INTRODUCTION

My approach to interpersonal and social problems can be traced to my work in psychotherapy. In the earlier years—almost four decades ago—I made a series of observations that turned around my understanding and treatment of patients’ psychiatric problems. While conducting classical psychoanalysis with patients, I discovered—almost by chance—that they had not been reporting certain thoughts they were experiencing during free association. Although they believed—and I assumed—that they were following the cardinal rule of disclosing everything that went through their minds during therapy, I discovered that they had certain highly significant thoughts at the fringe of their consciousness. The patients were barely aware of, and were certainly not concentrating on, these preconscious thoughts. Based on repeated observations, I suspected that the experience of an emotion or an impulse to do something was generally preceded by such thoughts.

When I coached a patient to focus on these thoughts, I realized that they helped to explain the emotional experience in a more understandable way than the more abstract psychoanalytic interpretations I had been offering. A young woman, for example, was able to access the thought, “Am I boring him?” just prior to spurts of anxiety during therapy. Another patient would have thoughts such as, “Therapy can’t help. I’m only going to get worse and worse,” prior to a sad feeling. In each instance, there was a logical and plausible connection between thought and feeling. I used a simple technique to capture these fleeting automatic thoughts. When a patient would appear sad or anxious, or report having those feelings, I would ask, “What is going through your mind right now?” The patients quickly learned to focus their attention on these thoughts, and it was clear that the thoughts were responsible for the feelings.

Focusing on the thoughts provided a wealth of information that served as
a database for explaining not only the patients' emotions but also other psychological phenomena. I discovered, for example, that the patients consistently monitored their own behavior as well as that of other people. They issued orders to themselves to direct or inhibit activities. They experienced self-critical thoughts when they fell below expectations and self-congratulations when they succeeded.

The themes of their thoughts helped to clarify the specific psychological patterns that produced particular emotions. For example, thoughts (or cognitions) that diminished the patient made him feel sad. These included thoughts of having failed, having been rejected, or having lost something of value. Thoughts of gain and self-enhancement led to feelings of pleasure. Thoughts of danger or threat led to anxiety. Relevant to the topic of this book was the observation that ideas of being wronged by somebody else produced anger and a desire to retaliate. A rapid sequence of thoughts such as, "I should get even," and, "It's okay to hit her," could even culminate in physical violence.

An interesting feature of those thoughts was their fleeting nature. I was surprised to note that even a relatively brief peripheral thought could produce a profound emotion. Moreover, the cognitions were involuntary—the patient could neither initiate nor suppress them. Although they were often adaptive and would reflect an actual loss, gain, danger, or transgression, they were frequently disproportionate or inappropriate to the particular circumstances that triggered them. An anger-prone person, for example, would blow a minor slight or inconvenience out of proportion and want to punish the offender severely.

I also noted, to my surprise, that these patients showed a regular pattern of thinking errors (cognitive distortions). They would greatly magnify the significance of aNovocain incident. They exaggerated the frequency of such events: "My assistant always messes up," or, "I never get things right." They would attribute what was clearly an accidental or situational difficulty to the other person's bad intentions or character flaw.

The patients characteristically accepted their exaggerated interpretation or misinterpretation at face value—s it seemed completely credible. However, when patients learned to focus their attention on these interpretations and to evaluate and question them, they generally realized that they were inappropriate or erroneous. The patients were able to gain perspective on these reactions and, in most instances, to correct them. An easily provoked mother, for example, first observed that she became angry with her children for very minor infractions. When she was able to recognize and respond to her critical thoughts ("they're bad kids") with the idea that they were "just behaving like normal kids," she found that her anger did not last as long. With repeated corrections of her critical, punitive thoughts, they became less frequent.

I was puzzled, however, by this question: why didn't the patients in analytic therapy report these thoughts spontaneously—especially since they were conscious in expressing whatever came to mind, no matter how embarrassing? Hadn't they been aware of these thoughts in their everyday lives? I came to the conclusion that these thoughts were different from the kind that people generally report to other people. They were part of an internal communication system oriented to the self, a kind of network that was geared to providing ongoing observations about themselves, interpretations of their behavior and that of others, and expectations of what would happen. For example, a middle-aged patient who was engaged in an angry conversation with his older brother had the following sequence of automatic thoughts, which he was able to access despite being involved in the heated interchange. "I'm talking too loudly. . . He's not listening to me. I'm making a fool of myself. . . He's got a lot of nerve ignoring what I'm saying. Should I tell him off? He would probably make me look foolish. He never listens to me." My patient was becoming increasingly angry, but on reflecting about the conversation later, he recognized that his anger was not due to the argument but to his overriding interpretation: "My brother does not respect me."

A wife would have the fleeting thought, "My husband is late because he prefers to go out with the other guys," and would feel bad. That is what she communicated to herself. To her husband she would blurt out, "You never come home on time. How can I prepare dinner for the family if you are so irresponsible?" In actuality, her husband would have a beer with the other men in order to unwind after a hard day at work. Her scolding obscured from her husband and herself her feelings of rejection.

The intercommunication system also includes the expectations and demands that people place on themselves and others—something that has been labeled "the tyranny of the shoulds." It is important to recognize these injunctions and prohibitions because rigid expectations or compulsive attempts to regulate the behavior of others are bound to lead to disappointment and frustration.

I was also intrigued by the observation that each patient had his or her
own unique set of responses to specific situations and consistently overreacted in an excessive way to certain stimuli but not to others. I was able to predict which interpretations or misinterpretations a particular patient would make in response to a given situation. These overreactions would be apparent in his or her automatic response to specific situations. The patient would characteristically distort, overgeneralize, or exaggerate certain situations but not others that other patients might overreact to.

Certain patterns of beliefs would be activated by a specific set of circumstances and thus generated the thought. These formulas or beliefs constituted a specific vulnerability: when activated by relevant situations, they would shape the patient's automatic interpretation of the situation. The beliefs were highly specific for example, “If people interrupt me, it means they don't respect me,” or “If my spouse doesn't do what I want, it means she doesn’t care.” The beliefs provided the meaning of the situation, which was then expressed in the automatic thoughts.

I previously described the angry mother who held the belief, “If kids do not behave themselves, it means they are bad kids.” The hurt came from a deeper meaning yielded by the belief, “If my kids misbehave, it shows I'm a bad mother.” The overgeneralized belief led to an overgeneralized interpretation. The mother diverted her attention away from the pain of the negative images of herself by blaming her children. Each patient had his or her own specific set of sensitivities.

A similar kind of automatic thought and action occurs when a person is engaged in a routine activity like driving a car. When I'm driving along a city street, for example, I slow down for a pedestrian to cross, steer around a pothole, and pass a slow car ahead of me—all while carrying on a serious conversation with a friend. If I shift my attention to my automatic thoughts about my driving, I become aware of a very rapid sequence—“Watch out for the pothole . . . swerve around it . . . that guy's going awfully slow . . . is there enough space to pass him?” These thoughts are completely divorced from my conversation with my friend but are controlling my behavior at the wheel.

**A NEW THERAPY**

As my observations centered on the relations between patients' problematic thoughts—or cognitions—and their feelings and behavior, I developed a cognitive therapy of psychiatric disorders. Applying the theory, I found that helping patients to modify their cognitions resulted in improvement. I consequently applied the term "cognitive therapy" to my therapeutic approach. Cognitive therapy addresses the patients' problems in a number of ways. First, I attempted to give the patients more objectivity toward their thoughts and beliefs. I accomplished this by encouraging them to question their interpretations. Does your conclusion follow from the facts? Are there alternative explanations? What is the evidence for your conclusion? Similarly, we would evaluate the underlying beliefs and formulas. Were they so rigid or extreme that they were used inappropriately and excessively?

These therapeutic strategies helped the patients avoid overreacting to situations. Around the same time that I was formulating my theory and therapy, I was pleased to discover the writings of Albert Ellis. His work, which anticipated my own publication by several years, was based on observations similar to my own. I derived a number of new ideas regarding the therapy from his writings. Several of the strategies just described were adapted from Ellis's work.¹

I observed that these findings were not restricted to people with common, "garden-variety" psychiatric disorders, such as depression and anxiety. The same kinds of erroneous beliefs influenced the feelings and behavior of people experiencing marital problems, addictions, and antisocial behavior.² Other therapists who were specialists in these areas developed and applied cognitive theory and therapy to their specific area of specialization. A large body of literature has evolved on the cognitive therapy of various forms of antisocial behavior: spouse beating and child abuse, criminal assaults, and sexual offenses. We observed a common denominator across these various forms of harmful behaviors: namely, that the victim is perceived as the Enemy, and the aggressor sees himself as an innocent victim.

Because I believe that people have the same mental processes when they are engaged in either individual or group violence, I explored the literature on such social ills as prejudice, persecution, genocide, and war. Although there are large differences in the sociological, economic, and historical causes, the final common denominator is the same: the aggressors have a positive bias regarding themselves and a negative bias toward their adversary, often conceived as the Enemy. I was struck by the similarities between a spouse's image of his estranged husband, a militant's image of a racial or religious minority,
and a soldier's image of a sniper shooting at him from a tower. Words such as
monster, evil, or bastard are frequently used by these individuals to designate the
dangerous Other. When they are in the grip of these extreme patterns of
thought, their evaluations of their supposed foes are warped by hatred.

I have prepared this volume with the goal of clarifying the typical psycho-
logical problems that lead to anger, hatred, and violence. I have also tried to
clarify how these problems manifest themselves in conflicts between friends,
family members, groups, and nations. Sharpening our insights into the cog-
nitive factors (interpretations, beliefs, images) can provide some leads in remed-
ating the personal, interpersonal, and social problems of modern society.

In preparing a volume such as this, certain questions naturally arise.
What is new and useful about this approach? What is the evidence that the
approach is valid and not simply a statement of opinion? I had to ponder
similar questions when I first proposed my cognitive theory and therapy of
depression, first in 1964 and then in extended form in 1976. Since then my
colleagues and I have reviewed almost one thousand articles evaluating spe-
cific aspects of the theory. These articles have been largely supportive of the
empirical basis and validity of the theory and therapy. A substantial portion
of the assumptions validated in these studies also form the basis for the con-
cepts offered in this volume.

In addition to the clinical material, a substantial component of the vol-
ume rests on a body of knowledge regarding the cognitive aspects of anger,
hostility, and violence in the literature of clinical, social, development, and
cognitive psychology. Many formulations regarding broader issues such as
group violence, genocide, and war were developed in part from the literature
of political science, history, sociology, and criminology.

I have planned the book to introduce the interlocking concepts in a
sequential fashion, although they are all part of the same matrix. I begin with
the clarification of hostility and anger in everyday life, a subject that readers
may be able to relate to their own experiences. I then move on to topics of
crucial societal importance: family abuse, crime, prejudice, mass murder, and
war. Even though these phenomena are far removed from the personal experi-
ences of most readers, the underlying psychology is similar. Finally, I offer
suggestions regarding the application of these insights to personal and soci-
etal problems.

PART 1

THE ROOTS OF HATE