IDENTIFYING AUTOMATIC THOUGHTS

The cognitive model states that the interpretation of a situation (rather than the situation itself), often expressed in automatic thoughts, influences one's subsequent emotion, behavior, and physiological response. Of course, certain events are almost universally upsetting: a personal assault, rejection, or failure. People with psychological disorders, however, often misconstrue neutral or even positive situations and thus their automatic thoughts are biased. By critically examining their thoughts and correcting thinking errors, they often feel better.

This chapter describes the characteristics of automatic thoughts along with techniques to identify patients' automatic thoughts, explain automatic thoughts to patients, differentiate between automatic thoughts and interpretations, and teach patients to identify their own automatic thoughts. The next chapter focuses on negative emotions: how to teach patients to differentiate automatic thoughts from emotions and to identify and rate the intensity of emotions.

CHARACTERISTICS OF AUTOMATIC THOUGHTS

Automatic thoughts are a stream of thinking that coexists with a more manifest stream of thought (Beck, 1964). These thoughts are not peculiar to people with psychological distress; they are an experience common to us all. Most of the time we are barely aware of these thoughts, though with just a little training we can easily bring these thoughts into consciousness. When we become aware of our thoughts, we may automatically do a reality check if we are not suffering from psychological dysfunction.

A reader of this text, for example, while focusing on the content of

this chapter, may have the automatic thought, "I don't understand this," and feel slightly anxious. He may, however, spontaneously (i.e., without conscious awareness) respond to the thought in a productive way: "I *do* understand *some* of it; let me just reread this section again."

This kind of automatic reality testing and responding to negative thoughts is a common experience. People who are in distress, however, may not engage in this kind of critical examination. Cognitive therapy teaches them tools to evaluate their thoughts in a conscious, structured way, especially when they are upset.

Sally, for example, when she is reading an economics chapter, has the same thought as the reader above. "I don't understand this." Her thinking becomes even more extreme, however: "And I'll *never* understand it." She accepts these thoughts as correct and feels quite sad. After learning tools of cognitive therapy, however, she is able to use her negative emotion as a cue to look for, identify, and evaluate her thoughts and thereby develop a more adaptive response: "Wait a minute, it's not necessarily true that I'll never understand this. I am having some trouble now. But if I reread it or come back to it when I'm fresher, I may understand it more. Anyway, understanding it isn't crucial to my survival, and I can ask someone else to explain it to me if need be."

Although automatic thoughts seem to pop up spontaneously, they become fairly predictable once the patient's underlying beliefs are identified. The cognitive therapist is concerned with identifying those thoughts that are dysfunctional, that is, those that distort reality, that are emotionally distressing and/or interfere with the patient's ability to reach her goals. Dysfunctional automatic thoughts are almost always negative unless the patient is manic or hypomanic, has a narcissistic personality disorder, or is a substance abuser.

Automatic thoughts are usually quite brief, and the patient is often more aware of the *emotion* she feels as a result of the thought than of the thought itself. Sitting in session, for example, a patient may be somewhat aware of feeling anxious, sad, irritated, or embarrassed but unaware of her automatic thoughts until her therapist questions her.

The emotion the patient feels is logically connected to the content of the automatic thought. For example, Sally thinks, "I'm such a dope. I don't really understand what [my therapist] is saying," and feels sad. Another time she thinks, "He's watching the clock. I'm just another case to him," and feels slightly angry. When she has the thoughts, "What if this therapy doesn't work? What will I do next?" Sally feels anxious.

Automatic thoughts are often in "shorthand" form but can be easily spelled out when the therapist asks for the *meaning* of the thought. For example, "Oh, no!" may be translated as "[My therapist] is going to give me too much homework." "Damn!" may be the expression of an idea

such as "I left my appointment book at home and I can't schedule another appointment with my therapist today; I'm so stupid."

Automatic thoughts may be in verbal form, visual form (images), or both. In addition to her verbal automatic thought ("Oh, no!") Sally had an image of herself, alone at her desk late at night, toiling over her therapy homework (see Chapter 13 for a description of automatic thoughts in image form).

Automatic thoughts can be evaluated according to their *validity* and their *utility*. The most common type of automatic thought is distorted in some way and occurs despite objective evidence to the contrary. A second type of automatic thought is accurate, but the *conclusion* the patient draws may be distorted. For example, "I didn't do what I promised [my roommate]" is a valid thought, but the conclusion "Therefore, I'm a bad person," is not.

A third type of automatic thought is also accurate but decidedly dysfunctional. For example, Sally was studying for an exam and thought, "It's going to take me hours to finish this. I'll be up until 3:00 A.M." This thought was undoubtedly accurate, but it increased her anxiety and decreased her concentration and motivation. A reasonable response to this thought would address its *utility*. "It's true it will take a long time to finish this, but I can do it; I've done it before. Dwelling on how long it will take makes me feel miserable, and I won't concentrate as well. It'll probably take even longer to finish. It would be better to concentrate on finishing one part at a time and giving myself credit for having finished it." Evaluating the validity and/or utility of automatic thoughts and adaptively responding to them generally produces a positive shift in affect.

To summarize, automatic thoughts coexist with a more manifest stream of thoughts, arise spontaneously, and are not based on reflection or deliberation. People are usually more aware of the associated emotion but, with a little training, they can become aware of their thinking. The thoughts relevant to personal problems are associated with *specific* emotions, depending on their content and meaning. They are often brief and fleeting, in shorthand form, and may occur in verbal and/or imaginal form. People usually accept their automatic thoughts as true, without reflection or evaluation. Identifying, evaluating, and responding to automatic thoughts (in a more adaptive way) usually produces a positive shift in affect.

EXPLAINING AUTOMATIC THOUGHTS TO PATIENTS

It is desirable to explain automatic thoughts by using the patient's own examples. Chapter 3 provided a sample transcript; following is another.

THERAPIST: Now I'd like to spend a few minutes talking about the connection between thoughts and feelings. Can you think of some times this week when you felt upset?

PATIENT: Yeah. Walking to class this morning.

T: What emotion were you feeling: sad? anxious? angry?

P: Sad.

T: What was going through your mind?

P: I was looking at these other students, talking or playing frisbee, hanging out on the lawn.

T: What was going through your mind when you saw them?

P: I'll never be like them.

T: Okay. You just identified what we call an *automatic thought.* Everyone has them. They're thoughts that just seem to pop in our heads. We're not deliberately trying to think about them; that's why we call them automatic. Most of the time, they're real quick and we're much more aware of the emotion—in this case, sadness—than we are of the thoughts. Lots of times the thoughts are distorted in some way. But we react *as if* they're true.

P: Hmmm.

T: What we'll do is to teach you to identify your automatic thoughts and then to evaluate them to see just how accurate they are. For example, in a minute we'll evaluate the thought, "I'll never be like those students." What do you think would happen to your emotions if you discovered that your thought wasn't true—that when your depression lifts you'll realize that you *are* like the other students?

P: I'd feel better.

Here the therapist suggests an alternative scenario in order to illustrate the cognitive model. Later in the session, he uses Socratic questioning to examine the thought with the patient so she can develop her own adaptive response. In the next portion, he has Sally write down the automatic thought, emphasizing the cognitive model. (See Figure 6.1.)

T: Let's get that down on paper. When you have the thought, "I'll never be like those students," you feel sad. Do you see how what you're thinking influences how you feel?

P: Uh huh.

T: That's what we call the *cognitive model.* What we'll do in therapy is to

Thoughts → Feelings

What you think influences how you feel.
Sometimes your thinking is not right or is just partially right.

Thought		Feeling
I'll never be like those students.	→	Sad

Steps in Therapy

1. Identify automatic thoughts.
2. Evaluate and respond to automatic thoughts.
3. Do problem-solving if thoughts are true.

FIGURE 6.1. Sally's notes from Session 1.

teach you to identify your automatic thoughts when you notice your mood changing. That's the first step. We'll keep practicing it, until it's easy. Then you'll learn how to evaluate your thoughts and change your thinking if it's not completely correct. Is that clear?

P: I think so.

T: How about if we get that down on paper? Step 1: Identify automatic thoughts; Step 2: Evaluate and respond to thoughts. Could you tell me back in your own words about the relationship between thoughts and feelings?

P: Sometimes I have thoughts that are wrong and these thoughts make me feel bad. . . . But what if the thoughts are right?

T: Good point. Then we'll do some problem-solving or find out what's so bad about it if they *are* right. My guess, though, is that we'll find a lot of errors in your thinking because you *are* depressed and negative; negative thinking is always part of depression. In any case, we'll figure out together whether your interpretations are wrong. Now, can you think of any other time this week when you felt upset so we can try to identify more automatic thoughts?

At the end of this session, the therapist checks again to ascertain how well the patient seems to understand the cognitive model.

T: To review a bit, could you tell me what you now understand about the relationship between thoughts and feelings?

P: Well, sometimes automatic thoughts just pop in my head and I accept them as true. And then I feel . . . whatever: sad, worried—

T: Good. How about for homework this week if you look for some of these automatic thoughts?

P: Okay.

T: Why do you think I'm suggesting this?

P: Because sometimes my thoughts aren't true and if I can figure out what I'm thinking, I can change it around and feel better.

T: That's right. Now how about if you write this assignment down: Whenever I notice a change in mood or my mood is getting worse, ask myself . . . (*The patient writes it down.*) Now what was that $64,000 question?

P: What was just going through my mind?

T: Good! Get that down.

ELICITING AUTOMATIC THOUGHTS

The skill of learning to identify automatic thoughts is analogous to learning any other skill. Some patients (and therapists) catch on quite easily and quickly. Others need much more guidance and practice to identify automatic thoughts and images. The next two sections describe procedures for eliciting automatic thoughts (summarized in Figure 6.2).

The first method is to identify automatic thoughts the patient is having in the session itself. The second method is to elicit the automatic thoughts a patient has had about a problematic situation between sessions through recall, imagery, role-playing, or hypothesizing.

Eliciting Automatic Thoughts That Arise in Session

An opportune time to elicit a patient's automatic thought is when the therapist notices an affect shift in session.

T: Sally, I just noticed a change in your eyes. What just went through your mind?

It is vital to be alert to both verbal and nonverbal cues from the patient, so as to be able to elicit "hot cognitions"—that is, important automatic thoughts and images that arise in the therapy session itself and are associated with a change or increase in emotion. These hot cognitions may be about the patient herself ("I'm such a failure"), the therapist ("He doesn't understand me"), or the subject under discussion ("It's not fair that I have so much to do"). Eliciting the hot cognitions are important because they often are of critical importance in conceptualization. Generally, these affect-laden thoughts are the most important to work with. In addition, these hot cognitions may undermine the patient's

TECHNIQUES TO ELICIT AUTOMATIC THOUGHTS

Basic question:

What was going through your mind just then?

To identify automatic thoughts:

1. Ask this question when you notice a shift in (or intensification of) affect during a session.
2. Have the patient describe a problematic situation or a time during which she experienced an affect shift and ask the above question.
3. If needed, have the patient use imagery to describe the specific situation or time in detail (as if it is happening now) and then ask the above question.
4. If needed or desired, have the patient role-play a specific interaction with you and then ask the above question.

Other questions to elicit automatic thoughts:

1. What do you guess you were thinking about?
2. Do you think you could have been thinking about _____ or _____? (Therapist provides a couple of plausible possibilities.)
3. Were you imagining something that might happen or remembering something that did?
4. What did this situation mean to you? (Or say about you?)
5. Were you thinking _____? (Therapist provides a thought opposite to the expected response.)

FIGURE 6.2. Summary of techniques to identify automatic thoughts. Copyright 1993 by Judith S. Beck, Ph.D.

motivation or sense of adequacy or worth. They may interfere with the patient's concentration in session. Finally, they may interfere with the therapeutic relationship. Identifying automatic thoughts on the spot gives the patient the opportunity to test and respond to the thoughts immediately so as to facilitate the work in the rest of the session.

How does the therapist know when a patient has experienced an affect shift? He is on the alert for nonverbal cues such as changes in facial expression, tightening of muscles, shifts in posture, or hand gestures. Verbal cues include change in tone, pitch, volume, or pace. Having noticed a change, the therapist infers an affect shift and checks it out by asking the patient what just went through her mind. If the patient is unable to report a thought, the therapist may choose to jog her memory by having her focus on her emotion and physiological reaction.

T: Sally, what's going through your mind right now?

P: I'm not sure.

T: How are you feeling right now?

P: I don't know. Sad, I guess.

T: Where do you feel the sadness?

P: In my chest. And behind my eyes.

T: So, when I asked, "How's school going?" you felt sad. Any idea what you were thinking about?

P: I think it was about my economics class. I was thinking about getting back my exam.

T: What were you thinking? Or did you imagine something?

P: Yeah. I pictured a "C" at the top, in red ink.

With a little gentle persistence, Sally was able to report her image. Had focusing on the emotion *not* helped, the therapist might have chosen to change the subject so as not to make Sally feel that she was being interrogated or to reduce the possibility of Sally's viewing herself as a failure for not being able to identify her automatic thought.

T: No big deal. How about if we continue on with the agenda.

On the other hand, it might be wise to pursue this hot cognition. Although it is more desirable to get the patient to identify her specific thoughts rather than speculating about them, a number of questions can be useful when she is unable to do so. The therapist might ask Sally to make a guess or he might pose plausible possibilities. He could specifically ask about an image or ask for the meaning of the situation to her. Or he could suggest a specific thought which is actually the *opposite* of what he conjectures her thought was.

T: What went through your mind when I asked, "How's school going?" and you felt sad?

P: I don't know. I really don't. I just felt so down.

T: If you had to take a guess, what would you guess you were thinking about? [Or, do you think you could have been thinking about school, or about your work, or about therapy? Or, could you have been picturing something in your mind? Or, what did it mean to you that I asked you about school? Or, were you thinking how great everything is going?]

Identifying Automatic Thoughts in a Specific Situation

These same questions can be used to help the patient identify automatic thoughts she had between sessions. Again, the therapist first tries the

standard question ("What was going through your mind?") when the patient describes a problematic situation. Often the patient is helped by the therapist's request for a more detailed description of what had been going on.

T: So, you were sitting in class, and you suddenly felt nervous? What was going through your mind?

P: I don't know.

T: What was happening?

P: The professor was explaining what the requirements of the paper were, and the guy next to me whispered a question to me about when it was due.

T: So, this guy whispered while the professor was explaining? And you felt nervous?

P: Yes, I know, I was thinking, "What did she say? What did I miss? Now I won't know what to do."

If verbally describing the situation is insufficient to elicit the automatic thoughts, the therapist asks the patient to imagine the specific situation as if it is happening *right now*. He encourages her to use as much detail as possible, speaking in the present tense.

T: Sally, can you imagine that you're back in the class *right now*, the professor is talking, the student next to you is whispering, you're feeling nervous. . . . Describe it to me in as much detail as you can, as if it's happening right now. How big is the class? Where are you sitting? Where is the professor? What is she saying? What are you doing, and so on.

P: I'm in my economics class. The professor is standing in front of the class. Let's see, I was sitting about three-quarters of the way back, I was listening pretty hard—

T: So, "I'm sitting three-quarters of the way back, I'm listening pretty hard. . . ." (*Guiding the patient to speak as if it's happening right at the moment.*)

P: She's saying something about what topics we can choose, a macroeconomic view of the economy or . . . something, and then this guy on my left leans over and whispers, "When's the paper due?"

T: And what's going through your mind right now?

P: What did she say? What did I miss? Now I won't know what to do.

The therapist helps the patient reexperience the situation as if it is happening right then. When he notices that the patient seems to be reverting to past tense, he gently guides her back to the present tense so the experience is more immediate. Likewise, if a patient has difficulty identifying automatic thoughts in an interpersonal situation, the therapist can help recreate the situation through role-play. The patient describes who said what verbally, then the patient plays herself while the therapist plays the other person in the interaction.

T: So, you were feeling down as you were talking to your classmate about the assignment?

P: Yes.

T: What was going through your mind as you were talking to her?

P: (*Pauses.*) . . . I don't know. I was just really down.

T: Can you tell me what you said to her and what she said to you?

P: (*Describes verbal exchange.*)

T: How about if we try a role-play? I'll be the classmate and you be you.

P: Okay.

T: While we're recreating the situation, see if you can figure out what's going through your mind.

P: (*Nods.*)

T: Okay, you start. What do you say first?

P: Karen, can I ask you a question?

T: Sure, but can you call me later? I've got to run to my next class.

P: It's fast. I just missed part of what Dr. Smith said about our paper.

T: I'm really in a hurry now. Call me after 7:00, okay? Bye. . . . Okay, out of role-play. Were you aware of what was going through your mind?

P: Yeah. I was thinking that she was too busy for me, that she didn't really want to help me, and I wouldn't know what to do.

T: You had the thoughts, "She's too busy for me." "She doesn't really want to help me." "I won't know what to do."

P: Yes.

T: And those thoughts made you feel sad?

P: Yeah.

If the patient is still unable to report her thoughts, the therapist might move onto something else or use the more specific questions outlined in Figure 6.2.

Identifying Additional Automatic Thoughts

It is important to continue questioning the patient even after she reports an initial automatic thought. This additional questioning may bring to light other important thoughts.

T: So when you got the test back, you thought, "I should have done better. I should have studied harder." What else went through your mind?

P: Everyone else probably did better than me.

T: Then what?

P: I was thinking, "I shouldn't even be here. I'm such a failure."

The therapist should be aware that the patient may, in addition, have other automatic thoughts not about the same situation itself but about her *reaction* to that situation. She may perceive her emotion, behavior, or physiological reaction in a negative way.

T: So you had the thought, "I might embarrass myself," and you felt anxious? Then what happened?

P: My heart started beating real fast and I thought, "What's wrong with me?"

T: And you felt . . . ?

P: More anxious.

T: And then?

P: I thought, "I'll never feel okay."

T: And you felt . . . ?

P: Sad and hopeless.

Note that the patient first had automatic thoughts about a specific situation (volunteering in class). Then she had thoughts about her anxiety and her bodily reaction. In many cases, these secondary emotional reactions can be quite distressing and significantly compound an already upsetting situation. In order to work most efficiently, it is important to determine at which point the patient was *most* distressed (before, during, or after a given incident) and what

her automatic thoughts were at that point. The patient may have had distressing automatic thoughts in *anticipation* of a situation ("What if she yells at me?"), *during* the situation ("She thinks I'm stupid"), and/or at a *later* point, reflecting on what had happened ("I can't do anything right; I should never have tried").

IDENTIFYING THE PROBLEMATIC SITUATION

Sometimes, in addition to being unable to identify automatic thoughts associated with a given emotion, a patient has difficulty even identifying the one situation or issue that is most troublesome to her (or which part is the most upsetting). When this happens, the therapist can help her pinpoint the most problematic situation by proposing a number of upsetting problems, asking the patient hypothetically to eliminate one problem, and determining how much relief the patient feels. Once a specific situation has been identified, the automatic thoughts are more easily uncovered.

T: (*Summarizing.*) So, you've been very upset for the past few days and you're not sure why and you're having trouble identifying your thoughts—you just feel upset most of the time. Is that right?

P: Yes. I just don't know why I'm so upset all the time.

T: What kinds of things have you been thinking about?

P: Well, school for one. And I'm not getting along well with my roommate. And then I tried to get hold of my mother again and I couldn't reach her, and, I don't know, just everything.

T: So, there is a problem with school, with your roommate, with reaching your mom . . . anything else?

P: Yeah. I haven't been feeling too well. I'm afraid I might be getting sick just before this big paper is due.

T: Which of these situations bothers you the most—school, roommate, reaching your mom, feeling sick?

P: Oh, I don't know. I'm worried about all of them.

T: Let's jot these four things down. Now let's say hypothetically we could completely eliminate the feeling sick problem, let's say you now feel physically fine, how anxious are you now?

P: About the same.

T: Okay. Say, hypothetically, you do reach your mom right away after therapy and everything's fine with her. How do you feel now?

P: A little bit better. Not that much.

T: Okay. Let's say the school problem—what is the school problem?

P: I have a paper due next week.

T: Okay, let's say you've just handed the paper in early, and you're feeling good about it. Now how do you feel?

P: That would be a great relief, if that paper were done and I thought I'd done well.

T: So it sounds as if it's the paper that is the most distressing situation.

P: Yeah. I think so.

T: Now just to make sure. . . . If you still had the paper to do, but the roommate problem disappeared, how would you feel?

P: Not that good. I think it *is* the paper that's bothering me the most.

T: In a moment, we'll focus on the school problem, but first I'd like to review how we figured it out so you'll be able to do it yourself in the future.

P: Well, you had me list all the things I was worried about and pretend to solve them one by one.

T: And then you were able to see which one would give you the most relief if it had been resolved.

P: Yeah.

[Therapist and patient then focus on the school problem; they identify and respond to automatic thoughts and do some problem-solving.]

The same process can be used in helping the patient to determine which *part* of a seemingly overwhelming problem is most distressing.

T: So you've been pretty upset about your roommate. What *specifically* has been bothering you?

P: Oh, I don't know. Everything.

T: Can you name some things?

P: Well, she's been taking my food and not replacing it. Not in a malicious way, but it still bothers me. And she's got a boyfriend and whenever she talks about him, it reminds me that I don't have one. And she's messy; she leaves stuff all around. . . . And she's kind of inconsiderate. She forgets to give me phone messages and things like that.

T: Anything else?

P: Those are the major ones.

T: Okay, we've done this before. Let me read these back to you so you can figure out which one bothers you the most. If you can't, we'll

hypothetically eliminate them one by one and see which one makes the biggest difference in how you feel. Okay?

DIFFERENTIATING BETWEEN AUTOMATIC THOUGHTS AND INTERPRETATIONS

When the therapist asks for the patient's automatic thoughts, he is seeking the *actual* words or images that have gone through her mind. Until they have learned to recognize these thoughts, many patients report *interpretations*, which may or may not reflect the actual thoughts. In the following transcript, the therapist guides the patient to report her thoughts.

T: When you saw that woman in the cafeteria, what went through your mind?

P: I think I was denying my real feelings.

T: What were you actually thinking?

P: I'm not sure what you mean.

In this exchange, the patient reported an *interpretation* of what she was feeling and thinking. Below, the therapist tries again, by focusing on and heightening her emotion.

T: When you saw her, what emotion did you feel?

P: I think I was just denying my feelings.

T: Uh huh. What feelings were you denying?

P: I'm not sure.

T: When you saw her, did you feel happy? Excited? (*Supplying an emotion opposite to the expected one to jog her recall.*)

P: No, not at all.

T: Can you remember walking in the cafeteria and seeing her? Can you picture that in your mind?

P: Uh huh.

T: What are you feeling?

P: Sad, I think.

T: As you look at her, what goes through your mind?

P: I feel really sad, an emptiness in the pit of my stomach. (*Reporting an emotion and a physiological reaction instead of an automatic thought.*)

T: What's going through your mind now?

P: She's really smart. I'm nothing compared to her.

T: (*Jotting down the thoughts.*) Okay. Anything else?

P: No. I just walked over to the table and started talking to my friend.

DIFFERENTIATING BETWEEN USEFUL AND RELATIVELY LESS USEFUL AUTOMATIC THOUGHTS

Until the patient learns to recognize the *specific* automatic thoughts that distress her, she may report a number of thoughts. Some thoughts are simply descriptive and innocuous or irrelevant to a problem. *Relevant* automatic thoughts are usually associated with marked distress. As in the previous section, the therapist tries to determine which thought or thoughts will be most productive to focus on.

T: So you were feeling pretty sad when you hung up the phone. What was going through your mind right then?

P: Well, my friend from high school is really doing well. She's got a job, she's hanging out with a lot of our friends. She gets to use her family's car so she's not hemmed in. Sometimes I wish I were more like her. She's doing really good. I'm such a loser—.

T: Did you have that thought "I'm such a loser," as you hung up the phone?

P: (*Nods.*)

T: Anything else go through your mind just then?

P: No, just that I'm a loser. I'll never be like her.

SPECIFYING AUTOMATIC THOUGHTS EMBEDDED IN DISCOURSE

Patients need to learn to specify the actual words that go through their minds in order to evaluate them effectively. Following are some examples of embedded thoughts versus actual words:

Embedded expressions	*Actual automatic thoughts*
I guess I was wondering if he likes me.	Does he like me?

(*cont.*)

I don't know if going to the professor would be a waste of time.	It'll probably be a waste time if I go.
I couldn't get myself to start reading.	I can't do this.

The therapist gently leads the patient to identify the *actual* words that went through her mind.

T: So when you turned bright red in class, what went through your mind?

P: I guess I was wondering if he thought I was strange.

T: Can you recall the exact words you were thinking?

P: (*Puzzled.*) I'm not sure what you mean.

T: Were you thinking, "I guess I was wondering if he thought I was strange," or were you thinking, "Does he think I'm strange?"

P: Oh I see, the second one. Or actually I think it was, "He probably thinks I'm strange."

CHANGING THE FORM OF TELEGRAPHIC OR QUESTION THOUGHTS

Patients often report thoughts that are not fully spelled out. As it is difficult to evaluate such a telegraphic thought, the therapist guides the patient to express the thought more fully.

T: What went through your mind when the paper was announced?

P: Uh, oh. I just thought, "Uh, oh."

T: Can you spell the thought out? "Uh, oh" means . . .

P: I'll never get the work done in time. I have too much to do.

If the patient had been unable to spell out her thought, the therapist might have tried supplying an opposite thought: "Did 'Uh, oh' mean 'That's really good'?"

Automatic thoughts are sometimes expressed in the form of a question, making evaluation difficult. Therefore, the therapist guides the patient in expressing the thought in a statement form prior to helping her evaluate it.

T: So you felt anxious? What was going through your mind right then?

P: I was thinking, "Will I pass the test?"

T: Okay, now before we evaluate that thought, let's see if we can restate it in the form of a statement, so we can work with it more easily. Were you thinking you probably would or wouldn't pass the test?

P: That I wouldn't.

T: Okay. So can we rephrase your thought as, "I might not pass the test"?

Another example follows:

T: So you had the thought, "What will happen to me [if I get more and more nervous]?" What are you *afraid* could happen?

P: I don't know . . lose control, I guess.

T: Okay, let's look at that thought, "I could lose control."

In the previous example, the therapist leads the patient into revealing precisely what she fears. In the next example, the patient initially has difficulty identifying the fear behind her automatic thought, so the therapist tries several different questions to identify the thought:

T: So you thought, "What next?" What did you think would happen next?

P: I don't know.

T: Were you afraid something specific might happen?

P: I'm not sure.

T: What's the worst thing that *could* happen in this situation?

P: Ummm . . . that I'd get kicked out of school.

T: Do you think that was what you were afraid would happen at the time?

The box illustrates other examples of how questions can be restated in order to be evaluated more effectively.

Question	*Statement*
Will I be able to cope?	I won't be able to cope.
Can I stand it if she leaves?	I won't be able to stand it if she leaves.
What if I can't do it?	I'll lose my job if I can't do it.
What if she gets mad at me?	She'll hurt me if she gets mad at me.

(*cont.*)

How will I get through it?	I won't be able to get through it.
What if I can't change?	I'll be miserable forever if I can't change.
Why did this happen to me?	This shouldn't have happened to me.

TEACHING PATIENTS TO IDENTIFY AUTOMATIC THOUGHTS

As described in Chapter 4, the therapist can begin teaching the patient the skill of identifying automatic thoughts even at the first session. Here the therapist has just demonstrated the cognitive model, using the patient's own examples.

T: Sally, when you notice your mood changing or getting worse in the next week, could you stop and ask yourself, "What is going through my mind right now?"

P: Yeah.

T: Maybe you could jot down a few of these thoughts on a piece of paper?

P: Sure.

In later sessions, the therapist might also explicitly teach the patient other techniques if the basic question ("What's going through your mind right now?") is not helping enough.

T: Sometimes you may not be able to tell what you were thinking. So either at the time or later you can try what we just did here in session. Replay the scene as vividly as you can in your imagination, as if it's happening again, and concentrate on how you're feeling. Then ask yourself, "What's going through my mind?" Do you think you could do that? Or should we practice it again?

P: I'll give it a try.

Again, if asking the basic questions and trying the imagery technique are not sufficient, the therapist might explicitly teach the patient to hypothesize about her thoughts. This method is a second choice because it is more likely the patient will report a later interpretation instead of her actual thoughts at the time.

T: If you still have trouble figuring out what was going through your mind, here are some other questions [see Figure 6.2] you can ask yourself.

P: Okay.

T: First question: If I had to, what would I guess I was thinking about? Or, could I have been thinking about _____ or _____? Or, was I imagining something or remembering something? Or, finally, what does this situation mean to me? Or you might try to figure out what the opposite thought might be to jog your memory.

P: Okay.

T: How about trying out these questions this week if you have trouble identifying your automatic thoughts and if imagining the situation again doesn't help?

P: Fine.

To summarize, people with psychological disorders make predictable errors in their thinking. The cognitive therapist teaches patients to identify their dysfunctional thinking, then to evaluate and modify it. The process starts with the recognition of specific automatic thoughts in specific situations. Identifying automatic thoughts is a skill that comes easily and naturally to some patients and is more difficult for others. The therapist needs to listen closely to ensure that a patient is reporting actual thoughts and may need to vary his questioning if the patient does not readily identify her thoughts. The next chapter clarifies, among other things, the difference between automatic thoughts and emotions.

Chapter 7

IDENTIFYING EMOTIONS

Emotions are of primary importance to the cognitive therapist. After all, a major goal of therapy is symptom relief, a reduction in a patient's level of distress when she modifies her dysfunctional thinking.

Intense negative emotion is painful and may be dysfunctional if it interferes with a patient's capacity to think clearly, solve problems, act effectively, or gain satisfaction. Patients with a psychiatric disorder often experience an intensity of emotion that is excessive or inappropriate to the situation. Sally, for example, felt enormous guilt and then sadness when she had to cancel a minor social event with her roommate. She was also extremely anxious about going to a professor for help.

Although the therapist may recognize the excessiveness or inappropriateness of an emotion, he refrains from labeling it as such, especially early in therapy. Rather, he *acknowledges* and *empathizes* with how the patient feels. He does not challenge or dispute the patient's emotions but rather focuses on evaluating the dysfunctional thoughts and beliefs underlying her distress in order to reduce her dysphoria.

The therapist does not analyze *all* situations in which the patient feels dysphoric, however; cognitive therapy aims to reduce the emotional distress that is related to *misinterpretations* of a situation. "Normal" negative emotions are as much a part of the richness of life as positive emotions and serve as important a function as does physical pain, alerting us to a potential problem that may need to be addressed.

In addition, the therapist seeks to increase the patient's *positive* emotions through discussion (usually relatively brief) of the patient's interests, positive events that occurred during the week, positive memories, and so forth. He often suggests homework assignments aimed at increasing the number of activities in which the patient is likely to experience mastery and pleasure (see Chapter 12).

This chapter explains how to differentiate automatic thoughts from

emotions, how to distinguish among emotions, how to label emotions, and how to rate the intensity of emotions.

DISTINGUISHING AUTOMATIC THOUGHTS FROM EMOTIONS

Many patients do not clearly understand the difference between what they are thinking and what they are feeling emotionally. The therapist tries to make sense of the patient's experience and shares his understanding with the patient. He continually and subtly helps the patient view her experiences through the cognitive model.

The therapist organizes the material the patient presents into the categories of the cognitive model: situation, automatic thought, and reaction (emotion, behavior, and physiological response). It is important to be alert to occasions when the patient confuses thoughts and emotions. At these times, based on the flow of the session, their goals, and the collaboration, the therapist decides whether to ignore the confusion altogether or to address it later or right at the time (either subtly or explicitly).

At times, mislabeling a thought as a feeling is relatively unimportant in a given context, and it is better to address the confusion when discussing something else later on, if ever. In this case, the therapist ignores the confusion altogether.

THERAPIST: You mentioned when we set the agenda that you wanted to talk about the phone call you had with your brother.

PATIENT: Yeah. I called him a couple of nights ago, and I felt like he really didn't want to talk. He sounded kind of distant. I was feeling like he didn't really care if I had called or not.

T: If it were true that he didn't really care if you had called or not, what would that mean to you?

In this case, the therapist wants to uncover the underlying belief and so ignores the patient's verbal mix-up of feeling and thought. They proceed to evaluate and modify a key dysfunctional assumption.

In another session, the therapist views the confusion as important. He judges, however, that helping to clarify the confusion at the time might interrupt the flow of the session or interfere with his goal for the session (or that segment of the session). In this case, he finishes the topic at hand and returns to make the distinction between thoughts and emotion later.

T: I want to get back to something we talked about a few minutes ago. Do you remember when you were telling me that you knew you should go to the library last night but you didn't feel like going?

P: Yeah.

T: Actually, my guess is that you had a *thought* like, "I don't want to go," or "I don't feel like going." Is that right?

P: Yeah, I thought, "I don't feel like going."

T: What *emotion* went along with the thought, "I don't feel like going"?

P: I was a little anxious, I guess.

In many cases, the therapist subtly corrects the patient who has confused thoughts with emotions.

P: I was lying in bed, staring at the ceiling, feeling like I'd never be able to get up and that I'd be late for class.

T: So you were lying in bed and you had a couple of thoughts: I'll never be able to get up. I'll be late for class.

P: Yes.

T: And how did those thoughts make you feel emotionally?

Finally, the therapist occasionally decides to make a sharp distinction for the patient, judging that it is important to do so at the time and that the flow of the session will not be unduly interrupted or important data forgotten.

T: Were there any times this week when you thought about doing therapy homework?

P: Yeah, a few times.

T: Can you remember one time specifically?

P: Last night, after dinner, I was cleaning up, and I realized our appointment was today.

T: What was going through your mind right then?

P: Oh, I was feeling like it's no use. It probably won't help.

T: Those are good thoughts. We'll get back to evaluating them in a minute, but first I'd like to review the difference between thoughts and feelings. Okay?

P: Sure.

T: Feelings are what you feel *emotionally*—like sadness, anger, anxiety, and

so on. Thoughts are *ideas* that you have; you think them either in words or in pictures or images. Is that clear to you?

P: I think so.

T: So let's get back to the time last night when you thought about doing therapy homework. What emotion were you feeling?

P: Sad, I think.

T: And what thoughts did you have?

P: "This is no use. I'll never get better."

T: So you had the thoughts, "This is no use. I'll never get better," and those thoughts made you feel sad. Is that right?

P: Yeah.

In the examples in the transcript, the patient initially labeled thoughts as feelings. At times, the patient does the reverse, that is, labels an emotion as a thought:

T: As you walked into your empty dorm room, Sally, what went through your mind?

P: Sad, lonely, real down.

T: So you felt very sad and lonely and down. What thought or image made you feel that way?

IMPORTANCE OF DISTINGUISHING AMONG EMOTIONS

The therapist is continuously conceptualizing or reformulating the patient's problems, trying to understand the patient's experience and point of view. He tries to figure out how the patient's underlying beliefs gave rise to specific automatic thoughts in a specific situation and influenced the patient's emotions and behavior. The connection among the thoughts, emotion, and behavior should make sense to the therapist. He investigates further when the patient reports an emotion *that does not seem to match* the content of her automatic thought, as in the transcript below.

T: How did you feel when your mother didn't call you back right away?

P: I was sad.

T: What was going through your mind?

P: What if something happened to her? Maybe there's something wrong.

T: And you felt sad?

P: Yes.

T: I'm a little confused because those sound more like anxious thoughts. Was there anything else going on through your mind?

P: I'm not sure.

T: How about if we have you imagine the scene. You said you were sitting by the phone, waiting for her call?

[The therapist helps the patient vividly recall the scene in imagery form.]

P: And then I thought, "What if something happened? Maybe there's something wrong."

T: What happens next?

P: I'm looking at the phone, and I get teary.

T: What's going through your mind right now?

P: If anything happened to Mom, there would be no one left who cares.

T: There would be no one left who cares. How does that thought make you feel?

P: Sad. Real sad.

This interchange started with a discrepancy. The therapist was alert and picked up a possible inconsistency between the content of the automatic thought and the emotion associated with it. He was then able to help the patient retrieve a key automatic thought by using imaginal recall. Had he chosen to focus on the anxious thoughts, he may have missed the patient's more central concern. Although it may have been helpful to focus on a less central thought, finding and working with *key* automatic thoughts usually speed up therapy.

DIFFICULTY IN LABELING EMOTIONS

Most patients easily and correctly label their emotions. Some, however, display a relatively impoverished vocabulary for emotions; others understand emotional labels intellectually but have difficulty labeling their own specific emotions. In either of these two cases, it is useful to have the patient link her emotional reactions in specific situations to their labels. Devising an "Emotion Chart" such as the one in Figure 7.1 helps the patient learn to label her emotions more effectively.

T: I'd like to spend a few minutes talking about different emotions so we can both understand better how you feel in different situations. Okay?

Angry	Sad	Anxious
1. Brother says he's leaving to see friends.	1. Mom does not return phone call.	1. Raising hand in class.
2. Roommate does not return book.	2. Dorm meeting—no one pays attention to me.	2. Writing economics paper.
3. Roommate plays music too loud.	3. "C" on midterm.	3. Asking friend to go to dinner.

FIGURE 7.1. Sally's emotion chart.

P: Sure.

T: Can you remember a time when you felt angry?

P: Uh, yeah. . . . When my brother came home from college and acted all high and mighty. . . . He didn't want to spend any time with me.

T: Do you remember a specific scene?

P: Yes. It was Christmas vacation. I hadn't seen him since Thanksgiving. I thought we would hang out together that first day he got home, but he announced that he was leaving right away to go see his friends.

T: And what was going through your mind?

P: Who does he think he is? He thinks he's so great just because he's in college now.

T: And you felt–

P: Mad.

The therapist has the patient recall a *specific* event in which the patient felt a given emotion. From her description, it sounds as if the patient has correctly identified her emotion. The therapist, however, wants to make sure so he asks her to identify her automatic thoughts. The content of the automatic thoughts does match the stated emotion.

Next, the therapist asks the patient to recall two more occasions when she felt angry. This interchange occurs fairly quickly and the therapist does not ask for specific thoughts because he is reasonably certain from her description that she is accurately labeling the emotion. He follows up with an assignment.

T: Let's have you jot down these three situations in which you felt angry. Here, let's make columns and label the first one "angry." Can you jot

down a couple of words that will describe the three situations? [See Figure 7.1.]

P: (*Does so.*)

T: We're a little short on time. Suppose we label these other two columns "sad" and "anxious." Would you see if you can think of specific situations when you felt these emotions and jot them down at home? Do you think you could do it without too much trouble?

P: Yeah, I think so.

T: (*Checking whether the patient remembers rationale for the assignment.*) Do you remember why it's worth spending this time to differentiate your emotions?

P: Well, sometimes I'm not sure how I feel or what is bothering me, so doing this should help.

T: Right. And maybe you could refer to this sheet during the week when you notice you feel upset and try to figure out which emotion you *are* feeling. Okay?

P: Okay.

T: Let's have you write these things down on your homework sheet, to finish this "Emotion Chart" and refer to it when you're upset.

Again, with most patients, it is not necessary to use this technique to differentiate emotions. Others may benefit from a quick discussion along the above lines. A few might profit from a list of negative emotions (see Figure 7.2) and a brief discussion.

Sad, down, lonely, unhappy

Anxious, worried, fearful, scared, tense

Angry, mad, irritated, annoyed

Ashamed, embarrassed, humiliated

Disappointed

Jealous, envious

Guilty

Hurt

Suspicious

FIGURE 7.2. Negative emotions.

DIFFICULTY IN RATING DEGREE OF EMOTION

It is important for patients not only to identify their emotions but also to quantify the *degree* of emotion they are experiencing. Some have dysfunctional beliefs about emotion itself, for example, believing that if they feel a small amount of distress, it will increase and become intolerable. Learning to rate the intensity of emotions will aid the patient in testing this belief.

In addition, it is important to assess whether questioning and adaptively responding to a thought or belief have been effective. The therapist and patient judge whether a cognition requires further intervention by roughly measuring the drop in intensity of the emotion. Therapists who neglect to assess the change in distress may mistakenly assume that an intervention has been successful and proceed to the next thought or problem prematurely. Or the opposite may happen; they may continue discussing an automatic thought or belief, not realizing that the patient is no longer distressed by it.

Finally, gauging the intensity of an emotion in a given situation helps the patient and therapist determine whether that situation warrants closer scrutiny. A situation that is relatively less emotionally laden may be less valuable to discuss than one that is more distressing to the patient, where important beliefs may have been activated.

Most patients learn to judge the intensity of an emotion fairly easily, without a visual aid.

T: How did you feel when your friend said, "Sorry, I don't have time now"?

P: Pretty sad, I guess.

T: If 100% is the saddest you ever felt or could imagine feeling, and 0 is completely *not* sad, how sad did you feel right when he said, "Sorry, I don't have time now"?

P: About 75%.

Some patients have difficulty putting a specific number to the intensity. The therapist may then draw a scale:

0%	25%	50%	75%	100%
Not sad at all	Somewhat sad	Medium sad	Quite sad	Saddest I have been or could imagine being

T: Sometimes it's easier to remember if you imagine yourself back in the situation. (*Asks the patient to "relive" the experience as if it is happening now.*) Now take a look at this scale. How sad do you think you felt after the meeting? Somewhat sad? Medium sad? Quite sad?

P: Oh, somewhere between quite sad and the saddest I've ever been.

T: Somewhere between 75% and 100% sad? Which number is it closer to?

P: Oh, I guess 80% sad.

If the patient *still* has difficulty rating the intensity of her emotions, the therapist may consider helping the patient to build an idiosyncratic Emotional Intensity Scale to use as a guide for future ratings (Figure 7.3). The therapist chooses the patient's predominant emotion and provides or elicits a rationale.

T: Sometimes making a list of specific situations that were associated with an emotion can help. But, first, do you know why I'm even emphasizing this? Why might it be important to rate how intense your emotion is?

P: You said last week that it's one way to know if it's worth discussing something. And also to know if answering back a thought has helped.

Degree of emotion/anxiety	Situations
0%	Watching movie on TV last Saturday
10%	Wondering if I'd be late to therapy today
20%	Pain in side: appendicitis?
30%	Wondering why mom called unexpectedly
40%	Thinking about how much work I have to do
50%	Volunteering in class when I'm sure of the answer
60%	Thinking about going to the teaching assistant
70%	Talking to friends about life after graduation
80%	Volunteering in class when I'm unsure of my answer
90%	The night before my economics midterm
100%	My father's car accident

FIGURE 7.3. Sally's emotional intensity scale.

T: Okay. Now let's make a list of situations in which you felt anxious. What is the *most* anxious you've ever felt or could imagine feeling?

P: Uh . . . that probably was when my father was in a car accident, and I thought he was going to die.

T: (*Writes or has the patient write "Father's car accident" at bottom of paper.*) Now when was a time when you weren't the least bit anxious?

P: Oh, I guess on Saturday when I was watching a movie on television.

T: We'll put that at the bottom of the page. (*Does so.*) Okay, how about a situation in between?

P: Well, yesterday, when I thought about how much work I had to do.

T: (*Writes this item near the middle.*) Okay, another time that you were anxious.

P: When I had a sharp pain in my side, and I was worried it could be appendicitis.

T: Okay. Were you more nervous when you had the pain in your side or when you were thinking how much work you had to do?

P: Thinking about my work. I was just a little nervous about the appendicitis. It turned out to be nothing anyway.

T: (*Writes "Pain in side: appendicitis" near top of the page.*) Okay, another situation?

P: Well, the night before my economics exam.

T: Where would that go?

P: Below my dad's car accident.

Therapist and patient continue in the same vein until they have collected about 10 situations of different intensities. Sometimes they need to reassess the relative intensity of a situation. Sometimes a situation is eliminated if the patient judges that it evokes the same emotional intensity as does another situation. If there is insufficient time in session to record 10 situations, the therapist can ask the patient to continue the assignment at home. When the situations are ranked from not at all anxious to most anxious, the therapist then assigns percentages in degrees of 10. He confirms with the patient that the numbers assigned roughly correspond to each situation. If not, the numbers and/or situations are revised. Next he teaches the patient how to use the scale:

T: Okay, we've got our scale now. Let's see how useful it is. Did any other situation come up this week in which you found you were anxious?

P: Yeah, last night when I remembered that I hadn't finished my therapy homework.

T: Use your new scale as a guide. About how anxious did you feel?

P: Well, a little bit more than being worried that I'd be late for therapy.

T: What number would you put on it?

P: About 15%, I guess.

T: Good. I'd like you to use this scale as a guide whenever you're trying to figure out how anxious you are. Do you see any problems with doing that?

P: No. I think it'll be easier.

USING EMOTIONAL INTENSITY TO GUIDE THERAPY

The patient may not realize which situations she should bring up for discussion in therapy. The therapist can ask her to rate the degree of distress she feels or felt in order to decide whether discussion of a given situation is likely to benefit her. In the next transcript, the therapist quickly realizes that they will probably not accomplish much by focusing on an initial situation which Sally describes:

T: How did you feel when your roommate went out with her boyfriend instead of you?

P: Sad.

T: About how sad, 0–100%?

P: Not much. Maybe 20, 25%.

T: Sounds like you didn't feel *too* bad then. Was there another time this week when you got pretty upset with her?

In summary, the therapist aims to obtain a clear picture of a situation that is upsetting to a patient. He helps her clearly differentiate her thoughts and her emotions. He empathizes with her emotions throughout this process and helps her evaluate the dysfunctional thinking that has influenced her mood.