Chapter 1
INTRODUCTION

There are very few human tragedies that stir sympathy and concern more deeply than seeing society suffer during war and the other increasingly frequent epidemics of violence around the world. In the past, wars were fought between soldiers on the battlefield, but today, more than ever before, cities, villages, and towns are the battlefields, and it is the common man who gets caught in the crossfire. Falling victim to acts of war stirs an array of powerful human emotions. Regardless of the specific character of any particular war or act of terror, such circumstances by definition involve destruction, pain, and death (Joshi and O’Donnell, 2003).

Although these physical losses can be reconstructed or replaced, with the accompanying pain and sorrow gradually diminishing, the psychological scars—the trauma, and the horrifying images and memories of war do not heal as easily. Wartime survival is perhaps most challenging and complex for people who have been engaged in war and are handicapped. It has, generally, been found that the psychological ethics related to war are similar to those associated with natural and human-initiated disaster events. However, the intertwined contributions of economic, political, cultural, religious, and community variables have come to be appreciated as confounding factors having an enormous psychological impact on war soldiers-especially those who have been handicapped (Joshi and O’Donnell, 2003).

Until recent times, very little attention was paid to the psychological well-being of the victims of war. The resulting paucity of psychological interventions has given rise to spirits of hopelessness, helplessness and increased incidences of alcohol and drug use among the war handicapped. This has a negative impact on society at large. In an environment characterized by such suffering, deprivation, and violence, the developmental aspects of even children in the society are severely affected. Sometimes one meets survivors of war and/or torture, who have been victims of terror and relive their trauma, frequently transmitting trauma to the next generation. There are war veterans, who endure and shoulder the burden of posttraumatic stress for years to come (Yeager and Lewis, 2000).
War is particularly traumatic for soldiers because it often involves intimate violence, including witnessing death through direct combat, viewing the enemy before or after killing him, and watching friends and comrades die. Heavy combat exposure, seeing comrades injured, witnessing death, prisoner-of-war (POW) experience and being wounded are traumatic beyond the time spent in military service or other military events (Escobar et al., 1983; and Kulka et al., 1990). Young adults exposed to military combat may also be at greater risk than their older peers. Vietnam veterans who were 19 years or younger during the war were significantly more likely to have substance abuse problems, criminal activity, employment difficulties, and problems with social relationships after discharge (Harmless, 1990), and long-term distress and mental health symptoms were high among Vietnam veterans.

According to Kang and Heyams, (2005), fifteen percent or more of some populations of veterans of the Vietnam War and the 1991 Gulf War have received diagnoses of post-traumatic stress disorder (PTSD). Given this history and the fact that U.S. troops in Iraq and Afghanistan had been serving for prolonged periods in a hazardous combat environment, they expected the mental health care needs of newest veterans to be great. In a survey of 3671 Army soldiers and Marines who were involved in combat in Iraq and Afghanistan, up to 17 percent of those returning reported symptoms consistent with major depression, generalized anxiety or PTSD.

In the last decade there is a more or less circumscribed body of research that brings together the various aspects of trauma of war. The recent wars in the Balkans, Afghanistan, and the Middle East provide good examples of the array of trauma victims who are displaced from their homes and communities and forced to live in refugee camps or in exile. The situation in other parts of the world such as South Africa and South East Asia also illustrates the strife, war, and trauma many young lives come to know too well. Soldiers who live in war zones are exposed to persistent violence and danger. They are at high risk for the development of mental illnesses (Winnicott, 1992).

Pizarro and Silver (2006), reported that many investigators have examined the mental health consequences of exposure to war trauma and injury and found substantial postwar psychiatric difficulties among war handicapped. Research has also linked war trauma to physical health outcomes, including an increase in negative physical symptom
reporting. Chronic illness, and death. Traumatic war exposure and war handicapped have also been linked to specific self-reported and objective health problems, such as cardiovascular diseases, hypertension and gastrointestinal disorders." Literature detailing patterns of physical health problems among aging veterans have grown. Thus negative impact of war is manifold among soldiers handicapped in war.

WAR

The 1980-1988 IRAN-IRAQ War inflicted enormous human costs, as each side sustained hundreds of thousands of casualties. According to Iranian government estimates, Iran sustained approximately 387 chemical attacks (via rocket, air, or artillery) during the 8-year war, (Taheri, 1993) which resulted in high rates of medical morbidity and psychological distress among an estimated 60,000 Iranian survivors (News chronology, 1995; and Hashemian et al., 2006).

If one looks at human history, one may notice war is all the rage. Wars have been fought on every continent and in every century—and we have the written records of events to prove it. In 1976, anthropologist Ashley Montagu detailed evidence of 14,500 wars over the last 5,600 years. That’s 2.6 wars per year. Corroborating Montagu’s research, Charles Burke stated in his 1975 book, Aggression in Man, that there have been only 268 years of peace during the last 3,400 years of civilization (Scott, 2003).

To look at the psychology of war and not discuss the effects of combat that linger after the bombs and bullets have been put back in storage seems obscene. A soldier’s experiences are trunked up in his mind and carried home to be unpacked and repacked throughout the rest of his life. This is a heavy cargo of blurred faces, piercing noises, and friends lost to history’s violence.

The idea that returning home from war can be more difficult than war itself appears so often in literature about combat that it can seem like a cliché. Yet the psychological turmoil that faces those who have fought is undeniable. Nearly every soldier returning home will have psychological symptoms, according to psychologists Laurie Sloane and Matthew Friedman.93 The former psychology instructor and soldier Lt. Col. Grossman writes, “Within a few months of sustained combat, some symptoms of stress will develop in almost all participating soldiers” (Grossman, 1996). The severity
of post-war psychological issues varies from individual to individual. But no soldier is left untouched.

Psychological distress is the legacy of war. The more openly we admit that, the better we as a society can assist returning soldiers in their recovery. In 2008, Sloane and Friedman released a book intended to educate and advise American soldiers returning from Iraq and Afghanistan about potential psychological issues. In the middle of After the War Zone: A Practical Guide for Returning Troops and Their Families, they frankly tell soldiers to expect at least a few adjustment problems. “It would be abnormal if you didn’t experience some of the feelings and behaviors following what you have been through in the war zone” (Sloane and Matthew, 2008).

What Sloane and Friedman emphasized was that for war veterans mental distress. Many studies have been conducted to study the impact of war. The predominant impact of war which has been reported is loss of loved ones (Pefferbaum et al., 1999); Displacement (Adjukovic and Adjukovic, 1998; and Shaw, 2000); Loss of loved ones; Living with distressed adults (Moro and Vidovic, 1992). In addition, physical effects of war have been reported.

**Physical Effects of War**

**Loss of Physical Capacity**

Survivors of physically disfiguring trauma experience a series of assaults on the mind and body that present extraordinary and complex challenges to human resilience. The injurious event itself is traumatic, but additional traumas can also occur from painful and frightening medical treatments. The physical changes in the Survivor’s body are permanent reminders of the fear, horror, sadness, and pain experienced. The real and imagined reactions of others to then-disfigured bodies’ present survivors with the additional and ongoing trauma of feeling rejected, isolated, unworthy, and humiliated. In the last decade as many as 4 million soldiers became physically handicapped and disabled after they had been wounded (Shaw, 2000). In the majority of cases these injuries resulted from explosions and shootings during artillery and air force bombing, exposure to land mines in the case of war, and direct or indirect injuries sustained during a terrorist act. Many injured soldiers become permanently disabled. This seriously
incapacitates them, resulting in prolonged suffering, hospitalizations, and rehabilitation (Adjukovic and Adjukovic, 1998). Exposure to war also affects Intelligence, Cognition, Memory, and Attention; Central Nervous System Structure and Function; Metabolic and Endocrine Function which are neurological characteristics (Kutrovac et al., 1994).

Psychological and Emotional Effects of War

There is increasing evidence that soldiers who are victims of accidents disfigurement and trauma are prone to behavioral and emotional difficulties. Cicchetti and Toth (1995) noted a wide range of effects including affect deregulation, disruptive and aggressive behaviors, insecure and atypical attachment patterns, impaired peer relationships with either increased aggression or social withdrawal.

Anxiety disorders and post traumatic stress disorders are also common after effects of war. Milliken et al., (2007) reported large scale prevalence of Post Traumatic Stress Disorder (PTSD), depression, alcohol misuse and other mental health problems among US soldiers returning from Iran war.

War Zone Stress Reactions

War zone stress reactions are also known as combat stress reactions or acute stress reactions. Previously, these physical and mental responses were believed to affect only those with direct combat experience. Today, however, even soldiers who never see a battle must face enemy hostility and the constant risk of explosives or suicide bombers. Even if no attack ever comes, soldiers who are stationed in the middle of a hostile population or who are confronting an insurgency must be ready for an attack at all times. When the battlefield can be anywhere, war zone stress is constant.

That stress can manifest as a variety of symptoms, including many of the behaviors covered under Battlemind. The physical consequences include restlessness, insomnia, a loss of appetite, and headaches.

Depression and Traumatic Grief

Depression may be a consequence of war trauma. War handicapped soldiers are prone to affective withdrawal, diminished capacity for pleasure, and a tendency to exhibit
negative effects such as sadness and distress (Green, 1997).

Depression is not an unusual condition. Studies indicate 17% of Americans will experience it at some point in their lives. Returning soldiers have to be monitored carefully since expected withdrawal and detachment behavior can seem like depression (Kern and Berdichevsky, 2010).

Traumatic grief is another disturbing difficulty for returning soldiers. While grief is felt by nearly all who leave war with friends injured or dead, some forms of grief can grow excessive. With traumatic grief, the soldier focuses on a specific loss, clinging so tightly to the memory of the deceased he recreates his friend’s passing over and over again in his mind. Essentially, the trauma sufferer stops living in order to become a permanent griever (Kern and Berdichevsky, 2010).

Marshall and colleagues (Marshall et al., 2005) showed that twenty years after resettlement in the US, 62 percent of randomly selected Cambodian refugees still suffered from PTSD, 51 percent from Major Depression and low, but significant rates of alcohol abuse. A follow-up study by Goenjian and colleagues showed the persistence of PTSD symptoms in untreated adolescent survivors of an earthquake, with a mild increase even from 3-year to 5-year follow-up (Goenjian et al., 2005). These studies suggest that regardless of the passage of time, many young survivors continue to suffer from distressing symptoms, with PTSD being most persistent.

**Post-Traumatic Stress Disorder**

One of the most serious and debilitating psychological conditions is post-traumatic stress disorder or PTSD. Defined as “a reaction to a psychologically traumatic event outside the range of normal experience”, it can afflict anyone who has gone through a trauma, not just soldiers (Grossman, 1996). About 7% of Americans may suffer from it in their lifetime. More may experience at least a few of its symptoms. There are three indicators for PTSD: re-experiencing symptoms, avoidance and a state of emotional numbness, and hyper actions or responses. For a confirmed diagnosis, a veteran must display one consistent re-experiencing episode, three signs of avoidant or numb behavior, and two markers of intense, hyper reactions. Likely every soldier returning from war will face some of these problems (Kern and Berdichevsky, 2010).
As the traumatic memories take over, sufferers of PTSD withdraw from friends and family—and from themselves (Sloane and Matthew, 2008).

Research conducted after military conflicts has shown that deployment and exposure to combat results in increased risk of posttraumatic stress disorder (PTSD), major depression, substance abuse, functional impairment in social and employment settings, and the increased use of health care services (Helzer et al., 1987; The Centers for Disease Control Vietnam Experience Study Group, 1988; Jordan et al., 1991; Kessler et al., 1995; The Iowa Persian Gulf Study Group, 1997; Prigerson et al., 2001, 2002; Kang et al., 2003; and Hoge et al., 2008).

Of the Americans who fought in the Vietnam War, various studies suggest that anywhere from 500,000 to 1.5 million of them developed post-traumatic stress disorder. That amounts to 18-54% of those who served. The wide disparity in these numbers may be due to the lack of knowledge about the disorder at the time. Many people likely did not receive the proper diagnosis. Another reason for misdiagnosis results from how PTSD can work on the mind. Doctors consider there to be three classes of the condition: chronic PTSD, PTSD in remission (with occasional relapses), and delayed onset PTSD. Fifteen percent or more of some populations of veterans of the Vietnam War and the 1991 Gulf War have received diagnoses of posttraumatic stress disorder (PTSD) (Kulka et al., 1990; and Kang et al., 2003).

Delayed onset PTSD describes those who return home and at first have no problems with traumatic memories. Then, a few months or years later, a traumatic event or other trigger will pull up buried thoughts and feelings. As with PTSD in remission, these zombie memories abruptly attack the mind. The sad reality is that almost no soldier will ever completely escape his or her war trauma (Kern and Berdichevsky, 2010).

**War and Dissociative States**

During times of trauma, fight or flight is rarely an option for the war handicapped, as they are often physically unable to defend themselves or escape. The most readily accessible response to the pain of trauma may be to activate Dissociative mechanisms, involving disengagement from the external world through the use of primitive defenses such as depersonalization, de-realization, numbing, and, in extreme cases, catatonia.
Dissociative disorders may result from exposure to the horrors of war. Dissociation is protective, allowing the soldier to psychologically survive the trauma. Over time, however, it often becomes maladaptive, emerging at inappropriate times during, for example, situations that may trigger verbal or nonverbal/bodily memories of earlier trauma.

According to Perry (2001), males tend to utilize hyperarousal responses whereas females and children are more likely to dissociate.

### War and Behavioral Disorders

A frequent outcome of trauma is aggression. Pathological defense mechanisms, including identification with the aggressor, may play a role. War handicapped who have been traumatized engage in more frequent aggressive behavior than their peers (Klimes-Dougan and Kistner, 1990) and more often attribute hostile intent to others (Dodge et al., 1990). Traumatized children have also been reported to be at risk for violent criminal behavior in adolescence (Herrenkohl et al., 1997) and adulthood (Widom, 1998). Lewis (1992) reported how traumatic war experiences could beget violence. “In short, whatever increases impulsivity and irritability, engenders hyper vigilance and paranoia, diminishes judgment and verbal competence, and curtails the ability to recognize one’s own pain and the pain of others and also enhances the tendency toward violence. It is known that the repeated experience of pain can lead to aggression. Lewis (1992) wrote that aggressive and violent experiences provide a model for violence, teach aggression through reinforcement, inflict pain, and cause central nervous system injuries associated with impulsivity, emotional liability, and impaired judgment. Further, this creates a sense of being endangered and thus increases paranoid feelings and diminishes the one’s capacity to recognize feelings, put them into words, and inhibit aggressive behavioral impulses.

### War and Alcohol and Substance Use

War handicapped are also more prone to develop substance abuse, likely in a self-medicating fashion. Alcohol serves to reduce anxiety; opiates trigger soothing dissociation, and stimulants such as cocaine activate dopaminergic and mesolimbic/areas of the brain (Perry and Pollard, 1998).
Kang et al., (2005) said that the most common diagnosis among combat veterans were problems of cardiovascular system, musculoskeletal system and the digestive system. Possible mental disorders have been reported in 26 percent. The most common diagnoses were adjustment disorders, among them viz PTSD – a possible diagnosis of which was recorded in 10 percent of these patients.

Pizarro and Silver (2006) reported that hundreds of thousands of soldiers face exposure to combat during wars across the globe. The health effects of traumatic war experiences have not been adequately assessed across the lifetime of these veterans. They did a study to identify the role of traumatic war experiences in predicting postwar nervous and physical diseases and mortality using archival data from military and medical records of veterans from the Civil War. Results reported signs of physician-diagnosed diseases, including cardiac, gastrointestinal, and nervous diseases. Results revealed that Military trauma was related to signs of disease and mortality. Younger soldiers (<18 years), compared with older enlistees (>30 years), showed a higher mortality risk, signs of co morbid nervous and physical disease, and more unique ailments within each disease. Greater exposure to death of military comrades and war trauma were associated with increased signs of physician diagnosed cardiac, gastrointestinal, and nervous disease and more unique disease ailments across the life of Civil war veterans.

Effects of War on the family

The impact of trauma spreads in families. Other family members may develop their own trauma symptoms, the functioning of the entire family may be affected and, sometimes, the effects of traumatization are so powerful when the trauma occurred. This phenomenon of secondary traumatization has become a major source of interest among those who work with trauma and families (Catherall, 2004).

Children who lose a family member are not only losing a key component of their familial support network but are also faced with a significant source of distress. The literature has mainly focused on the loss of a parent, however additional studies investigated the emotional impact resulting from a loss of siblings and other family member. Parents reported that 73% of their children showed negative effects after the
death of a parent or sibling. Actually, 47% of the parents reported that their children experienced extremely negative effects (Lehman et al., 1989). The experience of families who suffer war-related deaths is heavily influenced by social attitudes about the war involvement (Walsh and McGoldrick, 2004).

Parents or other caregivers who suffer often have difficulties interacting with their children; for example, they may become less sensitive, less tolerant, and less able to feel and express love for their children. They may also be less able to maintain normal rules and boundaries for their children. Sometimes, they also become overprotective, irritable or violent (Kalantari et al., 1993; Field, 1995; and Cairns, 1996). Threats to caregivers, parents’ own traumatic reactions and symptoms, increased anxiety, perceived rejecting or guilt, anxiety and parents’ own history of psychiatric disorder have all been associated with children’s increased symptoms (Deblinger and Heflin, 1996; and Scheeringa and Zeanah, 2001).

DEPRESSION

Beck's Cognitive Therapy

The most prevalent cognitive model of depression is that posited by Beck (1976; Beck et al., 1979) and is composed of three key elements: (a) negative cognitive triad, (b) negative schemas, and (c) cognitive distortions. The cognitive triad consists of three patterns of negative ideas and attitudes that characterize depressed individuals and includes negative views of the self, the world, and the future.

Schemas are stable, long-standing thought patterns representing a person’s generalizations about past experiences. They serve to organize from past experiences information relevant to a current situation and serve to determine the manner in which information is perceived, remembered, and later recalled. Depression-prone individuals tend to respond to their environment in a fixed, negative manner involving specific distortions responsible for the way the depression-prone individual perceives and interprets new experiences in a logically inaccurate manner. Cognitive errors include arbitrary inference, selective abstraction, overgeneralization, magnification/minimization, personalization, and dichotomous thinking.

Cognitive Therapy (CT) is perhaps the most recognizable and popular form of
psychosocial treatment for depression. Large numbers of controlled outcome studies have been conducted during the past two decades supporting the efficacy of CT. Results from two recent meta-analyses (Dobson, 1989; and Robinson et al., 1990), as well as numerous reviews (Hollon et al., 1991), underscore its relative efficacy, its comparability to psychopharmacological approaches, and occasional superiority to other psychosocial therapies with regard to depression (Nezu et al., 2002).

The effect of War on common man has very adverse. Physical injuries, Displacement, loss of loved ones etc. are very painful. Worsen is the psychological effect of War. War veterans develop many types of psychological disorders like anxiety, PTSD, depression etc. Depression and Anxiety are high and Self-Esteem and Well-Being are low in War veterans. They need therapy. Cognitive Behavior Group Therapy is one of them.

COGNITIVE BEHAVIOR GROUP THERAPY (CBGT)

Cognitive-behavioral therapy (CBT) is an empirically validated form of psychotherapy that has been shown to be effective in over 350 outcome studies for myriad psychiatric disorders, ranging from depression to the anxiety disorders, and more recently to personality and psychotic disorders (Beck and Weishaar, 2000). Despite its relatively young age, both as a theory and treatment, the cognitive-behavioral approach has generated unparalleled volumes of research data. There is widespread support for both the therapy itself and many of its theoretical explanations for psychopathology (Clark et al., 1999; and Bieling and Kuyken, 2003).

Traditionally, CBT was described and practiced in an individual format. However, even the original, now classic text on treatment of depression by Beck et al., (1979) described the use of a group format. The reasons for this exploration of a group approach then was simple and is as applicable now as in 1979: “More patients can be treated within a given period of time by trained professional therapists than can be treated individually” (Hollon and Shaw, 1979). Some authors have found that in terms of therapists’ time, groups offer as much as 50% greater efficiency when compared to individual treatment (Morrison, 2001). There may also be overall financial savings for
the health care system when a group format is used (Scott and Stradling, 1990; and Morrison, 2001).

The efficacy of the group CBT approach has also been confirmed by carefully conducted research that started in the 1970s. For example, in the area of depression, small early studies by Hollon, Shaw, and other collaborators found that a CBT group was superior to several other treatments, but not as effective as individual CBT (Beck et al., 1979). Subsequent reviews and at least one meta-analysis since that time suggest a high level of efficacy, even to the point of equivalence between group and individual CBT for depression (Burlingame et al., 2004; and Robinson et al., 1990). In other clinical areas, for example, many different anxiety disorders, considerable evidence for the efficacy and effectiveness of a group approach has emerged (Morrison, 2001; and Bieling et al., 2006).

COGNITIVE-BEHAVIORAL THERAPY
History and Background

Cognitive-behavioral therapy, as the name indicates, comes from two distinct fields. CBT is based in behavioral theory and cognitive theory.

Behavioral Theory

The development of behavioral theory in the late 1950s and 1960s provided the foundation of the behavior component of cognitive-behavioral therapy, but behaviorism itself has a longer history. It dates back to John B. Watson’s groundbreaking 1913 journal article, “Psychology as the Behaviorist Views It” (often referred to as “The Behaviorist Manifesto”), and includes Ivan Pavlov’s work in “classical conditioning” (involuntary behavior triggered by a stimulus; Pavlov, 1927) and the “operant conditioning” models of B. F. Skinner (voluntary behavior encouraged or discouraged by consequences; Skinner, 1938).

As behaviorist theories developed, so did a number of efforts to apply them clinically (Glass and Arnkoff, 1992). Among noteworthy examples are Knight Dunlap’s use of “negative practice” (involving the intentional repetition of undesirable behaviors such as tics; Dunlap, 1932) and Andrew Salter’s “conditioned reflex therapy” (a method
of directly practicing a behavior in a particular situation; Salter, 1949).

Emerging methods such as “systematic desensitization” to manage anxiety (gradual exposure to an anxiety-causing stimulus; Wolpe 1958), and the application of Skinner’s work to behavioral management (Skinner, 1958), spelled the beginning of modern behavioral therapy in the 1950s and 1960s. It soon gained a strong foothold in the field of psychology with the introduction of the concepts and applications of “modeling” (observing and copying the behaviors of others; Bandura, 1969); anxiety management through “flooding” (intensive exposure to an anxiety-causing stimulus); and social skills training (Lange and Jakubowski, 1976), which is an important component of contemporary cognitive-behavioral therapy.

Cognitive Theory

The historical roots of the cognitive component of CBT are found in philosophy as well as psychology. The basic concept of cognitive psychology—that one’s view of the world shapes the reality that one experiences—is found in ancient Greek thinking such as Plato’s concept of “ideal forms” (Leahy, 1996). Plato saw these forms as existing within the mind and representing what is real in the world. Philosophers of the 17th and 18th centuries also built their view of the world around the idea that the mind determines reality. This is particularly found in René Descartes’ concept that “I think, therefore I am,” and Immanuel Kant’s idea that the mind makes nature (Collingwood, 1949).

In modern psychology, the cognitive approach was a reaction to the more narrow view of behavioral psychology, which did not attend to—and even rejected—the importance of internal thought processes. Albert Bandura’s classic work Principles of Behavioral Modification (1969) challenged the traditional notions of behavioral psychology and stressed the importance of internal mental processes in the regulation and modification of behavior.

Albert Ellis’s development of “rational-emotive therapy” (based on the idea that thoughts control feelings; Ellis and Harper, 1961) has been cited as the genesis of modern cognitive theory (Arnkoff and Glass, 1992). The work of Ellis is considered an important precursor to the work of Aaron Beck, who is commonly seen as the founder and developer of cognitive therapy (Arnkoff and Glass, 1992; Beck, 1995; and Leahy,
Beck’s concepts emerged from his work on depression at the University of Pennsylvania (Beck, 1963, 1964). George Kelly, developer of the theory of “personal constructs” (mental templates, unique to the individual, that shape perceptions; Kelly, 1955), has also been called an early founder of cognitive therapy. Beck later made it clear that he borrowed from Kelly’s work in devising his own theory on the “thinking disorder” of depression (Beck, 1996). The work of Jean Piaget on the structure of thinking (Piaget, 1954) also provided a foundation for the development of cognitive therapies.

**Blending the Two Theories**

Following the work of Beck in applying the cognitive model to the treatment of depression (Beck, 1963, 1970, 1976), other cognitive therapies began to develop that blended the elements of behavioral therapy with cognitive therapy. The earliest of these cognitive-behavioral therapies (as noted in Dobson and Dozois, 2001) emerged in the early 1960s (Ellis, 1962), and the first major texts on cognitive-behavioral modification appeared in the mid- to late 1970s (Mahoney, 1974; Meichenbaum, 1977; and Kendall and Hollon, 1979).

The “stress inoculation method” (Meichenbaum, 1975) involved teaching the individual mental coping skills and then practicing those skills when deliberately exposed to an external stressful situation. This cognitive approach had a strong behavioral therapy flavor, as does “systematic rational restructuring,” which teaches the individual to modify internal sentences (thoughts) and then to practice the rational reanalysis of these thoughts through role playing and behavioral rehearsal (Goldfried et al., 1974). At the same time that behavioral theory was being added to cognitive practices, cognitive problem-solving therapies and training became prominent features of numerous behavioral treatment methods (D’Zurilla and Goldfried, 1971; Spivack and Shure, 1974; and Shure and Spivack, 1978).

Thus, although behavioral therapies and cognitive approaches seemed to develop in parallel paths, over time the two approaches merged into what is now called cognitive-behavioral therapy. As Arnkoff and Glass of The Catholic University of America noted, “the line distinguishing behavior therapy from cognitive therapy has become blurred, to the point that cognitive-behavioral is a widely accepted term” (Arnkoff and Glass,
1992). Similarly, Marlatt of the University of Washington has remarked that the cognitive therapy of Ellis and Beck has over the years become progressively more behavioral while the behavioral therapy of Bandura and Meichenbaum has over the years become progressively more cognitive—together creating contemporary CBT (Dimeff and Marlatt, 1995).

A review of the literature leads to the conclusion that the combining element of cognitive and behavioral approaches is found in the principle of “self-reinforcement.” This concept simply states that cognitive and behavioral changes reinforce each other. When cognitive change leads to changes in action and behavior, there occurs a sense of well-being that strengthens the change in thought and in turn further strengthens the behavioral changes. This self-reinforcing feedback process is a key element of the cognitive-behavioral approach and is the basis for helping clients to understand the cognitive-behavioral process (Milkman and Wanberg, 2007).

Principles of CBT

CBT uses two basic approaches in bringing about change: (1) restructuring of cognitive events and (2) social and interpersonal skills training. The two approaches are built on two pathways of reinforcement: (1) strengthening the thoughts that lead to positive behaviors and (2) strengthening behavior due to the positive consequence of that behavior. The former has its roots in cognitive therapy, the latter in behavioral therapy. Together, they form the essential platform of CBT.

The Cognitive Focus of CBT: Cognitive Elements and Structures

Very early cognitive therapy theorists and practitioners focused on certain key cognitive structures and processes (Ellis and Harper, 1975; Beck, 1976; Beck et al., 1979; and Burns, 1989). These processes are automatic thoughts and underlying assumptions and core beliefs.

Automatic thoughts. Automatic thoughts are short-term cognitive events. They seem to occur “without thought” or “automatically” as a response to external events (Beck, 1976, 1996; Freeman et al., 1990; and Beck, 1995). These kinds of thoughts can also called “thought habits” in order to help clients understand that thinking habits are
similar to behavioral habits, which can become the focus of change (Wanberg and Milkman, 1998, 2006).

Expectations, appraisals, and attributions are types of automatic thoughts. Expectations are thoughts that certain behaviors will bring certain outcomes (e.g., pleasure or pain). Efficacy expectancy (or self-efficacy) refers to an individual’s assessment of his or her ability to successfully execute a particular behavior in an impending situation. If a person believes that he or she can perform a particular behavior, then most likely that individual will engage in that behavior. If the behavior is performed successfully, this reinforces the efficacy expectation.

This concept is of particular importance in the treatment of offenders. It is “perceived control.” Efficacy expectations have a major effect on whether a person initiates a coping behavior and how much effort will be put toward implementing that coping behavior (Bandura, 1982). Self-efficacy is reinforced if the person copes successfully over time (Dineff and Marlatt, 1995). Research has demonstrated that there is a strong association between an individual’s level of perceived situational self-efficacy and that individual’s actual level of performance accomplishments (Bandura, 1982).

Appraisals are the cognitive processes that continually evaluate the value and meaning of what an individual is experiencing as well as his or her responses to those experiences (Rosenhan and Seligman, 1995; Seligman et al., 2001; and Clark, 2004). Often, cognitive appraisals become distorted and result in thinking errors. Identifying and changing thinking errors or distortions have become salient components of cognitive therapy. For example, an appraisal of the depressed person who experiences rejection might be “I’m no good.” This would also be classified as a thinking error or an error in logic. Appraisals, whether appropriate or distorted, usually precede and cause emotions (Beck, 1996). For example, the appraisal that, “he is taking advantage of me” usually leads to the emotion of anger.

Attributions are the individual’s explanation of why things happen or the explanation of outcomes of certain behaviors. An important part of attribution theory is where the individual sees the source of his or her life problems and successes (Rotter, 1966). This locus of control might be internalized (“I’m responsible for the accident”) or externalized (“If they would have locked their doors, I wouldn’t have ripped off their
Attributions can also be global or specific (Abramson et al., 1978). “I stole the car because life is not fair” is a global attribution whereas a specific attribution would be “I hit my wife because she yelled at me.”

**Underlying assumptions and core beliefs**

The long-term cognitive processes—underlying assumptions and core beliefs—are less available to an individual’s consciousness than automatic thoughts (Seligman et al., 2001). These mental processes are more durable and stable, and they help determine the short-term mental processes that are in the conscious state. Underlying assumptions and core beliefs can be seen as schemas, or organizational systems, that structure a person’s automatic thinking (Beck, 1996).

One of the long-term cognitive processes is belief (Seligman et al., 2001). Beliefs are ideas that people use to judge or evaluate external situations or events. Changing irrational underlying core beliefs is a primary focus of cognitive therapy.

Most cognitive approaches see the process of treatment as starting with helping the client to identify automatic thoughts and cognitive distortions and then addressing the long-term underlying core beliefs that are associated with them (Freeman et al., 1990; Beck, 1995; Leahy, 1997; and Dobson and Dozois, 2001). Cognitive restructuring (CR) is the main method and technique used to change cognitive processes and structures that have become maladaptive. “Self-talk” is a CR method that includes thought stopping, planting positive thoughts, countering, shifting the view, exaggerating the thought, etc. (McMullin, 2000). Other examples of cognitive restructuring approaches are training in problem-solving skills (D’Zurilla and Goldfried, 1971; and D’Zurilla and Nezu, 2001); mood-management training (Beck, 1976; Monti et al., 1995); critical reasoning training (Ross et al., 1986); and “rational responding,” “scaling emotions,” and “de-catastrophising” (Reinecke and Freeman, 2003).

**The Behavioral Focus of CBT: Interpersonal and Social Skills**

Coping and social skills training evolved over the last two decades of the 20th century to become an essential component of cognitive-behavioral therapy. It emerged out of social learning theory (Bandura, 1977) and has a solid empirical support from
outcome research (Monti et al., 1995). Its premise is that clients with maladaptive thinking and behavioral patterns lack adequate skills for facing daily issues and problems. There are a number of specific focal areas for interpersonal and social skill building (Wanberg and Milkman, 1998, 2006, 2007). These include learning communication skills, assertiveness training, improving relationship skills, conflict resolution training, and aggression management.

The Community Responsibility Focus of CBT: Prosocial Skills Building

In this focus is added to the traditional CBT focus on cognitive restructuring and interpersonal skill building: developing skills for living in harmony with the community and engaging in behaviors that contribute to positive outcomes in society. This involves building attitudes and skills needed to be morally responsible and to develop empathy and concern for the welfare and safety of others (Ross and Fabiano, 1985; Wanberg and Milkman, 1998; and Little, 2000, 2001). Traditional psychotherapy is egocentric; it helps individuals resolve their personal problems, feel better about themselves, and fulfill their inner goals and expectations. That certainly is an important component of the treatment of the judicial client. However, this egocentric psychotherapy, in and of itself, has failed to have significant impact on changing the thinking, attitudes, and behaviors of offenders (Wanberg and Milkman, 2006, 2007). Therapy must also include a sociocentric approach to treatment that focuses on responsibility toward others and the community. This encompasses an emphasis on empathy building, victim awareness, and developing attitudes that show concern for the safety and welfare of others. It also includes helping offenders inculcate the belief that when a person engages in behavior that is harmful to others and society, they are violating their own sense of morality (Wanberg and Milkman, 2006).

Exhibit 1 (taken from the program Strategies for Self-Improvement and Change (SSC)) shows the composite of skills (relationship, cognitive self-control, and community responsibility) that form the basis for improved treatment outcomes in the areas of recidivism and relapse prevention and the attainment of more meaningful and responsible patterns of living (Wanberg and Milkman, 2006, 2007).
The Cognitive-Behavioral Change Map

Exhibit 2 illustrates how clients learn to restructure previous patterns of antisocial thought and behaviors (Wanberg and Milkman, 2006, 2007). This cognitive-behavioral map is the centerpiece of the CBT rationale, providing a visual anchor for cognitive-behavioral restructuring. Clients use this model in individual or group settings to recognize high-risk situations, consider and rehearse lifestyle modifications, and learn a variety of strategies for identifying and changing distorted thinking processes through role plays and social skills rehearsal exercises.

The exhibit shows how events experienced by an individual trigger automatic thoughts (shaped by underlying beliefs), which are then translated into emotions that lead to behaviors. If an individual chooses a positive (adaptive) course of action (through rational thought and emotional control), or opts against a negative one (distorted thought and emotional dysregulation), the outcome will likely be good, which strengthens the recurrence of positive behavior and encourages positive thought processes. Conversely, if the individual chooses a negative (maladaptive) course of action, the outcome will likely be bad, strengthening more negative thought processes.

**BRIEF HISTORY OF THE GROUP MODALITY**

The group psychotherapy movement, with its roots in psychodynamic models of pathology, focus on experiential (or encounter) groups, and historical antithesis to research, appears to be diametrically opposed to the scientist–practitioner mind-set of CBT (Bieling et al., 2006).

Burlingame and colleagues (2004) wrote that in the traditional group approach, "high value is placed on interpersonal and interactional climate of the group, undergirded by the belief that the group is the vehicle of change and that member-to-member interaction is a primary mechanism of change".

The modern form of group psychotherapy was pioneered by Joseph H. Pratt in the 20th century in the United States (Dreikurs and Corsini, 1954). On July 1, 1905, Pratt used group education to treat groups of patients with tuberculosis. The original intent of this approach was to expedite educating his patients on their condition of pulmonary tuberculosis. He quickly realized, however, the psychological benefits this approach demonstrated with his patients and proceeded to generalize this approach to other medical populations. Pratt later went on to work with psychiatric patients where he began to focus more on the emotional responses to their illnesses and the impact the illness had on the patients’ psychological condition. This occurred in the group setting and eventually became one of the staples to Pratt’s work in therapy (Pratt, 1945; and Blatner, 1988). Although Pratt was most likely unaware at that time, he had created a methodical approach to the use of groups as a treatment modality.

Between 1908 and 1911, not long after Pratt began utilizing group methods, Jacob
Moreno implemented the idea of creative drama with children in Vienna. This was among the first group methods implemented that did not focus on the concepts of individual therapy (Dreikurs and Corsini, 1954). Creative drama has become a valuable vehicle for teaching social skills, self expression, and ways of learning to groups of children. Compiling his insights from this process, in 1912 Moreno began the first known self-help group. He gathered together a group of prostitutes in Vienna to discuss their concerns, health issues, and life problems. During this group process, Moreno expected that each woman would become the therapeutic agent for the other women by sharing stories and experiences to which each woman could relate. These groups brought about a sense of community, of self-awareness, and an enhanced ability to solve problems. Moreno later applied the process of group psychotherapy to working with inmates in the prison system, focusing on the interaction between group members with less emphasis on education. In presenting this work at the American Psychiatric Association conference in Philadelphia in 1932, Moreno used the terms “group therapy” and “group psychotherapy” for the first time.

Indeed, perhaps the most comprehensive perspective in the group psychotherapy field has been offered by Irvin Yalom (1995) in The Theory and Practice of Group Psychotherapy. Yalom describes nine relevant therapeutic factors that groups offer, and how each of these can be fostered in the group environment to produce change. These factors are: (1) instillation of hope, (2) universality, (3) imparting information, (4) altruism, (5) the corrective capitulation of the primary family group and interpersonal learning, (6) development of socializing techniques, (7) imitative behavior, (8) group cohesion, and (9) catharsis. Each of these factors is seen to be important in a unique way and more or less present in almost any type of therapeutic group.

Yalom’s Group Factors

Yalom (1995) describes instillation of hope as a necessary ingredient in all psychotherapies, including group therapy. Yalom suggests that it is important for therapists to reinforce directly the potency of a group approach and to emphasize positive outcomes in members of other groups. Instillation of hope, including narratives of “overcoming” provided by members, appears to be an important component of many
self-help groups, including Alcoholics Anonymous (Yalom, 1995).

Universality describes the discovery that others suffer from similar difficulties, often despite patients’ conviction that their problems are unique and hence isolating. This factor is more unique to groups than instillation of hope, because it can often be difficult for patients in individual therapy to recognize that their disorder(s) have been experienced by others. Yalom (1995) describes the palpable relief that group members can experience when they, perhaps for the first time, recognize that they are not alone in their suffering.

According to Yalom, the imparting of information is a central feature of most groups. This can be further broken down into two specific categories of information, didactic instruction and direct advice. Didactic instruction can be in the form of psychoeducation about the nature of a particular diagnosis or problem, specification of a treatment plan, and a description of how a specific technique might alleviate suffering. At an implicit level, learning about the nature of interpersonal processes and the patient’s own interpersonal impact can also occur (Yalom, 1995). The central source of change is seen to be provision of an explanation, a narrative to help the patient understand why and how problems came to exist. Direct advice from the therapist or a co-patient may also provide new and helpful information for the patient. Yalom emphasizes the process of advice giving, rather than the content, as offering the most critical learning.

The interpersonal factor of altruism refers to the opportunity that group members are given to help one another in the group. If a group member benefits from advice given by another member, then both members benefit. The person receiving the advice obtains helpful information, whereas the person providing the advice benefits from helping another. Groups offer individuals who are often demoralized and marginalized many opportunities to provide others with help, whether by giving advice or offering support, empathy, or understanding. In this way, the group members learn that they can make valuable contributions and have much to offer. Yalom also describes altruism as a sort of antidote to the morbid self-preoccupation that often characterized distressed individuals (Yalom, 1995).

Groups, because they involve peers and “leaders,” can also offer opportunities for corrective recapitulation of the primary family group and interpersonal learning (Yalom,
Based on the work of attachment theorists such as John Bowlby, and Harry Stack Sullivan’s emphasis on interpersonal relationships, the group is thought to constitute a social microcosm, a crucible in which the interpersonal patterns of each member will emerge and interact. This offers many opportunities, but in the case of particularly problematic interpersonal styles, can also cause significant strife between members and disrupt the group as a whole. Group leaders are important for helping to moderate rather than amplify these dysfunctional patterns. Similarly, individuals with early experiences of mistrust may have difficulty becoming meaningfully engaged with other group members. The corrective aspects of the experience are provided by both the group members and the leaders, who are able to observe objectively these interpersonal patterns in others. The interpersonal learning is therefore thought to occur at a fully conscious level; individuals become aware of how they are constructing their interpersonal world and that they have the power to change it. Yalom also emphasizes affect and consequences of this learning. The more affect involved in this realization and behavior change, the more potent the experience (Yalom, 1995).

At a more basic interpersonal level, a group can offer socializing techniques that involve the development of more basic social skills, either implicitly or through direct exercises including role plays. Groups can give members opportunities to “try out” a variety of new skills or approaches and, unlike many real-world situations, receive direct feedback on the consequences of those actions.

Another area emphasized by Yalom from a traditional group perspective is imitative behavior. This factor is based directly on the work of social learning theorists, including Albert Bandura, who identified the process of vicarious or observational learning. In a therapy group, a group member can learn by observing other models of behavior, potentially including both the leaders and group members, from which he or she can gain important information about appropriate and effective interpersonal strategies.

Paralleling the importance of the therapeutic alliance in individual therapy, group cohesiveness is seen as a critical ingredient in the process and outcome of any group (Yalom, 1995; and Burlingame et al., 2002). Operationally, “cohesiveness” is defined as the attraction the members have for the group and for the other members. The
ingredients of cohesiveness include acceptance, support, and trust. Similar to unconditional positive regard in individual therapy, the group ideally provides its members an environment in which they can disclose their most private emotions and thoughts, and know in advance that the group will understand and empathize. Yalom (1995) suggested that attendance and, in “open” groups, lower levels of turnover are indicators of cohesion. Cohesion is typically described as an overarching condition under which groups operate, and level of cohesion is seen to affect almost all other interpersonal aspects of group process.

Like cohesion, catharsis is a seen to be a critical variable in groups but one that defies simple categorization as a single type of event that occurs under specific conditions. Virtually any verbalization made by group members to the leader or to one another can involve an aspect of unburdening, sharing something that has not previously been articulated or even part of self-awareness. However, catharsis is also seen as necessary but not sufficient for a positive outcome: “No one ever obtains enduring benefit for ventilating feelings in an empty closet” (Yalom, 1995).

Burlingame, MacKenzie, and Strauss Group Model

Burlingame et al., (2004) utilized a different framework that is informed on the one hand by Yalom’s work and on the other hand by the developing literature on treatment outcome that supports the efficacy of a group approach in many disorders (Burlingame et al., 2004). With therapeutic outcome as the overarching “fact” to be explained, Burlingame and colleagues include a number of evident contributing factors. One of these is the “formal change theory,” in other words, the treatment modality. In the case of CBT, this would correspond to a protocol or session plan describing the CBT principles and techniques to be worked through. The modality occupies an important but by no means primary position in the Burlingame model. The second critical component in the model, the principles of small-group process, corresponds in many ways with the processes described by Yalom, essentially the various interpersonal relationships that come into operation when a group of individuals gather in a “therapeutic” context.
The other three components are more specific but are seen to have a powerful and unique effect on outcome (Burlingame et al., 2004). One is the patient, in terms of not only his or her, their specific disorder but also personal and interpersonal characteristics. Various factors, such as the individual’s ability to be empathic to other group members, as well as a host of basic social skills, are believed to have a strong potential to interact with the specific treatment modality (Piper, 1994). Group structural factors make up another component that “explains” the positive impact of a group. This includes factors such as length and number of sessions, frequency of meeting times, group size, and the setting in which treatment takes place. Also considered here is the number of group therapists, and whether or not there exists a hierarchy of leadership.

The final component of the model is at the nexus of the other components (Burlingame et al., 2004). To a great extent, all aspects of group experience are seen to flow through a single source, the group leader(s). The model points out that the style and practice of leadership determine exactly how the formal change techniques are delivered in a group setting. Also, the leader helps to direct and redirect a host of group process variables throughout the moment-to-moment interactions for the duration of the group.
The interpersonal approach taken by the leader and levels of warmth, openness, and empathy have been shown to predict cohesiveness and outcome, and are seen to parallel the importance of the therapeutic alliance in individual therapy (Burlingame et al., 2002).

The Stage of Group therapy explained by Bieling et al., are included four stages

1. Initial Stage

Pre-group individual meetings are recommended to educate prospective members about the group and group process before it begins. This is also a final opportunity for the group leaders to screen prospective members to ensure their appropriateness for the group. In the initial stage, the identity of the group is formed. Norms are established and members develop an understanding of the group experience. Members get acquainted, trust is developed, and initial resistance may occur. The latter term is important to define before moving on.

The concept of resistance is rooted in psychoanalytic theory, yet one can operationalize resistance from a cognitive-behavioral framework (Leahy, 2001). Resistance is the interruption of therapeutic progress (e.g., noncompliance) due to factors related to the patient (e.g., lack of understanding of the therapeutic rationale, lack of readiness for action-oriented treatment, lack of commitment to treatment), the therapist (failure to develop strong therapeutic alliance, lack of clarification around the rationale for a specific therapeutic strategy, focus on the wrong problem), or the therapeutic strategy (inappropriate treatment strategy for patient).

In the initial stage, the main tasks of the group leaders are to build cohesiveness (develop trust within the group), impart group structure, and establish treatment targets or goals (Corey, 2000).

Specific strategies for attending to and managing group process during this phase include the following:

- Ensuring that the therapist and co-therapist are spaced appropriately in the group.
- Going through introductions (e.g., have group members go around and say their
name and something about themselves, such as a hobby, a pet, or a favorite place
to travel). An ice-breaker exercise may also be useful (e.g., have group members’
pair off in dyads and share something about themselves, then report back on the
group member they have met when the group resumes).

- Encouraging group members to participate spontaneously, without calling on
  them by name or going around in a circle.
- Reviewing the norms of group (e.g., expectations for participation, attendance,
  missed sessions, homework requirements, and confidentiality).
- Discussing group members’ reactions, thoughts, and feelings about being in the
group.
- Normalizing anxiety or apprehension that members may feel about being in a
group.
- Encouraging interaction among group members.
- Making associations between group members’ symptoms to encourage group
  cohesiveness.
- Asking other group members if they can relate to a particular group member’s
  experience to promote group cohesion.
- Encouraging group members to go at their own pace.
- Transition from being directive to allowing group members to become more
  active in the group.

2. Transition Stage

In the transition stage, often just a few sessions into a CBT group, group members
have become more comfortable in the group and conflict may arise as group members’
voice concerns about the group leaders, other group members, or the therapy and
techniques. Group members may become more aware of their thoughts, feelings, and
behaviors, as well as their symptoms. They may express concern that their symptoms
have worsened since the group started or wonder whether the group leaders can help
them if they themselves have not experienced the problem the group is focused on. Group
members may not be ready to engage in treatment actively, or they may be apprehensive
or ambivalent.
3. Working Stage

In the working stage, the group actively works on material in the group and between sessions. These middle sessions also feature the bulk of the techniques. During this phase it is important to continue to encourage feedback, particularly support and positive reinforcement between group members for changes and progress. Group leaders also need to encourage sharing of difficulties and obstacles group members are encountering, as well as unresolved issues. Homework should be planned collaboratively, ideally with feedback from the group around what types of work or exercises would be most useful for the group as a whole. It is also important to remind group members that time is passing, so that they are prepared for termination and gain motivation to practice the CBT skills they are developing outside of the group.

4. Final Stage

In the final stage of the group, members are considering how they will proceed once the group has ended. As in individual therapy, it is important to allow time for discussion of termination issues, including thoughts and feelings about the group ending. A formal “good-bye” exercise or closing can be included. There should also be time devoted to a review of what members have gained from the group (where they were, where they are now, and where they are going), what obstacles they have overcome, and what goals they will continue to work on. Sharing the “effective ingredients” of the group for each group member will be important for relapse prevention and maintenance of CBT skills.

Benefits and cautions of Cognitive-Behavior Group Therapy

Group treatments can have a number of distinct advantages for clinicians, as well as clients. However, clinicians must use their judgment in determining the appropriateness of group intervention for particular clients, as it is not always the treatment of choice.

Convenience

A primary benefit of the group modality is simply the capability to reach a large
number of children and adolescents at one time. For some professionals, this has become a primary modality as a matter of necessity, based on healthcare limitations and restrictions on resources, rather than a desire to work with groups of clients. Yet for other clinicians, group interventions afford them the ability to deliver therapy to multiple clients within a limited timeframe, thus maximizing efficiency while not compromising effectiveness. While this is convenient from time, space, staffing, and financial standpoints, groups also (and more importantly) allow clinicians to begin seeing clients sooner to prevent the increase in difficulties or the decline in coping that may arise during a long wait period (Freeman et al., 2004). This issue of convenience can also have some disadvantages, as well. For instance, although clinicians may be able to see individuals in group sooner, it also means that there will be less time devoted to each individual client.

**Ongoing Assessment**

Many patients who present for therapy do so because of difficulties interacting with others. This may manifest for some through social anxiety, while for others may relate to being disrupting or disturbing, as is the case with children with anger problems or difficulty with behavioral inhibition. In individual therapy, it is difficult to see patients demonstrate skills with others and more challenging to facilitate the generalization of skills outside of the therapeutic setting. Goldstein and Goldstein (1998) suggest that interventions must occur in a setting in close proximity to where the problem occurs. In this case, a group format offers an ideal way for clinicians to directly observe participants’ emotional and behavioral reactions and interactions with peers. This affords valuable information regarding members’ repertoire of interpersonal responses and skills (e.g., decision making, coping, problem solving, communication), as well as their abilities to implement them successfully. Clinicians can use this information to refine their ongoing conceptualization of the client, as well as to monitor his or her progress.

**Psychoeducation**

Groups also provide an increased emphasis on psychoeducation, which facilitates skill acquisition. This is a primary premise to providing psychotherapy to children and adolescents—that is, educating them about specific skills they can apply to their daily life
in order to deal with their presenting problem. Group interventions often begin by simple teaching of the skills necessary to remediate deficits or just to refine their existing skills for effectiveness.

**Social Comparison and Support**

According to Festinger’s (1954) social comparison theory, change is internally motivated and occurs more readily when relevant others are available for social comparison, particularly in the presence of an ambiguous situation. The situations that typically produce the emotional and behavioral disturbances for people are oftentimes new and ambiguous to them, as they are largely unaware of their mental processes. Observing and hearing others who are similar to them, in terms of presenting problems or circumstances, affords group members reference points to offer information and increase motivation to adapt to their challenges and difficulties, as well as to help normalize what makes members feel “different” or alone. Yalom (2005) offered that “normalizing behavior” promotes a sense of universality that is one of the most helpful features of group therapy. It is common, especially in working with adolescents, for patients to discount the therapist’s ability to understand what they are “going through.” However, the group setting makes it less feasible for members to dismiss the observations of others who share similar problems.

**Natural Laboratory**

Group therapy settings offer a unique opportunity for clients to interact and practice skills in a safe setting. In essence, the group therapy setting serves as a natural laboratory in which members can “test out” their beliefs, as well as newly acquired strategies and interventions they have learned during the skill acquisition phase. This skill implementation aspect of group therapy offers an environment for group members to have the opportunity to experiment with new behaviors. This can occur naturally during group interactions or through role-play and practice activities used to prepare them before trying the new skills out in the “real world.” While members may practice any number of skills, the group setting is especially beneficial for experimenting with effective coping strategies (e.g., relaxation, feeling identification and tracking, goal setting, problem
solving) and interpersonal skills (e.g., appropriate self-disclosure, effective communication and listening skills, developing empathy, conflict management). As participants often model the behaviors of other group members or the therapists, group facilitators must be mindful, however, of the potential for ineffective or dysfunctional thoughts and behaviors to be repeated and strengthened, or acquired by other members.

Group therapy requires that therapists have strong management skills to avoid being sidetracked and to be cognizant of negative patterns occurring within the group. One individual can negatively affect the experience for the entire group (Freeman et al., 2004).

**SEQUENCING AND LENGTH OF CBT**

Treatment manuals are inconsistent with respect to the relative ordering of behavioral and cognitive interventions. Some begin with behavioral interventions (Beck et al., 1979), whereas others begin with psychoeducation regarding cognitive distortions and cognitive restructuring (Antony and Swinson, 2000). Recommended practices are generally to start with behavioral strategies, and then interweave Cognitive interventions into therapy fairly quickly thereafter. In this way, we obtain objective change in functioning, even as we continue to understand better the client’s patterns of thinking, and the optimal ways to intervene with negative thinking. The sequencing of cognitive-behavioral therapy usually proceeds in the following manner, although movement back and forth across the various phases may occur, if necessary:

1. Assessment.
2. Clinical case formulation.
3. Feedback to the client and reformulation, as needed.
4. Goal setting.
5. Psychoeducation.
10. Reassessment and discussion of schemas.
11. Schema monitoring (if needed).
12. Schema change therapy (if needed).
13. Relapse prevention, maintenance, and ending therapy.

Assessment and formulation are ongoing processes. Although the preceding order is common, the sequence must be flexible and adapted to each client, according to the clinical case formulation. For example, some clients require minimal psychoeducation but a greater focus on their cognitions. Other clients may respond very well to behavioral interventions and promptly state that they do not require any more help. Still other clients may require the full treatment package. In some cases, it is necessary to move back and forth among these treatment stages, because the client may initially improve, then suffer a setback that requires more basic interventions. Also, for some problems, a behavioral strategy is necessary and sufficient for change, but for other issues, cognitive interventions are needed. Obviously, behavioral interventions affect cognitions, and cognitive interventions affect behavior. It is extremely difficult to tease apart the effect of the many components of treatment. Your initial formulation may suggest that the client requires schema change treatment; however, these underlying beliefs may gradually start to shift during the early phases of therapy, making this type of treatment shorter or at times even unnecessary.

The average duration of interventions in treatment studies varies but averages between 12 and 16 sessions. The average duration of therapy in clinical practice is much more variable, and ranges from one session to many sessions. Consequently, the interweaving of behavioral and cognitive interventions is crucial, because each reinforces the other. For example, behavioral experiments may be conducted during early, middle, or late phases of therapy. These experiments may not only help the client practice behavior change but also challenge his or her underlying thoughts and beliefs. Consequently, an astute cognitive-behavioral therapist constantly assesses the client’s in-session reactions to behavior change experiments and points out discrepancies with the client’s identified and expressed beliefs.
Orientation and Session Structure

Although orientation to a theoretical model is not specifically an intervention, it is crucial to the success of treatment. Successful therapy orientation increases the client’s buy in to the therapeutic model, in the process enhancing his or her motivation, compliance, and willingness to take some of the risks required in therapy. Orientation begins during the initial interview or even before the therapist meets the client. Some clients who come to therapy are already aware of cognitive behavioral therapy; consequently, they may already have accepted the model to some extent.

Therapy orientation occurs in a number of different ways and varies depending on the needs of the client and the goals of therapy. One of the ways that orientation occurs is through the structure of cognitive-behavioral sessions. The typical format for a cognitive-behavioral therapy session includes the following:
1. A general check-in, including a mood or distress rating and a comment about, or bridge, from the previous session.
2. A brief review of homework that was assigned, attempted, and completed.
3. A discussion of any pressing issues for the current session.
4. Agenda setting, including the setting of priorities and approximate time allocated for each topic.
5. Discussion and work on each agenda item.
6. Summary of the session’s main points.
7. Feedback about the session.
8. Discussion of the overall homework, including anticipation of problems, practice regarding any concerns, and final homework assignment.

It is very common for new therapists to overestimate the amount of work that can possibly be completed in a session, and to find that they have only a few minutes remaining at the end of the session to summarize and plan homework. If homework assignments are rushed, then they are less likely to be collaborative, flexible, and successful. Mentally dividing each session into three “chunks” is helpful-beginning the session (items 1 to 3), the work of the session (items 4 to 6), and ending the session (items 7 to 8). In this way, neither the beginning nor the end of the session receives short shrift, and therapist expectations for the work that can be completed are reduced. In
Thus, in a typical session, you should begin winding down, or moving to the conclusion, about 10 minutes before you actually plan to end the session. Although the 50-minute therapy hour is a tradition and is often a convenient way to organize our schedules, there may be good reasons to vary the length of sessions at times. Exceptions to the usual length of session can include planned exposure exercises or group interventions. Exposure sessions are frequently longer than 50 minutes, particularly for clients with obsessive-compulsive disorder, posttraumatic stress disorder, or for clients whose anxiety takes longer than 30 minutes to reduce in intensity. When planning an exposure session it is wise to schedule longer sessions, if possible. Although cognitive-behavioral group sessions typically last 90-120 minutes, the rough division of the sessions into thirds can still be followed. Occasionally, 30-minute sessions may be scheduled for clients nearing the end of therapy, who require only a maintenance session. It also is helpful to consider briefer sessions for clients with concentration or other cognitive problems, particularly near the beginning of therapy. For example, clients with severe depression or psychotic disorders may require shorter but more frequent sessions to promote therapeutic change.

**CBT and Depression**

CBT was initially developed for working with depressed patients, and there is a voluminous literature supporting the efficacy of CBT with major depressive disorder and other variants of unipolar depression (DeRubeis and Crits-Christoph, 1998). Some authors have suggested that because CBT teaches the patients a set of skills they can implement after therapy ends, CBT is likely to have a more lasting and potentially prophylactic effect than comparator conditions such as antidepressant medications. More recently, CBT has also been shown to be as efficacious as pharmacotherapy even for severe depression (DeRubeis et al., 1999).

Depression was the first kind of disorder to which a CBT group format was formally applied and evaluated. These early validation studies conducted by Hollon, Shaw, and colleagues were small but important, in that they compared group CBT not
only to medication, but also to individual CBT. Hollon and collaborators found that a CBT group was superior to several other treatments, but seemingly not as effective as individual CBT (Beck et al., 1979).

Specific studies of group CBT have tended to bear out these conclusions regarding individual and group treatments defined more broadly. Individual CBT and group CBT perform at approximately equivalent levels (Scott and Stradling, 1990; Morrison, 2001; and Burlingame et al., 2004). Group CBT has also been found to be superior to gestalt group treatment (Beutler et al., 1991, 1993). On the other hand, much as with individual CBT, evidence that adding group CBT to medication treatment has a more beneficial impact than either treatment alone has been somewhat more elusive (Burlingame et al., 2004; and Bieling et al., 2006).

Cognitive Behavior Therapy (CBT) brings a problem-solving approach to the identification of thoughts and behaviors that precipitate and perpetuate depression.

In the sequence—event—thought—reaction—most people aren’t consciously aware of the step in the middle: thought. Habits of mind aren’t a problem unless we find ourselves constantly feeling bad.

CBT is aimed at making patients aware of their thinking habits and how they contribute to feelings of depression. It aims to change negative thinking habits so that people can stop themselves feeling so bad. It is also something they can learn to do for themselves (Parker, 2002).

Many qualitative and quantitative reviews now conclude that cognitive therapy 1) effectively treats depression, 2) is at least comparable if not superior to medication treatment, and 3) may result in lower rates of relapse in comparison with medication treatments (Hollon 1981; Miller and Berman 1983; Hollon and Beck 1986; Hollon and Najavits 1988; Dobson 1989; Hollon et al., 1991; Sanderson and McGinn, 2001; and Weissman, 2001).

CBT and Anxiety disorders

Psychotherapy development and research has been particularly fruitful across the anxiety disorders, with evidence emerging for the efficacy of cognitive–behavioral approaches for each individual disorder (Barlow, 2002). Recent meta-analyses confirm
that cognitive–behavioral treatments (CBTs) for panic disorder (Gould et al., 1995), obsessive–compulsive disorder (OCD; Eddy et al., 2004), generalized anxiety disorder (GAD, Borkovec and Ruscio, 2001), and posttraumatic stress disorder (PTSD; Bradley et al., 2005) are associated with recovery from, or improvement in, anxiety symptoms.

Despite these promising findings, much more work is needed to translate the gains achieved in the randomized clinical trials (RCTs) to widespread clinical success in reducing the significant distress and life interference associated with anxiety among clients who seek relief from primary care clinicians and mental health providers in the community. The meta-analyses of the effectiveness of RCTs on CBT for anxiety conducted to date highlight the significant average reductions in anxiety symptoms from pre- to posttreatment among clients who present for and accept randomization in clinical trials. Yet, they do not uniformly account for clients who refuse randomization (or treatment), those who are excluded on the basis of the severity or complexity of their presentation, those who fail to complete treatment, and those who fail to respond.

Moreover, outcome may be defined much more narrowly in RCTs than it is in clinical practice. RCTs tend to rely too heavily on measures of symptom reduction as the primary indices of treatment success, ignoring the more salient, but difficult to measure, potential impact of treatment on quality of life. Further, many clients who are categorized as treatment responders continue to experience substantial residual symptoms and associated impairment (Bradley et al., 2005). More extensive data addressing the stability and maintenance of treatment gains are needed (Eddy et al., 2004; and Bradley et al., 2005), as well as studies that measure or report on the number of participants who seek additional treatment following their participation in the clinical trial (Barlow, 2002; and Orsillo et al., 2005).

Cognitive–behavioral therapy is the most empirically supported psychosocial treatment for anxiety disorders. The cognitive–behavioral understanding of anxiety disorders is largely based on learning theory. Mowrer’s two-factor theory suggests that anxiety disorders are created initially via classical conditioning, and then maintained via operant conditioning. According to this theory, anxiety develops when a neutral stimulus becomes paired with an aversive response.

Cognitive factors can also play a large role in the development and maintenance
of anxiety disorders, because in addition to learned associations, anxiety can also result from people’s perceptions of a given situation.

Cognitive–behavioral treatments for anxiety disorders generally directly target the hypothesized causal and especially maintaining factors. Treatment usually focuses on physiological, behavioral, and cognitive responses of anxiety (Meadows and Butcher, 2005; and Freeman, 2005).

Cognitive–behavioral therapy for GAD comprises a package of treatment involving both behavior (relaxation strategies) and cognitive approaches. It is predicated on the assumption that there is a need for specific treatment strategies tailored to the main cognitive, behavioral, and physiological features of GAD. As described above, treating the physiological component involves a variety of relaxation strategies, the behavioral component focuses on modifying problematic coping strategies such as reassurance seeking, avoidance, and procrastination using in vivo exposure methods. As GAD patients often avoid situations, there is a reduced opportunity for engaging in pleasurable activities; therefore activity scheduling can be used to counteract low mood as well as providing opportunities to modify anxiogenic cognitions (Wells and Fisher, 2010; and Hofmann and Reinecke, 2010).

Cognitive behavior therapy (CBT) is a useful and helpful treatment for GAD (Rynn and Brawman-Mintzer, 2004) The aim of CBT is to ameliorate the symptoms of GAD by helping patients deal with basic fears and uncertainties that lead to overwhelming anxiety. Education and enhanced awareness may allow some patients to come to grips with their disorder. The components of CBT include techniques of relaxation, increased awareness, and education. The following techniques of CBT are useful in the treatment of GAD (Rynn and Brawman-Mintzer, 2004):

- Applied relaxation
- Education about GAD etiology and what the symptoms represent
- Cognitive restructuring
- Increased awareness of self
- Understanding and monitoring anxiety symptoms and their relationship to somatic sensations
- Learning to cope with and modify automatic reactions to known anxiety-inducing stimuli
Cognitive behavior therapy is usually managed best by someone trained in the fields of psychology and counseling. Group therapy may be useful in some cases. Therapy may require up to 4 months to complete (Rynn and Brawman-Mintzer, 2004; Helsley, 2008; and Vanin and Helsley, 2008).

Posttraumatic Stress Disorder

Several brief CBT programs have been found to be highly effective in ameliorating PTSD symptoms and related psychopathology. Arising from an experimental background, cognitive-behavioral interventions typically have been subjected to rigorous testing and traditionally involve repeated assessments of target symptoms, comparison groups, and well-delineated and replicable procedures.

One set of cognitive-behavioral approaches employed with PTSD patients is exposure treatment, in which patients confront feared situations. This approach is designed to activate memories of the trauma to modify the pathological aspects of those memories (Foa and Rothbaum 1998; Marshall and Rothbaum, 2004; and Stein, 2004).

Embry (1990) has outlined seven major parameters for effective psychotherapy with war veterans with chronic PTSD: 1) initial rapport building, 2) limit setting and supportive confrontation, 3) affective modeling, 4) defocusing on stress and focusing on current life events, 5) sensitivity to transference-counter transference issues, 6) understanding of secondary gain, and 7) maintaining a positive treatment attitude.

Group psychotherapy can also serve as an important adjunctive treatment or as the central treatment mode of traumatized patients (van der Kolk, 1987). Because of past experiences, such patients are often mistrustful and reluctant to depend on authority figures, whereas the identification, support, and hopefulness of peer settings can facilitate therapeutic change.

People involved in traumatic events frequently develop phobias or phobic anxiety related to or associated with these situations. When a phobic anxiety or avoidance is associated with PTSD, systematic desensitization or graded exposure has been found to be effective. This approach is based on the principle that when patients are gradually exposed to a phobic or anxiety-provoking stimulus they will become habituated or de-
conditioned to the stimulus. Variations of this treatment include using imaginal techniques (i.e., imaginal desensitization) and exposure to real-life situations, (i.e., in vivo desensitization). Prolonged exposure (i.e., flooding), if tolerated by a patient, can also be useful and has been reported to be successful in the treatment of a group of Vietnam War veterans (Fairbank and Keane 1982; and Hollander and Simeon, 2003).

Most evidence-based CBT protocols involve some combination of exposure to trauma-related memories, in vivo exposure to feared contexts, implicit or explicit cognitive processing and restructuring, and stress management or emotion regulation skills-building (Foa et al., 1999; and Hofmann and Reinecke, 2010).

Several studies have found CBT as an effective treatment method for PTSD (Peniston, 1986; Cooper and Clum, 1989; Keane et al., 1989; Boudewyns and Hyer, 1990; Boudewyns et al., 1990; and Glynn et al., 1999).

The accumulation of evidence from randomized controlled trials has been recognized in the Practice Guidelines from the International Society for Traumatic Stress Studies (Foa and Rothbaum, 1998) which state that “compelling and consistent evidence exists for demonstrating the efficacy of cognitive behaviour therapy for posttraumatic stress disorder...” (p. 102). Similarly, in a recent publication on treatment choice, the Department of Health (2001) recommended the use of psychological treatments for PTSD while concluding that there is “most evidence for cognitive behavioral methods.” (Gillespie et al., 2002).

CBT and Psychological Well-Being

There is a little review available for enhancing Psychological Well-Being by CBT as it is not considered as a disorder. Karwoski et al., (2006) believed that the acute and long-term efficacy of CBT can be enhanced by integrating principles of positive psychology—specifically, those related to cultivating and enhancing positive affectivity and overall well-being.

In cognitive-behavioral therapy (CBT), therapists use a variety of techniques to bring about change in clinical symptoms and other therapeutic outcomes such as increased quality of life. Techniques may be specific to CBT (such as helping clients to identify, test, and modify underlying maladaptive cognitions) or common among many
psychotherapeutic approaches (such as establishing a strong therapeutic alliance), and both appear to make important contributions to therapeutic outcomes (Lambert and Barley, 2002; Messer and Wampold, 2002; and Oei and Shuttlewood, 1997).

Proudfoot et al., (1997) demonstrated that a cognitive-behavioral intervention was associated with significant gains in well-being and job-finding among long term unemployed people, and Ruwaard et al., (2007) showed that a cognitive-behavioral program conducted via email brought about improvements in employees’ anxiety and stress. However, there have not been any direct attempts to apply cognitive-behavioral techniques to work variables (Proudfoot et al., 2009).

Tomba et al., (2010) derived protocol of a psychotherapeutic strategy for the promotion of well-being and optimal functioning (well-being therapy, WBT) which had been already tested in controlled trials, both alone (Fava et al., 1998) and in addition to cognitive-behavioral packages (Fava et al., 1998, 2002, 2004, 2005). The results of these studies have documented its efficacy in adult clinical populations in terms of decreasing of residual symptoms and relapse rate in mood and anxiety disorder and in improving the patients’ levels of psychological well-being and optimal functioning (Fava and Ruini, 2003).

CBT and Self-Esteem

The concept of self-esteem is grounded in cognitive distortions; thus cognitive behavioral therapy has been a popular method for the treatment of low self-esteem. Cognitive behavioral therapy attempts to positively manipulate an individual's interpretation of various situations in order to bring about desired changes outside of a clinical setting. It is believed the cognitive connection between illogical thought patterns and unhealthy self-esteem can be examined and manipulated to create schemas and belief systems that are positive, and chosen by the individual. However, low self-esteem has been relatively neglected in cognitive therapy literature. This is perhaps because it is neither a specific psychiatric disorder nor a personality disorder. Rather, it emerges as an aspect of, consequence of, or vulnerability factor for many presenting problems (Fennell, 1998; and Tillman, 2008).

The effects of cognitive–behavioral group treatment on self-esteem mainly focus
on patients with anxiety, depression, or diabetes. Treatments occur once a week for 2 
hours per treatment and continue for 8–15 weeks. The most commonly used 
questionnaires are the Rosenberg Self-Esteem Scale, the Self-Esteem Inventory, and the 
BDI. Results showed a significant increase in self-esteem (mean from 25.1 to 41.1) and a 
decrease in depression levels. Follow-up at 1 and 6 months indicated persistence of 
treatment effects (Zust, 2000; Peden et al., 2001; and Vitteng et al., 2003). The results of 
many studies support evidence on the effectiveness of cognitive group therapy on 
depressed patients’ depression and self-esteem (Chen et al., 2006).

McKay and Fanning (1992) proposed that the relationship between self-esteem 
and circumstances is most appropriately conceptualized as only indirectly related and the 
intervening factor that determines self-esteem is the cognitive interpretation of events. 
CBT may therefore offer an ideal approach for working with low self-esteem. As CBT 
focuses on thoughts, beliefs, attitudes, and opinions, a person’s opinion of himself or 
herself may lie at the heart of self-esteem. CBT provides a framework for understanding 
development and maintenance of psychological problems. In low self-esteem, the 
cognitive representation of the self is assumed to be characterized by central negative 
characteristics (Hall and Tarrier 2005).

In recent studies, cognitive-behavioral treatment was found to help overweight 
adolescents become more assertive in coping with the adverse social stigma of being 
overweight, enhance their self-esteem, and reduce their dissatisfaction with body image 
regardless of weight loss. However cognitive-behavioral treatment seems to be more 
effective in children when delivered before puberty than for adults (Melnyk et al., 2006).

RELAXATION

The Merriam Webster's Collegiate Dictionary defines relaxation as, "the act of 
relaxing or state of being relaxed, a relaxing or recreative state, activity, or pastime, and 
the lengthening that characterizes inactive muscle fibers or muscles (Mish, 1996)". In a 
paper written by Arron T. Beck relaxation is referred to as doing nothing (Beck, 1984).

A more comprehensive view of relaxation is quoted in the book "Relaxation 
Techniques" which defines relaxation as a 'state of consciousness characterized by 
feelings of peace, and release from tension, anxiety and fear' (Payne, 2004). A large
variety of relaxation techniques can evolve from these definitions.

There are many relaxation techniques which can be loosely grouped into physical (muscle to-mind) and mental (mind-to-muscle) relaxation techniques. The first category includes techniques that focus on the bodily aspects. An example of physical relaxation is **Progressive Muscular Relaxation (PMR)** which is probably the most common form of relaxation used; working under the assumption that anxious mind cannot exist within a relaxed body. That is, the degree of relaxation and tension exist on continuum. The second category techniques include the cognitive or mental approaches to relaxation. These work from "mind-to-muscle". Benson's relaxation response, meditation stretching, breathing, yoga, autogenic training and imagery all approach relaxation from mind to muscle perspective among a large quantity of other methods (Bernstein and Carlson, 1993; and Hardy et al., 1997).

Relaxation is the most fundamental psychological skill. Every performer needs to learn relax both the mind and body appropriately during performance (Mohan and Kaur, 2004). Many relaxation techniques have been tailored to fit specific stressors such as music relaxation with gynecological procedures (Davis, 1992) and expectant mothers during labor (Hanser et al., 1983), the personal story approach used with psychotherapy clients learning to listen to themselves while seeking intimate connectedness (Goldberg and Crespo, 2003), progressive relaxation on "high pressure" job professionals (Bernstein and Carlson, 1993) and yoga and meditation beneficial with all ages, and reduction of stress in staff members at a chemical dependency/alcoholism unit (Hammer, 1996).

Payne (2004) opined that relaxation has three aims, being a preventive measure, a treatment to stress, or as a coping skill to allow the mind to become clearer. These aims suggest that there are physiological and psychological aspects associated with relaxation. Physiological aspects of relaxation include the autonomic nervous system, the endocrine system, and the skeletal musculature system. Psychological aspects of relaxation include cognitive, behavior, and cognitive-behavior.

**RELAXATION THERAPY**

There are countless methods used to achieve relaxation, but the procedures that
are most commonly practiced in the clinical setting are Jacobson’s Progressive Muscular Relaxation, Schultz and Luthe’s Autogenic Training, and Benson’s Relaxation Response (Weiten and Lloyd, 1998).

In the last few decades, a substantial amount of data has been collected on many factors relating to relaxation such as: specific effects of different methods of relaxation; individual differences in response to treatment; variables that increase adherence to treatment; and relaxation therapy effects on specific health problems.

**Relaxation According to Jacobson**

Physician Edmond Jacobson developed Progressive Relaxation in the 1920’s. He consistently conceptualizes anxiety and relaxation as incompatible physiological states, defined by muscle tension levels. Jacobson developed an effective method, progressive relaxation, to relax and reduce anxiety bringing one more directly and efficiently to a state of quieting the entire nervous system. Jacobson focused on the phenomena, neuromuscular hypertension, because it could be observed and measured (Jacobson, 1938). He observed that many people lived in a chronic or intermittent state of hypertension with frequent symptoms of insomnia or emotional irritation. Jacobson noted that neuromuscular hypertension has an interesting, intricate relationship with disease in that it precedes some diseases even as part of or the entire cause. Other diseases also manifest it either during or after the disease.

**Jacobson's Method versus Modified Jacobsonian Procedures**

The many differences between the Jacobson's Progressive Muscle Relaxation technique (PMR) and modified PMR methods warrant separate consideration. Applied relaxation, Differential relaxation, and Rapid relaxation are included among the modified methods. Table-1 presents a comparison between these methods.
Table-1 Comparison between Jacobson's PMR method and modified PMR methods

<table>
<thead>
<tr>
<th>Jacobson's Method</th>
<th>Modified Jacobsonian Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater somatic physiological emphasis</td>
<td>greater cognitive and behavioral emphasis</td>
</tr>
<tr>
<td>focuses on changing levels of muscle tension per se, using tensing and relaxing exercises</td>
<td>focuses on perception of physical and emotional tension, or cognitive activity associated with relaxation</td>
</tr>
<tr>
<td>avoid aids (e. g., hypnotic suggestion) because risks of dependence on them</td>
<td>use aids to enhance compliance and perception of relaxation</td>
</tr>
<tr>
<td>use methods to produce perception of very low levels of muscle tension</td>
<td>use methods that involve gross tension-release instructions</td>
</tr>
<tr>
<td>emphasize using sessions to teaching muscular relaxation (a state of emotional or cognitive relaxation may not be experienced during training sessions)</td>
<td>emphasize using sessions to create a sense of relaxation (a state of emotional or cognitive relaxation may be experienced during training sessions)</td>
</tr>
<tr>
<td>generalization of relaxation skills are achieved by daily practice, particularly applying the skills in situations that might elicit emotional or physical tension</td>
<td>generalization of relaxation is achieved by cognitively creating cue words that can be used as &quot;conditioned stimuli&quot; to reproduce the relaxation state</td>
</tr>
</tbody>
</table>


Jacobson’s (1938) seminal work, Progressive Relaxation, is a detailed treatise on neuromuscular hypertension, its deleterious effect on health, and how progressive relaxation is the successful and correct response for treating this condition. The technique involves tensing and relaxing specific muscle groups throughout the body in a particular sequence. This is an exercise, both tedious and arduous, requiring strict concentration and a degree of perfection in performance. Becoming proficient in progressive relaxation allows one to get rid of residual tension, which is the essential feature of the technique. Residual tension is “a fine tonic contraction along with slight movements or reflexes. Often it is reflexly stimulated, as by distress or pain, yet under these conditions relaxation
is to be sought” The tension often disappears gradually, within as few as fifteen minutes of practicing progressive relaxation. Jacobson explains that to an ordinary observer relaxation appears to be occurring when a person simply lies down and is still and “relaxed,” but until the person is carefully trained in how to truly relax, clinical signs reveal prevailing residual tension. Common signs of residual tension include: irregular respiration; pulse rate often still moderately increased when compared with tests after real Jacobsonian relaxation; slight marks of the forehead; eye movements; frown; tenseness of eye muscles; knee jerk, or other deep reflexes can be elicited. “It is amazing that a faint degree of tension can be responsible for all this. Jacobson adds, “…it has been my experience that wherever there is psychic disturbance, trained observation will reveal corresponding signs of neuromuscular hyperactivity or hypoactivity”.

Jacobson (1938) reported that because anxiety accompanies tension one can reduce anxiety by learning to relax the tension itself. He noted that reducing physical tension could reduce psychological tension. “The emotions subside as the individual completely relaxes the striated muscles, particularly those which he seems to find specifically concerned in the emotion at hand: the esophagus in one instance of fear; the forehead and brow as a rule in worry and anxiety” Years of study showed Jacobson that present results indicate that an emotional state fails to exist in the presence of total relaxation of the peripheral parts of the body”. Because these two conditions are total opposites they cannot occur simultaneously.

One of the problems stressed people encounter today is actually finding the time to relax. Not only are people too busy to relax on a schedule, it is likely that they are unaware of its benefits. Time is one of modern man’s greatest shortages.

This was also a problem back in Jacobson’s day, and to those of this mindset he responded unsympathetically, “Willingness (to engage in relaxation) is the cardinal requirement for the method of relaxation …even the healthy adult would rather be up and doing than lying down to relax; in this he is like the child who does not wish to go to bed at night.” Unwillingness to give up activities is increased during fretfulness and distress.

The limited impact of each therapy is inherent in the technique and philosophy involved in the development of those tests.