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Words that Heal: Rapid Results from Cognitive Therapy

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Abstract

It is proposed that targeting words and phrases instead of larger structures like irrational beliefs and automatic thoughts permits more rapid and better articulated patient improvement for more diagnoses. Cognitive therapy modifies the perceptions of patients in ways that reduce disability and distress. This is done by eliciting a narrative from the patient and then stimulating changes in key perceptions in the narrative. The altered narrative will control the patient's emotions and behaviors as did the old narrative, but will produce less distressing and disabling thoughts, emotions and behaviors. The fit of the new narrative to the simple underlying data in the patient's life must be at least as compelling as the old narrative. If the fit is adequate, the patient experiences the new narrative as veridical. The methods therapists use to modify perceptions define the "school" of cognitive therapy. The proposed method embraces all of them. Examples are provided.

Keywords: Cognitive therapy, brief therapy, behavioral therapy, therapy, therapy methods, perception, case studies, rapid therapy

1. Introduction

Counselors and psychotherapists can be regarded as members of a mental health repair crew. They do not have special access to what is real or true, but they have become skilled in uttering the words that heal. These words, in the contexts provided by their patients, bring change to the very perceptions that are causing the patients disability and distress. The healing words render the patients more functional by rendering their perceptions more useful, less troubling, and at least as consistent with the available data as the troubling perceptions were. Embedded in this process is, perhaps, the therapist's hope that in so doing, the patient's perceptions come more closely to approximate the truth of what really is. That this hope be realized is not essential for therapy to be useful and successful, and is, in any event, intrinsically unknowable.

A critic might immediately object that this is unrealistic, that the therapist seems to say, "Since one cannot know what is real or true, guide patients to select a story that minimizes their distress and maximizes their happiness." This critic is suggesting that what is real and true is knowable, and that appropriate therapy should align the patient's perceptions with the real, in the manner of correcting an erroneous bank balance. To avoid engaging the philosophical question of the possibility of knowing the real, the question will be left at the status of an asserted but unproven conjecture. It will be assumed that reality cannot be known or verified. Perceptions are the patient's best efforts to make sense of self and the world. Making this assumption has had rather large practical consequences in making highly effective therapies available for a host of mental health problems.

Assuming, then, the patient can't know what really is going on in his/her life, why should a distressing perception be accepted, unless available evidence is incontrovertible? And even then, in the face of apparent evidence, should the alternatives or modifications which minimize distress not be sought out and preferentially adopted? Albert Ellis pointed out that this view was accepted since ancient times, and often quoted Epictetus' remark found in the *Enchiridion* from the first century, that people are not disturbed by events but by their view of the events. This implies that events cannot be known as they really are. If they were, only one view of them would be possible. Ellis brought this up when discussing his rational emotive behavior therapy (e.g. Ellis, 2008) to acknowledge this central point without engaging a philosophical debate, as is being done here. But the point is essential: if reality is knowable and verifiable, cognitive therapy (CT for short) is not possible or needed. The extensive body of research supporting the effectiveness of the cognitive therapies indirectly supports the usefulness of the assumption and of the therapies built upon it, but, of course, does not prove it.

1.1 Simplifying the Language

A person's experience of self-in-world is a web of perceptions, built upon data from senses, memory and possibly other sources, and manipulated by mental processes such as associating, sequencing, etc. The perception is expressed in words and phrases, as formed thoughts, which, taken together, describe the patient in his/her world. Even when pathologically dysfunctional, the patient's view of self-in-world is remarkably reasonable in the sense that the many perceptions are consistent with the raw data of the patient's life, with each other and with patient's emotions and behaviors as well. CT addresses the parts that are not functioning, or are unreasonable and inconsistent to bring about improved functioning and relief.

To facilitate this discussion, the authors have abbreviated the experience of self-in-world and the web of perceptions involved to the word "story." The patient's "story" is the experiential envelope in which he/she lives. The story is composed of words and phrases, and the authors take the existentialist view that the words and phrases both express the story and cause it. When words or phrases in the story change, the patient's experience of self and world change, and emotion and behavior changes. The heart of the argument presented here is that targeting change in the words and phrases a patient uses instead of the usual larger targets of irrational beliefs, automatic thoughts and the like, which are complete perceptions, is advantageous to the therapist. It permits the therapist to work on a more molecular level, making the treatment result more precise fit to the patient with his/her goals, and to bring relief more rapidly.

2. Source of the CT model: Spontaneous Story Changes in day-to-day Occurrences

One easily discovers that words can harm. Confidence is lost, feelings hurt, dreams abandoned, and friendships are distanced by words. These words can be either thought or spoken. Whether formulated in the silence of thought or heard aloud in speech, these pain-inflicting words are received as enlightenment rather than brickbats. Though painful, their message is received as true, even when supportive evidence is lacking or not even sought out. Relying on incomplete or inaccurate information is a routine part of the human condition. Even when all the "facts" seem available, some or all can be weighted inappropriately, selectively disregarded, or misinterpreted. Thoughts, emotions and behaviors ensue as if all data were correct, complete and fully understood. If a change in perception comes about, the new view is experienced as just as coercive as the previous one had been. People live with a great degree of certainty that things actually are the way they view them.

2.1 Story Changes with Distressing Outcomes

A salient example of this appeared in a story in the evening news about a robbery of cash and merchandise from an expensive designer's boutique in a large city. The large city was one of the many with security cameras almost everywhere. Because of the cameras, the story was made more interesting because the news reporters were able to assemble a fairly complete video clip of the entire event. A silent alarm had summoned the police. On the video a tall woman struggles to move a number of obviously heavy cartons out of the store, across the sidewalk, and into a waiting auto. Incredibly, a passer-by stops to assist the lady, the cartons are quickly loaded, and the woman is off. Within less than a minute of her departure, the police are seen arriving, making everything clear. First, the woman was not a shopper or a woman, but a man, disguised as a woman, and a robber. Second, he would never have gotten away successfully without the unanticipated help of the passer-by. Regarding the passerby, there can be little doubt what he thought. He had encountered a woman faced with a difficult task, and assisted, in a disinterested way, without desire of pay or reward. What he quite likely felt is also known: the heaviness of the boxes, the hurry the woman was in, his success in getting her rapidly underway.

All these elements coalesced to engender a feeling of satisfaction, of mutually shared and supported humanity, of being, if for today alone, a true “good samaritan.” The 7:00 news ended all that. Here he watched the video clip and saw himself aiding unwittingly in a robbery. His perceptions and consequent feelings changed abruptly and completely. He now regarded himself a fool, replaying the event over and over both on TV and in his head, writhing mentally as he watched himself helping the robber. He anticipated his friends’ recognizing him, or worse, a later newscast identifying him as a fool, or a suspect.

The point is not that someone’s faulty information was corrected. The point is that a comprehensive change in story, and consequently in emotion and behavior in a complex situation occurred on the basis of a change that can be summarized in a single word or phrase. A congratulatory self-perception of “good samaritan” was replaced with one of “fool”. This story change is likely to cause distress and reevaluation of many other events in this person’s life, with related changes in emotions and behaviors in new situations. This person, from now on, is unlikely to help a stranger with anything without a good deal of information. It is also worth noting that the story change will often seem to condense into a short word or phrase. The patient typically views this word or phrase as a distillation of the new insight. The instant authors argue that the word or phrase came first, and actually caused the story to change. The word or phrase created further helps to sustain the patient’s changed story. Conversely, changes in this condensed word or phrase will trigger new changes in the story.

Another example, this one of a young wife, married some four years to a husband she loved and admired, illustrates the same type change in another context. He was a treasure house of good qualities, and chief among these was his single-minded dedication. He worked all the time, took calls late at night, and had even taken calls during their wedding honeymoon in Paris. He was a tower of strength and purpose, building a sound future for them and their children. She was very proud of him, and never objected for a minute when calls, late nights or unexpected trips interrupted their plans. As a less naïf might have guessed, she was an unwitting member of a triangle. When she found out there was another woman, she refused to believe until the proof became incontrovertible. It was at that point that her wonderful life turned into intolerable torture. The feelings of pride in her husband were replaced with anger, and her sense of her life as charmed vanished in an instant. The caption word of her previous history “very fortunate” was replaced with “betrayed” even before she resisted the evidence. The cascade of change in story and consequently in emotions and behaviors began there. Note that, in keeping with the assumption of the unknow ability of reality, the possibility remains that a cogent and better fitting explanation will repair the damage or redirect it.

2.2 Story Changes with Desirable Outcomes

One might expect an equal likelihood of parallel situations, in which words are just as suddenly and dramatically beneficial. While the authors argue that this is, indeed, the case, beneficial changes encounter more resistance. Words of praise, encouragement, support and admiration are often received with reluctance and suspicion, as if, by some cosmic perversity, bad news is intrinsically more believable than good news. The fragile self seems ever ready to set aside a compliment as uninformed or flattering, and the credibility and motivation of the speaker is scrutinized. If the news is this good, one thinks, it can’t be true, at least about me. And yet, one does, often enough accept good news readily in melancholy instances, as in stories of retired people who hadn’t realized how much their employers valued them, or of grown children who had been unaware of their parents’ sacrifices for them, or of true love’s being discovered by the suspicious partner, but too late. This resistance undoubtedly has some survival value in providing resistance to flattery, sales talks and bland reassurances. The work of the cognitive therapist eludes some of the resistance because, unlike flattery and sales pitches, therapy’s purpose is to assist the patient in achieving his/her own goals, not those of someone else. The cognitive therapist further combats this resistance to positive changes in story regarding the self by engineering the word and phrase changes carefully, constructing them of words and elements within the patient’s understanding, and guiding the discourse so the patient discovers and produces the changes by him or herself, and experiences these changes as his or her own. The patient experiences this as a flash of insight, and the therapist carefully guides the patient as the insight is explored for goodness of fit to other accepted information and or for contradictions. The therapist does this by offering word alternatives to improve the fit or resolve any contradictions. At the point of insight”, the patient also experiences a sampling of the relief the new perception offers, and is motivated to discover supporting evidence for the perception. This offsets much of the remaining resistance to the positive change.

2.3 Summary of Spontaneous Story Changes

Though what is true and real is unavailable to a person, it is easy enough to come up, consciously or not, with a perception that will serve in its place. The patient looks the situation over. He/she then listens carefully. But most anyone who has enjoyed a magician's show has learned that seeing and hearing alone do not merit believing. The patient then draws on memory resources. Thought processes follow. The patient may remind him/herself to rely on observation and proceed scientifically. The patient constructs a perception or perceptions from this process until an "aha" is experienced, at which point the patient's view changes, he/she accepts this result as reality, incorporates it into his/her story, and immediately adjusts emotions and behavior to conform to the changed story. Typically the patient proceeds on the basis of this changed story not as one rides a surfboard, balanced and prepared for further sudden shifts both large and small, but instead with great assurance of, finally, really seeing the picture.

These sudden and unanticipated shifts are, of course, the surprises of everyday life. But the real potential for distress and disappointment lies in the parts of the story involving important other persons, and most especially, in the parts about self. For example, if a trusted person lets one down, "I thought he was my friend" are words showing the patient's change of story, hopefully, ultimately to a more adequate view of the other, who may indeed be his/her friend, but is also much else as well. "I thought I could do it" expresses a disappointing evaluation of one's own performance which could generalize into an undesirable reduction in self-esteem. Naturally, not all sudden shifts bring disappointments. The person thought of as conceited turns out to be shy, thus opening an unexpected opportunity for friendship or intimacy previously thought impossible. Further exploration of this type event is not needed here, since the therapist's task is concerned with repairing damaging changes.

In short, when little data, gleaned from limited senses, is quickly assembled into a picture, change of story occurs. It is magnificent process whose typical limitations must be kept firmly in mind: the view is often narrow, the exposure brief, the penetration superficial, the computations primitive, the biases strong, the results unverifiable. Yet the flawed process is undeniably useful for survival. If one error in the process could be avoided, it would be that of mistaking the story for reality, believing that one's story, however complex, contains more than a hint or what truly is. Avoiding this error would greatly reduce the incidence of many mental health problems. But this is rarely so. Actual day-to-day story change has clear landmarks: First, there are incomplete and/or inaccurate perceptions in the story about important things. Second, there is no way of validating the story, of making sure what is true. Third, action is taken on the basis of the story. Fourth, emotions adjust to stay consistent with story and actions: if one think he/she is doing well, he/she feels good; if he/she thinks he/she is doing poorly, he/she feels bad. Fifth, behaviors adjust to stay consistent with the story and the complexly interconnected emotions.

3. *The CT Model: Intentionally-Caused Story Changes*

Under the assumption that there is no way of knowing what is true in a story, one might expect people to despair of figuring things out. But, as discussed above, this does not happen. Instead, people stagger from one set of information to the next, always sure, or pretty sure, they have the true story. The therapist sees in this situation an opportunity to reduce disability and distress. That is, clinicians have developed a clinical parallel by engineering a therapeutic process that takes advantage of the flawed functioning of our perceptual process to reduce patients' disability and distress. No harm is done nor freedom lost so long as the perceptions built on necessarily flawed data remain simply that: useful but limited constructions of recognized elements crafted into an intelligible view, a working hypothesis to be handled tentatively and relied upon with caution, at least by the therapist. The fit of a changed story to the raw data of the patient's life is impossible to optimize to match external reality, and is instead optimized to improve the patient's mental health.

3.1 Key Features/Description of CT

Finding the words that heal the individual patient within his/her own complete context of personal history, pathology, beliefs, perceptions, culture, religion, gender, abilities, limitations and needs was initiated in the 1950s and systematized in the 1960s. The usefulness of this method for a host of mental health problems was immediately evident and is well supported in many studies (Miller, 2012). Albert Ellis (1962) focused on the reasonableness of patient thought processes, and identified commonly occurring irrational beliefs. He devised ways of discovering them in patients and modifying them by discussion and debating methods. He continued to articulate and improve the methods throughout his career (Ellis, 2008).

Aaron Beck's purpose was to uncover "automatic thoughts" causing and maintaining depression or some of the features of depression, such as not experiencing sufficient pleasure in their daily activities, loss of interest, poor sleep, disturbed appetite, fatigue, difficulty concentrating, and excessive thoughts of death and dying. He developed a system of dialectical processes to alter or eliminate these thoughts. Like Ellis and many of their contemporaries, the usefulness of these methods was also borne out in research and Beck continued development of his system (Beck, 2005, 2008) for many years. These therapies produce the rapid, sweeping and durable changes in story like those people experience in everyday life but which the therapist has intentionally designed and maximized for reduction of disability and distress and improvement of adjustment and happiness.

3.2 CT Methods and Systems

Since the early work of Beck (e.g., 1964), Ellis (e.g., 1962) and their contemporaries launched the "cognitive revolution" in the 1970's, cognitive theorists have developed a skein of methods to create the changes in perceptions that reduce patient distress and disability directly, or cause emotional and behavioral changes in patients that reduce distress and disability. As mentioned above, effective BT methods have been integrated with CT in a combination called cognitive-behavioral therapy or CBT. For many diagnoses medication is added to the treatment regimen, and this, too, has been integrated with CT by priming the patient with the anticipated good effects of the medication. This is done both to gain earlier and stronger beneficial effects through the placebo effect and to strengthen patient compliance with prescribed usage. A very typical example of this is when a depressed patient is admitted to the hospital because of risk of suicide, and is stabilized in just 72 hours on an antidepressant that will have no appreciable effect for weeks. The stabilization can reasonably be attributed almost entirely to the cognitive parts of the treatment at that point.

3.3 Summary of the CT Model used in Therapy

3.3.1 Conduct Clinical Interview

3.3.2 Target Perceptions for Modification

3.3.3 Assist Patient in Discovering that Target Perceptions are Flawed

This can be done by discovering that they are based upon automatic thoughts (Beck, 2005), irrational beliefs (Ellis, 2001), are age or role inappropriate (Berne, 1961), are inconsistent with other more useful personal constructs (Kelly, 2003), etc.

3.3.4 Guide or Support Patient in Developing Replacement Perceptions

Guide patient toward those with fewer or less distressing/disabling flaws, using the same methods.

3.3.5 Stabilize Gains

Use the methods that enabled a patient to change his/her targeted perceptions to inoculate him/her against reverting to old perceptions or changing perceptions in undesirable ways. This is done by practicing patients in recognizing automatic thoughts, etc., in self and others and avoiding these in their thinking.

3.3.6 Provide Aftercare and Discharge

The patient is then discharged from treatment, CT's having stimulated changes in the patient's perceptions, emotions and behavior to reduce disability and distress.

4. Proposed Changes in CT: Targeting Words Instead of Perceptions

Starting with the same assumption that there is no way of knowing what is true in one's story, the critical question in therapy will never be inquiring what is true, but what the patient thinks or feels or believes to be true, and the clinical interview, the starting point of CT, is conducted accordingly. Having ascertained the patient's goals, which is typically reduction of some type of distress or disability, the therapist employing CT proceeds as above but with the changes noted in the following sections:

4.1 Conduct Clinical Interview

The therapist elicits in detailed narrative the "world view" and "self-in-world view" of the patient' which is being called the patient's "story." This story, however inchoate, exists and consists of a web of perceptions, which in turn consist of semantic units (words and phrases) which are gathered by the therapist in adequate detail particularly in the areas relevant to the patient's goals.

4.2 Target Perceptions for Modification

Since the patient's story adapts to changes in perception and is altered, slightly or dramatically, when one changed perception sequentially adjusts many others, the therapists select one or a few perceptions that seem instrumental for achieving the patient's goals and seem susceptible to stimulated change.

4.3 Tailor the Intended Changes Precisely

The patient's story is viewed by the therapist as semi-arbitrary, a better or worse fit to the available raw data of the patient's life. The therapist gently and carefully invites and assists the patient in disclosing these raw data. The intended change in the patient's story must account for these data as completely and economically as possible. The patient discloses the raw data contextually, within his story. The therapist sees the problematic aspects of the patient's story, and sees a number of other possible stories which account for the raw data of the patient's life equally well, but are less disabling and distressing to the patient. The therapist selects one of these and proposes it as his view of the patient. If the patient accepts it, even on a trial basis, the patient's relief will be rapid, almost immediate, and apparent. If the patient rejects it with finality, the therapist instantly drops it and tries another.

4.4 Substitute Words in Patient Story

Perceptions, the building blocks of the patient's story, consist of words and phrases (semantic units), and change when the words or phrases change. For this reason, the therapist takes care to observe and select exact words and phrases the patient uses in telling his narrative for modification. Even a relatively small substitution of one adjective for another during the interactive process of the session can have immediately beneficial results in reduced anger or sadness, or increased hope that goals may be achieved. For example, a therapist's reflecting the patient's description of a "devastating financial loss" as a "very disappointing financial loss" can visibly decrease rage and point patient in a problem-solving direction, if the patient accepts the substitution (i.e., does not correct the therapist and re-assert the original adjective, but instead adopts it in the continuing dialog). As reflecting patient statements is a method most typically associated with client-centered therapy (Rogers, 1951), the therapist will make use of tools from the various cognitive therapies throughout the dialog with the patient, inserting the changes in words.

4.5 Observe Behavioral and Emotional Changes and Adjust Word Substitutions

Patient goals are behavioral (e.g. cease using addictive drugs, behave more assertively, etc.) and emotional (e.g. feel less depressed, less anxious, happier, etc.) and the cognitive therapist causes these changes by assisting the patient in changing his/her story. The new perceptions in the changed story enable the patient to experience the stimuli in his/her environment differently, and respond to them, both behaviorally and emotionally, in ways that produce less distress and disability.

Although it is recognized that change in behavior and emotion (insofar as emotion can be viewed simply as a change in rate of behavior (Skinner, 1971)) can sometimes be effected using the principles of behavioral therapy (BT for short) only, as for example, in shaping (Sullivan & Sullivan-Nunes, 2013), the use of BT without integrated CT components has steadily diminished to the point where seamlessly integrated cognitive and behavioral components are typical. Even in the cases that are still managed with BT treatment plans, the cognitive changes which spontaneously occur are what facilitate the patient's retaining and generalizing the gains made in BT. Very many common diagnoses are not vulnerable to BT only, and require CT either instead of or in combination with BT. Substance dependence, in the instant authors' view and contrary to Beck's (Beck, 2008; Miller, 2012) view, is an example of this: unless CT's methods are used to undermine the reinforcing power of cocaine, for example, which maintains the addictive behavior, the cocaine use will continue.

4.6 Resolve Inconsistencies and Contradictions

When new perceptions coalesce or existing perceptions change, there is a point at which the changes are adopted by the patient as "true" or "real" and they become part of his/her story. The therapist elicits narration of the changing story, examining and resolving inconsistencies, modifying words and phrases which fine tune patient responses to daily stimuli in the context of the changed story.

4.7 Stabilize Gains

As emotions and behaviors align with the new self-in-world story and its consistency is established in patient's view of self and environment, the therapist attends to supporting the perceptual changes that will enhance durability of patient gains. This is done by reviewing the perceptions most directly related to the new or changed ones together with resultant behavioral and emotional sequelae and fine tuning words and phrases in the narration as needed. The process continues until adequate achievement of goals has occurred.

4.8 Provide Aftercare and Discharge

The patient is then discharged from treatment, CT's having stimulated changes in the patient's semantic units, which in turn changed perceptions, emotions and behavior to reduce disability and distress.

5. Example of CT Targeting Words Instead of Perceptions

Consider the case of a male aged 69 who sought therapy for persistent depression and suicidal thoughts. On clinical interview it was learned that the man had no children, never married or dated, and had no sexual experience whatever. His education stopped at high school, after which he got a low-level clerical job in a small city bureaucracy which he retained until retirement. His retirement finances were adequate and would permit some limited travel and other activities, but he had never had any interest in these things and didn't feel any now. He had no living relatives except a possibly still-living brother with whom he had not been in contact for several decades. He characterized his entire life as going to work, coming home, eating, watching TV and sleeping. His physical health was typical for his age, with some complaints but no illness. The mental status examination revealed enough symptoms for major depressive disorder but beyond that was within normal limits. The patient provided a credible guarantee of safety, so hospitalization was not indicated. In summary, the patient seemed to have faced the existential question typical for that stage of life as described by Erikson(1997) and concluded that his life was not worth having lived. The depression was the result of the sweeping self-condemnation.

5.1 Standard CT Therapy: Identify the Erroneous Thinking

A therapist using, for example, Ellis' style of CT abbreviated REBT follows the outline in section 3 above. The therapist would use discussion, debate and confrontation with the patient to help him discover his irrational belief, some version of "a person absolutely must be competent, adequate and achieving in all important respects or else he/she is an inadequate, worthless person." The therapist would then guide the patient in a more rational evaluation of his life, and permit him to characterize it in any significantly less distressing way he wished. In short, the therapist would disable the patient's current story by demonstrating that the thinking was flawed and then help him build a new story.

5.2 Alternative CT Process: Focus on Words and Phrases Used by the Patient

The therapist who chose to focus on words and phrases instead of larger cognitive structures would follow the outline in section 4 above. The therapist, by the end of the clinical interview, sees many ways the data of the patient's life could be construed, many equally reasonable stories told to account for the raw data. In this case, the therapist might select a story about resources, in which the patient comes to see that he did the best he could under the circumstances. Or the therapist might take advantage of perceptions needing figures to focus on against a ground. After finding and highlighting the patient's unappreciated successes, they would stand out against a background of "the rest." Or again, the therapist could set the patient's raw data in advantageous relief against much worse outcomes that could have happened. This particular therapist in this particular instance decided to redefine success.

In the session, the therapist continued to ask the patient questions after the completion of the clinical interview. The questions included many extremes which would certainly be denied. Questions like "How many people have you killed?" and "How many children have you seriously harmed?" would be followed by questions exploring lesser criminal activity, disloyalty, and other damaging acts. For this patient, few or none of these actions will be found. When the patient is beginning to feel the pattern of his responses, that he is able to deny all antisocial activity, the therapist is able to introduce a new story, characterizing the patient's life as one in which he has "done no harm." The therapist pointed out that "to do no harm" is enshrined in the Hippocratic Oath as the goal of the medical profession. The unexpressed definition of success has been replaced for the patient by this well-recognized high standard and the patient merits a pass. The number of potential therapy sessions was greatly reduced and relief was experienced immediately, even before all the details were worked out.

In follow-up, as details were sorted out, the patient brought up instances where his conduct was less than exemplary, and the therapist coached him to realize that he had not attained perfection, but aimed at and achieved a lofty goal during his life. Relief was rapidly experienced by the patient, and the solution provided him a sense of self that will help him acquire and use the skills needed for the rest this stage of life: he has a functional story within which to live.

5.3 Other uses for Focusing on Words and Phrases

During the clinical interview and at other times when the patient is disclosing and discussing his/her thoughts, emotions and behaviors, the therapist can reflect the patient's words with minor changes. If the change is accepted, the patient often immediately experiences the beneficial difference the changed word causes. This way a dysphoric emotion can be immediately attenuated even before the situation causing it is fully explored. Reflecting the patient's statement of being "in a rage" as being "very angry" may help the patient become a little calmer while he describes the event. Once the event is fully explored, the therapist might adjust the patient's saying "so you can see why I was so very angry" to "yes, I can see why you were so justifiably, if a bit excessively angry." As the words are shaped, the behaviors and emotions shape as well. Usefulness is found when a patient finds an event or details of an event too embarrassing to disclose, yet appreciates that the disclosure is needed. The therapist acknowledges the possible embarrassment and offers to proceed by assuming that the content is something specific that is clearly far worse than this patient could be having difficulty speaking of. The patient will typically then proceed with the actual disclosure experiencing much relief, saying words like "oh, no, nothing like that. What happened was just..." and the difficulty is solved. Finally it may be worth noting that the therapist is not experienced as a task master, brilliant expert, or needed support, and no dependence has been risked. In the patient's view the therapist simply saw the truth of the patient's life and pointed it out. A valuable service and worth the fee.

6. Conclusion

Since patients often condense their story or experience of self-in-world in a single word or phrase, cognitive therapists are invited to consider direct modification of that word or phrase to effect change in the patient's cognitions and linked emotions and behavior. This is argued to heal more rapidly than by the usual CT methods of identifying erroneous cognitions, correcting them, and then helping the patient to find more useful cognitions.

In addition, cognitive therapists can also refocus their efforts in therapy upon the words and phrases the patient uses when speaking and offering some substitutions when reflecting patient content. This can help the patient in disclosing difficult material and reduce dysphoric emotion.

7. References

- Beck, A. T. (1964). Thinking and depression: Theory and therapy. *Archives of General Psychiatry*, **10**, 561–571.
- Beck, A. T. (2005). The current state of CT: A 40-year retrospective. *Archives of General Psychiatry*, **63**, 953–959.
- Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American Journal of Psychiatry*, **165**, 969–977.
- Berne, E. (1961). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry*.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, New Jersey: Lyle Stuart
- Ellis, A. (1994). *Reason and Emotion in Psychotherapy*, NY: Birch Lane Press
- Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors: new directions for rational emotive behavior therapy*. Amherst, New York: Prometheus Books.
- Ellis, A. (2008) Cognitive restructuring of the disputing of irrational beliefs. In W. O'Donohue & J. Fisher(Eds.), *Cognitive behavior therapy*, 2nd Ed. Hoboken, NJ: John Wiley & Sons.
- Erikson, J. (1997) *The life cycle completed*. New York: W. W. Norton
- Kelly, A. (2003) A brief introduction to personal construct theory. In F. Fransella (Ed.), *International Handbook of Personal Construct Psychology*. New York: John Wiley & Sons (pp. 3-20).
- Miller, A. (2012). *Manual for Aaron Beck on CT with Aaron Beck*. Mill Valley CA: Psychotherapy network.
- Rogers, C. (1951). *Client-centered therapy*. Cambridge, Mass: Riverside Press.
- Skinner, B. F. (1971). *Beyond freedom and dignity*. Indianapolis, Indiana: Hackett Publishing
- Sullivan, A. P., Sullivan-Nunes, P. (2013, December). Translational research in Psychology: An instructive case. *International Journal of Business and Social Science*, Special Issue, 4(17), 11-14.