

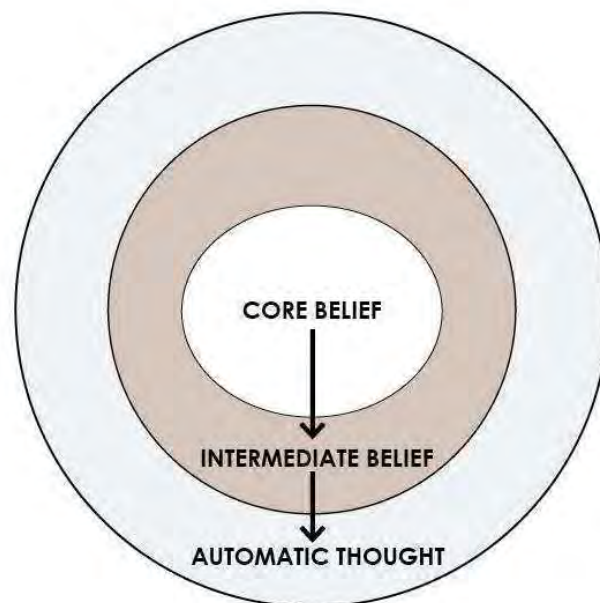
Module 9: Identifying Maladaptive Thoughts and Beliefs

Objectives:

- To understand the role of maladaptive thoughts and beliefs in Brief CBT
- To learn methods for educating the patient about maladaptive thoughts and beliefs

What are maladaptive thoughts, and beliefs and why they are important in Brief CBT?

The cognitive-behavioral model (as depicted below) suggests that three layers of cognitive dysfunction exist in individuals struggling with social and/or psychological problems: Automatic thoughts, intermediate beliefs, and core beliefs.



An automatic thought is a brief stream of thought about ourselves and others. Automatic thoughts largely apply to specific situations and/or events and occur quickly throughout the day as we appraise ourselves, our environment, and our future. We are often unaware of these thoughts, but are very familiar with the emotions that they create within us.

Maladaptive automatic thoughts are distorted reflections of a situation, which are often accepted as true. Automatic thoughts are the real-time manifestations of dysfunctional beliefs about oneself, the world, and the future that are triggered by situations or exaggerated by psychiatric states, such as anxiety or depression.

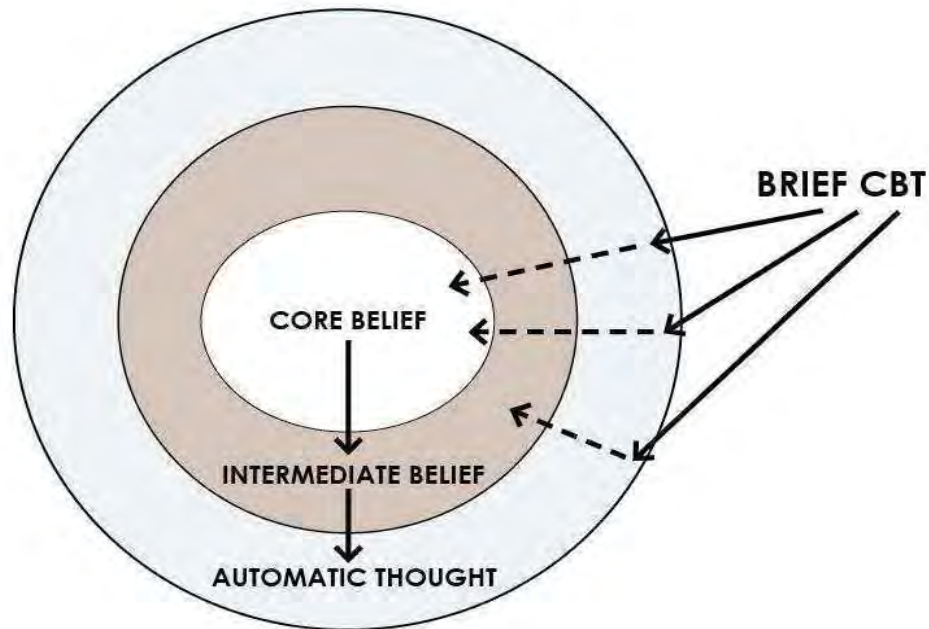
Intermediate beliefs are attitudes or rules that a person follows in his/her life that typically apply across situations (not situation specific as with automatic thoughts). Intermediate beliefs can often be stated as conditional rules: "If x, then y." For example, "*If I am thin, then I will be loved by others.*" Individuals create these assumptions by categorizing the information they receive from the world around them. These rules guide thoughts and subsequently influence behaviors.

Dysfunctional core beliefs drive dysfunctional rules and automatic thoughts. For example, the belief, *I am unlovable*, may be driving the conditional rule, *If I am thin, then I will be loved by others*, which may drive obsessive thinking about one's appearance, excessive exercise, or disordered eating habits. Core beliefs are often formed in childhood and

solidified over time as a result of one's perceptions of experiences. Because individuals with psychological disorders tend to store information consistent with negative beliefs but ignore evidence that contradicts them, core beliefs tend to be rigid and pervasive. Although automatic thoughts are often tied to a specific situational trigger, intermediate and core beliefs are more global and cut across domains. Beck suggests that individuals tend to have core beliefs that involve either interpersonal ("I'm unlovable") or achievement issues ("I'm incompetent").

When? (Indications/Contraindications)

Identifying maladaptive automatic thoughts is the first step in the cognitive component of therapy. The focus of intervention in Brief CBT is the dysfunctional automatic thought. Patients must master identifying and challenging thoughts to be able to grasp the concept and techniques of challenging beliefs. Because of the interrelated nature of thoughts and beliefs, an intervention targeting automatic thoughts may also change underlying beliefs (depicted below). Therefore, Brief CBT can result in belief modification, even if the target of treatment was automatic thoughts.



Because patients progress through treatment at different rates, you may be able to identify and challenge some beliefs late in brief therapy (sessions 5-8) for some patients. For other patients, work will be limited to automatic thoughts.

Because skill building to alleviate symptoms and prevent relapse is a central focus of CBT, mastery of skills is paramount. Focus on building a skill set with the patient that he or she can generalize to different situations, thoughts, or beliefs. It is less important to identify and modify deep-seated childhood beliefs. For most patients in Brief CBT, this will not be necessary for symptom reduction. However, some patients may benefit from this work.

Although you may not discuss beliefs directly with the patient, as part of the case conceptualization, he/she should constantly be forming hypotheses about what beliefs may be driving the thoughts (see Module 4: Case Conceptualization and Treatment Planning).

In identifying thoughts and beliefs, ask yourself several questions.

- Is the thought/belief secondary to another thought/belief?
- How much does the patient believe it?
- Does it affect the patient's life negatively?
- Is the patient prepared to work on it now, or should he/she tackle the belief at a later date?

After an automatic thought or belief is identified, it is challenged using the skills in Module 9.

How? (Instructions/Handouts)

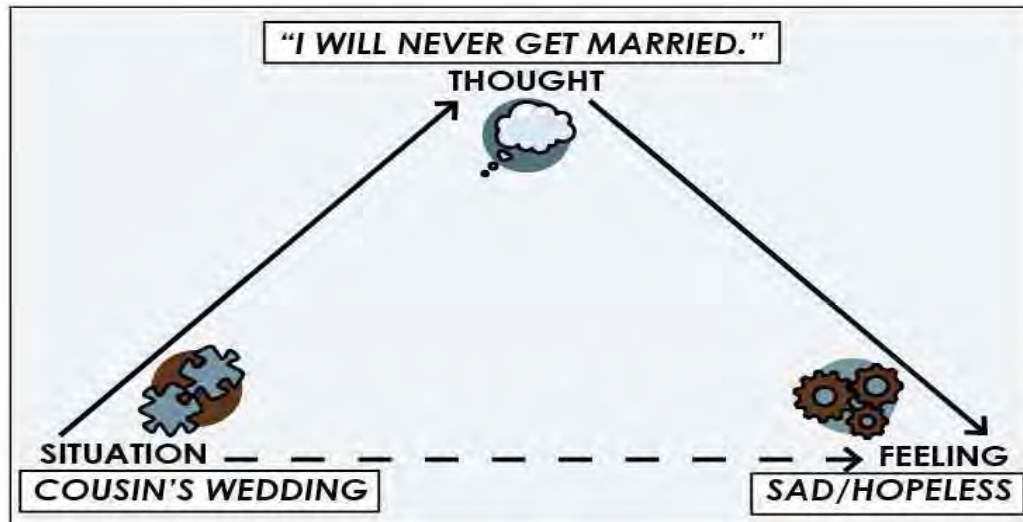
Explaining Automatic Thoughts to Your Patient

It is important for the patient to understand the rationale for identifying automatic thoughts before acquiring the skill of addressing his/her own thoughts. Using the situation→thought→feeling triangle introduced in Module 5 (Orienting the Patient to Brief CBT) can be helpful in explaining automatic thoughts. Completing the triangle with the patient's recent or current automatic thoughts can facilitate his/her understanding.

Therapist:	"So, Pamela, how have you been feeling this week?"
Pamela:	"Just really sad...as usual. It seems like I'm always feeling that way."
Therapist:	"Did anything in particular trigger this sad feeling this weekend?"
Pamela:	"Yes, I had to go to my cousin's wedding, and it was really difficult because I started thinking about how I will never get married."
Therapist:	"Pamela, that's what we call an automatic thought. It's something that just pops into our heads over and over again without our really thinking about it or examining the truth of the thought. It affects the way we feel and act in a negative way. Maybe we should look at some of your automatic thoughts a little closer."

Using the patient's example, describe the association between thoughts and feelings to build awareness of the connection. This is a good time for the patient to write down the thought and begin using the cognitive-behavioral model.

Therapist:	"So, let's write down this automatic thought that you are having. I will never get married. Your going to your cousin's wedding was the situation that triggered the thought, 'I will never get married'."
Pamela:	"Yes, that's true."
Therapist:	"When you were at the wedding and that thought came to you, how did you feel?"
Pamela:	"I felt really sad and hopeless."
Therapist:	So, can you see how our thoughts can affect our mood and change the way we are feeling?"
Pamela:	"Yeah, I guess if I hadn't had that thought, I wouldn't have felt so bad."



Eliciting Automatic Thoughts

It is important for therapists to teach patients how to identify automatic thoughts during and outside of session.

Automatic Thoughts in Session

Be aware of patient's hot thoughts during sessions. Hot thoughts are automatic thoughts that occur in combination with a change in emotion or mood. Hot thoughts are particularly poignant or strong thoughts that are often associated with dysfunctional core beliefs, and should be targeted in therapy. Hot thoughts and the accompanying situation and emotion are tracked on the first three columns of the thought record (see p. 47).

To identify which automatic thoughts are “hot”, the therapist listens for verbal cues, such as the language used in the thought (see Cognitive Distortion worksheet, p. 49), and watches nonverbal cues, such as increased volume of speech or fidgeting. Changes in facial expression, shifts in position, or hand movements can be helpful in determining whether a patient is experiencing an automatic hot thought. Listening to tone, pitch, volume, and the pace of a patient's speech is also beneficial. When you notice these actions, this is an opportune time to bring it to the patient's attention and assist him/her in identifying an automatic thought associated with the shift in emotions. In these instances, you are simply an observer of the behavior and make a note of your observation to the patient (“You are speaking more loudly; what is going through your mind right now?”). The patient then provides an explanation of the behavior.

Patient:	“My boss reprimanded me again yesterday” (<i>sighs heavily.</i>)
Therapist:	“Tell me more.”
Patient:	“Well, we were at a meeting; and I had just made my presentation, and he said he had expected a better product for the client. (<i>voice gets softer, begins wringing hands</i>).
Therapist:	“Your voice changed a little when you said that; tell me what is going through your mind right now?”
Patient:	“I just feel like a failure at everything. My work has always been the one thing I was good at, and now I am failing at that, too.”

Example continued:

Therapist: "Let's take a look at that line of thinking and the feelings it creates. It seems that when that thought entered your mind, your mood changed very quickly. Did you notice that?"

Patient: "Yeah, I guess it did upset me pretty fast."

You usually will also need to use specific questions to elicit an automatic hot thought. These questions are found on p. 48-49 and in Module 10.

Automatic Thoughts Between Sessions

In Brief CBT, a principal characteristic is the work the patient does outside of session. Because identifying automatic thoughts is a novel concept to many, practicing outside of session will facilitate movement and change in therapy. In fact, Burns and Nolen-Hoeksema (1992) found that patients who completed homework had significantly better treatment outcomes than those who did not. Practicing key skills between sessions allows session time to be used for new skill acquisition and troubleshooting. Initially, when a specific situation is brought up in session, always ask, "What was going through your mind at that moment?" This helps the patient build awareness of his/her automatic thought, both within and outside of session.

Because automatic thoughts may occur outside awareness, asking for a more detailed description of the situation is also helpful in pinpointing maladaptive thoughts. For example, you could "take the patient back" to when it happened, using imagery (e.g., Where were you when this happened? What time of day was it?). If the patient reverts to past tense, remind him/her to tell the story in present tense to help bring back the thoughts and feelings that occurred in this situation.

With continued questioning, it is possible that there may be more than one automatic thought associated with a problematic situation. Elicit and record all automatic thoughts given for a particular situation.

Therapist: "Craig, what else were you thinking during this phone call with your wife?"

Craig: "I was thinking that she knows how bad I feel for not coming to the party and she wants me to feel even worse."

Therapist: "So you weren't thinking only that they were using you. You were also thinking that they knew you felt bad, and they wanted you to feel worse?"

Craig: "Yes."

Therapist: "So, that is really three different thoughts that you were having that were creating feelings of anger?"

Craig: "I guess so."

Remember that a patient's automatic thoughts should be the actual words or images that go through his or her mind. Patients (or therapists) may often interpret or rephrase thoughts; however, the goal is to get unprocessed thoughts verbatim.

Deciding Which Automatic Thoughts to Focus On

Once a patient becomes aware of how many automatic thoughts he/she has, he/she may feel overwhelmed by their sheer number. Uncovering one thought may lead to another and so on. Therefore, it is important to focus on the most important automatic thoughts and the hot thoughts that are likely to bring about the greatest change. There are several things a patient can do once he or she has identified an automatic thought. The patient can decide to focus on that thought, choose another thought associated with the situation, or move on to another topic if he/she feels that there is a more powerful thought that he/she would like to tackle.

You can help the patient choose automatic thoughts to focus on by frequently checking:

- Goals for this session
- Patient's agenda items and addressing those problems
- The importance of the thought chosen in reaching therapeutic goals

Another technique is to identify a few automatic thoughts and then rate them on a scale of 0-100, based on how intense the associated feeling is (rate the feeling from 0-100), and how much he/she believes the thought (rate believability from 0-100). This helps to quantify which automatic thoughts are most important. The thoughts with the strongest ratings should be considered first.

Dysfunctional automatic thoughts often fall into certain categories. These are common "cognitive distortions" or thinking errors. Identifying patterns of cognitive distortions in the patient's thought records or speech is instrumental for choosing a hot thought, case conceptualization, and treatment planning. A patient often has one or two common patterns of maladaptive thinking. Identifying these patterns helps him/her identify them when they come up and provides you an opportunity to intervene on a thought triggered in multiple situations. Therefore, changing a particular thought that is part of a dysfunctional thinking pattern (e.g., tendency to ignore the positive) may have multiple benefits for the patient. For list of common thinking errors, see the Cognitive Distortion worksheet (page 49).

Intermediate Beliefs

To identify an intermediate belief, you must first know how to recognize a patient's automatic thoughts. You can do this by identifying an automatic thought and then attempting to identify an attitude or assumption the patient feels about him-/herself, the future, others, or the world. These assumptions can be identified by listening for themes in the patient's thoughts and behavior. You can use several techniques to identify an intermediate belief:

- Look for an intermediate belief that comes in the form of a patient's automatic thought.
- Provide the first part of an assumption ("If x..."), and enlist the help of the patient to complete it.
- Elicit a rule or an attitude from the patient, and change it into an assumption.
- Look for themes in the patient's automatic thoughts. Either come up with a hypothesis, or ask the patient to identify a theme.
- Ask the patient directly about his or her beliefs.
- Have the patient complete a questionnaire or inventory that will help identify his/her beliefs (e.g., Dysfunctional Attitudes Scale).

Core Beliefs

Throughout therapy, hypothesize core beliefs that may be underlying dysfunctional behaviors and thoughts. These hypotheses aid development of the case conceptualization and treatment plan (see Module 5). A belief that is likely to be core will appear in several different areas of the patient's life (i.e., relationships, work, parenting).

If time permits in Brief CBT, after you have collected enough evidence to support the alleged core belief, present and discuss it with the patient.

"I've heard you say several times that you either didn't do a good job, or that someone else put in more time and energy. It seems to me that you feel inadequate a lot of the time. Is that right?"

At this point, you can also elicit childhood experiences consistent with the belief. This helps identify the possible origin of the belief and helps you explain it to the patient.

In educating the patient about core beliefs, make several things clear:

- Core beliefs are only ideas. Feeling them strongly does not make them true.
- These beliefs started developing during childhood. The patient believes them today because he/she has stored evidence to support them and rejected evidence to contradict them.
- These beliefs can be tested and changed through use of the techniques that will be taught in therapy.

Example Homework Assignments

1. Keep a notepad with you and attempt to list automatic thoughts you have during the day.
2. Use the triangle diagram to dissect three to five situations when you experienced a strong emotion.
3. Create a list of assumptions and evidence for and against those assumptions.
4. Complete the first three sections of the Thought Record for one to two situations.

Supplemental Readings

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press; Chapters 6, 7, 8, 10, and 11.

Safran, J.D. & Greenberg, L.S. (1982). Eliciting "hot cognitions" in cognitive behavioral therapy: Rationale and procedural guidelines. *Canadian Psychology*, 23, 83-86.

Greenberg, D. & Padesky, C. A. (1995). *Mind over mood: Changing the way you feel by changing the way you think*. New York: Guilford Press; Chapters 5, 6, 7, and 9.

THOUGHT RECORD

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(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 any more. 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)				
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 they were (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

Helpful Questions

Situational Questions	Feeling Questions	Thought Questions
▪ What happened? What were you doing? ▪ Who was there? ▪ Who were you speaking to? ▪ When did this happen? ▪ What time of day was it? ▪ Where did this incident occur?	▪ How were you feeling before this happened? ▪ How did you feel while it was happening? ▪ What mood were you in after this happened? ▪ Can you rate your mood on a scale of 1-100?	▪ What was going through your mind before you started to feel that way? ▪ What made you feel that way? ▪ Do you have any other thoughts? ▪ Which thought bothered you the most? ▪ What images did you have with these thoughts? ▪ What are you afraid might happen? ▪ What if this is true? What does this say about you? ▪ What could happen if this were true? ▪ What other ways could we think of this?

Cognitive Distortions

1. **All-or-nothing thinking:** Viewing situations on one extreme or another instead of on a continuum.
Ex. "If my child does bad things, it's because I am a bad parent."
2. **Catastrophizing:** Predicting only negative outcomes for the future.
Ex. "If I fail my final, my life will be over."
3. **Disqualifying or discounting the positive:** Telling yourself that the good things that happen to you don't count.
Ex. "My daughter told her friend that I was the best Dad in the world, but I'm sure she was just being nice."
4. **Emotional reasoning:** Letting one's feeling about something overrule facts to the contrary.
Ex. "Even though Steve is here at work late every day, I know I work harder than anyone else at my job."
5. **Labeling:** Giving someone or something a label without finding out more about it/them.
Ex. "My daughter would never do anything I disapproved of."
6. **Magnification/minimization:** Emphasizing the negative or playing down the positive of a situation.
Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."
7. **Mental filter/tunnel vision:** Placing all one's attention on, or seeing only, the negatives of a situation.
Ex. "My husband says he wishes I was better at housekeeping, so I must be a lousy wife."
8. **Mind reading:** Believing you know what others are thinking.
Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."
Ex. "My daughter's boyfriend got suspended from school. He's a loser and won't ever amount to anything."
9. **Overgeneralization:** Making an overall negative conclusion beyond the current situation.
Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."
10. **Personalization:** Thinking the negative behavior of others has something to do with you.
Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."
11. **"Should" and "must" statements:** Having a concrete idea of how people should behave.
Ex "I should get all A's to be a good student."

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....

Developing Balanced Thinking

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.

Troubleshooting Thought/Belief Modification

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 than 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.