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Representative Abstracts and Articles
The purpose of this review is to give an overview of randomized controlled trials (RCTs) concerning the efficacy of psychological and pharmacological treatments of posttraumatic stress disorder (PTSD), with a focus on treatments combining both. Psychological treatments, in particular exposure-based interventions, have been shown to be efficacious in reducing PTSD symptoms as have pharmacological agents, in particular several antidepressants, but the efficacy of either treatment modality needs to be improved. Attempts to enhance the efficacy of psychotherapy or pharmacotherapy by combining one type of treatment with the other have remained scarce, and the results of adding one to the other have been mixed. All in all, exposure-based psychological interventions have emerged as the best treatment option, either alone, or, if and when appropriate, in combination with a second-generation antidepressant. Recent new treatment directions, involving use of cognitive enhancers such as d-cycloserine to improve exposure-based treatments have shown promising results.

A substantial body of evidence has supported the efficacy of cognitive-behavioral therapy (CBT) for adolescent depression. Fewer studies have addressed mechanisms that contribute to positive youth CBT outcomes. The CBT model holds that adolescents acquire skills through active involvement in sessions and completion of homework assignments between sessions. Skill acquisition including cognitive modification is assumed to contribute to reductions in depressive symptoms. This study examined hypothesized associations among client involvement in cognitive therapy tasks, change in cognitive distortions, and reductions in depressive symptoms with a sample of 44 clinically depressed adolescents. Results partially supported the CBT model. Specifically, change in cognitive distortions prospectively predicted reductions in depressive symptoms, whereas change in depressive symptoms did not predict change in cognitive distortions. Neither in-session involvement nor between-session homework adherence predicted changes in cognitive distortions or depressive symptoms. The importance of cognitive modification for depression reduction in CBT for adolescent depression is highlighted.
None of the published factor analyses of the Automatic Thoughts Questionnaire—Negative (ATQ-N; Hollon & Kendall, 1980) have been with adult clinical populations. To address this omission, we examined the factor structure of the ATQ-N among an adult sample (N = 178) seeking treatment for depression. A series of confirmatory factor analyses revealed poor fit indices with all previous models, suggesting that the automatic thinking of depressed clients is composed of different cognitive dimensions than that of nonclinical samples. An exploratory analysis with our clinical sample identified five factors with eigenvalues >1 (demoralization, self-criticism, brooding, amotivation, and interpersonal disappointment) that accounted for 61% of the variance. Of these five factors, only the first two independently accounted for significant variability in levels of depression. Implications of the results and for further use of the ATQ-N within cognitive therapeutic research and practice are discussed.

Cognitive-behavioral therapy is an established efficacious, first-line treatment for the spectrum of anxiety disorders. While treatments have been developed to target primary disorders in isolation of comorbid conditions, comorbidity between anxiety and mood disorders has been found to be substantial, making it the rule rather than the exception in clinical settings. Notwithstanding the high rates of comorbidity, there has been little research addressing whether standard CBT treatments are equally effective in the presence of a comorbid depressive disorder, in contrast to the wealth of research on the efficacy of CBT for each of the anxiety disorders separately. The purpose of this review was to examine the impact of depression comorbidity on the CBT treatment of primary anxiety disorders based on empirical studies identified by electronic search (Medline and PsychInfo). We organize our review by considering, first, the research addressing the predictive/moderating role of comorbid depression in CBT for anxiety disorders and, second, the research examining the efficacy of CBT on secondary depression in the context of the treatment of a primary anxiety disorder. We provide a synthesis of the differential effects of anxiety/depression comorbidity depending on the specific primary anxiety disorder that is targeted in treatment and offer guidelines to determine if and when protocols require adjustment to target comorbidity.

The ability to assess and correct biases in thinking is central to cognitive-behavioral therapy. Although measures of cognitive distortions exist, no measure comprehensively assesses the cognitive errors that are typically cited in the literature. The development and initial validation of the Cognitive Distortions Scale (CDS), a questionnaire that measures the tendency to make 10 cognitive distortions (e.g., mindreading, catastrophizing, all-or-nothing thinking) as they occur in interpersonal and achievement domains, is described. Across two studies, undergraduate students (n = 318) completed the CDS and other clinically relevant measures. The CDS and its two subscales appear to exhibit good psychometric properties; however, a factor analysis supported the use of a one-factor solution. Additional analyses suggested that some errors occur more frequently in some domains than others and that some errors may have more clinical significance than others. Notwithstanding issues inherent in measuring cognitive errors, and study limitations, the CDS appears to be a promising new measure of cognitive distortion, with good research and clinical potential.


We investigated perfectionism in clinical samples using new measures of maladaptive cognitive-personality dimensions—the Evaluative Concerns Perfectionism Scale (ECPS) and Self-Critical Perfectionism Scale (SCPS), as well as the Frost (FMPS) and the Hewitt and Flett (HMPS) Multidimensional Perfectionism Scales. Outpatients (N = 190) with a principal diagnosis of social anxiety disorder (SAD), panic disorder with or without agoraphobia (PDA), obsessive-compulsive disorder (OCD), or predominantly major depressive disorder were compared to non-psychiatric controls. Patients with depression and SAD had similar or significantly higher scores than the controls, and patients with PDA and/or OCD on many perfectionism measures. OCD patients were also higher than controls and those with PDA on many scales. PDA patients were similar to controls on all but a few measures. The SCPS was the only consistent unique positive predictor of variance on the Depression Anxiety Stress Scale (DASS) in a combined patient group.
Although Cognitive Behavioral treatments for eating disorders are improving, recovery rates, particularly for Anorexia Nervosa, remain low. Recent developments in the understanding of the etiological and maintenance factors in eating disorders have indicated that transdiagnostic treatments may be effective. Compassion Focused Therapy for Eating Disorders (CFT-E) has been developed as a transdiagnostic approach to eating disorders, specifically to address affect regulation difficulties, shame, self-directed hostility, and pride in eating disordered behavior. The current article outlines the philosophical model of CFT-E and describes the stages and phases of CFT-E.

This article describes a new cognitive-behavioral treatment Broad Minded Affective Coping (BMAC) based upon Frederickson and colleagues' "broaden and build" theoretical model of positive emotions. Simply, negative emotions are threat-focused and survival based whereas positive emotions broadened thought-action repertoires and increase access to a much wider range of psychological resources. Thus constructive and positive cognition and behavior are more likely to arise from the experience of positive emotional states. The theoretical underpinnings of, and the clinical procedures to, BMAC are described. BMAC aims through the use of mental imagery to elicit positive past memories and the positive emotional states associated with them. BMAC is indicated as a tactical addition to cognitive behavioral treatments and a number of cases are briefly described to indicate its clinical feasibility and acceptability.

This article outlines the early origins of Compassion Focused Therapy (CFT) from within the Cognitive Behavioral tradition (CBT). It will then focus on how our new understanding in the areas of affect regulation systems, and the importance of affiliative and kind relationships in regulating mental states, point to key processes that underpin mental health difficulties—as well
as to possible mechanisms for therapy and change. CFT recognizes the huge debt to Eastern psychologies such as Buddhism that have articulated the importance of compassion for our personal and social well-being for thousands of years. However CFT was originally developed for, and with, people who suffer from high levels of shame and self-criticism and who find experiences of support, kindness, and compassion—both from themselves and from others—difficult or even frightening. The article will provide the conceptual background for the articles that follow which focus on the applications of CFT.


Mindfulness-based cognitive therapy (MBCT) is an effective treatment for reducing depressive relapse as well as residual depressive symptoms among adults with recurrent depression but the specific mechanisms through which this treatment works have yet to be examined. This study investigated MBCT’s immediate (pre to post) effects on depressive symptoms and its potential theory-driven change mechanisms in a wait-list randomized control trial. Recurrently depressed patients, the majority of them in partial remission, were randomized to either an 8-week MBCT group ($N = 26$) or a wait-list control group ($N = 19$). Participants completed measures of depressive symptoms as well as measures of rumination and trait mindfulness before and after the intervention. Consistent with the MBCT change theory, bootstrapping-based mediation analyses demonstrated that reductions in brooding (an aspect of rumination) and increases in mindfulness independently and uniquely (accounting for other mediators) mediated the effects of the intervention on depressive symptoms. Given the pre-post design and the lack of temporal precedence, these findings provide initial evidence supporting the notion that mindfulness and brooding may be important change processes through which MBCT affects depressive outcomes.

Examined the mediating effect of changes in expectancy/credibility from sessions 4-7 of 14-session cognitive and behavioral therapy for generalized anxiety disorder (GAD). In 76 adults with primary GAD, we predicted that expectancy/credibility would change significantly from sessions 4-7, that degree of change in expectancy/credibility would predict degree of reliable change at posttreatment, and that changes in expectancy/credibility would mediate the relationship between pretreatment severity and change at posttreatment. In support of the hypotheses, a latent growth model revealed significant increases in expectancy/credibility over the critical period. In addition, baseline GAD severity, expectancy/credibility intercept, and rate of change in expectancy/credibility all positively predicted degree of reliable change at posttreatment. Rate of change in expectancy/credibility during the critical period partially mediated the effect of baseline GAD severity, accounting for 38% of the variance in this relationship. This effect was not accounted for by preceding or concurrently changing anxiety levels.


Clinicians and researchers have increasingly embraced cognitive and cognitive-behavioral therapies (CBT) for treating psychological difficulties following bereavement. The present review summarizes the existing empirical literature on CBT based interventions for bereaved persons and the extent to which these therapies alleviated distress compared to non-CBT approaches and no-treatment control groups. Initial results for me 11 studies included in the review showed CBT-based interventions were more effective than other commonly practiced therapies (posttest $d = 0.27$; follow-up $d = 0.25$) and the relative efficacy of CBT did not vary across different bereavement-related distress symptoms. However, after accounting for the influence of researcher allegiance, differences between therapies were reduced in size and no longer statistically significant (posttest $d = 0.12$; follow-up $d = 0.19$). Compared to no-treatment control groups, CBT-based interventions were beneficial immediately after intervention ($d = 0.38$) but did not yield statistically significant overall effects at follow-up ($d = 0.18$). Findings of the review provide preliminary evidence for the helpfulness of CBT-based interventions with bereaved persons but also highlight the importance of studying the relative efficacy of different cognitive-behavioral change strategies as well as those from other theoretical orientations.


In order to examine the benefit of adding pharmacotherapy to cognitive-behavioral therapy (CBT) for anxiety disorders, we searched for studies comparing CBT plus pharmacotherapy and CBT plus pill placebo for adults meeting DSM-III-R or DSM-IV diagnostic criteria for an anxiety disorder between the 1st available year and July 1, 2008. Of 874 studies that were initially considered, 11 studies were identified, representing 471 patients with posttreatment completer data and 236 participants with follow-up completer data. CBT plus pharmacotherapy was generally more effective than CBT plus placebo at posttreatment for measures of anxiety disorder severity (Hedges’ $g = 0.59$, 95% confidence interval: 0.29-0.90) and treatment response (OR: 1.95, 95% confidence interval: 1.25-3.03), but not at 6-month follow-up. Despite the relatively small number of studies, the fail-safe $N$ suggested that the results are reliable. The largest effect sizes at posttreatment were found for panic disorder and generalized anxiety disorder. No differences were observed between self-report and clinician-administered measures. The reported effect sizes linearly decreased with publication year. In sum, there is preliminary evidence to suggest that adding pharmacotherapy to CBT is a useful short-term treatment strategy at least for some of the anxiety disorders.


Increasingly, bipolar disorder is being treated with maintenance combinations of medication and psychotherapy. We examined the feasibility and benefits associated with an 8-week mindfulness-based cognitive therapy (MBCT) class for bipolar patients who were between episodes. Participants ( $N = 22$; mean age, 40.6 yrs; 14 bipolar I, 8 bipolar II) were existing patients in outpatient clinics at Oxford University ($n = 14$) or the University of Colorado, Boulder ($n = 8$), most undergoing pharmacotherapy with mood stabilizers and/or atypical antipsychotic agents. Patients underwent a pretreatment assessment of symptoms and then received the 8-week MBCT in four separate groups, two at each site. MBCT consisted of mindfulness meditation strategies and traditional cognitive-behavioral techniques to address the mode in which negative thoughts and feelings and emerging manic symptoms are processed. We
examined within-group changes from pre- to posttreatment in the four aggregated groups. Of the 22 patients, 16 (72.7%) completed the groups. Reductions were observed in depressive symptoms and suicidal ideation, and to a lesser extent, manic symptoms and anxiety. A case study illustrating the effects of MBCT is given. In conclusion, MBCT is a promising treatment alternative for bipolar disorder, particularly for managing subsyndromal depressive symptoms. There is a need for larger-scale randomized trials that examine the cost effectiveness and relapse-prevention potential of this modality. (PsycINFO Database Record (c) 2012 APA, all rights reserved)


Studies using the Thought Control Questionnaire (TCQ) have identified maladaptive thought control typified by worry and punishment. In the present study patterns of thought control strategy used by patients with GAD and MDD were compared with each other and with a group of nonpatient controls. The relationship between individual strategies and psychological vulnerability (trait-anxiety) was also examined. GAD and MDD groups could be distinguished from the control group by greater use of worry as a strategy, while the GAD group also used more punishment than either the MDD or control group. The results show evidence of a preponderance of maladaptive control strategies in these patients. In contrast, the control group used more social control and distraction. Worry was an independent positive predictor of trait-anxiety and distraction was an independent negative predictor. The theoretical implications are discussed in the context of the metacognitive model of psychological disorder.


Recent psychosocial theories implicate disturbances in reward pursuit among individuals putatively at risk for mania. The present study examined associations of a measure of risk for mania (the Hypomanic Personality Scale; HPS) with four trait positive emotions (joy, pride, compassion, and love) and ambitious life goals in five domains (fame, wealth, political influence,
family, and friends) among 302 participants from two university settings. Findings indicated that higher HPS scores were related to reward (joy) and achievement-focused (pride) positive emotions, with weaker relations to prosocial (compassion, love) positive emotions. HPS scores were more robustly related to extrinsic (fame, politics) as compared to other-oriented (friends, family) ambitious life goals, with the exception of wealth. These effects were independent of current symptoms of mania and depression. Discussion focuses on the implications of elevated reward and achievement-related positive emotions and goals in understanding risk factors for mania.


A number of models of Obsessive Compulsive Disorder (OCD) stress the role of beliefs in the development of symptoms. However, they differ as to which beliefs they consider central. These beliefs fall into two categories—cognitive and metacognitive. The current study compared the relative contribution of cognition and metacognition as prospective predictors of obsessive-compulsive symptoms. We used measures of cognitive beliefs derived from cognitive theories of OCD (e.g., Salkovskis, 1985) a measure of metacognition derived from Wells' metacognitive model (Wells, A., 1997), and another metacognitive measure that draws from several models of OCD (e.g., Rachman, 1997). We controlled for worry and beliefs concerning overestimation of threat. Thought-fusion, a metacognitive belief implicated in Wells' model, emerged as an independent prospective predictor of O-C symptoms but other beliefs did not. The results add to a growing database supporting the metacognitive model. (PsycINFO Database Record (c) 2010 APA, all rights reserved)


It has been hypothesized that anxious rumination may focus on ruminative content themes pertaining to gaining control and coping with future uncertainty (Nolen-Hoeksema, 2000), although it is unclear to what extent this content of repetitive thought is distinct from dimensions
of depressive rumination, worry, and anxiety sensitivity. Two studies were conducted to test the role of rumination in the anxiety spectrum. Nonclinical (N = 491) and clinical participants with DSM-IV anxiety disorders (N = 282) completed a newly constructed measure of anxious rumination, as well as measures of depressive rumination, worry, anxiety sensitivity, and other symptoms. Support was found for a two-factor model of anxious rumination in both nonclinical and clinical samples. Anxious rumination factors showed convergence with depressive rumination and worry, but provided unique predictive validity in relation to anxiety, depressive, and composite symptom constellations. There was partial support for mood-state ruminative specificity, with anxious rumination factors and worry relating to measures of anxiety symptom severity, and factors of depressive rumination uniquely predicting the presence of secondary mood disorders in patients with primary anxiety disorders. Dimensions of anxious rumination were found to be elevated in all of the anxiety disorders except specific phobia, and significantly greater in the clinical sample than the nonclinical sample. These results provide support for the importance of rumination in the intensification and prolongation of clinically anxious


The current paper provides an updated review of repetitive negative thinking as a transdiagnostic process. It is shown that elevated levels of repetitive negative thinking are present across a large range of Axis I disorders and appear to be causally involved in the maintenance of emotional problems. As direct comparisons of repetitive negative thinking between different disorders (e.g., GAD-type worry and depressive rumination) have generally revealed more similarities than differences, it is argued that repetitive negative thinking is characterized by the same process across disorders, which is applied to a disorder-specific content. On the other hand, there is some evidence that—within given disorders—repetitive negative thinking can be reliably distinguished from other forms of recurrent cognitions, such as obsessions, intrusive memories or functional forms of repeated thinking. An agenda for future research on repetitive negative thinking from a transdiagnostic perspective is presented.

This meta-analysis multiple well-controlled studies were combined to help clarify the overall impact of psychological treatments for social anxiety disorder. A comprehensive literature search produced 32 randomized controlled trials (N = 1,479) that were included in the final analyses. There was a clear overall advantage of treatment compared to waitlist (d = 0.86), psychological placebo (d = 0.34), and pill-placebo (d = 0.36) conditions at posttreatment on the primary domain specific outcome measures. The average treated participant scored better than 80% of the waitlist and 66% of the placebo participants. Treatment also faired better than control conditions across secondary outcomes including cognitive measures (d = 0.55), behavioral measures (d = 0.62), and general subjective distress measures (d = 0.47). Treatment gains were maintained at follow-up (d = 0.76). Combined exposure and cognitive therapy (vs. control: d = 0.61) was not significantly different from exposure (vs. control: d = 0.89; p = 0.33) or cognitive treatments (vs. control: d = 0.80; p = 0.70). Likewise, group treatments (vs. control: d = 0.68) were not significantly different from individual treatments (vs. control: d = 0.69; p = 0.62). Effect sizes were not associated with treatment dose (p - 0.91), sample size (p = 0.53), or publication year (p = 0.77). The results add confidence to previous meta-analytic findings supporting the use of psychological treatments for social anxiety disorder with no significant differences in treatment type or format.