5

Capturing Emotional Thoughts: The Philosophy of Cognitive-Behavioral Therapy*

Michael McEachrane

Ever since Albert Ellis introduced his ABC-theory of emotional dysfunction in the 1950s one premise of *cognitive-behavioral therapy* (CBT) has been the idea that emotional disturbances are caused by beliefs. Following Stoic philosophy Ellis argued that emotional disturbances are a *consequence* (C) of *beliefs* (B) rather than of *activating events* themselves (A) (e.g., Ellis 1962). Since then, beliefs have been the focal point of CBT – be it Ellis' *rational emotive behavior therapy* (REBT), Aaron T. Beck's *cognitive therapy* (CT) or the so-called 'new wave' of cognitive-behavioral therapies such as *acceptance and commitment therapy* (ACT) (e.g., Beck 1979; Beck et al. 1979; Ellis and Blau 1998; Hayes, Follette and Linehan 2004).

A second premise of CBT is that emotion causing beliefs are mentally represented; primarily as 'internal dialogues' – what Ellis refers to as 'self-talk' and Beck as 'automatic thoughts' – but also as mental images (e.g., Beck 1979; Ellis 1994; Segal, Williams and Teasdale 2001). On the basis of this second premise, a central idea to the practice of CBT is that we can become aware of the beliefs that elicit our emotional reactions by becoming aware of the words or images that elicit them.

This chapter examines these two premises – that emotions are caused by beliefs and that those beliefs are represented in the mind as words or images. Being a philosophical examination, the chapter also seeks to demonstrate that these two premises essentially are *philosophical* premises. Although the space of a single article does not allow for more than a cursory sketch, its upshot, that CBT in part is based on misleading philosophical assumptions, should come as a great surprise to those who think that CBT is firmly based on science.

The chapter will begin with a brief methodological suggestion of how to properly evaluate the theory of CBT. From there it will work its way from examining the therapeutic practice of capturing the mental representations that supposedly elicit emotional reactions to examining the assumption

that emotions are caused by beliefs. The chapter will end by briefly pointing to some consequences of what has been said to the practice of CBT.

1. The theory of CBT: science or philosophy?

How should one examine the two central assumptions of CBT, that emotional disturbances are caused by beliefs and that those beliefs are internally represented? In a relatively recent debate between the Beck-camp of CT and the Ellis-camp of REBT, Christine A. Padesky and Aaron T. Beck criticize REBT for being *philosophical* rather than *scientific* (Padesky and Beck 2003, 2005; Ellis 2005; Still and Dryden 2003).

It is widely known that REBT largely grew out of Ellis' interest in philosophy, particularly Stoicism (e.g., Ellis 1994, p. xv, 1989, p. 215). His development of REBT in the 1950s was not based on empirical research, but on applying Stoic ideas in his clinical practice. As Padesky and Beck point out, CT on the other hand was developed on the basis of Beck's empirical research on depression in the 1950s (and early 60s) (Padesky and Beck 2003, p. 212). On the whole, Padesky and Beck argue, a 'fundamental difference between the two is that REBT is a philosophically based psychotherapy and CT is an empirically based psychotherapy' (Padesky and Beck 2003, p. 211). There is no doubt that CT is deeper rooted in experimental psychology than REBT, and perhaps Padesky and Beck are right that, 'The empirical foundation of CT is undoubtedly one of the reasons it is such a highly regarded therapy approach' (Padesky and Beck 2003, p. 213).

But although it seems fair to say that empirical studies are relevant to, say, pinpointing how people suffering from (or who are particularly susceptible to) certain mental disorders tend to view themselves, other people, certain situations, and so forth, and also to evaluating the efficacy of treatment methods, it does not seem fair to say that empirical studies are sufficient to evaluate what Padesky and Beck refer to as the key assumptions of CT:

> All CT conceptualizations include two key assumptions. The first is that people actively construct meaning and derive rules that guide their behavior. This construction process involves information processing which frequently includes selective filtering and even distortion of what is perceived .... The second is an assumption that cognitions, emotions, behaviors, physical responses and life events are interactively linked to one another .... Although cognitions are not always causally linked to emotional or behavioral disorders, cognitive theory proposes that cognitions mediate all change efforts. For example, regardless of the original causes, someone with a substance abuse disorder may need to change beliefs about the problem before developing a motivation to participate in treatment. There is empirical support for each of these assumptions .... (Padesky and Beck 2003, p. 218)

Here I take the first assumption to mean that people have beliefs and 'automatic thoughts' (that guide their behavior) and the second assumption to mean that emotional disorders are caused by such 'cognitions'. This is in line with what Beck elsewhere has described as the core of the cognitive model of emotions and emotional disorders:

> The thesis that the special meaning of an event determines the emotional response forms the core of the cognitive model of emotions and emotional disorders: The meaning is encased in a cognition – a thought or an image. (Beck 1979, p. 52)

What I am going to try to demonstrate in the remainder of this article is that this cognitive model, what I take to be the two key assumptions of CBT – again, that emotions are caused by beliefs and that these beliefs are mentally represented as words or images – depend on certain understandings (or misunderstandings rather) of the meanings of emotion-reports. What I will try to show is how the theoretical foundation of cognitive therapy hinges on an understanding of the meanings and uses of emotion terms, and such terms as 'thought' and 'belief'. This is also to show precisely how philosophy is relevant to CBT: clarifying the meanings of words by reflecting on their use – what, in philosophy, sometimes is referred to as 'conceptual analysis' – is needed in order to inquire into its underlying theory (cf. McEachrane 2006, and in press).[1] As we proceed, I hope that the practice and relevance of such an approach will become sufficiently clear.

2. Capturing emotional thoughts

The typical course of treatment in CBT is to go from *automatic thought* (CT) or *self-talk* (REBT) to *core belief* (CT) or *core philosophy* (REBT) (cf. e.g., Beck, J.S. 1995, p. 16). The initial focus, in other words, is to seek to capture the thoughts that supposedly elicit emotions in the moment, and then from there explore the deeper lying, general beliefs that these thoughts often are expressive of. Typically, these 'thoughts' are assumed to be in the form of 'inner speech'.

Early on in his career Ellis put an emphasis on such 'inner speech' – which he called *self-talk* – and theorized that what makes humans particularly prone to be emotionally disturbed, and remain so, is their linguistic facility 'to translate their psychological *desires* – such as the desires for love, approval, success, and leisure – into *definitional needs*' and to thereby 'abuse this facility by talking nonsense to themselves: to *define* things as *terrible* and *impermissible* when, at worst, these things are very inconvenient and annoying' (Ellis 1994, pp. 29–30). Over the years, though, Ellis went from putting an emphasis on emotion-eliciting beliefs as *self-talk* to putting a greater

emphasis on emotion-eliciting beliefs as a matter of the general *philosophy* of the client.

> When I first started to do REBT, I wrongly thought that disturbed people almost always talk to themselves to create their emotional problems. I now see that they often do this and literally tell themselves, 'I failed again. That means I'll *always* fail and am no damned good as a person!' Now I see that they *sometimes* but not always explicitly say these sentences to themselves. But whether they do or don't tell themselves these negative statements, they have a *core philosophy* (sometimes called, by Aaron Beck and others, a schema) that they implicitly, and usually strongly, believe that underlies their self-statements. (Ellis 1994, p. 28)

REBT's current view on the relation between emotional disturbance, core philosophy, and self-talk seems to be something like the following.[2] Emotional disturbances depend on core philosophies[3] that create tendencies to view events and circumstances in a disturbing manner. Such disturbing perceptions may be 'non-verbal' as initial or momentary reactions, but are typically followed by self-talk resulting from a core philosophy. Nevertheless, these core philosophies are themselves quite literally understood as *statements* – be they *tacit*, as in the case of core philosophies, or *explicit*, as in the case of self-talk (cf. e.g., Ellis 1994, pp. 26–27). And so, a central task of REBT is to track these emotion-eliciting statements down.[4]

CT's analogue to REBT's 'self-talk' is so-called *automatic thoughts* – 'self-talk' which occur 'in a kind of shorthand; ... as in telegraphic style' and not 'as a result of deliberation, reasoning, or reflection' but 'as if by reflex' (Beck 1979, p. 26). According to Beck emotional reactions to external events are made understandable by such intervening automatic thoughts, which people can learn to capture:[5]

> When a person is able to fill in the gap between an activating event and the emotional consequences, the puzzling reaction becomes understandable. With training, people are able to catch the rapid thoughts or images that occur between an event and the emotional response. (Beck 1979, p. 26)

Although emotions are typically mediated by 'automatic thoughts', they may also, as maintained by Beck, be mediated by *mental imagery* (e.g., Beck 1979, p. 26 and pp. 37–38; Beck et al. 1979, pp. 150–157; cf. also Beck, J.S. 1995, p. 88).

However, what is key here, both in Ellis' and Beck's rendition of how thought elicits emotion, is the notion that *thought must consist of some kind of mental representation, be it words or images*. This – I dare say – unexamined presupposition is a central and recurrent theme in REBT, CT, and what

sometimes is referred to as 'new wave cognitive therapy' or 'third wave behavior therapy' (cf. Hayes 2004).[6]

3. What are emotional 'thoughts' anyway?

Here is a clinical example by Judith S. Beck of how this cognitive model of emotion might be introduced in a therapy session:

> *THERAPIST*: Now I'd like to spend a few minutes talking about the connection between thoughts and feelings. Can you think of some times this week when you felt upset?
> *PATIENT*: Yeah. Walking to class this morning.
> *T*: What emotion were you feeling: sad? anxious? angry?
> *P*: Sad.
> *T*: What was going through your mind?
> *P*: I was looking at these other students, talking or playing Frisbee, hanging out on the lawn.
> *T*: What was going through your mind when you saw them?
> *P*: I'll never be like them.
> *T*: Okay. You just identified what we call an *automatic thought*. Everyone has them. They're thoughts that just seem to pop in our heads. We're not deliberately trying to think about them; that's why we call them automatic. Most of the time, they're real quick and we're much more aware of the emotion – in this case, sadness – than we are of the thoughts. Lots of times the thoughts are distorted in some way. But we react *as if* they're true.
> *P*: Hmmm.
> *T*: What we'll do is to teach you to identify your automatic thoughts and then to evaluate them to see just how accurate they are. For example, in a minute we'll evaluate the thought, 'I'll never be like those students'. What do you think would happen to your emotions if you discovered that your thought wasn't true – that when your depression lifts you'll realize that you *are* like the other students?
> *P*: I'd feel better. (Beck, J.S. 1995, p. 78)

As should be clear by now, in CBT a question such as 'What was going through your mind when you saw them?' is asked literally, and the answer 'I'll never be like them' is understood as the actual words (or perhaps image) that went through the client's mind and elicited the sadness. Whether or not this practice reflects an accurate understanding of what it means 'to think' something may seem like hair-splitting, but, as we will see, how the question is answered may significantly change the therapeutic approach.

The assumption underlying the practice of cognitive therapy to ask what is going through a client's mind, what they are telling themselves when they feel a certain way (cf. Ellis 1994), or that they should learn to capture

their emotional thoughts, is that the word 'thinking' refers to something particular going on in their mind (e.g., a stream of words) that *is* the thinking. But this wrongly conflates thinking with whatever is going on in a person's mind when they think something.

In the clinical example above, it is possible that the client thought 'I'll never be like them' without formulating those words to herself (i.e., without these words popping in her head) for at least two reasons.

1. What it means 'to think' something is not equivalent to what it means 'to have thoughts' about something.
2. 'To think' something may mean to perceive something a certain way (rather than to have certain words or images before one's mind, as it were).

(1) When speaking of thinking there is a crucial difference between 'to think' and 'to have thoughts' (cf. Malcolm 1977). When speaking of 'to think' or 'thinking' (as in 'to think' that one is living a good life or 'thinking' that one is an intelligent individual) we do not necessarily mean that certain words, or even images, are before our own or someone else's mind. For instance, one need not be entertaining the thought 'I'm an intelligent individual' or have the image of oneself as an 'intelligent individual' (whatever that would mean) present to one's mind so long as one thinks that one is an intelligent individual (which might be practically all the time). A student might be overconfident about her own intelligence and categorically react to something a professor is saying as nonsense since she does not understand it. Here, though, *thinking that she is intelligent* does not imply *having the thought (present to her mind as it were) that she is intelligent*.

In general, to say of someone that they 'thought that *p*' does not imply that they 'thought of *p*' or 'thought about *p*' or formulated *p* or that *p* occurred to them or were in their thoughts. So, for instance, if a client says that in a particular situation they thought that, say, 'I'll never be like them' or 'I'm worthless at interacting with people' or 'I'm not a likeable person', then this does not necessarily mean that the client in that situation thought *of* these things, formulated these things to herself, that these things occurred to her or were in her thoughts. That fact, that the formula 'she thought that *p*' does not imply the formula 'the thought that *p* occurred to her', may perhaps be easier to digest if we keep in mind that,

> The same holds for a host of propositional verbs. You and I notice, for example, that Robinson is walking in a gingerly way, and you ask why. I reply, 'Because he realizes that the path is slippery'. I do not imply that the proposition 'This path is slippery' crossed his mind. Another example: I wave at a

> man across the quad. Later on I may say to someone, 'I saw Kasper today'. It may be true that I recognized Kaspar, or recognized that the man across the quad was Kaspar, but not true that I thought to myself, 'That is Kaspar'. (Malcolm 1977, p. 52, cf. also p. 57)

Consider, again, the thought 'I'll never be like them' in Judith Beck's clinical example above. What went on when the client thought that she would 'never be like them' might have been something like this. She saw these other students, talking or playing Frisbee, hanging out on the lawn. It was a sunny day to which she already felt a sense of alienation: merely registering that it was a sunny day but not being able to enjoy it, experiencing it as a sharp contrast to how she felt. Then she saw these contemporaries of hers, students like herself, that seemed to be hanging out and enjoying themselves with ease. The contrast between herself and these students seemed stark and interminable and this saddened her.

Later, during counseling, when asked what went through her mind that made her sad, she said: 'I'll never be like them'. That was what she was thinking. And this thought had saddened her. If she had thought, say, that her generally gloomy frame of mind was merely temporary – like a Sunday evening blues or something of the sort – and that she was likely to feel o.k. tomorrow, perhaps she would not have reacted the way she did. Now note that although it makes perfect sense for her to say that she in fact thought 'I'll never be like them', such words (or equivalent images) need not have flitted through her mind while she thought this. To insist otherwise, to insist that such words *must* have flitted through her mind if this is what she thought, is like insisting that after having sat down on a chair that broke under our weight and saying 'I certainly thought it would hold', then such words *must* have flitted through our mind – as if each time we sit down on a chair we tell ourselves something like, 'This chair will certainly hold'. In fact, when we utter the words 'I'll never be like them' or 'I certainly thought it would hold' to express what we thought at a particular moment it might very well be the first time these words occur to us.

Of course, this is not to deny that we in fact do tell ourselves things – far from it! – and that what we tell ourselves is often what we think. However, if we, for instance, think, as the client in the above example did, that 'I'll never be like them', then that might very well be a matter of how we take things to be rather than what we tell ourselves – which brings us to the second reason why a client may think something, which makes them react emotionally, without the thought being words or images in his or her mind.

(2) Generally speaking, 'thinking that *p*' (e.g., thinking that 'I'll never be like them', 'I'm worthless', 'She's angry with me', 'I don't know what to do', and so on) is not a particular internal representation, but experiencing, acting upon, reflecting upon, reacting to, *something (or someone) as being a*

certain way (cf. Travis 2000, pp. 158–159).[7] That is to say, when we say that we or someone else 'think' or are 'thinking' this or that, we are *reporting on a perceived or appraised state of affairs*, if you will – not on the words or images before our minds. For instance, if I thought that I saw a person in the dark that turned out to be a tree, this 'thought' signifies a perceived or appraised state of affairs ('I saw a person ...') and not internal words or images – that is words or images may or may not have occurred to me at the moment I saw a person (... that turned out to be a tree), nevertheless they do not define the 'thought'.

A similar story can be told of 'beliefs'. Sometimes 'thought' and 'belief' may be used synonymously – as in, 'When I sat down on this chair, of course I believed/thought it would bear me' (cf. Wittgenstein 2001, § 575). And just as 'to think' does not imply 'having a thought' (or, on the whole, having an internal representation) neither does 'to believe'. However, there are also obvious differences between 'belief' and 'thought'. Whereas we can 'think of' something, 'think about' something, and the like, we cannot likewise 'believe of' or 'believe about' something. A 'belief', one could say, is more like an attitude than an activity of the mind and in this sense more related to expecting and hoping than it is to thinking (i.e., 'thinking of', 'thinking about', 'thinking over', 'thinking through', etc.) (cf. Wittgenstein 2001, § 574). Therefore, one could also say, we have even less reason to assume that 'belief' is some kind of internal representation like an image or self-talk. Hence, I will not directly address the issue whether or not 'beliefs' are constituted by what we tell ourselves. Besides, I take it that the assumption in CBT is that it is thought that consists of what we tell ourselves and the like, and that a belief can only be what we tell ourselves so long as it is a thought (e.g., there is never any talk of 'automatic beliefs' in cognitive therapy).

4. On declaring one's feelings

However, there is another assumption concerning beliefs that makes CBT put an undue emphasis on automatic thoughts, self-talk and the like. CBT tends to treat any declarative expression of an emotion – such as 'I'm worthless', 'My life's a disaster', or 'I'll never be like them' – as an emotionally constitutive belief. Beck, for instance, asks therapists to be wary of allowing clients to 'preface a wide assortment of opinions, beliefs, speculations, and other attributions with words such as "I feel" ' (Beck et al. 1979, p. 37). When a client 'makes a statement such as "I feel I am worthless" or "I feel I have to be successful in order to be happy" ', Beck goes on, 'he is verbalizing an *idea* that may be associated with a feeling' (Beck et al. 1979, p. 37). Therefore 'it is desirable for the cognitive therapist to get an early start in making appropriate translations of "I feel ..." into "You believe ..." ' (Beck et al. 1979, p. 37).

In this piece of advice, and in CBT in general, there seems to be at least two related and misleading assumptions about declarative sentences:[8]

1. Declarative sentences are generally treated as constitutive rather than merely expressive of emotional experiences – whereas it would seem that they can be both.
2. Declarative sentences such as 'I feel I am worthless' or 'I feel I have to be successful in order to be happy' are generally treated as *beliefs* without distinction.

(1) What seems misleading about the first assumption is that an internal dialogue, or a statement in therapy, may very well be words that *express* or *describe* an emotional experience rather than words that *constitute* or *cause/determine* it. So, for instance, an internal dialogue, or a statement in therapy, such as 'I'm worse than my mother ever was. I'm not fit to care for my children. They'd be better off if I were dead' (cf. Beck et al. 1979, pp. 150–151) may be words that *express* or *describe* her emotional experience rather than words that *constitute* or *cause/determine* it – much the same way one may, for instance, think or say of a rotten fish that it is disgusting although it is not the thought that makes it disgusting but the way it smells, looks, and tastes. Furthermore, the declaration 'I'm worse than my mother ever was. I'm not fit to care for my children. They'd be better off if I were dead' may not be a literal statement about her motherhood – and, thereby, understood as a statement that may stand in a causal relation to her depression, as CBT would have it – but merely be an *expression* of, say, just how bad a mother the client thinks that she is. In that case it would be off the mark to take the literal meaning as being constitutive of the client's emotional state or to dispute the literal meaning of the expression (unless this indirectly changes the perception of herself as a poor mother).

(2) The mistreatment of declarative sentences in CBT essentially boils down to this: more than merely being beliefs, opinions, or ideas, declarative sentences may have several kinds of meanings. For example, a client may declare that they are worthless or will never be happy without actually believing it. 'I'm worthless', for instance, may be a way of emphatically saying that they are unsatisfied with their life and the way they are living it, or as a way of expressing an experience they have of themselves rather than a literal belief. Saying that 'I feel worthless' may, for instance, be a way of expressing 'a sense of worthlessness' rather than a belief that one lacks worth or value. 'I feel worthless' may be a way of for example saying just how low their confidence in themselves, their likeability, capabilities, and opportunities in life is, and just how bad they feel about this. In such a case, to assume that the client actually *believes* that they are worthless – or even to ask whether or not they believe that they are worthless – would be to misunderstand the meaning of what they are saying. And rather than

translating 'I feel worthless' into 'I *believe* that I am worthless', 'I *feel* worthless' would, in fact, be the more appropriate expression.

An obvious reason why there is a tendency in CBT to interpret any declarative sentence as a belief seems to be the ABC-theory of emotional dysfunction with its emphasis on beliefs as what determines emotional disorders. In the spirit of this theory Ellis writes that in REBT when clients'

> feelings are negative and self-defeating, they are shown how to look for their underlying cognitive and ideational correlates. They are shown how they *create* most of their self-destructive emotions by consciously or (more usually) unconsciously believing and retaining their dysfunctional philosophies. Thus, when they feel hurt about being rejected, they are shown that their feeling probably accompanied (a) the sane Belief 'I don't like being rejected', and (b) the irrational Belief (iB) 'It is *terrible* being rejected. Because I don't like it, I can't *stand* to be rejected in this fashion. I must *always* be accepted!' (Ellis 1994, p. 266)

But how is 'I don't like being rejected' a belief? Would it, for instance, be fitting to ask a person, after they have expressed their hurt about being rejected, whether they are sure that they did not like being rejected, what their reason or evidence for claiming this is, and so forth? That would generally be nonsense. Now, if a person upon having being rejected and hurt says how *terrible* it is and that they can't *stand* it, are they stating a belief? What is obvious is that they are saying something about how they feel about the rejection. But what, if anything, makes it a belief-statement? Ellis would presumably say that it is a belief because it is a self-defining statement about a rejection as 'terrible' and 'unbearable', whereas there is nothing inherently terrible or unbearable about being rejected (cf. e.g., Ellis 1994, p. 117). But how does this make saying that a rejection is 'terrible' a belief? This seems to depend on what the client means by saying that the rejection is 'terrible'. If the client merely is saying, for instance, that the person that did the rejecting meant a lot to the client and that the client is very disappointed, that alone will not make it a belief. How could it? On the other hand, if the client by 'terrible', and especially 'I can't stand it', is thinking for example that they will never meet another person to love, that the person that did the rejecting is a bad person because of it, or that there is no life worth living without this person, then there does seem to be some 'belief' involved. Again, this is just to say that whether or not a declarative expression of an emotion is a belief, or involves a belief, depends on its meaning.

5. The 'B' in the ABC-theory

This naturally brings us to the central idea of CBT, that emotional disturbances are caused by ('irrational' or 'dysfunctional')[9] beliefs (e.g., Beck 1979;

Ellis 1994).[10] As I am about to argue, this ABC-model carries with it at least three misconceptions:

1. Emotional reactions are caused by beliefs which are mentally represented as words or images.
2. To believe something (that disturbs us) is to entertain a proposition.
3. Emotional dysfunction is caused by belief.

Contrary to (3), both (1) and (2) are presuppositions rather than explicit theories, and do not follow from the ABC-model itself. Fair to say, though, especially (1), but also (2), are widespread presuppositions in CBT. And, as we will see, their correctives – as, obviously, the corrective of (3) – should lead to a significant change in therapeutic practice.

(1) To repeat, there is a tendency in CBT to treat beliefs as words or images in our minds waiting to be tracked down and observed. Although I have already addressed this issue above in showing that thinking or believing that *p* does not imply having the thought that *p*, and that speaking of beliefs generally is a way of indicating how we take something to be, not a way of naming an internal representation, let me still add a few words regarding mental imagery.

It may be tempting to assume that if a belief is not something that we tell ourselves, then it must be represented in our minds in some other way and that that other way is as an image. In that view, a belief is an image in our minds representing a certain state of affairs. But – to reiterate the point that to believe something generally is a way of indicating how we take something to be, not a way of naming an internal representation – insisting on mental imagery is to misunderstand what it may mean to take something to be a certain way. For instance, if I believe that a tree seen at night is a person, then, surely, it is not a picture in my mind of a person that I see, but simply a person (although it is a misperception; an optical illusion if you will).

Similarly, it would be wrongheaded to presume that if a client believes, say, that he or she is not a likeable person, then that belief is a mental image that the client has of him- or herself as not being likeable. Although it seems fair to describe the belief that one is not likeable as a self-perception, it seems unfair to presume that this belief/self-perception is a mental image. Because a client believes that he or she is not likeable a client might expect that people are going to respond to him or her accordingly. But that does not mean that so long as the client has such expectations because of such a belief, then there must be a mental image present to the client of him- or herself as not being likeable. If anything, rather than describing the belief/self-perception as a *mental image*, it would be more appropriate to describe it as a *propensity* of the client to have thoughts (including mental images) about him- or herself as not being likeable and to make assumptions about how other people relate to, think of, respond to, and so forth, him or her as

not being likeable. For instance, because the client believes that he or she is not likeable he or she might incorrectly think that a facial expression is contemptuous and feel dismayed. However, despite the thinking, believing, and the emotional reaction, no mental image needs be present – merely a perception, even if false, of a contemptuous face of flesh and bone.

(2) A related assumption of CBT is that to believe something that disturbs us – whether the belief is conscious, semiconscious or unconscious – is to entertain a proposition (e.g., the proposition, 'I'm unlovable'). This assumption generally seems to go with the assumption that beliefs are internally represented as words or images. But there is another way in which the assumption that to believe something is to entertain a proposition may mislead. One might identify – or rather *mis*identify, as I will argue – a 'belief' with a proposition (or, perhaps more accurately, with an attitude toward a proposition) and assume that a belief simply *is* to entertain a proposition, and, thus, that without the proposition, no belief. However, at least typically, this would be to confuse the linguistic expression of a belief – which is done in propositional form – with the belief itself.

Again, speaking of beliefs may simply be a way of expressing how we take something to be – that is to say, how we perceive, or, more generally, experience something. This is an important point to keep in mind in doing therapy since it points to what the therapeutic focus ought to be and what needs to change in order to change an emotionally held belief. Consider, for instance, the following clinical example by Ellis about a patient who is having problems in seeing that feelings depend on beliefs:

> '(...) I know I'm doing better of course, and I'm sure it's because of what's gone on here in these sessions. And I'm pleased and grateful to you. But I still feel basically the same way – that there's something really rotten about me, something I can't do anything about, and that the others are able to see. And I don't know what to do about this feeling.'
>
> 'But this "feeling", as you call it, is largely your *belief* – do you see that?'
>
> 'How can my feeling be a belief? I really – uh – *feel* it. That's all I can describe it as, a feeling?'
>
> 'Yes, but you feel it *because* you believe it. If you believed, for example, really believed you were a fine person, in spite of all the mistakes you have made and may still make in life, and in spite of anyone else, such as your parents, thinking that you were not so fine; if you really *believed* this, would you then feel fundamentally rotten?'
>
> 'Oh. Hmm. No, I guess you're right; I guess I then wouldn't feel that way.' (Ellis 1994, pp. 32–33)

Here, again – as I pointed out in the previous section – 'I feel rotten', may in fact be the more accurate expression, rather than 'I believe that I'm rotten'

or the like. However, let us, for the sake of argument, go along with Ellis and assume that, in this case, 'I believe that I'm rotten' would be an accurate depiction. In this case, Ellis may indeed be right that the patient would not feel rotten if he believed that he was a fine person. Nevertheless, here one need to keep in mind that what constitutes the belief is not the proposition 'I'm rotten', but the client's self-perception. In fact, the therapy session may be the first time he has formulated his belief as a proposition. For example, the client might be putting himself down a lot (e.g., he thinks that he is too fat, that he will never find someone to love, that he is incapable of bonding with people, and that he is professionally incompetent); he might have a tendency to interpret gestures, facial expressions, comments, and so on, as personal rejections, and might not be able to see how his future could possibly be bright. Of such a self-conception it might be accurate to say that, 'I believe that I'm rotten' or 'He believes that he is rotten'. But note that speaking of *belief* here is a depiction of how he sees himself in the world, as it were. What is primary to the clients' belief is the perception of himself as 'rotten', whereas the proposition 'I'm rotten' is a linguistic expression of his self-perception.

One might want to object to this order and claim that the clients' perception of himself as rotten has to flow from his (propositional) belief 'I'm rotten', and not the other way around. A likely rationale for this assumption is that one cannot perceive that *p* (e.g., 'I'm rotten') unless one has a concept of what the perception is a perception of (e.g., 'being a rotten person'), and that the perception 'I'm rotten' is not possible without applying the concept 'rotten' to oneself. On this account, the client would not have any perception of himself as *rotten* if he did not entertain the proposition that he is 'rotten'. But this exaggerates the power of words. 'I'm rotten' may very well be exchanged by, say, 'I'm nothing', 'I'm worthless', 'I'm a failure' or 'I don't amount to much' – although, perhaps, the word 'rotten' may better capture this clients' particular sense of self – which is to say that 'rotten' is a way of articulating an experience rather than a prerequisite of it. In a similar fashion we should not confuse how something smells with the expression 'What an odor!', or how we take someone's behavior with the expression 'He's being hostile', or our impression of a book with the expression 'It sucks!'[11]

(3) Let us now turn to the general claim that emotions are caused by beliefs. Besides the reservations that CBT misunderstands beliefs as mental representations in the form of words or images, CBT also, I will argue, exaggerates the role of beliefs in our emotional lives. Not only are emotion-eliciting beliefs, as I have mentioned, best understood in terms of how we take things to be. I would like to go further and suggest that how we take things to be is fundamental to our emotions and not always a matter of belief.

Without much ado it seems fair to assume that emotions typically are about something, that they have what philosopher's call *intentionality*

(cf. e.g., Kenny 1963; Nussbaum 2001). Anger, sadness, jealousy, anxiety, and so on, are typically about something – say, an offense, the loss of a loved one, someone else's success, or an uncertain outcome. The ABC-theory, as I will argue, mistakenly reduces this aboutness or intentionality of emotions to beliefs.

Consider the following example. A client, Jill, is depressed. When asked what makes her depressed she describes that she is one year away from turning forty and that what pains her more than anything else is that she is childless, without a partner and that her chances of ever having a family seems slimmer by the day. Granted that Jill's depression actually is about these circumstances, then, according to the ABC-theory, it is not the circumstances per se that depresses her, but the beliefs that she has about them (or, more generally, the beliefs that are activated by them). But is this assumption correct?

Let us examine the supposition that Jill's depression is caused by belief. Could it be that her depression simply is caused by the belief that her chances of ever having a family are becoming slimmer by the day? Well it might certainly be true that her depression depends on this belief in that if she did not have it then neither would she be depressed. On the other hand, the logic of the ABC-theory seems to suggest that this belief alone is not sufficient to make someone depressed. On the logic of the ABC-theory, Jill's belief, that her chances of ever having a family are becoming slimmer by the day, is arguably the activating event (A), while the cause of her depression needs to be a belief (or several beliefs) of a more evaluative kind (cf. Daniel 2003). For instance, it may, at least in principle, be possible for Jill to believe that her chances of ever having a family are becoming slimmer by the day and yet not be depressed. In fact, this seems to be a condition for the therapy to be relevant, not to mention successful – for it might very well be a true belief.

So it would seem that a therapist need dig deeper as to what this belief means to Jill in order to understand what causes her to feel depressed.[12] However, although it seems right to assume that the diminishing prospect of ever having a family is depressing to Jill because of what this means to her, it seems wrong to assume that the meaning is a matter of belief. Suppose that Jill has dreamt of having a family her whole life and made that prospect a central part of how she envisions a happy life for herself – so much so that the prospect of not attaining that dream depresses her. How is this necessarily a matter of belief? Here a traditional cognitive-behavioral therapist might suggest (especially if the therapist practices REBT) that Jill believes that she *cannot be happy without a family* (i.e., that she *must* have a family in order to be happy) or that *her life will be awful without a family*. It may also be that she simply believes that she *must* have a family, period (without any specific conditional). In either case, a traditional cognitive-behavioral therapist might argue, her depression may be caused by such beliefs.

However, this is likely to be a mischaracterization of Jill's depression. What is likely to cause Jill's depression is not literal beliefs such as, 'I cannot be happy without a family' or 'My life will be awful without a family', but more fundamentally how she sees her life, as it were, with and without a family. 'My life would be empty without a family' or 'My life would be pointless without a family' may be further ways, alongside the other two beliefs, of expressing how she sees her life with and without a family – where what is critical is not any of these literal expressions, but the outlook that they are expressive of.

Understanding the significance to Jill's depression of how she takes her life to be with and without a family is critical to understanding the role beliefs, and the changing of beliefs, actually may play. For instance, once we realize that, say, how Jill envisions a happy life for herself as one with a family, perhaps a certain kind of family, and how much she desires this, is more fundamental to her depression than any belief, then it should come as no surprise if she remained depressed although she believed that she, at least in principle, in fact could lead a happy and fulfilling life without a family. Changing Jill's beliefs – say, 'I cannot be happy without a family' or 'I'm worthless without a family' – may very well be critical to alleviating her depression. But a change of belief without a corresponding change of perception – say, helping her envision the possibility of a happy and fulfilling life for herself without a family – will be of little help.

In addition to implying what the therapeutic focus ought to be, getting this point says something about the kind of role beliefs play in emotions – where what is essential to the beliefs (and the emotions) are perceptions, not propositions. It also says something about the role speaking of emotions in terms of beliefs may have as a shorthand for a way of seeing something, for how one takes something to be. And, it shows how one can feel something against one's best judgment, as it were (e.g., feeling rotten although one does not believe that one is rotten, or being terrified of the sight of a spider in a book although one knows it is not an occasion for danger).[13]

6. A more philosophically accurate CBT?

Then what are the consequences, if any, of all this to cognitive-behavioral therapy? Here are some brief suggestions.

First, there is the notion of 'automatic thoughts'/'self-talk' as emotion-eliciting words (or images) in our minds. In the practice of CBT, this notion may become falsely asserted and reaffirmed in the relationship between therapist and client as well as in the clients' own therapeutic work outside the therapists' office. For instance, to borrow an example from Albert Ellis, cognitive-behavioral therapists may be in the habit of asking leading questions such as, 'What are you telling yourself anxious and depressed about failing some important project?' And in response a client might rummage

for self-statements and reply, 'If I fail at this project, everyone will despise me' or 'If I fail at this project, I'll never succeed at anything important' even if such statements never actually ran through their mind (cf. Ellis 1994, p. xx). Both therapist and client may also falsely assume that if the client cannot find such words or images in their minds, then it is because they are not being conscious enough.

An alternative, and more accurate practice, would be to *not* assume the existence of such emotion-eliciting words and images in the minds of clients. To ask clients, or to make clients ask themselves, what they were thinking when they reacted a certain way may be fine. However, as I have argued, rather than understanding such talk of emotion-eliciting 'thoughts' as representing words or images in our minds, it would be more accurate to understand them as representing how we, as I have put it, *take something to be* or broadly speaking *perceive* something. This means that it should never be assumed that when a client 'thought' something then this 'thought' was words or images in the client's mind, or that the verbal expressions of what he/she was thinking when he/she, say, felt a pang of guilt must reflect a mental process that took place at the time. So, for instance, in finding out what a client was thinking that made them react in a certain way to a situation, we had better focus on the particulars of the situation and what it meant to the client than on what was running through the client's mind at that moment.

Still, encouraging clients to become more aware of what is going on in their minds may be fine so long as this is accurately understood in the broader context of trying to get a handle on how they take things to be. In addition to that it should not be assumed that it is a client's 'self-talk' (or mental images) that causes him or her to react the way he or she does, neither should it be assumed that when such 'self-talk' (or mental images) *does* cause a client to react the way he or she does then it must be in the form of a 'belief'. Moreover, if, as I have argued, a declarative expression of an emotion can be both expressive *and* constitutive of an emotion, and it would be wrongheaded to treat all declarative sentences as beliefs, then this is true of self-talk too.

Secondly, there is the general notion that emotional disturbances are caused by beliefs – be they 'automatic thoughts'/'self-talk' or 'core beliefs'/'core philosophies'. As I have argued, a client's 'beliefs' should not be understood as words or images in the client's mind either. CBT seems generally to have fallen for the misleading temptation of understanding 'beliefs' literally as propositions. Instead beliefs are, again, more properly understood as *how we take something to be* or more broadly *perceive* something. This means that, in the practice of CBT (as elsewhere), the expression of 'beliefs' in propositional form should be understood as *descriptions* (of which there may very well be several alternative ones) rather than expressions of propositions (or equivalent images) in our minds. This also means that the challenge of formulating clients' beliefs is typically not to unearth propositions in their mind, but to

find the words that accurately describe how they understand or see something (where how the client understands or sees something cannot be reduced to propositions in the client's mind).

Moreover, as I have argued, although emotions may be said to be caused by how we take things to be, how we take things to be is not always a matter of 'belief'. What this means to the practice of CBT is that rather than exclusively focusing on 'beliefs' it would be more accurate to focus on the outlook of the client more generally. Then, the primary goal of CBT would not be to change the beliefs of the client – especially if these are understood as propositions – but to change how the client, more broadly, sees things. From this perspective focusing on beliefs may be a pragmatic way of challenging, and changing, how a client sees things – but only to the extent that such a focus actually leads the client to develop emotion-altering outlooks.

Notes

*I would like to thank Ylva Gustafsson, Lars Hertzberg, Camilla Kronqvist, and Thomas Teufel for helpful comments on earlier drafts of this paper.

1. Given this approach it is secondary how the cognitive model initially was reached at (cf. Beck 1979, pp. 52 and 83).
2. Exchange 'core philosophy' with 'core belief', and 'self-talk' with 'automatic thoughts', and you will find the same general idea in CT.
3. Characteristically so-called 'masturbatory philosophies'.
4. Some followers of REBT might disagree with this characterization as did Ellis himself who, in the 1990s, claimed that he nowadays emphasized clients' 'self-*meanings* and self-*philosophies*, which may be held in the form of self-sentences or self-talk but also in more complex or more tacit kinds of self-communication' (Ellis 1994, p. 39). But, as I will try to show, there is nonetheless some unclarity concerning the nature of beliefs and thoughts in REBT (and cognitive-behavioral therapy in general) that once resolved should suggest an entirely different approach than the current one. Besides, anyone in disagreement with my characterization should, for instance, consider this relatively recent statement by Ellis (2004):

   > People have a basic belief system, or system of values, which they consciously or unconsciously strongly and emotionally believe. And this belief system instantaneously flashes, if you want to use that term, into their heads every time they contemplate a certain feared activity.
   >
   > Thus, in the illustration just given, the man who fears subway rides may have the basic philosophy, or set of beliefs, that it is terrible if people stare at him in a pitying manner. And this philosophy, this series of fundamental *assumptions* that he holds at point 'B', induces him, in any given case where he contemplates taking a subway ride, to 'flash' to himself, 'Oh, no! I couldn't do that!' – which is a logical deduction from his illogical or irrational premise – namely, that it is terrible if people stare at him in a pitying manner.
   >
   > It is this irrational premise we would clearly bring to awareness and persistently and strongly (emotionally) challenge. (Ellis 2004, pp. 35–36)

5. A first step in the therapeutic process of CBT is to teach a client 'to monitor his negative, automatic thoughts (cognitions)' (Beck 1979, p. 4). How this is done may vary depending on the emotional problem and the clients' capabilities. In the

treatment of depression, however, the client is typically 'instructed to "catch" as many cognitions as he can and to record them' (Beck et al. 1979, p. 150). This is preferably done right after they occur. But if, for whatever reason, a client may not be able to record his cognitions immediately, 'a second method', Beck goes on,

> is to direct the patient to set aside a specific brief period of time, for example, 15 minutes each evening, to replay the events that led to his cognitions as well as the actual cognitions. The therapist instructs the patient to record any upsetting thoughts as precisely as possible. That is, rather than noting, 'I had the feeling I was incompetent in my job', as he would be likely to report the thought in a conversation, the patient would write, 'I'm incompetent in my job', a more precise reproduction of the thought. (Beck et al. 1979)

Beck also suggests further methods in assisting clients to capture their emotional thoughts (cf. Beck et al. 1979).

6. Rather than seeking to 'correct' the thoughts involved in emotional disturbances *new wave cognitive therapies* (such as *acceptance and commitment therapy, mindfulness-based cognitive-behavior therapy* or *dialectical behavior therapy*) seeks to help patients loosen their identification with such thoughts (so-called 'decentering'), to become less caught up and more accepting and mindful or witnessing of them, to be able to see them as 'just thoughts', and thereby change their context and function (rather than content) (cf. Hayes 2004; Marra 2005; Segal et al. 2001).
7. What may easily mislead us into to assuming that thinking consists of an internal representation is a picture of thinking as having an *essence* so that each time we speak of 'thinking' we mean the same thing – a particular kind of activity, process, or phenomena in our minds (cf. Canfield 1994; Hanfling 2002, pp. 135–140; Malcolm 1977, p. 55). If we actually study the circumstances of which we speak of 'thinking' we should notice, however, that it is a term with diverse uses and meanings that need not refer to any particular kind of mental activity. One need only remind oneself of such uses as 'He thought a tree he saw in the dark was a person', 'It was a difficult equation that he thought about for over an hour before he solved it', 'I was thinking to myself what would have happened if I hadn't surprised her', 'It took a lot of thinking to figure out how to carry that sofa up those stairs and into her apartment', 'And all those years I thought she loved me'. It would no doubt be in vain to insist that everyone of these examples have a particular mental activity in common (such as self-talk or mental imagery) that constitutes or defines the thinking.
8. Not surprisingly, from the very beginning cognitive-behavioral therapy has based many of its theoretical assumptions on clients' verbal reports during therapy sessions (cf. e.g., Beck 2005, p. 955).
9. Although both Ellis and Beck emphasize the significance of beliefs in emotional disorders, there are some crucial differences in the kind of beliefs they think are involved. Whereas Ellis typically labels some beliefs as categorically *irrational* – by which he essentially means 'self-defeating' (e.g., Ellis 1994, pp. 25 and 70) – Beck puts an emphasis on the *functionality* vis-à-vis *dysfunctionality* of beliefs. And whereas Ellis thinks that emotional disorders typically involve faulty *global philosophies* (e.g., so-called 'musturbatory philosophies'), Beck thinks that emotional disorders involve *local beliefs* specific to the emotional disorder and life-circumstances of the person suffering from the disorder (cf. Backx 2003, p. 56; Beck 1967,1979, 1999; Beck et al. 1979, pp. 11, 12–13; Beck, J.S. 1995; Dryden 2003b; Ellis 1994, pp. 34–35 and 29–30, 2005, p. 182; Ellis and Blau 1998; Ellis and Dryden 1997, p. 14; Ellis and Harper 1975, pp. 138–139; Padesky and Beck 2003, p. 217).

10. Although both Ellis and Beck emphasize the significance of beliefs, Beck sometimes expresses himself more ambiguously as to exactly what sorts of 'cognitions' determine emotional disorders. For example, in a book coauthored with David A. Clark and Brad A. Alford he writes that,

    > The cognitive content or meaning of an event determines the type of emotional experience or psychological disturbance an individual experiences.... Thus (a) sadness involves appraisals of personal and significant loss or failure leading to a sense of deprivation, (b) happiness is associated with thoughts of personal gain or enhancement, (c) anxiety or fear results from evaluations of threat or danger to one's personal realm, and (d) anger the perception of an assault or transgression to one's personal domain .... (Clark et al. 1999, pp. 62–63)

    Here Beck and his coauthors describe what determines emotions in terms of 'cognitive content', 'meanings', 'appraisals', 'thoughts', 'evaluations', and 'perceptions'. Are these 'cognitions' identical? But, then, how? However, if one studies the examples Beck gives of the sort of 'cognitions' involved in emotional disorders and how he tends to describe the practice of cognitive therapy, it seems fair to say that he thinks that beliefs are what essentially determines emotional dysfunction. For example, in a book aimed at fleshing out the methodology of cognitive therapy of depression he explicitly writes that its final goal is to help the patient 'learn to identify and alter the dysfunctional beliefs which predispose him to distort his experiences' (Beck et al. 1979, p. 4).
11. Not identifying beliefs with propositions (or attitudes toward propositions) is essential to understanding how we appropriately can ascribe beliefs to infants and animals without linguistic competence (cf. Hutchinson's contribution to this anthology). This is not to deny, though, that some beliefs cannot be had without linguistic competence or that some beliefs (say, in doing philosophy) cannot be divorced from their linguistic expression.
12. For instance, by using the so-called 'downward arrow technique' – a staple technique of cognitive therapy – a therapist could ask, say, 'What is it about the thought of not having a family that you find so depressing?' or 'What would it mean to you if it were true that you would never have a family?' (cf. DeRubeis et al. 2001, pp. 361–362).
13. A paradigmatic example of how emotions may be caused by how we perceive something or take something to be, rather than by beliefs, may be phobic fears of, for instance, spiders – where a person may believe that a spider is harmless and still be terrified by it. Compare this to what David Hamlyn has to say about an irrational fear of mice (Hamlyn 1983, 271–272).

Bibliography

Backx, W. (2003), 'REBT as an Intentional Therapy', in Dryden, W. (ed.), *Rational Emotive Behavior Therapy* (East-Sussex, England, New York: Brunner-Routledge), pp. 55–76.

Beck, A.T. (1967), *Depression: Clinical, Experimental and Theoretical Aspects* (New York: Harper & Row).

——. (1979), *Cognitive Therapy and the Emotional Disorders* (New York, London, Victoria, Australia, Auckland, New Zealand: A Meridian Book).

——. (1999), 'Cognitive Aspects of Personality Disorders and Their Relation to Syndromal Disorders: A Psychoevolutionary Approach', in Cloninger, C.R. (ed.), *Personality and Psychopathology* (Washington, D.C.: American Psychiatric Publishing).

Beck, A.T. (2005), 'The Current State of Cognitive Therapy: A 40-Year Retrospective', *Archives of General Psychiatry*, 62, 953–959.
——., Rush, A.J., Shaw, B.F. and Emery, G. (1979), *Cognitive Therapy of Depression* (New York: Guilford Press).
Beck, J.S. (1995), *Cognitive Therapy: Basics and Beyond* (New York and London: The Guilford Press).
Bernard, M.E. and DiGiuseppe, R.D. (eds) (1989), *Inside Rational-Emotive Therapy: A Critical Appraisal of the Theory and Therapy of Albert Ellis* (San Diego, New York, Berkeley, Boston, London, Sydney, Tokyo, Toronto: Academic Press).
Canfield, J.V. (1994), 'The Phenomena of Thinking', in Teghrarian, S. (ed.), *Wittgenstein and Contemporary Philosophy* (London: Continuum International Publishing Group).
Clark, C.A., Beck, A.T. and Alford, B.A. (1999), *Scientific Foundations of Cognitive Theory and Therapy of Depression* (New York, Chichester, Weinheim, Brisbane, Singapore, Toronto: John Wiley & Sons, Inc.).
Cloninger, C.R. (1999), *Personality and Psychopathology* (Washington, D.C.: American Psychiatric Publishing).
Daniel, D. (2003), 'Rational Emotive Behavior Therapy (REBT): The View of a Cognitive Psychologist', in Dryden, W. (ed.), *Rational Emotive Behavior Therapy. Theoretical Developments* (East-Sussex, England, New York: Brunner-Routledge), 130–159.
DeRubeis, R.J., Tang, T.Z. and Beck, A.T. (2001), 'Cognitive Therapy', in Dobson, K.S. (ed.), *Handbook of Cognitive-Behavioral Therapies* (New York and London: The Guilford Press), pp. 349–389.
Dobson, K.S. (ed.) (2001), *Handbook of Cognitive-Behavioral Therapies* (New York and London: The Guilford Press).
Dryden, W. (ed.) (2003a), *Rational Emotive Behavior Therapy. Theoretical Developments* (East-Sussex, England, New York: Brunner-Routledge).
——. (2003b), ' "The Cream Cake Made Me Eat It": An Introduction to the ABC Theory of REBT', in Dryden, W. (ed.), *Rational Emotive Behavior Therapy* (East-Sussex, England, New York: Brunner-Routledge), pp. 1–20.
Ellis, A. (1989), 'Comments on Mahoney, Lyddon, and Alford's Chapter', in Bernard and DiGiuseppe (eds.), *Inside Rational-Emotive Therapy: A Critical Appraisal of the Theory and Therapy of Albert Ellis* (San Diego, New York, Berkeley, Boston, London, Sydney, Tokyo, Toronto: Academic Press).
——. (1994), *Reason and Emotion in Psychotherapy* (Secaucus, NJ: Lyle Stuart).
——. (1994), *Reason and Emotion in Psychotherapy. Revised and Updated* (New York; Toronto: Carol Publishing Group).
——. (2004), *The Road to Tolerance: The Philosophy of Rational Emotive Behavior Therapy* (Amherst, New York: Prometheus Books).
——. (2005), 'Discussion of Christine A. Padesky and Aaron T. Beck, "Science and Philosophy: Comparison of Cognitive Therapy and Rational Emotive Behavior Therapy" ', *Journal of Cognitive Psychotherapy: An International Quarterly*, 19 (2), 181–185.
——. and Blau, S. (eds) (1998), *The Albert Ellis Reader. A Guide to Well-Being Using Rational Emotive Behavior Therapy* (Secaucus, NJ, Toronto: A Citadel Press Book Published by Carol Publishing Group).
——. and Dryden, W. (1987), *The Practice of Rational-Emotive Therapy (RET)* (New York: Springer Publishing Company).
——. and Harper, R.A. (1975), *A New Guide to Rational Living* (Eaglewood Cliffs, New Jersey: Prentice-Hall, Inc.).
Hamlyn, D.W. (1983), *Perception, Learning and the Self: Essays in the Philosophy of Psychology* (London, Boston, Melbourne, Henley: Routledge & Kegan Paul).

Hanfling, O. (2002), *Wittgenstein and the Human Form of Life* (London and New York: Routledge).

Hayes, S.C. (2004), 'Acceptance and Commitment Therapy and the New Behavior Therapies: Mindfulness, Acceptance and Relationship', in Hayes, S.C., Follette, V.H. and Linehan, M.M. (eds), *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* (New York and London: The Guilford Press), pp. 1–29.

——., Follette, V.H. and Linehan, M.M. (eds.) (2004), *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* (New York and London: The Guilford Press).

Kenny, A. (1963), *Action, Emotion and Will* (London, New York: Routledge and Kegan Paul).

Malcolm, N. (1977), *Thought and Knowledge* (Ithaca and London: Cornell University Press).

Marra, T. (2005), *Dialectical Behavior Therapy* (Oakland, CA: New Harbinger Publications).

McEachrane, M. (2006), 'Investigating Emotions Philosophically', *Philosophical Investigations*, 29 (4), 342–357.

——. (in press), 'Emotion, Meaning and Appraisal Theory', *Theory & Psychology*.

Nussbaum, M.C. (2001), *Upheavals of Thought. The Intelligence of Emotions* (Cambridge, New York: Cambridge University Press).

Padesky, C.A. and Beck, A.T. (2003), 'Science and Philosophy: Comparison of Cognitive Therapy and Rational Emotive Behavior Therapy', *Journal of Cognitive Psychotherapy*, 17 (3), 211–224.

——. and Beck, A.T. (2005), 'Response to Ellis' Discussion of "Science and Philosophy: Comparison of Cognitive Therapy and Rational Emotive Behavior Therapy" ', *Journal of Cognitive Psychotherapy: An International Quarterly*, 19(2), 187–189.

Segal, Z.V. Williams, J.M.G. and Teasdale, J.D. (2001), *Mindfulness-based Cognitive Therapy for Depression: A New Approach to Preventing Relapse* (New York: The Guilford Press).

Still, A. and Dryden, W. (2003), 'Ellis and Epictetus: Dialogue vs. Method in Psychotherapy', *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 21 (1), 37–55.

Travis, C. (2000), *Unshadowed Thought: Representation in Thought and Language* (Cambridge MA, London: Harvard University Press).

Wittgenstein, L. (2001), *Philosophical Investigations: The German Text, with a revised English translation.* 3rd edn (Malden, Oxford, Victoria, Berlin: Blackwell Publishers Ltd).