Chapter 8

EVALUATING AUTOMATIC THOUGHTS

Patients have many thousands of thoughts a day, some dysfunctional, some not. In the interest of efficiency, the therapist selects just one or a few key thoughts to evaluate in a given session. This chapter describes how to select the most useful automatic thoughts for evaluation, how to evaluate these thoughts, and how to teach patients a system for evaluating their own thoughts.

DECIDING WHETHER TO FOCUS ON AN AUTOMATIC THOUGHT

A therapist may uncover several or many automatic thoughts in a given session. Having uncovered one, how does he decide what to do next? He has several options. He can:

1. *Focus on the automatic thought.* ("How much do you/did you believe this thought?" "How did this thought make you *feel emotionally*?" "What did you *do* after you had this thought?")
2. *Find out more about the situation associated with the automatic thought.* ("What had Karen said to you just *before* you had that thought?" "When did this happen?" "Where were you?" "Tell me more about the situation.")
3. *Explore how typical the automatic thought is.* ("How often do you have this kind of thought?" "In what situations?" "How much does this kind of thought bother you?")

(*cont.*)

4. *Identify other automatic thoughts and images in this same situation.* ("Anything else go through your mind?" "Any images or pictures?")
5. *Do problem-solving about the situation associated with the automatic thought.* ("What are some things you could do about this?" "How have you handled this kind of thing before?" "What do you wish you could do?")
6. *Explore the belief underlying the automatic thought.* ("If this thought is true, what would it mean to you?")
7. *Move on to another topic.* ("Okay. I think I understand that. Can you tell me what else happened this week?")

How does the therapist choose among these options? He asks himself:

1. What am I trying to accomplish in this session? Will working on this thought help us reach the therapeutic goals I have for the session?
2. What did the patient put on the agenda? Will focusing on this thought address the problem(s) she wants to work on? If not, will we have sufficient time to get to her concerns? Will she collaborate with me in evaluating this thought?
3. Is this an important thought on which to focus? Does it seem significantly distorted or dysfunctional? How typical or central is it? Will focusing on it help the patient in more than just this one situation? Will exploring it help me to conceptualize the patient better?

Sally, for example, was describing a problem she had had in the library.

THERAPIST: What went through your mind when you couldn't find the book you needed?

PATIENT: That they are so inefficient there. The system is so poor.

T: How did that thought make you feel?

P: Frustrated.

T: How frustrated?

P: 90%.

T: Then what happened?

P: I said, "To hell with it," and went back to my room and worked on my chemistry problems instead.

T: What happened to your mood then?

P: I felt better. I ended up borrowing the book from Lisa. I have to give it back to her by Monday, though.

T: So you solved the problem. Anything else important about this before we move on?

Here the therapist judges that the automatic thought, while distressing at the time, did not warrant further discussion because (1) Sally was no longer distressed by it, (2) Sally had acted in a functional way, (3) the situation was resolved, (4) there were more pressing problems on the agenda, and (5) Sally had not previously exhibited a dysfunctional pattern in this kind of situation.

FOCUSING ON AN AUTOMATIC THOUGHT

Having decided to attend to an automatic thought, the therapist tries to confirm that the thought is worth exploring by asking the following:

1. How much do you believe this thought now (0–100%)?
2. How does this thought make you feel (emotionally)?
3. How strong (0–100%) is [this emotion]?

If the degree of belief and distress is low, the therapist most likely suggests moving on to something else. If the patient believes the automatic thought strongly and is significantly distressed by it, the therapist fleshes out the picture by asking questions according to the cognitive model:

1. When did you have this thought? In what specific situation?
2. What other distressing thoughts and images did you have in this situation?
3. [Especially for anxious patients:] What did you notice, if anything, happening in your body?
4. What did you do next?

After obtaining a fuller picture, the therapist might do one or more of the following:

1. Conceptualize aloud or to himself how the thought(s) in this particular situation fit into his broader conceptualization of the patient: "Sally, could this be another example of how you consistently predict you'll fail?"
2. Use this automatic thought to reinforce the cognitive model (usually early in therapy) implicitly or explicitly; for

(*cont.*)

example, "So when you were in the library, trying to study, you had the thought, 'I'll never learn all of this.' This thought made you feel sad and led to your closing the book and giving up. Is that right?"

3. Help the patient evaluate and respond to the thought through Socratic questioning, as in the following situation: "Sally, what's the *evidence* that you'll never learn all the chemistry?"
4. Do problem-solving with the patient: "Sally, what could you do to learn this material better?"
5. Use the downward arrow technique (see Chapter 10 pp. 145–146) to uncover an underlying belief: "Sally, if it's true that you can't learn all the chemistry, what would that mean to you?"

QUESTIONING TO EVALUATE AN AUTOMATIC THOUGHT

Having elicited an automatic thought, determined that it is important and distressing, and identified its accompanying reactions (emotional, physiological, and behavioral), the therapist may decide to help the patient evaluate it. *He does not directly challenge the automatic thought*, however, for two reasons. First, he does not know in advance that any given automatic thought is distorted. Second, a direct challenge violates a fundamental principal of cognitive therapy, that of collaborative empiricism: The therapist and patient together examine the automatic thought, test its validity and/or utility, and develop a more adaptive response. The therapist keeps in mind that automatic thoughts are rarely completely erroneous. Usually, they contain a grain of truth, and it is important to acknowledge the grain of truth if it exists.

The therapist may use questioning from the very first session to evaluate a specific automatic thought. In the second or third session, he begins to explain the process more explicitly:

T: (*Summarizes past portion of the session; writes automatic thoughts on paper for both to see.*) So when you met your friend, Karen, on the way to the library, you had the thought, "She doesn't really care what happens to me," and that thought made you feel sad?

P: Yeah.

T: And how much did you believe that thought at the time?

P: Oh, pretty much. About 90%.

T: And how sad did you feel?

P: Maybe 80%.

T: Do you remember what we said last week? Sometimes automatic thoughts are true, sometimes they turn out not to be true, and sometimes they have a grain of truth. Can we look at this thought about Karen now and see how accurate it seems?

P: Okay.

T: Here's a list of questions I'd like us to refer to. [See Figure 8.1.] You can keep this copy. We'll look at the first five questions. Let me ask you—what evidence was there that the thought was true, that she didn't really care what happened to you?

P: Well, when we passed on Locust Walk, she seemed like she was real rushed. She just quickly said, "Hi, Sally, see you later," and kept going fast. She hardly even looked at me.

T: Anything else?

P: No . . . nothing I can think of now. Except that sometimes she's pretty busy and doesn't have much time for me.

T: Anything else?

P: No. I guess not.

T: Okay, now is there any evidence on the other side, that maybe she *does* care about what happens to you?

P: (*Answering in general terms.*) Well, she is pretty nice. We've been friends since school started.

T: What kinds of things does she do or say that might show she likes you? (*Helping the patient think more specifically.*)

P: Ummm . . . she usually asks if I want to go get something to eat with her. Sometimes we stay up pretty late just talking about things.

QUESTIONING AUTOMATIC THOUGHTS

1. What is the evidence?
   What is the evidence that supports this idea?
   What is the evidence against this idea?
2. Is there an alternative explanation?
3. What is the *worst* that could happen? Could I live through it?
   What is the best that could happen?
   What is the most realistic outcome?
4. What is the effect of my believing the automatic thought?
   What could be the effect of changing my thinking?
5. What should I do about it?
6. What would I tell _____ (a friend) if he or she were in the same situation?

FIGURE 8.1. Questioning automatic thoughts. Copyright 1993 by J. S. Beck, Ph.D.

T: Okay. So, on the one hand, on this occasion yesterday, she rushed by you, not saying much. And there have been other times, too, when she's been pretty busy. But, on the other hand, she asks you to eat with her, and you stay up late talking sometimes. Right?

P: Yeah.

The therapist gently probes to *uncover evidence* regarding the validity of Sally's thought. Having elicited evidence on both sides, he summarizes what Sally has already said. In the next section, he helps Sally *devise a reasonable alternative explanation* for what has happened and asks her to *examine possible outcomes*.

T: Good. Now, let's look at the situation again. Could there be another way of explaining what happened, other than she doesn't care about what happens to you?

P: I don't know.

T: Why else might she have rushed by quickly?

P: I'm not sure. She might have had a class. She might have been late for something.

T: Okay. Now, what would be the *worst* that could happen in this situation?

P: That she would truly not like me, I guess. That I couldn't count on her for support.

T: Would you survive that?

P: Yeah. But I wouldn't be happy about it.

T: And what's the *best* that could happen?

P: That she does like me. That she was just rushed then.

T: And what's the *most realistic outcome?*

P: I guess I do think she still likes me.

In the previous section, the therapist helps Sally see that even if the worst happened, she would live through it. Sally also realizes that her worst fears are unlikely to come true. In the next section, Sally's therapist has her *assess the consequences of responding and not responding to her distorted thinking* and then helps her *become problem-solving oriented*, devising a plan to ameliorate this situation.

T: And what is the *effect of your thinking* that she doesn't like you?

P: It makes me sad. I think it kind of makes me withdraw from her.

T: And what 'd be the *effect of changing your thinking?*

P: I'd feel better.

T: And what do you think you should *do* about this situation?

P: Uh . . . I'm not sure what you mean.

T: Well, have you withdrawn any since this happened yesterday?

P: Yeah, I think so. I didn't say much when I saw her this morning.

T: So this morning you were still acting as if that original thought were true. How could you act differently?

P: I could talk to her more, be friendlier myself.

If Sally's therapist were unsure of Sally's social skills or motivation to carry through with this plan of being friendlier to Karen, he might have spent a few minutes asking Sally such questions as: When might you see her again? Would it be worth it, do you think, to seek her out yourself? What could you say to her when you do see her? Anything you think could get in the way of your saying that? (If needed, he might have modeled for her some things she could say to Karen and/or engaged her in a role-play.)

In the last part of this discussion, Sally's therapist assesses how much Sally now believes the original automatic thought and how she feels emotionally in order to decide what to do next in the session.

T: Good. Now how much do you believe this thought: "Karen doesn't really care what happens to me"?

P: Not very much. Maybe 20%.

T: Okay. And how sad do you feel?

P: Not much either. 20%.

T: Good. It sounds like this exercise was useful. Let's go back and see what we did that helped.

The therapist and patient do not apply all the questions in Figure 8.1 to every automatic thought they evaluate. Sometimes none of the questions seems useful and the therapist takes another tack altogether (see pp. 116–118). The therapist chooses to use the first five questions in this case because his goal for the session is to demonstrate to the patient a structured method to investigate and respond to her thinking. He purposely selects an automatic thought that seems important (i.e., significantly contributes to the patient's distress), is not an isolated idea (but a recurrent theme that is likely to crop up again), seems distorted and dysfunctional, and is likely to serve as a useful model in teaching the patient how to evaluate and respond to other thoughts in the future. He also notes how strongly the patient believes the automatic thought and

how intense her emotion is *before and after* the Socratic questioning so he can assess how well this intervention worked.

The therapist may decide to review the process of using Figure 8.1 to confirm that the patient understands how to use it and perceives its value. He might use the same example (as follows) and/or demonstrate with a new example in the next session.

T: Let's review what we just did. We started with an automatic thought, "Karen doesn't really care what happens to me."

P: Right.

T: Then we evaluated that thought using these questions. [See Figure 8.1.] And what happened to your mood?

P: I felt a lot less sad.

T: Do you think evaluating your thoughts with these questions could help you this week if another troublesome situation comes up?

P: It might. But what if a thought turns out to be true?

T: In that case, we would probably do some problem-solving. For example, we might have discussed how you could approach Karen yourself this week. In any case, neither of us knows in advance if evaluating a given thought will be helpful. How do you feel about trying to use these questions sometime this week, when you've identified a thought that has upset you?

P: Okay, sure.

T: If you're like most people, I should warn you, using these questions is sometimes harder than it looks. In fact, there may be times when we really need to work together to help you examine a thought. But give it a try and, if you do have trouble, we can talk about it next week. Okay?

Learning to evaluate automatic thoughts is a skill. Some people grasp it right away; others need much repeated, guided practice. In the previous transcript, the therapist predicts in advance that Sally might have some difficulty because he wants to allay self-criticism or defeatism. Had he suspected, despite his admonition, that Sally would judge herself harshly for not being able to fulfill the homework assignment perfectly, he would have pursued the subject more thoroughly.

T: Sally, if you do have trouble evaluating your thoughts this week, how are you likely to feel?

P: Frustrated, I guess.

T: What's likely to go through your mind?

P: I don't know. I'll probably just quit.

T: Can you imagine looking at the sheet of paper and not being able to figure out what to do?

P: Yeah.

T: What's going through your mind as you look at the paper?

P: "I should be able to do this. I'm so stupid."

T: Good! Now how are you going to answer those thoughts?

The therapist and Sally come up with some coping statements that Sally writes on a card.

> **Automatic thoughts.** *I should be able to do this. I'm so stupid.*
>
> **Adaptive response.** *Actually, I shouldn't be able to do this. It's a new skill; I'll learn to do it eventually, but it may take more practice with my therapist first. It has nothing to do with whether or not I'm stupid. Either I'm trying to work with a difficult thought or I just need more guidance. In any case, it's no big deal. We predicted this might happen.*

T: Do you think this card will help enough? Or do you think we should put off this assignment until we have more time to practice together?

P: No. I think I can try it.

T: Okay, now if you should get frustrated and have automatic thoughts, be sure to jot them down. Okay?

P: Yeah.

Here the therapist makes the assignment into a no-lose proposition: Either Sally does it successfully or she has some difficulty that the therapist can help her with at the next session. If frustrated, she either reads her card (and probably feels better) or keeps track of her thoughts so she can learn to respond to them in the next session.

Finally, it is important to remember that not all the questions are suitable for every automatic thought. Moreover, using all the questions, even if they all do logically apply, may be too cumbersome and time-consuming. The patient may not evaluate her thoughts at all if she considers the process too burdensome.

T: Okay, so we'll use these questions as a guide this week, but remember not all of them will be relevant. Question 2, especially, often applies

in situations where you have a problem with another person, but not in all situations. In the future, you won't necessarily go through this *whole* list of questions, but I'd like you to try them this week to make sure you understand them. In the next couple of weeks, we'll add a couple more. Okay?

Sometimes a patient has difficulty using the questions on the top part of Figure 8.1 because she cannot examine her thought objectively. At these times, it is often useful to have the patient distance herself from the thought in order to evaluate it more rationally. One distancing technique is to have the patient *imagine that the identical situation is happening to a specific friend* and that she is giving the friend advice.The following transcript first demonstrates Sally's difficulty in evaluating a thought and shows how the therapist helps Sally gain a new perspective through the "friend question."

T: Okay, to summarize then, you just got a C– on a surprise quiz, and you had the thought, "I'll never make it [in college]," which made you quite sad.

P: Right.

T: Sally, is there any other evidence that you can't make it?

P: Yeah, I can't seem to concentrate anymore. I just read and read my economics book, and it doesn't get through my head. I have a paper due in 2 weeks, and I haven't started it yet–

T: Any evidence on the other side? That maybe you can make it?

P: No. I don't think so.

At this point, the therapist could help Sally uncover evidence he knows about or guesses might be there: "Didn't you tell me you did better on your first quiz, which was announced? Is that evidence that you can make it? Is it possible that you could have done better if this quiz had been announced? Do you know how everyone else did on this surprise quiz? Are you looking at the grade as if it were an F instead of a C–?" Instead, though, he tries a different tack.

T: Sally, if your roommate were in your situation and had gotten a C– on a surprise economics quiz, and *she* had had the thought, "I'll never make it," what would you tell her?

P: Hmmm . . . I don't know.

T: Would you agree with her? Would you say, "Yeah, Jane, you're probably right, you're not going to make it"?

P: No. Not at all. I guess I'd say, "Listen, this was a surprise quiz, you just weren't ready for it. If you had known about it, you probably would have studied more or gone to see the TA [teaching assistant] for help and you would have done better. It doesn't mean you can't make it. It just took you by surprise."

T: Okay, now how does what you would say to your roommate apply to you?

P: Well, it *was* a surprise. It's true I hadn't studied much for it–I mean I spent an hour staring at the pages, but if I had known there was a quiz, I think I would have made myself concentrate better.

T: Good. So how can you respond to this thought, "I'll never make it," if it comes up again?

In this instance, the therapist supplies a "friend" for Sally to imagine. Usually, though, the therapist asks the patient to supply the name of a specific person: "Sally, I wonder if you can imagine another person in this same situation, maybe a friend or a relative, and imagine they had the same thought."

Having successfully used the technique, the therapist next seeks to maximize the chance that Sally will use it herself, so he explicitly teaches it to her.

T: So was it helpful to evaluate this thought, "I'll never make it," by taking it away from yourself and seeing how you would help your roommate with it, and then seeing how your advice applied to you?

P: Yeah. I guess I could see it more clearly then.

T: Do you have your sheet from last week, the one with questions that help you evaluate automatic thoughts? This question is number 6. If you get a chance this week, how about trying out this question to evaluate an automatic thought? Then if you have any trouble, or you find it's not helpful, we can discuss it next time.

Finally, when the patient has progressed in therapy and can automatically evaluate her thoughts, the therapist may sometimes just ask the patient to *devise an adaptive response.*

P: [When I get ready to ask my roommate to keep the kitchen neater] I'll probably think I should just clean it better myself.

T: Can you think of a more adaptive way to view this?

P: Yeah. That it's better for me to stand up for myself. T[illegible]t I'm doing

something reasonable. I'm not being mean or asking her to do more than her share.

T: Good. What do you think will happen to your anxiety if you say that to yourself?

P: It'll go down.

Alternatively, if the therapist judges that a patient's automatic thoughts might interfere with her plans, he might just ask her *how she can respond* (assuming that she is already somewhat proficient at using the aforementioned questions).

T: Anything you can think of that might get in the way of your starting the statistics assignment?

P: I might think there's too much to do and get overwhelmed.

T: Okay, if you do have the thought, "There's too much to do," what can you tell yourself?

P: That I don't have to do it all in one night, that I don't have to understand it perfectly this first time through.

T: Good. Will that be enough, do you think, to go ahead and start the assignment?

USING ALTERNATIVE QUESTIONING

The beginning cognitive therapist is advised to use Figure 8.1 as a guide when initially evaluating automatic thoughts. These standard questions, however, frequently need to be modified for specific automatic thoughts. Various examples of different types of Socratic questions are described by Overholser (1993a, 1993b).

The following transcript is just one illustration of how the therapist varies his questioning when he judges that the standard questions will be ineffective.

T: What went through your mind [when you asked your mom if it was all right with her to shorten your time together and she sounded hurt and angry]?

P: That I should have known it was a bad time to call. I shouldn't have called.

T: What's the evidence that you shouldn't have called?

P: Well, my mother is usually rushed in the morning. If I had waited until

after she got home from work, she might have been in a better frame of mind.

T: Had that occurred to you?

P: Well, yeah, but I wanted to let my roommate know right away if I could visit her or not so she could make plans.

T: So you actually had a reason for calling when you did, and it sounds as if you knew it might be risky but you really wanted to let your roommate know as soon as you could?

P: Yeah.

T: Is it reasonable to be so hard on yourself for taking the risk?

P: No—

T: You don't sound convinced. How bad is it anyway, in the scheme of things, for your mom to feel hurt that you want to spend part of your summer vacation with your roommate?

The therapist follows up these questions with others: How hurt did your mother feel? How long did the hurt last at that level? How does she probably feel now? Is it possible for you to spare your mother hurt all the time? Can you possibly do what is good for you and not hurt your mother at all—given that she wants to spend as much time with you as she can? Is it desirable to have a goal of *never* hurting someone else's feelings? What would you have to give up yourself?

T: Let's go back to the original thoughts, "I should have known it was a bad time to call. I should have waited." How do you see it now?

P: Well, it wasn't such a terrible thing. She probably would have felt somewhat hurt no matter when I called because she does want to spend as much time with me as she can. But maybe that's not good for me, always doing what she wants and ignoring what's good for me. I guess she'll get over it.

The previous transcript demonstrates how the therapist varies his questioning to help the patient adopt a more functional perspective. Although he starts out questioning the *validity* of the thought, he shifts the emphasis to the *implicit underlying belief* (which they had previously discussed in other contexts): It is bad to hurt other people's feelings. At the end, he asks Sally an open-ended question ("How do you see the situation now?") to assess the effect of the questioning and to evaluate whether further work on the automatic thought is required. Note that many questions the therapist asked were a variation of question 2 in Figure 8.1: Is there an alternative explanation (for why you called when

you did and for why your mother was hurt [other than that you were bad and at fault])?

IDENTIFYING COGNITIVE DISTORTIONS

Patients tend to make consistent errors in their thinking. Often there is a systematic negative bias in the cognitive processing of patients who suffer from a psychiatric disorder (Beck, 1976). When the patient expresses an automatic thought, the therapist notes (mentally, verbally, or in writing) the type of error she seems to be making. The most common errors are presented in Figure 8.2 (see also Burns, 1980).

Some patients like the intellectual challenge of labeling their distortions themselves. The therapist might give this type of patient a copy of Figure 8.2.

T: We've been talking about how when people are distressed they often have thoughts which are not true or not wholly true. Right?

P: Right.

T: I have a list here to give you that describes the most common mistakes people make in their thinking. Often it's helpful to try to figure out what mistake you might be making because it'll help you respond to the thought better. Let me show you the list so you can see if you'd like to try to use it.

P: Okay.

T: So here are 12 common mistakes. Let's see if we can identify any you've made recently. The first one is "all-or-nothing thinking" where you see things in very black and white terms, instead of shades of gray. . . . How about when you had the thought last week, "Either I get an A or I'm a failure"? Can you see how that's very black and white?

P: Yeah.

T: Can you think of any other examples? [The therapist and patient spend another couple of minutes on this cognitive distortion. Then the therapist picks another distortion typical of this patient, and they review this second kind of error in the same way.] Anyway, for homework would you like to label the distortion when you catch an automatic thought? We can keep this sheet in front of us during our sessions, too, and occasionally see if we can figure out the distortion when we talk about other automatic thoughts.

For many patients, the list in Figure 8.2 is overwhelming. In this case, the therapist might label and describe just the distortions typical of this patient:

Although some automatic thoughts are true, many are either untrue or have just a grain of truth. Typical mistakes in thinking include:

1. *All-or-nothing thinking* (also called black-and-white, polarized, or dichotomous thinking): You view a situation in only two categories instead of on a continuum.
   Example: "If I'm not a total success, I'm a failure."
2. *Catastrophizing* (also called fortune telling): You predict the future negatively without considering other, more likely outcomes.
   Example: "I'll be so upset, I won't be able to function at all."
3. *Disqualifying or discounting the positive*: You unreasonably tell yourself that positive experiences, deeds, or qualities do not count.
   Example: "I did that project well, but that doesn't mean I'm competent; I just got lucky."
4. *Emotional reasoning*: You think something must be true because you "feel" (actually believe) it so strongly, ignoring or discounting evidence to the contrary.
   Example: "I know I do a lot of things okay at work, but I still feel like I'm a failure."
5. *Labeling*: You put a fixed, global label on yourself or others without considering that the evidence might more reasonably lead to a less disastrous conclusion.
   Example: "I'm a loser. He's no good."
6. *Magnification/minimization*: When you evaluate yourself, another person, or a situation, you unreasonably magnify the negative and/or minimize the positive.
   Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
7. *Mental filter* (also called selective abstraction): You pay undue attention to one negative detail instead of seeing the whole picture.
   Example: "Because I got one low rating on my evaluation [which also contained several high ratings] it means I'm doing a lousy job."
8. *Mind reading*: You believe you know what others are thinking, failing to consider other, more likely possibilities.
   Example: "He's thinking that I don't know the first thing about this project."
9. *Overgeneralization*: You make a sweeping negative conclusion that goes far beyond the current situation.
   Example: "[Because I felt uncomfortable at the meeting] I don't have what it takes to make friends."
10. *Personalization*: You believe others are behaving negatively because of you, without considering more plausible explanations for their behavior.
    Example: "The repairman was curt to me because I did something wrong."
11. *"Should" and "must" statements* (also called imperatives): You have a precise, fixed idea of how you or others should behave and you overestimate how bad it is that these expectations are not met.
    Example: "It's terrible that I made a mistake. I should always do my best."
12. *Tunnel vision*: You only see the negative aspects of a situation.
    Example: "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

FIGURE 8.2. Thinking errors. Adapted with permission fro aron T. Beck, M.D.

T: Well, we've just identified a number of automatic thoughts you had this week about your job, your health, and your children. I wonder if you see a common thread—in each case, it seems that you're predicting the worst that could happen. Is that right?

P: Yeah.

T: When people predict the worst, we call it fortune telling or catastrophizing—believing that a catastrophe might happen. Are you aware of catastrophizing much?

P: I think I probably do.

T: How about if you try this week to catch yourself catastrophizing? When you write down an automatic thought, see if that's what you're doing, and if so, write "catastrophizing" next to it.

A third option is to offer the list of distortions to the patient but to check off only one, two, or three errors most common to that patient so she does not become overwhelmed by trying to focus on them all. When the patient can determine the type of distortion she is making, she can often evaluate the validity of her thought more objectively. The next section describes how to help patients assess how *useful* their thoughts are.

QUESTIONING TO EVALUATE THE UTILITY OF AUTOMATIC THOUGHTS

Some automatic thoughts may be entirely valid or, despite evaluation, a patient may still believe they are entirely valid when they are not. At these times, the *usefulness* of the thought is assessed. The therapist can either help the patient determine the effect of her thinking (as in question 4 from Figure 8.1) or ask specifically for the advantages and disadvantages of continuing to have the thought, followed by an adaptive response to the thought.

T: Sally, you may be right that your chances aren't good to get the summer job you want. But what's the advantage of continuously telling yourself, "I'll never get it, I'll never get it"?

P: Well, I won't be so disappointed when I don't.

T: And what's the disadvantage of saying it over and over?

P: The disadvantage?

T: Does that thought bring you great satisfaction? Does it help you get your application finished? Does it enhance your enjoyment of school?

P: No.

T: So you can see that saying you'll never get it has disadvantages?

P: Yeah.

T: What would be a useful response, then, when you have the thought, "I'll never get the job"?

P: I will get the job?

T: Well, I wonder if that might be taking *too* rosy a view. How about reminding yourself of the likelihood that you will get *some* job, even if it's not your first choice. Then maybe you could remind yourself to refocus your attention on whatever you're doing. Do you think that could help? . . . Do you want to try that this week?

At another time the therapist might turn his attention to the thought, "I'll never get the job I want," and explore the underlying meaning. In this session, however, he chooses to explore the utility of the automatic thought. In the next section, he explicitly teaches the process to the patient.

T: Sally, let's review what we just did. We started with the thought, "I'll never get the summer job I want." We looked at the evidence that the thought is true, but it turned out that it isn't all that clear whether your prediction is probably right or not. So then we looked at how *useful* the thought is. Do you remember how we judged that?

P: Yeah. We looked at the advantages and disadvantages.

T: Right. And discovering it was pretty disadvantageous, we came up with a plan of how to respond to that thought the next time it comes up. So even when a thought is true, or when you truly can't evaluate it, you can still respond to it, based on its disadvantages.

ASSESSING THE EFFECTIVENESS OF EVALUATING THE AUTOMATIC THOUGHT

Having used standard or nonstandard questions (or a behavioral experiment; see Chapter 12, pp. 197–200) to evaluate an automatic thought, the therapist assesses the effectiveness of the evaluation in order to decide what to do next in the session. If the patient no longer believes the automatic thought as much and if her emotional reaction has

decreased significantly, the therapist has an indication that he should move on to something else.

T: How much do you believe now that Jane will get angry and stay angry with you if you bring up the problem of noise?

P: Not much. Maybe 25%.

T: And how worried do you feel now?

P: Less. About 20%.

T: Good. Anything else on this? No? How about if we move on to the next thing on the agenda.

CONCEPTUALIZING WHY THE EVALUATION OF AN AUTOMATIC THOUGHT WAS INEFFECTIVE

If the patient still believes the automatic thought to a significant degree and does not feel better emotionally, the therapist seeks to understand why this initial attempt at cognitive restructuring has not been sufficiently effective. Common reasons to consider include the following:

1. There are other more central automatic thoughts and/or images left unidentified or unevaluated.
2. The evaluation of the automatic thought is implausible, superficial, or inadequate.
3. The patient has not sufficiently expressed the evidence she believes supports the automatic thought.
4. The automatic thought itself is also a core belief.
5. The patient understands "intellectually" that the automatic thought is distorted but does not believe it on a more "emotional" level.
6. The patient discounts the evaluation.

In the first situation, *the therapist has not elicited the most central automatic thought or image.* Sally, for example, reports the thought, "If I try out [for the school newspaper], I probably won't make it." Evaluating this thought does not significantly affect her dysphoria because she has other important (but unrecognized) thoughts: "What if they [the editors] think I'm a lousy writer?" "What if I write something really bad?" She also has an image of the editors reading her article with mocking, scornful faces.

In a second situation, *the patient responds to an automatic thought superficially.* Sally has the thought, "I won't finish all my work. I have too much to do." Instead of carefully evaluating the thought, Sally merely responds, "No, I'll probably get it done." This response is insufficient, and Sally's anxiety does not decrease.

In a third situation, *the therapist does not sufficiently elicit the patient's evidence that her automatic thought is true,* resulting in an ineffective adaptive response, as seen here:

T: Okay, Sally, what evidence do you have that your brother doesn't want to bother with you?

P: Well, he hardly ever calls me. I always call him.

T: Okay, anything on the other side? That he does care about you, that he does want a good relationship with you?

Had Sally's therapist probed a little more, he would have uncovered other evidence that Sally has to support her automatic thought: that her brother spent more time with his girlfriend during vacations than with Sally, that he sounded impatient on the phone whenever she called, and that he had not sent her a birthday card. Having elicited this additional data, the therapist could have helped Sally weigh the evidence more effectively and investigated alternative explanations for her brother's behavior.

In a fourth situation, *the patient identifies an automatic thought that is also a core belief.* Sally often has the thought, "I'm incompetent." She believes this idea so strongly that a single evaluation does not alter her perception or the associated affect. Her therapist needs to use many techniques over time to alter this belief (see Chapter 11).

In a fifth situation, *the patient indicates that she believes an adaptive response "intellectually," in her mind, but not "emotionally," in her heart, soul, or gut.* In this case, the therapist and patient need to explore an unarticulated belief that lies *behind* the automatic thought.

T: How much do you believe that the professor won't think you're wasting his time and, even if he does, that's his job?

P: Well, I can see it intellectually.

T: But?

P: Even though I think he should help me, I still think he'll think I'm wasting his time.

T: Okay, let's assume for a moment that he *does* think you're wasting his time, what's so bad about that?

Here, Sally's therapist discovers that she does not really believe the adaptive response and uncovers an underlying belief: If I ask for help, it means I am weak.

In a sixth situation, the patient discounts the adaptive response.

T: How much do you believe that the professor won't think you're wasting his time or, if he does, that that's what he's being paid for anyway?

P: I do believe it, but–

T: But?

P: But I still think I should work it out myself.

T: Well, that's another possibility, maybe you should. Should we look rationally at whether you're better off working it out yourself or going to him for help?

P: Okay.

Discounting the adaptive response often takes the form of a "yes, but . . . " statement: "Yes; I believe [this response], but . . . . " The "yes, but . . . " statement can then be treated as another automatic thought and subjected to rational evaluation.

To summarize, having evaluated an automatic thought, the therapist asks the patient to rate how much she believes the adaptive response and how she feels emotionally. If her belief is low, and she is still distressed, he tries to conceptualize why the examination of the thought did not alleviate her distress. The next chapter describes how to help patients respond to their automatic thoughts.

Chapter 9

RESPONDING TO AUTOMATIC THOUGHTS

The previous chapter demonstrated the use of questioning to help a patient evaluate an automatic thought and determine the effectiveness of the evaluation. In many cases the therapist chooses to follow up this verbal interaction with another intervention to fortify a more adaptive viewpoint. This follow-up activity is often a written response which the patient can read for homework. Writing down important learnings during the therapy session not only reinforces new understandings at the time but also provides an opportunity for the patient to refer to important therapy notes weeks and months (and even years) after therapy has ended. This chapter describes the Dysfunctional Thought Record, the primary tool for patients to evaluate and respond in writing to their automatic thoughts, and other methods for responding to automatic thoughts.

DYSFUNCTIONAL THOUGHT RECORDS

The Dysfunctional Thought Record (DTR), also known in an earlier version as the Daily Record of Dysfunctional Thoughts (Beck et al., 1979), is a worksheet that helps a patient respond more effectively to her automatic thoughts, thereby reducing her dysphoria (see Figure 9.1). Some patients use it quite consistently. Others, despite the best efforts of their therapist, cannot or will not write down their thoughts and so rarely use it. Most patients fall someplace in the middle; that is, with proper instruction and encouragement from the therapist, they use DTRs on a fairly regular basis. If the therapist judges that a patient may be overwhelmed by the format of the DTR, he may teach the patient to use the questions listed in Chapter 8, Figure 8.1, instead.

Directions: When you notice your mood getting worse, ask yourself, "What's going through my mind right now?" and as soon as possible jot down the thought or mental image in the Automatic Thought column.

Date/time	Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
	1. What actual event or stream of thoughts, or daydreams or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad/anxious/angry/etc.) did you feel at the time? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What will you do (or did you do)?
Friday 2/23 10 A.M.	Talking on the phone with Donna.	She must not like me any more. 90%	Sad 80%		
Tuesday 2/27 12 P.M.	Studying for my exam.	I'll never learn this. 100%	Sad 95%		
Thursday 2/29 5 P.M.	Thinking about my economics class tomorrow.	I might get called on and I won't give a good answer. 80%	Anxious 80%		
	Noticing my heart beating fast and my trouble concentrating.	What's wrong with me?	Anxious 80%		

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) What should I do about it? (6) If _____ [friend's name] was in the situation and had this thought, what would I tell him/her?

FIGURE 9.1. Dysfunctional thought record. Copyright 1995 by Judith S. Beck, Ph.D.

Patients are more likely to use the DTR if it is properly introduced, demonstrated, and practiced. A few guidelines are suggested:

1. The therapist should have mastered the DTR himself (with his own automatic thoughts) before presenting it to a patient.
2. The therapist should plan to introduce the DTR in two stages over two or more sessions. Stage 1 covers the first four columns; Stage 2, the last two columns.
3. The therapist should ascertain that the patient really grasps and believes in the cognitive model before introducing the DTR (otherwise she will not understand the value of identifying and evaluating her thoughts).
4. The patient should demonstrate an ability to identify her automatic thoughts and emotions before being introduced to the DTR. She should be able to state the situation, her emotions, and her physiological response without confusing these three with automatic thoughts. If she does not have a clear understanding and ability to differentiate among these phenomena, she will most likely experience difficulty with the DTR. Thus, the therapist should verbally elicit several clear, important examples of specific situations with their accompanying automatic thoughts and emotions prior to demonstrating how to record such data on a DTR.
5. The patient should demonstrate success in completing the first four columns on her own with several different situations before being introduced to the last two columns.
6. The therapist should have *verbally* evaluated at least one important automatic thought with a patient and have produced some decrease in dysphoria prior to demonstrating how to complete the last two columns.
7. If the patient fails to complete homework assignments using the DTR, the therapist should elicit automatic thoughts about doing the DTR itself, help with practical problem-solving, propose doing a DTR as an experiment, consider disclosing his own use of the DTR, and otherwise motivate the patient.

Having identified a problematic situation, the therapist first helps the patient identify specific automatic thoughts and the associated emotions through verbal questioning alone. He may choose these examples to illustrate the use of the DTR. If the therapist presents the DTR without first successfully identifying an important situation, automatic thought, and emotion, he runs the risk of confusing the patient if she subsequently cannot correctly identify these different items.

In the following section, the therapist has already ascertained the content of the first four columns of the DTR for a specific automatic thought before he presents the patient with a blank DTR.

THERAPIST: Okay, Sally, let me make sure I understand. The situation was that your high school friend Donna called and said she couldn't come this weekend. You had the thought, "She must not like me anymore," and you felt sad. Is that right?

PATIENT: Yes.

T: Good. Now in a few minutes I'd like us to evaluate that thought, but first I'd like to show you a worksheet that I think will help you. It's called a DTR—a Dysfunctional Thought Record—and it's just an organized way of responding to thoughts that are distressing you. Okay? (*Pulls out Figure 9.1.*)

P: Sure.

T: Here it is. Today we'll concentrate on the first four columns, so I'll just cross out the last two. We'll look at them at another session. Now, before I start, I have to tell you a couple of things. First, spelling, handwriting, and grammar don't count.

P: (*Laughs.*)

T: Second, this is a useful tool, and it may take some practice for you to get really good at it. So expect to make some mistakes along the way. These mistakes will actually be useful—we'll see what was confusing so you can do it better the next time. Okay?

P: Uh huh.

T: Okay. How about if we use your thought, "She must not like me any more," as an example. The first column is easy. When did you have that thought?

P: Today. This morning.

T: Okay. In the first column put down today's date and about what time it was.

P: (*Does so.*)

T: Would you put down the day of the week, too? I think it'll make it easier for us when we refer back to it. Now, in this second column, you write down the situation. When you had the thought, "She must not like me any more," were you on the phone with her, or did you have it afterwards?

P: It was while I was talking to her.

T: Okay. Under situation, you could write, "Talking on the phone with Donna." If you had had the thought later, you could have written, "Thinking about my phone call with Donna." So the situation can either be an *actual* event or what you're *thinking* about or imagining in your mind. Is that clear?

P: I think so.

T: We'll be going over a lot of examples so it'll become clearer to you. You'll see, too, that the questions at the top of the column prompt you. There's a third kind of situation, too, if your automatic thought is about how you're feeling, emotionally or physically. For example, the situation might be "Noticing that I feel sad," and the thought might be, "I shouldn't be feeling this way. I'm hopeless."

P: Okay. I think I get it.

T: Now, the next column is for the automatic thoughts. Here's where you write down the actual words or pictures that went through your mind. In this case, you had the thought, "She must not like me any more." . . . How much did you believe the thought at that time?

P: A lot: 90%.

T: Good. Write down the thought and then write 90% next to it. . . . And in the fourth column, you write your emotion and how intense it was. In this case, how sad did you feel?

P: Pretty sad: 80%.

T: Okay, write that down. How about if we try this again. Do you remember another time this week when you noticed your mood changing?

P: Sure . . . I was looking for a book at the library today. I started feeling really sad.

T: Okay, let's go back to that time. It's earlier today, you're at the library, looking for a book. You start feeling really sad and now you ask yourself the question at the top of the DTR: *"What is going through my mind right now?"* (*Circles or highlights this question on the DTR.*)

P: I'll never make it here. I can't even find the book I need.

T: Okay, let's see if you can fill in the first four columns of the DTR yourself. I'll help if need be.

When the patient has successfully completed the first four columns in session with little or no assistance, the therapist may collaboratively set a follow-up homework assignment.

T: Okay, Sally, how would you feel about trying to fill in the first four columns a few times this week for homework? You'll use a change in your mood as a cue to pull this out and ask yourself what's going through your mind, just as it says at the top here.

P: Okay.

T: Let me remind you of a couple of things. First, you don't have to fill it out in order from left to right. Sometimes it's easier to identify the emotion you're feeling first—sad, anxious, angry, and so on—and write it down before you figure out the automatic thought you've just had. Also, you'll remember that this is a skill, and you may not do it perfectly the first time you try it, right? But the more you practice it, the better you'll become at it and the more helpful it can be.

P: Okay.

T: Do you think you could try to write down one automatic thought a day this week?

P: Sure. I'll try.

In the next session, the therapist realizes that Sally has some confusion about situations and automatic thoughts, physiological responses, and emotions (see bottom of Figure 9.1), so he postpones the introduction of the last two columns and instead reviews the DTR that Sally did for homework.

T: Okay, let's take a look at this DTR you did at home. This first example looks good. On Tuesday, you were studying for an exam; you had the thought, "I'll never learn this," which you believed 100%; and you felt 95% sad. Good. If we have time today, we'll evaluate that thought, but first let's talk about this second item you wrote down.

P: I didn't do it right. I couldn't figure out what my automatic thought was.

T: Okay, let's look at it. I see it was yesterday, around 5:00. What were you doing?

P: Well, I should have been studying, but I couldn't, like concentrate very well. I was walking around my room—

T: What were you thinking about?

P: About my economics class that I had today. I thought I might get called on and I was sure I wouldn't give a good answer.

T: Oh, so you had the thought, "I might get called on and I won't give a good answer."

P: Yeah.

T: Good. Write that under "automatic thought." . . . Now at the time, how much did you believe this thought?

P: About 80%.

T: Okay. Write that down. . . . Now how did that thought make you feel?

P: Anxious. My heart started beating fast.

T: How anxious, 0–100%?

P: About 80%.

T: Write that down under emotion: anxious, 80%. Now under situation, write down, "Thinking about class tomorrow." . . . Okay, it sounds like "heart beating fast" and "difficulty concentrating" were symptoms of anxiety. Did anything go through your mind about these symptoms?

P: Yeah. I was thinking, "What's wrong with me?"

T: Okay. So a second situation was noticing your heart beating fast and having trouble concentrating; and the automatic thought was, "What's wrong with me?" Can you fill those things in, too?

At the next session, her therapist notes that Sally has mastered the first four columns of the DTR, as evidenced by her homework. One of his goals for the session, if the opportunity arises, is to teach Sally to use the last two columns. He uses the questions at the bottom of the DTR to help her evaluate one of the thoughts she had written down for homework (see Figure 9.2). He does so verbally at first, to make sure the use of these questions is effective.

T: Okay, now let's see if you can transfer some of what we just talked about to the DTR. What cognitive distortion did we say you made?

P: Fortune telling.

T: Okay, you can write that at the top of fourth column, which is called "adaptive response." Do you see the instructions for this column? Writing down the type of cognitive distortion is optional.

P: Okay.

T: Next, you use the questions at the bottom of the DTR to evaluate your thinking and compose an adaptive response in column 4. These questions are the same ones we used just a minute ago when we did this verbally.

P: Okay.

T: First we looked at the evidence, and what did you conclude?

P: That I don't really know if Bob wants to go out or not. That he does act friendly to me in class.

T: Okay, write down those two things in the fifth column. . . . Now, how much do you believe each statement?

P: Oh, pretty much: 90%.

Directions: When you notice your mood getting worse, ask yourself, "What's going through my mind right now?" and as soon as possible jot down the thought or mental image in the Automatic Thought column.

Date/time	Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
	1. What actual event or stream of thoughts, or daydreams or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad/anxious/angry /etc.) did you feel at the time? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What will you do (or did you do)?
Friday 3/8 3 P.M.	Thinking about asking Bob if he wants to have coffee.	He won't want to go with me. 90%	bad 75%	(Fortune-telling error) I don't really know if he wants to or not. (90%) He is friendly to me in class. (90%) The worst that'll happen is he'll say no and I'll feel bad for a while. (90%) The bad is he'll say yes. (100%) The most realistic is he may say he's busy but still act friendly. (80%) If I keep on assuming he doesn't want to go out with me, I'll have no chance with him. (100%) I should just go up and ask him. (50%) What's the big deal, anyway. (75%)	1. AT–50% 2. bad–50% anxious–50%

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) What should I do about it? (6) If _____ [friend's name] was in the situation and had this thought,, what would I tell him/her?

FIGURE 9.2. Dysfunctional Thought Record. Copyright 1995 by Judith S. Beck, Ph.D.

T: Good. Put 90% next to each statement.... Next, we looked at the consequences. What's the best, worst, and most realistic outcome? (*The patient continues to write down the adaptive response and her degree of belief in each statement.*) Good. Now let's look at the last column. How much do you believe your automatic thought now?

P: Maybe 50%.

T: And how do you feel now?

P: Not quite so sad. But more anxious.

T: Okay, in the last column, write down "A.T." for automatic thought and next to it, 50%. Then write down "sad" and rate the degree of sadness 0–100%.

P: (*Does so.*)

T: Now, maybe we should look at the thought that's making you anxious.

Next, the therapist might have the patient practice the DTR with another automatic thought, set a homework assignment using the DTR, or proceed to another topic.

MOTIVATING PATIENTS TO USE DYSFUNCTIONAL THOUGHT RECORDS

Some patients immediately gravitate to the Dysfunctional Thought Record and consistently use it when they feel upset. For others, the following interchange may help:

T: Well, Sally, it looks as if this DTR [the one they just did together] has helped. Your sadness went from 75% down to 50%.

P: Yeah.

T: Do you think using this form could help in the future?

P: Yeah.

T: You're already pretty good at evaluating and answering back your thoughts in your head. But most people find it's much more effective to put it down on paper. What do you think?

P: I think it would help.

T: How likely are you to try it at home this week?

P: I guess I could try it.

T: You know, I occasionally still do DTRs myself when I find I'm overreacting. I find it's much more helpful to do it on paper than just

doing it mentally. But we don't really know if that's true for you. How would you feel about doing an experiment? At least once this week, you could adaptively respond to your thoughts in your head. See how it affects your mood. Then pull out the DTR and put it all on paper and see if you feel even better. What do you think?

P: Okay.

T: How likely is it that you'll try this experiment?

P: I will.

In order to encourage the patient to try the DTR, the therapist asks the patient to try an experiment. If she returns the following week with a correctly completed thought record (which has been effective in modifying her mood), she may not need further motivation. If she did not complete a DTR, did not do it correctly, or did not experience an improvement in mood, the therapist will try to determine why difficulties arose and plan accordingly. At times, commonsense suggestions smooth the way:

P: I know I'll probably have a lot of automatic thoughts during class. But I can't write a DTR then and there.

T: That's true. Do you think it might help to predict a typical, upsetting thought in advance and write a DTR *before* class? Or maybe you could just jot down the automatic thoughts on a piece of paper during class and transfer them to a DTR afterwards.

P: Well, it probably would help to do one beforehand so maybe I won't start off so anxious, but unless I'm coming from therapy, I won't have one with me.

T: Some people carry a blank DTR in their wallet. Would that work for you?

P: Yeah. I guess the only problem would be *where* to write it. I wouldn't want anyone else to see it.

T: Sometimes you have to be inventive. Some people do it at their desk like any other paperwork, or in the car, or even in the bathroom. How about if you see what you can come up with? If you have trouble or if you're still concerned about other people seeing it, we can talk more about it next week.

A discussion of the patient's concerns in the following session might involve identification of automatic thoughts and images about others seeing the DTR, about hopelessness related to being able to feel better, about not wanting to put forth the effort required to modify her mood,

or other dysfunctional ideas which get in the way of the patient doing the DTR.

WHEN THE DYSFUNCTIONAL THOUGHT RECORD IS NOT SUFFICIENTLY HELPFUL

As with any technique in cognitive therapy, it is important not to overemphasize its importance. Most patients, at some point, find that completing a particular DTR did not provide much relief. By emphasizing its *general* usefulness and "stuck points" as an opportunity for learning, the therapist helps the patient avoid automatic thoughts critical of herself, the therapy, the therapist, or the DTR itself.

Depending on the individual patient, the therapist might explain common reasons why a DTR did not significantly reduce the patient's dysphoria. As described in the previous chapter, evaluation of an automatic thought (with or without a DTR) may be less than optimally effective if the patient failed to respond to her most upsetting thought or image, if her automatic thought was a core belief or activated an underlying belief, if her evaluation and response were superficial, or if she discounted her response.

ADDITIONAL WAYS TO RESPOND TO AUTOMATIC THOUGHTS

This chapter has thus far emphasized written methods to respond to automatic thoughts. It is not practical or desirable, however, for a patient to respond to every automatic thought in writing. If she did so, her life would become consumed with such an undertaking. In fact, some patients (especially those with obsessive-compulsive personality disorder) may use the DTR too much. Other patients cannot or will not do written assignments. The following are alternative techniques which do not require writing.

1. Doing a DTR mentally.
2. Reading a previously written DTR or notes from therapy that contain an identical or similar automatic thought.
3. Dictating a modified version of a DTR to someone else to write down or having someone else read previously written responses (if the patient can understand but cannot read or write herself).
4. Reading a coping card (see Chapter 12, pp. 214–216).
5. Listening to a therapy session or part of one on audiotape.

Finally, it is more useful at times to do problem-solving instead of evaluating an automatic thought. Sally, for example, had the thought, "I'll never learn the econ stuff before the test." Through careful questioning, her therapist concluded that if Sally continued studying as she had been, it was indeed likely that she *would not* learn the material adequately. He judged that it would be a better use of therapy time to help her devise possible solutions to her real-life problems, including borrowing notes from a classmate, going to the professor for help, outlining the textbook chapters as she read, arranging to study with a friend, and so on.

In summary, the therapist teaches the patient a variety of ways to respond to her distorted thinking. Careful teaching of the DTR maximizes the chance that patients will use this important tool themselves, but there are also other ways for patients to respond to their automatic thoughts if they cannot or will not use a DTR.

Chapter 10

IDENTIFYING AND MODIFYING INTERMEDIATE BELIEFS

Previous chapters described the identification and modification of automatic thoughts, the actual words or images that go through a patient's mind in a given situation and lead to distress. This chapter describes the deeper, often unarticulated ideas or understandings that patients have about themselves, others, and their personal worlds which give rise to specific automatic thoughts. These ideas are often not expressed before therapy but can easily be elicited from the patient or inferred and then tested.

As described in Chapter 2, these beliefs may be classified into two categories: intermediate beliefs (composed of rules, attitudes, and assumptions) and core beliefs (absolutistic, rigid, global ideas about oneself and/or others). Intermediate beliefs, while not as easily modifiable as automatic thoughts, are still more malleable than core belief(s).

This chapter is divided into two parts. In the first part, *cognitive conceptualization* (initially introduced in Chapter 2) is described, and the process of developing a Cognitive Conceptualization Diagram is illustrated. Conceptualization is emphasized throughout this volume to help the therapist plan therapy, become adept at choosing appropriate interventions, and overcome "stuck" points when standard interventions fail. *Eliciting and modifying intermediate beliefs* are the focus of the second part of this chapter. These techniques are also applicable to the next chapter, which presents additional specialized techniques for eliciting and modifying core beliefs.

COGNITIVE CONCEPTUALIZATION

Generally, a therapist and patient work on automatic thoughts first before tackling beliefs. From the beginning, though, the therapist starts formulating a conceptualization, which logically connects automatic thoughts to the deeper-level beliefs. If the therapist fails to see this larger picture, he will be less likely to direct therapy in an effective, efficient way. Novice cognitive therapists often jump from one intermediate belief to another instead of identifying the most central beliefs and doing sustained work on them.

Therefore, the therapist should start filling in a Cognitive Conceptualization Diagram (Figure 10.1) as soon as he has gathered data about the patient's typical automatic thoughts, emotions, behavior, and/or beliefs. This diagram depicts, among other things, the relationship between core beliefs, intermediate beliefs, and current automatic thoughts. It provides a cognitive map of the patient's psychopathology and helps organize the multitude of data that the patient presents. The diagram in Figure 10.1 illustrates the basic questions the therapist asks himself in order to complete the diagram.

Initially, the therapist may have data to complete only a portion of the diagram. He either leaves blank other boxes or fills in items he has inferred with a question mark to indicate their tentative status. He checks out with the patient missing or inferred items at future sessions. The therapist at some point shares the conceptualization with the patient, when his goal for a session is to help the patient understand the broader picture of her difficulties. At that time, he reviews the conceptualization orally, develops a fresh diagram with the patient, or presents the completed diagram. Whenever the therapist presents his interpretations, he labels them as hypotheses, asking the patient whether they "ring true" to her. Correct hypotheses generally resonate with the patient.

Usually it is best to start with the bottom half of the conceptualization diagram. The therapist jots down three *typical* situations in which the patient became upset. Then, for each situation, he fills in the key automatic thought, its meaning, and the patient's subsequent emotion and relevant behavior (if any). If he has not directly asked the patient for the meaning of her automatic thoughts, he either hypothesizes (with a written question mark) or, better still, does the downward arrow technique (pp. 145–146) with the patient at the next session to uncover the meaning for each thought.

The meaning of the automatic thought for each situation should be logically connected with the Core Belief box near the top of the diagram. For example, Sally's diagram (Figure 10.2) clearly shows how her automatic thoughts [illegible] the meaning of those thoughts are related to her core belief of inadequacy

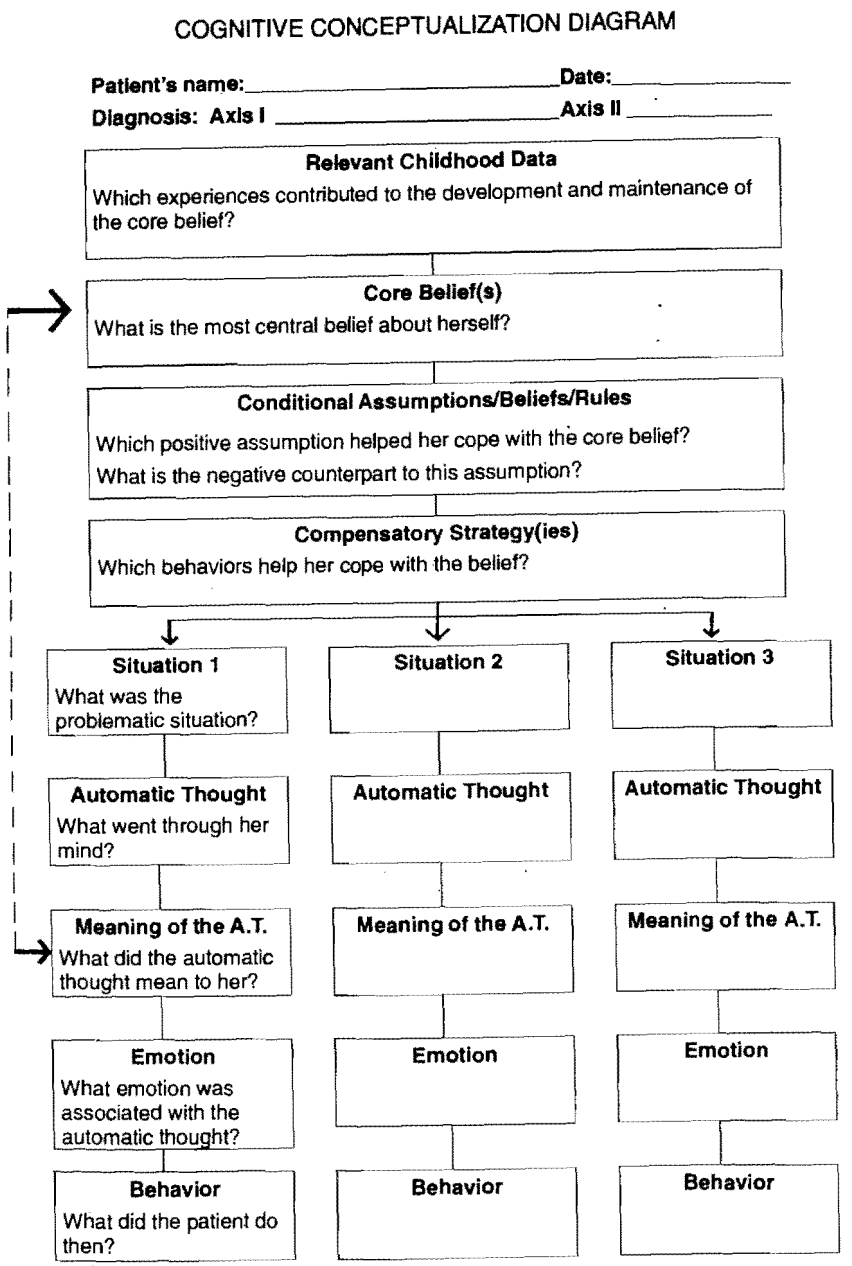


FIGURE 10.1. Cognitive Conceptualization Diagram. Copyright 199[illegible] by Judith S. Beck, Ph.D.

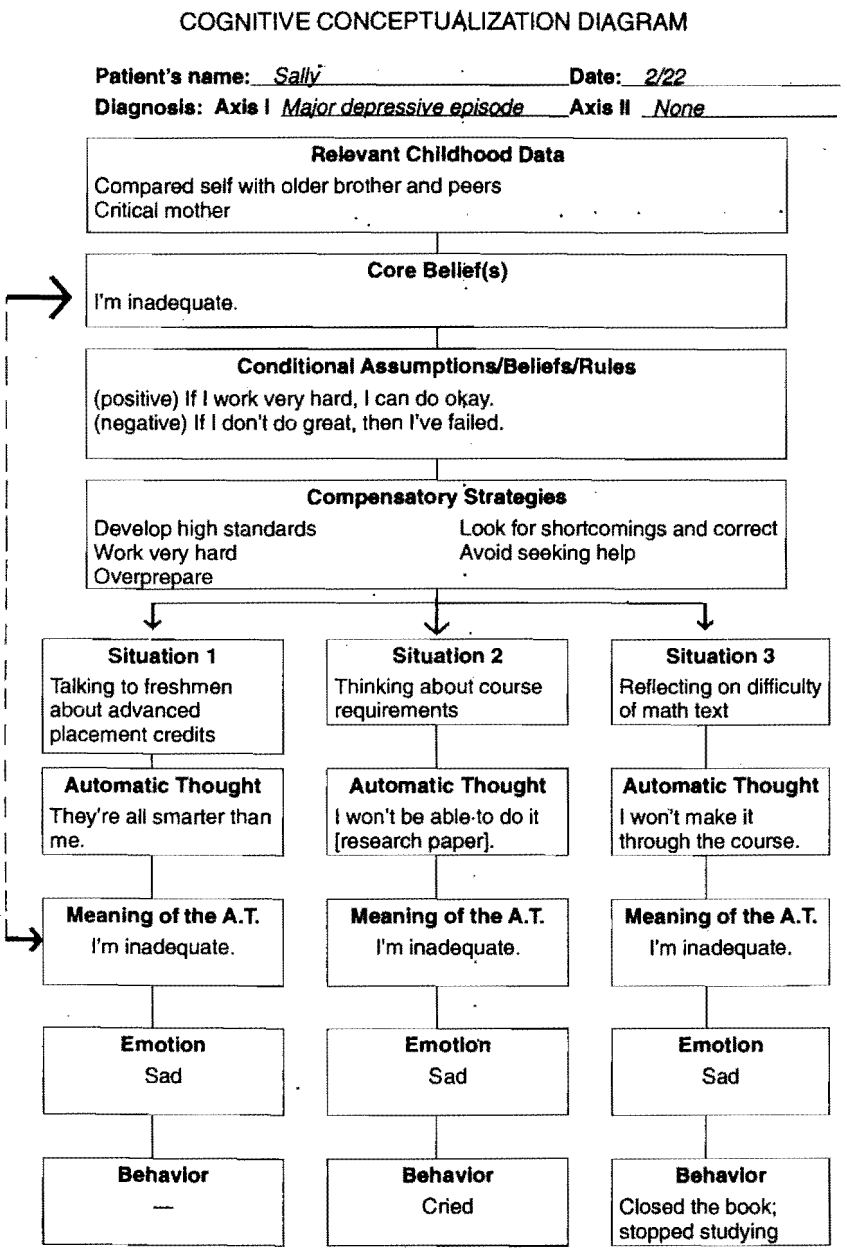


FIGURE 10.2. Sally's Cognitive Conceptualization Diagram. Copyright 1993 by Judith S. B[illegible] Ph.D.

To complete the top box of the diagram, the therapist asks himself (and the patient): How did the core belief originate and become maintained? What life events (especially those in childhood) did the patient experience that might be related to the development and maintenance of the belief? Typical relevant childhood data include such significant events as continual or periodic strife among parents or other family members; parental divorce; negative interactions with parents, siblings, teachers, peers, or others in which the child felt blamed, criticized, or otherwise devalued; illness; death of significant others; physical or sexual abuse; and other adverse life conditions, such as growing up in poverty, facing chronic racial discrimination, and so on.

The relevant childhood data may, however, be more subtle: for example, the child's perception (which may or may not have been valid) that parents favored a sibling over her; the child's continual self-criticism over not measuring up in some important way to a sibling; the child's feeling different from or demeaned by peers; or the child's perception that she did not meet expectations of parents, teachers, or others.

Next the therapist asks himself, "How did the patient cope with this painful core belief? What intermediate beliefs (i.e., underlying assumptions, rules, and attitudes) has she developed?"

Sally's beliefs are depicted hierarchically in Figure 10.3. As Sally has many intermediate beliefs that could be classified as attitudes or rules, it is particularly useful to list the key *assumptions* in the box below the core belief. (See p. 149 for how the therapist can help a patient reexpress an attitude or rule as an assumption.) Sally, for example, developed a positive assumption which helped her cope with the painful idea of inadequacy: "If I work very hard, then I can do okay." Like most patients, she also had a negative assumption, which was the flip side of the positive, "If I don't work hard, then I'll fail." Most Axis I patients tend to operate according to their positive assumptions until they become psychologically distressed, at which time the negative assumption surfaces.

To complete the next box, "compensatory strategies," the therapist asks himself, "Which behavioral strategies did the patient develop to cope with the painful core belief?" Note that the patient's broad assumptions often link the compensatory strategies to the core belief: "If I [engage in the compensatory strategy], then [my core belief may not come true]. However, if I [do *not* engage in my compensatory strategy], then [my core belief *may* come true]." Sally's strategies were to develop high standards for herself, work very hard, overprepare for exams and presentations, and be hypervigilant for her shortcomings and avoid seeking help (especially in situations in which asking for assistance could, in her mind, expose her inadequacy). She believes that doing these things will protect her from failure and the exposure of her i[illegible]quacy (and

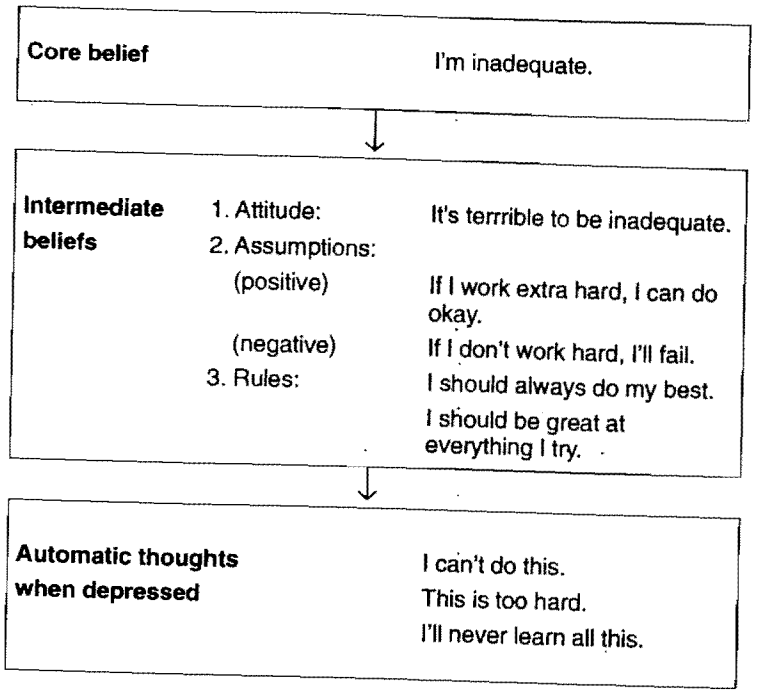


FIGURE 10.3. Hierarchy of beliefs and automatic thoughts.

that not doing these things *could* lead to failure and exposure of inadequacy).

Another patient might have developed strategies that are the opposite of Sally's behaviors: avoiding hard work, developing few goals, underpreparing, and asking for excessive help. Why did Sally develop her set of coping strategies while a second patient developed the opposite set? Perhaps nature endowed them with different cognitive and behavioral styles; in interaction with the environment they developed different intermediate beliefs that reinforced their particular behavioral strategies. The second hypothesized patient, perhaps because of her childhood experiences, had the same core belief of inadequacy but coped with it by developing another set of beliefs: "If I set low goals for myself, I may be able to meet them, and even if I don't meet them, I'll have less to lose"; "If I try minimally and fail, then my failure is due to lack of effort rather than to inadequacy"; "If I rely on myself then I won't be able to accomplish what I need to. Therefore it is better to depend on others." The therapist might explain to this latter patient that her childhood environment in conjunction with her hereditary predisposition may account for the development of her particular beliefs and coping strategies, stressing that through therapy she can learn to override or modify the beliefs and strategies when they prove dysfunctional.

Note that compensatory strategies are *normal* behaviors that everyone engages in at times. The difficulty of patients in distress lies in the *overuse* of these strategies at the expense of more functional strategies. Figure 10.4 lists a few examples of strategies that patients develop to cope with painful core beliefs.

To summarize: The Cognitive Conceptualization Diagram should make logical sense to the therapist and patient. It should be continually reevaluated and refined as additional data are collected. The therapist introduces it to the patient as an explanatory device, designed to help make sense of the patient's current reactions to situations. The therapist may introduce just the bottom half initially, saving the top portion for a time when he judges the patient will benefit. Whereas some patients are intellectually and emotionally ready to see the larger picture early on in therapy, others (especially those who do not have a sound therapeutic relationship or do not really believe in the cognitive model) should be exposed to the diagram much later in therapy (if at all). As mentioned previously, whenever the therapist presents his conceptualization, he asks the patient for confirmation, disconfirmation, or modification of his hypotheses.

Identifying Intermediate Beliefs

How does the therapist identify intermediate beliefs? He does so by:

1. Recognizing when a belief is expressed as an automatic thought.
2. Providing the first part of an assumption.
3. Directly eliciting a rule or attitude.
4. Using the downward arrow technique.
5. Examining the patient's automatic thoughts and looking for common themes.
6. Reviewing a belief questionnaire completed by the patient.

These strategies are illustrated below.

1. First, a patient may actually articulate a belief as an automatic thought, especially if she is depressed:

THERAPIST: What went through your mind when you got the quiz back?

PATIENT: I should have done better. I can't do anything right. I'm so inadequate. [*core belief*]

Avoid negative emotion	Display high emotion (e.g., to attract attention)
Try to be perfect	Purposely appear incompetent or helpless
Be overly responsible	Avoid responsibility
Avoid intimacy	Seek inappropriate intimacy
Seek recognition	Avoid attention
Avoid confrontation	Provoke others
Try to control situations	Abdicate control to others
Act childlike	Act in an authoritarian manner
Try to please others	Distance self from others or try to please only oneself

FIGURE 10.4. Typical compensatory strategies.

2. Second, the therapist may be able to elicit a full assumption by providing the first half of it.

T: So you had the thought, "I'll have to stay up all night working."

P: Yes.

T: And if you don't work as hard as you possibly can on a paper or a project—

P: Then I haven't done my best. I've failed.

T: Does this sound familiar, based on what we've talked about before in therapy? Is this generally how you view your efforts, that if you don't work as hard as you can, then you've failed?

P: Yes, I think so.

T: Can you give me some more examples so we can see how widespread this belief is?

3. Third, the therapist can identify a rule or an attitude by direct elicitation.

T: So it's pretty important to you to do really well in your volunteer tutoring job?

P: Oh, yes.

T: Do you remember our talking about this kind of thing before: having to do very well? Do you have a rule about that?

P: Oh . . . I hadn't really thought of it . . . I guess I have to do whatever I do really well.

4. More often, the therapist uses a fourth technique to identify intermediate (and core) beliefs: the *downward arrow technique* (Burns, 1980). First, the therapist identifies a key automatic thought which he suspects may be directly stemming from a dysfunctional belief. Then he asks the patient for the *meaning* of this cognition, assuming the automatic thought were true. He continues to do so until he has uncovered one or more important beliefs. Asking what a thought means *to* the patient often elicits an intermediate belief; asking what it means *about* the patient usually uncovers the core belief.

T: Okay, to summarize, you were studying late last night, you were looking over your class notes, you had the thought, "These notes stink," and you felt sad.

P: Right.

T: Okay, now we haven't yet looked at the evidence to see if you're right. But I'd like to see if we can figure out *why* that thought made you feel so sad. To do that, we have to assume for a moment that you *are* right, your notes stink. What would that mean to you?

P: I didn't do a very good job in class.

T: Okay, if it's true that you didn't do a very good job in class, what would that mean?

P: I'm a lousy student.

T: Okay, if you're a lousy student, what does that mean about you?

P: I'm not good enough. [I am inadequate.] [*core belief*]

Sometimes the therapist gets stuck in the course of a downward arrow technique when the patient answers with a "feeling" response, such as "That would be terrible," or "I'd be so anxious." As in the example below, the therapist gently empathizes and then tries to get back on track. To minimize the possibility that the patient will react negatively to his probing, the therapist provides a rationale for his repeated questioning and varies his inquiry through questions such as the following:

"If that's true, so what?"
"What's so bad about—"
"What's the worst part about—"
"What does that mean *about* you?"

The transcript below demonstrates the provision of a brief rationale and the variation of questions in the downward arrow technique.

T: It's important to me to understand the most upsetting part of this to you. What would it mean if your roommates and friends did get better grades than you?

P: Oh, I couldn't stand it.

T: So you'd be pretty upset, but what would be the worst part about it?

P: They'd probably look down on me.

T: And if they did look down on you, what would be so bad about it?

P: I'd hate that.

T: Sure, you'd be distressed if that happened. But so what if they looked down on you?

P: I don't know. That would be pretty bad.

T: Would it mean something *about* you, if they looked down on you?

P: Sure. It'd mean I'm inferior, not as good as they are.

How does the therapist know when to stop the downward arrow technique? Generally the therapist has uncovered the important intermediate beliefs and/or core belief when the patient shows a negative shift in affect and/or begins to state the belief in the same or similar words.

T: And what would it mean if you are inferior and not as good as them?

P: Just that, I'm inferior; I'm inadequate. [*core belief*]

5. A fifth way to identify beliefs is to look for common themes in a patient's automatic thoughts across situations. The therapist can ask an insightful patient whether she can identify a recurrent theme or he can hypothesize a belief and ask the patient to reflect on its validity:

T: Sally, in a number of situations you seem to have the thought, "I can't do it," or "It's too hard," or "I won't be able to get it done." I wonder if you have a belief that you are somehow incompetent or inadequate?

P: Yes, I think I do. I do think I'm inadequate.

6. A sixth way to identify beliefs is to ask the patient directly. Some patients are able to articulate their beliefs fairly easily.

T: Sally, what is your belief about asking for help?

P: Oh, asking for help is a sign of weakness.

7. Finally, a patient may be asked to complete a belief questionnaire such as the Dysfunctional Attitude Scale (Weissman & Beck, 1978). Careful review of items that are very strongly endorsed can highlight problematic beliefs. The use of such questionnaires is a useful adjunct to the techniques described above.

To summarize, the therapist can identify beliefs, both intermediate and core beliefs, in a number of ways:

- Looking for the expression of a belief in an automatic thought.
- Providing the conditional clause ("If . . .) of an assumption and asking the patient to complete it.
- Directly eliciting a rule.
- Using the downward arrow technique.
- Recognizing a common theme among automatic thoughts.
- Asking the patient what she thinks her belief is.
- Reviewing the patient's belief questionnaire.

Deciding Whether to Modify a Belief

Having identified a belief, the therapist determines whether the intermediate belief is central or more peripheral. Generally, in order to conduct therapy as efficiently as possible, he focuses on the most important intermediate beliefs (Safran, Vallis, Segal, & Shaw, 1986). The therapist's time and effort can be wasted by working on dysfunctional beliefs that are tangential or by working on a belief that the patient believes only slightly.

T: It sounds as if you believe if people don't accept you, then you're inferior.

P: I guess.

T: How much do you believe that?

P: Not that much, maybe 20%.

T: It doesn't sound as if we have to work on that belief, then. How about if we get back to the problem we were discussing before?

Having identified an important intermediate belief, the therapist decides whether he will make the belief explicit to the patient and, if so, whether he will merely identify the belief as one to be worked on in the future or whether they will work on it at the present time. To help him decide among these options, the therapist asks himself:

- What is the belief?
- How strongly does the patient believe it?
- If strongly, how broadly does it affect her life? How strongly does it affect her life?
- If strongly, should I work on it now? Is the patient ready to work on it? Is it likely she will be able to evaluate it with sufficient objectivity at this point? Do we have enough time in the session today to begin work on it? Does it fit into the items left on our agenda or will the patient be amenable to postponing discussion of our agenda item to make time for us to explore this belief?

Generally the therapist refrains from belief modification until the patient has learned the tools to identify and modify her automatic thoughts and has gained some symptom relief. Belief modification is relatively easy with some patients and much more difficult with others. Modification of intermediate beliefs is generally accomplished before modification of core beliefs as the latter may be quite rigid.

Educating Patients about Beliefs

Having identified an important belief and having checked that the patient believes it strongly, the therapist may decide to educate the patient about the nature of beliefs in general, using a specific belief as an example. He stresses that there are a range of potential beliefs that the patient could adopt and that beliefs are learned, not innate, and so can be revised.

T: Okay, so we've identified some of your beliefs: "It's terrible to do a mediocre job." "I have to do everything great." "If I do less than my best, I'm a failure." Where do you think you learned these ideas?

P: Growing up, I guess.

T: Does everyone have these same beliefs?

P: No. Some people don't seem to care.

T: Can you think of someone specifically who seems to have different beliefs?

P: Well, my cousin Emily, for one.

T: What belief does she have?

P: I think she thinks it's okay to be mediocre. She's more interested in having a good time.

T: So she learned different beliefs?

P: I guess so.

T: Well, the bad news is that you currently have a set of beliefs which aren't bringing you much satisfaction, right? The good news is that since you *learned* this current set of beliefs, you can unlearn them and learn others—maybe not as extreme as Emily's, but somewhere in between hers and yours. How does that sound?

P: Good.

Changing Rules and Attitudes into Assumption Form

It is often easier for patients to see the distortion in and test an intermediate belief that is in the form of an assumption rather than a rule or an attitude. Having identified a rule or an attitude, the therapist uses the downward arrow technique to ascertain its meaning.

T: So you believe pretty strongly that you should do things yourself [*rule*] and that it's terrible to ask for help [*attitude*]. What does it mean to you to ask for help, for example with your schoolwork, instead of doing it yourself?

P: It means I'm inadequate.

T: How much do you believe this idea right now, "If I ask for help, I'm inadequate?"

Logical evaluation of this conditional assumption through questioning or other methods often creates greater cognitive dissonance than does evaluation of the rule or attitude. It is easier for Sally to recognize the distortion and/or dysfunctionality in the assumption, "If I ask for help, it means I'm incompetent," than in her rule, "I shouldn't ask for help."

Examining Advantages and Disadvantages of Beliefs

Often it is useful for patients to examine the advantages and disadvantages of continuing to hold a given belief. The therapist then strives to minimize or undermine the advantages and emphasize and reinforce the disadvantages. (A similar process was previously described in the section on evaluating the utility of automatic thoughts in Chapter 8, pp. 120–121.)

T: What are the *advantages* of believing if you don't do your best then you're a failure?

P: Well, it might make me work harder.

T: It'd be interesting to see if you actually *need* such an extreme belief to

keep you working hard. We'll get back to that idea later. Any other advantages?

P: . . . No, not that I can think of.

T: What are the *disadvantages* of believing you're a failure if you don't do your best?

P: Well, I feel miserable when I don't do well on an exam. . . . I get really nervous before presentations. . . . I don't have as much time to do other things I like because I'm so busy studying—

T: And does it cut some enjoyment out of studying and learning itself?

P: Oh, definitely.

T: Okay, so on one hand, it may or may not actually be true that this belief is the only thing that makes you work hard. On the other hand, this belief about having to live up to your potential makes you feel miserable when you don't do great, makes you more nervous than you have to be before presentations, cuts into your enjoyment of your work and stops you from doing other things you like. Is that right?

P: Yes.

T: Is this an idea, then, that you'd like to change?

Formulating a New Belief

In order to decide which strategies to use to modify a given belief, the therapist clearly formulates to himself a more adaptive belief. He asks himself, "What belief would be more functional for the patient?"

For example, Figure 10.5 lists Sally's current beliefs and the new beliefs the therapist has in mind. Although constructing a new belief is a *collaborative* process, the therapist nevertheless mentally formulates a range of more reasonable beliefs so he can appropriately choose strategies to change the old belief.

To summarize, before the therapist tries to modify a patient's belief, he confirms that it is a central, strongly held belief and he formulates in his own mind a more functional, less rigid belief that is thematically *related* to the dysfunctional one, but which he believes would result in greater satisfaction for the patient. He does not impose this belief on the patient but rather guides the patient in a collaborative manner, using Socratic questioning, to construct an alternative belief. He may, in addition, educate the patient about the nature of beliefs (e.g., that they are ideas, not necessarily truths; that they have been learned and so can be unlearned; that they can be evaluated and modified) and/or help the patient assess the advantages and disadvantages of continuing to hold the belief.

Sally's old beliefs	More functional beliefs
1. If I don't do as well as others, I'm a failure.	If I don't do as well as others, I'm not a failure, just human.
2. If I ask for help, it's a sign of weakness.	If I ask for help when I need it, I'm showing good problem-solving abilities (which is a sign of strength).
3. If I fail at work/school, I'm a failure as a person.	If I fail at work/school, it's not a reflection of my whole self. (My whole self includes how I am as a friend, daughter, sister, relative, citizen, and community member, and my qualities of kindness, sensitivity to others, helpfulness, etc.) Also, failure is not a permanent condition.
4. I should be able to excel at everything I try.	I shouldn't be able to excel at something unless I am gifted in that area (and am willing and able to devote considerable time and effort to it at the expense of other things).
5. I should always work hard and do my best.	I should put in a reasonable amount of effort much of the time.
6. If I don't live up to my potential, I have failed.	If I do less than my best, I have succeeded perhaps 70%, 80%, or 90%; not 0%.
7. If I don't work hard all the time, I'll fail.	If I don't work hard all the time I'll probably do reasonably well and have a more balanced life.

FIGURE 10.5. Formulation of more functional beliefs.

MODIFYING BELIEFS

Listed below are common strategies for modifying both intermediate and core beliefs. (Additional techniques for modifying core beliefs are presented in more detail in the next chapter.) Some beliefs may change easily but many take concerted effort over a period of time. The therapist continues to ask the patient how much she currently believes a given belief (0–100%) in order to gauge whether further work is needed.

It is usually neither possible nor necessarily desirable to reduce the degree of belief to 0%. Knowing when to stop working on a belief is therefore a judgment call. Generally, a belief has been sufficiently attenuated when the patient endorses it less than 30% and when she is likely to continue to modify her dysfunctional behavior despite still holding onto a remnant of the belief.

It is advisable for patients to keep track of the beliefs they have explored in their therapy notes. A useful format includes the dysfunc-

tional belief, the new, more functional belief, and the strength of each belief, expressed in a percentage, as in the following example:

Old belief: If I don't achieve highly, I'm a failure. (55%)
New belief: I'm only an overall failure if I acutally fail at almost everything. (80%)

A typical homework assignment is to read and rerate daily how strongly the patient endorses both beliefs each day.

Some of the strategies used to modify beliefs are the same as those used to modify automatic thoughts, but there are additional techniques as well, including:

1. Socratic questioning
2. Behavioral experiments
3. Cognitive continuum
4. Rational-emotional role-plays
5. Using others as a reference point
6. Acting "as if"
7. Self-disclosure

Socratic Questioning to Modify Beliefs

As illustrated in the next transcript, the therapist uses the same kinds of questions to examine Sally's belief that he used in evaluating her automatic thoughts. Even when he identifies a general belief, he helps her evaluate it in the context of specific situations. This specifity helps make the evaluation more concrete and meaningful, and less abstract and intellectual.

T: (*Summarizing what they learned from the just completed downward arrow technique.*) Okay, so you believe about 90% that if you ask for help, it means you're inadequate. Is that right?

P: Yes.

T: Could there be another way of viewing asking for help?

P: I'm not sure.

T: Take therapy, for example. Are you inadequate because you came for help here?

P: A little, maybe.

T: Hmmm. That's interesting to me because I usually view it in the opposite way. Is it possible it's actually a sign of strength and adequacy that you came to therapy? Because what would have happened if you hadn't?

P: I might still be pulling the covers over my head, not going to class.

T: Are you suggesting that asking for appropriate help when you have an illness like depression is a more adequate thing to do than remaining depressed?

P: Yeah . . . I guess so.

T: Well, you tell me. Let's say we have two depressed college students. One seeks treatment and the other doesn't but continues to have depressive symptoms. Which do you consider more adequate?

P: Well, the one who goes for help.

T: Now how about another situation you've mentioned—your volunteer job. Again, we have two college students, this is their first tutoring experience; they are unsure of what to do because they've never done it before. One seeks help, the other doesn't, but continues to struggle. Who's the more adequate?

P: (*Hesitantly.*) The one who goes for help?

T: Are you sure?

P: (*Thinks for a moment.*) Yeah. It's not a sign of adequacy to just struggle if you could get help and do better.

T: How much do you believe that?

P: Pretty much: 80%.

T: And how do these two situations—therapy and help in tutoring—apply to you?

P: I guess they do.

T: Let's have you write something down about this. . . . Let's call the first idea "old belief"—now what did you say?

P: If I ask for help, I'm inadequate.

T: And let's see, you believed it 90% before. Put "90%" next to it. And how much do you believe it now? . . . The same amount? More? Less?

P: Less. Maybe 40%.

T: Okay, write "40%" next to the "90%."

P: (*Does so.*)

T: Now, write "new belief." How would you put that?

P: If I ask for help, I'm not inadequate?

T: You could put that. Or how about, "If I ask for help when it's reasonable, it's a sign of adequacy."

P: Okay. (*Writes that.*)

T: How much do you believe the new belief now?

P: A lot. . . . (*Reads and ponders the new belief.*) Maybe 70 to 80%. (*Writes that down.*)

T: Okay, Sally, we'll be coming back to these beliefs again. How about for homework this week if you do two things? One is to read these beliefs every day and rate how much you believe them—actually write down the percentage next to the beliefs themselves.

P: Okay.

T: Writing down how much you believe them will make you really think about them. That's why I didn't say just read them.

P: Okay. (*Writes down the assignment.*)

T: Second, could you be on the lookout for other situations this week where you *could* reasonably ask for help? That is, let's imagine that you believe the new belief 100%, that asking for reasonable help *is* a sign of adequacy. When during this coming week might you ask for help? Jot down those situations.

P: Okay.

In the previous segment, the therapist uses Socratic questioning in the context of specific situations to help Sally evaluate an intermediate belief. He judges that the standard questions of examining the evidence and evaluating outcomes will be less effective than leading Sally to develop an alternative viewpoint. His questions are much more persuasive and less evenhanded than when he helps her evaluate more malleable cognitions at the automatic thought level. A follow-up homework assignment is designed to have her continue to reflect daily on both the dysfunctional assumption and the new belief.

Behavioral Experiments to Test Beliefs

As with automatic thoughts, the therapist can help the patient devise a behavioral test to evaluate the validity of a belief (see also Chapter 12, pp. 197–200). Behavioral experiments, properly designed and carried out, can modify a patient's beliefs more powerfully than verbal techniques in the office.

T: Okay, Sally, we've identified another belief: "If I ask for help, others will belittle me," and you believe that 60%. Of course, I haven't actually belittled you, have I?

P: No, of course not. But that's your job, to help people.

T: True, but it would be useful to find out if other people, in general, are more like me or not. How could you find out?

P: Ask other people for help, I guess.

T: Okay, whom could you ask and for what kind of help?

P: Ummm. I'm not sure.

T: How about if we make a list of some of the possibilities? I'll go first; maybe that'll help jog some of your ideas. After we have a list, you can decide whom you'd like to test this idea with.

P: Okay.

T: Could you ask your roommate?

P: Yeah, actually I already do. And I could ask my resident adviser for help with something.

T: Good. How about your academic adviser?

P: Uh huh. I could also ask my brother. No. I won't ask my roommate or my brother. I know they wouldn't belittle me.

T: Oh, so you know already there are some exceptions?

P: Yes. But I guess I could go to my adviser or my teaching assistants.

T: What could you ask for help with?

P: Well, the teaching assistants . . . I could ask questions about the papers I have due or about the readings. The resident adviser, I don't know. My academic adviser . . . I would feel a little funny going to her. I don't really even know what I want to major in.

T: That would be an interesting experiment—going for help in deciding a major to the person whose job it is to help students make those kinds of decisions.

P: True—

T: So you might kill two birds with one stone—testing the belief that you'll be belittled *and* getting some guidance for a real-life problem you have.

P: I guess I could.

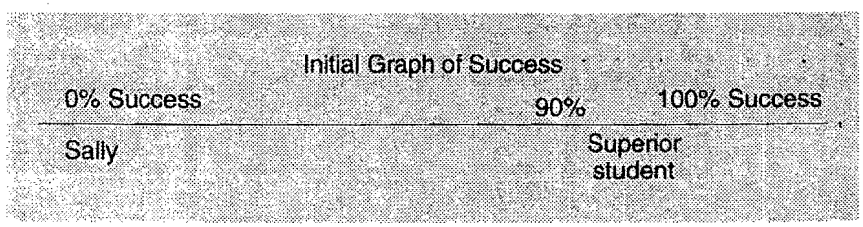
T: Good. So would you like to test the belief, "If I ask others for help, they'll belittle me?" How would you like to do that this week?

In the previous segment, the therapist suggests a behavioral experiment to test a belief. Had he sensed hesitation on the patient's part, he would probably ask her how likely she was to do the experiment and what practical problems or thoughts might get in her way. He might also have her do covert rehearsal (see Chapter 14, pp. 257–259) to increase the likelihood of her following through. In addition, if he judged that there was the possibility of others' belittling Sally, he might have discussed in advance what such belittling would mean to her and how she could cope if the belittling did occur. Also, he might have asked Sally for a description of belittling to ensure that she would not inaccurately perceive others' behavior as belittling when they did not intend it to be.

Cognitive Continuum to Modify Beliefs

This technique is useful to modify both automatic thoughts and beliefs that reflect polarized thinking (i.e., when the patient sees something in all-or-nothing terms). Sally, for example, believed that if she was not a superior student, she was a failure. Building a cognitive continuum for the concept in question facilitates the patient's recognition of the middle ground, as the following transcript illustrates:

T: Okay, you believe pretty strongly that if you're not a superior student, you're a failure. Let's see what that looks like graphically. (*Draws a number line.*)



T: Now, where does the superior student go?

P: Up here. I guess 90–100%.

T: Okay. And, you're a failure. Are you at 0% success then?

P: I guess.

T: Are you also saying everything from 90% down equals a failure?

P: Maybe not.

T: Okay, where does failure start?

P: Around 50%, I guess.

T: 50%? Then, everyone who falls below 50% is a failure?

P: I'm not sure.

T: Now, is there anyone else who more realistically belongs at 0% than you?

P: Ummm . . . Maybe this guy, Jack, who's in my economics class. I know he's doing worse than I am.

T: Okay. We'll put Jack at 0%. But, I wonder if there is anyone who's doing even worse than Jack?

P: Probably.

T: Is it conceivable that there is someone who is failing every test, every paper?

P: Yeah.

T: Okay, now if we put that person at 0%, a real failure, where does that put Jack? Where does that put you?

P: Probably Jack's at 30%. And I'm at 50%.

T: Now, how about a person who is failing everything but he isn't even showing up at any classes or doing any of the reading or turning in any papers?

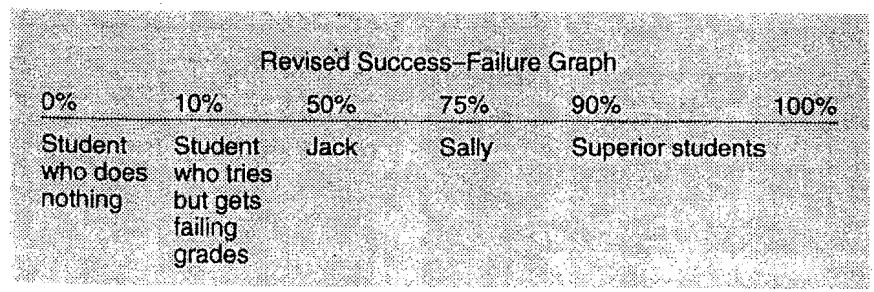
P: I guess *he* would be at 0%.

T: Where does that put the student who is at least trying but not passing?

P: I guess he would be at 10%.

T: Where does that put you and Jack?

P: Jack goes to about 50%; I guess I'm at 75%.



T: How about for homework if you see whether even 75% is accurate? Even if it is for this school, perhaps for schools and students in general, you would rank higher. In any case, how accurate is it to call someone a failure who is at the 75% mark?

P: Not very.

T: Maybe the *worst* thing you can say is that she is 75% successful.

P: Yeah. (*Brightens visibly.*)

T: Okay, to get back to your original idea, how much do you believe now that if you are not a superior student, you are a failure?

P: Not as much. Maybe 25%.

T: Good!

The cognitive continuum technique is often useful when the patient is displaying dichotomous thinking. As with most techniques, the therapist may directly teach the patient how to employ the technique herself so she can use it when it is applicable.

T: Sally, let's review what we did here. We identified an all-or-nothing error in your thinking. Then we drew a number line to see whether there were really only two categories—success and failure—or whether it's more accurate to consider *degrees* of success. Can you think of anything else that you see in only two categories and that distresses you?

Rational–Emotional Role-Play

This technique, also called point-counterpoint (Young, 1990), is usually employed after the therapist has tried other techniques such as those described in this chapter. It is particularly useful when a patient says that *intellectually* she can see that a belief is dysfunctional but that *emotionally* or in her gut it still "feels" true. The therapist first provides a rationale for asking the patient to play the "emotional" part of her mind that strongly endorses the dysfunctional belief, while he, the therapist, plays the "rational" part. In the second segment they switch roles. Note in both segments patient and therapist speak as the patient; that is, they both use the word "I."

T: It sounds from what you're saying that you still believe to some extent that you're inadequate because you didn't do as well in school last semester as you would have liked.

P: Yeah.

T: I'd like to get a better sense of what evidence you still have that supports your belief.

P: Okay.

T: What I'd like to do is a role-play. I'll play the "rational" part of your mind which intellectually knows that just because you didn't get all A's

doesn't mean you are inadequate through and through. I'd like you to play the "emotional" part of your mind, that voice from your gut that still really believes you *are* inadequate. I want you to argue against me as hard as you can so I can really see what's maintaining the belief. Okay?

P: Yeah.

T: Okay, you start. Say "I'm inadequate because I didn't get all A's."

P: I'm inadequate because I didn't get all A's.

T: No, I'm not. I have a *belief* that I'm inadequate, but I am reasonably adequate most of the time.

P: No, I'm not. If I were truly adequate, I *would* have gotten all A's last semester.

T: That's not true. Adequacy doesn't equal total academic perfection. If that were true, only 1% of the students in the world would be adequate and everyone else would be inadequate.

P: Well, I got a C in chemistry. That *proves* I'm inadequate.

T: That's not right either. If I had flunked the course *perhaps* it might be reasonable to say I wasn't adequate in chemistry, but it doesn't make me inadequate in *everything*. Besides, maybe I really am adequate in chemistry, but I flunked for other reasons; for example, I was depressed and couldn't concentrate on my studying.

P: But a truly adequate person wouldn't become depressed in the first place.

T: Actually, even truly adequate people get depressed. There isn't a connection there. And when truly adequate people get depressed, their concentration and motivation definitely suffer, and they don't perform as well as usual. But that doesn't mean they are inadequate through and through.

P: I guess that's true. They're just depressed.

T: You're right, but you're out of role. Any more evidence that you're completely inadequate?

P: (*Thinks for a moment.*) No, I guess not.

T: Well, how about if we trade roles now and this time you be the "rational" part who disputes my "emotional" part? And I'll use your same arguments.

P: Okay.

T: I'll start. "I'm inadequate because I don't get all A's."

Switching roles provides the patient with an opportunity to voice the rational arguments just modeled by the therapist. The therapist uses the same emotional reasoning that the patient used and tries to use the same words, as well. Using the patient's own words and not introducing new material helps the patient to respond more precisely to her specific concerns.

If the patient is unable to formulate a response while in the rational role, patient and therapist can either switch roles temporarily or they can both come out of role to discuss the stuck point. As with any belief modification technique, the therapist evaluates both its effectiveness and the degree to which the patient needs further work on the belief. He does so by asking the patient to rate how much she believes the belief after the intervention.

Many patients find the rational–emotional role-play useful. A few, however, feel uncomfortable doing it. As with any intervention, the decision to use it should be collaborative. Because it is a more argumentative technique than most, the therapist takes care to avoid the patient's perceiving it as confrontational by watching for her nonverbal reactions during the role-play. He also takes care to make sure that the patient does not feel criticized or denigrated by his elevation of the rational part of her mind over the emotional part.

Using Other People as a Reference Point in Belief Modification

When patients consider *other* people's beliefs, they often get psychological distance from their own dysfunctional beliefs. They begin to see an inconsistency between what they believe is true or right for themselves and what they more objectively believe is true about other people. Following are four examples of using other people as a reference point to gain distance.

Example 1

T: Sally, you mentioned last week that you think your cousin Emily has a different belief about having to do everything great.

P: Yeah.

T: Could you put what you think her belief is into words?

P: She thinks she doesn't have to do great. She's an okay person, no matter what.

T: Do you believe she's right? That she doesn't have to do great to be an okay person?

P: Oh, yes.

T: Do you see her as inadequate, through and through?

P: Oh, no. She might not get good grades but she's certainly adequate.

T: I wonder if Emily's belief could apply to you: "If I don't do great, I'm still an okay, adequate person."

P: Hmmm.

T: Is there something different about Emily that makes her okay and adequate no matter how well or poorly she does, but not you?

P: (*Thinks for a moment.*) No. I don't think so. I guess I hadn't really thought of it that way.

T: How much do you believe right now, "If I don't do great, I'm inadequate"?

P: Less, maybe 60%.

T: And how much do you believe this new belief, "If I don't do great, I'm still an okay, adequate person"?

P: More than before. Maybe 70%.

T: Good. How about if we have you write down the new belief, and start making a list of the evidence that supports this new belief.

At this point, the therapist might introduce the Core Belief Worksheet, described in Chapter 11, which can be used for both core beliefs and intermediate beliefs.

Example 2

Another way to help the patient modify an intermediate or core belief is to have her identify someone else who plainly seems to have the same dysfunctional belief. Sometimes the patient can see the distortion in someone else's belief and apply this insight to herself. This technique is analogous to the Dysfunctional Thought Record question: "If [friend's name] was in this situation and had this thought, what would I tell [him/her]?"

T: Do you know anyone else who you think has your same belief, "If I don't work hard, I'll fail"?

P: I'm sure my friend, Donna, from high school, believes that. She's always studying, night and day.

T: How accurate do you think that belief is for her?

P: Oh, not at all. She's very bright. She probably couldn't fail if she tried.

T: Is it possible that she might consider anything less than an A a failure, too?

P: Yes, I know she does.

T: And do you agree with her, that if she gets a B, then she's failed?

P: No, of course not.

T: How would you view it?

P: She got a B. An okay grade, not the best, but not a *failure*.

T: What belief would you like her to have?

P: It's good to work hard and try for A's but it's not the end of the world if you don't get them. And it doesn't mean you've failed.

T: How does all this apply to you?

P: Hmmm. I guess it's the same.

T: Could you spell out what's the same?

P: That if I don't get all A's, I haven't failed. I still think I should work hard, though.

T: Sure. It's reasonable to want to work hard and do well. The unreasonable part is to believe you've failed if you haven't done perfectly. Do you agree with that?

Example 3

The therapist could also do a role-play with the patient in which he instructs her to convince another person that the belief they both share is invalid for the other person.

T: Sally, you say you think your roommate also believes that she shouldn't go to a professor for help because he might think she's unprepared or not smart enough?

P: Yes.

T: Do you agree with her?

P: No. She's probably wrong. But even if he is critical, it doesn't mean he's right.

T: Could we try to role-play this? I'll be your roommate; you give me advice. Don't let me get away with any distorted thinking.

P: Okay.

T: I'll start. Sally, I don't understand this stuff. What should I do?

P: Go to the professor.

T: Oh, I couldn't do that. He'll think I'm dumb. He'll think I'm wasting his time.

P: Hey, it's his job to help students.

T: But he probably doesn't like students bothering him.

P: Tough, that's what he's getting paid for. Anyway, good professors like to help students. If he's impatient, that says something about him, not about you.

T: But even if he doesn't mind helping, he'll find out how confused I am.

P: That's okay. He won't expect you to know everything. That's why you're coming to him.

T: What if he thinks I'm dumb?

P: First of all, you wouldn't be here if you were dumb. Second, if he does expect you to know everything, he's just wrong. If you did know everything, you wouldn't be taking his course.

T: I still think I shouldn't go.

P: No, you should. Don't let his snobby attitude make you feel like you're imposing or you're dumb. You're not.

T: Okay. I'm convinced. Out of role, how does what you told your roommate apply to you?

Example 4

Finally, many patients can get distance from a belief by using their own children as a reference point or by imagining that they have children.

T: Sally, so you believe 80% that if you don't do as well as everyone else then you've failed?

P: Yeah.

T: I wonder, can you imagine that you have a daughter? She's 10 years old and in fifth grade, and she comes home one day very, very upset because her friends got A's on a test and she got a C. Would you want her to believe that she's a failure?

P: No, of course not.

T: Why not? . . . What would you like her to believe? (*The patient responds.*) Now how does what you've just said apply to you?

Acting "As If"

Changes in belief often lead to corresponding changes in behavior. And changes in behavior, in turn, often lead to corresponding changes in belief. If a belief is fairly weak, the patient may be able to change a target behavior easily and quickly, without much cognitive intervention. Many beliefs do require some modification before the patient is willing to change behaviorally. However, frequently only *some* belief modification, not complete belief change, is needed. And once the patient begins to change her behavior, the belief itself becomes somewhat more attenuated (which makes it easier to continue the new behavior, which further attenuates the belief, and so on, in a positive upward spiral).

T: Okay, Sally, how much do you believe *now* that it's a sign of weakness to ask for help?

P: Not as much. Maybe 50%.

T: That's a good drop. Would it be to your benefit to act as if you don't believe it at all?

P: I'm not sure what you mean.

T: If you didn't believe it was a sign of weakness, in fact, if you believed it was *good* to ask for help, what might you do this week?

P: Well, we've been talking about my going to see the teaching assistant. I guess if I really believed it was *good* to ask for help, I would go.

T: Anything else?

P: Well, I might try to find a tutor for economics. . . . I might ask to borrow notes from the guy down the hall–

T: Hey, that's good. And what positive things could happen if you did some of these things?

P: (*Laughs.*) I could get the help that I need.

T: Do you think you're ready this week to act as if you believe it's a good thing to ask for help?

P: Maybe.

T: Okay, in a minute, we'll find out what thoughts might get in the way, but first, how about if you jot down those ideas you had. And do you want to write down this technique to get you going? Act *as if* you believe the new belief, even if you don't totally.

This acting "as if" technique is equally applicable to core beliefs as were the preceding intermediate belief modification techniques.

Using Self-Disclosure to Modify Beliefs

Appropriate and judicious self-disclosure by the therapist can help some patients view their problems or beliefs in a different way. The self-disclosure, of course, should be genuine and relevant.

T: You know, Sally, when I was in college, I had some trouble going to professors for help because I thought I'd be showing my ignorance, too. And to tell you the truth, the few times I did end up doing it anyway, I had mixed results. Sometimes the professors were really nice and helpful. But a couple of times, they were pretty brusque, just told me to reread a chapter or something. The point is, just because I didn't understand something didn't mean I was inadequate. And the professors who were brusque—well, I think that said a lot more about them than about me. What do you think?

In summary, the therapist helps the patient to *identify* intermediate beliefs by recognizing when a belief has been expressed as an automatic thought, by providing part of an assumption, by directly eliciting a rule or an attitude, by using the downward arrow technique, by looking for common themes among the patient's automatic thoughts, and/or by reviewing a belief questionnaire completed by the patient. The therapist next determines how *important* the belief is by ascertaining how strongly the patient believes it and how broadly and strongly it affects her functioning. Then he decides whether to begin the task of *modifying* it in the current session or to wait for future sessions. When beginning belief modification work, the therapist *educates* the patient about the nature of beliefs, *changes rules and attitudes into assumption form*, and explores the *advantages and disadvantages* of a given belief. He mentally *formulates a new, more functional belief* and guides the patient toward its adoption through many *belief modification techniques*, including Socratic questioning, behavioral experiments, cognitive continua, rational–emotional role-plays, using others as a reference point, acting "as if," and self-disclosure. These techniques are often somewhat more persuasive than standard Socratic questioning of automatic thoughts because the beliefs are much more rigidly held. These same techniques can also be used to modify core beliefs.

Chapter 11

CORE BELIEFS

Core beliefs, as described in Chapter 2, are one's most central ideas about the self. Some authors refer to these beliefs as schemas. Beck (1964) differentiates the two by suggesting that schemas are cognitive structures within the mind, the specific content of which are core beliefs. Further, he theorizes that negative core beliefs essentially fall into two broad categories: those associated with helplessness and those associated with unlovability (Beck, in press). Some patients have core beliefs that fall in one category; others have core beliefs in both categories.

These beliefs develop in childhood as the child interacts with significant others and encounters a series of situations. For most of their lives, most people may maintain relatively positive core beliefs (e.g., "I am substantially in control"; "I can do most things competently"; "I am a functional human being"; "I am likable"; "I am worthwhile"). Negative core beliefs may surface only during times of psychological distress. (Some personality disorder patients, however, may have almost continuously activated negative core beliefs.) Often, unlike automatic thoughts, the core belief that patients "know" to be true about themselves is not fully articulated until the therapist peels back the layers by continuing to ask for the meaning of the patient's thoughts as in the downward arrow exercise mentioned earlier.

It is important to note that patients may also have negative core beliefs about other people and their worlds: "Other people are untrustworthy"; "Other people will hurt me"; "The world is a rotten place." Fixed, overgeneralized ideas such as these often need to be evaluated and modified in addition to core beliefs about the self.

Sally, as described earlier, did see herself as competent and likable most of the time. It was not until she became depressed that a latent belief, "I'm inadequate," became activated. Her therapist determined that they

should work directly on modifying this core belief, not only to alleviate her current depression but also to prevent or reduce the severity of future episodes.

Negative core beliefs are usually global, overgeneralized, and absolute. When a core belief is activated, the patient is easily able to process information that supports it, but she often fails to recognize or distorts information that is contrary to it. Sally, for example, basically saw herself in a realistically positive, balanced way until she became depressed. Then she believed almost completely that she was inadequate. Any evidence to the contrary, such as her competent performance in some of her classes, was ignored or discounted: "Doing well in English lit doesn't mean I'm adequate; it just comes easily to me." Evidence supporting her belief about inadequacy, however, was readily processed and then overgeneralized: "Getting a C on my economics quiz shows how inadequate I am."

As emphasized throughout this volume, the therapist begins to formulate a conceptualization (including core beliefs) from the beginning of therapy. He does so mentally at first or privately on paper. At some point in therapy he shares his conceptualization with the patient, presenting it as a hypothesis and asking if it "rings true" to her.

In order to decide when and how much of his conceptualization to share with a patient, the therapist considers the following: how strong their therapeutic alliance is, how strongly the patient believes the cognitive model, how activated her core beliefs are in session, how much insight she already has, how concrete her thinking is, and so forth. So, although the therapist has been conceptualizing the patient's core beliefs from the beginning, he carefully chooses when and how he will share his understanding with the patient. Likewise, he chooses when and how he will try to start modifying the core belief. Therapists generally teach patients to learn the tools of identifying, evaluating, and adaptively responding to automatic thoughts and intermediate beliefs before using the same tools for core beliefs.

At times, however, the therapist and patient unwittingly try to evaluate a core belief early in therapy because it has been expressed as an automatic thought. Such evaluation often has little effect. In another case, the therapist may intentionally test the modifiability of a core belief even before they have done much work at the automatic thought and intermediate belief level.

The degree of difficulty in identifying and modifying core beliefs varies from patient to patient. In general, patients who are in significant emotional distress are more easily able than others to express their core beliefs (because the beliefs are activated in session). And, in general, it is far easier to modify the negative core beliefs of Axis I patients whose counterbalancing positive core beliefs have been activated throughout

much of their lives. Negative core beliefs of personality disorder patients are usually much more difficult to modify (Beck et al., 1990; Young, 1990) because they typically have fewer positive core beliefs and they have developed a multitude of negative core beliefs that interconnect, supporting each other like a network.

In identifying and modifying core beliefs, the therapist does the following during the course of therapy (each step is described later in this chapter):

1. Mentally hypothesizes from which category of core belief ("helplessness" or "unlovability") specific automatic thoughts appear to have arisen.
2. Specifies the core belief (to himself) using the same techniques he uses to identify the patient's intermediate beliefs.
3. Presents his hypothesis about the core belief(s) to the patient, asking for confirmation or disconfirmation; refines his hypothesis about the core belief as the patient provides additional data about current and childhood situations and her reactions to them.
4. Educates the patient about core beliefs in general and about her specific core belief; guides the patient in monitoring the operation of the core belief in the present.
5. Begins to evaluate and modify the core belief with the patient; assists the patient in specifying a new, more adaptive core belief; examines the childhood origin of the core belief, its maintenance through the years, and its contribution to the patient's present difficulties; continues to monitor the activation of the core belief in the present; uses "rational" methods to decrease the strength of the old core belief and to increase the strength of the new core belief; and uses experiential or "emotional" techniques with heightened affect when the patient no longer strongly believes a core belief "rationally" or "intellectually" but still believes it "emotionally."

CATEGORIZING CORE BELIEFS

As mentioned previously, patients' core beliefs may be categorized in the helplessness realm, the unlovability realm, or both. Whenever the patient presents data (problems, automatic thoughts, emotions, behavior, history), the therapist "listens" for the category of core belief that seems to have been activated. For example, when Sally expresses thoughts about her work being too hard, about her inability to concentrate, and about her fears of failing, her therapist hypothesizes that a core belief in the helpless category was operating. (Another patient consistently expresses thoughts of others not caring about her and fears that she is too different

from others to sustain a future relationship. This patient has a core belief in the category of unlovability.)

The top of Figure 11.1 lists typical core beliefs in the helpless category. Themes include being personally helpless (powerless, vulnerable, trapped, out of control, weak, needy) and not measuring up in terms of achievement (failure, inferior, not good enough, loser, disrespected).

The bottom of Figure 11.1 lists typical core beliefs in the unlovable category. Themes include being unworthy, undesirable, and not measuring up (not in achievement but rather in being defective in some way so as to preclude gaining the sustained love and caring of others).

Sometimes it is clear in which category a given core belief belongs, especially when the patient actually uses words such as "I am helpless," or "I am unlovable." At other times, the therapist may not know initially which category of core belief has been activated. For example, a depressed patient says, "I'm not good enough." The therapist then needs

Helpless core beliefs	
I am helpless.	I am inadequate.
I am powerless.	I am ineffective.
I am out of control.	I am incompetent.
I am weak.	I am a failure.
I am vulnerable.	I am disrespected.
I am needy.	I am defective (i.e., I do not measure up to others).
I am trapped.	I am not good enough (in terms of achievement).
Unlovable core beliefs	
I am unlovable.	I am unworthy.
I am unlikable.	I am different.
I am undesirable.	I am defective (i.e., so others will not love me).
I am unattractive.	I am not good enough (to be loved by others).
I am unwanted.	I am bound to be rejected.
I am uncared for.	I am bound to be abandoned.
I am bad.	I am bound to be alone.

FIGURE 11.1. Categories of core beliefs. Copyright 1995 by Judith S. Beck, Ph.D.

to ascertain the meaning of the thought to determine whether the patient believes she is not good enough to achieve or to gain respect (helpless category) or if she is not good enough for others to love her (unlovable category).

To summarize, the therapist begins mentally to formulate a hypothesis about a patient's core beliefs whenever the patient provides data in the form of her reactions to situations (automatic thoughts and their associated meanings, emotions, and behaviors). He first makes a gross distinction (to himself) between cognitions that seem to fall in the helpless category and those in the unlovable category.

IDENTIFYING CORE BELIEFS

The therapist uses the same techniques to identify the patient's specific core belief that he used to identify her intermediate beliefs (see Chapter 10). In addition to the *downward arrow* technique, he looks for *central themes in the patient's automatic thoughts*, watches for *core beliefs expressed as automatic thoughts*, and *directly elicits* the core belief.

The therapist often identifies a core belief early in therapy in order to conceptualize the patient and plan therapy. He may gather data about and even try to help the patient evaluate the core belief early in therapy. In many cases, such early evaluation is ineffective but helps the therapist test the strength, breadth, and modifiability of the core belief.

THERAPIST: What went through your mind when you couldn't finish the statistics assignment?

PATIENT: I can't do anything right. I'll never be able to make it here.

T: And if that's true, that you can't do anything right and you can't make it here, what does that mean? [*downward arrow technique*]

P: I'm hopeless. I'm so inadequate. [*core belief*]

T: How much do you believe you're inadequate?

P: Oh, 100%.

T: And how inadequate are you, a little, a lot?

P: Completely. I'm completely inadequate.

T: In every way?

P: Just about.

T: Any evidence that you're not inadequate?

P: No. . . . No, I don't think so.

T: Did you say you're doing okay in your other courses?

P: Yeah, but not as well as I should be.

T: Does the fact that you're doing okay in them contradict this idea that you're inadequate?

P: No, if I were really adequate, I'd be doing much better.

T: How about other areas of your life—managing your apartment, managing your finances, taking care of yourself . . . ?

P: I'm doing pretty badly at them, too.

T: So this idea that you're inadequate extends to other things, too?

P: Just about everything.

T: Okay, I can see how strongly you believe this idea now. We'll come back to it another time.

Here the therapist uses the downward arrow technique to identify an idea he conceptualizes as a core belief. He gently tests its strength, breadth, and modifiability and decides not to pursue further evaluation at this time. However, he labels it as an "idea" (implying it is not necessarily a truth) and marks it as a future topic.

PRESENTING CORE BELIEFS

When the therapist believes he has collected sufficient data to hypothesize about the core belief, and when he believes the patient will be sufficiently receptive, he tentatively poses his conceptualization to her.

T: Sally, we've talked about a number of different problems in the past few weeks—your schoolwork, decisions about how to spend the summer, your volunteer job. It sounds as if behind all these problems is an idea you have about yourself, that you're inadequate. Is that right?

P: Yeah. I think so.

Or he might review with the patient a number of related automatic thoughts she had in a variety of situations, and then ask the patient to draw a conclusion as to an underlying theme ("Sally, do you see a common theme in these automatic thoughts?").

With certain patients the therapist uses the Case Conceptualization Diagram (see Chapter 10, Figure 10.1) early in therapy. Either with or without the diagram, he might briefly explore childhood precursors.

T: Do you remember feeling inadequate like this at other times in your life, too? As a child?

P: Yeah, a lot. I remember never being able to do things my brother could.

T: Can you give me some examples?

Obtaining historical data aids the therapist at a later date when he hypothesizes to the patient how she came to believe a core belief and explains how it could be untrue or mostly untrue even though she currently believes it so strongly.

EDUCATING THE PATIENT ABOUT CORE BELIEFS AND MONITORING THEIR OPERATION

It is important for the patient to understand the following about her core belief:

- That it is an idea, not necessarily a truth.
- That she can believe it quite strongly, even "feel" it to be true, and yet have it be mostly or entirely untrue.
- That, as an idea, it can be tested.
- That it is rooted in childhood events; that it may or may not have been true at the time she first came to believe it.
- That it continues to be maintained through the operation of her schemas, in which she readily recognizes data that support the core belief while ignoring or discounting data to the contrary.
- That she and the therapist working together can use a variety of strategies over time to change this idea so that she can view herself in a more realistic way.

In the transcript that follows, the therapist educates Sally about her core belief. (She had previously confirmed the conceptualization he had presented.)

T: Sally, does this [her automatic thought that she will not be able to write her economics paper] sound familiar? Do you think your idea that you're inadequate could be getting in the way?

P: Yeah. I do feel inadequate.

T: Well, Sally, one of two things has been going on. The problem is either you really *are* inadequate, and we'll have to do some work together to make you more adequate . . . or, the problem is that you *believe* you are inadequate; and sometimes, you believe it so strongly that you actually *act* in an inadequate way, like not going to the library to start researching your paper. What do you think?

P: I don't know.

T: Why don't we have you write these two possibilities on paper? This is what I'd like to start doing in therapy, if it is okay with you, seeing which possibility seems more true—that you really *are* inadequate or that you *believe* you're inadequate.

Later in this session or in another session, the therapist explains core beliefs to Sally, in small parts, making sure she understands as he proceeds.

T: This idea, "I'm inadequate," is what we call a core belief. Let me tell you a little bit about core beliefs so you'll understand why they're more difficult to evaluate and respond to. First of all, a core belief is an idea that you may not believe very strongly when you're not depressed. On the other hand, we'd expect you to believe it almost completely when you *are* depressed, even if there's evidence to the contrary. Follow me so far?

P: Yes.

T: When you get depressed, this idea becomes activated. When it's activated, you'll easily notice any evidence that seems to support it and you'll tend to ignore any evidence that contradicts it. It's as if there is a screen around your head. Anything that fits in with the idea that you are inadequate sails straight through the screen and into your head. Any information that contradicts the idea won't fit through the screen and so either you don't notice it, or you change it in some way so it *will* fit through the screen. Do you think you might be screening information like this?

P: I'm not sure.

T: Well, let's see. Looking back at the past few weeks, what evidence is there that you *might* be adequate?

P: Ummm . . . I got an A– on my statistics exam.

T: Good! And did that evidence go right through the screen? Did you tell yourself, "I got an A–; that means I'm smart or adequate or a good student," or anything like that?

P: No. I said, "Well, the exam was easy. I learned some of that stuff last year."

T: Oh, so it looks like the screen *was* operating. Do you see how you discounted information that contradicted your core belief, "I am inadequate"?

P: Hmmm.

T: Can you think of any other examples from this week? Situations where

a reasonable person might think something you did showed you were adequate, even if you didn't?

P: (*Thinks for a moment.*) Well, I helped my roommate figure out how to solve a problem with her father. But, that doesn't count; anyone could have done what I did.

T: Good example. Again, it sounds as if you didn't recognize information that doesn't fit in with "I'm inadequate." I'm going to let you think about how true the idea is that anyone could have done what you did. Maybe this is another instance of not giving yourself credit when another person might have thought it was evidence that you are *not* inadequate.

P: Well, my roommate did think I helped her a lot.

T: Okay, just to summarize, "I'm inadequate" seems to be a core belief which goes back a long time with you and which you believe much more strongly when you're depressed. Can you summarize how it seems to work?

P: Well, you're saying that when I'm depressed, I screen in information that agrees with it and I screen out information that doesn't agree with it.

T: Right. How about for homework this week if you try to notice each day how the screen is operating—jot down information that seems to support the idea that you're inadequate. And here's the harder part. Really hunt for and jot down any information that another person might think contradicts it. Okay?

In the next session, the therapist explains why Sally believes her core belief so strongly and how it could still be untrue.

T: Okay, you did a good job this week noticing how you tend to let in only the negative information which seems to support your idea that you're inadequate. As we predicted, it was much harder to recognize positive information that contradicts your idea.

P: Yeah. I didn't do it very well.

T: Are you feeling inadequate now?

P: (*Laughs.*) Yes. I guess so.

T: Is the screen operating right now? Did you put more emphasis on the part of the homework you didn't do as well and forget about the part you did do well?

P: I guess I did.

T: What do you think is the effect of having a screen like this?

P: Makes me not notice the good things.

T: Right. And, day after day, what happens to this idea, "I'm inadequate"?

P: Gets stronger, I guess.

T: Right. To the point where it "feels" true, even if it's not.

P: Hmmm.

T: Do you see now how the idea that you're inadequate *could* be false even though it feels so true?

P: Well, I can kind of see it intellectually, but I still do *feel* inadequate.

T: That's pretty common. In the next few weeks, we'll keep on evaluating this idea. And then we'll work together on helping the more reasonable, rational part of your mind talk to the more emotional side. Okay?

P: Yeah.

Bibliotherapy can reinforce the important core belief work of therapy. Two books in particular, *Prisoners of Belief* (McKay & Fanning, 1991) and *Reinventing Your Life* (Young & Klosko, 1994), are helpful in this phase of therapy.

MODIFYING CORE BELIEFS AND STRENGTHENING NEW BELIEFS

Having identified the negative core belief, the therapist mentally devises a new, more realistic and functional belief and guides the patient toward it. He may use some of the techniques listed on the left side of Figure 11.2 to start attenuating the old belief. Fairly soon, he and the patient collaboratively develop a new, more adaptive belief. A relatively positive belief is generally easier for a patient to adopt than a belief that is at an extreme.

For example:

Old core belief	New core belief
I'm (completely) unlovable.	I'm generally a likable person.
I'm bad.	I'm a worthwhile person with positive and negative features.
I'm powerless.	I have control over many things.
I'm defective.	I'm normal, with both strengths and weaknesses.

Already described	Additional techniques
Socratic questioning techniques	Core Belief Worksheet
Examining advantages and disadvantages	Extreme contrasts
Rational–emotional role-play	Developing metaphors
Acting "as if"	Historical tests
Behavioral experiments	Restructuring early memories
Cognitive continuum	Coping cards (see Chapter 12)
Self-disclosure	

FIGURE 11.2. Techniques to modify core beliefs.

The Axis I patient may have believed the "new" core belief during much of her life, and thus it is relatively easy to specify. The Axis II patient, in contrast, may have never had a positive core belief. Therefore, the therapist may need to help her develop an alternative positive core belief. Sally's therapist finds it easy to help her put a more positive core belief into words:

T: Sally, we've been talking about this core belief, "I'm inadequate." What do you rationally think a more accurate belief might be?

P: I am adequate?

T: That's good. Or we could work on a new belief that might be easier for you to adopt, say, "I'm adequate in most ways, but I'm only human, too." Which sounds better?

P: The second.

THE CORE BELIEF WORKSHEET

Having identified the old core belief and developed a new one, the therapist may introduce the Core Belief Worksheet (CBW) (see Figure 11.3). As mentioned previously, it is preferable to introduce this tool after the patient has learned that some of her ideas (automatic thoughts) have been inaccurate or distorted in some way. In addition, core belief work is usually started after the patient has successfully learned the process of evaluating and modifying her automatic thoughts, truly understands that she can modify her dysfunctional thinking, and has established a firm therapeutic alliance with her therapist.

CORE BELIEF WORKSHEET

Old core belief: *I'm inadequate*

How much do you believe the old core belief right now?(0–100) 60%

*What's the most you've believed it this week?(0–100) 90%

*What's the least you've believed it this week?(0–100) 60%

New belief: *I'm adequate in most ways (but I'm only human, too).*

How much do you believe the new belief right now?(0–100) 50%

Evidence that contradicts old core belief and supports new belief	Evidence that supports old core belief with reframe
Did good work on literature paper	*Didn't understand econ concept in class BUT I hadn't read about it and I'll probably understand it later. At worst it's an inadequacy but maybe it's actually her fault for not explaining it well enough.*
Asked a question in statistics	
Understand this worksheet	
Got a B on chemistry test	*Didn't go to the teaching assistant for help BUT that doesn't mean I'm inadequate. I was nervous about going because I think I should be able to figure out these things myself and I thought he'd think I was unprepared.*
Made decisions about next year	
Arranged to switch phones, bank accounts, insurance, etc.	*Got a B on my literature paper, BUT it's an okay grade. If I were really inadequate, I wouldn't even be in college.*
Got together all the references I need for econ paper	
Understood most of Chapter 6 in statistics book	
Explained statistics concept to guy down the hall	

*Should situations related to an increase or decrease in the strength of the belief be topics for the agenda?

FIGURE 11.3. Sally's Core Belief Worksheet. Copyright 1993 by Judith S. Beck, Ph.D.

The CBW has two parts: the top part guides the patient to identify and rate her degree of belief in the "old" dysfunctional belief and in the "new," more adaptive belief. Therapist and patient fill out this part together at the beginning of each session following the introduction of the CBW. The bottom part is to be filled out by the patient, both in session and for homework, as she monitors the operation of her beliefs and reframes evidence that seemed to support the old belief.

T: Sally, let me show you a Core Belief Worksheet, which is just an organized way of working on your beliefs. Here, let's write your core belief, "I'm inadequate," at the top. How much do you believe that right now?

P: Maybe 60%.

T: Okay, write "60%" under it. Now, for the next two lines, think about this past week. What's the most and least you've believed it?

P: Most? When I started studying for my statistics exam. Ninety percent, I guess. And least? Now, 60%. (*Writes it down.*)

T: Last week we talked about a more adaptive, not to mention more accurate, belief. Do you remember how we phrased it?

P: Yes. I am adequate in most ways but I am only human, too.

T: Good. Write that under new belief. How much do you believe this new belief today?

P: Maybe . . . 50%.

T: Okay, Sally, we can fill out these ratings every week together at the beginning of our sessions, or you can fill them out just beforehand. I'd like you to keep this sheet in front of you during our sessions to see if the topic we're discussing is relevant to the idea, "I'm inadequate," or not.

P: Okay.

T: Let's start filling out the bottom part now, together, so you can learn how to do it, if that's okay with you. Then, if it's helpful, you can add to it every day.

P: Okay.

T: One more thing. Learning to fill out this sheet takes time and practice, just as it took you a while to get good at the Dysfunctional Thought Record. Okay?

P: Sure.

T: All right. Is it okay if we start with the right side, evidence that you're inadequate?

P: Sure.

T: Okay, think over what you did *today*. What evidence do you have that you're inadequate?

P: Well, I didn't understand a concept my economics professor presented in class today.

T: Okay, write that down on the right side, then put a big "BUT" next to it. . . . Now, let's think if there could be another explanation for why you might not have understood the concept *other* than that you're inadequate.

P: Well, it was the first time she talked about it. And it wasn't in the readings.

T: Good. Now might you be able to grasp it after she has reviewed it, or you've read something about it, or asked someone else to explain it better?

P: Probably.

T: Okay. Now next to the "BUT" you'll write what we call the "reframe"—another, more adaptive way of looking at the evidence. What could you say here?

P: I guess I could say, "But I hadn't read about it, and I'll probably understand it later."

T: Okay, write that down. . . . Now let's see if we can make the reframe even stronger. Would you agree that not understanding a concept at worst means a person has *an* inadequacy, not that she's completely inadequate as a person?

P: Yes, that's true.

T: Is it possible that *many* adequate people don't necessarily grasp concepts at the first presentation?

P: True.

T: I wonder, is it possible that it was actually an inadequacy of the *professor*, because if she had explained it more clearly, more people might have understood it?

P: That's possible.

T: Why don't you take a minute and see if there is anything else you want to add in writing. . . . Okay, let's try the left side now. What evidence

do you have from *today* that you *are* adequate at many things? I'll warn you, this can be hard if your screen is operating.

P: Well, I worked on my literature paper.

T: Good. Write that down. What else?

P: I asked a question in my statistics course.

T: You did! Good. What else?

P: (*No response.*)

T: How about the fact that you seem to grasp how to do this worksheet?

P: I guess so.

T: Okay, how about for homework if you try to add to the bottom of this sheet every day. Can you see that to start, doing the first part of the right side will be easiest, but the second part and the left side will probably be harder?

P: Yeah.

T: So do what you can. It may be that we'll have to work together to do the reframes and look for positive evidence. I'll give you a clue, though. If you have trouble with these two parts, pretend someone else, your roommate, for example, has done exactly what you've done, and see how you'd view her actions. Okay?

P: Sure.

T: Can you think of anything that might get in the way of your doing this assignment this week?

P: No, I'll try it.

T: Good.

Had Sally displayed difficulty in identifying any positive data during the session, her therapist would have postponed this homework assignment, trying different techniques in session first to help her successfully elicit items for the left side. For example, he might use a contrasting technique:

T: How about the fact that you battled your way through the student health system so you would get seen right away? Doesn't that belong on the left side?

P: I don't know. I was just so mad; it was easy.

T: Wait a minute. If you *hadn't* asserted yourself, wouldn't you have put that on the right side as a sign of inadequacy?

P: Probably.

T: So think of it this way. Anything that you would criticize yourself for or put on the right side if you *didn't* do it, probably belongs on the left.

Other ways of having the patient recognize positive data that belong on the left side of the worksheet include:

1. [As in the transcript on p. 180,] asking the patient to think of data that she would say were positive evidence for *another* person: "Sally, can you think of someone else who you consider is adequate in most ways? Who would that be? What have *you* done today that you would say shows that Donna is adequate if *she* had done it?"
2. Asking the patient to think of data that *someone else* would probably say indicate positive evidence for the patient: "Sally, who's someone you think knows you pretty well, whose judgment you trust? What would [this person] say you had done today that's evidence you're adequate?" or "Sally, what have you done today that *I* probably think indicates you're adequate?"
3. Asking the patient to reflect on whether she would discount specific positive evidence if she compared what she did to a hypothetical *negative* model: "Sally, you don't believe that finishing that brief paper is a sign of adequacy. But would a *truly* inadequate person have been able to write it? Would a truly inadequate person even have made it to where you are now?"
4. Asking the patient to fill out the ratings at the top of the CBW (with a previously agreed-on core belief filled in) at the beginning of each session, before setting the agenda. Then the therapist can ask, "When you believed *least* strongly that you were inadequate, what was going on? Is this something we should put on the agenda?" Discussion of these (more positive) situations provides an opportunity to gather or reinforce evidence for the left side. (Note that the CBW has reminders of these questions printed at the bottom.)

The therapist may also take the opportunity throughout the session to question the patient about the applicability of the CBW to the topic at hand.

T: Sally, can you summarize what we've just been talking about?

P: Well, I was pretty down because I didn't get the summer job I wanted, and where anyone would probably be disappointed, I got pretty depressed because what it meant to me was that I was inadequate.

T: Good. Can you see how this is relevant to the Core Belief Worksheet?

P: Yeah. It's the same idea.

T: How can you write it down on the worksheet?

P: I guess it goes on the *right side*. . . . I didn't get the research assistant job . . . but that doesn't mean I'm completely inadequate. A lot of people applied for it, some with lots more experience than me.

Using Extreme Contrasts to Modify Core Beliefs

At times, it is helpful for patients to compare themselves with someone, either real or imagined, who is at a negative extreme of the quality related to the patient's core belief. The therapist suggests that the patient imagine someone within her frame of reference. (This technique is similar to the cognitive continuum described in Chapter 12.)

T: I wonder, do you know anyone at your school who truly *is* inadequate or at least *behaves* very inadequately?

P: Ummm . . . There is one guy in my dorm who never, I think, goes to classes or does work. He just seems to party all the time. I think he's failing.

T: Okay, so compared to him, how inadequate are you?

P: (*Pauses.*) Not very.

T: If you truly were an inadequate person, through and through, what would you be doing differently?

P: . . . I guess I'd drop out of college, sit around all day . . . not support myself . . . not do anything worthwhile . . . not have any friends—

T: How close are you to that now?

P: Not at all, I guess.

T: So how accurate would you say it is to label yourself as truly inadequate?

P: I guess it's really not accurate.

Developing Metaphors

Therapists can help patients distance themselves from core beliefs by reflecting on a different situation. One patient believed she must be bad because as a child (and as an adult) her mother treated her so badly. It was helpful for her to reflect on the story of Cinderella, in which a wicked stepmother treats a child quite badly without the child's being at fault or being bad.

Historical Tests of the Core Belief

It is often useful to have the patient examine how a belief originated and became maintained through the years (Young, 1990). The therapist helps the patient to search for (and reframe) evidence that seemed to support the core belief from an early age and also to uncover evidence that contradicted it. (The CBW can be used for such a process.) Usually, this process is initiated after the patient has been monitoring the operation of her core belief in the *present* and has started the process of modifying it, via the CBW or other techniques.

It is not always necessary for the patient to have a strong activation of her core belief for this process to be effective, though some patients may not have access to some important memories unless they are emotionally aroused with an activated core belief. The therapist first provides a rationale.

T: Sally, I'd like to see where this idea that you're inadequate started.

P: Okay.

T: Let's pull out the Core Belief Worksheet and work forward in time. Do you remember anything when you were quite young that made you believe at the time that you were inadequate? Say, before elementary school?

P: I remember nursery school. I remember doing something with puzzles and the teacher yelling at me. I was crying and crying—

T: Were you slow to finish it?

P: Yes, something like that.

T: And you felt pretty inadequate?

P: Uh huh.

T: Okay, write that down on the right-hand side. We'll fill in the reframes later. What else?

P: I remember this time my family went to Valley Forge State Park. And everyone else could ride their bikes around, but I couldn't keep up, and I got left really far behind.

Either in session, or for homework, the patient continues this first step: recording memories that may have contributed to the core belief. She may reflect on preschool, elementary school, high school, college, her 20's, 30's, etc. The second step of the historical review involves searching for and recording evidence that supports the new, positive belief for each period. Having evoked more positive memories, the patient is ready for the third step: reframing each piece of negative

evidence. Finally, in the fourth step, the patient summarizes each period. For example:

> *High School Years*—I did a lot of things competently, from sports to being responsible for a lot of things at home to doing well at school. It's true that I didn't get all A's, and I wasn't good at everything, and I *felt* inadequate at times, but basically I was adequate.

Restructuring Early Memories

For many Axis I patients, the "rational" or "intellectual" techniques that have already been presented are sufficient to modify a core belief. For others, special "emotional" or experiential techniques, in which the patient's affect is aroused, are also indicated. One such technique involves role-playing, reenacting an event to help the patient reinterpret an earlier, traumatic experience. In the transcript that follows, the therapist helps the patient restructure the meaning of an earlier event related to a current distressing situation.

T: Sally, you look pretty down today.

P: Yes. (*Crying.*) . . . I got my paper back. I got a C–. I can't do anything right.

T: Are you feeling pretty inadequate?

P: Yes.

T: (*Heightening her affect to facilitate memory retrieval.*) Do you feel this sadness and inadequacy somewhere in your body?

P: Behind my eyes. And my shoulders feel heavy.

T: When is the first time you remember feeling this way, as a kid?

P: (*Pause.*) When I was 6 or 7. I remember I brought home my report card, and I was a little scared because I hadn't done very well. My dad was okay about it, but my mom got pretty mad.

T: What did she say?

P: She yelled, "Sally, what am I going to do with you! Just look at this report card!"

T: What did you say?

P: I don't think I said anything. But that just made her madder. She kept saying, "Don't you know what will happen if you don't get good grades? Your brother always does well. Why can't you? I'm so ashamed of you. What are you going to amount to?"

T: You must have felt pretty bad.

P: I did.

T: Do you think this was a reasonable way for her to act?

P: No . . . I guess not.

T: Well, is this something you'd say to your own kids some day?

P: No. I'd never say that.

T: What would *you* say if you had a 7-year-old daughter who brought home a report card like that?

P: Ummm . . . I guess I'd say what my father did, "That's okay. Don't feel bad. I didn't do great in school either and it didn't matter one bit."

T: That's good. Do you have any idea why your mother didn't say that?

P: I'm not sure.

T: I wonder, from what you've told me before, if it could be because she thought other people might look down on *her* if her kids didn't do well.

P: That's probably right. She was always bragging about my brother to her friends. I think she was always trying to keep up with the Joneses.

T: Okay, how about if we do a role-play. I'll play you at age 7; you play your mom. Try to see things from her point of view as much as you can. I'll start. . . . Mom, here's my report card.

P: Sally, I'm ashamed of you. Look at these grades. What am I going to do with you?

T: Mom, I'm only 7. My grades aren't great like Robert's, but they're okay.

P: Don't you know what will happen if you don't get good grades? You'll never amount to anything.

T: That's silly, Mom. I'm only 7.

P: But next year, you will be 8, and after that 9–

T: Mom, I didn't do that bad. Why are you making such a big deal? You're making me feel like I'm completely inadequate. Is that what you mean to do?

P: No, of course not. I don't want you to think that. It's not true. I just want you to do better.

T: Okay, out of role. What do you think?

P: I wasn't really inadequate. I did okay. Mom probably was hard on me because *she* didn't want to be criticized. (*Brightens.*)

T: How much do you believe that?

P: A lot. 80%.

T: How about if we do the role-play again, but this time we'll switch parts. Let's see how well the 7-year-old Sally can talk back to her mother.

Following this second role-play, the therapist asks Sally what she learned and how this learning applies to the situation which upset her this week (getting a C– on a paper).

Another technique uses imagery to restructure early memories in the presence of affect (Edwards, 1989; Layden et al., 1993). This Gestalt therapy type of technique has been adapted specifically to change core beliefs and is more often used with patients with personality disorders than with Axis I patients. Again, the therapist has the patient reexperience an early distressing event that seems to have helped originate or maintain a core belief. The following extended case example illustrates how the therapist does the following:

1. Identifies a specific situation that is currently quite distressing to the patient and seems linked to an important core belief;
2. Heightens the patient's affect by focusing on automatic thoughts, emotions, and somatic sensations;
3. Helps the patient identify and reexperience a relevant early experience;
4. Talks to the "younger" part of the patient to identify automatic thoughts, emotions, and beliefs; and
5. Helps the patient develop a different understanding of the experience through guided imagery, Socratic questioning, dialogue, and/or role-play.

In the following transcript, Sally reports an upsetting experience from the previous day in which she felt criticized by her study group.

T: Can you imagine this scene again, as if it's happening right now? You're all sitting around the table–

[Therapist has Sally vividly picture and describe the distressing incident.]

P: Peggy is saying, "Sally, you didn't do this thoroughly enough. You'll have to beef it up." And I'm feeling so down, so sad. [I'm thinking] "I'm letting everyone down. I'm not good enough. I can't do anything right. I'll probably flunk out."

T: Are you feeling the sadness right now?

P: (*Nods.*)

T: Where in your body do you feel it?

P: Behind my eyes.

T: Anywhere else? Where else is the sadness?

P: In my chest . . . and my stomach. There's a heaviness.

T: Okay, can you focus on the heaviness? Can you really feel it now, in your stomach, in your chest? And behind your eyes?

P: (*Nods.*)

T: Okay, just focus on your eyes, your stomach, your chest. . . . (*Waits about 10 seconds.*) Sally, when do you remember feeling this heaviness before, when you were a kid? When's the *first* time you remember feeling like this?

In the next section, the therapist has Sally reexperience a distressing, significant memory and interviews the "child" part of Sally to identify what sense she had made of this early experience at the time. (Note that the therapist continually reinforces the emotional immediacy of the experience by having the patient use the present tense throughout.)

P: . . . My mom. My mom is yelling at me.

T: How old are you, Sally?

P: About 6 or 7. I'm not sure.

T: Where are you? Describe it for me as vividly as you can.

P: I'm home. I'm doing my homework. I have to do some kind of worksheet. I can't do it. I have to mark long and short vowels or something. I don't know what to do. I've been absent. I don't know how to do this.

T: What happens next?

P: Mom walks in the kitchen: "Get to bed, Sally." "I can't. I have to finish my homework. . . ."

T: And then?

P: She says, "You've been at this forever. I told you half an hour ago to go to bed."

T: What do you say?

P: "But I have to do this. I'll get in trouble."

T: And then?

P: She says, "What's the matter with you? Why can't you finish this? It's easy. What are you, stupid? Get in bed, now!"

T: And then?

P: I run to my room.

T: And then?

P: I don't know. Go to sleep, I guess. (*Looks down, very sad.*)

T: When is the worst point?

P: When she's yelling at me.

T: Okay, can you picture this again? Where are you?

P: I'm sitting at the kitchen table.

T: And you're struggling with your homework? You don't know what to do?

P: Yeah..

T: And your mom comes into the kitchen? How does she look? Where is she?

P: She's tall. Standing up. She looks mad.

T: How can you tell?

P: (*Eyes begin to tear.*) Her face is scrunched up. Her body looks tense.

T: And she says . . . ?

P: "Sally, go to bed."

T: Keep going.

P: "Mom, I can't. I have to finish this." "I said, Get to bed! What's the matter with you? This stuff is easy. Are you stupid?" (*Sobs.*)

T: (*Gently.*) Six-year-old Sally, how are you feeling?

P: Sad. (*Cries a little.*)

T: Real sad?

P: (*Nods.*)

T: (*Softly.*) Six-year-old Sally, what's going through your mind right now?

P: I *am* stupid. I can't do anything right.

T: How much do you believe that?

P: Completely.

T: Anything else going through your mind?

P: I'll never be able to do stuff right.

Note that the intensification of affect in the experience is the clue that verifies that this is a core issue for this patient. In the next section, the therapist helps Sally reinterpret this experience.

T: Six-year-old Sally, I'd like to help you see this a different way. What do you think would help? Would you like to talk to your mom, explain to her why you're having a hard time? Or, would you like someone to explain to *you* what's going on . . . your 18-year-old self, maybe? Or someone else? How can we get you to see this a different way, 6-year-old Sally?

P: I don't want to talk to Mom. She'll just yell at me.

T: Would you like your older self to explain it to you, 6-year-old Sally?

P: Yes.

T: Okay, can you imagine that your mom walks out of the kitchen and your 18-year-old self walks in? Where would you like her to be?

P: Next to me, I guess.

T: Real close?

P: (*Nods.*)

T: Would you like her to put her arm around you?

P: (*Nods.*)

T: Okay. Let's have 18-year-old Sally talk to 6-year-old Sally. Have her ask 6-year-old Sally what's wrong.

P: "What's wrong?" "I feel so stupid. I can't do anything right."

T: What does your older self answer back?

P: "No, you're not. This homework is too hard. It's not your fault. You're not stupid."

T: What does 6-year-old Sally say?

P: "But I should be able to do it."

T: Have your older self keep talking to her.

P: "No, that's not true. You shouldn't be able to do it. You've been absent. You were never taught this. Actually, it's your teacher's fault for giving you something too hard."

T: Does 6-year-old Sally believe her?

P: A little.

T: What does 6-year-old Sally want to ask?

P: "Why does everything have to be so hard? Why can't I do anything right?"

T: What does the older Sally say?

P: "You do lots of things right. Some things like math papers are easy, and getting dressed all by yourself and playing baseball. . . ."

T: What is 6-year-old Sally thinking?

P: "But I can't play baseball well. Robert is so much better."

T: What does your older self say to that?

P: "Listen, he *is* better at baseball than you. But he's *older*. When he was your age, he could only do what you can do now. You'll get better, just wait."

T: How is 6-year-old Sally feeling now?

When the patient reports that her younger self is feeling significantly less sad, the therapist wraps up the exercise (e.g., "Is there anything else you want to ask your older self, 6-year-old Sally?"). If the patient reports that she is still quite upset, he might try another tack; for example:

T: Let me talk to 6-year-old Sally for a minute. Six-year-old Sally, you're still so sad. Why do you *still* think you can't do anything right?

P: (*Thinks.*) Mom. She tells me so. She's right.

T: Would you like to try to talk to her?

P: (*Reluctantly.*) I'm not sure.

T: How about if we do a role-play? Six-year-old Sally, you be your mother. I'll be you. You start. Pretend you're coming in the kitchen and you see me doing my homework.

P: Okay . . . Sally, get to bed. Now!

T: But, Mom, I have to finish my homework or I'll get in trouble.

P: What's the matter with you? You must be stupid.

T: No, I'm not, Mom. The teacher made a mistake. This worksheet is too hard.

P: If it's too hard, there must be something wrong with you.

T: No, Mom. That's not true. Mom, do you really think there's something wrong with me? Do you want me to grow up thinking I'm stupid and can't do anything right?

P: (*Pauses.*) No . . . no. I don't think you're stupid. I don't want you to grow up thinking that.

T: Then why did you call me stupid if it's not true?

P: I shouldn't have. It's not true.

T: Why did you?

P: (*Pauses.*) I don't know. I just get so frustrated sometimes. I really just want you in bed so I can have some peace and quiet.

T: You mean you don't think I'm stupid?

P: No . . . no. I don't. You're not stupid.

T: But there are so many things I can't do. I can't read very well. I can't even ride a two-wheeler bike. Robert can do those things.

P: But he's older. You'll be able to do them someday, too.

T: But you yell at me a lot for not doing things well. You yelled at me about this worksheet. You're always yelling at me about not cleaning my room well enough or not doing the dishes well enough or not getting good enough marks on tests.

P: I do expect a lot from you. I don't know. Maybe too much, sometimes. But that's my job. I'm supposed to push you. How will you grow up if I don't?

T: Mom, your pushing me makes me feel like I'm inadequate and stupid and like I can't do anything right. Is that what you want me to grow up believing?

P: No, of course not.

T: What *do* you want me to believe?

P: That you're smart, that you can do whatever you want to.

T: Do you believe that, Mom? That I'm smart and can do anything I want?

P: Yes, I do. I'm sorry.

T: Okay. Out of role-play for the moment. Now how are you feeling?

P: Better.

T: Let's do the role-play again. This time you play 6-year-old Sally, sitting at the kitchen table, struggling with her homework. Pay close attention to how she's feeling and what she's thinking. Let's start. I'm Mom, and I walk into the kitchen and I say, "Sally, get to bed. Now!"

Sally and the therapist continue the role-play to give Sally the opportunity to test the validity of her thoughts and conclusions with her mother. At the end, the therapist asks Sally to write down the old belief that was activated in this memory and the new belief and to rate how much she now believes each one. Then they discuss the present distressing incident involving her friend Peggy and the study group and help Sally draw a more reality-based, more adaptive conclusion. By the end of the session, Sally believes only 20% that she is inadequate and 70% that she is adequate. She believes an alternative explanation quite strongly: that her contribution may not live up to Peggy's expectations, but that does not make it completely inadequate; that even if it is not as good as it could be does not mean *she* is completely inadequate as a

person; and that the major reason for its lack of breadth was the study group's lack of specified guidelines and Sally's relative inexperience working in a study group.

In summary, core beliefs require consistent, systematic work. A number of techniques, applicable to restructuring automatic thoughts and intermediate beliefs, may be used along with more specialized techniques oriented specifically toward core beliefs.