# Aaron Temkin Beck (born July 18, 1921-) Biography

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Aaron Beck was born in Providence, Rhode Island, USA, the youngest child of four siblings. Beck attended Brown University, graduating magna cum laude in 1942. Then he attended Yale Medical School, graduating with an M.D. in 1946. After his graduation, he served a rotating internship, followed by a residency in pathology at the Rhode Island Hospital. Although initially not interested in psychiatry, a residency in neurology at the Cushing Veterans Administration Hospital in Framingham, MA, required rotation in psychiatry intrigued him with some of the more recent developments in the field. He spent two years as a fellow at Austin Riggs Center at Stockbridge where he acquired substantial experience in conducting long-term psychotherapy. The Korean War shifted Beck's area of work to the Valley Forge Army Hospital where he was Assistant Chief of Neuropsychiatry.

Dr. Beck joined the Department of Psychiatry of the University of Pennsylvania in 1954. He initially conducted research into the psychoanalytic theories of depression. He developed a different theoretical-clinical approach that he labelled cognitive therapy. Since 1959 he has directed funded research investigations of the psychopathology of depression, suicide, anxiety disorders, panic disorders, alcoholism, drug abuse, personality disorders, and schizophrenia and of cognitive therapy of these disorders.

Currently Aaron T. Beck, M.D., is the President Emeritus of the non-profit Beck Institute for Cognitive Therapy and Research, and University Professor in the Department of Psychiatry at the University of Pennsylvania and the director of the Psychopathology Research Unit (PRU), which is the parent organization of the Center for the Treatment and Prevention of Suicide.

He has published more than 550 scholarly articles and 18 books and has developed widely-used assessment scales. He has received many prestigious awards including the 2006 Albert Lasker Clinical Medical Research Award for developing cognitive therapy, which fundamentally changed the way that psychopathology is viewed and its treatment is conducted. He has been listed as one of the "10 individuals who shaped the face of American Psychiatry" and one of the 5 most influential psychotherapists of all time by The American Psychologist (July 1989). He was elected a Fellow of

the American Academy of Arts and Sciences in 2007.

Beck is noted for his research in psychotherapy, psychopathology, suicide, and psychometrics, which led to his creation of cognitive therapy, for which he received the 2006 Lasker-DeBakey Clinical Medical Research Award, and the Beck Depression Inventory (BDI), one of the most widely used instruments for measuring depression severity. Beck is also known for his creation of the Beck Hopelessness Scale and the Beck Anxiety Inventory, and has founded the Beck Institute in Philadelphia, Pennsylvania, in which his daughter, Dr. Judith Beck, works. He is married with four children, Roy, Judy, Dan, and Alice. He has eight grandchildren.

***Awards***

- The 7th Annual Heinz Award in the Human Condition
- The 2004 University of Louisville Grawemeyer Award for Psychology
- The 2006 Lasker-DeBakey Clinical Medical Research Award
- The 2010 Bell of Hope Award
- The 2010 Sigmund Freud Award
- The 2010 Scholarship and Research Award
- The 2011 Edward J. Sachar Award
- The 2011 Prince Mahidol Award in Medicine

***Books by Aaron Beck***

- The Diagnosis and Management of Depression (1967)
- Depression: Causes and Treatment (1972)
- Cognitive Therapy and the Emotional Disorders (1975)
- Cognitive Therapy of Depression (with John Rush, Brian Shaw, & Gary Emery, 1979)
- Cognitive Therapy in Clinical Practice: An Illustrative Casebook (with Jan Scott & Mark Williams, 1989)
- The Integrative Power of Cognitive Therapy (with Brad Alfred, 1998)
- Prisoners of Hate: The Cognitive Basis of Anger, Hostility, and Violence (1999)
- Scientific Foundations of Cognitive Theory and Therapy of Depression (with David Clark, 1999)
- Cognitive Therapy of Personality Disorders (with Arthur Freeman, 2003)
- Cognitive Therapy with Inpatients: Developing A Cognitive Milieu (with Jesse Wright, Michael Thase, & John Ludgate, 2003)
- Cognitive Therapy With Chronic Pain Patients (with Carrie Winterowd & Daniel Gruener, 2003)
- Anxiety Disorders and Phobias: A Cognitive Perspective (with Gary Emergy & Ruth Greenberg, 2005)
- Schizophrenia: Cognitive Theory, Research, and Therapy (with Neil Rector, Neal Stolar, & Paul Grant, 2008)
- Cognitive Therapy of Anxiety Disorders: Science and Practice (with David Clark, 2010)

## REFERENCES

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Talbott, J.A. (2002). Dix Personalité Qui Ont Changé le Visage de la Psychiatric Américaine. L'Information Psychiatrique, 78(7), 667–675

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## Interview with Aaron T. Beck

**Question: How did you get interested in psychotherapy?**

**Answer:** Actually I had never intended to be a psychiatrist. I was involved in a career in neurology, and as part of the residency program I was assigned to spend 6 months in psychiatry. I became intrigued by psychoanalytic therapy and decided to get training in the field and practice psychoanalysis.

**Question: What changed you from psychoanalysis to cognitive therapy?**

**Answer:** After I became a fully fledged psychoanalyst, I decided that the field needed to have empirical validation. I initiated a study of dreams in order to validate the psychoanalytic notion of repressed hostility. According to the theory, individuals who are depressed have a good deal of internal rage, which they have repressed. I thought I would find signs of anger and hostility in the dreams of depressed patients. To my surprise, I found that the dreams showed less hostility than those of non-depressed patients.

**Question: What relationship did these findings have for the development of cognitive therapy?**

**Answer:** Once I got the negative findings in the dreams, I conducted other studies of the responses of depressed patients to various experimental manipulations. I also reviewed the dreams and found that there was a common theme. Basically the dreamer saw himself as defective, undesirable, or helpless. These same themes appeared in the waking reactions of the patients, but in less dramatic form. At this point I decided that the psychoanalytic theory was probably invalid, and that the core of the depression was the patient's negative beliefs about himself, his experiences, and his future. Thus, the core of depression is this negative triad, rather than inverted rage.

**Question: How did cognitive therapy evolve from this theory?**

**Answer:** The theoretical foundation consisted of negative beliefs, which then produced a negative bias in the patient's processing of information. I discovered the negative bias when I trained the patients to identify their automatic thoughts, that is, the rapid thoughts that intervene between a situation and their sad response. Patients generally were not aware of these automatic thoughts until they learned to look for them. These thoughts then imparted the negative meaning to the situations. At this point I was able link up negative beliefs with the negative interpretations of situations as identified in the automatic thoughts. I realized that in order to get at the thoughts which would occur frequently in the therapeutic session, I had to sit the patients up and start asking them more questions. I thus moved from the psychoanalytic mode of passive listening to active questioning.

My theoretical framework was enlarged when I came across the work of Albert Ellis. His A-B-C model of Activating Stimulus, Beliefs, and Consequences, showed that the individuals' beliefs actively controlled information processing. The negative bias they imposed on their thinking then permeated the individuals' responses to situations and accounted for their negative emotions and maladaptive behavior.

**Question: How did you develop cognitive therapy from that point?**

**Answer:** At this point I became aware of the cognitive revolution in psychology. This helped to flesh out the theoretical infrastructure of the theory. Thus, I conceived of the dysfunctional beliefs as imbedded in cognitive schemas. When activated, these cognitive schemas (containing beliefs such as "I am… helpless," "worthless," "undesirable," etc.) acted as information processors. Thus, changing the belief should lead to improvement in the patient's depression. However, I realized the best way to deactivate these schemas was through:

A) Getting the patients to revaluate their negative interpretations of situations (what Ellis called "challenging the irrational ideas.")

B) Conducting behavioral experiments to indicate the patient's faulty negative expectations.

I also was influenced by the behavioral therapy movement in drawing largely on the kind of therapeutic structures that behaviorists employed. I modified my interview format to include

a) Setting the agenda and reviewing patients' goals,

b) Obtaining and providing feedback to the patients throughout the interview,

c) Summary and action plan (previously called homework assignments).

**Question: How did your formulation of depression generalize to other conditions that you treated?**

**Answer:** I proposed what I called "the generic cognitive model." This model applies across the board to all psychiatric disorders, as well as medically related psychological problems. I condensed the formulation to what I called the "Generic Quartet." This consists of the stimulus situation (which may be internal or external) the dysfunctional belief, symptoms of disorder and excessive focus on symptoms, belief, or activating stimulus. Each of the components of the quartet interact with one another so that changes in one, impact the others.

Thus, the generic cognitive model spins off mini models for each of the disorders. These range from anxiety and Obsessive compulsive disorder to hallucinations and delusions, to chronic fatigue syndrome.

**Question: What therapeutic techniques do you use in this model?**

**Answer:** I use methods and techniques for each of the facets of the disorder-specific model. Thus, in a patient with chronic lower back pain, we would propose engagement in external activities (refocusing and diversion), restructuring the beliefs such as "This is hopeless, I'm not able to do anything," counteracting the basic avoidance by getting them engaged in activities, and distancing them from the experience of pain with mindfulness. The therapist can draw on all of these methods. Their differential effectiveness will vary from patient to patient and from disorder to disorder.

**Question: What do you see as the future of cognitive therapy?**

**Answer:** The next step in the development of the underlying theory is the integration with the newer findings in neurobiology. There has been some exciting finding relevant to the cognitive model of depression and anxiety. The treatment will be based on a case conceptualization based on these findings.

Aaron T. BECK

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