like Lisa, you'd like to be better able to refuse to do extra work when it's inconvenient for you.

Client: Yes.

Therapist: Such as telling your boss that it's inconvenient for you to work late on given day?

Client: (*visibly embarrassed*): Uh . . . Well . . . But that was different.

Therapist: How so?

Client: (*Pause*) I see what you're getting at. I guess it's just hard for me to see myself that way. But it's true; I *was* able to stand up for my rights in that situation (Goldfried & Robins, 1983, p. 62).

Retrieving Past Successes

In order for clients to update their self-schemas and have more of a sense of positive self-efficacy for behaving effectively, they need to have ready access to their newly emerging competent behavior patterns. However, because their personal histories are likely to have been made up of less than effective functioning, their new patterns may be viewed the exception, not the rule. Thus their schema-based expectations are likely to be used in how they estimate their self-efficacy, rather than their less accessible, more recently acquired data-based competencies.

It is important for therapists to discuss this natural tendency to "forget" their recent, more competent experiences, and that steps need to be taken to overcome this very human cognitive bias. One such method is the use of self-monitoring, so

that therapeutic success experiences can be "stored" and used as a basis for making future self-efficacy predictions—as opposed to predictions made on the basis of anachronistic schemas. This record-keeping can be supplemented by the therapist's encouragement to use their recent success experiences as a basis for future responding. This is illustrated in the following transcript:

Therapist: Because you've had difficulty in asserting yourself for so long in the past, it's sometimes hard to keep in mind the changes that have been happening to you.

Client: I know. And it feels kind of different, almost as if it's not me that's doing it.

Therapist: That's certainly a natural part of the change process, which will probably continue until you start to build up more of a backlog of positive experiences. With each new situation you handle well, it should get a little bit easier. As a way of helping you to change, it's also important for you to remember the successes you have had.

Client: I do think of them sometimes.

Therapist: That's good, because there *is* a natural tendency to think of the more typical way you've reacted in the past—which is to *not* assert yourself—and that's why it's so important for you to really focus in on what seems to be a new pattern of handling situations on your part.

Client: Yes.

Therapist: In fact, when you think about your past successes, it can often help you to continue along those lines in the future. For example, when you finally speak to that friend of yours who is always showing up late, you might keep in mind successful instances of assertiveness you've experienced in the past. Before speaking to this friend, you might say to yourself something like: "I was able to say what was on my mind in these past situations, and I can do the same here as well." It doesn't have to be in those exact words; any way that you can remind yourself of past successes will help you in new situations where you want to stand up for your rights (Goldfried & Robins, 1983, pp. 64–65).

Aligning Expectancies, Feelings, Intentions, Behavior, Consequences, and Self-Evaluation

During therapeutic change, there typically exist inconsistencies in clients' thoughts, feelings, intentions, actions, consequences, and self-evaluations. For example, clients may be able to behave effectively, even though they initially expected to fail. Or they may function effectively, but not give themselves credit for their efficacious behavior. In making predictions for how they are likely to handle a given situation, clients often base their prediction on their pessimistic expectations or their anticipatory fears, and not their behavioral effectiveness in similar situations in the recent past. Given the fact that negative thoughts and feelings are more intense and immediate than are past actions, and also because they are more "representative" of past reactions (Kahneman & Tversky, 1973), this is to be expected. Clients need to be aware of this potential bias in making their predictions, as well as the difficulty in giving themselves credit for their efficacious behavior. How this can be done

clinically is illustrated in the following example:

Therapist: Immediately before you told your boss that you couldn't work late that evening, what thoughts ran through your head?

Client: I don't know, it all happened so fast. I didn't want to stay late, but I didn't think I could do anything about it. I was really nervous.

Therapist: And some of your fears were . . .?

Client: I was afraid my boss would get angry at me, that she would think I was not interested in my job. I didn't think that she would fire me or anything like that, but rather that she'd be annoyed at me.

Therapist: And despite these thoughts, you nonetheless decided to say something. What did you say to yourself that helped you to do that?

Client: That I worked hard all day, and that I really had other things to do.

Therapist: But these are thoughts you've had in past instances, where you *didn't* assert yourself. What did you think differently this time?

Client: Well, I had a fleeting thought that maybe I was being unrealistic. I also thought that I no longer want to always go along with what other people want, especially when it's not good for me.

Therapist: And your feelings right before you said anything?

Client: I was scared and nervous, but I spoke up anyway.

Therapist: And your response itself?

Client: It was straightforward and very matter-of-fact, even though inside I was shaking in my boots.

Therapist: And your boss's reaction?

Client: It wasn't really bad at all. In fact, she was even a little bit apologetic about having asked me. As I mentioned to you earlier, everything worked out okay anyway.

Therapist: Right. And how did you feel after it was all over?

Client: Well, I was certainly relieved. Nothing terrible happened; in fact, it turned out just fine.

Therapist: And how did you feel about *yourself*?

Client: Okay, I guess.

Therapist: You don't sound all that positive about this experience. If you had to evaluate yourself on a 1 to 5 scale, with 5 being most satisfied with yourself and 1 being least, how would you rate yourself?

Client: (*Pause*) About a 3.

Therapist: What would you have to have done differently to have given yourself a 5?

Client: (*Pause*) I guess I would give myself a 5 if I didn't have this problem to begin with!

Therapist: But if we focus in on how you felt about your response to this *particular situation*, what would you have to do differently to give yourself a 5?

Client: (*Pause*) I don't know that I really could have done anything *any* differently. I guess it's just difficult for me to fully accept the fact that I handled it well. It's difficult for me to see myself in that way.

Therapist: I can understand that. But aren't you being overly harsh on yourself? At least in that situation?

Client: When you put it that way, I guess I am. I guess I *did* handle that situation fairly well.

Therapist: I think it's important for you to be really clear about what went on and how you handled it. If we step back and look at what went on, we have the following: You started off by thinking you couldn't do anything about the situation, for fear that something negative would happen. You were nervous, but still were able to talk yourself into speaking up. What you said certainly sounded appropriate, and was well received by your boss. The payoff was good, in that things turned out well.

Client: Right.

Therapist: There is a second payoff that you need to recognize as well, and that is that you have every right to feel good about yourself in that situation.

Client: I see what you're saying. In fact, I did feel proud of myself at the time.

Therapist: I think it's real important for you to hold onto this experience. Although it's only one small instance, it nonetheless can provide you with a good turning point, or something that you can fall back on in the future. Next time you're in a situation where you're afraid that you can't speak up, or that something negative will happen if you say anything, and where you also feel yourself apprehensive about doing so, think back about how these very same thoughts and feelings occurred in this situation, how you were able to overcome them, and how things worked out well. It will probably take a number of such instances before you start to feel more self-confident about your ability to stand up for you own rights, but if you continue as you have, there's every reason to believe you'll eventually get there (Goldfried & Robins, 1983, pp. 66–68).

In processing therapeutic successes in this manner, the acronym STAIRCASE can prove to be useful for both therapist and client in focusing on different aspects of the client's reaction to a specific situation. It refers to **S**ituation, **T**hought, **A**ffect, **I**ntention, **R**esponse, **C**onsequence, and **S**elf-**E**valuation. The STAIRCASE acronym may be seen as an update of the S-O-R-C (stimulus-organism-response-consequence) model mentioned earlier in this article. In addition to helping the client process success experiences, STAIRCASE can be clinically useful in conducting a comprehensive cognitive–behavioral assessment and case formulation (Goldfried, 1995). However, when used by the therapist as a guideline in processing clients' therapeutic success experiences—as indicated in the above transcript—or used by clients to monitor their own reactions (see Fig. 1), it serves to increase the likelihood that clients will more fully benefit from their new experience. With the accumulation of such success experiences, and the processing of them in this manner, the goal is to align each aspect of the client's functioning as much as possible, so that a new pattern of functioning and a more positive self-schema emerges.

SITUATION
THOUGHT
AFFECT
INTENTION
RESPONSE
CONSEQUENCE
and
SELF-EVALUATION

SITUATION: Describe the situation.

THOUGHTS: Before responding.
Unrealistic Thoughts:

Realistic Reevaluation:

AFFECT: Feelings before responding.

INTENTION: What I want to accomplish in this situation.

RESPONSE: Actual behavior in situation.

CONSEQUENCES: The consequences of my action.

---

and SELF-EVALUATION: How pleased I was with how I handled the situation (Circle one)

0	1	2	3	4
Not at all	Just a little	Somewhat	Quite a bit	Very much so

How might I do things differently to improve my reaction in the future

Fig. 1. Form for monitoring a client's cognitive, affective, intentional, and behavioral reaction to a life situation.

COGNITIVE–BEHAVIOR THERAPY VERSUS COGNITIVE THERAPY

In discussing how therapeutic change may be processed, I have placed most of the emphasis on cognitive factors. However, it is important not to lose sight of the fact that what is being processed consists of new, corrective experiences. Moreover, in cognitive–behavior therapy, these newly acquired experiences are likely to have been facilitated by one or a number of behavioral interventions (e.g., the use of behavior rehearsal for purposes of assertiveness training). And while there are points of similarity between cognitive–behavior therapy and cognitive therapy, the two are different in both their tradition and methods (Hollon & Beck, 1986). As noted earlier, cognitive–behavior therapy developed by the incorporation of cognitive factors into behavior therapy, and had as its foundation the behavioral/social learning model as described by Bandura, Davison, Goldfried, Lazarus, Mahoney, Meichenbaum, Mischel, and Peterson. Cognitive therapy, on the other hand, grew out of the pioneering work of Beck (1967) on the role of cognition in depression. This failure to make a distinction between cognitive–behavior therapy and cognitive therapy has characterized the field for several years, and began when cognitive therapy was inaccurately labeled as "cognitive–behavior therapy" in the description of the NIMH collaborate study for the treatment of depression (Elkin, Parloff, Hadley, & Autry, 1985). Since that time, cognitive therapy has erroneously been labeled as cognitive–behavior therapy.

One of the differences between cognitive–behavior therapy and cognitive therapy is illustrated in a process analysis of a demonstration therapy session conducted by Beck (cognitive therapy), Meichenbaum (cognitive–behavior therapy), and Strupp (psychodynamic therapy) with the same client—Richard (Goldsamt, Goldfried, Hayes, & Kerr, 1992). As presented to each of the three therapists, Richard had become depressed following the breakup of his marriage. The process analysis of their interventions revealed that all three therapists were similar in some respects, such as in their comparable focus on the impact that others made on Richard (e.g., "Richard, how did you feel when your wife said that to you?"). However, Meichenbaum differed from Beck—but was similar to Strupp—by placing a greater emphasis on the impact that Richard was having on others. This was done by asking such questions as "Richard, do you think you might have done something to contribute to the problems in your relationship?" and "What might you have done to make your wife angry at you?" Thus, in Beck's cognitive therapy, Richard's depression was construed as being the result of the way he interpreted the reactions of others. Although both Meichenbaum and Strupp focused on this as well, they additionally paid attention to Richard's behavior, and the possibility that he may have done things that resulted in the negative reactions he was receiving from others. This tendency for cognitive therapy to pay more attention to the impact that other people make on the client and less to the impact the client makes on others has similarly been found in a process analysis of cognitive therapy for depression (Castonguay, Hayes, Goldfried, & DeRubeis, 1995).

In our eagerness to explore the important impact that cognition has on emotion and behavior, we seem to have lost sight of the important role that behavior and corrective experiences can play in both assessment and treatment. Without negating

the importance of cognitive mediators and moderators, I believe that we need to broaden our perspective. For example, in providing a cognitive–behavioral analysis of depression, Goldfried and Davison (1976) have suggested that depression may be the result of "*a perceived absence of any contingency between the person's own efforts and the reinforcing nature of the consequences that follow?*" (p. 234). In this conceptualization, clinical assessment and intervention would need to focus on cognition ("perceived absence of any contingency"), behavior ("person's own efforts"), and impact ("consequences that follow"). Thus, individuals may become depressed because they misperceive their ability to make an impact on their world, because they lack the ability to do so, and/or because they are in a life circumstance that is not responsive to their—or anyone's—efforts. From a purely cognitive point of view, the focus would be on reevaluating the client's interpretation of another person's behavior (e.g., "She doesn't love me, and the reason is because I'm unlovable"), perhaps by reattributing the motive for the other person's behavior or reevaluating the implication it has for the client's self-worth. Although cognitive–behavior therapists might consider this as a viable formulation, they would also entertain the possibility that the client may be behaving in ways that result in the other person's withdrawal of affection. Sometimes people don't get what they want or need because they do not know how to ask for it. When this occurs, a more behavioral intervention would be in order.

An important intervention that is frequently used by practicing cognitive–behavior therapists is assertiveness training, whereby clients learn to express what they need, feel, and believe. Once clients move from being passive and helpless victims of their life circumstances and learn to become more empowered, they typically experience themselves as being "confident," "strong," and "centered." McCullough (2000), who has developed a cognitive–behavioral approach to the treatment of chronic depression that places an important emphasis on assertiveness, reports having observed this very same phenomenon. What such assertiveness may be facilitating is the "corrective experience," which many therapists believe to be the very core of the therapeutic change process (Brady et al., 1980).

The corrective experience may be thought of as involving a cognitive–affective–intentional–behavioral sequence comprised of the following elements: (1) clients have fearful expectations that it is dangerous for them to say or do something in a given situation; (2) there is an intellectual appreciation that the anticipatory fear may not be realistic; (3) there is a desire to take the risk in saying or doing something that he or she wants; (4) the clients actually take the risk; (5) there is both relief and surprise that their worst fears did not occur; (6) there is a feeling of personal empowerment, in contrast to the self-recrimination that typically accompanies avoidance and passivity; and (7) this experience is used to help reevaluate and change their maladaptive cognitive, affective, and behavioral pattern.

BEYOND COGNITIVE–BEHAVIOR THERAPY

In his presidential address to the 15th annual meeting of the Association for the Advancement of Behavior Therapy, Wilson (1982) suggested that the 1980s would

be the decade of affect in cognitive–behavior therapy. Although psychodynamic and experiential schools of thought have emphasized the importance of emotion in the therapeutic change process (Greenberg, 2002; Greenberg & Safran, 1987), this has not typically been the case with cognitive–behavior therapy. To be sure, behavior therapy has had a long tradition of dealing with emotion, but the primary focus has typically been on *reducing* symptomatic emotions. This view of emotion was revealed in a therapy process study by Wiser and Goldfried (1993), which compared segments of sessions that were identified by cognitive–behavior therapists and psychodynamic–interpersonal therapists as being clinically significant. For the cognitive–behavior therapists, the significant segments reflected a *lowering* of clients' emotional experiencing levels. By contrast, the psychodynamic-interpersonal therapists identified those portions of their sessions involving an *increase* in client experiencing as being significant.

However, there is a growing trend within cognitive–behavior therapy to recognize the therapeutic role that emotional activation can play in the change process (Samoilov & Goldfried, 2000). Although it generally has been accepted that emotions can be affected by changes in cognition (and vice versa), neuroscience has more recently found a unique pathway that can directly activate emotional reactions (LeDoux, 1996). Specifically, research by LeDoux has revealed a neural pathway that leads directly from the thalamus to the amygdala—the "emotional brain"—which allows the amygdala to receive direct input from sensory organs and to initiate reactions before the information is registered by the neurocortex. According to LeDoux, signals that have higher emotional significance are more likely to be responded to by the amygdala. Thus, events that are highly emotional are registered at subcortical—emotional—as well as cortical or thinking levels. This work has direct implications for psychotherapy: In order to restructure emotionally laden meaning structures, interventions must target not only cortical, but also subcortical levels.

Cognitive science and experimental psychology have similarly found personal meaning to be linked to emotion, and have emphasized the importance of implicit meaning structures in the process of change (Greenberg, 2002; Samoilov & Goldfried, 2000). For example, two different types of knowledge have been described: One has been "explicit" knowledge, which involves the rational, logical knowledge system, and the other involves "implicit" knowledge, an emotional-affective knowledge system. Whereas the explicit or logical processing may influence rational judgments, the implicit or tacit processing, by contrast, is closely linked to emotion and is considered primary in changing global experiential states. Moreover, implicit meaning, together with its emotional overtones, is often evoked by sensory input, such as familiar smells and sounds (Teasdale & Barnard, 1993).

As I have described elsewhere, the role that sensory input can play in eliciting emotion and tacit meaning structures is vividly illustrated in an experience I had not too long ago when visiting Auschwitz and other concentration camps. It was a highly emotional experience, seeing the camps and viewing films of how people were transported there. When the time came for me to leave Poland, I was unable to locate the train car in which my compartment was located. The train station was very crowded, and no one spoke English well enough to help me. Following directions to walk toward the front of the train, I eventually found myself at the end of the platform,

where my luggage fell off the cart and scattered off the platform. At that moment, the whistle blew, the train started to move, and I experienced an overwhelming sense of helplessness and panic. It was at that point in time that I was convinced I was being transported to a concentration camp! Even though I intellectually knew that the train was really going to Prague, emotionally I felt as if I was being shipped off to a camp.

Inasmuch as many clinical problems involve emotionally induced implicit meaning structures, it would seem that cognitive–behavior therapy could enhance its effectiveness by making use of interventions that involve a focus not solely on cognition and behavior, but also by using methods that serve to enhance emotional experiencing. Although appealing to reason and logic may be useful in counteracting irrational cold cognitions, changing implicit meaning structures may require a reevaluation that occurs in the context of emotional arousal. The contributions of experiential therapy would be particularly useful for this purpose, a suggestion that has been discussed in greater detail elsewhere (Samoilov & Goldfried, 2000).

Interestingly enough, there have been some recent studies by Castonguay, Hayes, and their colleagues indicating that emotional experiencing may play an important role in cognitive therapy for depression. For example, Castonguay, Goldfried, and Hayes (1996) found that clients who manifested in-session emotional experiencing during the course of cognitive therapy were more likely to show a reduction of depressive symptoms. Hayes and Strauss (1998) similarly revealed that increases in emotional distress were positively related to symptom reduction in cognitive therapy for depression. Castonguay, Pincus, Agras, and Hines (1998) found that clients who manifested increased emotional experiencing during a course of cognitive–behavior therapy for eating disorders were more likely to benefit from the treatment. Finally, preliminary findings by Newman, Castonguay, and Molnar (in press) suggest that emotional experiencing may enhance the efficacy of cognitive–behavior therapy in the treatment of general anxiety disorder.

As we broaden the scope of behavior therapy to include cognition and emotion, it is only natural to entertain the possibility that contributions from other orientations may prove to be relevant. In marking the 25th anniversary of *Cognitive Therapy and Research*, which has helped to advance the clinical and research progress made in cognitive–behavior therapy and cognitive therapy, it is important to look ahead for new goals. Some may argue that we should endeavor to make cognitive–behavior therapy or cognitive therapy the therapy to end all therapies, with the hope that therapists from other approaches will eventually see the light. My own vision is somewhat different. The central theme that has characterized behavior therapy and cognitive–behavior therapy over the years is that of *change*. We have moved from an exclusive emphasis on behavior by adding cognition to our conceptualizations and interventions. Having lost some perspective by overemphasizing cognition, we need to revisit our behavioral roots. Moreover, there exists clinical and empirical evidence to suggest that our clinical effectiveness may be enhanced with increased emotional experiencing. Although I firmly believe that cognitive conceptualizations and interventions have made a most significant impact on the field of psychotherapy, the time has come when the contributions made by the different orientations need to be viewed as being complementary. Rather than continuing to maintain the adversarial

stance that has characterized our field for so many years, I suggest that we strive to develop a more comprehensive and integrative perspective of the therapeutic change process.

ACKNOWLEDGMENTS

The author would like to thank Louis G. Castonguay, for his helpful comments on an earlier version of this article.

REFERENCES

Arnkoff, D. B., & Glass, C. R. (1992). Cognitive therapy and psychotherapy. In D. K. Freedheim (Ed.), *The history of psychotherapy* (pp. 657–694). Washington, DC: American Psychological Association.

Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, & Winston.

Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice-Hall.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper & Row.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Bergin, A. E. (1970). Cognitive therapy and behavior therapy: Foci for a multidimensional approach to treatment. *Behavior Therapy*, *1,* 205–212.

Brady, J. P., Davison, G. C., Dewald, P. A., Egan, G., Fadiman, J., Frank, J. D., Gill, M. M., Hoffman, I., Kempler, W., Lazarus, A. A., Raimy, W., Rotter, J. B., & Strupp, H. H. (1980). Some views on effective principles of psychotherapy. *Cognitive Therapy and Research*, *4,* 269–306.

Breger, L., & McGaugh, J. L. (1965). Critique and reformulation of "learning-theory" approaches to psychotherapy and neurosis. *Psychological Bulletin*, *63,* 338–358.

Castonguay, L. G., Goldfried, M. R., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, *64,* 497–504.

Castonguay, L. G., Hayes, A. M., Goldfried, M. R., & DeRubeis, R. J. (1995). The focus of therapist interventions in cognitive therapy for depression. *Cognitive Therapy and Research*, *19,* 485–503.

Castonguay, L. G., Pincus, A. L., Agras, W. S., & Hines, C. E. (1998). The role of emotion in group cognitive–behavioral therapy for binge eating disorder: When things have to feel worse before they get better. *Psychotherapy Research*, *8,* 225–238.

Craighead, W. E. (1990). There's a place for us: All of us. *Behavior Therapy*, *21,* 3–23.

Elkin, I., Parloff, M. B., Hadley, S. W., & Autry, J. H. (1985). NIMH Treatment of Depression Collaborative Research Program: Background and research plan. *Archives of General Psychiatry*, *42,* 305–316.

Glass, C. R., & Arnkoff, D. B. (1992). Behavior therapy. In D. K. Freedheim (Ed.), The history of psychotherapy (pp. 587–628). Washington, DC : American Psychological Association.

Goldfried, M. R. (1995). Toward a common language for case formulation. *Journal of Psychotherapy Integration*, *5,* 221–244.

Goldfried, M. R., & Davison, G. C. (1976). *Clinical Behavior Therapy*. New York: Holt, Rinehart, & Winston.

Goldfried, M. R., & Davison, G. C. (1994). *Clinical Behavior Therapy* (expanded ed.). New York: Wiley-Interscience.

Goldfried, M. R., & Robins, C. (1982). On the facilitation of self-efficacy. *Cognitive Therapy and Research*, *6,* 361–379.

Goldfried, M. R., & Robins, C. (1983). Self-schema, cognitive bias, and the processing of therapeutic experiences. In P. C. Kendall (Ed.), *Advances in cognitive–behavioral research and therapy* (Vol. II, pp. 33–80). New York: Academic Press.

Goldsamt, L. A., Goldfried, M. R., Hayes, A. M., & Kerr, S. (1992). Beck, Meichenbaum, and Strupp: A comparison of three therapies on the dimension of therapist feedback. *Psychotherapy*, *29,* 167–176.

Greenberg, L. S. (2002). Integrating an emotion-focused approach to treatment into psychotherapy integration. *Journal of Psychotherapy Integration*, *12,* 154–189.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change*. New York: Guilford.

Hayes, A. M., & Strauss, J. L. (1998). Dynamic systems theory as a paradigm for the study of change in psychotherapy: An application of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, *66,* 939–947.

Hollon, S. D., & Beck, A. T., (1986). Cognitive and cognitive–behavioral therapies. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 443–482). New York: Wiley.

Kahneman, D., & Tversky, A. (1973). On the psychology of prediction. *Psychological Review*, *80,* 237–251.

Landau, R. J., & Goldfried, M. R. (1981). The assessment of semantic structure: A unifying focus in cognitive, traditional, and behavioral assessment. In S. D. Hollon & P. C. Kendall (Eds.), *Assessment strategies for cognitive–behavioral interventions*. New York: Academic Press.

LeDoux, J. E. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon and Schuster.

Markus, H. (1977). Self-schemata and processing information about the self. *Journal of Personality and Social Psychology*, *35,* 63–78.

McCullough, J. P., Jr. (2000). *Treatment for chronic depression: Cognitive behavioral analysis system of psychotherapy.* New York: Guilford.

Mischel, W. (1968). *Personality and assessment*. New York: Wiley.

Newman, M. G., Castonguay, L. G., & Molnar, C. (in press). Integrative therapy for generalized anxiety disorder. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized anxiety disorder: Advances in research and practice*. New York: Guilford.

Peterson, D. R. (1968). *The clinical study of social behavior*. New York: Appleton-Century-Crofts.

Raimy, V. (1975). *Misunderstandings of the self.* San Francisco: Jossy-Bass.

Samoilov, A., & Goldfried, M. R. (2000). Role of emotion in cognitive–behavior therapy. *Clinical Psychology: Science and Practice*, *7,* 373–385.

Teasdale, J. D., & Barnard, P. J. (1993). *Affect, cognition, and change: Re-modeling depressive thought.* Hillsdale, NJ: Erlbaum.

Wilson, G. T. (1982). Psychotherapy process and procedure: The behavioral mandate. *Behavior Therapy*, *13,* 291–312.

Wiser, S., & Goldfried, M. R. (1993). Comparative study of emotional experiencing in psychodynamic–interpersonal and cognitive–behavioral therapies. *Journal of Consulting and Clinical Psychology*, *61,* 892–895.