Module 10: Challenging Maladaptive Thoughts and Beliefs

Objectives

- To learn techniques for addressing dysfunctional thoughts and beliefs
- To understand and manage potential difficulties using thought records

What are the techniques for challenging maladaptive thought, and why are these techniques important for Brief CBT?

Several techniques can be used to challenge dysfunctional thoughts or beliefs. Most are used in conjunction with a thought record. Challenging thoughts and beliefs in a collaborative, Socratic way allows patients to use their own statements to counter dysfunctional thinking. Generating counter-statements based on the data patients bring to session increases the believability of the thoughts/beliefs and, thus, the effectiveness of the counter thoughts/beliefs.

When? (Indications/Contraindications)

Typically dysfunctional automatic thoughts are the first targets in the cognitive component of CBT. Following the introduction of the cognitive model (see Module 5: Orienting patient to Brief CBT), and skills for identifying automatic hot thoughts and their accompanying emotions (see Module 9: Identifying Maladaptive Thoughts and Beliefs), techniques for challenging hot thoughts are introduced. These techniques should immediately follow the session on identifying hot thoughts, to build continuity and familiarity with the skill set and instill hope of change after identifying problematic thinking patterns. Although intermediate and core beliefs will be challenged in advanced stages of therapy, the techniques are similar for challenging thoughts. Many techniques below can be used interchangeably for challenging thoughts or beliefs. Brief CBT session time is best used for modifying thoughts or beliefs that are tightly held and strongly believed.

How? (Instructions/Handouts)

Socratic questioning is a therapist stance for questioning maladaptive thoughts and beliefs. This process involves asking a series of open-ended, brief questions that guide the patient to discover his/her idiosyncratic thoughts, feelings, or behaviors associated with a particular situation. Socratic questioning is nonjudgmental but is based on the therapist's insight that the original premise of a thought or belief may be untrue; therefore, the questions are designed to expose the dysfunctional thought or belief so that it may be challenged.

The Dysfunctional Thought Record (DTR) is the staple of cognitive work in Brief CBT. The first three columns (see Thought Record handout on p. 55) are used for identifying troubling situations and the accompanying emotions and dysfunctional thoughts. These three columns are used in conjunction with Module 8, in that when the situation→ thought → feeling triangle is unfolded, it forms the first three columns of a DTR (see figure).

A seven-column thought record is used to challenge dysfunctional thoughts and beliefs. Instructions for completing columns 4-7 are described in detail below.

Once a hot thought and its accompanying emotion have been identified and rated, the hot thought is questioned to generate evidence for and against it. Building evidence may be introduced in the following way:

> **Example:** We have identified a thought that is very powerful for you. You rated this thought as 90 out of 100 for sadness. Before spending a lot of time and energy on this thought, I want to know whether or not it is true. Often when people are depressed or anxious, they take thoughts like this at face value, without first asking whether it is true. Accepting thoughts like this as true would certainly lead to the symptoms you've been struggling with. If I thought, "I am worthless and can't do anything right," I wouldn't want to get out of bed in the morning either, and I would probably feel pretty hopeless and sad. When we test a thought like this, we are going to generate evidence for and against the thought. It is as though the thought were on trial, and you were a lawyer for the case. Remember, you have to be able to prove the evidence you are generating. So, now let's see how your thought stands up….

<u>Developing Balanced Thinking</u>

These instructions might be useful to help patients develop balanced thinking:
1. Help the patient question automatic thoughts by asking
   - What evidence is there that this thought is true?
   - What evidence is there that this thought is not true?
   - What would I tell someone I loved if they were in this situation and had these thoughts?
   - If my automatic thought is true, what is the worst that could happen?
   - If my automatic thought is true, what is the best thing that could happen?

2. Once evidence has been generated, combine it to form a more balanced thought. This thought will likely be much longer and more nuanced than the original hot thought.

> **Example:** Taking all this information (from columns 4-5) into consideration, what is a more balanced thought that more accurately reflects the facts?

You might want to ask the following questions:
- Taking the information into account, is there an alternative way of thinking about the situation?
- Can someone I trust understand this situation in a different way?

3. Rate the believability of the alternative thought between 0-100). If the thought is not more than 50 believable, more work is needed to identify an alternative thought. Go back to the evidence and keep working.

4. Once a believable alternative thought is generated, re-rate the mood associated with the hot thought (0-100) after reading the new thought. Reducing a thought/belief to a rating of 0 is not a realistic goal. Instead, a reduction of 30-50 often provides relief. Often

patients will generate new emotions from the alternative thought. However, it is most important first to re-rate the old mood before generating new emotions.

The same strategy of generating an alternative thought for a dysfunctional thought is used when challenging a core belief. Once the belief is identified, the evidence is weighed and a new more balanced belief is generated.

Summary: Completing DTRs

- ☑ Identify situation and corresponding thoughts and feelings.
- ☑ Identify cognitive distortions in thoughts (e.g., all or none thinking).
- ☑ Use Socratic questioning to identify hot thought.
- ☑ Elicit and rate emotions associated with hot thought.
- ☑ Rate believability of hot thought.
- ☑ Generate evidence for and against hot thought.
- ☑ Generate alternative thought from evidence.
- ☑ Rate believability of alternative thought.
- ☑ Re-rate emotion of hot thought that is elicited by alternative thought.

<u>Troubleshooting Thought/Belief Modification</u>

Some patients can see the benefits of doing a thought record immediately, but others might need to be motivated to be engaged. It is useful to use positive reinforcement to praise the effort of completing a DTR, point out the sections completed correctly, and review skills for the sections completed incompletely or inaccurately. If a DTR is assigned for homework, it must always be reviewed during the subsequent session. Taking session time to review the DTR emphasizes its importance to the patient.

Introducing the DTR as an "experiment" helps alleviate any performance anxiety the patient may have about completing it and may generate interest ("Give the DTR a try this week, and we'll see how it works for you. Let me know next session how the experience to complete it was. That will help us decide whether or not this is a useful tool for you.")

Occasionally, a patient will show disinterest in doing the DTR or get tired of it after a while. For instances like this, there are other ways you can suggest that the patient can continue to attempt the DTR:

- If a patient complains of never having time to do a DTR when certain situations occur, suggest that the patient carry a blank DTR in his/her wallet or purse.
- If a patient has done the DTR for awhile and is becoming disinterested, suggest doing a "mental" DTR, since he/she is familiar with the process.
- Suggest reading old DTRs that have similar situations and automatic thoughts of their own.
- The patient can verbally dictate a DTR to someone, and have that person write it down.

There will not always be an immediate change to a patient's mood after a thought record is completed. It might be necessary to assess why there is no change. It could be attributed to the patient's deeply rooted belief in the automatic thought, to an unchanged underlying core belief, or to additional automatic thoughts that have not been evaluated. It is necessary to ask: Why was there no mood change after completion of the Thought Record? These other questions will also be helpful.

- Have I described the situation in enough detail?
- Did I identify and rate the right moods?
- Is the thought I am testing an automatic thought?
- Do I believe a dysfunctional core belief is driving this thought?
- Did I list multiple thoughts? Do I need more information for each individual thought?
- Is there a stronger automatic thought that I have not put in my Thought Record?
- Do I believe the alternative thought? What other alternative thoughts are available?

If thought/belief testing is ineffective in reducing negative mood, you can also explore the advantages and disadvantages of maintaining a thought/belief. As we know, there are many disadvantages to negative beliefs we have, but there are also advantages. The patient's perceptions of the advantages may be obstructing the change process. Understanding the function of the thought/belief for the patient may be useful in clarifying why certain thoughts/beliefs are resistant to modification. The therapist should evaluate both the advantages and disadvantages of a patient's assumptions and beliefs, but in doing so work to diminish the advantages and highlight the disadvantages.

Often, when working to modify thoughts and beliefs, the patient may find evidence that supports the negative belief instead of evidence that contradicts it. If there is a good amount of evidence to support that negative core belief, then problem solving, rather then thought testing, is an appropriate strategy (see Module 12).

Seven Tips for Effective DTRs

1. You must have mastered the use of DTR before introducing it to patients.
2. Reinforce and make sure that the patient believes in the cognitive model being used.
3. Teach the DTR in two sections: (1) The first three columns; Situation, Automatic thought(s), and Emotion(s), and (2) the last four columns; Evidence for and against thought, Alternative response, and New rating of emotion.
4. Use the patient's exact words when recording thoughts and feelings. Working with thoughts verbatim preserves the emotions or personal meaning for each thought.
5. The patient should be able to adequately complete the first three columns of the DTR before learning about the last four columns.
6. Completing a DTR is a skill and, like other Brief CBT skills, requires practice. Success depends on the patient's understanding of the steps. Encourage the patient to take time with the skill and work through any frustration.
7. If the patient is not collaborative in completing the DTR in session or does not complete DTR homework, it is possible that he or she might have automatic thoughts about this type of exercise. Ask the patient to create a thought record of the DTR experience.

Example Homework Assignments

1. List the advantages and disadvantages of keeping a Thought Record.
2. Use an old Thought Record and analyze it using the Automatic Thought Questions we have discussed.
3. Complete the first three columns of a thought record for homework, and complete columns 4-7 with you in session.

Supplemental Readings

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press; Chapter 9.

Greenberg, D. & Padesky, C.A. (1995). *Mind over mood: Change the way you feel by changing the way you think.* New York: Guilford Press; Chapters 5, 6, & 7.

			THOUGHT RECORD			
(1) Situation	**(2) Automatic Thought(s)**	**(3) Emotion(s)**	**(4) Evidence to Support Thought**	**(5) Evidence That Doesn't Support Thought**	**(6) Alternative Thought**	**(7) Rate Mood Now**
Out of breath when I played in the park with my granddaughter	I'm too old to play with her. I can't do what I used to do. I can't be her caregiver. I have nothing to offer my family anymore. I am a burden to my family. I am no good to my family.	Defeated Sad Sad Disappointed Hopeless Hopeless Worthless Hopeless (80) Worthless (90)	My family has to look in on me more often than they used to.	I can still babysit my grandkids. I contribute to my family in new ways, such as offering advice and support. I still live independently. I am able to do many things physically, though I do have more limitations than I used to.	Because of my COPD and because I am getting older, I have more physical limitations than I used to, and I do need my family's help from time to time, but I am able to offer them many valuable things and contribute to my grandkids' lives.(80)	Hopeless (10) Worthless (5)
What actually happened? Where? What? How? When?	***What thought(s) went through your mind? How much did you believe it? (1-100)***	***What emotion(s) did you feel at the time? Rate how intense were they?(1-100)***	***What has happened to make you believe the thought is true?***	***What has happened to prove the thought is not true?***	***What is another way to think of this situation?***	***0-100***