Beck’s cognitive model of psychopathology stresses the central role of thinking in the elicitation and maintenance of depression, anxiety, and anger (Beck, 1970, 1976; Beck, Emery, & Greenberg, 1985; Beck et al., 1979). Cognitive biases impute vulnerability to negative life events, such that a loss or impediment will more likely be interpreted in an exaggerated, personalized, and negative fashion. Beck’s cognitive model suggests that there are several levels of cognitive assessment. At the most immediate level are the automatic thoughts that come spontaneously, appear valid, and are associated with problematic behavior or disturbing emotions. These automatic thoughts can be classified according to their specific biases or distortions—for example, mind reading, personalizing, labeling, fortune telling, catastrophizing, or dichotomous (all-or-nothing) thinking (see Beck, 1976; Beck et al., 1985; Beck, 1995; Leahy & Holland, 2000). Automatic thoughts can be true or false—that is, the automatic thought “She doesn’t like me” may be based on mind reading (i.e., I lack sufficient evidence to derive this belief), but nonetheless it may prove to be true.

The emotional vulnerability to this thought will result from the underlying assumptions or rules (e.g., “I must get the approval of everyone to be worthwhile”) and the underlying personal schemas (e.g., “I am unlovable” or “I am worthless”) held by the individual. Underlying maladaptive assumptions or rules are typically rigid, overinclusive, impossible to attain, and impute vulnerability to future depressive episodes or to anxiety states (see Ingram, Miranda, & Segal, 1997; Persons & Miranda, 1992). Thus individuals who believe that they must gain the approval of everyone are more vulnerable to depression and anxiety because they inevitably will fail to live up to these standards. Their mind reading and personalizing will make them more likely to perceive rejection when it is not there.

Incoming information is channeled through these automatic thoughts (e.g., “Did she reject me?”) and then evaluated according to the underlying assumptions (e.g., “If I don’t get approval, then I am worthless”). The underlying assumptions are linked to the personal schema (e.g., “I am unlovable”), further reinforcing the negative personal belief and adding confirmation to the distrust and fear of oth-
ers. These negative personal schemas ("I am unlovable," "worthless," "defective") create selective attention and memory—that is, these individuals will be more likely to detect or interpret and recall information consistent with the schema thereby further strengthening the schema. Thus depressive and anxious styles of thinking are "theory-driven" and "research-based," in that they are continually looking for information to confirm the schema. This model is consistent with the considerable literature on the schematic processes underlying attention and memory (Hastie, 1980; Segal, Williams, & Teasdale, 2002). Like personal schemes, scientific theories are often guided by paradigms that direct the misinterpretation of information and that conserve themselves even in the face of contradictory data (Hanson, 1958; Kuhn, 1970). The cognitive model of therapy is based on George Kelly’s (1955) model of "man (or woman) as scientist”—that is, that humans can identify their personal "constructs" or beliefs and test them. The current cognitive model, advanced by Beck and his colleagues, stresses the aspect of scientific thinking that seeks "disconfirmation" or "falsification" of a belief—that is, examining how a belief could be proven wrong or inadequate, rather than simply seeking out confirmatory evidence (see Popper, 1959). The depressed individual may focus selectively on information consistent with the negative state of feeling depressed, ignoring the relevance of disconfirming evidence. The cognitive model seeks to examine both kinds of evidence.

Although I emphasize the Beckian model of cognitive therapy in this book, I also recognize the substantial contribution made by Albert Ellis and his colleagues (see Dryden & DiGiuseppe, 1990; Ellis, 1994; Kassinove & Tafrate, 2002). Ellis’s system, developed contemporaneously with Beck’s model, provides a more general approach to psychopathology by emphasizing a set of common cognitive vulnerabilities. These include low frustration tolerance, "shoulds," and other demanding and irrational cognitive distortions. The current approach does not conflict with the rational–emotive behavioral model advocated by Ellis and may be usefully integrated with it.

Throughout this chapter (and the book) we examine how therapists can assist patients in identifying and evaluating thoughts of various kinds. (Appendix A contains cognitive therapy conceptualizations for the major depressive and anxiety disorders; also see Leahy & Holland, 2000.) The cognitive model of psychopathology recognizes commonalities in thinking distortions and biases across diagnostic categories (e.g., automatic thought distortions), but also recognizes that there are specific conceptualizations for each diagnostic grouping. The goal here is to help patients adapt a cognitive approach to their problem by stressing the importance of identifying patterns of thinking, rather than focusing on the expression of emotion. However, experienced cognitive therapists also recognize that emotions often contain valuable information—indeed, Leslie Greenberg and Jeremy Safran have indicated how emotional expression and the therapeutic alliance can help patients utilize their emotions as a source of information about unmet needs (Greenberg & Safran, 1987). These emotional schemas about unmet needs—often evoked by activating emotional intensity and helping patients to differentiate various emotions—can be a rich source of information about cognitions and an important part of modifying these thoughts and feelings. I describe these “experiential techniques” in a later chapter; here we focus on more traditional cognitive techniques.

**TECHNIQUE: EXPLAINING HOW THOUGHTS CREATE FEELINGS**

**Description**

The fundamental assumption guiding cognitive therapy is that the individual’s interpretation of an event determines how he or she feels and behaves. Many people, in fact, are surprised to learn that their feelings are the result of how they think about an event and that by modifying their interpretation, they can have very different feelings. In this chapter, I review a variety of techniques that are use-
ful in helping patients learn how to recognize the ways in which their thoughts and feelings interact. After all, people seek therapy not because they think they are irrational but because their feelings, behavior, and relationships are problematic. Two foundational points are worth considering:

1. Thoughts and feelings are distinct phenomena.
2. Thoughts create feelings (and behavior).

Thoughts are not the same thing as feelings. Feelings are internal experiences of emotions—for example, I may feel anxious, depressed, angry, afraid, hopeless, happy, exhilarated, indifferent, curious, helpless, regretful, or self-critical. To say I have a particular feeling or emotion is similar to saying, “This hot iron hurts” or “This scone tastes good to me.” We do not challenge feelings—it would not make sense to say to a patient, “You’re not really anxious.” To do so would be equivalent to saying, in essence, that the hot iron did not really hurt the patient when he or she said, Ouch. “Ouch” is a report of a sensation—just as the words “I am happy” or “I am sad” are reports of feelings. We do not dispute feelings. We challenge and dispute the thoughts that give rise to those feelings.

Therapists can explain to patients how their thoughts may create their feelings or may increase or decrease a feeling. Consider, for example, the different feelings these two statements engender: “I think I’m unlovable and, therefore, I feel hopeless”; or “I think I’m better off without him and, therefore, I feel hopeful and relieved.” Figure 1.1 provides additional explanatory examples.

Question to Pose/Intervention
Therapists can use the following wording as a model for explaining these ideas to patients in straightforward, jargon-free language: “Before you can challenge and change thoughts, you have to understand how thoughts affect your feelings. When you are feeling down or anxious, you may have certain thoughts. For example, imagine you are walking down the street in a strange part of town very late at night and you hear someone walking behind you. Glancing over your shoulder, you see that it’s two very large men. Your thought might be, ‘They’re going to rob me.’ How would you feel? Afraid? But

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ll never be happy again.</td>
<td>Hopeless</td>
</tr>
<tr>
<td>Life is not worth living.</td>
<td>Suicidal</td>
</tr>
<tr>
<td>She left me because I was unattractive.</td>
<td>Hopeless</td>
</tr>
<tr>
<td>I’m going crazy.</td>
<td>Frightened, panicky</td>
</tr>
<tr>
<td>He’s taking advantage of me.</td>
<td>Angry, vengeful, defensive</td>
</tr>
<tr>
<td>No one cares about me.</td>
<td>Lonely, rejected</td>
</tr>
<tr>
<td>I won’t be able to take care of myself.</td>
<td>Anxious, helpless, dependent</td>
</tr>
<tr>
<td>I’ve solved problems before, I can solve them again.</td>
<td>Hopeful, energized</td>
</tr>
<tr>
<td>I don’t need to be perfect.</td>
<td>Relieved, less pressured</td>
</tr>
<tr>
<td>I should give myself credit for trying.</td>
<td>Proud, happy</td>
</tr>
</tbody>
</table>

FIGURE 1.1. How Thoughts Create Feelings.
what if you thought, “They’re my friends from work? How would you feel? Relieved? When you are feeling down or anxious in your day-to-day life, you have different thoughts. So, let me ask you, when you were sitting in your apartment thinking, and you noticed that you felt anxious, what were you thinking?”

**Example**

As indicated in Figure 1.1, thoughts can create both positive and negative feelings. Sometimes the patient may get so focused on what he or she is feeling that he or she does not recognize that it is a particular thought that creates the feeling. Consider the following dialogue:

THERAPIST: What seems to be bothering you?

PATIENT: I just feel sad.

THERAPIST: Can you tell me why you feel sad?

PATIENT: I just feel awful, like a sense of doom. I cry a lot.

THERAPIST: OK. Maybe you can help me understand what you are saying to yourself that’s making you feel sad. Complete this sentence: “I feel sad because I think . . . ”

PATIENT: I’m unhappy.

THERAPIST: *Unhappy* is a feeling. But what are you saying to yourself that makes you feel sad? For example, are you saying anything about yourself as a person, about the future, or about this experience?

PATIENT: I guess I’m saying that I think that I’ll never be happy.

In this example, the therapist was able to elicit the hopeless prediction, “I’ll never be happy.” This prediction can be evaluated by using the following techniques: cost–benefit analysis, examining the evidence for and against the validity of the prediction, examining logical errors (e.g., “I feel sad now, therefore, I’ll always feel sad.”) All of these techniques are discussed in the pages to follow.

**Homework**

Patients are asked to keep track of their feelings and how these feelings are related to their thoughts. The therapist can say: “I want you to keep a record of your negative feelings over the next week, using this form [Form 1.1 at the end of the chapter]. When you notice that you are having a feeling or an emotion, write down what that feeling is in the left-hand column. Examples of feelings are *sad*, *anxious*, *afraid*, *hopeless*, *angry*, and *confused*. Now, in the right-hand column, write down the thought that goes with that feeling. For example, the feeling might be ‘anxious’ and the thought might be ‘I am afraid I’ll do badly at work.’ So the entire thought is, ‘I feel anxious because I am afraid I’ll do badly at work.’”

**Possible Problems**

Patients commonly confuse thoughts with feelings. It is useful to anticipate this problem by offering an example: “Sometimes people confuse a thought with a feeling. For example, someone might say, ‘I feel anxious because I am nervous.’ This is really a report of two feelings or emotions—that is, *anxious* and *nervous*. ‘I feel anxious’ is a feeling, and ‘I am nervous’ is another feeling. The thought might be ‘I think I won’t do well’ or ‘I think I’ll always be anxious.’”
Another common problem initially is that patients are unable to identify the thoughts associated with their feelings. In these cases, the therapist might use some of the other techniques described in this chapter or in Chapter 8, which contains a section on imagery techniques.

**Cross-Reference to Other Techniques**

As indicated, we can utilize other techniques in this chapter—such as “guessing the thought”—or we can use the imagery induction techniques described in Chapter 8. Many patients receive assistance in identifying automatic thoughts from reading books on cognitive therapy, such as David Burns’s *Feeling Good Handbook* (1989) or Dennis Greenberger and Christine Padesky’s *Mind over Mood* (1995). In addition, providing patients with a list of common cognitive distortions (Figure 1.6) and a form for them to fill in (see below) is quite helpful.

**Form**

Form 1.1 (Self-Help Form: How Thoughts Create Feelings, p. 27).

**TECHNIQUE: DISTINGUISHING THOUGHTS FROM FACTS**

**Description**

Often, when we are angry or depressed, we treat our thoughts as if they are facts. I might say, “He thinks that he can take advantage of me,” and I might think that I am absolutely right—but I could also be wrong. When I am anxious, I might think “I know I’ll do poorly in this presentation”—but I could be either right or wrong. I can believe or think that I am a giraffe, but it does not mean that I am a giraffe. Just because I believe something is true does not mean that it is true. Thoughts are hypotheses, descriptions, perspectives, and even guesses. They can prove to be either true or false. Patients need to learn how to identify their thoughts and then examine the facts. In order to distinguish thoughts, feelings, and facts, therapists can use the A-B-C technique in which patients have an opportunity to recognize how the same activating event can lead to different beliefs (thoughts) and consequences (feelings and behavior). If I believe I can never do well on the exam (my thought), I might feel hopeless and behave accordingly—for example, by not bothering to study. On the other hand, if I believe that I have a good chance of doing well on the exam, I might feel hopeful and therefore study for it.

What is interesting about this example is that my initial thought—“I won’t do well on the exam”—leads to the maladaptive behavior of not preparing for the exam, which then leads to the self-fulfilling prophecy of doing poorly on the exam.

Many people who are depressed, anxious, or angry treat their thoughts as if they were facts—that is, “It’s true that I won’t do well on the exam” or “I know she’ll reject me.” Figure 1.2 contains a number of examples of the same activating event leading to different thoughts, feelings, and behaviors.

The importance of distinguishing a negative thought from possible facts is illustrated by Figure 1.3. Here the patient is asked to imagine that he or she is having a negative thought, such as, “I am not prepared for my exam.” The right-hand column prompts the patient to consider any facts that might be relevant to a valid evaluation of his or her preparedness? The initial thought is a belief; the possible facts can become beliefs, once they are considered. The patient can be asked, “Is it possible that your thoughts are not the only things to consider? Wouldn’t you want to look at other possible facts?” Thoughts and facts are not equivalent.
<table>
<thead>
<tr>
<th>A = Activating Event</th>
<th>B = Belief (Thought)</th>
<th>C = Consequence: Feelings</th>
<th>C = Consequence: Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hear the window rattling.</td>
<td>Someone is breaking into my house.</td>
<td>Anxious</td>
<td>Lock the door, call police.</td>
</tr>
<tr>
<td>I hear the window rattling.</td>
<td>It’s windy outside and the window is old and loose.</td>
<td>Slightly irritated</td>
<td>Try to tighten the window, go back to sleep.</td>
</tr>
<tr>
<td>A man is approaching me on a dark, empty street.</td>
<td>I’m going to get mugged.</td>
<td>Terrified</td>
<td>Run.</td>
</tr>
<tr>
<td>A man is approaching me on a dark, empty street.</td>
<td>I wonder if that’s my old friend Steve.</td>
<td>Curious, pleased</td>
<td>Call out Steve’s name.</td>
</tr>
<tr>
<td>My husband is sitting reading the newspaper.</td>
<td>He doesn’t care about my feelings.</td>
<td>Angry, resentful</td>
<td>Tell him he’s self-centered.</td>
</tr>
<tr>
<td>My husband is sitting reading the newspaper.</td>
<td>He’s withdrawing from me because he’s angry with me.</td>
<td>Upset, guilty</td>
<td>Avoid interacting with him.</td>
</tr>
<tr>
<td>I feel my heart beating rapidly.</td>
<td>I’m having a heart attack.</td>
<td>Anxiety, panic</td>
<td>Go to emergency room.</td>
</tr>
<tr>
<td>I feel my heart beating rapidly.</td>
<td>I’ve had too much coffee.</td>
<td>A little regretful</td>
<td>Try to cut back on caffeine.</td>
</tr>
</tbody>
</table>

**FIGURE 1.2.** The A-B-C Technique. The same event gives rise to different thoughts that lead to different feelings and behaviors. You determine if your thought is true by examining the facts.

<table>
<thead>
<tr>
<th>Negative Thought</th>
<th>Other Possible Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel my heart beating rapidly.</td>
<td>I’ve had too much coffee.</td>
</tr>
<tr>
<td>I am not prepared for my exam.</td>
<td>I have read the material, gone to class, and done some work.</td>
</tr>
<tr>
<td>I’ll always be alone.</td>
<td>I don’t have all of the facts, since I don’t know what is in the future. I have friends. I have a lot of qualities that people like.</td>
</tr>
</tbody>
</table>

**FIGURE 1.3.** Thoughts versus Possible Facts.
Question to Pose/Intervention

“Thoughts and facts are not the same. Just because you think something is true does not necessarily mean that it is true. I can think that I am a zebra—but my thought does not mean I am a zebra. We have to check out the thought against the facts.”

Example

THERAPIST: Can you tell me what you’re thinking about that’s making you so anxious?

PATIENT: I think I’m going to get fired.

THERAPIST: How do you know that you will get fired?

PATIENT: I just know it. I can see it coming.

THERAPIST: You may believe or think that you’ll get fired, but isn’t it possible that you could be wrong about this?

PATIENT: I feel pretty strongly about this. I just know it’s going to happen.

THERAPIST: Although it could be true—it could happen that you might be fired—it may also be possible that it won’t happen. There’s a difference between a belief and a fact. Believing it’s true doesn’t make it true. Would you consider the possibility of examining the reasons why you might get fired and the reasons why you might not get fired?

In this example, the therapist acknowledges the patient’s strong belief and explains that belief does not equal truth. The therapist then invites the patient to examine the evidence and the reasoning that leads to the belief about getting fired. The recognition that thoughts are not facts is the starting point of helping the patient construct alternative interpretations of events.

Homework

The therapist can ask the patient to keep track of activating or preceding events that lead to specific beliefs and feelings by using Form 1.2 at the end of the chapter. In addition, the patient can use the Thought versus Possible Facts form (1.3) to examine how a particular thought does not always take into account all of the possible facts. For example, the thought “I am not prepared for the exam” does not include the possible facts that I am intelligent, I have attended class, and I have read the assignments.

Possible Problems

Some people believe that their thoughts are the last word on the truth. Indeed, sometimes the negative thoughts are true. We do not want patients to get the impression that we believe that everything they believe is false. This distinction can be made in the following way: “Sometimes your thoughts will accurately describe the facts, and sometimes your thoughts will not accurately reflect all of the facts. Wouldn’t it be a good idea to use a general rule of checking out your negative thoughts against all of the relevant facts?”

Some patients respond that examining the facts seems invalidating and critical of the patient’s position. I have described this problem in Overcoming Resistance in Cognitive Therapy (Leahy, 2001b). The feeling of invalidation can be explored directly by asking the patient if these questions about the facts seem like “put-downs” or “rejections.” Again, the important point to make is that examining the facts does not necessarily mean that the patient is incorrect.
Cross-Reference to Other Techniques

Other relevant techniques include looking at the evidence for and against the validity of a thought, distinguishing thoughts from feelings, categorizing cognitive distortions, and looking at variations in believing a thought. For example, the patient who has variation in a thought such as “I am a failure” can be asked if his or her belief in the thought depends on the facts to which he or she is attending.

Forms

Forms 1.2 (Self-Help Form: The A-B-C Technique, p. 28); Form 1.3 (Thoughts versus Possible Facts, p. 29).

TECHNIQUE: RATING THE DEGREE OF EMOTION AND DEGREE OF BELIEF IN THE THOUGHT

Description

We may have many different emotions and beliefs about a single event. What is really important is how strongly we feel something and how strongly we hold a belief.

Emotions obviously vary in degree. I can feel slightly sad, somewhat sad, very sad, extremely sad, or overwhelmingly sad. Since many people who are sad, anxious, or angry are often undifferentiated in their thinking or in their observations of their own emotions, it is useful to teach them how to distinguish the various degrees of their emotions. Furthermore, given that change in therapy is often gradual, it is important that patients be able to detect various degrees of change in their feelings or emotions. For example, a patient whose feelings change from overwhelmingly sad to somewhat sad might realistically conclude that good progress has been achieved.

Question to Pose/Intervention

“How much do you feel upset, and how strongly do you hold your belief? Rate your feeling (emotion) from 0% to 100%, where 0% corresponds to having none of that feeling and 100% corresponds to the most intense experience of that feeling. The same with your beliefs: 0% corresponds to not holding that belief at all, and 100% corresponds to believing your thought 100%. To what degree do your feelings and thoughts change? What could be some reasons why you feel better at certain times than other times? Are you doing different things when you are feeling down? Or up? Are you thinking differently when you are down? Or up?”

Example

THERAPIST: You said that you are feeling sad since you and John broke up. Can you describe this sadness for me?
PATIENT: Oh, I feel very sad. Sometimes I cry when I think of how he left me.
THERAPIST: Your feelings are important, so I want to be able to really understand how you feel when you’re thinking about the breakup. If you were to rate your sadness from 0% to 100%, where 0% represents absolutely no sad feelings and 100% represents the greatest sadness imaginable, how would you rate your sadness?
PATIENT: I guess I’ve never thought about how I rate my feelings. I’d say about 95% sadness.
Eliciting Thoughts and Assumptions

Similarly, the patient may hold an absolute belief—for example, “I can never be happy without John”—but the patient’s degree of belief (i.e., the credibility or strength of the belief) might be less than 100%. This recognition that beliefs vary in strength is a very important beginning in gaining distance from distressing beliefs. If I can hold a belief in which I invest less than 100% veracity, then it means that I already have some doubt about that belief. It also means that my belief can vary—it could be less than its current strength. Consequently, I can imagine changing this belief even more vividly.

THERAPIST: You said you feel very sad when you think about John leaving you. Can you complete this sentence with the first thoughts that come to your mind? “I feel very sad when I think of John leaving me because I think . . .”

PATIENT: I can never be happy without him.

THERAPIST: OK. The automatic thought is “I can never be happy without him.” Why don’t you write that down. [The therapist has given the patient a clipboard with paper and pen to take notes during the session.] Now let’s see how much you believe that thought: “I can never be happy without him.” If you were to rate that thought from 0% to 100%, where 0% represents the complete absence of that belief and 100% represents your absolute certainty that this belief is true, how would you rate it?

PATIENT: I guess I’d have to say it’s a pretty high rating. I really believe this—most of the time. I’d give it about 90%.

Some people have a hard time using this kind of scale. The idea of rating emotions and beliefs is foreign to their thinking. The therapist may need to provide visual aids.

THERAPIST: You said you felt sad, but it’s hard for you to use the scale. Let’s define what this scale is. (Draws the scale shown in Figure 1.4.) Let’s say that 0% represents absolutely no sadness, and that 100% represents the most sadness that anyone could imagine—you are absolutely overwhelmed with sadness, so that you can’t think of anything else. Fifty percent represents a moderate amount of sadness, whereas 90% represents an extreme amount of sadness—a very disturbing amount—but you are still able to function, to a large degree. Now, when you think about John leaving you, where would you place your sadness on this scale?

PATIENT: I’d say at about 95%. I’m extremely sad, but I’m still able to function, to some degree.

Homework

The therapist can ask patients to keep track of how their degree of belief in their thoughts changes during the course of the next week. Patients are asked to use the self-help form (1.4) for rating emotions and beliefs (at the end of the chapter), on which they note what events preceded the thoughts and feel-

<table>
<thead>
<tr>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>No sadness</td>
<td>Slight</td>
<td>Moderate</td>
<td>Very</td>
<td>Extreme overwhelming sadness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FIGURE 1.4.** Rating Emotions on a Scale from 0 to 100.
ings and rate the degree of belief and the degree of emotion associated with each event. After this exercise has been completed, it can be suggested that patients reflect on what could account for the variation in the negative thoughts and feelings they experience.

**Possible Problems**

Problems that typically occur with this exercise include a lack of motivation to write down the same belief more than once during the week. Patients may think, “I’ve already done this.” However, the purpose of the exercise is to examine carefully the variation in the belief and the feeling and what accounts for this change. This differentiation also helps us identify possible “trouble times” for patients—that is, times when they are more likely to feel depressed or anxious. This knowledge can assist the therapist in focusing treatment around these problematic times.

**Cross-Reference to Other Techniques**

Other relevant techniques include examining how thoughts lead to feelings, distinguishing thoughts from facts, the vertical descent technique, categorizing negative thoughts, and looking for variations in a particular thought.

**Forms**

Form 1.4 (Self-Help Form: Rating Emotions and Beliefs, p. 30).

**TECHNIQUE: LOOKING FOR VARIATIONS IN A SPECIFIC BELIEF**

**Description**

In order to gain distance from a belief, it is often useful to recognize that even in the present circumstances, our beliefs may change in strength or credibility. The cognitive therapist is always interested in the flexibility of beliefs; extremely depressed or anxious persons, in contrast, may think that their beliefs are fixed in concrete and never change. Consequently, the therapist directly assesses variability of belief. This technique is closely related to the technique of rating degree of emotion and degree of belief in the thought described above. The emphasis here is on a specific belief and its variation across time and situations.

**Question to Pose/Intervention**

“Are there times that you believe this thought with less conviction? What is going on when you believe this negative thought less? If your thought were entirely true, then how could you believe it to be less true at certain times?”

**Example**

**Therapist:** You said that you believe that you can never be happy without John and that you give this belief a 90% rating.

**Patient:** That’s right. I really believe this. That’s why I’m so unhappy.
Eliciting Thoughts and Assumptions

THERAPIST: Now during the course of the day, I imagine that your moods change—sometimes you’re more unhappy than at other times?

PATIENT: Yes. I’m not always crying or even thinking about John.

THERAPIST: What are you thinking about when you’re not thinking of John?

PATIENT: I’m thinking about changing the apartment—maybe getting some new furniture. Or I’m thinking of having lunch with my friends.

THERAPIST: Obviously, when you’re not thinking about John, the strength of the belief is 0%—since at that very moment, you’re not feeling unhappy, even though John is not with you.

PATIENT: Well, that’s a novel way of thinking about it. But I guess you’re right.

THERAPIST: Are there times during the day when you think of John but you are not 90% unhappy?

PATIENT: Yes. Sometimes I think, “Maybe I’m better off without him.”

THERAPIST: So, if I were to jump into your head at that moment and ask you, “Tell me—right now—how much do you believe ‘I can never be happy without John?’ how would you answer?”

PATIENT: Oh, well, at those times, my belief would be very low, maybe even 10%.

THERAPIST: So this belief that you have right now can change—even in the course of a few hours.

What do you make of that?

PATIENT: I guess that my thoughts about the breakup might change.

THERAPIST: When people go through breakups, they often have very strong, negative, powerful beliefs. I’m sure you have friends who have gone through this experience.

PATIENT: Yes, my friend Alice got divorced 5 years ago.

THERAPIST: Perhaps she had the exact same belief that you have right now. Have her beliefs changed over the years?

PATIENT: You’re right, they have! Now she can’t even imagine being in the same room with her ex-husband.

THERAPIST: Well, let’s keep this in mind—how your beliefs change and the beliefs of other people change.

Homework

Using Form 1.5 (at the end of the chapter), the patient can be given the homework assignment of tracking the degree of belief in a specific thought for several days. Presumably, the patient’s focus and concern about a belief will vary with time of day, events, and other thoughts. This variation further reinforces the idea that a strongly held belief can be changed. Furthermore, the patient’s strongly held belief may vary during the session. Periodically during the session, as the patient and therapist focus on challenging beliefs and planning behavior, the therapist can ask the patient how strong the belief is at those different points. It is not uncommon for a patient to begin the session with a belief held at 90% and end the session with the belief held at 40%.

This change in belief is then linked to the change in emotion—for example, sadness has decreased as the strength in the belief has diminished—further reinforcing the assumptions of cognitive therapy and providing hope to the patient that strongly held beliefs and unpleasant emotions can be modified.

THERAPIST: Your belief has changed from 90% to 40% in 30 minutes, and your sadness has greatly decreased. What do you make of that?

PATIENT: I guess my thoughts and feelings can change in this kind of therapy.
THERAPIST: If we were able to change your thoughts and feelings in just 30 minutes, what do you think would happen if you were able to use these techniques on your own?

PATIENT: Well, I guess I’d feel better.

THERAPIST: Why don’t we see what happens, then?

Possible Problems

As with the foregoing techniques in this chapter, patients may be less motivated to write down a negative belief when he is feeling better. The therapist needs to make clear that there is a lot of useful information when they are feeling better. For example, if the patient believes “I have nothing to offer because I am a loser” but notices that his or her degree of belief in this thought is 0% when talking with friends, the patient has gained useful information that can lead to the following intervention and question: “If your belief changes, then assign yourself tasks that are associated with more positive beliefs. If your belief changes, then it may not be accurate. What information are you considering when you are feeling less negative?”

Cross-Reference to Other Techniques

As suggested above, other relevant techniques include graded task assignment, examining all of the information or facts, challenging beliefs by examining the evidence for and against the validity of the belief, distinguishing a fact from a thought, and distinguishing a thought from a feeling.

Form

Form 1.5 (Tracking Degree of Belief in a Thought, p. 31).

TECHNIQUE: CATEGORIZING THE DISTORTION IN THINKING

Description

Continually distorting thoughts in the same manner—for example, by jumping to conclusions, personalizing bad events, or labeling oneself as a failure—are common patterns in people who are depressed or anxious. The cognitive model proposes that unpleasant emotions are often associated with these biases or distortions in thinking. Automatic thoughts (i.e., thoughts that come spontaneously) are associated with negative affect or dysfunctional behavior and seem plausible to the individual. Examples of automatic thoughts are “I’ll never be happy,” “I’m stupid,” “No one likes me,” “It’s all my fault,” and “She thinks I’m boring.” Automatic thoughts can be true, false, or have varying degrees of validity. The same thought may contain more than one distortion—for example, “When I go to the party, she’ll think I’m boring.” This thought reflects both fortune telling and mind reading. Beck (Beck, 1976; Beck et al., 1979) and Burns (1989) have identified various automatic thought distortions. Form 1.6 (at end of chapter) provides common thought distortions that are associated with depression, anxiety, and anger.

Question to Pose/Intervention

“Are you continually distorting your thinking in the same way? Look at the checklist of cognitive distortions. Are there certain kinds of distortions that you are using? What are they?”
Eliciting Thoughts and Assumptions

Example

The therapist elicits the patient’s automatic thoughts by asking, “What were you thinking when you felt sad?” or by supplying a sentence stem for the patient to complete, such as, “I felt anxious because I thought . . .” The automatic thoughts are then categorized. The therapist explains: “Write down your negative or upsetting thought in the left-hand column and categorize the distortion in the right-hand column.” See Figure 1.5 for an example.

Homework

The patient can be given the assignment of monitoring any negative automatic thoughts over the following week and categorizing them, using Forms 1.6 and 1.7 at the end of the chapter. The value of this exercise is that patients see how they repeat the same categories of automatic thoughts—for example, fortune telling: “I’ll never be happy,” “Nothing will work out,” “No one will ever want me,” “I’ll always be alone.” If there is a clear repetition of a specific category of negative thoughts, then the therapist and patient can develop a specific set of challenges that can be used repeatedly to depotentiate the thoughts. For example, the patient who continually engages in mind reading (e.g., “He thinks I’m a loser,” “They don’t like me,” “I must look pathetic”) might be instructed to compose a list of challenges to these repetitive thoughts. These challenges could include the following: “I don’t have any evidence,” “I’m jumping to conclusions,” “Why should they dislike me if they don’t even know me?,” “I’m just as good as anyone here,” “I don’t need their approval,” “I don’t need to impress everyone,” or “Maybe they’re thinking about whether I like them.”

Possible Problems

As indicated above, some patients believe that categorizing their thoughts as distortions implies that they are stupid or crazy. It is important to clarify that some negative thoughts are true. For example, the thought might be, “She doesn’t like me.” We can categorize this thought as mind reading, but it could also be true. Perhaps she doesn’t like me. I indicate to patients that we use the form “cognitive distortions” because it is a handy way of categorizing thoughts—but that many negative thoughts have a degree of truth to them. Once we are able to find a pattern to the thoughts—let’s say, mind reading—that is associated with feeling down, then we can develop some specific interventions for that pattern. Categorizing thoughts should not be equated with refuting or negating thoughts. We have to examine the facts.

<table>
<thead>
<tr>
<th>Automatic Thought</th>
<th>Distortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m a failure.</td>
<td>Mislabeled</td>
</tr>
<tr>
<td>She thinks I’m unattractive.</td>
<td>Mind reading</td>
</tr>
<tr>
<td>Nothing I do works out.</td>
<td>All-or-nothing thinking</td>
</tr>
<tr>
<td>Anyone can do this job—it doesn’t mean anything.</td>
<td>Discounting positives</td>
</tr>
</tbody>
</table>

FIGURE 1.5. Examples of Automatic Thought Distortions.
Cross-Reference to Other Techniques

Other relevant techniques include the thought monitoring described above, whereby the patient keeps track of thoughts, facts, feelings, and variations in the degree of belief in a thought. In addition, the checklist of cognitive distortions can assist the therapist in planning interventions or questions, such as using vertical descent, identifying underlying assumptions and schemas, evaluating feared fantasy, looking at the costs and benefits, and considering the evidence for and against the validity of certain thoughts.

Forms

Form 1.6 (Checklist of Cognitive Distortions, p. 32); Form 1.7 (Categorizing Your Thought Distortions, p. 33).

TECHNIQUE: VERTICAL DESCENT

Description

Sometimes negative thoughts turn out to be true. Let’s say that a male patient predicts he will be ignored or rebuffed at a party. This is fortune telling, but it may prove accurate. Exploring the beliefs underlying the fear of that outcome helps to depotentiate the thought. With this technique, the therapist continues to ask about that thought or event: “What would then happen if that were true?” or “What would that mean to you if that happened?” We refer to this process as vertical descent we are attempting to burrow down to the bottom-most belief. Accordingly, the therapist writes the patient’s thought on the top of a page and then draws a downward arrow to the series of thoughts or events that is implied by the thought (see Figure 1.6).

Question to Pose/Intervention

“If your thought is true, why would it bother you? What would it make you think? What would happen next?”

Example

Vertical descent is a useful way at getting at the underlying fears of which patients are unaware. I use this technique frequently, because I have found that I can never really tell what the patient’s underlying beliefs and fears might be. For example, most of us have a fear of dying—but what is it that each of us really fears? Consider these two patients, each of whom had a fear of dying.

THERAPIST: You said that you sometimes fear you might have cancer. Even though the doctor has reassured you that you are OK, what would it mean to you if you did have cancer?

PATIENT: I’d be afraid that I might die.

THERAPIST: Almost everyone has a fear of that, of course, but let me ask you about your own fears of dying. Complete this sentence: “I’d be afraid of dying because . . . ”

PATIENT: I’d be afraid that I wasn’t really dead—that I was only in a coma—and that I would wake from the coma in my grave, buried alive.
This patient’s fears of being buried alive are quite symbolic (to use a noncognitive term). Many of her problems revolved around the issue of constraints on her behavior, such as food restrictions, limits set on her by her boss, and the limits of her finances. It is useful to write out on a sheet of paper or a blackboard in the office the string of thoughts showing the downward progression to the core fear. The example of the first patient, with the fear of being buried alive, is shown in Figure 1.7.

Another patient, whom I would describe as a compulsive caretaker who tries to take care of everyone’s needs, also had a fear of dying. His fear revolved around the well-being of his wife and daughter, were he to die.
I’d be afraid that I might die.

I’d be afraid that I wasn’t really dead but in a coma.

I’d be afraid that I would wake up buried alive.

**FIGURE 1.7.** Taking the Vertical Descent to the Implication of a Thought.

**THERAPIST:** What about dying would bother you the most?

**PATIENT:** It’s not the physical pain. I don’t really worry about that. And I’ve already done enough for five lifetimes. It’s that if I died, I would be worried that I didn’t take care of everyone.

**THERAPIST:** Who is it that you would have to take care of?

**PATIENT:** My wife and my daughter. I could die if I knew they’d be alright.

**THERAPIST:** So you’re saying that you can accept death if you know that the people you love are taken care of?

**PATIENT:** That’s right.

**THERAPIST:** Are you assuming that they are helpless without you?

**PATIENT:** I guess I am.

The therapist can ask any number of questions about an event or thought. For example:

- Why would that be a problem for you?
- What would happen?
- Why would that bother you?
- Then what?
- What would that mean to you?

**Homework**

The patient is asked to draw out the implication of negative thoughts by using the vertical descent form (1.8, at the end of the chapter). This form asks the patient to identify a string of implications. The therapist might say to the patient: “Your negative thoughts are connected with other negative thoughts. We are interested in how you think and what each negative thought means to you. For example, someone might have the negative thought ‘I’m not prepared for the exam,’ which then leads to the thought ‘I’ll fail the exam,’ which tumbles into the thought ‘I’ll have to drop out of school.’ Try to identify some of your negative thoughts and then examine the string of thoughts that follows. Keep asking yourself, ‘And if that were true, it would bother me because it would mean . . .’”
Possible Problems

Some patients stop identifying their negative thoughts in the middle of the sequence. For example, the patient might stop with the thought, “I’ll flunk the exam,” and not go any further in the vertical descent. The patient might say “Flunking seems bad enough” or “I don’t really believe I would flunk the exam.” It is helpful to ask the patient to keep pushing for even “deeper” or “worse” thoughts that would follow from the first few thoughts. Often we find that the patient’s thoughts about having any failure or rejection are associated with fantasies of awful or catastrophic consequences. These underlying “worst fears” fuel the anxiety about the initial thoughts.

Cross-Reference to Other Techniques

Techniques related to the vertical descent include identifying thoughts and feelings, examining the evidence for and against the thought, examining the costs and benefits of the validity of the thought, evaluating the leaps in logic underlying the thought, calculating sequential probabilities, and challenging the thought.

Form

Form 1.8 (Using the Vertical Descent, p. 34).

**TECHNIQUE: ASSIGNING PROBABILITIES IN THE SEQUENCE**

Description

Using the vertical descent procedure described above, the patient can now estimate the probability of each event occurring in the sequence, given that the preceding event is true. We are not only interested in the thoughts that are implied in the vertical descent but also in the subjective estimates of probabilities. These subjective estimates are usually far beyond what we would expect to be true, given our knowledge of baseline information in the general population.

Question to Pose/Intervention

“What is the probability that X would happen?” “What is the likelihood from 0% to 100%?”

Example

The therapist might introduce the idea of probability in the following way.

**THERAPIST:** The likelihood that something will happen is called *probability*. Probabilities can vary between 0% and 100%—there are probably very few things that have a 0% or 100% probability. For example, the probability of getting heads when I flip a coin is 50%. The question that I will ask you is, What is the probability of each of your thoughts being true? Let’s take the first thought “I am not prepared for the exam.” What is the probability that this thought is true?

**PATIENT:** I’d say about 90%.
THERAPIST: Your next thought was that you would fail the exam. What’s the probability that you would fail the exam, given that you are not prepared?

PATIENT: Oh, I’d say about 30%. I actually know some of the things that will be on the test.

THERAPIST: OK. But if you did fail the exam, what is the probability that you would flunk out of school?

PATIENT: Probably 2%. I have already taken a lot of courses and passed them.

THERAPIST: OK, but if you did flunk out of school, what is the probability that you would never get a job?

PATIENT: Less than 1%.

THERAPIST: OK, now what if we got our calculator out and totaled up these probabilities. The way we do this is to take your first estimate 90%, enter .90, and multiply by each of the other probabilities. So that is .90 times .30 times .02 times .01. What do we get? The calculator says .000054.

PATIENT: That seems like an unlikely event.

THERAPIST: It’s about 5 in 100,000 or about 20,000 to 1.

Possible Problems

As with the previous vertical descent exercise, the patient may stop prematurely in the sequence, claiming that he or she really doesn’t believe the next thought in the sequence. Or the patient may claim that the initial thoughts would be bad enough. Again, the therapist should emphasize that even if the other thoughts don’t seem credible or likely, they still should be identified because they might illustrate underlying fears that need to be examined.

Another type of problem arises when the patient claims, in essence, “Well, I know that it is unlikely, but what if I’m the one to whom this happens? You can’t show me that it is impossible.” Patients who demand “certainty” can be asked, “What are the costs and benefits of demanding certainty?” “Are there any things in your life for which you don’t have certainty?” “Why do you tolerate that uncertainty?”

Cross-Reference to Other Techniques

Other relevant techniques include all of the techniques identified Chapter 4 on examining and challenging worries.

Form

Form 1.9 (Using the Vertical Descent, p. 35).

TECHNIQUE: GUESSING THE THOUGHT

Description

It is not always possible for the patient to identify the negative thought—sometimes the intensity of the emotion is so great that the patient finds it difficult to reflect on the thoughts that go with the feelings. Beck (1995) recommends having the therapist suggest some possible thoughts to the patient to determine if any of them seem consistent with how he or she is thinking and feeling. The therapist
must be careful not to suggest that the patient has an “unconscious” belief that only the therapist can identify. Both therapist and patient can attempt to speculate as to the nature of the thinking underlying the thought.

**Question to Pose/Intervention**

“You can’t say exactly what your thought is. What kinds of thoughts would go with these negative feelings? Is it possible you are saying these things to yourself? [Therapist suggests some possible thoughts.]”

**Example**

The patient feels overwhelmed with sadness and hopelessness after the breakup of her engagement. She focuses on her physical complaints—“I can’t eat, and I feel so tired.” She repeats to the therapist, “I feel so awful since we broke up. I just can’t think straight.” The therapist tries to elicit specific negative thoughts.

**Homework**

The therapist can request that the patient list any unpleasant moods and either identify or “guess” the thought.

**Possible Problems**

The therapist could have tried to get the patient to review the differences between a thought and a feeling, but sometimes the patient is unable to gain enough emotional distance to identify the thought. Once the negative thoughts are identified, the therapist can continue with the vertical descent procedure: “I could never be happy without Roger because . . . Roger was unique . . . I could never love
anyone like I loved him . . . I can never be happy unless I have a man in my life.” Sometimes the patient insists that there are no thoughts, just feelings. The therapist can ask the patient to close her eyes and attempt to induce the negative feeling as intensely as she can. The therapist can instruct the patient to imagine the situation that has elicited this feeling—for example, “sitting at home alone thinking of [Roger].” The therapist can guide the patient toward identifying the negative thoughts while the feeling or emotion is intensely felt: “While you are feeling really sad, can you imagine what you are thinking? Could it be that you are thinking ‘I can never be happy without Roger’?”

I provide a form (at the end of the chapter) for the patient and therapist to write down their “guesses” about these possible negative thoughts. These guesses need to be examined quite carefully, since many patients may believe that everything is driven by mysterious unconscious thoughts and motivations. The therapist will want to examine, with the patient, the plausibility that these are the real thoughts underlying the feeling. Furthermore, patients can verify the guesses by staying on the lookout for the problematic thoughts the next time they feel sad or hopeless.

Cross-Reference to Other Techniques

Techniques related to this one include the use of vertical descent, monitoring emotions, thoughts, and situations, reviewing the list of cognitive distortions to determine if there are any suggestions that remind the patient of the underlying thought, imagery techniques, emotional evocation, point–counterpoint, challenging the thought, and role playing negative and positive thoughts with the therapist.

Form

Form 1.10 (Guessing at the Negative Thought, p. 36).