Evaluating thoughts: Socratic questioning and guided discovery

It can be tempting for CBT therapists to become overly persuasive. As you practice CBT regularly, certain patterns of discussion of NATs will start to become familiar to you. It is unlikely that clients will be as familiar with the form of these discussions as you are. CB the rapists must therefore put a brake on the tendency to use this knowledge to overpower clients. Firstly, only the client can really know what will prove most persuasive to him, and, secondly ,there is evidence that when clients begin to see their therapists as being too persuasive, they become much more resistant to what the therapist is saying (Heesacker & Meija-Millan, 1996). It is preferable to use guided discovery rather than persuasion when trying to help a client to open out her thinking. Guided discovery involves asking questions that invite the client to explore what she is saying and then to look at things from different angles and look 'outside the box' for additional information. These questions are Socratic because they are similar in intent to Socratic Dialogue. Socrates was an Athenian philosopher who displayed a seemingly endless delight in getting people to examine the assumptions of their arguments. He hardly ever expressed his own opinions but asked questions that made his debating partners think more deeply. These debates often ended in what has been called *aporia*[3] – a kind of confusion resulting from the abandonment of an old idea without entirely being sure of what to replace it with. This state of mind has some similarity with the modern psychological concept of cognitive dissonance, when ideas or facts seem incompatible and irresolvable. Cognitive dissonance theorists have considered that such dissonance produces the necessary discomfort that often precedes change, that is, the discomfort motivates us to think out there solution. Therapists should learn not to be too alarmed when initial cognitive interventions lead to apparent confusion. Over time confusion may result in higher-level resolution. This 'harder won' change may prove more meaningful and therapeutic to clients.

- What do you mean when you say x?
- What is the evidence that x is true? What is the evidence against x being true?
- What might be the worst that could happen?
- What leads you to think that might happen?
- And if that happened, what then?
- If it did happen, what would you do? How would you cope?

- Have you been in similar situations in the past? How did you cope then?
- How does thinking that make you feel?
- Are you thinking in a biased way? (See Figure 1.2) e.g. are you predicting the future or mind reading?
- Are you paying attention only to one aspect? What if you looked at it from a different angle?
- What would you say to a friend who kept on saying x to herself (e.g. 'I'm stupid'; 'I'm terrible')?
- How would that work in your body?
- Is there an alternative explanation?
- Is there any other way of seeing the situation?
- What are the advantages and disadvantages of thinking that?
- Is it helpful, or unhelpful?
- What would it mean to you to see things differently?
- Are you making decisions based on your feelings, or is reality telling you something different?
- What might you tell a friend to do in this situation?
- What would your friend say to you?
- Is there something else you could say to yourself that might be more helpful?
- What do you think you could change to make things better for you?
- How would you like things to be different?
- What would you like to do instead?
- What would have to happen to make that possible?

FIGURE 4.2 ***Socratic questions***

It is worth having a list of Socratic questions on hand for both therapist and client (see Figure 4.2). It is important that Socratic questions are used in an unfolding way in order to help the client expand her horizons. Padesky (1993, 2004a, 2004b) has identified a four-stage

process for building such questions into a guided discovery sequence:

1. Ask questions to uncover information outside the client's current awareness.
2. Accurate listening and empathic reflection.
3. Frequent summaries.
4. Ask synthesising questions that help to apply the new information to the client's original thought.

In the example that follows, client and therapist are discussing the client's statement that he feels that his boss has become critical of his work and that the boss is 'dangerous':

Therapist: So, how is that dangerous, do you reckon?

Client: Well, it means that I'm out of favour; he won't give me any plums, any of the good work. I'm used to being one of the players. I might get left on the shelf now.

Therapist: You'd be left out. What is the worst that could happen with that?

Client: I could lose my job…nah but that's not very likely, I don't think. More likely I could just become one of the old lags.

Therapist: The 'old lags'?

Client: Yeah, you know the guys who are just hanging round for their pension.

Therapist: That isn't how you see yourself there. How would you cope if you became an old lag?

Client: Well, I'd be fed up but I could hack it I suppose. There are worse fates. I'd probably start applying for other jobs.

Therapist: And would you find something, do you reckon?

Client: Eventually, I guess.

Therapist: Okay, so let's gather that up. It seems like you have been in favour with your boss but now, for some reason we haven't yet established, you're a bit out of favour. You might now get left out of certain things and if that went on long enough,

you might leave. So how does that tie up with him being 'dangerous'?

Client: No, no: not dangerous. It's just that he is a bit cold. To be honest, I was always quite glad to be on his right side and now I'm not on his right side and I'm not sure where that could go.

Therapist: Okay but saying he is dangerous … how did that affect you?

Client: I have been a bit paralysed, I think.

Therapist: Yeah, using a strong word like 'dangerous' may act as an 'amplifier' that inhibits your problem-solving. In a way, the problem is relatively straightforward: things have slipped with your boss and you're not sure how to put them right. Those are problems we can work on.

Client: Yeah, I think I have built up the fear and that's just got in the way really.

Therapists should not expect the identification of negative thoughts to go smoothly at all times. In practice a variety of problems occur and these require therapist patience and creativity. If the client finds it difficult to make the link between thoughts and feelings, the therapist may need to proceed more slowly and adopt a more educational style of work. This problem, other problems and frequently used solutions are shown in Table 4.1.

In order to use CBT methods well, the client should be able to distinguish between thoughts and feelings and be able to make links between the two. In everyday language, however, people regularly say things like 'I feel like I will fail the exam' when this statement masks the fact that 'I will fail the exam' is a cognition and a negative prediction. CB therapists need to gently point this out to clients without sounding pedantic. The best way to achieve this clarity is to work through examples with clients in sessions, clarifying that it is the 'appraisal' (what the thoughts mean) element in cognitions and the link to feelings that makes them significant. Other problems listed in Table 4.1 include the way certain other figures of speech also mask cognitions: 'typical' in the third statement, for example, seems to mask the thought 'This is typical of my bad luck.' CB therapists may take educated guesses at what the underlying thought is, though they should be wary of engineering or gaining shallow consent. Certain clients seem to have difficulty identifying any kind of thinking.

Therapists can then go back to the rationale-giving stage and build up understanding in simple steps or even put the main emphasis on behavioural work.

Table 4.1 Problems and solutions for difficulties in identifying negative thoughts and feelings

Problems working with negative thoughts	Possible solutions
The client confuses feeling with thinking: E.g. 'I just feel like I'm going to fail the exam'	*Reflect back to the client with the correct terms: 'So you think you'll fail the exam, I guess then you feel anxious?' Refer back to the terminological difficulty when the client has put it the right way round.*
The client cannot identify a clear thought associated with distress: E.g. 'I was on my own, I just started feeling anxious. I didn't seem to have a thought.'	*Work back to a set of theoretical explanations and ask the client which one seems closest to his experience. 'When people are anxious they often fear something bad will happen. Does that ring any bells for you?'*
The client's negative thought is a 'megaphone statement': E.g. 'When my car failed, I thought "typical".'	*Reflect back and add a probe: 'So you thought typical… of your luck? Like fate is against you?*
The client's negative thought is in the form of a question: E.g. 'Why was it me who was left out?'	*Point out that the question could mask a negative thought and ask, 'If so, what would the "negative answer" to the question be?'*
The client's negative thought is hidden in other material: E.g. 'I was thinking about how my work had been going' (in relation to feeling low).	*Make the thought/feeling link by asking 'Does the fact that you were feeling low imply that you fear that your work hasn't been going well?'*
The client cannot identify the negative feeling associated with the negative thought: E.g. 'I just felt yewk.'	*Go with the client's vocabulary in the belief that a more precise feeling is likely to emerge as therapy progresses.*
The client cannot rate the emotion experienced.	*Use an analogue scale (draw a line with the two extremes of emotion on either end and*

	amid-point), and ask clients to indicate where their emotions would fall on the line.

It should also be remembered that negative emotions and thoughts are only part of the client's way of functioning. CB therapists probably have had a tendency to be over-concerned with the problematic in both its general formulations (Kuyken, 2006) and its general ways of working (Seligman, 2002; Duckworth et al., 2005). The 'positive psychology' and 'solution-focused therapy' movements may help us to balance this tendency by, for example, asking clients about exceptions[4] to periods of feeling bad:

Client: I just get these periods of just feeling so stressed. I do a fair amount of work at home and sometimes after a difficult customer has called and asked me to do something that pisses me off, I get so morose. … The other day my wife said to me, 'You're having an Eeyore morning.' And I thought 'Yes, you're right, I'm turning into a misery guts.'

Therapist: Okay then, some mornings you feel like Eeyore and that seems to be morose and depressed, I guess. But some mornings are you more like Pooh? (**Client:** Yeah.) So what happens then when a difficult customer calls?

Client: Oh, I don't know, I just shrug it off, I suppose. I can be pleased to hear from them, pleased to give them a service or I just roll up my sleeves and get on with it.

Therapist: Okay, so it could be good to work out the thinking that goes with Pooh and 'sleeves-up' days and the thinking that goes with Eeyore days and to see if we could get more Pooh and less Eeyore?

Client: (animated) Yeah, that would be good!

Therapist: It may also be worth thinking about whether Eeyore has any good points too. Many people do find him quite endearing.

It is helpful to ask questions about 'exceptions' early in therapy: they set a good tone but also point to goals in user-friendly terms, for example 'less Eeyore, more Pooh'.

Suggestion: Good day/bad day

Writers from Marcus Aurelius (c. 100 CE) to Carlson (1997) have noted our proclivity to 'sweat the small stuff' (that is, over-react to the minor frustrations of life) so I assume that the reader is no exception! Taking one such frustration, work out your negative thinking, feeling and behavioural reaction to such frustrations on a 'bad day'. Then trace out your reaction on a 'good day'. What is different between the 'bad day' and the 'good day' reactions? How would you have to change your reactions to get more good days and/or less bad ones? Would it be worth the effort?

Evaluating negative thoughts: testing cognitive distortions

Everyone is familiar with the scenario in which one attempts to cheer up a friend who is thoroughly fed up. All the things that used to be a joy to him seem now beyond imagination. If you try to remind him about a good thing about his life, he will tend to 'disqualify the positive' by saying something like 'Oh anyone could do that!' Beck (1976) identified these as 'cognitive errors' and distortions that affect or exacerbate psychological problems. A certain degree of negative thinking is normal and non-problematic, but, as negative feeling states become more permanently established, distorted ways of thinking may play a maintenance role in problems such as feeling low and fearful. Early stages of working with negative thoughts involve helping clients to identify them, a process aided by learning to spot cognitive distortions as they arise. We will now discuss how therapists can facilitate this process.

Most books on CBT contain lists of cognitive distortions with definitions and examples in the belief that such a list can aid the process of recognising negative thinking. The number of terms in these lists has increased over time and I have found that sometimes trainees and clients may find them hard to use. They are perhaps too complex and contain too many overlapping concepts that are rather technical for easy take-up. In a recent paper (Wills, 2007), I analysed the negative thoughts and cognitive distortions from my therapy notes for a full year. I was able to discern four main subject areas: thoughts about the self, the self in relation to others, other people and life/the world. I was also able to discern three main types of distortion: applying a negative label, making negative predictions and making over-statements. I have put these two dimensions together in Table 4.2.

Table 4.2 Distortion types and domains of negative thinking

Distortions	About the self	About the self in relation to others	About other people	About life and/or the world
APPLYING A NEGATIVE LABEL: Attaching a highly negative and over-generalised label to oneself or others	*I am boring. I am worthless. I am a real Eeyore. Everything in my life is only ever half done. I am 'Billy No Mates'.*	*I just don't fit in. I don't measure up to the people around me. I have to placate people. Without a partner, I'm useless.*	*My boss is an idiot. He's a wee man in a big job. My wife is self-indulgent about her illness. My 4-year-old tries to wind me up.*	*The world is a cold, cold place. Life now is just a jungle. My workplace is full of sharks.*
MAKING NEGATIVE PREDICTIONS: Making predictions about the future based more on how you feel than on what is knowable	*If I take the exam, I will just go to pieces. I will never find another partner. I will never get back to how I used to feel. I won't enjoy that now.*	*People will think that I am pathetic. No one will be attracted to me now. If I tell people how I really feel, they will just use it against me.*	*Girlfriends will always dump me. My colleagues will criticise anything I say in the meeting. If I ask people to help, they will let me down.*	*It will be downhill all the way from here. People won't be prepared to give me a chance. I'll end up an outcast if I screw this up.*

OVER-STATEMENTS: Over-emphasising the bad aspects of a situation and/or understating or ignoring the good aspects	*The fact that I lost that account means I'm incompetent. All my good work goes up in smoke in light of that failure.*	*Life without Sam is unbearable. I just don't know what to say in social situations. It's horrible if people criticise my work.*	*They never think about other people. People always put their own advantage first.*	*Life is pointless. There is so much violence and hatred in the world. Society is very unforgiving of mistakes.*

A simplified list can help both the trainee and the client to get hold of the important idea of distortions. This is not to say that a fuller list of distortions cannot be used later in therapy, as the ability of therapists and clients to spot them develops. Some helpful categories of distortion can be profitably linked to certain problems. 'Catastrophisation' (subsumed under 'over-statement' in my short list), for example, is a very frequently found factor in anxiety problems of all types. A fuller list of distortions is therefore given in Table 4.3. In this list, however, the examples do not match up with the definitions because it is doubling as an exercise in helping the reader to become thoroughly conversant with helping clients to recognise them. This exercise aims to help the reader to learn for herself, and thereby become an even better tutor for the client. This type of exercise has also been included in the client self-help books by writers such as David Burns (1999a, 1999b).

Table 4.3 Cognitive distortions (adapted from Sanders & Wills, 2005: 7)

NB: *The distortion types below are not listed opposite appropriate examples. This is an exercise to train readers in being able to identify different types of distortion. The answers are given on page 82.*

Cognitive distortion types	Examples
1. EITHER/OR THINKING (about oneself). This style of thinking makes extreme demands on you to be one way and, if not, condemns yourself totally to the other extreme.	*a. Work was hell today. Ron didn't like my report and then no one seemed to have a good word for me.*
2. MIND READING. Assuming that people are thinking in a certain way.	*b. I forgot my wallet this morning: that's proof that I have really lost it.*

3. PREDICTING THE FUTURE. Assuming that you know what the future will bring – aka 'crystal ball gazing'.	*c. A few of my customers seem to trust my judgements but they are just the minor customers.*
4. DWELLING ON THE NEGATIVE. Over-emphasising a negative feature of living and ruminating on it.	*d. Unless pretty well everyone likes me a lot, that means I'm a failure.*
5. DISQUALIFYING THE POSITIVE. You reject good personal qualities you have by putting them down.	*e. My boss is just a total idiot. He deserves no respect at all.*
6. BLOWING UP THE NEGATIVE. Exaggerating things that go wrong.	*f. There's no way that I'd be offered a job like that.*
7. LABELLING. Attaching a highly negative label to something.	*g. I just have this real dread that everything will fall apart.*
8. CATASTROPHISING. Thinking that the very worst possibility will happen.	*h. Everyone will think that I am really stupid.*
9. EMOTIONAL REASONING. Assuming that something you feel strongly must be true.	*i I'll lose my job and then my family – I'll have nothing left to live for.*

Answer

1	
2	
3	
4	
5	
6	
7	
8	
9	

There are other helpful traditions in psychology that identify biases and distortions in thinking (Harvey et al., 2004). Cognitive theorists have pointed out that there are various homeostatic tendencies in thinking styles that keep distortions in place. Self-serving biases, for example, may stop people from identifying their own role in relationship breakdowns. Cognitive mechanisms such as 'limited search routines' may prevent people from searching

widely enough to find appropriate evaluative evidence regarding their thoughts. In these circumstances, therapists must be prepared to be persistent and devise creative Socratic questions to overcome these limitations.

Evaluating evidence on thoughts: validity and utility

If there is one sentence that captures the spirit of CBT, or perhaps more accurately cognitive therapy, it would be 'What is your evidence for that thought/belief?' followed shortly by 'What is the evidence against that thought/belief?' Because the client's negative thoughts often make highly malevolent charges against himself, some aspects of cognitive therapy have an uncanny resemblance to a 'defence attorney' (Leahy, 2003). I often ask my clients questions like: 'Is that (usually a minor discretion) really a *hanging offence*?' and 'Would that (self) charge (of being 'totally incompetent') *stand up in court*?' Ironically, I have had experienced lawyers as clients who have surprised me by finding it remarkably difficult to acquit themselves – testimony perhaps to the compelling plausibility of negative thoughts. Albert Ellis advances a telling argument against any form of judgement on the self: 'the results are not yet all in'. Usefulness is established over a lifetime. Late goals can change football matches. Churchill was considered a political failure in 1939. Furthermore, the accusation 'I am useless' implies a basic, core personality judgement, whereas usefulness and uselessness, in as much as the terms can offer any utility at all, emerge from many separate behaviours. This does not preclude the validity of judgements on some aspects of a person's behaviour.

These facts confront us with an aspect of evidence review in CBT: all the relevant information is hardly ever completely available. This is true, for example, by definition of the kind of negative predictions that so often accompany anxiety: we can never know how a future event will turn out. The best we can hope for is a range of probabilities concerning particular outcomes. Life and the universe remain frustratingly short of certainties. Clients who worry and obsess usually require more certainty than is available in life as we know it. They never look entirely convinced when I suggest that life might be boring if we could be as certain of key outcomes as they would like to be.

Also there are often issues concerning the relative strength of the quantity and quality of evidence. For instance, one big example of incompetence is usually remembered more fully and counts for more than many small examples of competence.[5]The therapist, however, has no other choice than to look for the devil in the detail: collect the small evidence along with the big. The overall evidence thus gathered is usually mixed and often allows therapist and

client to come down against gross generalisations and may well promote more benign views of life than are usually held by people in the grip of painful emotions.

Modifying and challenging negative thinking using thought records

The nature and purpose of thought records

The thought record sums up many of the manoeuvres we have already described in the identification and evaluation of negative thoughts:

It specifies trigger events that lead to negative thoughts.

It describes the thinking, feeling and behavioural responses to those triggers.

It evaluates evidence in relation to the negative thoughts.

The thought record also helps reframe negative thoughts:

It develops alternative, more adaptive thoughts or ways of thinking about specific trigger events should they arise in the future.

It summarises key elements of a new cognitive, emotional and behavioural response in light of the review of the original responses.

An example of a thought record is presented below so that the reader can match up the manoeuvres listed above with their appearance in the actual columns of the thought record. The client who completed the thought record was a well-qualified health professional who suffered from obsessional and intrusive thoughts with a theme of contamination. Some of her main obsessions were about fears of contamination coming from touching blood and other materials that result from medical work. She met the criteria for both obessive compulsive disorder (OCD) and Simple phobia: Blood (*DSM-IV-TR*). The thought record shown in Table 4.4 is an exact copy of the original thought record filled out by a client and then amended by the therapist and client working together. The upper part of the form (written in italics) shows the client's first attempt to fill out a thought record for homework. The bottom half of the form shows how the client and therapist reworked the form in the next session. There are skilled and unskilled ways of completing thought records and these skills have to be learnt and developed by both client and therapists. The way the client filled out the form for homework shows some misdirection and this meant that the thought record was not effective in helping her to manage her negative feelings better. The client reported that the reworked form made more sense and helped her to understand and feel better about her situation. This

was the first thought record that she had completed and it is therefore perhaps not surprising that it went a little off target. I had gone over one example in the previous session with her. In retrospect, I was a little over-hasty in encouraging her to use a full record so soon. I normally give clients a guide to using thought records[6]but on this occasion did not have a copy to hand. Each section of the thought record will now be described, opening with a statement of the basic aim of each section and followed by comments for each section of the original and reworked thought record entries shown in Table 4.4.

Table 4.4 Seven-column thought record (worked example)

Trigger	Emotion	NAT	Evidence for NAT	Evidence against NAT	Alternative adaptive thought	Outcome
Blood on money from cash point	*Anxious 80%*	*I have to wash my hands. I have to change my clothes.*	*Not hygienic*	*No infections transmitted this easily. Probably very common.*	*I should rationalize that the risk is negligible.*	*Anxiety 60%*
Blood on money from cash point	Anxious 80%	I have got dangerous germs on my hands. I could kill my son and husband.	Germs are everywhere.	Germs are only very rarely dangerous. Blood infections aren't that hardy.	I may have germs on my hands but they are almost certainly harmless.	Anxiety 30% Resist washing hands/ changing clothes.

Trigger/Emotion

The aim of these columns is to establish a specific trigger that leads to the specific problematic reaction. The trigger situation may be very obvious but is not always so. The problematic reaction might be part of the syndrome that constitutes the main aspect of the problem for which the client has been referred. In this case, anxiety is very much part of the

criteria for OCD.

In the top part of Table 4.4, the client makes an effective entry for these two columns. She has found a specific trigger that constitutes a moment when the thought and emotion, in her words, 'kicked in'. Sometimes thought records do not work because the client refers to a more general trigger in this section, such as 'my girlfriend finished with me'. Such an experience usually takes place over a number of days, weeks or months during which the client has many different thoughts and feelings. The therapist can encourage the client to make this type of trigger more specific by asking 'Which was the worst moment?' This may produce an answer that can be translated into a specific trigger: 'When she rang and told me that her ex had been in touch and she was having doubts about us now.' Getting the specific moment usually evokes a much stronger emotional reaction and is more likely to get to the most telling and significant negative thoughts. The negative emotion in Table 4.4 is clearly defined with a simple word for a primary emotion, but again we have to be prepared to deal with clients who are not always so clear in the way they identify feelings (see Tables 4.1 and 4.5).

Negative automatic thought (NAT) or image

The case has already been made for the importance of negative thoughts and images in the maintenance of emotional and psychological difficulties. As testing a specific thought is a key part of the thought record and CBT generally, it is important that the thought or image is clearly defined in a way that can be tested. It may be helpful if the client's reported thought is probably not exactly as it was in the moment. There is already some reconstruction in the memory of it so that a therapist can feel legitimacy in working to define the thought further – in ways that clarify its underlying meaning and make it more testable in the thought record.

In Table 4.4, the reported thought probably was something like what went through the client's mind but really amounts to a behavioural disposition rather than an appraising negative thought. It is sometimes difficult to define salient thoughts but, if in doubt, the therapist should ask herself 'Does this thought explain the negative feeling?' In this case, the answer must be 'no' because washing her hands would relieve the anxiety: it is a response to the anxiety, not the thought that evokes the anxiety. As they reviewed the thought record, the therapist asked the client 'Why did you think you should wash your hands and change your clothes?' The client answered 'Because I felt I had germs on my hands.' The therapist then asked a 'downwards arrow' question: 'And what was bad about that?' She answered 'They could be dangerous. I could infect other people. I could kill my son and husband.' These

thoughts do explain the anxiety. Notice also that the client did not rate the strength of her belief in the NAT. The therapist did not ask her to do so as they reviewed the form because her rating of the thought now in the relative calm of the therapy session would not have reflected how she would have rated it at the time. This is a frequent problem with thought records that are not filled out in the heat of the moment – in 'battle conditions'.

In a therapy session, unless a NAT comes up in the session itself, retrospective reports of negative thoughts are simply the best that can be achieved. The therapist can always encourage clients to fill out their thought records as close in time to the actual moment as possible. This may not, however, always be practically possible. Clients are often concerned that other people may discover their thought records and thus only ever fill them out when complete privacy is assured. When I kept thought records myself for three months, I devised a version that could be fitted into a pocket book and was surprised how often I could use it there and then. Practical issues should be discussed with clients when setting homework. For example, there may be various fears, including feeling more disturbed by a clearer recognition of thoughts that once were vague. Some people find it hard to access their thoughts and some, even when they can, find it hard to report them. Sometimes people find it easier to access what was in their minds by describing images that they experience. One client, for example, reported feeling depressed on deciding not to apply for a job. When we went further into her experience, it turned out that, as she was thinking about whether to apply, she had a vivid and detailed image of being rejected by the interviewing panel. I asked her to describe this image in great detail, which struck rich veins of negative meaning. I then explored these meanings with her. She imagined, for example, the interviewers shaking their heads as they read her application form. When I asked what this meant to her, she said 'They thought that I had a cheek to apply and that I was wasting their time.'

Evidence for and against the NAT and images

The aim of reviewing the evidence for and against the negative thoughts and images is to help the client to step back from them and consider them in a new light. This is because we know that when people are emotionally disturbed, they are likely to take negative thoughts as facts rather than interpretations or hypotheses. The negative thoughts play a major role in maintaining negative mood and thus their hold on the client's mind needs to be loosened.

In Table 4.4, the client has produced good pieces of evidence in the 'for' and 'against' sections, but they are responses to the behavioural disposition and so do not get at and evaluate the negative thoughts and underlying beliefs. The evidence presented in the

reworked version is similar to the client's original entries but *does* get closer to the underlying thinking. It is also more realistic. It accepts that there may be germs in public places but that the risk of harm is remote. Interestingly, we later realised that the chances of any possible infection were greatly increased by skin cuts, and skin cuts were made more likely by her excessive hand washing which can damage the skin. Images can be reviewed in very much the same way. For example, with the woman who had the negative image about applying for a job, we could examine the evidence on how likely it was that the image was a reasonable estimate of what might happen if she did decide to apply.

Alternative thought/outcome

The aim of establishing an alternative thought from the evidence columns is to make the point that it is possible to learn to think in another way when confronted by triggering situations. In Table 4.4, the non-avoidant tone of the second version is more realistic and produces a decrease in negative emotion. The therapist strengthens the outcome column by initiating a conversation about 'dropping the safety behaviour' of hand washing. In this case, the client agreed that this could be undertaken but 'at a time to be negotiated and agreed'.[7]

Looking back over this thought record, I notice that it is not wordy but comparatively parsimonious, that is it has only a single situation and thought and does not amass a great deal of evidence. In many cases, the thought records may contain multiple entries for all the columns which can make it harder to use them effectively. Simple thought records showing simple and understandable links between thoughts and feelings seem to work best. Sometimes a client's difficulty with obsessional thoughts and making lists interferes with simplicity, since every nuance of every thought and feeling is recorded. Obsessional thoughts may also be harder to evaluate because they often concern 'risk assessment': just how 'safe' do you have to be to be 'safe'? It is true, however, that thought records do vary enormously in the amount of material they throw up. I considered this example to be a good one for my purposes because it was parsimonious and therefore allowed parsimonious discussion. Thought records, however, can sometimes be counter-productive for clients with obsessional and intrusive worries. There is now more interest about working with intrusive and obsessional thoughts by working with cognitive processes, the subject of the final section of this chapter.

Using thought records in practice

Sanders & Wills (2005) show that it is possible to use thought records more slowly and cumulatively by breaking up their various elements into smaller separate records, for example

with just a few columns at a time. This chapter has shown that the various elements of a thought record can be used separately and it is now time to consider how they can be used in a wholly assembled format. It is usually suggested that the whole form (as in Table 4.4) is actually given in two phases. The first phase consists of giving just the columns for identifying triggers, feelings and negative thoughts, while the other columns are either left off or blocked out. The therapist should produce the form and explain it to the client, fielding questions as appropriate. Client and therapist should then fill out the form in the session, taking a recent incident in the client's life as the subject for a worked example. It is usually helpful to stress the collaborative element by encouraging the client to fill in the actual entries, perhaps running them past the therapist for comments first. Working with thought records rarely runs as smoothly as it is often portrayed in some textbooks. Most clients can make some connection with the logic of the thought record but are quite likely to report difficulties with getting it to work for them. It is likely that therapist and client will hit at least some of the problems described in Table 4.1 and 4.5.

Table 4.5 Problems and solutions in evaluating and responding to negative thoughts (seven-column thought record)

Problems	Solutions
Problems with evidence (columns 4 & 5)	
Strongly adverse life events.	*Focus on empathic listening. Identify ways of thinking that may be making the problem even worse. Suggest that it may be useful to review how helpful these thoughts are.*
The quantity of the evidence favours the negative. The quality of the evidence favours the negative	*Discuss the balance of the evidence. Where either the quantity or the quality of the evidence balances towards the negative, suggest an 'open verdict'.*
The client finds it difficult to evaluate a negative thought as anything but true (negative evidence is more compelling or credible).	*Use belief ratings: anything less than 100% indicates a degree of doubt that can be built on.*
Problems with the alternative thought (column 6)	
The client describes the alternative thought as	*Go back over the whole sequence. Check the*

having intellectual but not emotional conviction (head but not heart).	*exact wording of the NAT and the alternative. Recheck the quality of the evidence. Also suggest that emotional conviction does take longer and may take some time to 'bed in'.*
Clients say things like 'Yes (I know I'm not really a failure) but…'.	*Draw out the 'but'– often it is underlain by some unspoken fears or even by a meta-cognitive rule such as 'If don't worry about this, I'll get complacent.*
Problems with the end result (column 7)	
Client reports no change in negative feeling	*Discuss the need to use the method over time. Write in a comment on how it could be different next time. If persistent, review focus and consider shifting focus to cognitive processes rather than content.*

Client difficulties in responding to thought records are sometimes the result of a pessimistic belief about therapy: a lurking suspicion that it might work for some people but will not work for them. This belief can seem as though as it has been confirmed when they first hit a snag such as a thought record that leaves them both baffled and not feeling any better. The problems of the first three columns – identifying and rating thoughts and feelings – have already been shown in Table 4.1. Table 4.5 focuses more on difficulties that arise in relation to generating evidence and alternative thoughts (covered in columns 4 to 7). The process generated by these columns strives for credible evidence and credible cognitive change.

Problems with evidence

A major impetus to the growth of CBT was the recognition that depressed clients in particular tend to be ruled by cognitive distortions. Obviously, though, at times clients report severe adverse life experiences which are not at all exaggerated – life-threatening illnesses, for example (Moorey & Greer, 2002). The evidence about such events may well confirm the negative thoughts. Apart from expressing empathy and being supportive, additional cognitive work would involve looking at ways in which the client's thinking is unhelpful to them as opposed to ways it may be 'distorting' reality. For example, when working with a person with cancer, cognitive therapy can help the client think about how ruminating about how little time may be left to them, may get in the way of making use of the time that is left. This kind

of dialogue must not be led in a superior, knowing fashion; the therapist must herself become vulnerable to the hard truth of this moment and to the sheer difficulty of what the client may be facing.

Problems of evidence may also arise in other cases where the client's approach to evidence may seem to give disproportionate weight to some factors rather than others. It can be helpful to weigh the balance of the amount and quality of evidence, sometimes settling for an 'open verdict'. The credibility of evidence to the client can be assessed by the belief ratings they apply to the beliefs relating to them.

Problems with the credibility of cognitive change

Clients may quite often report that they believe the positive alternative thought with their heads but not in their hearts. It is actually in the nature of things that intellectual conviction often does precede emotional conviction and often this is just a sign that the client needs, in Albert Ellis' words, to 'work and practice' (Dryden, 1991). It is often helpful to recognise that the credibility of alternative thoughts and beliefs and change may take time to develop. One's view of self and life have developed over years and it may take constant repetition of alternatives to produce change. Sometimes, however, these problems are a sign that the therapy is not on track and the therapist may use them to consider alternatives, especially working on cognitive processes rather than on content and especially if the client has difficulty with intrusive thoughts, obsession, ruminations or worries (see later section in this chapter).

We must always try to empathise with any client difficulties with these processes. Thinking about our own attempts to change virtually any aspect of our lives tells us that such change is most frequently gradual and incremental. We may listen to some music several times before we really hear it, for example. Therapists and clients can sometimes be too eager for immediate change. Sometimes it takes time for new evidence and ideas to sink in and come to conscious realisation. Therapists should also be wary of arguing with clients when they seem to be blocking out new information. It can be very valid to simply acknowledge the client's doubts about the new information: 'So, the idea that you may actually be an okay person is simply not credible to you right now.'

It is important for CB therapists to take the time to deal with client reservations and difficulties as thoroughly as possible in therapy time, as the next move will be to ask the client if he can use thought records regularly at home. There is a good deal of evidence that clients who do homework regularly get significantly better results with CBT than those who

do not (Kazantzis et al., 2005). If the client is able to bring one or more thought records, completed as homework tasks, with him to the next session, these should be put on the agenda as an item and given attention and time. If the client has taken the trouble to do the task, it can be very disheartening if the therapist gives them only cursory attention or even fails to review them at all. Thought records require time and effort and clients can feel afraid that their efforts will be judged negatively. They may find it helpful if the therapist clarifies in advance that spelling and grammar, for example, are not an issue.

As we move into filling out the response and challenge columns of the thought record it becomes helpful to have more discussion about the therapeutic aims of the thought record and how it may best be used. The prime aim of the thought record is to help the client to develop a more reflective relationship with their thoughts. This new perspective can raise the hope that the client can feel better and think more clearly in both the shorter and longer terms. Sometimes a client will be able to progress to being able to reach a new alternative thought during a testing negative event. Alternatively, they may be able to use it in retrospect and thus prevent themselves from going into prolonged negative rumination. When I kept thought records for three months, I found it a highly instructive experience. Firstly, I was amazed by the amount of rubbish that came out of my head. Secondly, I found that writing down my thoughts and evaluating them often made me feel better and clearer, helping me to get on with my day. Thirdly, I noticed that records were sometimes ineffective in the short term but that I would find, later in the day, that my mood had lightened. The experience emphasised for me the importance of persistence in keeping thought records. I would recommend the experience to all CB therapists. Having kept a record for oneself, the therapist can ask the client to follow suit with more authority and understanding. Leahy (2003) emphasises the need for over-practice and over-learning. This is because the sheer weight and persistence of negative thoughts[8] means that 'one swallow' most definitely does not 'make a summer'. The best prescription for problems with thought records is usually to trouble shoot in sessions but then to suggest *increasing* practice rather than any kind of backing away from using them. Hollon (2003) reinforces the view that CBT techniques often do need to be persisted with to achieve enduring effects for CBT.

Developing a creative use of thought records

The real aim of cognitive work is to generate alternative ways of thinking. Such shifts in consciousness and thinking can be elusive and may occur in unusual ways at times. I recently dreamt that my father used a thought record as a client. The final alternative way of thinking,

however, was presented to him as a logo written on the side of a mug. My Dad loved his mug of tea and I reflected afterwards that it might have been a highly evocative and effective way for him to complete his experience of using a thought record! I sometimes feel that we could be a lot more creative in our working ways. Once, after participating in a particularly effective assertiveness training workshop, the presenter gave me an individualised badge that said 'I may not be perfect but parts of me are really nice.' I felt that this badge particularly spoke to my condition at that time and I treasured it for many years. I once made a customised T-shirt with a picture of Tim Beck and the slogan 'Put Your Beck into it!' for a CBT conference. As it happened, Tim and his daughter Judith were at the conference and Judith asked me if he could have the T-shirt. I duly posted it to him in Philadelphia. As CB therapists use coping cards with slogan-like adaptive thoughts, I have occasionally used the badge and T-shirt concept with clients (although it is helpful to discuss how other significant people in their lives are likely to react to them using such things).

I have identified over 20 different forms of thought record used by different CB therapists. They all include most of the steps indicated above, though they sometimes use different vocabularies and running orders. I usually use a version based on the 'Seven-column Thought Record' shown in Greenberger and Padesky (1995), though I sometimes find it helpful to use some other types of thought records with different clients. I find, for example, that some clients particularly benefit from using David Burns' self-help books as an accompaniment of therapy and therefore find it most congruent to use his version of a thought record that he calls a 'Mood Log'. I generally favour customising CBT materials for the idiosyncratic needs of both therapists and clients. Some thought record materials that can be used to customise exercises for the client are presented in Table 4.6 and are followed up in the next 'Suggestion' box.

Suggestion: Make your own thought record

Using the various elements and language of the thought record shown in Table 4.5, construct your own version in a way that will best suit you and your estimate of your clients' needs.

In the spirit of using different types of material, I follow the situation presented in the worked example of the seven-column record in Table 4.4 with the same example presented in the ABC format used in REBT in Table 4.7 (Dryden, 2006).

Table 4.6 Elements of a thought record

Language	Conceptual
THOUGHT RECORD: Mood Log;[1] Daily Thought Record; Dysfunctional Thought Record.	
TRIGGER: Situation; event; antecedent,(A)[2]	Might include questions on time, place, who with, what doing, etc.
EMOTION: Mood; feeling; emotional consequences (Ce = emotional consequences)[2](Also includes Cb = behavioural consequences)[2]	Might include intensity rating out of 5, 10 or 100.
NEGATIVE AUTOMATIC THOUGHT: Thoughts; cognitions; beliefs (B)[2]	Might include type of cognitive distortion.[1,3]. Might include negative images.
EVIDENCE SUPPORTING NAT:	Evidence columns only included in seven-column record[4].
EVIDENCE NOT SUPPORTING NAT:	
ALTERNATIVE BALANCED THOUGHT: Rational thought/alternative. Dispute (D)[2].	
OUTCOME (Change in emotion rating as result of holding alternative balanced thought) Effect (E)[2].	Might also include behavioural outcome or future plan based on alternative thought.

Notes:

1 See David Burns (1999b)

2 See Albert Ellis & Windy Dryden (1987)

3 See Gary Emery (1999)

4 Greenberger & Padesky (1995)

Table 4.7 ABCDE analysis (worked example)

A (Antecedent)	B (irrational Belief)	C (Consequences) emotional and behavioural	D (Dispute for each iB)	E (Effective rational beliefs)	F (Feelings and behaviours arrived at after considering effective rational belief)
Blood on money from cash point.	This is dangerous.	Anxiety. Urge to wash hands & change clothes.	Am I exaggerating the danger here? Do I really need to take these precautions? What is reacting this way doing to me in the long run?	There is a small possibility of harm but I am greatly exaggerating the danger. I can live with this possibility of harm without reacting like this.	Less anxiety. More resistance to washing hands, changing clothes.