The Journal of Mind and Behavior
Autumn 1992, Volume 13, Number 4
Pages 413–416
ISSN 0271–0137

Cognitive Therapy With Couples. Frank M. Dattilio and Christine A. Padesky. Sarasota, Florida: Professional Resource Exchange, 1990, 136 pages, $15.95 paper.

Reviewed by Catherine C. Loomis and Geoffrey L. Thorpe, University of Maine

---

"Cognitive therapy" describes a loosely grouped set of clinical postulates and procedures that have at least some connection with experimental psychology. The hope or promise of such a connection is appealing to those clinicians who prefer to anchor their work in psychological science, and a new book in the applied arena with "cognitive therapy" in the title therefore claims our critical attention.

Interested particularly in depression, Beck (1967, 1976) developed cognitive therapy in response to his frustration at the poor practical results and theoretical shortcomings of the dynamic psychiatry in which he was trained. Construing depression as primarily a disorder of thinking (form and content), Beck argued that depressive individuals systematically process information in a biased manner, leading them to make cognitive errors that in turn account for depressive phenomena (dysphoric mood, giving up easily, self-blame, etc.). In applying the treatment, the therapist seeks a collaborative relationship with the client in which dysfunctional beliefs are examined and gently challenged, and real-life "experiments" designed to falsify the unrealistic assumptions are encouraged (Beck, Rush, Shaw, and Emery, 1979). Prospective clinical trials have shown cognitive therapy to be as effective as standard psychiatric treatment (pharmacotherapy plus support), and to have the further advantages of fewer negative side-effects and less client attrition during, and continuing improvement after, treatment (Rush, Beck, Kovacs, and Hollon, 1977).

Several studies have supported a general link between negative thoughts and dysphoric mood, and the obvious connection between cognitive therapy concepts and attribution theory has been followed up diligently, but it is in application to panic disorder that cognitive therapy has proved particularly fruitful clinically and theoretically (e.g., Clark, 1986). Not only is it empirically effective in treating panic disorder (Barlow, 1988), but cognitive therapy and its assumptions have also helped advance understanding of etiology. Work with near-threshold tachistoscopic presentation of possible endings to sentence stems has shown that panic disorder clients are susceptible to enduring biases or distortions ("cognitive schemata") not shared by people without a history of panic. (In response to the stem, "When Sue's heart was pounding, she was _____," panic clients are quicker to recognize "dying" than "running" or "reading"— see Thorpe and Hecker, 1991.)

Requests for reprints should be sent to Catherine C. Loomis, Psychology Department, University of Maine, 5742 Little Hall, Orono, Maine 04469-5742.

In this context, it is interesting to contemplate applying cognitive therapy and its concepts and procedures to troubled relationships. This is the focus of the Dattilio and Padesky book, *Cognitive Therapy With Couples*, written as a "nuts and bolts resource" (p. x) for mental health professionals. The authors suggest that cognitive therapy is applicable to troubled couples in that the partners are likely to hold dysfunctional beliefs about, and unrealistic expectations of, the relationship. Potentially dysfunctional beliefs range from fleeting "automatic thoughts" that arise in specific situations (e.g., "she spilled the soup just to embarrass me"), to the more fundamental and lasting cognitive schemata that are typically learned in childhood through the interaction of personal experience with parental and cultural influences (e.g., "being alone is frightening and must be avoided at all costs").

The book presents clinicians with an array of techniques to help partners in a relationship to learn to identify and challenge their dysfunctional beliefs. Techniques often associated with behavioral couples therapy, such as problem-solving training and communication skills training, are also recommended. Written in a concise and engaging manner, the book provides a step-by-step guide to treatment, and examples abound, demonstrating the authors' extensive clinical experience.

One chapter is devoted to a discussion of practical issues faced by therapists, such as clients' anger, violence, or infidelity; cultural issues; therapy with gay and lesbian couples; and terminating relationships. The authors could probably have filled an entire book with such matters, but they receive only a few pages here; nonetheless, those pages condense a surprising variety of clear procedural guidelines and concrete suggestions for dealing with the range of possible impediments to successful therapy. This section, and the book in general, draws more obviously from clinicians' practical experience than from research data, quite understandably given that the field is poorly developed empirically, and that the authors' aim was to aid practitioners. Yet the balance of theory and practice is an important general issue in a book of this kind.

While the book excels in its detailed presentation of therapeutic techniques, discussion of matters of theory and degree of empirical support for cognitive therapy in this application is cursory and occasionally unclear. This may be consistent with the authors' stance of not requiring unswerving commitment to the cognitive therapy model. Their suggestion that clinicians with other theoretical orientations may find the techniques serviceable will be welcomed by eclectic practitioners. However, the unelaborated assertion that cognitive therapy combines "many of the insights from the psychodynamic therapies, along with many of the strategies introduced by Behavior Therapy" (p. 11) seems too bald to satisfy the critical reader. Similarly, given cognitive therapy's avowed connection with experimental psychology, it seems inconsistent for the authors to limit their review of the literature on therapeutic outcome to brief mention of an early study showing that cognitive therapy plus behavioral treatment was more effective than behavioral treatment alone in treating discord in couples. Later work producing different outcomes (e.g., Baucom and Lester, 1986) is not cited.

Experts in cognitive therapy may find the book shallow in its theoretical and empirical coverage, but it was not the authors' intent to supply a comprehensive scientific review. Rather, they have successfully reached their stated goal of providing a practical outline for therapists. Clinicians wishing to consult resource material on cognitive interventions with couples will find in this book a brief, clear, and explicit guide.

References

Barlow, D.H. (1988). *Anxiety and its disorders*. New York: Guilford.

Baucom, D.H., and Lester, G.W. (1986). The usefulness of cognitive restructuring as an adjunct to behavioral marital therapy. *Behavior Therapy, 17*, 385–403.

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

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

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

Clark, D.M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 24*, 461–470.

Rush, A.J., Beck, A.T., Kovacs, M., and Hollon, S. (1977). Comparative efficacy of cognitive therapy and imipramine in the treatment of depressed outpatients. *Cognitive Therapy and Research, 1*, 17–37.

Thorpe, G.L., and Hecker, J.E. (1991). Psychosocial aspects of panic disorder. In J.R. Walker, G.R. Norton, and C.A. Ross (Eds.), *Panic disorder and agoraphobia: A comprehensive guide for the practitioner*. Pacific Grove, California: Brooks/Cole.