**Inventory of Cognitive Distortions*.***

The ICD is a 69-item measure that describes 11 types of cognitive distortions.

The instrument, which is easy to administer, takes approximately 15 to 20 minutes to

complete, and can be used with people ages 18 and older. DiTomasso and Yurica (2011)

emphasize that the ICD is not a diagnostic measure and should not be used as the only

means of assessing clinical symptoms. This tool is a method of examining patients’

cognitive distortions, which may be intensifying a clinical condition, or making an

individual susceptible to future psychological difficulties. DiTomasso and Yurica also

suggest the potential clinical value of the ICD. The researchers describe the instrument’s

utility as being fourfold: (1) it is a method of identifying patients’ forms of distorted

thinking, (2) it can identify patients’ uses of particular cognitive distortions for particular

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diagnoses, (3) it can provide clinicians with a tool that focuses on improving patients’

meta-cognitive skills, including educating patients on cognitive distortions’ role in

psychological disorders, and (4) it can be used to assess changes in patients’ distorted

thinking patterns throughout treatment by measuring cognitive distortions pre-, post-, and

during treatment.

The principal investigation and development of the ICD used a sample of 188

patients from two outpatient clinics, with 66 participants composing a control group

(Yurica, 2002). Following a factor analysis, 11 factors were retained. The 11 factors

were said to measure the following cognitive distortions: (1) externalization of selfworth,

(2) fortune-telling, (3) magnification, (4) labeling, (5) perfectionism, (6)

comparison with others, (7) emotional reasoning, (8) arbitrary inference/jumping to

conclusions, (9) emotional reasoning and decision making, (10) minimization, and (11)

mind-reading. In a separate study that utilized the ICD to assess the relationship between

cognitive distortions and burnout in nurses, Diefenbeck (2005) found further evidence to

support this factor structure. Yurica (2002) investigated the ICD’s test-retest reliability

and total scale internal reliability. The total scale coefficient alpha demonstrated high

internal consistency reliability (.98) and following a five-week interval, test-retest

reliability was also found to have a high reliability coefficient (.998). In regard to

validity, the ICD correlated significantly with the DAS (*r* = .70) and with the BDI (*r* =

.70). These results suggested the higher the endorsement of cognitive distortions, the

higher the frequency of dysfunctional thinking and the greater the endorsement of

depressive symptoms (Yurica, 2002). Also, the ICD was able to distinguish between

depressed and non-depressed individuals, as well as differentiate between individuals

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suffering from an anxiety disorder and individuals in a control group (Yurica, 2002;

Rupertus, 2004).

Rosenfield (2004) investigated the relationship between cognitive distortions and

Axis I and Axis II psychopathology to examine the use of the ICD to determine the

association between distorted cognitions and psychological distress. The researcher

found that individuals meeting criteria for any Axis I or Axis II disorders reported a

higher frequency of cognitive distortion as measured by the ICD, than those individuals

free of a psychological disorder. Rosenfield found that approximately half of the

variance both in the severity and in the number of psychological dysfunctions was

accounted for by frequency of cognitive distortions. The study found that when there

was an increase in the number of clinical disorders for which an individual met the

criterion as well as an increase in the severity of the Axis I condition, there was also an

elevated frequency of engaging in cognitive distortion (Rosenfield, 2004). This same

positive, incremental correlation was found when investigating the relationship between

severity and quantity of Axis II personality disorders and frequency of cognitive

distortions (Rosefield, 2004). This research lends further support for the ability of the

ICD to differentiate between those with or those without psychological dysfunction; it

also demonstrates the utility of the measure because there was a direct relationship

between cognitive distortion and rate and severity of Axis I and Axis II psychopathology

(Rosenfield, 2004).

Last, Uhl (2007) investigated the utility of the ICD in a medical setting. The

researcher investigated the association between psychiatric and psychosocial factors that

influence how patients deal with health problems and the frequency of cognitive

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distortions as measured by the ICD. The results suggested that the more frequently a

patient engages in cognitive distortions, the more likely he or she is to engage in negative

psychological and health risk behaviors. Patients who were unlikely to have drug, eating,

caffeine, inactivity, and smoking problems had significantly lower ICD scores than those

likely to have such problems (Uhl, 2007). Within a medical setting, the ICD was also

found to be useful in identifying the relationships between distorted thinking and

psychological and behavioral health risks, as well as the relationship between patterns of

unhealthy behavior and cognitive distortions in those individuals who are obese (Goins,

2008; Shook, 2010).

In summary, the ICD has demonstrated good reliability and validity across

different populations. The instrument was able to differentiate among individuals

suffering from anxiety or depression as well as to predict unhealthy lifestyles in a sample

of medical patients, depending on the level of cognitive distortion (Yurica, 2002;

Diefenbeck, 2005; Rosenfield, 2004; Uhl, 2007; Goins, 2008; Shook, 2010; Rupertus,

2004). Following its development, the ICD has been used to investigate cognitive

distortions in a wide variety of settings, but there remains a dearth of research examining

the psychometric properties of the instrument in a community sample, as well as

examining its use in comparing cognitive distortions and perceived stress. According to

the diathesis-stress model, individuals’ cognitive distortions will only influence his or her

information processing of external events during a situation perceived as stressful (Beck,

1967). In the absence of stress, cognitive distortions may remain inactive and not

influence an individual’s pattern of thinking. If this theory is correct, then the level of

cognitive distortion as measured by the ICD should correlate with the level of perceived

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stress. If an individual has a high level of cognitive distortions, he or she should also

perceive stressful situations as more stressful than individuals with a low level of

distorted thinking.