

Annual Reviews Conversations Presents

A Conversation with Aaron T. Beck

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Judith Beck: I'm Judith Beck, and today I'm interviewing my father, Dr. Aaron Beck. We are, respectively, the University Professor Emeritus of Psychiatry and a clinical associate professor. We're both at the University of Pennsylvania, Perelman School of Medicine, and my father is the president emeritus and I am the president of the Beck Institute for Cognitive Behavior Therapy in Philadelphia.

We have a number of questions that span your career's work. How did you get into psychiatry?

Aaron Beck: That's a story of a big flip-flop. When I was in medical school, I was really turned off by psychiatry. The chairman of psychiatry at that time had been a student of [Emil] Kraepelin, and he saw psychiatric patients as falling into one of two categories: Either they were psychotic, or they had psychopathic personality disorder—psychopathic personality is what he called that—and neither were treatable. So that wasn't a very favorable introduction to somebody who wanted to actually help people.

There was, I believe, one psychoanalyst on the staff who did some teaching, and the way he talked was so esoteric I really could not

understand him. So when it came time for me to write an essay as part of my clinical clerkship on psychiatric patients, I really wasn't able to do it and I had some kind of a mental block, so one of my friends, Marty Gordon, actually helped me to write the paper.

I then went through my internship, and I really could not see much value to psychiatry, at least the way it was presented in those days, but I was very much interested in neurology. The thing that attracted me to neurology was, in a sense, [that] it was so scientific: You could locate a very precise area in the brain that could account for a whole multitude of neurological symptoms. I found that very interesting and very engaging, so I decided to do my residency in neurology. I had two years of neurology and it worked out very nicely, and I was planning to have a whole career as a neurologist—maybe do some teaching and some research, as well as clinical practice.

Then the chief of neuropsychiatry decided that all neurology residents should take a six-month rotation through psychiatry. I fought it, but he said, "You have to do it," and the reason was that they were short of psychiatric residents at the time, so I said, "Okay." I did my six months and I thought, "Geez, I've invested a whole six months here and I really don't have any kind of grip as to what psychiatry is about or what it has to offer."

I remember at times I would be doing group therapy with a group of psychotic patients, and I really had no idea of what to do with them. They would just be sitting around there. Some would be talking continuously, and the others would be zonked out, and so on. But I had several friends there who really were very involved, very passionate about psychiatry. I ran it by them and they said, "Well, why don't you take another six months?" So instead of going back to neurology, I spent another six months, and at the end of that time I decided, "Well, maybe I'll go back to neurology. I just don't dig psychiatry," and one of my good friends said, "You know, your big reason—the reason you can't really understand what's going on is you haven't been analyzed."

I said, "What does that have to do with it?" He said, "You have these kinds of personality problems, and when you're with these psychiatric patients, they stir up all kinds of unconscious conflicts. That's why psychiatry is so aversive to you, because it is bubbling all over and you get into all your defenses and the defenses prevent you from really understanding what's going on." So I said, "As long as I've invested six months, I'll take a leave of absence from neurology and I'll try to find out more about psychoanalysis."

I then went to the Austen Riggs Center in Stockbridge, Massachusetts. I did not get analyzed there, but it was kind of an analytic atmosphere, and it began to dawn on me that psychoanalysis really did have the answer not only to neuroses but to all kinds of human problems: War and peace and even medical problems like cancer could be due to some kind of psychodynamic conflict that people had.

When I came to Philadelphia, I decided to get analyzed. I went through my whole analysis, and at the end of the analysis I thought, "Well, psychoanalysis is really okay, and it really does have an awful lot of answers," but I didn't like the psychoanalytic establishment. I thought they were very arbitrary, and they were very ritualistic, and it was a little bit like a religion. In fact, I applied for accreditation by the American Psychoanalytic Society, having already gotten my credentials as an analyst. I got turned down twice. The first time was because I hadn't been analyzed long enough; I'd been analyzed for only two years, and they didn't like that. Then I had had four cases in analysis, but they all got better within a year, and they thought that I really was not really imbued with the whole psychoanalytic ethos, so they turned me down a second time.

Anyhow, I still stayed in the field of psychoanalytic therapy for awhile, but that was my transition from neurology to psychiatry, and they still probably have me on the books in Boston as being on a leave of absence.

Judith Beck: How did you move from psychiatry to cognitive therapy?

Aaron Beck: I moved from being a committed psychoanalyst to being an uncommitted psychoanalyst to being something nebulous to being a cognitive therapist. There were a series of stages, and basically it was due to a number of very surprising incidents that took place. When I finished my analysis—

Judith Beck: This was the late 1950s you're talking about?

Aaron Beck: Yes. In the very late 1950s I had finished my analysis, and I was interested in depression for a couple of reasons. One is: I had a lot of patients who were depressed, so I was interested in just being able to treat them as well as I could. And second, I was very much interested in evaluating the whole psychoanalytic notion of depression, and at that particular time there were two schools of thought in psychology. One believed in psychoanalysis, and the more academically oriented psychologists were really quite skeptical about psychoanalysis.

I thought that if I could do some good, solid research on some of the psychoanalytic hypotheses, this could help to persuade the very skeptical academic psychologists that there was something to it. The psychoanalysts didn't need any persuasion; they already were committed.

It's just reminded me of a story one of my friends told me: He had done some tests of psychoanalytic theory, and it turned out that Freud's notion, according to his testing, was correct. He said, "Should I write to Dr. Freud and tell him that I've now confirmed one of his theories?" He asked one of his friends about this, and the friend said, "Well, telling Freud this would be like telling the pope that you now have evidence on the existence of the trinity."

Judith Beck: Interesting.

Aaron Beck: But I was not deterred by this, and I thought it would be really very useful for society to be able to have some confirmation of the psychoanalytic theory. Depression was a very good topic to research, and the reason for this is that the theory was very clear cut. According to the psychoanalytic theory, people have a lot of hostility, for some reason or another, but the hostility is not acceptable to them and so they repress the hostility. When it gets repressed, it runs against this barrier of defense mechanisms and it then gets deflected inwardly, something that we call the theory of retroflected hostility. When the hostility gets reflected inwardly, it then is manifested in a whole series of symptoms. One of the symptoms, obviously, is that the person is very self-critical; they feel very bad about themselves, and even in the more ultimate phase, they might even become suicidal and want to commit suicide. This is all due to hostility against the self. It made very good sense clinically, but the big problem was there was no independent evidence to support this.

So I thought that I would do some research to try to support it, and where to look for support became the question. It occurred to me that if I could look at the dreams of my depressed patients and compare these with the dreams of nondepressed patients, I could look for the evidence of hostility in the dreams and I could then get into the unconscious. As you know, dreams are the royal road to the unconscious.

I worked with a psychology graduate student by the name of Marvin Hurvich. We prepared a manual for grading the hostility in the dreams, and we went through the usual scientific comparisons and statistical analyses and so on, and looked at the dreams of the depressed patients. After we did all the analyses, to my surprise—that was surprise number one—the dreams of the

depressed patients showed less hostility than the dreams of the nondepressed patients.

This was really a puzzle and it would seem to not really support the hypothesis, but that didn't seem to be possible, so we started to look for other explanations. Then, when we looked at the dreams again, we saw that there was a peculiar feature of the dreams of the depressed patients. That was that the depressed patients, in the dreams, were always the subject of some unpleasant occurrence: They would be rejected, abandoned, depreciated, desolated, diseased, whatever. This seemed to be a current that ran through all of the dreams of the depressed patients. One of the patients, for example, would have a dream of going to a formal dance and would discover that she only had shoes for the left foot, or somebody would be on a desert and would put a nickel in a Coke machine in the desert, and all that would happen is they'd get fizz.

Marvin and I talked about this, and then a lightbulb flashed in my mind, and we thought, "There's still the unconscious hostility, but the way it's showing up in the dreams is that the patient has a need to suffer and the need to suffer is then being expressed in these negative dreams." We called these masochistic dreams, and we published a paper in 1959 on masochistic dreams in depressed patients.

It looked here as though I did have some validation with psychoanalytic theory; however, I did want to get some independent confirmation of the whole masochistic theory, so we did several other studies that should have shown that the depressed patients have a need to suffer. But when we did these studies—they were nonverbal studies, experimental studies, of various types—far from having a need to suffer, the depressed patients would show a need for being reassured, for getting affection, for getting praise, and so on. So if there was any motivation, it seemed, from these other studies, that the motivation was not to suffer but to get positive reinforcement of some type. This was the second surprise.

When I started to rethink this, it occurred to me that maybe I should take the dreams at face value. Instead of seeing the dreams as being motivated by some unconscious drive, I could see the dreams as simply a representation of the way the patient perceives himself or herself, and the way they perceive their experiences, and that this could be rock bottom.

We started to look around, and I saw that in literature there was some work done on what was called cognition. I started to think, "Maybe there are certain thinking processes that are involved, and the thinking processes in the depressed patients take a negative turn." That was the experimental work that I did, and then I went on and did some more clinical work.

Judith Beck: How did you develop the theory and therapy of depression?

Aaron Beck: So now we have the beginnings of my theory of depression: I'm already starting to think that depression is related to cognitive processes, but that was only one piece of the action. The other piece of the action was based on the clinical work that I was doing. I was seeing patients two or three or four times a week, and they were on the couch and free-associating

One time I had an unusual experience—for me it was unusual—and one of the women patients whom I was seeing started to regale me with all kinds of stories about her sexual escapades and so on, and she continued on through the entire session doing all that. At the end of the session I asked her, "Now how do you feel?" She said, "Well, doctor, I feel quite anxious." I gave her a good psychoanalytic formulation, and I said, "You see, the big problem isn't talking about sex. It triggers anxiety because you consider that sex is somehow unacceptable, and then it triggers anxiety and some kind of fear of disapproval from me or from society, maybe from your parents." She said, "Yes, doctor, that makes very good sense, but..." and I said, "Well what's the 'but'?" thinking she

was going to show resistance now. She said, “Well, actually, what I was really thinking about was that I was boring you.” I said, “What? How many times did you have that thought?” She said, “I was thinking this all through the session.” I said, “Oh. Well, that’s interesting. Do you ever have these thoughts any other times?” She said, “I always have it, and I’m always anxious that I’m boring people.”

Another light went off in my head, and I started to think, “This seems to be totally contradictory to the way I was thinking because what she is doing is: She’s reporting having some thoughts that don’t fit into my theory, and it’s these thoughts themselves that seem to be stirring up the anxiety, not the sexual material. It’s these thoughts, and these thoughts have to do with self-critical thoughts.”

Then I started to ask other patients, during their session, what thoughts they were having, and it turned out that they were having the same type of negative, self-deprecatory thoughts. After having seen this in a number of patients, it occurred to me that there was a whole stream of preconscious thinking that goes on that people don’t generally report to the analyst, or at least they weren’t reporting it to me, and that these thoughts that they were having had to do with some kind of internal communication system. Not the kind of things that one reports to other people, but the kind of automatic thoughts that one has—such as when you’re driving, and you have an automatic thought: “There’s a bump in the road; I’ll steer around it.” These thoughts happen automatically, and not only are they very quick but they go away very quickly, and people don’t pay too much attention to them. But even though they don’t pay much attention to them, they can trigger all kinds of emotions: anger, euphoria, sadness, and so on.

Now I was getting another piece of material from my patients. At that point—and this has to do with the therapy part—at that point I decided that, instead of having them on the couch, I would sit my patients up and we would focus on things in general but also on automatic thoughts. For example, one of the women whom I was treating at the time—she actually was coming in for the first interview, and she told me that she was really depressed and hopeless and the reason for that [was that] her husband had just gone off to jail, she didn’t have any money, and she had some children to support. She then said, “Can you help me?” I said, “Well, we’ll work together, and the two of us will help you with the problem.”

I then saw a shadow go across her face and I went on to another question, and then I came back and said, “You know, you looked kind of sad when I made that comment that we’ll work together on this.” I said the key cognitive therapy question, which is “What was going through your mind just then?” She said, “I just thought you were telling me you weren’t going to help me.” It occurred to me: This is a distortion.

So first I discovered there were automatic thoughts, and this was like the thought that she had, the flash thought that I wasn’t going to help her but also was a misinterpretation. As I collected more material, I found that these patients were misinterpreting what I had to tell them quite a bit. Eventually I noted that the misinterpretations fell into [unintelligible] categories. One was called selective abstraction—one I gave that name to—where they would take one little element and then see everything through just that one little element. One little mistake would seem to them to represent everything.

Related to that was overgeneralization, and I noticed they tended to have dichotomous thinking: that everything was either good or bad, up or down, and so on. I started to see that there were a whole series of cognitive distortions that were taking place, particularly in patients who were depressed.

Now I put everything together. From my research work, I was getting the idea that patients—depressed patients—had a negative representation of the self, as indicated in the dreams. Then I

saw that they were having cognitive distortions. I got the notion that people had negative beliefs, and the negative beliefs would act as a kind of prism and would block out positive things and only allow in negative things. It was also a warped prism, so the interpretations that people would make of what was going on were distorted.

Now we have the representations and we have the distortions, and then the question is, “What do you do about it?” At that particular time, I became aware of the work of Albert Ellis. Ellis had actually come before me in terms of seeing a relationship between people’s thinking and their affect, or their thinking and their behavior. He had already written a book on this, and he had developed a therapy that he called rational emotive therapy.

I borrowed some of his thoughts—some of Ellis’s techniques—and I had people now start to examine their thinking, not challenge it, which was Ellis’s term, but to start to explore, investigate, evaluate their automatic thoughts. We would do this in a variety of ways. One is: If a person had a negative thought such as, “My wife doesn’t love me because she ran off without saying goodbye,” we’d say, “First of all, is this the only time she’s done this, or does she do this a lot? That’s selective abstraction. Are you making some general statement? This is overgeneralization,” and so on. Then we’d say, “Now, is there some alternative explanation? Does it logically follow that the reason she went off is because she didn’t care for you?”—a whole variety of techniques.

What happened, and this was my next surprise, was when I started to have people look at their automatic thoughts, they started to get better. While I could have patients doing analytic therapy with me for two or three years, after about 10 or 12 sessions the patient would say, “Well, doctor, you’ve helped me a lot. Bye-bye.” My caseload shrunk, and pretty soon I was down to very few patients.

And at that point the chairman of my department, [Albert J.] Mickey Stunkard, said, “Well, Tim, you don’t seem to be doing so well in private practice; why don’t you come full time to the university?” That’s how I then got going on a full academic career, where I did research and some clinical practice and teaching. That was the birth of cognitive therapy.

Judith Beck: Then you put cognitive therapy of depression to the test, and you were involved in an outcome study. Can you talk a little bit about that?

Aaron Beck: Yes, okay. So now I’m doing academic work, and I’m still doing some research, and I set up a little organization that we called the Mood Clinic. What I wanted to do was further research on the cognitive model of depression that I had developed at that particular time. I wanted to do research, but in order to do research I had to get patients. In order to get patients, I had to offer them something; we had to offer them therapy. In order to offer them therapy, I had to have therapists. I hooked up with the residency training people, and I said, “Send your residents over, and I’ll teach them a new type of therapy.”

Judith Beck: This is at the University of Pennsylvania?

Aaron Beck: At the University of Pennsylvania. So we had—the three things were all at once. I was able to do research; I did service and training. One day, one of the residents, by the name of John Rush, said, “Tim, I think you’ve got something there with this cognitive therapy.” I’d already given it the name cognitive therapy based on the fact it was dealing with cognitions. He said, “You’ve developed a good therapy, but nobody’s ever going to believe it unless you do a clinical trial.” I said, “So they won’t believe it; I’m not interested in this point in spreading it. I’m just interested in doing the research.” He said, “Yes, but it’s a very good therapy and you really should

be able to disseminate this.” So I said, “Okay, but I’m not going to do a clinical trial.”

He said, “I’ll tell you what: Why don’t you train the residents in cognitive therapy, and I’ll do the clinical trial and I’ll do the research part?” He did that, and that actually was the first clinical trial using psychotherapy specifically for depression—a randomized, controlled study.

What we did is: We compared cognitive therapy with imipramine, and depending upon the way you manipulate the statistics, you could say cognitive therapy did just as well, or you could say cognitive therapy did better, but that was a complicated thing. The patient was in treatment for just 12 weeks, and both groups did get better in 12 weeks. Then Marika Kovacs did a follow-up study—I think a year later—and it turned out the cognitive-therapy people still maintained their improvement and the drug-treated people didn’t do quite as well.

Judith Beck: I know there’s been some recent research in cognitive therapy for even very severe depression. Can you tell us a little bit about that research?

Aaron Beck: The general thinking in the field is that depression is best treated, at least in the mild and moderate stages, either with drugs or with some kind of therapy: interpersonal therapy or cognitive therapy. For the severe depressives, you need to have [pharmaceutical] therapy. That’s the general belief. However, a number of studies, mostly by Rob DeRubeis, who’s at the University of Pennsylvania, have shown that even the severe depressives will respond to cognitive therapy without the use of drugs.

However, as with anything else, the cognitive therapy has to be adapted to the particular patient’s problems. When a patient is in severe depression, you can’t necessarily start with a cognitive restructuring such as: What are the [unintelligible] of explanations? Does it logically follow? What they have to do is: They have to get activated. They’re in a state of torpor, basically, and by getting them activated you can help to neutralize their negative beliefs about themselves, such as, “I’m useless, worthless. I’m never going to get better, and things are only going to get worse,” and so on.

This is something that I described in a book that I wrote with a couple of other authors several years ago, called *Cognitive Therapy of Depression*. We use what is called behavioral activation. That consists of giving the patient a whole series of activities and having them rate the activities. So many of them have the attitude, “Okay, it was very hard for me to make a phone call, but I followed your advice and I made a phone call, but what does that matter? Anybody can make a phone call.”

Then you say, “No, that’s a mastery experience because for you, making a phone call is very difficult. What you have is a good mastery experience, so you have to rate this as a mastery experience.” The other thing is: We would have them note down anything that they did that was pleasurable. Ordinarily, if you ask a highly depressed patient if they had any pleasurable experiences during the week, they say, “No.” But as it happens, if they go hour by hour they do have pleasurable experiences but they don’t remember them, so what we try to do is to get it really indented into their minds that they are having pleasurable experiences and that life is not as unpleasant as it seems. That was really how we developed the corpus of depression.

Judith Beck: What formulations have you made of the development of depression, that is, the longitudinal cognitive model of depression?

Aaron Beck: That’s something that I’ve struggled with for a long time, and it has to do with the whole idea of the “blue gene.” I’ll just tell you how the blue genes get into it. Way back in the early 1960s, when I started a whole research program on depression, I was very much interested in the

longitudinal course of depression. As it happens, in those days the whole study of depression was virgin territory; there were practically no psychological studies going on in depression, so there were an awful lot of questions that would be in my mind, and there were no answers.

The prevailing notion was that a person had some kind of unpleasant event that would happen, and then they'd get depressed. But of course people have a lot of unpleasant events, and they don't necessarily get depressed. So the question is: Do people have a certain vulnerability to depression? Is there a diathesis for a depression as there is for other disorders?

We did a study of quite a large number of patients who were severely depressed, moderately depressed, and nondepressed. We took some case histories. This was all retrospective, although later on, prospective studies were done. This is what we found: that for the severely depressed patients there was a very high incidence of a loss of a parent in childhood. The parental loss was quite high in those days, much higher than nowadays, because a lot of our patients had lost a parent as a result of World War I or as a result of the influenza epidemic. So there was a relatively high rate of parental loss.

Now, the parental loss occurred significantly only in the severely depressed patients, not so much in the moderately depressed patients, and minimally in the nondepressed patients. Then we could get a nice formulation. People become vulnerable because they lose a parent in childhood. Then they have some unpleasant event, which seems to be consistent with the early loss—dealing with separation, or abandonment, or loss of some type. It could be a loss of status in some cases. Then they get depressed.

At this point we didn't know the second part of the equation, which is a loss in adulthood. One of my doctoral students, by the name of Brij Sethi, did a study, and he showed that the parental loss was also paralleled by a similar loss in adulthood. So there is some correlation between childhood loss and adult loss. That was neat. This was a good thing, and it was published; this, then, becomes part of the lore—that childhood trauma can predispose people to bad things happening later on and becoming depressed.

But there was one thing that bothered me. The thing that bothered me is: Not everybody who has a childhood loss and has an adulthood loss, and the two of them go together, get depressed. I thought, "Maybe there's something constitutional that makes some people much more vulnerable to trauma than other people." I had to wait a long time—I think this paper was published around 1961 or 1962—and around the year 2000, a group headed by [Avshalom] Caspi, who worked at the Institute of Psychiatry, I believe, in London, showed that people who had a variant of the serotonin transporter gene (let's call it the short form of the gene) and had childhood trauma were much more likely to become depressed than people who did not have this gene, which I call the blue gene. If they did not have the blue gene, they didn't get depressed. If they had the blue gene but did not have childhood trauma, they did not get depressed. But if they had the blue gene and the childhood trauma, then they did get depressed.

I could say that there's a lot of controversy about whether these genetic findings hold. In some cases they hold, in some cases they don't hold, and so on. Personally, I do believe that there is something to it, but depending upon the nature of the sample, you may or may not show this genetic influence.

However, what does that have to do with cognitive therapy or other cognitive models? This is what it has to do with them. If people have this blue gene, the serotonin short form—if children have this and they're subjected to—if they then receive certain psychological manipulations, it's shown that they already, at that age, have a negative cognitive bias. That is, they're much more likely to see at a preconscious level, at a subthreshold level, negative faces than happy faces, and at a much lower level than people who do not have the gene.

Already there seems to be some cognitive predisposition, which is represented in a negative cognitive bias. When these children are followed, they're much more likely to be the ones that develop depressive symptoms later on. In addition to that—and I'll be coming to this later, I hope—they also show negative attitudes. There's a scale that we developed, which is called the Dysfunctional Attitude Scale. It's been developed for children, and there were a lot of negative attitudes in the scale. If they have the blue gene and they have the negative bias, they also are more likely to have the negative attitudes, and they're more likely, then, to get depressive symptoms later on if they're subjected to particular types of stress.

This now pulls together observations that we made many decades earlier, and we've now got a biological explanation for it and a neurobiological—namely the negative cognitive bias is demonstrated to be part of the whole picture. We now have a much more complete picture of how depression develops, and it now includes the biological as well as the psychological.

Judith Beck: Some depressed patients become suicidal. Can you describe the various investigations into suicide behavior?

Aaron Beck: The suicide studies, to my mind, are the most elegant studies that I've done because they were done in a very specific sequence. It's the only group of studies that I had planned beforehand and extended over many decades that then came to fairly good results.

When I first started my suicide work, there was very little in the literature that cast any light onto what happens with suicidal people, and very little on how to treat them. However, in my work with depressed patients, I did make the following observation: If they were suicidal, they had a very high level of hopelessness. They would see the future as something painful and unending and unendurable, just extending totally into the future. I made the observation that there was a connection between the depression [and] the hopelessness, and even if they weren't very depressed—even if the major diagnosis might have been anxiety—if they were high in hopelessness, they were far more likely to be suicidal.

I then embarked on a program, first of all, of classification. I set up a classification system, then a system for evaluation of the suicides, then validation of the suicidal instruments that I had developed, then prediction of future suicides, and finally treatment. The classification came about like this: The NIMH (National Institute of Mental Health) had a task force on classification of suicide.

At that particular time, all types of suicidal behavior were lumped together. People who thought about suicide were lumped together with people who actually attempted suicide, and they were lumped together sometimes with people who actually killed themselves. So we set up a classification system. We talked about suicide ideators: people who think about it and who have a wish to do it. People who attempt suicide we call the attempters. So [there are] the ideators, the attempters, and the people who complete suicide—the completers.

Then we had the classification system, but there was no way at that point of assessing the degree of suicide ideation either in people who were just ideators or people who were attempters, nor of measuring the degree of suicide ideation of those who had completed suicide—we'd have to get the information not from the patient, obviously, but we could get the suicide ideation from the family.

We developed instruments for these three categories. We then found that there was a definite correlation between the degree of suicide ideation and the likelihood that the person would make a suicide attempt—the degree of suicide ideation in the attempters and the likelihood they would make a future attempt. We then got into prediction. We had the scales that would then predict

ultimate suicide or suicide attempts.

Now, where does the hopelessness come into it? We found that hopelessness correlated with suicide ideation, and it also was the best predictor we had at the time of ultimate suicides. We did a 10-year follow-up on patients who had high suicide ideation and hopelessness, and we found that the hopelessness was able to predict ultimate suicide. I subsequently worked with Amy Wenzel, and we did a 50-year follow-up on these patients. We found that it was a very good prediction of our variables.

Here we had a good deal of material on prediction, but we didn't have anything yet on treatment. The treatment itself is like a quasi-experiment: If you have a hypothesis about the suicide, and you attack the hypothesis during the treatment and get good results, then you've got it made. I teamed up—I think in the year 2005, many years later, after we had formulated this, when we were able to get funding for a suicide intervention—we had a 10-session intervention for people who had attempted suicide, and they had the 10-session intervention of cognitive therapy intervention, and then we followed them for a year after the intervention and had a control group. As compared with the control group, the reattempts of suicide was about half, so we were able to save about half of the people who would reattempt from actually doing it.

That finally clinched it. We went step by step over a period of many decades and finally clinched the whole thing.

Judith Beck: This last study you have just been talking about was really a landmark study in the field of psychology/psychiatry, suicidology. I believe you did that with Greg Brown.

Aaron Beck: Yes, that was a study by Greg Brown, and it was considered a landmark. It was published in the *Journal of the American Medical Association*; the only time I had an article published there was because it was considered a landmark and of general interest.

Judith Beck: We've been talking a lot about depression, a lot about suicide. When you first started off with the cognitive model and your cognitive theories, and you developed a treatment for depression, did you ever think that you or anyone would ever apply it to a condition such as schizophrenia?

Aaron Beck: Back in 1952, I actually published a study of psychotherapy with a patient with schizophrenia. This was a young man who had the belief that he was being followed by the G-men, the predecessors of the FBI. He thought that the G-men were following him all around, particularly in his workplace, where his father was working; he was working for his father.

I developed a very strong therapeutic relationship with him, and I felt the therapeutic relationship had a lot to do with his ultimate improvement. One of the techniques that I used with him was the following. I said, "You have these G-men following you all around, but how would I know what they looked like if I wanted to help you—maybe in some way help you with them?" He said, "Well, I can't exactly tell you but I just *feel* that a person is." I asked him to describe one of the G-men, and he came through with a description. He started to look at them and he would describe them. Each time I would ask him to keep looking for them so we'd be able to identify them and see who they were.

As he was able to really focus on them, he did not see them quite the same way. He started to discriminate between the G-men and the non-G-men, and the more he was discriminating the fewer there were. Finally he was down to just three. At that point, he thought that in the course of time, they would disappear. He already was beginning to get the sense that maybe he was

misinterpreting what was going on. Then I wrote that up.

A long time elapsed and I did no more work in the field, and I did—although I had success with that case—I did really wonder whether cognitive therapy could have any really enduring effect on patients with schizophrenia other than, maybe, some stabilization and some improvement, but nothing very drastic.

Then one time I was at a meeting in Brighton, England, a meeting of the Royal College of Psychiatrists, and I saw a poster there and it said, “Sixty Patients Treated Successfully with Cognitive Therapy.” I knew nothing about the study.

Judith Beck: Sixty schizophrenic patients?

Aaron Beck: Sixty schizophrenic patients, right, treated in one of the state hospitals in Britain. I managed to track down the authors. [Douglas] Turkington and [David] Kingdon were the two authors. One of the things that intrigued me about this was that they had cited my 1952 paper. I checked in with them, and it turned out that they were using cognitive techniques, particularly with the positive symptoms with depression—I’m sorry, they used depression techniques with the delusions, the hallucinations, and even with the thinking disorders, but predominantly with the delusions and hallucinations.

They would ask questions such as, “What is the evidence for your belief?” and if there were other alternative explanations. As far as the hallucinations were concerned, they would ask about beliefs, about the voices, and so on, but within a very easy, gradual, empathetic framework. Subsequently, several other groups in Britain, almost simultaneously, were using cognitive therapy or what they called cognitive behavior therapy with their patients.

Ultimately, I realized how many groups in England were using cognitive therapy, so I invited them all to come to Philadelphia, to come to the Beck Institute, and for the first time this group had actually started talking to each other. They developed a group of cognitive therapy, or CBT, of schizophrenia researchers.

However, the one aspect of schizophrenia that they did not tackle very much—they did somewhat, but they didn’t have any manuals for treating this group—was the people with negative symptoms. Negative symptoms consist primarily of social withdrawal, very poor work efficiency, general inertia, and so on. A typical patient with negative symptoms would be sitting at home smoking and watching television, totally withdrawn from mainstream society.

Judith Beck: Very low functioning schizophrenics.

Aaron Beck: Very low functioning, that’s right; they’re low functioning. The general belief at that time, and still to this day, is that this is all due to certain neurocognitive problems that they have. They have great difficulties in attention, memory, executive function and cognitive flexibility, and so on. They simply are not functioning well, and they can’t concentrate very long on things. There’s actually a very good correlation between this neurocognitive dysfunction and the behavior that they show.

But that didn’t strike me as plausible. There may be a correlation, but I could not see where a difficulty in concentration would necessarily lead to a person withdrawing socially and not being able to do anything at all. It occurred to me that there was a missing link, and the missing link had to do with motivation. The reason they have withdrawn this way—in a sense, wrapped themselves up into a cocoon—is that they’ve given up. And if they’ve given up, then they’re not motivated to do things.

So they might have a hidden capacity that goes way beyond what they're actually showing. The question is: How do you tap into that hidden capacity? First we had to find out what was behind this loss of motivation. Why were they just seemingly complacent about their condition?

We developed a number of scales, and I worked with Paul Grant on this. One scale was called the Defeatist Attitude Scale, which has to do with performance—performance and ambition, you could say, or performance disability. There are attitudes there, such as, “There’s no point in trying anything because I’m always going to fail,” or, “Failing at one thing is the same thing as failing at a lot of things.” So we developed that scale.

We then did a study, and what we showed was that the defeatist attitudes were a mediating variable between the neurocognitive and the actual performance. That is, if you put into the equation the score on the Defeatist Attitude [Scale], what it does is it soaks up much more of the variance than does the neurocognitive in terms of performance.

Now we saw that defeatist attitudes are a very important part of why they're not performing. How do you explain how the defeatist attitudes get in there? In the history of people with the negative symptoms, you find that they have always been functioning—or maybe, starting in school—functioning at a somewhat lower level than their peer group and their siblings. In the course of time they have a series of failures, and they feel disappointed in themselves and their family is disappointed in them. They're also subject to bullying and to depreciation, and they develop a really negative self-image.

Piled on that self-image is the attitude, “There’s no sense in doing anything, no sense in trying, because I’m always going to fail.” Later on, when they develop their [unintelligible] and hallucinations, this tends to accentuate the negative attitudes, and they become stigmatized and so on. The negative attitudes about themselves actually grow and then become frozen.

That has to do with performance, but we also had a scale in terms of social adjustment, and they had negative attitudes about social relations too. Now we have them frozen and with these negative attitudes about dealing with other people, which then accounts for the social withdrawal, and negative attitudes about performance, which then accounts for their inertia and very poor performance. Then the question is: Can cognitive therapy do anything for them? Well, negative attitudes—they're the meat and potatoes of cognitive therapy. There's nothing we like more than negative attitudes, something we call the schemas—nothing like schema therapy to get at that.

After we had done a series of studies such as this, and I won't go into the details, we then had a very good formulation of what to do about patients with schizophrenia. At this point, when we had the formulation all prepared—and Paul Grant and I and two other people actually wrote a book on this whole topic—we then felt prepared to do a study. We checked around with other people, and people would say, “You're never going to be able to get it funded because nobody's going to believe that cognitive therapy can help these people.”

I managed to get funding from a variety of smaller sources, and we started a study and had 30 patients in the cognitive therapy group, and 30 got treatment as usual. We applied the cognitive therapy techniques of dealing with the negative attitudes, giving the patients a lot of positive experiences. To draw on what I talked to you earlier about, behavioral activation, we had to use a lot of behavioral techniques in order to get the patients to see themselves in a different light. There's nothing that succeeds like success for these patients.

We would do video games with them, go for walks with them and so on, and get them to, in a very subtle way, have a series of positive experiences, which in themselves would neutralize the negative attitudes that they had. At the end of therapy, we found that the patients in general improved a whole order of magnitude beyond where they were before. If the patient had been at home not doing anything, [we would] maybe get them into a supportive living condition, or

maybe independent living, and get them a part-time job or a volunteer job and so on—depending upon what level they started at, they were able to go up to the next level.

Judith Beck: What ideas do you have regarding the transdiagnostic approach that has become so popular recently?

Aaron Beck: The transdiagnostic approach is interesting, and in a way it has to do with the lumpers and the splitters, but I'll come back to that in a minute. In a sense, cognitive therapy has always had a transdiagnostic approach, but it's also had a specification approach. Both things are consistent; let me explain what I mean.

First of all, the mind is not split up into certain areas, with each area having to do with a particular diagnostic category. The same mind is operating, whether it's schizophrenia or depression or anxiety or obsessive compulsive disorder. With each of the disorders, there's going to be some effect, probably, on different functions, different brain or mental functions, such as attention and memory and focus and beliefs and motivation and behavior. Any approach has to take into account that all of these functions, or any or many or all of them, may be affected within a particular diagnostic framework.

Now, the generic cognitive model is a template, and given this template one can look for specific features across any of the disorders and then look at what's actually specific for a given disorder. Many times when I've done a workshop, people would say, "Do I have to learn something new for each of the disorders, or is there some easy way of going about it?" My answer to that is that there is this generic cognitive model that runs across all of the disorders, but there's one difference for each of the disorders that can account for that disorder, and that is the meanings that the patients attribute to their experiences. The meanings have to do with the beliefs that the people have. So the disorders are similar in many ways, but they're differentiated by the specific beliefs that the people have.

The first person to deal with this was actually Albert Ellis, and he postulated what he called the ABC of mental disorders, A standing for activating stimulus, B for belief, and C for the consequences. So if a person is exposed to a particular stimulus—let's say he's an alcoholic; he's in a bar—it stimulates a belief that "I have to have a drink" or "I can't control this, and I have to have it." The activating stimulus is the alcohol smell; the belief is "I have to have a drink"; and the consequence, then, is that he has the drink.

I expanded that in my own work into the following. We still get the activating stimulus. The activating stimulus, though, is often internal, as opposed to external. It may be an internal activating stimulus, such as the stomach rumbling, and you think, "My stomach is rumbling," and that might activate the belief that "I'm going to get colitis" or "I'm going to get cancer of the stomach" or something of that nature.

Judith Beck: So it might be a physiological symptom?

Aaron Beck: It can be a physiological symptom. It can be any type of sensation—"I have a pain in the back," and that might trigger the belief that this pain is going to get worse. Any pain is a representation of severe pathology, and so on. If one has an addictive disorder, it could be simply the smell, or it could be white powder that could, almost by a reflex action, stimulate the desire to take cocaine.

So you get your internal activating stimulus, or it could be an external activating stimulus,

such as a student receiving a C on a report card. Then, next is a belief, and the belief would be, in terms of the report card, “I’m a total failure. I’m always going to be a failure; I’m going to end up on skid row.”

Now, what’s important about the beliefs is that they attach meaning to a particular stimulus. You get your activating stimulus, and then you get your reflex, which is the meaning that’s attached to whatever the stimulus is. Then you get a whole sequence after that, so you might get, in the case of the report card, anxiety or sadness.

Finally, the consequence—and in the case of the alcoholic, the consequence obviously is he has a drink. In the case of the student who doesn’t do well, the consequence is that he gets sad and depressed and withdrawn and won’t go to school or whatever.

Now, for many years this was the template that I used, but then it occurred to me that there’s something else that’s very important, and that’s something I called attentional fixation. This really struck me when I was dealing with panic patients.

With panic patients, the activating stimulus may be something like any kind of somatic sensation, or some kind of psychological sensation, can be the trigger. It could be something like pain in the chest, or it could be a feeling of faintness or a feeling of depersonalization—anything that seems to be a little bit strange or worrisome to the patient, and it will vary from person to person.

What happens next is that a particular belief gets activated—and a belief may very well be something such as “Faintness could be a sign of having a stroke,” or “It could be a sign of having a heart attack.” The patient then gets the belief, “Oh, I could be having a heart attack,” or “I could be having a stroke,” or “I could be dying from this.” The patients actually do feel as though they are dying, as though they are actually having a heart attack.

The imagination starts to play a role in this, and a lot of these patients actually have images of these things happening to them. I had patients who even would have the image of themselves having the heart attack and ending up in a coffin—they quickly get that image.

So you get the stimulus. You get your belief, which gives the meaning. The meaning then can come out in an imaginal pictorial form, not just in a verbal form. The important thing is the focus. The attention gets focused on this stimulus, and the more it gets focused on the stimulus the worse it gets: The more they think of the faint, the worse they feel.

The consequence of that is that they will run to the emergency room, or they’ll call somebody and get reassurance that this isn’t happening. Through something the learning theorists call reinforcement, positive reinforcement, as long as the patients go for reassurance, it tends to keep the cycle going. The consequence itself, then, the reinforcement or the reassurance that they get, tends to prevent them from working through the reality.

The therapy then follows very logically from this little paradigm. Let’s just say we get the stimulus of—the activation might be a pain in the chest, say, and of course you do want to get medical clearance if you’re actually working with such patients, but most of the time the pain in the chest may be simply in the ribcage. You can reproduce this little pain in the chest because people get these little pains lots of times, but they’re not aware of it unless they’re hypersensitive or hypervigilant.

You can reproduce the pain sometimes by just pressing on the chest. So you give the patients a different explanation for what’s going on. The people who feel faint may have something that’s called postural hypotension, which means their blood pressure drops, and you can get them to stop the faint feeling by squeezing a rubber ball, say. It’s not just a question of getting this thing to stop; it’s trying to disconfirm this belief that they have, so you disconfirm the belief through cognitive restructuring.

Another thing is they focus on the symptom. Another technique to use is to teach them to focus on something else. When they focus on something else, the panic attack tends to subside or go away. Sometimes, if a person's in the subway, let's say, you get them to focus on the advertisements over near the roof of the subway. They say, "Suppose I'm in a classroom and I get this attack?" I said—one of the techniques I've used with people is, "Review in your own mind the names of the presidents starting with George Washington."

Some of these verbal techniques will be enough of a distraction; it removes the focus away from the symptom that they're having onto something else, and when they remove the focus the symptom subsides. Now, this in itself is experiential learning because it means that if they, just by changing the focus, can relieve this, then it cannot be a fatal life-threatening disease. The next thing is the anxiety that they feel, and they can deal with that through something we called applied relaxation.

The consequence is seeking reassurance. You try to get the patient to use any one or all of these techniques. You train them in the techniques, or you do it in your office, and you demonstrate to them how the techniques work; you try to get them not to go to the emergency room or not to call up the doctor. This removes the reinforcement that they were getting.

That's where you can use this template for anxiety, but what's specific about the anxiety is the belief: the belief that they have an immediate life-threatening condition. There are other conditions that are not immediately life threatening, such as back pain. A fairly significant proportion of the population is disabled, or certainly very dysphoric, because of chronic back pain. They start to feel a pain in the back and then they get—the belief then is the pain in the back: "This is terrible. It's uncontrollable. I'm not going to be able to do anything." They then feel sad, and then they withdraw.

In these cases, you often have to work with the total withdrawal that they have and get them not to withdraw because they still have a capacity to do things; that can then neutralize the idea that this is a disability. Actually, we've done some research on this, so that's why I'm talking about that. They often become very self-critical. They think—their other belief is, "I'm just an anomaly and I'm different from everybody else. I'm not going to be able to do things for my family," and they become very self-critical. You then can deal with the depressive components.

So, those are two elements with totally different types of beliefs. Oh, another one that fit into the template—the template is there, but the beliefs differ—another thing is: I had a patient once who had pain in the back. Whenever she had back pain, she had the thought, "I've got cancer of the kidney." She went through all kinds of tests, and she kept going for tests, but it wasn't getting her anywhere.

What I did with her is: I said, "You've been going for tests for how many years?" She said, "Fifteen, twenty years." I said, "How about if you make an agreement with your doctor that you won't go for tests for about six months, and let's see what happens?" That simple kind of intervention actually helped her because, when she stopped going to the doctor, it removed this reinforcement that she had. Once the reinforcement got removed, she was able to face reality, and she started to see that the back pain was due to back pain and not due to a cancer of the kidney.

You can use the general template for every condition, but you have to be able to specify the different meanings that go with each condition.

Judith Beck: How does the cognitive model account for comorbidities, for example?

Aaron Beck: I'm glad you asked that because that comes right from the previous question. Let's take depression and anxiety; I mentioned earlier you have lumpers and splitters. Back in the

late 1920s—1928 and 1929—there was a big debate going on in Britain. One school of thought believed that depression and anxiety were lumped together and they were basically the same condition. The other school believed that depression and anxiety were two separate disorders.

Now we fast-forward to the present, and there's been a big move toward lumping various conditions that have a certain amount of overlap together. This is called the transdiagnostic approach. The various anxiety disorders are now being lumped together by some investigators as though there's one single anxiety type of thing that applies across the board. There is this comorbidity between depression and anxiety, which also raises questions as to just why this is.

That's the lumping. First of all, I would say that there is a difference between depression and anxiety, and in our early work we had a large sample to deal with. We found that we could split off patients who had depression and no anxiety and anxiety and no depression, but the two often go together, and the question is: Why do depression and anxiety go together so much? Well, that's because they're dealing with the same thing. Basically, depression and anxiety have to do either with damage to your self-esteem—that is, psychological damage—or with physical damage.

In the case of depression, the damage has already occurred, so the person has a negative bias and will see everything in terms of: "I am useless. I am worthless. I am inferior. I'm inadequate. I'm stupid," and so on. This is the way that they see themselves, and this is the way they interpret various events. They will selectively interpret events according to this negative self-image.

With the anxious patients—when there's anxiety there—it's the same thing, except it hasn't happened yet. They don't yet see themselves as different from other people, as inadequate, stupid, worthless, and so on, but they interpret future situations as possibly showing that.

A depressed patient in a social situation will think, "I'm out of it. People see that I'm useless, that I'm worthless." The anxious patient will think, "I'm in this social situation. If I stick my neck out I may be shown to be worthless, stupid, inadequate." They're afraid of something that may happen to them; they have anxiety about what may happen; they're vigilant about what may happen. But with a depressed patient, it's already happened, and when they think of the future—they always think of the future in terms of something that would definitely happen.

To be a little bit more specific: People have a tendency to catastrophize, to think of the worst possible thing that could happen. We did a study in which we asked people to have images of the worst possible thing that could happen to them in particular situations. We had depressed people who were high in depression and people who were high in anxiety.

The people high in depression would attribute a very high probability of their, say, ending up on skid row if they had some kind of loss of money or a job problem. You give the same scenario to the anxious patients, and you say, "What's the worst thing that can happen if you lose your job or lose your money?" and they also see themselves ending up on skid row. But when you ask the anxious patients, "What are the probabilities of this happening?" they'll say, "Maybe 40%." If you ask the depressed patients what the probability is, they'll say, "One hundred percent." The anxious patients still see this as a possibility in the future. The depressed patients see this as a certainty.

What you have, then, is between depression and anxiety—you're going to have people who may fluctuate from time to time in terms of how much they believe that they are inadequate or how much they believe that they might be shown up to be inadequate. So they could have depression and anxiety going on at the same time. Another way of looking at it is there are depressive schemas and there are anxious schemas, and the two sets of schemas are very close in terms of content: one having to do with the future, the other having to do with the certainty of the present. Since they overlap somewhat, it's not surprising that people would have both. That's why you would get comorbidity there.

Now, let's take this transdiagnostic notion of: There's one big anxiety that will manifest itself in panic attacks and generalized anxiety disorder, maybe specific phobias. For example, a particular patient may have social anxiety, that is, feels anxious in social situations, feels that, say, he's going to get looked down on; he's going to be perceived by other people as awkward and inept and not socially desirable. [He] might have a tunnel phobia, might have panic attacks, might have public speaking anxiety.

It's true that a particular person may have any of these things or might have only one of them. If they have any of them, what's the explanation for that? The explanation has to do with one thing—they feel vulnerable, and they have a very strong belief about vulnerability. They see themselves as somehow very fragile and therefore subject to a whole lot of different things, and/or they see the outside world as very threatening.

They might have any one of these things if they have a broad schema or broad belief in terms of vulnerability and a broad belief of a dangerous world. Or it can be then—so that's the lumpier type of thing that can happen in nature, but also you can get the specifics. Somebody might have a tunnel phobia or a bridge phobia or a phobia of knives and have nothing else. Then they just have a very specific vulnerability. You get comorbidity when there's a broad generalization of vulnerability, or you get a specific vulnerability when it just has to do with specific situations, and that's something we call phobias.

Judith Beck: What's being done in terms of dissemination of cognitive therapy?

Aaron Beck: I'm glad you asked that because dissemination is very important. One of my concerns has been: We write these papers, and eventually they might get bound into volumes and gather dust on somebody's shelf or take up some space in people's computers, but it never does anybody any good because it doesn't get out into the community. Particular individuals in the community that I've been most concerned about are the low-income individuals who, by and large, are not getting up-to-date therapy. Mostly they're being treated by master's-level therapists who have not already received any evidence-based training when they were in school.

Fortunately we have a contract with the City of Philadelphia—with a subsidiary of the City of Philadelphia—which provides services at the various community mental health centers. We have been engaged for several years now in training these master's-level therapists in cognitive therapy. It breaks down into three types of training. One is: We've been doing workshops for them, and we've probably given workshops to well over a thousand—perhaps a couple of thousand therapists. We've been doing intensive training with weekly tape reviews. They send in their tapes and the tapes get evaluated, and they're given feedback every week on the tapes. They originally would get a year's training; we're now doing a study to see if they can reach competency at six months. Their tapes are rated at the onset of their training and then at the end of the training, and about 90% reach competency and a certain percentage, about 10%, don't or drop out. So we've done very well in that.

The third type of training is a Web-based training, where they watch—for 26 weeks, they watch a computer-based program on cognitive therapy, and we're trying to see how effective that is. So that's one form of training.

There also are people—and many of them are actually doctoral level—postdoctoral level, who never received any training in the evidence-based treatments while they were in school, or they did not receive enough. There are also master's-level people, similar to what I'm talking about, who are in practice who haven't received training.

There are several research centers in the United States where they can get training, and this is very important. For example, at the Beck Institute for Cognitive Therapy, we have a series of monthly workshops that include the basics, and then other workshops are advanced. So we do try to teach the basic tools to people who come to the workshop, and then we have specialty workshops, say, for children or eating disorders, which is very important as a prevention and schizophrenia and so on. Our hope is that the therapists will also enroll in a yearlong or a six-month-long program will get the same type of tape review that we have in the community.

I think that's really important, and many of the people who've been through this training program have themselves become trainers and will train other people. We've had people from all over the world. One of the interesting things is that the greatest interest actually comes from the Islamic or Muslim countries, where cognitive therapy, for some reason that I don't know, seems to fit better with their culture than, certainly, psychodynamic therapy does.

In any event, we're interested now in not only spreading it out through North America, but throughout the world, and so far it's been very successful. Some places such as Australia and New Zealand, where cognitive therapy isn't the dominant therapy—from what I hear it's the only therapy that's being used. Recently we've set up—we're in the process of setting up a program in China. There's already been a large amount of dissemination through Asia, through places like South Korea and Japan and Singapore and Hong Kong, so it's moving there.

But the other problem is this. Nowadays the insurance companies do tend to favor the evidence-based treatments, so a lot of people are calling themselves cognitive therapists. When we go to workshops, we ask, "How many of you actually do a problem list or set an agenda at the beginning? How many give feedback?". It turns out that they're not really doing cognitive therapy. The problem comes up when somebody from Iowa wants a referral; what do we do about sending them a referral?

To solve this problem, we set up—we participated with our former students in setting up an organization called the Academy of Cognitive Therapy, and the Academy of Cognitive Therapy will then certify therapists. They have to be able to present their credentials. We're trying to get certified people, not only in North America, but in other countries in the world who will be able to do that.

Judith Beck: What do you think the future of cognitive therapy is?

Aaron Beck: I guess the big question is: What's the future of therapy and what's the future of psychotherapy? As far as psychotherapy is concerned, I think the future's going to really depend on therapies that are—and maybe one therapy in the future; everything will come together—which will be based on science. By science I mean the following: There has to be a science of psychopathology, and the science of psychopathology has to be based not only on a whole series of hypotheses, but these hypotheses have to be confirmed.

It has to be an empirically based foundation. Then the therapies have to be at least consistent with the theory of psychopathology, and ideally they should be derivable from the theory, from the evidence-based theory. The therapies themselves do have to—not only do they have to be derived from the theory, which then gives you the template as I mentioned earlier, but the therapies themselves have to go through validation.

There are also other forms of treatment. There are a variety of biological treatments, not only pharmacotherapy but transcranial magnetic therapy and so on. The question is: What therapies are best for individuals? Rob DeRubeis has been doing some work trying to show that certain psychological configurations seem to best predict people's response to either pharmacotherapy or

cognitive therapy, so that there can be a degree of personalization in the future.

There's another type of personalization, and that has to do with genes. It may be that people are genetically better constructed to respond to cognitive therapy, or they may be better constructed to respond, say, to pharmacotherapy or to some other type of treatment; we don't know. It may be that this is just a fad—the idea of what they call psychogenomics may be a fad, or there may be something to it. It may be that some people won't respond to any therapy, although that's a nihilistic point of view.

Judith Beck: What's your hope for how cognitive therapy might evolve?

Aaron Beck: I think cognitive therapy has evolved, and over the years what I've done personally is try to incorporate more and more of the findings that have come from various psychological disciplines. I've been quite influenced, say, by cognitive psychology and sociopsychology and experimental psychology. All of these disciplines have findings that are relevant to what I would consider the general theory. I think as there are new findings in psychology, they're going to be reflected in an expansion of the theory behind cognitive therapy.

As far as the techniques are concerned, a lot of what techniques are used really depends upon what the therapist is comfortable with, what the therapist has learned, and also the responsiveness of the patients. It's probably ideal for the ideal therapist if he has a number of approaches. With some patients, for example, whom I've treated in the past who are very intellectually oriented and are very much interested in causation, we can achieve a lot of the cognitive restructuring through talking about childhood experiences, let's say. Or showing the relationships, not talking about them, because talking about them doesn't do any good, but trying to show the relationship between childhood experiences and what their particular problems are right now—how the images that they developed as children are now producing the kind of cognitive biases that are going on now.

To get back to your question, how do I see it evolving: I see it as using more and more of the research that's going on and then incorporating the research into the whole corpus of cognitive therapy.

Judith Beck: How does cognitive therapy view the therapeutic relationship?

Aaron Beck: I used to think—for many years, even decades, I used to think that the therapeutic relationship was a crucial vehicle, a crucial part of the therapy, and it's a little bit like a surgeon using anesthesia. The anesthesia's essential in order to apply the techniques. Way back, I remember having debates with Jerry Frank, who was a big believer in the curative power of the therapeutic relationship itself.

I felt at that time, and still do today, that the technical aspects are really crucial but that the therapeutic relationship might be—is a very important facilitator for being able to deliver the particular techniques.

Recently there have been a number of different delivery systems that have been discussed, and they also—the different delivery systems—also seem to be effective. The most important work in this area has been done in Britain, and the British clinicians use what's called either low-intensity or high-intensity interventions for their patients.

Low-intensity interventions are used, let's say, for mild or moderate depression, and with low intensity there may not be a therapist involved at all. The patients may be given bibliotherapy. They might be given computer therapy. They may be given instructions about various mental

health organizations they can go to for education and so on. The high intensity involves the therapist. The high intensity, of course, would be relevant to having a therapeutic alliance.

That's one point, that therapy can be delivered successfully through methods that do not involve a therapeutic relationship, although I've been told that even people who have one of these computer programs for therapy develop a relationship with the computer—with the therapist who's written the program. They have a kind of remote relationship.

There are two things about the therapeutic relationship itself, when it does go on. One is: Although originally I felt that it was essential for the therapist to be warm and empathic and tuned in to the patient's feelings and that a warm, empathic, supportive relationship was critical to getting better, I found that after a certain period of time working with patients, there were some patients who did not want this nice bedside manner. What they wanted was to know what the tools were. They would supply the tools. They'd come to the sessions. When the session was over, they would be pleased to leave at the end of the session. They would do the homework very thoroughly. They got better very fast. They had no great affection for me. They were satisfied with the therapist, and they went their own way.

There were other people for whom the therapeutic relationship was very important, and they would cling at the end of the session. They would make phone calls between sessions. I did a little research study, and we found that there are two types of people, roughly. There's the autonomous, and there's the dependent. The autonomous people do very well if you just give them the techniques, and they're not interested in anything else. The dependent people are largely interested in the relationship, and you have to squeeze in the techniques as part of the relationship. I imagine it may be that the autonomous patients may do better with the other types of delivery systems that I mentioned.

Now, there's a big school of thought that believes that the therapeutic alliance is the key thing, but again, getting back to some work done by DeRubeis, he finds that the therapeutic alliance does not come before the improvement but comes after the improvement. Or, to put it another way, once the patient starts doing the therapeutic techniques and develops certain skills and sees that the skills are effective, then the patient starts to feel that he has a working alliance with the therapist. The whole sense of the alliance comes after the patient is actually going through and practicing the techniques. The other school of thought, which is the dominant one, is that you have to have the working alliance first, and then the patient will start using the techniques.

In any event, it's still an open question, and there are some patients who do get better just on the basis of the various therapeutic factors, such as warmth and empathy and so on. They do get better, but the question is, "Do they stay better?" This is what the research is going to have to show.

We believe that the people who have learned the therapeutic skills are the ones who are less likely to relapse later on because they have these skills, and they can keep exercising them for the rest of their lives. Anyhow, that's where things stand with the therapeutic alliance.

Judith Beck: Thank you so much for all the interesting things that you said today. You told a couple of stories that even I hadn't heard about. I'd like to thank you on behalf of the psychotherapeutic world for the work that you have done. We get emails constantly at the Beck Institute about how grateful both professionals are and consumers are for the work that you've done.

Aaron Beck: Well, thank you for the interview. Actually, it's been going down memory lane for me, going back many decades in some cases, and your questions have helped me to piece together things that I've thought about but haven't really put together before. Thank you so much for this

opportunity.

Judith Beck: You've celebrated your ninetieth birthday this year. It seems that you have the mind of a much younger person—certainly the energy and the work—and I know you still work pretty much 24/7.

Aaron Beck: Thank you.