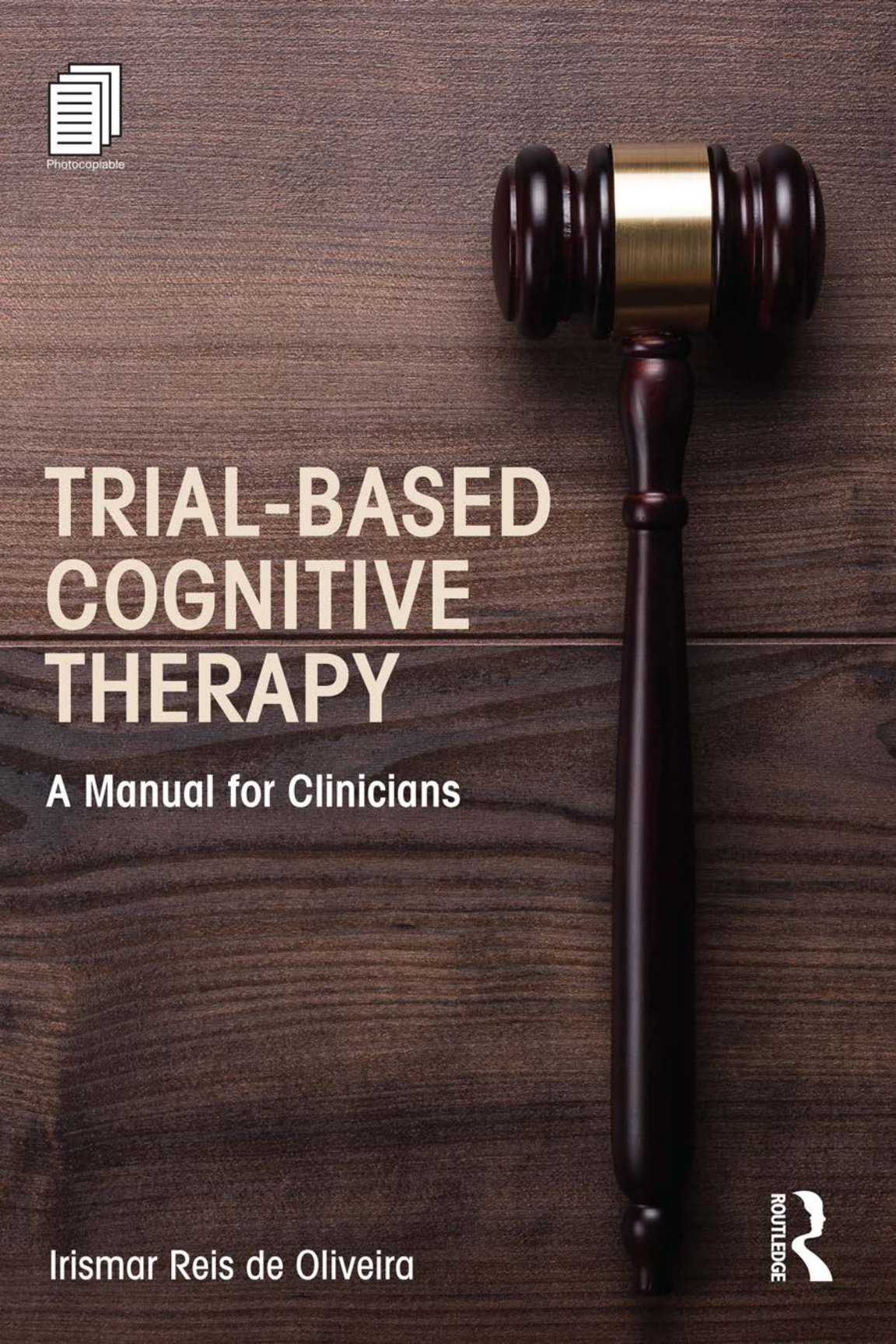
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TRIAL-BASED COGNITIVE THERAPY
A Manual for Clinicians
Irismar Reis de Oliveira
ROUTLEDGE

Trial-Based Cognitive Therapy

Trial-Based Cognitive Therapy presents a model that, although still inherently Beckian, organizes known cognitive and behavioral techniques in a step-by-step fashion in order to make cognitive therapy easier for the new therapist to learn, easier for patients to understand, and simpler to implement. Based on and backed up by a series of published studies, *Trial-Based Cognitive Therapy* lays out structured strategies for changing core beliefs about the self, and its clear, coherent, integrative conceptualization of psychopathology is presented as an easy-to-remember case formulation model that is useful for both the therapist and the client. This book introduces a new approach, trial-based cognitive therapy (TBCT), whose main technique, the trial-based thought record (TBTR), is a structured strategy to change core beliefs about the self and is presented as a law-centered analogy in which the therapist engages the client in a simulation of the judicial process. Perfect for psychotherapists at any level, *Trial-Based Cognitive Therapy* presents a balanced blend of theory advancement, scientific scrutiny of a new method, and practical application.

Irismar Reis de Oliveira, MD, PhD, is a professor in the department of neurosciences and mental health at the Federal University of Bahia, Brazil. Dr. de Oliveira maintains a private practice and is the editor of *Standard and Innovative Strategies in Cognitive Behavior Therapy* and coeditor of *Integrating Psychotherapy and Psychopharmacology.*

Clinical Topics in Psychology and Psychiatry
Bret A. Moore, PsyD, Series Editor

Anxiety Disorders
A Guide for Integrating Psychopharmacology
and Psychotherapy
Stephen M. Stahl and Bret A. Moore

Integrating Psychotherapy and Psychopharmacology
A Handbook for Clinicians
Irismar Reis de Oliveira, Thomas Schwartz, and Stephen M. Stahl

Trial-Based Cognitive Therapy
A Handbook for Clinicians
Irismar Reis de Oliveira

Trial-Based Cognitive Therapy

A Manual for Clinicians

Irismar Reis de Oliveira

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Series Editor Foreword

Trial-Based Cognitive Therapy: A Manual for Clinicians is the third book in one of Routledge's newest series, Clinical Topics in Psychology and Psychiatry (CTPP). The broad goal of CTPP is to provide mental health practitioners with practical information that is both comprehensive and relatively easy to integrate into day-to-day clinical practice. It is multidisciplinary in that topics relevant to the fields of psychology and psychiatry are covered and it appeals to both the student and the senior clinician. Books chosen for the Series are not only authored and edited by national and international experts in their respective areas but the contributors are also highly respected clinicians. The current volume exemplifies the intent, scope, and aims of the Series.

Author Irismar Reis de Oliveira, MD, PhD, delivers a straightforward and easy-to-understand manual on a burgeoning form of cognitive therapy—Trial-Based Cognitive Therapy (TBCT). Developed by de Oliveira, TBCT is a three-level, three-phase, case formulation approach that targets a patient's dysfunctional thoughts and core beliefs. Drawing from the foundation of Aaron Beck's Cognitive Therapy, TBCT utilizes structured, collaborative, and educative processes while incorporating the unique and clever analogy of the law. The patient and therapist engage in a back-and-forth process reminiscent of the famous novel *The Trial* by Franz Kafka. TBCT is not only effective and grounded in proven psychotherapeutic principles but it is also an entertaining yet sophisticated approach to cognitive therapy. The client familiar with Kafka's classic literary work will immediately appreciate the clever parallels de Oliveira draws between Joseph K's predicament and his or her maladaptive thought processes. For those not familiar with the story, the analogy will become evident at the outset and draw the client into the therapeutic process easily and fully.

Because of the step-by-step nature of the treatment and the clear and stepwise structure of the manual, the student, psychotherapist new to cognitive therapy, as well as the experienced cognitive therapist looking to expand and add "flavor" to his or her cognitive therapy practice, will learn the unique techniques of TBCT with ease. Another group of mental health professionals who will appreciate the approach of TBCT are psychopharmacologists. The

short-term and scientifically based principles of TBCT can be assimilated into most any psychopharmacology practice.

As stated by Dr. Stahl in the book's foreword, the user of this manual is in for a real treat. In a field that prides itself on being innovative, creative, and progressive, it is ironic that few novel approaches to psychotherapy have hit the scene since the introduction of cognitive therapy. de Oliveira has energized and diversified the field of psychotherapy by combining sound psychotherapeutic principles with classic literature and common sense with a modern-day *Law and Order* feel.

Bret A. Moore, PsyD, ABPP
Series Editor
Clinical Topics in Psychology and Psychiatry

Foreword

The reader of this book is in for a real treat. The manual that follows explains how to do trial-based cognitive therapy (TBCT), a new psychotherapy—or at least a new version of psychotherapy emerging from the well-known and broadly defined school of cognitive therapy. The clinical psychotherapist who applies the training provided by this manual is in for an even bigger surprise: TBCT works and can even at times be fun both for the therapist and for the patient. I have had the pleasure of reading this book, participating in extensive live training by the author, and applying this approach in my own practice. Yes, I must admit that, although I am a "recovering psychopharmacologist," TBCT has an important presence in the life of a psychopharmacologically oriented clinical practice because it augments medication treatments and is actually a delight to conduct and gratifying to see so many positive results.

It is a rare event for a new psychotherapy to emerge. Even more unique is for a psychotherapy to be built around scientific evidence rather than around the charisma of its founder. TBCT is evidence-based and has been proven effective in randomized controlled trials by the author. It is built on the solid foundation of cognitive therapy as popularized especially by Aaron Beck. In fact, practitioners and experts in cognitive therapy alike have even quipped that the author of this manual, Irismar Reis de Oliveira, should be considered "the Brazilian Beck," high praise indeed.

You will learn that TBCT has three levels, three phases and is based on a case formulation that takes aim at debunking closely held negative core beliefs of the patient. That is a brief statement of the science. What is really novel and so interesting about this approach is that it is based on a timely analogy with the law. Today, many of the most popular novels, movies, and television programming are based on crime fiction, with crime scene investigators solving crimes and larger-than-life prosecutors convicting the guilty. Patients are immersed in these aspects of popular culture and, when they present with negative core beliefs about themselves for help, are almost universally captivated by the prospect of investigating these beliefs to see if they are exaggerated or untrue, and doing this by quite literally putting their negative core beliefs on trial.

de Oliveira was inspired to "morph" the solid principles of cognitive therapy with the formal procedures of a courtroom, not only because of their popularity

and familiarity to modern patients but also because of the fundamental truth about core beliefs exemplified by the classical character Joseph K. in the novel *The Trial* by Franz Kafka. Just as the origin of so many of our patients' core beliefs is shrouded in mystery, Joseph K. was arrested and ultimately convicted of something he was never told about and for reasons never revealed to him. Instead of letting our patients continue through life being convicted of their negative core beliefs, de Oliveira teaches us to "put those negative core beliefs on trial" and, in that process, recognize how surreal and absurd these beliefs may be and that they are caused really by an abusive prosecutor rather than by truths about ourselves. When I successfully complete a trial with patients who see that their core beliefs are excessive and they gain subjective relief from that insight, I especially enjoy helping them sue their inner prosecutor for "prosecutorial malpractice." That enjoyment may be more about me than about the patient because as a physician I am not particularly enamored with lawyers.

So, I invite you to sit back, relax, and enjoy your journey into TBCT, and the principle that excessive self-accusation is universal and amenable to relief via a cognitive perspective, specifically that of organizing one's own defense and thereby restructuring therapeutically helpful core beliefs about oneself.

Stephen M. Stahl, MD, PhD

Acknowledgments

The first person to be acknowledged is Monica, my wife, for her endless patience and support. She generously forgave my frequent absences at important social and family moments, during which I was focused on writing this book.

Amy Wenzel gave support and advice about theoretical aspects in the construction of this approach.

Donna Sudak was present and attentive during the whole development of TBCT, and, in addition to encouragement, gave important suggestions. Teaching TBCT to her residents at Drexel University in 2011, and subsequently having her help as a faculty member in other workshops in the United States was a real pleasure and provided me the first opportunity to introduce TBCT in the United States.

I would like to acknowledge Robert Friedberg for being the first person who encouraged me to write this manual.

Also, Peter Trower made useful comments that helped me improve the use of imagery rescripting in TBCT.

Thanks are also due to Vania Powell who, in addition to being my partner in the specialization course in Salvador, Brazil, for several years, helped me conduct the study of the TBTR in social anxiety disorder. Ricardo Wainer was tireless in motivating me to pursue my work during the development of TBCT, believing in its value long before I could envision its importance.

Also, during the period I was writing this manual, Érica Duran was responsible for keeping our cognitive therapy specialization course working. Érica is likewise acknowledged for her extremely important leadership role in a randomized clinical trial to assess the efficacy of TBCT in a posttraumatic stress disorder study being conducted at the Institute of Psychiatry, University of São Paulo.

Part of the dialogues presented in this manual, shown as the composite fictional patient Leslie at the end of all the sessions, was extracted and modified from the simulation of a treatment conducted by psychologist Christiane Peixoto and myself in a workshop I gave several years ago in Maceió, Brazil. Of course, I am also grateful to my patients who gave me permission to include extracts of their recorded sessions, which were also modified to be included in some of Leslie's sessions.

Because English is not my first language, I was fortunate enough to meet Linda Soules, who not only revised this manual but has also helped me make my English written and oral communication clearer and more consistent in the last few years.

This manual would not be possible without thorough editorial assistance. Thus, I am grateful for the careful support provided by Anna Moore, senior editor at Routledge. In the same vein, Bret Moore made this manual possible by accepting its publication in his series. I am also grateful for his constant availability and valuable suggestions.

Finally, I would like to express my deepest gratitude to Stephen Stahl for his brotherly friendship and encouragement over the past two decades. I have supervised the translation of all Stahl's *Essential Psychopharmacology* textbook editions into Portuguese for the past 15 years. Steve has been a great enthusiast of my approach and a tireless friend in giving me the incentive to develop TBCT in the United States and in showing me how TBCT could be added as a new nonpharmacological strategy to enhance psychopharmacologists' effectiveness.

Introduction

Definitions: Cognitive Therapy vs. Trial-Based Cognitive Therapy

Cognitive therapy (CT) is one of the therapeutic approaches within the larger group of cognitive behavioral therapies (CBT), developed by Albert Ellis, Aaron Beck, and others in the 1950s and 1960s. CT is an active approach to treatment that helps patients to recognize situationally based thoughts and unhelpful beliefs that exacerbate emotional distress (Beck, 1979). One of the main goals of CT is to help patients modify the so-called core beliefs (CBs), which are those global, rigid, and over-generalized perceptions about themselves accepted as absolutely true to the point that they do not question them (Wenzel, 2012).

Trial-based cognitive therapy (TBCT) is conducted as a three-level, three-phase, case formulation approach that I developed at the Federal University of Bahia, in Brazil (de Oliveira, 2011b). TBCT's foundation is in CT, as developed by Beck (1979); however, it has a unique approach to conceptualization and techniques that makes it a distinct intervention in modifying patients' CBs, especially those about the self (de Oliveira, 2014).

The chief technique used in TBCT is the trial-based thought record (TBTR), sometimes also called trial I, a structured strategy that is presented as an analogy with law, in which the therapist engages the client in a simulation of a judicial process. Inspiration for this technique was found in the surreal novel by Franz Kafka, *The Trial* (Kafka, 1925/1998), in which the main character, Joseph K., is arrested and convicted without knowing the crime of which he was accused. Thus, TBCT is perhaps the first practical approach proposed to deal with the highly bullying nature of Joseph K.'s thoughts and beliefs (de Oliveira, 2011b), which were probably Kafka's own thoughts and beliefs, as demonstrated in his autobiographical *Letter to His Father,* written in 1919 (Kafka, 1966) and as suggested by some of his biographers (e.g., Stach, 2005). I hypothesized that Kafka's intention was to propose self-accusation as a universal principle, whose consequence could be allowing the subject to organize his or her own defense. In the CT perspective, this is the same as restructuring CBs about the self (de Oliveira, 2012b).

TBCT Research

The first use of TBTR, the main technique used in TBCT, was assessed in a psychotherapy one-hour session in a preliminary study in which, after taking part in a jury simulation, the patients ($N = 30$) showed changes in their attachment to negative CBs, as well as in the intensity of the corresponding emotions. Significant mean reductions were observed between the percentage figures after the investigation (taken as baseline), the defense attorney's allegation ($p < 0.001$), and the jury's verdict in terms both of the beliefs ($p < 0.001$) and the intensity of emotions ($p < 0.001$). Also, significant differences were observed between the first and second defense attorney's allegations ($p = 0.009$) and between the second defense attorney's allegation and the jurors' verdict with respect to the CBs ($p = 0.005$) and the emotions ($p = 0.02$). The conclusion was that trial I could, at least temporarily, help the patients reduce their attachment to negative CBs and the corresponding emotions (de Oliveira, 2008).

The TBTR's first use was also assessed in a trans-diagnostic replication (de Oliveira, Hemmany et al., 2012) of the preliminary investigation (de Oliveira, 2008). In this study, 166 patients were submitted to TBTR, and their adherence to the negative CBs and corresponding emotions were assessed. Significant reductions were observed in percent values after the first and second defense attorney pleas, as well as after the jury's verdict and initial preparation for the appeal ($p < 0.001$), relative to the investigation phase taken as baseline. Significant differences also emerged between the defense attorney's first and second pleas and between the defense attorney's second plea and the jury's verdict, as well as preparation for the appeal ($p < 0.001$). However, there was no difference between outcomes, regardless of the therapists' level of exposure (experience) to TBTR. The conclusion was that this approach might help patients reduce attachment to negative CBs and corresponding emotions, confirming the results of the preliminary study (de Oliveira, 2008). The sample size of this study was increased to 259 patients (de Oliveira, Duran, & Velasquez, 2012), confirming its findings regarding CBs and emotion change, but further indicating the following: The empty chair format may be more efficacious than the conventional static format in reducing the intensity of corresponding emotions, and significantly more patients treated with the empty chair format concluded all the steps of the technique.

TBTR was studied in a randomized clinical study (de Oliveira, Powell et al., 2012) with 36 patients diagnosed with social anxiety disorder (SAD). In this study, the experimental group was treated with TBTR ($n = 17$) and the contrast group ($n = 19$) with a conventional model of CT that included the seven-column dysfunctional thought record (DTR; Greenberger & Padesky, 1995) and the positive data log (PDL; Beck, 2012). After an individualized case conceptualization, both the TBTR and the CT groups received psychoeducation explaining the cognitive model and cognitive distortions. Both treatments aimed to restructure the CBs and to reduce the symptoms of social phobia. Exposure was not actively stimulated in either of the groups. A mixed ANOVA

showed significant reductions ($p < 0.001$) in both approaches in scores on the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987), the Fear of Negative Evaluation Scale (FNE; Watson & Friend, 1969), and the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988). However, the one-way ANCOVA, taking the baseline data as covariables, showed that the TBTR was significantly more effective than the contrast group in reducing the FNE ($p = 0.01$) and social avoidance and distress ($p = 0.03$). Quality of life was significantly better at post-treatment (bodily pain, social functioning, and emotional role) and at follow-up (emotional role) in the TBTR group relative to the contrast group (Powell et al., 2013). A significant treatment effect on the emotional role domain at 12-month follow-up also implied a sustained effect of the TBTR relative to conventional CT, suggesting that this approach is at least as effective as CT in improving several domains of quality of life in SAD.

A recent one-session randomized study (de Oliveira et al., 2013) aiming to assess the differential efficacy of the TBTR employed in the empty (multiple) chair relative to the static format (patient remained the whole session in the same chair) was conducted with 41 patients having any psychiatric diagnosis. The mixed ANOVA indicated a significant main effect, meaning that significant reductions in percent values both in the credit given to the CBs and in the intensity of the emotions were observed at the end of the session ($p < 0.001$), relative to baseline (investigation phase). There was no interaction between time and treatment. The ANCOVA showed a significant difference in favor of the empty chair approach for both the belief credit and the emotion intensity ($p = 0.04$), suggesting that the TBTR may help patients reduce their attachment to negative CBs and corresponding emotions, which confirmed the preliminary observations (de Oliveira, 2008, 2012b). However, contrary to previous observations, the empty chair format was more efficacious than the static format in reducing the credit given to CBs and the intensity of corresponding emotions (de Oliveira et al., 2013).

Duration of TBCT Treatment

Although TBCT is presented in this manual in 12 weekly sessions (3 months), treatment should be individualized and fit to the patient's needs and complexity. Each session, which is described in this book as a unique session, should be broken into two or more sessions when necessary. Taking the use of the intrapersonal thought record (Intra-TR) as an example (see Chapter 3 in this manual), in real-world situations of complex patients, the therapist may need two or three sessions until he feels the patient has mastered the Intra-TR use. Also, when using the consensual role-play (CRP) to help patients make decisions (see Chapter 4 in this manual), such decisions may have different levels of complexity and sometimes need to be broken into more, less complex steps. In this case, the therapist would propose that the patient repeat the CRP as many times as necessary in several sessions. In the same vein, when conducting a trial I to change a core belief (Chapter 5 in this manual), particularly in severely

ill patients, it may take two or three sessions to complete a single trial I. For the trial II as well, the patient may need to repeat it several times until a real sense of metacognitive awareness is developed. It is logical to conclude that a real-world TBCT therapy process may take several months or even a year, and sometimes longer in personality disorder patients, to be completed. Needless to say, TBCT is an assimilative integrative approach (Messer, 1992), and techniques from other approaches may be employed during therapy. It is not rare, however, that some uncomplicated patients will profit from a much shorter therapy duration, sometimes four to eight sessions or even fewer. In emergency or special situations in which the therapist might see a patient only once, the therapist might want to go directly to trial I (see a theatrical illustration of such a situation at http://youtu.be/s8NsdRDesfg).

Gender Challenges

Throughout this manual, instead of dealing with gender using the compound pronouns "he or she" and "his or her" in abstract situations, I decided to use "she" and "her" when referring to the patient, and "he" and "his" when referring to the therapist. The reason for that is that I am the therapist in all the case illustration dialogues presented in this book, and the complete session case illustration taken as the example at the end of every chapter is with a female patient. Of course, when I refer to a specific female or male patient, "he" or "she" is used accordingly.

1 Introducing the Cognitive Model to the Patient

Outline

- General Introduction to Therapy
- Case Conceptualization
- Explaining the Cognitive Model to a Patient (Paul)
- Explaining the Cognitive Model to a Patient (Kathleen)
- Introducing the Concept of Cognitive Distortions to a Patient

Case Illustration Dialogue

- General Introduction to the Therapy
- Identifying the Problems
- Setting Therapy Goals
- Introducing the Cognitive Model: First Level of the Cognitive Conceptualization Diagram
- Introducing Cognitive Distortions
- Designing Homework, Summarizing, and Concluding Session 1

General Introduction to Therapy

Cognitions may affect important aspects of our daily life, such as emotion, behavior, and interpersonal relationships, and involve structures necessary to support efficient information processing. Implicit (non-conscious) as well as explicit (conscious) levels of awareness on the part of both the client and the therapist interfere in the exchange of interpersonal information in therapy (Alford & Beck, 1997).

It is usually accepted that cognitions may be assessed on at least three information-processing levels (Fig. 1.1). On the most superficial level, cognitions are known as automatic thoughts (ATs). In the intermediate level, cognitions are usually called underlying assumptions (UAs) or conditional beliefs. In the deepest level of information processing, cognitions are known as core beliefs (CBs), sometimes also called schemas. Trial-based cognitive therapy

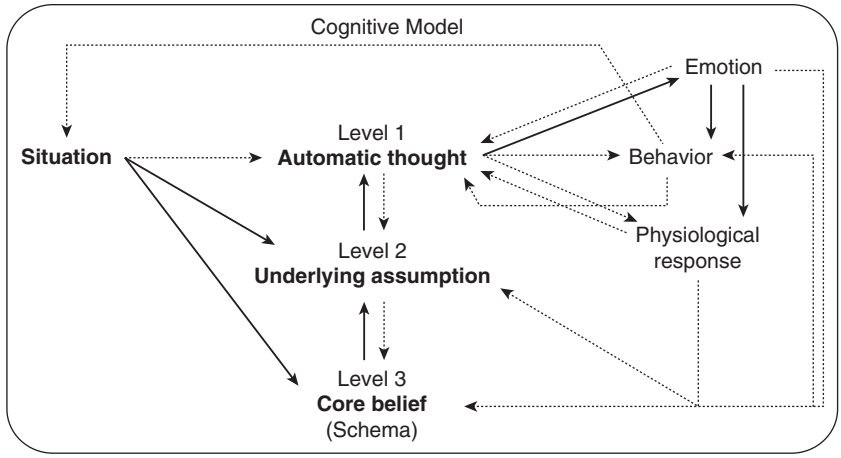

Figure 1.1 Diagram illustrating the cognitive model and reciprocal influences exerted by its components.

(TBCT) was devised to deal with the three levels, but especially the third level, in a step-by-step fashion (de Oliveira, 2014).

In the initial steps of TBCT, the therapist educates the patient about the cognitive model and basic concepts (e.g., ATs) in the same way as in standard cognitive behavior therapy (CBT). For a more detailed explanation of basic CBT concepts, I suggest reading the new edition of the classic, *Cognitive Therapy: Basics and Beyond* (Beck, 2012), or my edited book *Standard and Innovative Strategies in Cognitive Behavior Therapy* (de Oliveira, 2012b), the latter freely available for download at http://intechopen.com/books/standard-and-innovative-strategies-in-cognitive-behavior-therapy. In TBCT, as in standard CBT, initial sessions are used by the therapist to identify problems, set therapy goals, introduce the cognitive model, and educate the patient about cognitive distortions (de Oliveira, 2014).

Session 1 of TBCT is illustrated by the transcript of a complete session at the end of this chapter. From this chapter on, case illustration dialogues are available at the end of all the chapters throughout this manual and picture Leslie, a fictional patient; these case illustration dialogues are composed of dialogues extracted from workshop role-plays and real patients of mine.

Case Conceptualization

Case conceptualization, sometimes also called case formulation, is an essential component of CBT. It may be defined as the description of a patient's presenting problems that uses theory to make explanatory inferences about causes and maintaining factors, as well as to inform interventions (Kuyken,

Fothergill, Musa, & Chadwick, 2005). Nevertheless, sharing its components with patients is a complex task. Case conceptualization is an individualized work and should be collaboratively developed with the patient, while educating her about the cognitive model. There are many case conceptualization diagrams proposed by different authors for different disorders and problems. However, the conceptualization diagram proposed by Judith Beck (2012) is the most well known and used.

In developing TBCT, I designed a cognitive conceptualization diagram (CCD, Fig. 1.2) to make it easier for the patient to understand the cognitive model during therapy. Although this CCD was designed for use in TBCT (de Oliveira, 2012b), it is not limited to this approach, considering that its components are the same usually found in other conceptualization diagrams commonly used in standard CBT (J. S. Beck, 2012).

Also, as in standard CBT, TBCT may be conceptualized in three levels of information processing. In the first level (Fig. 1.2), a situation that is appraised by the patient as dangerous (*AT* box) might elicit anxiety (*emotion* box), which, in turn, could immobilize her (*behavior and physiological responses* box). The arrows pointing back to the *emotion, ATs*, and *situation* boxes tell the patient about the circular nature of these interactions (confirmatory bias) that prevents

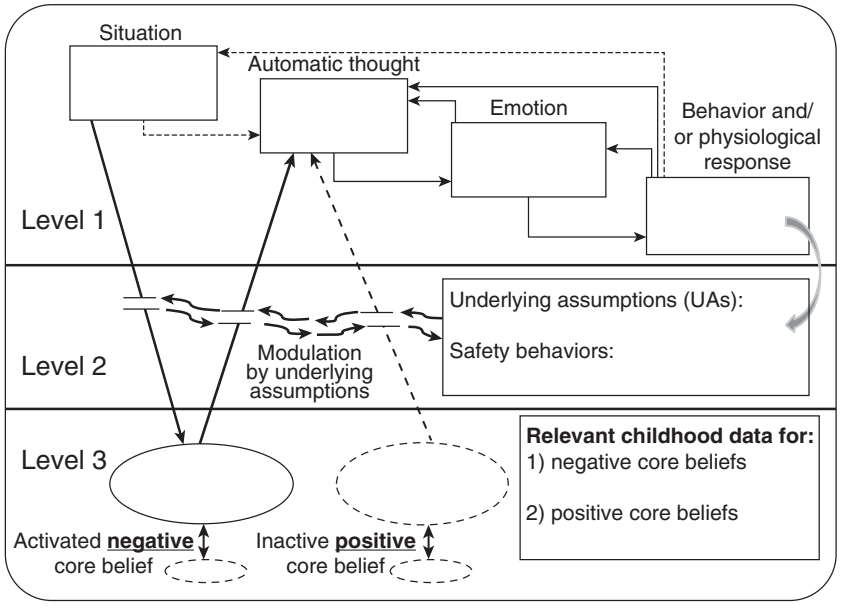

Figure 1.2 TBCT cognitive conceptualization diagram (CCD), phase 1, level 1, and its three-level cognitive components: automatic thoughts (ATs), underlying assumptions (UAs), and core beliefs (CBs).

her from reappraising the situation and consequently changing the erroneous perceptions it produces.

The CCD is also usually useful in helping the patient understand that the behaviors that she uses in specific situations, and that elicit less anxiety, thus yielding immediate relief (e.g., avoidance), may gradually develop into a *safety behavior* (shown in Fig. 1.2 as an arrow directed from the *behavior and physiological responses* box from the first to the second level on the right side of the figure). This means that perceptions in the first level (ATs) may progressively become *UAs* or *conditional rules* that are now maintained by the *safety behaviors* seen in the second level. One might accept here that UAs and their resulting safety behaviors have a modulatory function. Under the influence of the UAs' support of such safety behaviors, first-level appraisals (ATs) may be repeatedly and indefinitely confirmed. In the same vein, third-level *unconditional CBs* are activated when UAs are challenged (e.g., during exposure) and inactivated when UAs are not challenged (e.g., by avoidance).

When the patient has developed adequate practice in identifying and changing ATs by replacing them with more functional alternative appraisals, she may gradually notice changes in the other levels of information processing, for instance, more easily activating positive CBs. Nevertheless, restructuring negative CBs (see Chapters 5 through 9) is an essential step for durable results in therapy. Figure 1.2 graphically illustrates such changes.

Explaining the Cognitive Model to a Patient (Paul)

Cognitions and their relation to emotional and behavioral responses are complex phenomena. Figures 1.1 and 1.2 illustrate the highly complex interactions between different elements of the cognitive model and their reciprocal influences. The TBCT CCD (Fig. 1.2) was devised to make such complex interactions easier to understand both for therapists and patients. The CCD is introduced to the patient in a step-by-step fashion during the entire therapy process, starting with the first level of cognition.

The following transcript provides an idea of how the therapist may introduce, at the same time, the cognitive model and the first level of the CCD to the patient, Paul, who is a journalist (Fig. 1.3).

T: Paul, in order to have an idea of how this therapy can help you, it is important that you understand how our thoughts are connected to our feelings and behaviors. I'd like to ask you to look at this diagram so that I can show this more clearly to you. Can you remember a recent situation that caused you discomfort?

P: Yes. Yesterday, my boss made amendments to a paragraph of my text.

T: Maybe we'll write down exactly what you said—"My boss made amendments to a paragraph of my text"—in the situation box you see in this diagram. [The therapist introduces the CCD to Paul (Fig. 1.3).] What went through your mind in that moment?

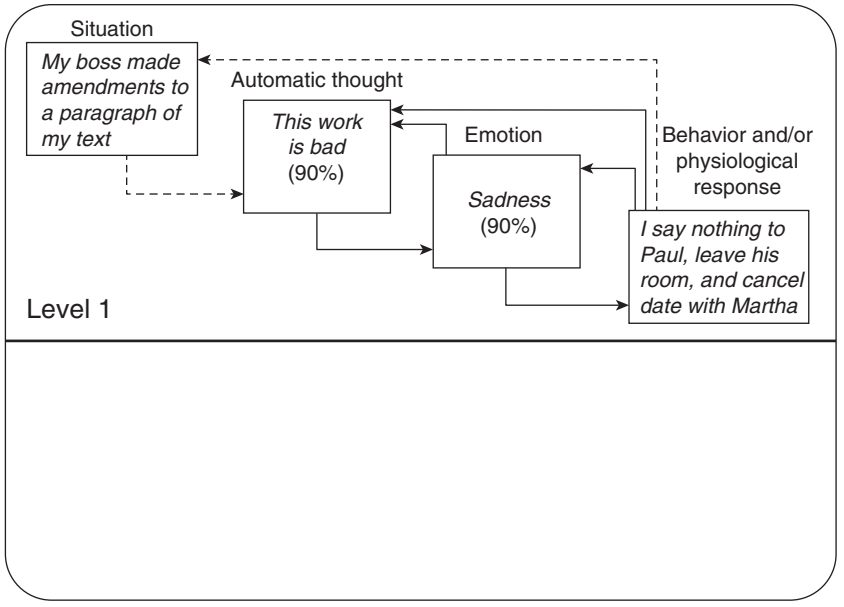

Figure 1.3 Case illustration of the cognitive conceptualization diagram (CCD), phase 1, level 1, designed to teach the patient the relation between the situation, the automatic thought (AT), the emotion, and the behavior or physiological response.

P: That my text is bad, and I'm sure John didn't like it.
T: This is what we call an automatic thought, because it pops into one's mind without any deliberation. Shall we write it down in the automatic thought box? [The therapist points to the AT box in the CCD so that Paul can write it down.] Paul, how much did you believe this thought right then, from zero to 100%?
P: I believed it very much, 90%.
T: Please, can you write it down here, also in the AT box? Do you remember what emotion you felt?
P: Sadness. I felt sad, very sad.
T: Would you please write down the word "sadness" in the emotion box?
T: How sad did you feel?
P: Also 90%, maybe more.
T: Please, write it down in the same box.
P: Sure.
T: What happened when you felt sad? Did you notice anything in your behavior or in your body?
P: I said nothing to John and I wanted to immediately leave his office. And I noticed my heart racing.

T: What happened next?
P: Nothing . . . I went home. I had a date with Martha, but I made an excuse and stayed home. The idea that my work was bad kept coming back again and again, and I thought that I wouldn't have fun going out with Martha.
P: Looking at this diagram, do you see these arrows going from the situation box, to the AT box, then to the emotion box, and finally to the behavior and physiological response box?
P: Yes.
T: Also, do you see these arrows pointing back?
P: Sure.
T: What happened after you left Paul's office?
P: I felt relieved, but the thought that John didn't like my text kept coming back to mind.
T: Can you see a self-perpetuating, circular mechanism in this diagram? When you had this automatic thought "John didn't like my work" you felt sad; then you didn't say anything and went home. This produced another flow of automatic thoughts like "I won't have fun going out with Martha," which left you feeling even sadder. Is this pattern clearer to you?
P: Yes, very clear. It closes an endless circle from which I can hardly escape.

Explaining the Cognitive Model to a Patient (Kathleen)

The unbroken arrows seen in Figures 1.1 through 1.3 represent more direct effects, and the interrupted arrows represent possible indirect effects in the chain of events triggered by a situation. It is important for the therapist to explain why different situations provoke different reactions (e.g., the interrupted arrow between *situation* and *AT*) in different people or in the same people in different situations. The CCD is designed to make these interactions more easily understood by the patient during the therapeutic process. The patient starts to identify cognitions at the first and most accessible level of information processing—negative ATs. The upper part (level 1) of the CCD is explained to the patient so that she understands the circular nature of ATs (circuit 1 in Fig. 1.4). Thus, this is an alternative way I use to explain the cognitive model to my patients.

T: Kathleen, can you imagine someone in the chair beside you? What do you think she would feel if I said, "You're a nice person. I like you."?
P: She would feel happy.
T: Why do you think she would feel happy? How would you explain this to me according to this diagram?
P: When you say that you like her—which is the situation—this makes her think something like "Dr. de Oliveira likes me, and this makes me feel good." This is the automatic thought.
T: What do you think she would do?

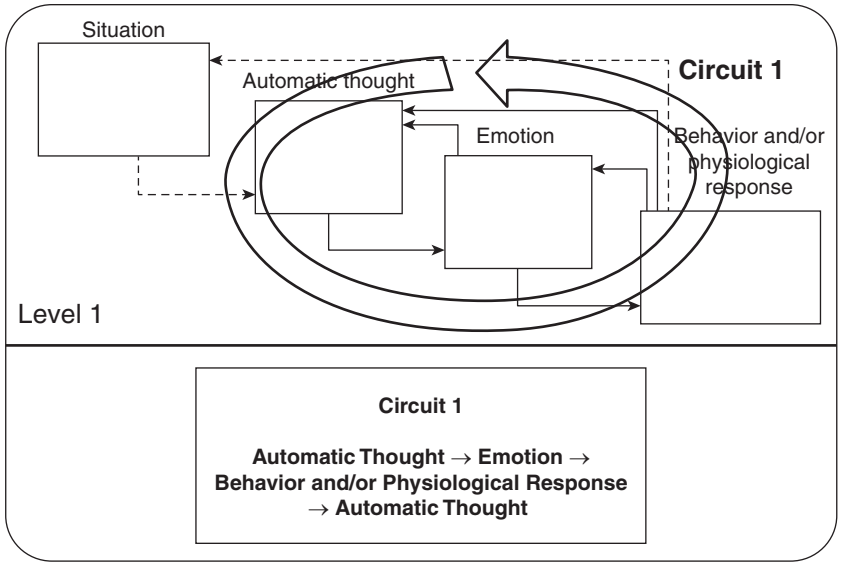

Figure 1.4 Illustration of the first level of the TBCT cognitive conceptualization diagram (CCD, circuit 1), designed to teach the patient the relation between the situation, the automatic thought (AT), the emotion, and the behavior or physiological response. The arrows also show that emotions and behaviors influence the generation of new thoughts and their reciprocal influences.

P: I think she would smile and say thank you.
T: Can you picture a second person in this chair who could feel sad in the same situation, after I said, "You're a nice person. I like you."?
P: I would hardly imagine that, but I think it is possible.
T: Why? How would you explain it according to this diagram?
P: Maybe, she had the thought: "Dr. de Oliveira is just trying to please me. I don't believe he's telling the truth. People usually don't like me."
T: Right. Can you imagine a third person feeling angry in the same situation?
P: It's possible. Maybe she thought, "Dr. de Oliveira is not sincere. He's trying to keep me as a patient and profit at the expense of my distress."
T: Perfect! And what would each person's behavior be in the three different situations?
P: The first person would smile and relax. The second one, who was sad, would be distant and quiet. And the third, angry person might not come back.
T: Exactly. Of course, new situations would come up from each of these behaviors, confirming the thoughts; isn't that true? Can you see how this circle is perpetuated? The unbroken arrows you see returning from the behavior and physiological response box back to the situation box represent possible indirect effects in the chain of events triggered by the situation.

Introducing the Concept of Cognitive Distortions to a Patient

Negative ATs are generally consistent errors in patients' thinking, or cognitive distortions. The following transcript demonstrates how the therapist can use the cognitive distortions list to teach the patient how he can identify them as he practices on a daily basis.

T: Paul, I think it is clearer to you how our thoughts influence our emotions and our behaviors; isn't that correct? These negative automatic thoughts are sometimes called cognitive distortions. I would like to introduce this cognitive distortions list to you. I would also like to ask you to read some of them. In the first column you have the names of the distortions, in the second you find their definitions, and in the third are the examples. You also have a space where you can jot down your own personal examples, but we will use this for homework. I will tell you about this later. [The patient reads two or three cognitive distortions in the cognitive distortions sheet (Table 1.1).] Can you find any distortions that fit the situation we discussed a few minutes ago?

P: Yes, dichotomous thinking. Just as in this definition, I tend to see situations in terms of "one thing or another," placing them in only two extreme categories and not in a continuum. My personal example is "John amended one paragraph in my text; therefore it is bad." This is the same as the example, "I made a mistake; therefore I am a failure."

T: Are you saying that you see situations in two extremes?

P: Yes, I am.

T: These 15 different thinking errors in this list are called cognitive distortions. Everyone makes them, and I would like you to become familiar with them, starting this week. I'd ask you to pay close attention to yourself and see if you find some of these cognitive distortions during the week, when you feel uncomfortable or distressed. If you identify any of these, please, jot them down in the fourth column where you read "My examples."

P: Sure, I can do that.

CASE ILLUSTRATION DIALOGUE

General Introduction to the Therapy

THERAPIST (T): Good morning, Leslie.

PATIENT (P): Good morning, Dr. de Oliveira.

T: Although we met last week, this is our first psychotherapy session. Last week you gave me an idea of the problems you are going through, and we arrived at the conclusion, after you told me your story, that you have social phobia. You are excessively shy, which really limits your life, so you decided to start therapy with me. We will have weekly sessions. Today I am going to explain to you how I will help you regarding this problem that we diagnosed as social phobia, OK?

P: OK.

Table 1.1 Cognitive distortions, definitions, and examples*

Please read the list of definitions and examples of cognitive distortions below, so that you can learn to identify your own examples. Write down these examples in column 4, under "My examples."

Cognitive distortion	*Definition*	*Examples*	*My examples*
1. Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking)	I view a situation, a person, or an event only in all-or-nothing terms, fitting them into only two extreme categories instead of on a continuum.	"I made a mistake; therefore I'm a failure." "I ate more than I planned, so I blew my diet completely."	
2. Fortune telling (also called catastrophizing)	I predict the future in negative terms and believe that what will happen will be so awful that I will not be able to stand it.	I will fail and this will be unbearable." "I'll be so upset that I won't be able to concentrate for the exam."	
3. Discounting or disqualifying the positive	I disqualify and discount positive experiences or events, insisting that they do not count.	"I passed the exam, but I was just lucky." "Going to college is not a big deal; anyone can do it."	
4. Emotional reasoning	I believe my emotions reflect reality and let them guide my attitudes and judgments.	"I feel she loves me, so it must be true." "I am terrified of airplanes, so flying must be dangerous."	
5. Labeling	I put a fixed, global label, usually negative, on myself or others.	"I'm a loser." "He's a rotten person." "She's a complete jerk."	
6. Magnification/ minimization	I evaluate myself, others, and situations magnifying the negatives and/or minimizing the positives.	"I got a B. This proves how inferior I am." "I got an A. It doesn't mean I'm smart."	

(*Continued*)

Table 1.1 (Continued)

Cognitive distortion	*Definition*	*Examples*	*My examples*
7. Selective abstraction (also called mental filter and tunnel vision)	I pay attention to one or a few details and fail to see the whole picture.	"My boss said he liked my presentation, but since he corrected a slide, I know he did not mean it." "Even though the group said my work was good, one person pointed out an error so I know I will be fired."	
8. Mind reading	I believe that I know the thoughts or intentions of others (or that they know my thoughts or intentions) without having sufficient evidence.	"He's thinking that I failed." "She thought I didn't know the project." "He knows I do not like to be touched this way."	
9. Overgeneralization	I take isolated cases and generalize them widely by means of words such as "always," "never," "everyone."	"Every time I have a day off from work, it rains." "You only pay attention to me when you want sex."	
10. Personalizing	I assume that others' behaviors and external events concern (or are directed to) me without considering other plausible explanations.	"I felt disrespected because the cashier did not say thank you to me" (not considering that the cashier did not say thank you to anyone). "My husband left me because I was a bad wife" (not considering that she was his fourth wife).	
11. Should statements (also "musts," "oughts," "have tos")	I tell myself that events, people's behaviors, and my own attitudes "should" be the way I expected them to be and not as they really are.	"I should have been a better mother." "He should have married Ann instead of Mary." "I shouldn't have made so many mistakes."	

12. Jumping to conclusions	I draw conclusions (negative or positive) from little or no confirmatory evidence.	"As soon as I saw him I knew he had bad intentions." "He was looking at me, so I concluded immediately he thought I was responsible for the accident."	
13. Blaming (others or oneself)	I direct my attention to others as sources of my negative feelings and experiences, failing to consider my own responsibility, or conversely, I take responsibility for others' behaviors and attitudes.	"My parents are the ones to blame for my unhappiness." "It is my fault that my son married a selfish and uncaring person."	
14. What if?	I keep asking myself questions such as "what if something happens?"	"What if my car crashes?" "What if I have a heart attack?" "What if my husband leaves me?"	
15. Unfair comparisons	I compare myself with others who seem to do better than I do and place myself in a disadvantageous position.	"My father always preferred my elder brother because he is much smarter than I am." "I am a failure because she is more successful than I am."	

T: The first thing I would like to explain to you today, in order for you to have a clear idea of how our undertaking will be here, is how our mind works, how our thoughts are connected to our feelings and to what we do and the way we behave, alright? What do you imagine will happen if these things become clear to you and you begin to understand why you have this difficulty with other people?

P: I think that maybe I'll be able to deal with people in a different way; maybe I can—that's what I came here for—face situations in a calm manner and communicate with people without sweating or blushing so much.

Identifying the Problems

T: Well, then. Let's do this: This psychotherapy that I call trial-based cognitive therapy, and that I am proposing to you, is based on the same kind of therapy developed by Dr. Aaron Beck, but I organize it in a slightly different sequence of techniques. It has a step-by-step sequence. When you get to know these steps, this will all become clear to you. I'd say the first step might be for you to present your problems more specifically. For example: could you tell me what the problems are, currently, in your life? Afterward we'd be able to decide clearly what goals to work toward during therapy.

P: My problems are very clear to me, Dr. de Oliveira. I am a judicial analyst, I work at a registrar's office, and I give assistance to the public. This causes me much anxiety; distress overtakes me and I am unable to speak to people. My fear is that a rude or aggressive lawyer will ask me about a lawsuit. I can't say no. For example, I'm not supposed to let people use the photocopier, and I end up doing this because of my difficulty in saying no. Furthermore, I don't have many friends.

T: OK. If we stop here and summarize these items, we can see that there are several problems that you would like to resolve. If we put the items here, what are these problems? You started out saying that you are very anxious. Could we put this down as one of the first problems?

P: Right.

T: And you also mentioned some other difficulties. I don't know if we could put this down, if you agree with me: "I have difficulty saying no."

P: Yes. I also have difficulty imposing limits on others.

T: Could you give me other examples?

P: I also have difficulty in assisting people at work. I start sweating a lot . . . and I blush. I have several anxiety symptoms.

T: Would you add any more problems that you would think of?

P: I have difficulty dealing with my emotions.

T: This could also be a problem you might want to include in your problems list. Are these situations where you imagine what people might be thinking about you?

P: Right. I have a fear of failing. And I always feel so embarrassed in these situations. I'm afraid of not finishing what I want to say. And I think that others will think that I'm not capable, that I'm not competent, that people can

see this. And when, for example, I say that I sweat a lot, I'm very afraid that people will see how much I sweat and how I'm abnormal.

T: That is a fear of what people think about you, right?

P: Right, fear of being incapable in situations, like buying something in a store.

T: Therefore, if we could summarize, did I hear correctly when you said a fear of failing?

P: Fear of failing.

T: Shall we put this in our list of problems?

P: Just talking about this creates enormous anxiety.

T: OK. I don't know if you really think these items cover what you would say are the current problems of your life. If you could resolve these problems, would this somehow bring you to a more comfortable situation? Do you think you would already feel better?

P: Oh! Sure. For sure it would be very good.

T: So let's summarize this. Anxiety, difficulty in saying no, difficulty in assisting people, difficulty in dealing with your emotions, fear of what people think, few friends, and fear of failing.

P: Right.

T: Good. As therapy continues, we could review these problems, and then maybe see if we need to add something that you forgot. Of course, we will need to make them more specific and concrete, and go into more details.

P: All right.

T: As we look at the problems more clearly, maybe it is easier to come up with goals; don't you think so?

P: Right.

Setting Therapy Goals

T: So why don't we start establishing the goals you would like to reach, or where you would like to get to? Starting with these problems, it looks as though they are already the goals, isn't that so?

P: Yes. I imagine speaking with people without feeling anxious.

T: So let's jot this down as a goal: speaking with people without feeling anxious.

P: Right.

T: OK. Another goal?

P: If I could say no . . . If someone asked me, for instance, to make photocopies at my job and I said that I couldn't, because of the policy at the registrar's office, this would make me very happy.

T: That is, to say no without much suffering . . .

P: Right, with no anxiety, the anxiety that I feel today.

T: OK. So I will write this down here: "Say no without much anxiety."

P: Give people assistance without thinking that I'm a failure, without thinking that I won't be capable.

T: OK. "Give people assistance without thinking I won't be capable," right?

P: Talk with people naturally, without the anxiety symptoms.

T: Great! Naturally, without feeling much anxiety?

P: Right. I think this would help me very much.
T: Can you see another goal that we could try to reach during this therapy, during the work we are doing here?
P: I will go out more, participate more in social meetings, and maybe also socialize more. So, I think that's it, Dr. de Oliveira. I will feel good about myself when relating more to other people.
T: When you reach these goals, what do you think will happen?
P: It will really make me feel well?
T: This is very important, Leslie, because when we have set the goals, it is fundamental that you know when you have reached them. And how will you know the moment that you reach these goals?
P: I will know when I do these things naturally, without much anxiety, right?
T: Exactly. And this will be something we can observe and measure. You'll be able to confirm this, and eventually other people will too. . .
P: Right. If I can see a practical change in my behavior, this will help me believe I can do it.
T: That's great, then. This is the first moment. If you see another goal and another problem during this week when you will be making closer observations, then we can make additions.
P: All right.
T: So, how would you summarize what we have done so far?
P: We have made a list of difficult situations in my life. And we decided that if I didn't have these thoughts of failure, of not managing, and if I could resolve this in therapy, I would reach my goals much more easily.
T: Exactly. So you were able to list your problems, and consequently we now have very clear goals in your mind that we will try to reach.
P: Thinking about this makes me feel better, because it gives me hope, Dr. de Oliveira.

Introducing the Cognitive Model: First Level of the Cognitive Conceptualization Diagram (Figs. 1.2–1.4)

T: Maybe now it is up to me to actually show you how we'll get this done. And if you learn step by step what we'll be doing here, maybe you'll be able to progressively reach these goals and consequently resolve these issues. So the first thing I have to describe is how our mind works, how our thoughts are connected to our feelings and behaviors. Then I can give you a sequence that involves exactly how you think, what is your thought pattern, and how this pattern affects your feelings and behaviors. Shall we take a look at this?
P: Yes.
T: Maybe we could look at this diagram so that I can show this more clearly to you. The first step is to identify a situation that causes discomfort for you.
P: Yes.
T: Can you remember a recent event that caused you much discomfort? Can you give me an example?

P: When I arrived at the registrar's office, a lawyer asked me if he could take a trial transcript that could not leave the office.
T: Do you think we could summarize this situation as: "At work, a lawyer asks me . . ." Why don't you write that here, so that the situation becomes quite clear? [The therapist asks the patient to write the triggering event in the situation box in Figure 1.5.]
P: At the registrar's office, a lawyer asks me for a trial transcript that can't be taken from the office.
T: Good. At the time he asks you to do this, what goes through your mind?
P: That if I don't do it, he'll be rude to me.
T: OK. So your idea is: "The lawyer will be rude to me." This is what we call an automatic thought, because it pops into our minds without any deliberation. Can you write this down here in the automatic thought box? [The therapist points to the AT box in the CCD.] When you have this thought, how much do you believe it?
P: 100%.
T: Please, could you write it down here? You believed it completely. The fact of believing 100% in this thought, what did you feel right then?
P: I felt anxious.
T: How much?
P: 100%.
T: Please write it down here, in the emotion box of the CCD. Can you see now that there is a direct relation between what you believed at that moment and the intensity of your emotional reaction?
P: Certainly.
T: What happens when you feel anxious? How do you behave then?
P: I give him the trial transcript.
T: In giving him the transcript, did you notice any physiological reaction as well? What do you notice in your body?
P: My heart rate increases, and I perspire very much.
T: So why don't you write that down? Racing heart and perspiration. All right, Leslie. What do you observe so far? Does this situation become clearer to you?
P: Yes, it does. I notice that when there is a situation that causes anxiety, I think that the person will be hostile toward me, that I will be criticized; this causes more anxiety, and I end up doing something so the other person won't become angry at me.
T: If you look at this diagram, there are arrows here that follow this sequence: from the situation box, to the AT box, then to the emotion box, and then to the behavior and physiological response box. Do you see these arrows pointing back? Let's try to understand this: as you hand him the transcript, what do you think will happen?
P: He will not get angry at me.
T: And as you think, "He will not get angry at me," what do you feel?
P: Relief.

T: And at the time you feel relief, what happens?
P: I feel calmer and relaxed.
T: This makes you feel calmer and relaxed. Therefore, it seems to me that this follows a sequence where one thing reinforces another. Is this clear to you? It makes it more likely you will do it again.
P: Yes. It's clear, Dr. de Oliveira.
T: On the other hand, when you feel relief and hand him the transcript, is this exactly what you want to do?
P: No, and it is something I am not allowed to do.
T: So, when you think, "I'm not allowed to do this," how do you feel?
P: More anxious. Then I keep having tachycardia and perspiring a lot.
T: Can you see here a mechanism that seems to be self-perpetuating? It is endless, right? That is, you think at first (your automatic thought), feel anxious (your emotion), then you do something, but it is something that you ultimately cannot, or at least, do not want to do. This leads you to another automatic thought, "I shouldn't have done this," which leaves you feeling more anxious. Consequently, you continue feeling bad, and doing things you do not want to. When you notice this pattern here, how do you see the problem? Is it clearer to you?
P: Yes, it's clearer, and the way you explained it, I thought now about something else: when I hand over the transcript, I do it to feel less anxious. Actually, at the time I do feel less anxious; then I realize that I become more anxious because I do something that I shouldn't do.
T: And apparently this might not end.
P: Right.
T: Now let's take a look to see if we can understand this a little more. You see here and observe this situation that unleashed the thought: "He will be rude to me." You can see this dotted arrow, right? Why do you think this arrow between the situation box and the AT box is dotted?
P: I don't know, Dr. de Oliveira.
T: Maybe we can find out together. Can you think of another person in the same situation? Can you think of a co-worker?
P: Yes, I can. I'm reminded of Anna. Anna has been working at the registrar's office as long as I have. In this situation, when someone asks for something that can't leave the office, she speaks very calmly that the papers belong to the registrar's office and cannot be taken out of there, that she won't be able to give them the papers.
T: This is a great example, because we will write down the exact same thing as a situation in this situation box; that is, "The lawyer asks Anna for the transcript." Of course, we cannot guess Anna's thoughts, but you have an idea of how she thinks, right?
P: But sometimes she tells us . . .
T: She does? What does she usually think at this time?
P: The lawyer already knows that the transcript cannot be taken out. And she thinks the lawyer has a lot of nerve to ask for it, knowing that it cannot leave the office.

T: So, at the moment this lawyer requests the transcript from Anna, she will think, "Gosh, he has a lot of nerve to ask me for this." Can you write it down here in the automatic thought box?
P: Right.
T: What does Anna feel?
P: She remains calm, and even thinks it's funny.
T: Finds it funny and feels calm. Please, write it down here in the emotion box: calm. What does she do?
P: She says in a very suitable manner, Dr. de Oliveira, that the transcript cannot be taken from the office and that she won't give him the transcript.
T: Would you please jot it down here, in the behavior box? As Anna does not hand over the transcript, what do you imagine that Anna continues thinking and feeling?
P: That she can do this easily. That this is part of her daily work.
T: OK. This seems to be resolved in Anna's mind.
P: Right.
T: So, can you see now that the same situation is evaluated here and is regarded in different ways by different people?
P: Yes, I see.
T: If you understood this up to here, now you see that, like I said before, it's as if it goes on forever, because, if you do something that you will regret, it seems to lead to more negative thoughts, which lead you to feel negatively, in turn leading you to have unwanted physiological reactions (like racing heart) and behavior (like handing over the transcript). Isn't that so?
P: Right, exactly. It's as if I am held hostage by my own thoughts.
T: Exactly. We won't work yet on these two other levels of this cognitive conceptualization diagram I have just introduced to you. We'll leave the second and third levels for further on in therapy.
C: All right.
T: Regarding this, then, I'd like you to leave here today with quite a clear notion about how this therapy with me will happen. It's likely, as we discussed in our first meeting, that we'll be working for several weeks, probably a few months, maybe 3 or 4. As we make advances, you'll be working to understand these three levels seen in this diagram. But can you already get an idea of what will be happening?
P: Yes, I can.
T: How do you see this?
P: I understand what you are saying about these negative thoughts I have during these unleashing events and situations, like that I won't be able to say no.
T: But what do you imagine would be happening with Anna? Does Anna have this kind of thought?
P: No. No.
T: What does Anna think then?
P: That it's easy to say no to the lawyer, that there is no problem at all, that this is part of one's daily work and there's no problem.
T: So it appears to be quite clear to you now.

P: Yes, it does.
T: So, what I'd like to propose that we do from now on is exactly to work step by step.
P: OK.
T: And, later, you'll understand what it means for us to be working through each one of these steps, all right? Just for us to go a little further, I'd like you to summarize what was important for you so far.
P: What I think was very important so far is that when the lawyer asks me for the trial transcript I have a negative thought; this thought will create an emotion in me, which will influence both what I'll do, my behavior, as well as my physical sensations. And that one thing prolongs the other. So my emotion strengthens my thoughts, and it keeps going.
T: This is great because that was exactly what we saw . . . If we look a little further back, did you gain any perspective on this knowledge that changed what we wrote down initially here, the problems and goals?
P: Yes, I do.

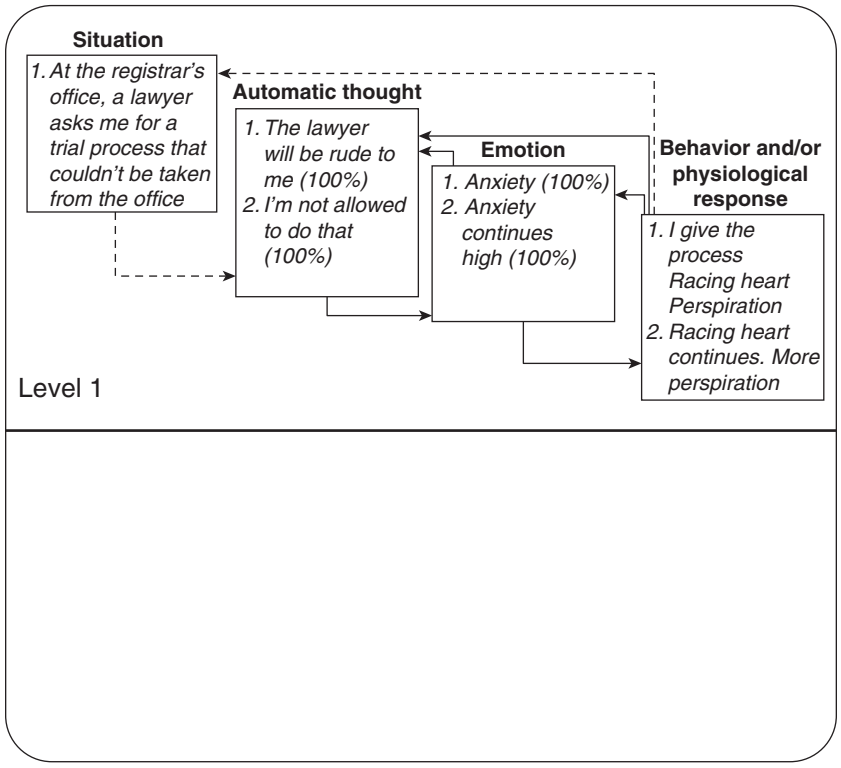

Figure 1.5 Illustration of Leslie's first level of the TBCT cognitive conceptualization diagram (CCD) teaching her the relation between the situation, the automatic thought (AT), the emotion, and the behavior and physiological responses, and how these emotions and behaviors generate new situations and thoughts.

Introducing Cognitive Distortions

T: Leslie, I think it is becoming clear to you how our thoughts influence our emotions and our behaviors. The negative thoughts you mentioned are sometimes called cognitive distortions. It is important that you learn what cognitive distortions are. Could you read the first three rows in this list? This is the cognitive distortions list. Although not all thoughts that we have are distortions, it is important that we give ourselves a chance to check, especially when we are distressed. In the first column you have the names of the distortions, in the second the definitions, and in the third, the examples. You also have a space where you can jot down your own examples in this column.

P: OK. "Dichotomous thinking, also called all-or-nothing, black-or-white, or polarized thought. Definition: I see the situation, the person, or event only in terms of "one thing or another," placing them in only two extreme categories, instead of in a continuum."

T: In the third column you have the examples.

P: Examples: "I made a mistake; therefore I am a failure." "I ate more than I intended, so I blew my diet completely."

T: What did you understand from this, Leslie?

C: Dr. de Oliveira, it's like the situation that I was telling you about Anna: if I hand the transcript over to the lawyer, I don't know how to say no. And if Anna gives it, she knows how to say no. So I'm not capable and she is capable. Is it about not thinking about something in between?

T: Exactly. And, strictly speaking, here it's as if you see things in two extremes. So, if you do not manage to say no, this means that you're not able at all to say no, and so on, right?

P: Right.

[The therapist asks Leslie to read two more examples of cognitive distortions and asks her to write down some of her own examples in column 4 of Table 1.1.]

T: All right, we won't go into details now. I just wanted to show you that all of us have these 15 different thinking errors that are called cognitive distortions, and I would like you to start to notice these this week.

P: Right.

T: Besides understanding this well, above all, I would like to ask you to pay close attention to yourself and see if you can find some of these cognitive distortions during the week, when you feel uncomfortable. If you find any of these possible distortions, please jot them down in the lines in the fourth column in this list. They may not happen, but some of them could happen.

P: Right.

T: All right? So, summarizing, what I want is that you learn the definitions of cognitive distortions and see if they happen to you. And a good way for you to know this is—at any time that you have any behavior that makes you feel

uncomfortable, take a look at this paper. See if any of these cognitive distortions are going through your mind. Is this good for you?

P: OK. Perfect.

Designing Homework, Summarizing, and Concluding Session 1

T: Before we finish I'd like to give you some homework. I'd like you to try working during the week, and I think that a large part of this therapy's success will be not only what you do here but also the things you can do outside this room. All the homework and experiments that I'm going to give you are really easy to carry out. What I'd like you to do is to take this cognitive distortions list. It contains a number of examples of how people think. I'd like you to take this sheet with you, and keep it with you at all times. And whenever you can, look at this paper, and discover if any of these types of thoughts are happening with you. I'll also send this list to your e-mail address so that you can look at it on your smart phone, if you prefer, all right? So, can you summarize what the homework is?

P: I'm going to learn about the cognitive distortions during the week, and when I notice a behavior that I think is inadequate, or when I feel uncomfortable, I'm going to read the cognitive distortions list and try to identify which possible distortions I am having.

T: Exactly. And I want you to jot down these thoughts in the lines of column 4 of this sheet, OK?

P: All right.

T: So can you give me some feedback? What is your impression of our first therapy session? Did something I did make you feel uncomfortable?

P: Actually, since the beginning of today's session I saw the possibility of getting better from my difficulties in the workplace and with people. You have helped me to think of my problems and their solutions, coming up with new goals. And you taught me that a situation will create thoughts, and these thoughts will produce emotions and behaviors that can make me suffer. If I learn to change my distorted thoughts, like mind reading, I'm going to improve. And now with this exercise you gave me to identify which mistakes are the most common in my thoughts, this gives me an idea that I can reach my goals. This gives me hope.

T: Great, OK. So we'll see each other next week?

P: Yes, thanks.

T: Not at all.

2 Introducing the Cognitive Distortions Questionnaire

Outline

- Cognitive Distortions Questionnaire (CD-Quest)
- Explaining the CD-Quest to the Patient

Case Illustration Dialogue

- Bridge from Session 1
- Setting the Agenda
- Reviewing Questionnaires and Homework
- Introducing the CD-Quest (Main Agenda Item)
- Filling in the CD-Quest
- Summarizing, Assigning Homework, and Concluding Session 2

Cognitive Distortions Questionnaire (CD-Quest)

The CD-Quest was developed to be filled in by the patients before each therapy session, in order to facilitate perceptions of the connection between cognitive distortions, sometimes also called thinking errors, and their consequent emotional states, as well as maladaptive behaviors (de Oliveira et al., 2014). Also, the CD-Quest was devised to help therapists quantitatively assess and follow the clinical evolution of patients by means of its scores. The CD-Quest contains 15 items that measure known cognitive distortions in two dimensions: frequency and intensity. The scores may range from 0 to 75; the higher the score, the higher the cognitive distorted thinking.

A preliminary study of the Brazilian Portuguese version of the CD-Quest (de Oliveira, Osório et al., 2011) was conducted to assess the initial psychometric properties in a sample of university students. A sample comprised of medical and psychology students ($N = 184$; age = 21.8 ± 2.37) was assessed by means of the following tools: CD-Quest, Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), and the Automatic Thoughts Questionnaire (ATQ). These self-report instruments were used collectively in classrooms.

It was concluded that the CD-Quest has good internal consistency (0.83–0.86) and concurrent validity with the BDI (0.65), BAI (0.51), and ATQ (0.65). Additionally, it was able to separate the groups possessing depressive (BDI ≥ 12) and anxious (BAI ≥ 11) indicators from those not possessing such indicators ($p < 0.001$). An exploratory factor analysis using principal components analysis with varimax rotation revealed the presence of four factors that together explained 56.6% of the data variance. The factors comprised the following types of cognitive distortions: (a) Factor I: dichotomous thinking, selective abstraction, personalizing, should statements, what if . . . , unfair comparisons; (b) Factor II: emotional reasoning, labeling, mind reading, jumping to conclusions; (c) Factor III: fortune telling, discounting positives, magnification/minimization; and (d) Factor IV: overgeneralizing, blaming. It was concluded that the CD-Quest has good psychometric properties, justifying more studies designed to determine its predictive validity, expand its construct validity, and measure the degree to which it is a useful measure of change achieved by patients in CBT.

Explaining the CD-Quest to the Patient

The following transcript provides an idea of how the therapist may introduce the CD-Quest to the patient.

T: Paul, I'm happy you appreciated the cognitive distortions sheet. It will be very useful in our session today. The idea is to help you become aware of your thinking errors and have an idea if they change over time, as the therapy goes on.
P: Yes.
T: I'd like you to come back to the situation you described to me between you and John. What went through your mind?
P: That my text was bad, that John wouldn't have made any correction if it were good.
T: Do you remember we called this an automatic thought, and that you believed it very much, 90%?
P: That's right. I believed it very much, 90%.
T: You know now that all of us have thousands of thoughts during the day. You also know that these thoughts are words, phrases, and images that go through our minds while we are doing things. Many of these thoughts are correct, but many are distorted. That's why they are called cognitive errors or cognitive distortions.
P: This is clear to me now.
T: So, can you read the first item?
P: Of course. Dichotomous thinking (also called all-or-nothing, black-or-white, or polarized thinking error): I see the situation, the person, or event only in terms of "it's one thing or another," placing oneself in only two extreme categories instead of in a *continuum.* Examples: "I made a mistake; therefore my performance was a failure." "I ate more than I planned, so I blew my diet completely."

T: Please, take a look at this grid. There are scores for the frequency of occurrence of the thoughts in the columns, and also scores for how much one believed the thoughts in the rows. How often did you have this kind of thought, like this one: "John didn't like my work"?
P: It came to my mind very often, from Friday to Sunday, that is, three days.
T: In which column do you put it?
P: Here, in this column: "Much of the time."
T: And how much did you believe the thought?
P: Up to 90%.
T: In which row do you place it?
P: In the one indicating "Very much (more than 70%)." So, I assume I should circle score 4, is that right?
T: Exactly. Can we go on and see the other items of this questionnaire?

Cognitive Distortions Questionnaire (CD-Quest)

Irismar Reis de Oliveira, MD, PhD
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All of us have thousands of thoughts a day. These thoughts are words, sentences, and images that pop into our heads as we are doing things. Many of these thoughts are accurate, but many are distorted. This is why they are called cognitive errors or cognitive distortions.

For example, Paul is a competent journalist who had his 10-page work assessed by John, the editor of an important local newspaper. John amended one paragraph and made a few other suggestions of minor importance. Although John approved Paul's text, Paul became anxious and found himself thinking, "This work is not good at all. If it were good, John wouldn't have made any correction."

For Paul, either the work is good or it is bad. This kind of thinking error is sometimes called dichotomous thinking. As this thought returned to Paul's mind several times from Friday to Sunday (3 days), and Paul believed it at least 75%, he made a circle around number 4 in the fourth column of the grid below.

1. **Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking):** I view a situation, a person, or an event in "either-or" terms, fitting them into only two extreme categories instead of on a continuum.

EXAMPLES: "I made a mistake; therefore my performance was a failure." "I ate more than I planned, so I blew my diet completely."
Paul's example: *This work is not good at all. If it were good, John wouldn't have made any correction.*

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	④	5

Please, turn the page and assess your own thinking style.

Cognitive Distortions Questionnaire
CD-Quest
Irismar Reis de Oliveira, MD, PhD

Name: _____ **Date:** _____

Please make a circle around the number corresponding to each option below, indicating cognitive errors or distortions that you have made *during this past week*. When assessing each cognitive distortion, please indicate *how much* you believed it in the exact moment it occurred (not how much you believe it now) and *how often* it occurred during this past week.

DURING THIS PAST WEEK, I FOUND MYSELF THINKING THIS WAY:

1. **Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking):** I view a situation, a person, or an event in "either-or" terms, fitting them into only two extreme categories instead of on a continuum.

EXAMPLES: "I made a mistake; therefore my performance was a failure." "I ate more than I planned, so I blew my diet completely."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

2. **Fortune telling (also called catastrophizing):** I predict the future in negative terms and believe that what will happen will be so awful that I will not be able to stand it.

EXAMPLES: "I will fail and this will be unbearable." "I'll be so upset that I won't be able to concentrate for the exam."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

3. **Discounting the positive:** I disqualify positive experiences or events, insisting that they do not count.

EXAMPLES: "I passed the exam, but I was just lucky." "Going to college is not a big deal, anyone can do it."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

4. **Emotional reasoning:** I believe my emotions reflect reality and let them guide my attitudes and judgments.

EXAMPLES: "I feel she loves me, so it must be true." "I am terrified of airplanes, so flying must be dangerous." "My feelings tell me I should not believe him."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

5. **Labeling:** I put a fixed, global label, usually negative, on myself or others.

EXAMPLES: "I'm a loser." "He's a rotten person." "She's a complete jerk."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

6. **Magnification/minimization:** I evaluate myself, others, and situations placing greater importance on the negatives and/or placing much less importance on the positives.

EXAMPLES: "I got a B. This proves how bad my performance was." "I got an A. It means the test was too easy."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

7. **Selective abstraction (also called mental filter and tunnel vision):** I pay attention to one or a few details and fail to see the whole picture.

EXAMPLES: "Michael pointed out an error in my work. So, I can be fired" (not considering Michael's overall positive feedback). "I can't forget that a small piece of information I gave during my presentation was wrong" (not considering its success and the audience great applause).

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

8. **Mind reading:** I believe that I know the thoughts or intentions of others (or that they know my thoughts or intentions) without having sufficient evidence.

EXAMPLES: "He's thinking that I failed". "She thought I didn't know the project." "He knows I do not like to be touched this way."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

9. **Overgeneralization:** I take isolated negative cases and generalize them, transforming them in a never-ending pattern, by repeatedly using words such as "always", "never", "ever", "whole", "entire", etc.

EXAMPLES: "It was raining this morning, which means it will rain during the whole weekend." "What a bad luck! I missed the plane, so this will interfere in my entire vacation". "My headache will never stop".

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

10. **Personalization:** I assume that others' behaviors and external events concern (or are directed to) myself without considering other plausible explanations.

EXAMPLES: "I thought I was disrespected because the cashier did not say thank you to me" (not considering that the cashier did not say thank you to anyone). "My husband left me because I was a bad wife" (not considering that she was his fourth wife).

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

11. **Should statements (also "musts", "oughts", "have tos"):** I tell myself that events, people's behaviors, and my own attitudes "should" be the way I expected them to be and not as they really are.

EXAMPLES: "I should have been a better mother." "He should have married Ann instead of Mary". "I shouldn't have made so many mistakes."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

12. **Jumping to conclusions (also called arbitrary inference):** I draw conclusions (negative or positive) from little or no confirmatory evidence.

EXAMPLES: "As soon as I saw him I knew he would do a lousy work." "He looked at me in a way that I immediately knew he was responsible for the accident."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

13. **Blaming (others or oneself):** I direct my attention to others as sources of my negative feelings and experiences, failing to consider my own responsibility; or, conversely, I take responsibility for others' behaviors and attitudes.

EXAMPLES: "My parents are the only to blame for my unhappiness." "It is my fault that my son married a selfish and uncaring person."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

14. **What if?:** I keep asking myself questions such as "what if something happens?"

EXAMPLES: "What if my car crashes?" "What if I have a heart attack?" "What if my husband leaves me?"

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

15. **Unfair comparisons:** I compare myself with others who seem to do better than I do and place myself in a disadvantageous position.

EXAMPLES: "My father always preferred my elder brother because he is much smarter than I am." "I can't stand she is more successful than I am."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

CASE ILLUSTRATION DIALOGUE

Bridge from Session 1

T: Good morning, Leslie.
P: Good morning, Dr. de Oliveira.
T: How was your week? I ask this in relation to what we discussed last week. I'm curious to know what this week represented to you, looking at what we discussed here.
P: Dr. de Oliveira, last week was different from the others, although the same things happened. I began to identify some things that I hadn't identified earlier, things I didn't know. So, I observed my emotions, as well as my behavior and my physiological reactions at work.
T: And maybe you observed these things because of what you learned in the last session, can I say that?
P: Yes.
T: Did that diagram I showed you last week help you?
P: Yes, it helped a lot, because I started understanding my situation in a clearer way. I started seeing how a situation can activate a thought, which activates the emotion, the behavior, and my physiological reactions. I observed what you explained so well, the self-perpetuation, and what you taught from the distortions list, and I observed some situations at work, too. I started noticing when my emotion changed or when I would feel more anxious. Or still, when I'd want to escape from a situation, afraid to face it. So, I started reading that list and began to identify some thinking errors I was making.
T: Great! You made an excellent summary of our first therapy session.

Setting the Agenda

T: This makes me quite curious and I'd like it if we reviewed the homework I gave you, but I'd also like to establish something that we'll always do in the next sessions. It is what, in cognitive therapy, we call agenda. We can abstain from calling it agenda, we can call it topics, or we can speak of problems that will be discussed during each session. But what really matters is that we set the most important subjects for you each time. Therefore, can we put on the agenda the task review that I gave you?
P: Yes, we can.
T: Is there anything else you'd add that is important for today, something that has been mobilizing for you during the week?
P: No, no, Dr. de Oliveira. Actually, what mobilized me the most was perceiving my anxiety and the physical symptoms I have because of the thoughts you call cognitive distortions. They explain the situation of my life today very well.
T: OK. So then we may continue learning these things, even without having a specific theme?

P: Yes.
T: So, besides reviewing homework and the anxiety questionnaire you filled in before our session, maybe our agenda item might be introducing to you a questionnaire to help you learn more about the cognitive distortions.
P: OK.

Reviewing Questionnaires and Homework

T: Great! So let's do the following: tell me how it was for you to read that list of distortions. Did you learn them, become familiar with them?
P: With some of them, since there are many, right?
T: Exactly, there are many. Did you have difficulty with any of them?
P: No, Dr. de Oliveira. Some of them I found to be similar, you know? They seemed to be alike. But I managed to visualize most of them. Of course, the thought came up that I wasn't managing to do these things well. But I also thought it was interesting that, in the situation at work, for example, the judge had said to Anna, my co-worker I talked about last week, that he wanted to speak with me. So then I was already imagining that he didn't like my work, that he wanted to fire me . . .
T: And when you could look at that list, what were you able to identify?
P: Fortune telling, catastrophizing.
T: Great, great! I asked you to do this during the week and become familiar with the definitions of those examples, because today I'd like you to learn a little more about your style of thinking.
P: Good.
T: Before I introduce the CD-Quest to you, I see you filled in the anxiety questionnaire, and your score was 39. It seems to reflect your anxiety level. Maybe you will have a better understanding of this when you become more familiar with the CD-Quest. Can I introduce it to you?
P: Of course.

Introducing the CD-Quest (Main Agenda Item)

T: So I'll present the same definitions, the same examples, only now in another format, Leslie, which is the CD-Quest, named this because it is an acronym of Cognitive Distortions Questionnaire. Initially, we have an example in order for this to be clear to you. Would you like to see the initial example? I'll give you a moment to read it and see if everything is clear, OK? Can you read it?
P: [Leslie reads the CD-Quest instructions aloud.] "All of us have thousands of thoughts during the day. These thoughts are words, phrases, and images that go through our minds while we are doing things. Many of these thoughts are correct, but many are distorted. That's why they are called cognitive errors or cognitive distortions. For example, Paul is a competent journalist whose work of about 10 pages was revised by John, the editor of an important local newspaper. John made corrections in one paragraph and made some

suggestions of lesser importance. Although John had approved Paul's text, the latter became anxious and thought: 'This work is really bad. If it were good, John wouldn't have corrected anything.' To Paul, the work is either good or bad. This type of thinking error is usually called dichotomous thinking. As the thought returned to Paul's mind several times from Friday to Sunday (3 days), and Paul believed it at least 75%, he circled number 4 in the fourth column of the CD-Quest grid."

T: OK. So, you can see how this occurs. Look how he marked it to see if it is clear to you, because this is what I will ask you to do next.

P: "Dichotomous thinking (also called all-or-nothing, black-or-white, or polarized thinking error): I see the situation, the person or event only in terms of 'it's one thing or another,' placing oneself in only two extreme categories instead of in a *continuum.* Examples: 'I made a mistake; therefore my performance was a failure.' 'I ate more than I planned, so I blew my diet completely.'"

T: And then you have Paul's example, right?

P: Right. "This work is really bad. If it were good, John wouldn't have made any corrections."

T: OK, what do you see here in this grid?

P: That I'm supposed to write down the frequency and intensity of how much I believed it during the week, right?

T: Right. Do you see these columns? [The therapist shows the columns of the CD-Quest.] The columns will indicate the frequency of what happened. So, it's down there, for example: it happened during 3 days, in this case, with Paul, right? Consequently, you notice that you will write it down in this column here.

P: Now I understand.

T: OK. But I also want to know how much he believed it. And you can see here that he believed it 75%. So, if this happened most of the time for 3 days, and he believed it a lot, more than 70%, where would he have marked it down?

P: Ah! I get it now, Dr. de Oliveira. That's why the number 4 is circled in this example.

T: Exactly.

P: So, there are columns and rows with the frequency of the days that it happened, and how much I believed one of my thoughts.

T: So, it seems to be clear now, isn't it?

P: Yes, it's clear.

T: OK. So, what I'd like for you to do now is look over each item, one by one, and we will now see your own thought style.

P: All right.

T: Then I'll give you the same sheet of paper with the distortions list, which contains the same items and examples on the CD-Quest. I'd like you to continue using this list so that you'll be prepared to fill out the CD-Quest when you arrive for the next session, alright?

P: Yes.

T: Let's see what you will mark down then.

Filling in the CD-Quest

T: [The therapist and the patient take about 20–25 minutes to go over the CD-Quest.] So, Leslie, I see that we've finished filling in this questionnaire. What did you discover when you filled it in? They are the same items that you examined during the week. I noticed also that you had some difficulty with one of them, which we had to discuss while you filled it in: emotional reasoning. Apparently, you hadn't perceived this thinking error during the week, and, upon evaluation, it appeared to me that you scored pretty high on it. What happened?

P: Dr. de Oliveira, I wrote down some situations that you had asked me to. Every time someone comes to the registrar's office, I feel so anxious, so nervous that I'm sure that everyone can see it.

T: OK. But this is exactly what we see here. You hadn't identified this as possibly being emotional reasoning; that is, you believe that it is true by the fact that you are feeling it, right?

P: Yes.

Summarizing, Assigning Homework, and Concluding Session 2

T: That's great! Leslie, how would you summarize what we have done today?

P: Before the session, I filled in the questionnaire that gives my level of anxiety. In this case, I arrived at a score of 39. Apparently, what I am thinking seems to influence the way I feel, isn't that so? Then, you taught me how to fill in the CD-Quest, as the main agenda item. Although I'm a little concerned—because I noticed how anxious I am—now, I hope I'll be able to think differently. And if I do think differently, all this can change, right?

T: I hope so. When you come upon a thought of this type and see that you are reading the mind of another person, and you say, like this, "Gee, I'm 'doing' mind reading. What is the chance of my being able to read someone else's mind?"

P: It's true.

T: Do you think you'll believe this thought in the same way?

P: No. I'll be really relieved, right, Dr. de Oliveira? When someone enters the office and I realize that I'm thinking that the person thinks I'm nervous, anxious, and I'm not competent, and that I don't have the actual power to think this.

T: OK. You don't have the power to read his or her mind, and neither do they have the power to read your mind.

P: That's true.

T: Great, Leslie. So, what do we have for next week? I'd like you to take another sheet like this one with the cognitive distortions definitions. Actually, let me make a copy of the one you brought so that I can have one with your examples, all right?

P: Right. I can do that.
T: Great, Leslie. I'll be curious to see if you will be able to find cognitive distortions more easily this week, if they occur. OK?
P: OK, thank you so much.
T: Have a good day.

3 Changing Dysfunctional Automatic Thoughts

Outline

- Introduction
- Intrapersonal Thought Record (Intra-TR)
- Introducing the Intra-TR to the Patient
- Interpersonal Thought Record (Inter-TR)
- Introducing the Inter-TR to the Patient

Case Illustration Dialogue

- Bridge from Session 2
- Setting the Agenda
- Reviewing Questionnaires and Homework
- Working on the Agenda Item
- Introducing the Intra-TR to Work on the Main Agenda Item
- Assigning Homework, Summarizing, and Concluding Session 3

Introduction

For cognitive therapists, exaggerated or biased cognitions, such as often happen with automatic thoughts (ATs), tend to maintain or exacerbate stressful states such as depression, anxiety, and anger (Leahy, 2003). ATs are defined as rapid, evaluative thoughts that do not result from deliberation or reasoning; as a result, the person is expected to acknowledge them as true and act upon them without analysis (J. S. Beck, 2012).

Beck, Rush, Shaw, and Emery (1979) designed the Dysfunctional Thought Record (DTR) as a worksheet aiming to help patients respond to ATs more effectively, thus changing negative mood states and problematic behaviors. This approach is helpful for many patients who use the DTR consistently. Some patients, nonetheless, tend not to believe the alternative thoughts generated through DTR, which are intended to be perceived as adaptive and rational. Greenberger and Padesky (1995) modified the original five-column DTR

proposed by Beck et al. (1979) by adding two more columns, allowing the patient to include evidence that does and does not support the ATs. The resultant seven-column DTR was supposed to bring about more balanced thoughts by the patient, and consequently reduce their intensity and improve associated dysfunctional behaviors.

Although eliciting new, balanced alternative thoughts has been shown to be effective, one problem with the newly generated, rational, alternative responses is that they leave open the possibility of disqualifying "yes, but . . . " thoughts about self and others (see Chapter 5 in this manual for an approach designed to deal with this difficulty). Another important limitation of the traditional DTR is that some patients, despite repeated practice in session with the therapist, resist filling them out as homework, because they find it difficult to think of new alternative and balanced responses.

Intrapersonal Thought Record (Intra-TR)

I proposed the Intra-TR (de Oliveira, 2012a) to reduce the difficulties faced by the patient when trying to change ATs (Fig. 3.1). Although at first sight this thought record appears to be more complex and cumbersome than the conventional DTR, it has three advantages:

1. It includes the same components as the first level of the CCD, to which the patient was introduced in Session 1, and is supposed to be familiar with.
2. The patient is directed to respond to specific questions, reducing vagueness when looking for alternative thoughts and feelings.
3. When the patient memorizes the Intra-TR questions (and this is done in session with the therapist's assistance), it is easier for her to respond to them.

I suggest that the therapist limit this work to just one Intra-TR during each session (usually for one to three sessions) in order to have time to practice and explore the Intra-TR optimally. Going back and forth over the details, repeatedly summarizing, and then asking the patient to also summarize each part of the form helps her become familiar with this thought record, so that after a few repetitions as homework the patient feels at ease in handling it.

This session—in which the therapist and the patient go over the questionnaires filled in before it started—is devoted to teaching the patient how to respond to dysfunctional ATs by means of the Intra-TR and, sometimes, additionally, the interpersonal thought record (see Inter-TR, discussed in a later section). So, with the CD-Quest filled in, a detailed review of homework, which consisted of identifying cognitive distortions during the week, is essential. The therapist can point out and discuss with the patients the types of distortions that were more frequent and those with the highest scores in the CD-Quest.

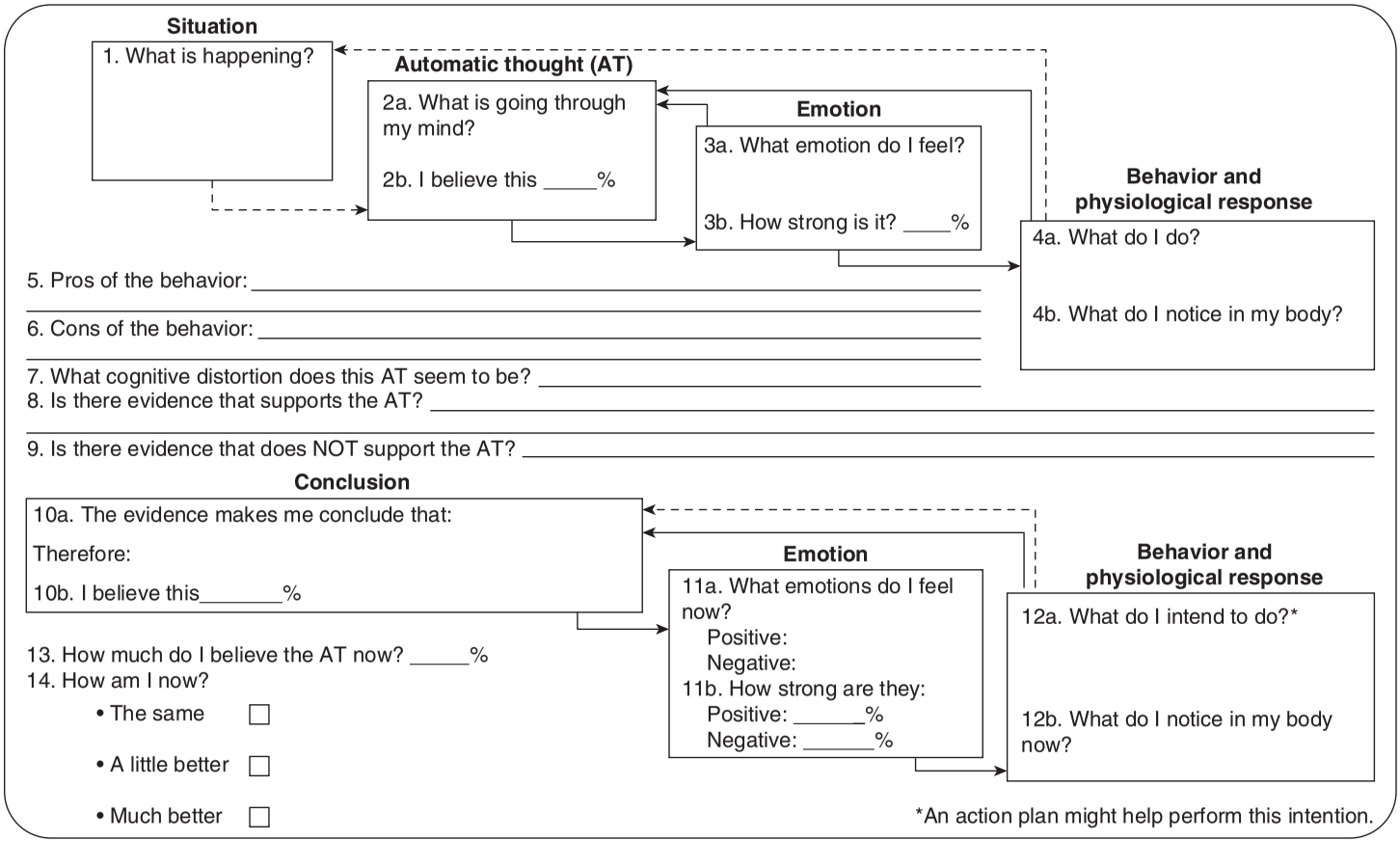

Figure 3.1 TBCT intrapersonal thought record (Intra-TR), in which patients are asked to respond to each numbered question in the order they are presented.

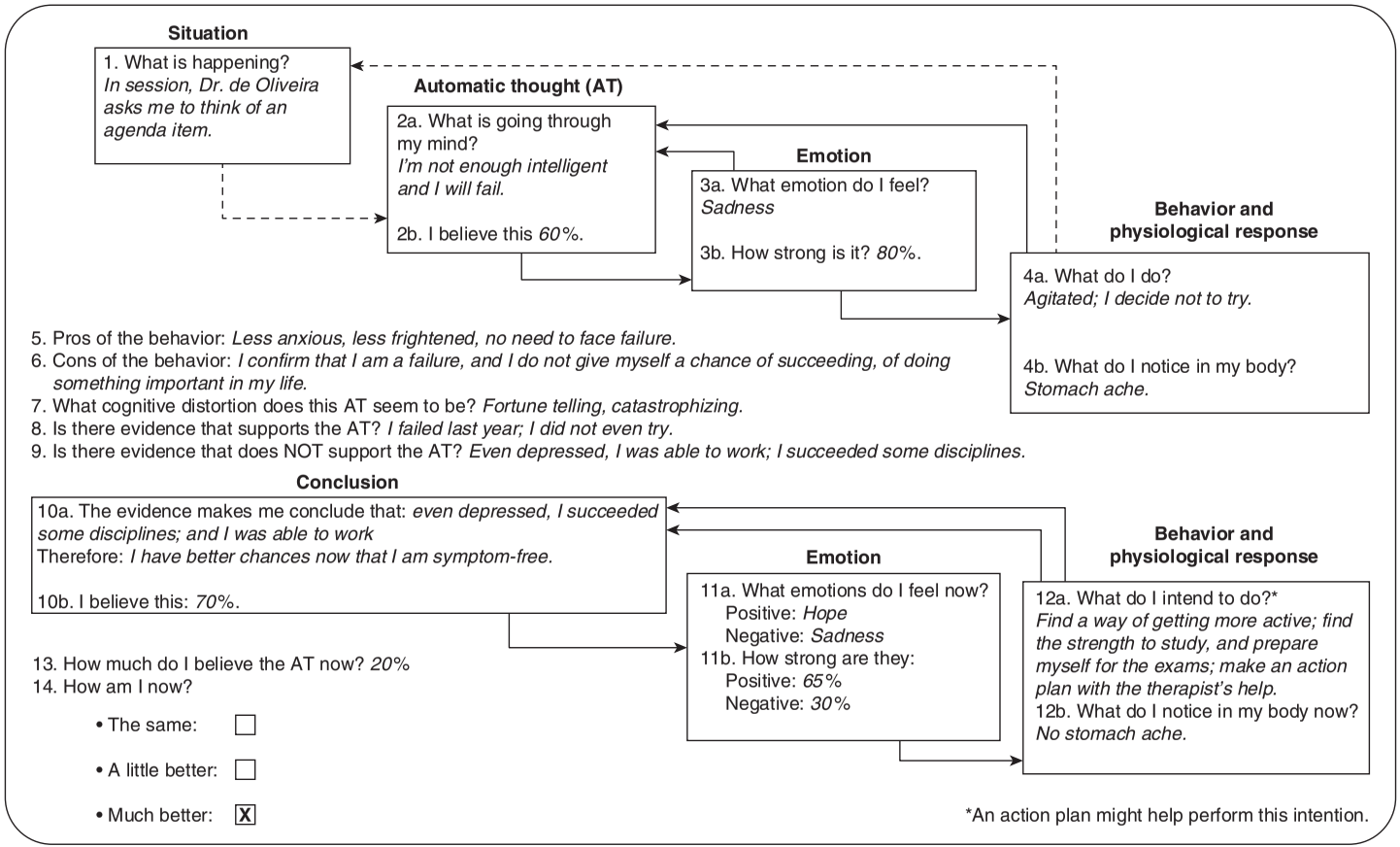

Figure 3.2 Kathleen's TBCT intrapersonal thought record (Intra-TR).

Table 3.1 Questions to be answered by the patients when they fill in the Intra-TR

Question number	*Question*	*Intra-TR*
Q1	What is happening?	Situation box
Q2a Q2b	What is going through my mind now? How much do I believe it?	Automatic thought box
Q3a Q3b	What do I feel? How strong is my emotion?	Emotion box
Q4a Q4b	What do I do? What do I notice in my body?	Behavior and physiological response box
Q5	What are the pros of the behavior?	Pros of behavior
Q6	What are the cons of the behavior?	Cons of behavior
Q7	What cognitive distortion does this automatic thought seem to be?	Cognitive distortion
Q8	Is there evidence that supports the AT?	Evidence supporting the AT
Q9	Is there evidence that does not support the AT?	Evidence not supporting the AT
Q10a Q10b	What does the above evidence make me conclude? How much do I believe the conclusion?	Conclusion box
Q11a Q11b	What positive and negative emotions do I feel now? How strong are they?	New emotions box
Q12a Q12b	What do I intend to do? What do I notice in my body now?	Action plan box
Q13	How much do I believe the AT now?	Final evaluation of the AT
Q14	How am I now?	Final global evaluation

Introducing the Intra-TR to the Patient

The Intra-TR contains 14 questions that should be answered by the patient in order to restructure dysfunctional ATs (see Fig. 3.2). In the following extract, question numbers according to Table 3.1 are indicated after each corresponding question (e.g., Q1, Q2a, etc.).

T: Kathleen, what is going on now that you decided to go to college? Can you describe the situation? [**Q1**]

P: I don't know. The idea came to mind now, when you asked me to bring something for our agenda.
T: Are you saying that when I asked for an agenda item, this theme came to your mind?
P: Yes.
T: So, maybe you can describe the situation as something like: "In session, Dr. de Oliveira asks me to think of an agenda item." When I asked you to think of an agenda item, what went through your mind? [**Q2a**]
P: That I'm not intelligent enough and that I will fail.
T: How much do you believe this automatic thought now? [**Q2b**]
P: Very much: 80%.
T: Believing 80% that you are not intelligent enough, and that you will fail, what does it make you feel? [**Q3a**]
P: Sad, very sad.
T: How strong is your sadness, from 0 to 100%? [**Q3b**]
P: Also 80%.
T: Kathleen, what do you think you do, by believing 80% you will fail and feeling 80% sad? [**Q4a**]
P: I don't know. Just thinking of this, I am agitated and I think I will give all this up.
T: What do you notice in your body? [**Q4b**]
P: Stomachache: my stomach is churning.
T: Are there advantages of behaving like this, giving up? [**Q5**]
P: I don't see any. There are only disadvantages.
T: Are you sure? We always have good reasons to do what we do, whatever it is. Any sense of relief?
P: Seeing things in this perspective, yes. Not trying makes me feel less anxious, less frightened, and I will not have to face failure. It's kind of a relief, you are right.
T: Are there disadvantages of behaving like this, giving up? [**Q6**]
P: Sure. I confirm that I am a failure, and I do not give myself a chance of succeeding, of doing something important in my life.
T: Do you think this thought could be a cognitive distortion? [**Q7**]
P: Yes, fortune telling. I'm clearly catastrophizing.
T: Kathleen, can you find any evidence supporting the thought that you are not intelligent and that you will fail? [**Q8**]
P: I failed last year. I did not even try because of my depression.
T: Maybe you could find evidence on the other side, not supporting this thought. [**Q9**] Can you try?
P: Even depressed, I was able to work. And I did not fail all the disciplines. I succeeded in passing some of them.
T: Taking the above evidence into account, what is your conclusion? Can you find an alternative view to the automatic thought? [**Q10a**]
P: The above evidence makes me conclude that I was depressed and that now it may be different. If I succeeded in some disciplines and was able to work

even being depressed, maybe I could have better chances now that I am almost symptom-free. I will never succeed if I do not try.

T: Kathleen, how much do you believe the new conclusion that you have better chances now? [**Q10b**]

P: I believe it a lot: 70%.

T: And what does this conclusion make you feel now? What positive emotion does it produce? [**Q11a**]

P: My positive emotion is hope.

T: How hopeful are you? [**Q11b**]

P: 65%.

T: And what happens to the negative emotion, sadness? [**Q11a**]

P: I am still sad, but less.

T: And how sad are you now? [**Q11b**]

P: I'm less sad now, much less: maybe 30%.

T: What do you intend to do now, Kathleen? [**Q12a**]

P: I have to find a way of getting more active, find courage to study, prepare myself for the exams.

T: Do you see the asterisk in the second behavior and physiological responses box? It means that I can help you make an action plan. [Action plans are explained in Chapter 4 of this manual, but can be implemented in this session, after filling in an Intra-TR.] We can talk about this in a minute. Kathleen, you told me you had a stomachache a few minutes ago. What do you notice in your body now? [**Q12b**]

P: I feel better. I do not have a stomachache anymore.

T: How much do you believe now that you are not intelligent enough and that you will fail? [**Q13**]

P: I believe it much less: 20%.

T: How are you now, Kathleen, after this work we have just finished? [**Q14**]

P: Much better, much better.

Interpersonal Thought Record (Inter-TR)

Although most problems brought by the patient are interpersonal in nature, it is always useful to start teaching the patient to use the Intra-TR first and the Inter-TR thereafter. The Inter-TR may be invaluable to help patients understand how their behaviors affect others' behaviors and vice versa. Informing the patient that she has more control over her own behavior can be demonstrated with the Inter-TR shown next (see Fig. 3.3).

The Inter-TR contains 10 numbered questions that should be answered by the patient in order to restructure dysfunctional ATs (Table 3.2) whenever there are other people involved in the situation. It can be useful in interpersonal conflicts and can also be particularly useful for social anxiety disorder patients.

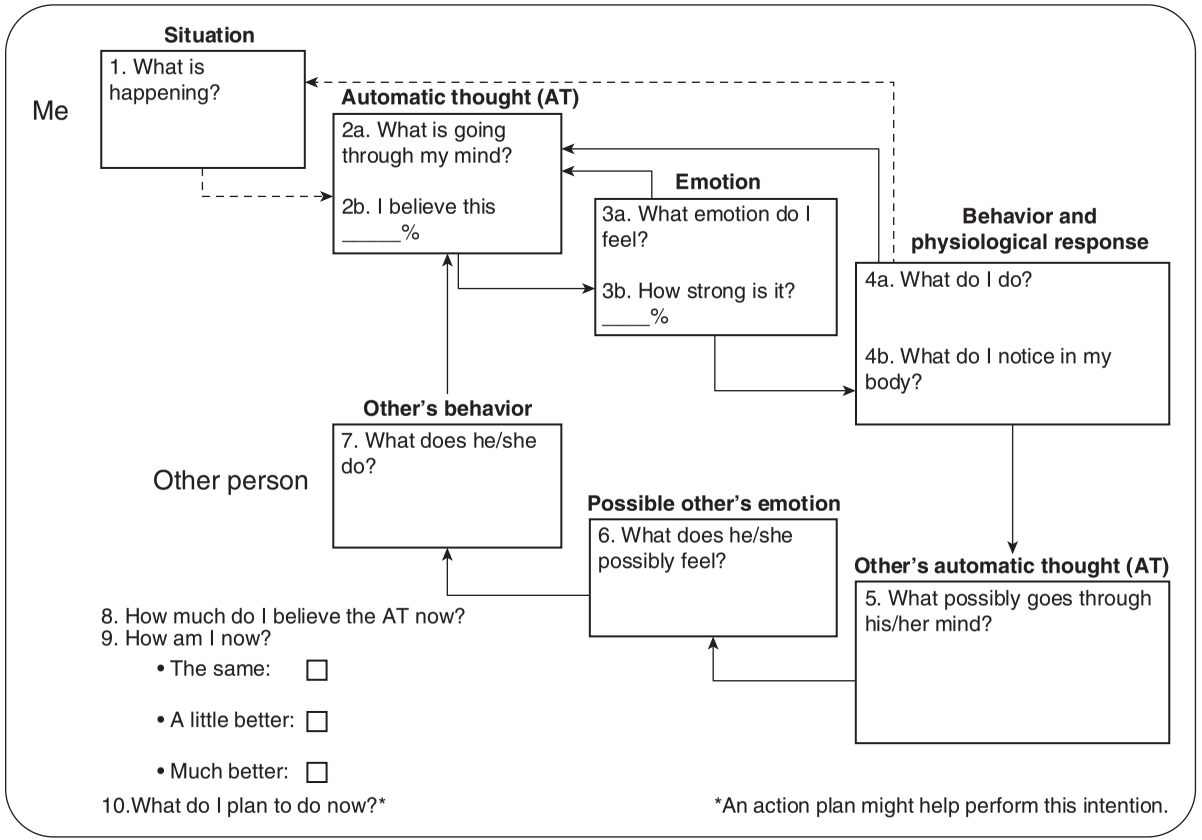

Figure 3.3 TBCT interpersonal thought record (Inter-TR), in which patients are asked to respond to each numbered question in the order they are presented.

Table 3.2 Questions to be answered by the patients when they fill in the Inter-TR

Question number	*Question*	*Inter-TR*
Q1	What is happening?	Situation box
Q2a Q2b	What is going through my mind now? How much do I believe it?	AT box
Q3a Q3b	What do I feel? How strong is my emotion?	Emotion box
Q4a Q4b	What do I do? What do I notice in my body?	Behavior and physiological response box
Q5	What possibly goes through his/her mind?	Other's AT box
Q6	What does he/she possibly feel?	Other's possible emotion box
Q7	What does he/she do?	Other's behavior box
Q8	How much do I believe the AT now?	Final evaluation of the AT
Q9	How am I now?	Final global evaluation
Q10	What do I plan to do now?	Action plan

Introducing the Inter-TR to the Patient

In the following extract, question numbers according to Table 3.2 are indicated after each corresponding question (e.g., Q1, Q2a, etc.).

T: Kathleen, what is going on now if you imagine the same situation you have just mentioned to me? Can you describe the situation as though it were happening now? [**Q1**]
P: My husband has just arrived home. He says hello, but does not kiss me as he always does.
T: So, maybe you can describe the situation as something like "My husband arrives home, says hello and does not kiss me." Supposing it is happening now, what goes through your mind? [**Q2a**]
P: Something wrong happened. I think Michael doesn't love me anymore.
T: Can you write it down in the AT box? How much do you believe this automatic thought now? [**Q2b**]
P: Very much: 90%.
T: Believing 90% that Michael doesn't love you anymore, how does it make you feel? [**Q3a**]
P: Very sad.
T: How strong is your sadness, from 0 to 100%? [**Q3b**]
P: Also 90%.
T: Kathleen, what do you think you do, by believing 90% Michael doesn't love you anymore and feeling 90% sad? [**Q4a**]

P: I become distant. I just say hello and keep watching TV.
T: What do you notice in your body? [**Q4b**]
P: Muscle tension.
T: If we were filling in the Intra-TR, the following logical question would be: do you think this thought could be a cognitive distortion? If it were the case, which cognitive distortion could it be?
P: It could be mind reading . . . and catastrophizing.
T: But the following question is, What is possibly going on in Michael's mind? [**Q5**]
P: He might think: Kathleen is angry with me.
T: Of course, you cannot read his mind. But can you imagine what he would feel if he had an AT like "Kathleen is angry with me"? [**Q6**]
P: Yes. Most of the time, he gets upset, even mad at me.
T: What does he do?
P: He becomes distant. I know Michael. He always waits for me to start conversations about our relationship problems. He never takes the initiative.
T: Is this what you notice? Does Michael become mad at you? [**Q7**]
P: Yes. This is what is happening now.
T: What do you think, when Michael is mad at you and becomes distant?
P: I confirm my thought that Michael doesn't love me, and I do not give myself a chance to test out this thought. And maybe I force him to be even more distant from me.
T: Kathleen, how much do you believe the AT "Michael doesn't love me anymore" now? [**Q8**]
P: Much less. Maybe 20%.
T: How are you now, Kathleen, after this work we have just finished? [**Q9**]
P: Much better.
T: What do you plan to do? [**Q10**]
P: I have to stop being so silly and believing my ATs. I have to challenge them as soon as they pop into my mind. I'll talk to Michael.
T: Do you think an action plan might be useful to help you accomplish this goal?
P: Yes, I do.
T: So, let's make an action plan.

CASE ILLUSTRATION DIALOGUE

Bridge from Session 2

T: Good morning, Leslie.
P: Good morning, Dr. de Oliveira.
T: How are you today?
P: I'm fine, thank you.
T: Good. If possible, I'd like you to give a small summary about what the last session represented to you.
P: Dr. de Oliveira, I really liked that material you gave me, the CD-Quest we filled in here, because with that I was able to identify much better several

thoughts of mine and their influence on my emotions. So, the situations that before would make me feel more anxious, today I'm already able to deal with them better. Of course, there are still situations that are difficult for me. For example, this week there was a very rude lawyer, but I didn't blush, my hands didn't sweat as much like before. And the fact that I observed, using the list you gave me of the distortions, that things can sometimes be about how I deal with them, how I think, and having noticed the influence of this on my emotions, made a difference.

T: Right, while you continue observing certain thought patterns as distortions, does this allow you to correct them?

P: Yes. There was mind reading there. So, when the lawyer arrives, I think that he'll think I'm not worth much, that I'm incapable, that I'm not a good employee.

T: So, I think it is worthwhile for us to structure our work today, Leslie, and my proposal is that we could initially review homework. Before we had a seat here, you handed me a list of definitions from the CD-Quest, which you just cited. And one of the aspects that we agreed on since our last session was that you would not only always have this list with you but also you'd have your own examples too, and it appears to me that you have three or four examples here that would deal with what you just said.

P: Right.

Setting the Agenda

T: So, I think that it's worth it to review homework and maybe we could already, within our agenda, establish something that is bothering you as the agenda item. You already started speaking of this problem you are having at work, right?

C: Yes, and it bothers me very much, Dr. de Oliveira.

T: Is there something particularly bothersome you would like to talk about today?

P: Yes. There was a very rude lawyer, and he insisted that I give him some papers, a lawsuit that couldn't leave the office. I was very disturbed by this situation.

T: Should we put this in the agenda for discussion?

P: Yes.

T: Do you mind if we start reviewing homework and then come to this issue that is bothering you?

P: No, that would be fine.

Reviewing Questionnaires and Homework

T: I gave you this cognitive distortions sheet. You had already filled it in last session, and from now on, I'd like you to have it easily accessible; is this possible? It is important that you find other examples during the week, because, at the beginning of each session, you'll receive the CD-Quest to fill

in. Today's CD-Quest didn't change much comparing with last week's, but it seems to me that it was quite easy for you to fill it in.

P: Yes, it was easier.

T: Having received this list and bringing these examples, did this help you remember more?

P: Yes, it did. For instance, at work, when a lawyer gets there who wants to talk to me, I'd already start thinking he or she wanted to talk with me because it's hard for me to say no.

T: And you found that in the sheet?

P: Yes. I discount my positives a lot. There was a young lawyer, Carla, who was at the office and told me she liked being assisted by me because I was calm. So, I think that, instead of finding me calm, she really thinks I'm foolish, because I do what she wants.

T: And how did you write this down?

P: Discounting positives.

T: And maybe, also mind reading, right?

P: Right. I imagine what the other person is thinking of me.

T: Exactly.

P: Right, I do this. I also do personalizing; that is, I interpret comments or questions as if they were attributed to me. So, when something happens at work, I keep thinking that it's my fault, even if I had nothing to do with it. And then anxiety comes, and I start blushing. Now, at least, I'm able to stop and identify the thoughts in some situations, give them a name, and know that they may be distortions.

T: Does stopping and identifying these situations, and realizing that they can be cognitive distortions (because they are not cognitive distortions all the time), give you the chance to have a little more critical stance regarding these thoughts?

P: Right.

Working on the Agenda Item

T: Great. Leslie, does the fact that you are a little more familiar with this list, with the cognitive distortions, and that you can even define them, make it easier for you to identify them?

P: Yes.

T: This might make it easier for you to do the task I would like to propose that we do today, already on our agenda, if you'd like us to begin. You are bringing a situation from work, and maybe we can already move on to this part of the session. and you can bring this example for us to work on here—what do you think?

P: Good, I think it's fine.

T: Would you like to tell me what happened?

P: All right. A very rude lawyer insisted that I give him some papers, a lawsuit that couldn't leave the office. I told him that unfortunately I couldn't hand

over the papers, but that he should come back later, and then I'd see what I could do. So then I think that he thinks I'm foolish, that he can get away with anything with me, but I was able to not give him the papers.

T: Which was, in fact, progress, wasn't it?

P: Right.

T: And this was what you wanted, wasn't it?

P: Yes. And I used to always hand over the papers. I'd do it, even if they couldn't leave the office.

T: And this time you could at least not give him the papers; is that correct?

P: Yes, Dr. de Oliveira, but I keep blaming myself. I get anxious, because I should have told him that I couldn't, and that's that. Anna, my co-worker says, "Look, you can't take the lawsuit papers; that's the office policy." And I still told him to come back later.

Introducing the Intra-TR to Work on the Main Agenda Item

T: Well, maybe we could do something else today, Leslie, which would eventually help you with this. I'm going to introduce a type of thought record to you. In trial-based cognitive therapy we call it the intrapersonal thought record, or just Intra-TR. You see that the upper part of this record looks like the conceptualization diagram I introduced to you—do you remember?

P: Yes, I do.

T: Let's use this thought record to try to understand this situation. Can you respond to Question 1 of the Intra-TR? What was happening? How would you describe it in the situation box, Leslie? [The therapist points to **Question 1** in the situation box in Figure 3.4.]

P: A lawyer asked me for the lawsuit papers.

T: So, at the moment the lawyer asks you for the lawsuit papers, what goes through your mind, Leslie? [**Question 2a**]

P: That he thinks I'm foolish, that he will get the papers.

T: Why don't you write this there in the automatic thought box?

P: He thinks I'm foolish.

T: Leslie, do you believe this now? Or was it more at that moment?

P: I believe it 60% now.

T: Right now?

P: Yes. Before, I believed it 100%.

T: So maybe it would be worthwhile for us to treat this as your thought now; don't you agree?

P: Yes, I do.

T: Why don't you write down 60% here? [The therapist points to **Question 2b** in the AT box.] And, while believing this thought 60%, "He thinks I'm foolish," what is it that you feel? Can you respond to **Question 3a?**

P: Anxiety.

T: How strong is the anxiety, Leslie?

P: 80%.

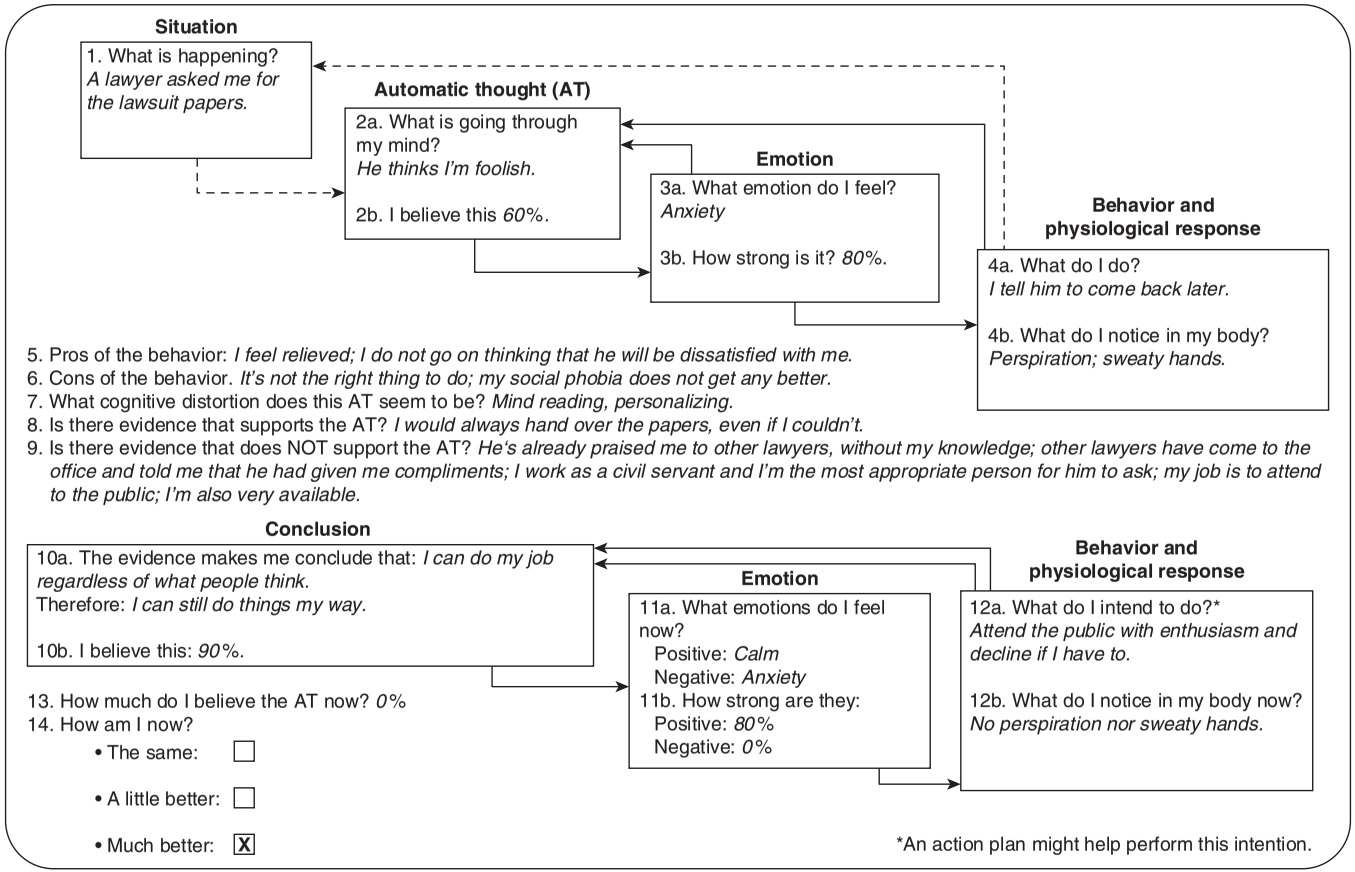

Figure 3.4 Leslie's TBCT intrapersonal thought record (Intra-TR).

T: I suppose you can't respond to **Question 4a** now, "What do I do?" but maybe you could write down what you did at that time.
P: Yes. I told him to come back later.
T: Please write it here, in the behavior box. At this moment, do you notice anything in your body?
P: Yes, I do.
T: What do you notice in your body?
P: I'm perspiring.
T: The simple fact of thinking about this now?
P: Yes, it's making me more anxious.
T: What do you notice now in your body? [**Question 4b**]
P: Sweaty hands.
T: Leslie, at the other times that we worked through this kind of situation, which corresponds to the upper part of our conceptualization diagram, we tried to see how this would close a cycle, didn't we?
P: Right.
T: Today we will do it a little differently. I'd like you to continue to answer these questions. Would you please go to **Question 5?** What are the pros of acting according to the automatic thought? This question is about your behavior.
P: I feel relieved. I do not go on thinking that he will be dissatisfied with me. [Leslie writes it down.]
T: And the cons? Are there disadvantages of giving him the lawsuits? [**Question 6**]
P: It's not the right thing to do, and so my social phobia does not get any better.
T: Next question is: What cognitive distortion does this thought seem to you at this time? [**Question 7**]
P: Actually, Dr. de Oliveira, I believe I had mind reading.
T: Why don't you write down there then, mind reading, in this space?
P: Do you think I also had personalizing, by attributing things to myself?
T: It's possible; at the time he asked you for the papers, what did it mean to you?
P: I thought that he asked me because he thinks I'm foolish and that I'll do what he wants.
T: Yes, this could also be, in part, personalizing. Leslie, is there evidence (and when I say evidence, I'm speaking of facts) that confirms this thought? [The therapist points to **Question 8.**]
P: Actually, he always prefers to have my assistance, but there is no evidence that he prefers this because I am foolish.
T: But if you had to find some piece of evidence confirming this thought, "He thinks I'm foolish," would you find it?
P: I would always give in to him.
T: Why don't you write that down here as evidence confirming the automatic thought?
P: I would always hand over the papers, even if I couldn't.
T: Is there any other piece of evidence that you could write down that confirms this thought?

P: He prefers that I give him assistance; could that be one?
T: Yes, it could, if you interpret this as evidence that he thinks you are foolish; is that what you mean?
P: Yes, to manipulate me.
T: Although you have no evidence that he does this in order to manipulate you, it seems to be so for you; is that right?
P: Yes.
T: OK, Leslie, you have **Question 9,** which is, "Is there evidence that does not support the automatic thought?"
P: He's already praised me to other lawyers, without my knowledge. Other lawyers have come to the office and told me that he had given me compliments.
T: Why don't you write that as evidence contrary to the automatic thought?
P: He praised me to other lawyers.
T: Can you find any other evidence that goes against this thought, "He thinks I'm foolish"?
P: In fact, I work as a civil servant. I'd be the most appropriate person for him to ask. My job is to attend to the public.
T: That is, in principle, he asks you because you are serving the public; that's how you want to write it down, right?
P: Yes. And I'm also very available.
T: Please, write this down. Leslie, looking at the evidence you have on both sides, what do you conclude? Can you complete this sentence, "The evidence makes me conclude that . . . ? [**Question 10a**]
P: It allows me to conclude that I can do my job regardless of what people think.
T: I would like you to complete: therefore . . .
P: . . . I can still do things my way.
T: OK, Leslie, tell me something. When you write down this new thought ("The evidence shows that I can do my job regardless of what people think"), how much do you believe it? [**Question 10b**]
P: I believe it 90%.
T: Can you write that down here? What happens with your emotions now? [**Question 11a**] First, I would like to know if you have any positive emotion after this conclusion. Then, I'd like to know what happens to your anxiety.
P: I'm calm.
T: If you had to record this here in the emotion box, what percentage would you place for the emotions? [**Question 11b**] You said you're calm. How much?
P: 80%.
T: You mentioned anxiety. How strong is your anxiety now?
P: I'm not anxious at all: 0%.
T: What do you intend to do? [**Question 12a**]
P: I can attend to the public with enthusiasm and decline if I have to.
T: What happens with what you were noticing in your body a little while ago? [**Question 12b**] You'd reported sweaty hands.
P: My hands are no longer sweaty.

T: Leslie, how much do you believe the automatic thought, "He thinks I'm foolish"? [**Question 13**]
P: I don't believe it at all.
T: You had put 60%. And now?
P: 0%.
T: And by believing this 0%, after the work we did here, how do you feel? [**Question 14**] What would you mark down here? The same thing, a little better, much better?
P: I feel much better.
T: OK, Leslie, this is what we call the intrapersonal thought record, because it refers to the things that are inside you, to your own thoughts and to what you observe, even if this is regarding another person. How would you summarize what we just finished doing now?
P: Dr. de Oliveira, you were able to make me change my way of thinking to an easier way. I feel as if I wasn't seeing my difficulties as they were. It's as if I realized that lots of things are just the result of how I think.
T: So we can conclude that you had a thought that generated an unpleasant emotion, and that also caused some physical reactions in you, which are quite annoying. And this had the tendency to self-perpetuate as we had seen in our cognitive conceptualization diagram.
P: And I would avoid him, because if I could keep from giving him assistance, I would.
T: So, after all these questions that you answered in this record, you were able to come up with an alternative thought, another conclusion, right?
P: Right.
T: And, consequently, you saw that our diagram is redone in this lower part of the conceptualization diagram, leading you to a more balanced thought.
P: Yes. At the same time that I care less about whether he thinks I'm foolish or not, I'm thinking, "Whether or not he thinks I'm foolish, I can still do things my way."
T: Great. All right, Leslie. This is excellent. What I would like you to do now is to try to review this work we have done, and try to memorize the questions in the Intra-TR. I'll show you a song that can help you memorize the questions. It is on YouTube and I will send you the link.

[The therapist and Leslie go over a detailed review of the Intra-TR so that she can be more familiar with the questions and memorize them. The therapist also shows her the song with the questions that are the same she answered during the session: http://youtu.be/tB7BeByHgeg.]

Assigning Homework, Summarizing, and Concluding Chapter 3

T: Seeing as you filled in the intrapersonal thought record in the session, and after reviewing this work, do you think that taking two or three more sheets to fill in regarding situations outside my office could help?

P: Yes, sure. I think it will help. In a similar situation, I can decline politely, in a courteous manner. I will try to do this.

T: That's great that you really have this spirit of challenging your thoughts. Leslie, how would you summarize what we have done today?

P: I was able to learn through this record that my thoughts are generally negative, sometimes catastrophic, and that this generates much anxiety and makes me behave in a way that ends up strengthening and confirming the wrong and distorted idea that I have about myself. If I evaluate my thoughts better, I can identify and name the cognitive distortions I am having. I can come up with an alternative view of the situation, and perceive that sometimes it is the fruit of distorted thoughts, and that, even if something is not the fruit of my thoughts, I can still survive this situation.

T: Great, Leslie. So, what do we have for next week? I'd like you to take another sheet like this one with the cognitive distortions definitions. Actually, let me make a copy of the one you brought so that I can have one with your examples. And I'd like you to take one more of these definition sheets, so that you could not only have the task of bringing other examples but also work through the examples that you find, by way of this new thought record you practiced in session. Is this something you could do?

P: Sure. Sure I can.

T: I think it would be worthwhile to establish a number: how about three this week?

P: That's doable. Of these things that bother me, right?

T: Right. What feedback can you give me, Leslie? With today's session, what can you tell me?

P: Dr. de Oliveira, this technique you showed me today will help me a lot because, actually, filling in the CD-Quest and reviewing the distortions have already helped me a lot. It was important that I observe, when you said, "Look, Leslie, pay close attention when you perceive that your emotions change, when you feel more anxious, and evaluate what is going through your mind in these situations." Identifying this was great, but writing in these little boxes in the Intra-TR, putting down my thoughts and the situations makes it much clearer; I can see the change of thoughts more clearly. And having specific questions to respond to makes it easy. It isn't a hard form to fill in, because you notice how much difference it makes in the emotional reaction.

T: Great, Leslie. So I'll be very curious to see next week how you will be with this new thought record, the Intra-TR, that you are receiving today, OK, Leslie?

P: OK, thank you so much.

T: Have a good day.

P: Same to you (Fig. 3.4).

4 Assessing and Changing Underlying Assumptions

Outline

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- Summarizing Session 4
- Assigning Homework and Concluding Session 4

Introduction

Behavioral experiments are the most important strategies for promoting change in CBT (Bennett-Levy et al., 2004) and provide the essential basis for communication between knowledge resulting from the rational mind and that resulting from the emotional mind (Padesky, 2004). Behavioral experiments are especially used to change underlying assumptions (UAs). UAs are expressed as conditional beliefs such as "If I exercise, then I will have a heart attack." Consequently, one usually avoids feared situations.

In this chapter, I introduce the color-coded symptoms hierarchy (CCSH) approach, proposed to organize and facilitate exposure to feared actions and situations, and a decision-making technique called consensual role-play (CRP), designed to help patients resolve ambivalence.

The session described in this chapter introduces the patient to the second level of the CCD and behavior experiments in order to change dysfunctional UAs. An easy way to illustrate this process is by means of the CCSH. Often, the therapist and the patient use CRP to make decisions, when the experiment involves exposure to actions or experiments about which the patient is ambivalent and fearful.

TBCT Cognitive Conceptualization Diagram, Phase 1, Level 2 (CCD-1.2)

Figure 4.1 illustrates how situational behaviors that are repeatedly used by the patient become customary, being progressively transformed into safety behaviors. Conditional UAs behind such safety behaviors are intended to protect the patient against distressing emotional reactions produced by specific situations and their appraisals by the patient (e.g., avoidance). When the therapist asks a simple question like "If you do not avoid, what happens?," the patient comes up

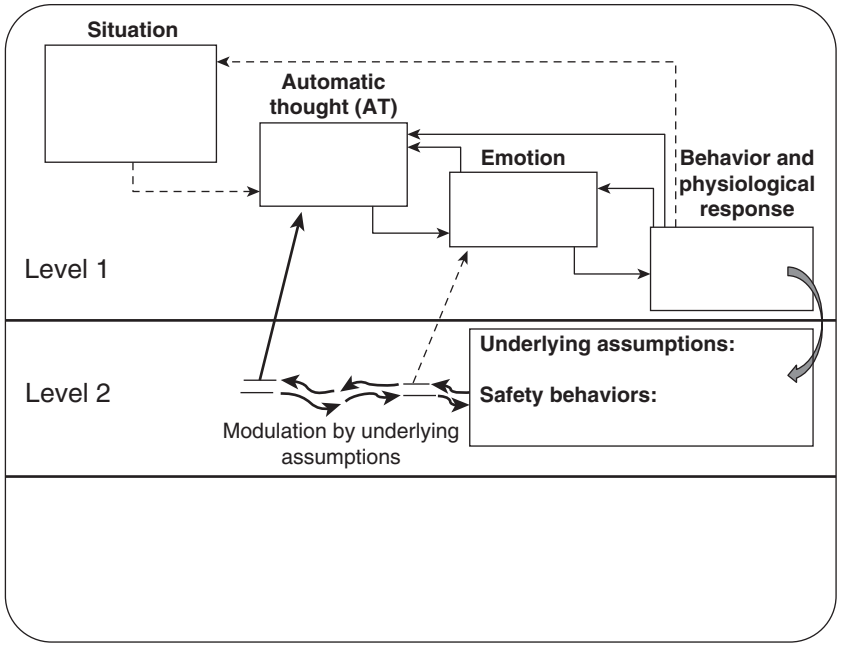


Figure 4.1 The arrow from the behavioral response box to the underlying assumptions box illustrates the second level of the TBCT cognitive conceptualization diagram, in which the repetition of situational behaviors makes them habitual and transforms them into safety behaviors.

with the answer that corresponds to the "if-then" UA (e.g., "If I go to parties, then people will criticize me!).

In circuit 2 (Fig. 4.2) the UA elicits a safety behavior, which produces ATs that generate emotional reactions that confirm the behaviors (now, habitual) and the original UA, closing a vicious circle. The UA may be so automatized that, in certain situations, challenging them elicits emotional reactions in the absence of explicit ATs (dotted arrow from second to first level).

Color-Coded Symptoms Hierarchy (CCSH)

The CCSH is a tool that may help patients increase the chances of doing behavioral experiments, by providing a hierarchy of symptoms to which they are supposed to be exposed in order to obtain symptom remission. After collecting a detailed list of symptoms (e.g., OCD or social phobia symptoms), in which the patient scores each one according to the hierarchy shown in Figure 4.3, the therapist informs her that there will be no focus on light gray symptoms, that is, those scoring 0 and 1, but she will choose three or four medium gray symptoms (those scoring 2 and 3) to practice exposure as homework during the week.

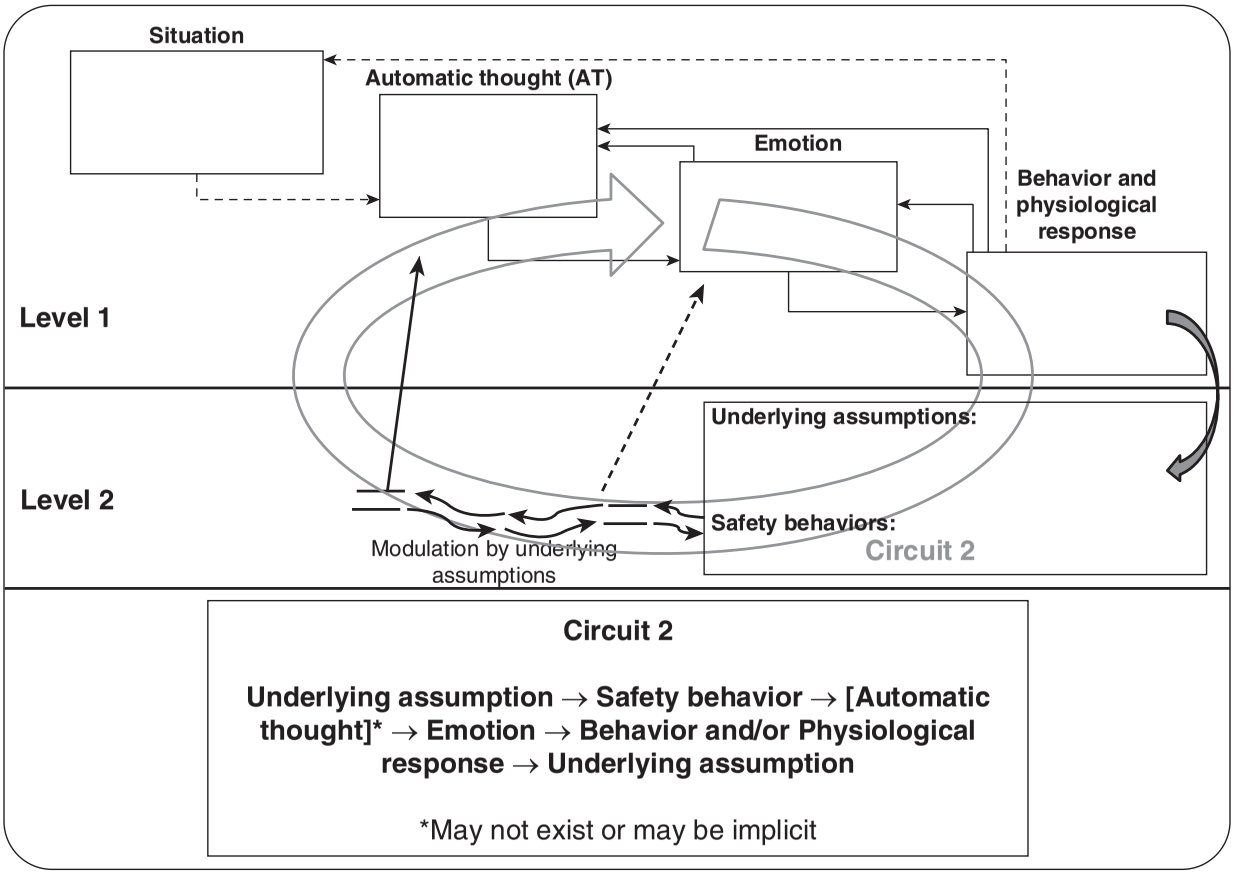


Figure 4.2 Circuit 2 comprises the UA, the safety behavior, the ATs, the emotional reactions, and the habitual behaviors.

0	**Exposure is comfortable or indifferent**
1	**Exposure is a little uncomfortable**
2	**Exposure is uncomfortable**
3	**Exposure is very uncomfortable**
4	**Exposure is so distressful that I do it only if really necessary**
5	**Exposure is so distressful that I cannot imagine myself doing it**

- *Light gray symptoms (0 and 1) are not a reason for concern*
- *Medium gray symptoms (2 and 3) should always be challenged*
- *Dark gray symptoms (4) are challenged in session or with the therapist's help*
- *Black symptoms (5) are NEVER challenged*

Figure 4.3 Color-coded symptoms hierarchy (CCSH) card to facilitate exposure implementation.

Introducing the CCSH to the Patient

The following transcript shows how the therapist introduces the CCSH to Kathleen. Her OCD symptoms scores are shown in Figure 4.4.

T: Kathleen, now that we have this list showing your OCD symptoms, would you please score each symptom according to this card we call the color-coded symptoms hierarchy? It's very simple and I will explain it to you. All you have to do is to choose the score that suits the way you feel when exposed to each situation. For instance, I assume you are comfortable now while talking to me. If you had to score this situation "talking with Dr. de Oliveira during therapy session," which score would you choose?
P: Certainly zero. I'm comfortable talking to you now.
T: Right. If I asked you to touch my hand, which score would you mark?
P: I would score a 2, clearly uncomfortable.
T: May I ask you to score all the items in your symptom list?
P: Of course.

Patient's name: Kathleen
Please, choose the scores (0-5) corresponding to what you would feel if you were to expose yourself to each item below.

Session	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
Date	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Go to the supermarket	5	5	5	5	5	5	4													
Go out	5	4	3	3	3	1	0													
Touch objects coming from street	5	5	5	5	4	3	3													
Touch people	5	5	5	5	5	5	4													
Be touched by people	5	5	5	5	5	5	4													
Touch money	5	5	5	5	5	5	5													
Eat with hands	4	4	3	2	1	0	0													
Not washing hands	5	5	5	5	5	4	2													
Touch telephone	5	5	5	5	5	5	4													
Touch door knob	5	5	5	5	5	5	5													
Not discard towel after bath	3	2	1	0	0	0	0													
Work with computer	2	2	2	1	0	0	0													
Touch mail	3	3	3	2	2	1	0													
Touch shoes	5	5	5	5	5	5	5													
Touch/hug daughters	5	5	4	4	3	2	0													
Kiss daughters	5	5	4	3	3	3	0													
Kiss and being kissed by others	5	5	5	5	4	4	3													
Wash dishes	2	1	0	0	0	0	0													
Touch my string of beads	1	0	0	0	0	0	0													
Touch therapist's hand	2	1	0	0	0	0	0													
Touch my books	3	3	3	2	1	0	0													
TOTAL SCORE (sum of individual items)	85	80	73	67	61	53	39													
Number of exposures I do not allow myself to do (dark grays and blacks)	14	14	12	11	10	9	7													

Figure 4.4 Kathleen's OCD symptoms scores according to the color-coded symptoms hierarchy (CCSH) card.

Introducing Exposure to the Patient

T: Kathleen, you told me that you stopped therapy because you were afraid of exposures, didn't you? You told me you improved a little of your OCD symptoms, but knowing that the therapist would ask you to expose yourself to feared situations made you fear the therapy itself. Was that the reason you stopped visiting your last therapist?

P: Yes. I was very anxious before sessions because I knew the therapist would ask me to do things that made me suffer.

T: Kathleen, if I told you that I would never ask you to expose yourself to things you do not want to . . . even more, if I told you that I would never ask you to suffer in this therapy, would you believe me?

P: It's hard to believe it because my previous therapist said I would not get better without confronting my fears; that is, I would never improve without exposure. He was very kind and tried to make me confront the symptoms I feared less, but knowing that I would sooner or later have to face my worst fears made me anxious. I anticipated distress each time I had to go to therapy.

T: Your therapist was right. Exposure is the most efficacious treatment for your symptoms. However, I can tell you that you do not need to suffer or being distressed, but you must accept discomfort. Did you notice that the CCSH separates discomfort from distress?

P: Yes. I can see in the card that exposures to light gray and medium gray symptoms [1–3] are considered uncomfortable situations and dark gray and black symptoms [4, 5] are distressful situations.

T: Exactly. Let me ask you something. Why do you think some people go to gym or resist a delicious chocolate?

P: Because they don't want to get fat or because it is good for their health.

T: How uncomfortable would you consider going to gym or resisting a chocolate according to the CCSH?

P: I would say 2 for resisting the chocolate and 3 to going to gym.

T: You are right. And why do you think people go to work when sometimes they don't want to because of an unpleasant and demanding boss?

P: They have to; otherwise they wouldn't be paid.

T: Exactly. Am I hearing you say that if you want to have financial health you must face uncomfortable and sometimes even distressful situations?

P: Yes, that's right.

T: And that if you want to have physical health you also need to face uncomfortable situations like exercising and sometimes resisting a delicious dessert?

P: Yes.

T: So, let me propose something to you. I will ask you to confront uncomfortable situations here; that is, I will ask you to expose yourself to medium gray symptoms during our sessions and also as homework on a daily basis. The reason is that I want you to get your mental health back. I want you to get free from your OCD symptoms. But I promise you that I will NEVER ask you to do distressful things ever. Do you agree with me?

P: Of course. And this gives me a great sense of relief. I don't want to suffer.

Consensual Role-Play (CRP)

CRP is a seven-step decision-making approach designed to help patients deal with ambivalence, challenge safety behaviors (e.g., avoidance) and facilitate behavioral experiments (e.g., taking the elevator in the case of claustrophobia) (de Oliveira, 2014). Used trans-diagnostically, CRP typically takes around 30–40 minutes and can be repeated as many times as necessary regarding the same or different decisions (Fig. 4.5). In introducing the rationale to the patient, the therapist explains to her that the most important thing is what she learns and not the decision itself. Assuring that she will not be pressured to make the decision decreases the patient's defensiveness, freeing her to express any concerns and therefore, not try to please the therapist.

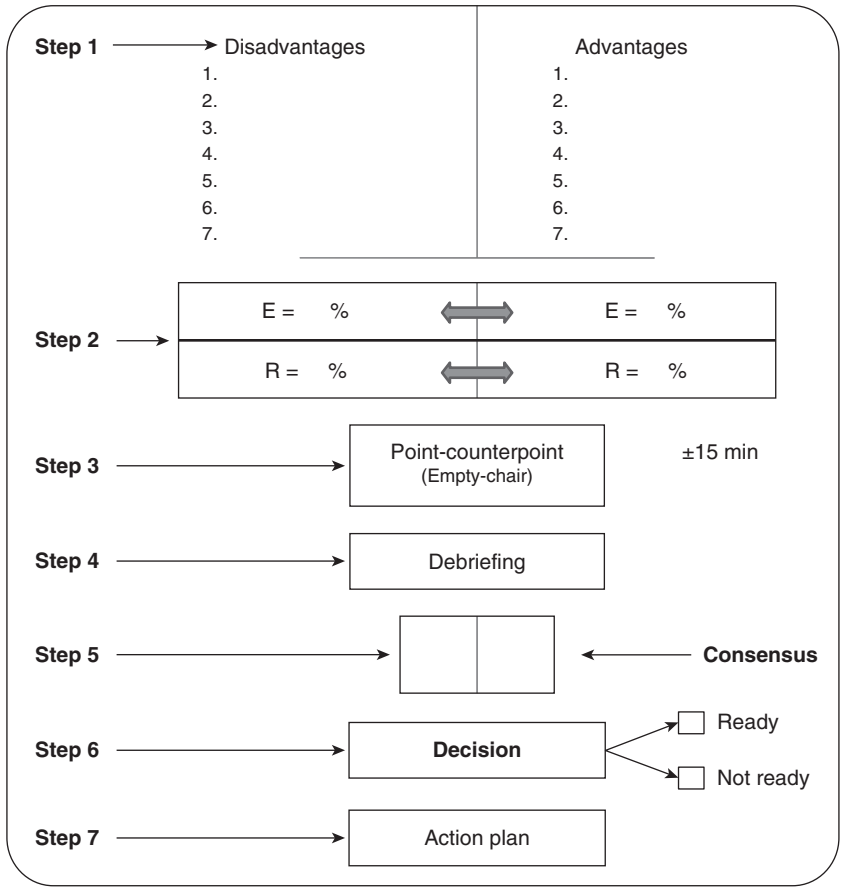


Figure 4.5 Consensual role-play (CRP), a decision-making approach.

Description of CRP

Below are the steps followed by the patient during the use of CRP, depicted in Figure 4.5.

Step 1: Identifying Advantages and Disadvantages with a Decisional Balance

The patient is encouraged to list the advantages/pros and disadvantages/cons of implementing the desired/necessary, but unpleasant/feared, action/behavior.

Step 2: Identifying Ambivalence by Weighing Advantages and Disadvantages According to the Rational and Emotional Selves

The patient is helped to confront the dissonance between "reason" and "emotion" (Padesky, 2004) by giving a percentage weight to the advantages of implementing the action (versus a percentage for the disadvantages) according to reason, and a percentage weight to the disadvantages of implementing the action (versus a percentage for the advantages) according to emotion. Some patients are unable to discern between reason and emotion (e.g., those with alexithymia). In those cases, the therapist asks them to distinguish "the internal voice that says 'go'" from the "internal voice that says 'don't go'" (see Table 4.1 for useful questions in Step 2).

Step 3: Resolving Ambivalence by Reaching a Consensus Between Rational and Emotional Selves with the Empty Chair Approach

The patient is encouraged, by means of the empty chair approach (Carstenson, 1955), to reach a consensus between "the rational self" (Chair 1) and "the emotional self" (Chair 2) in a ±15-minute dialogue, making emotion speak to reason and vice versa.

Step 4: Debriefing Previous Steps and Assessing What Was Learned

The patient is asked to use a third chair ("consensual self," Chair 3) to review what was learned from steps 1 through 3.

Step 5: Assessing the Consensus Between Rational and Emotional Selves

Still in Chair 3, and role-playing the "consensual self," the patient is requested to reassess the weight of advantages vs. disadvantages, the goal being to attain a consensus between the rational and emotional selves.

Step 6: Making the Decision

The patient is asked if she is ready to make the decision; that is, if she is ready to implement the unpleasant/feared action/behavior.

Step 7: Helping the Patient Maintain the Decision with an Action Plan

The patient is helped, if the answer is "yes," to design an action plan (Greenberger & Padesky, 1995) in order to increase the chances of success in implementing the action—so that not only can she organize what to do, as well as how and when, but also anticipate obstacles, find solutions, and follow up the outcomes—or, if the answer is "no," to design an action plan to collect information and decide later (Fig. 4.6).

1. Proposed actions:
a. _____
b. _____
c. _____
d. _____
2. Possible obstacles to actions:
a. _____
b. _____
c. _____
d. _____
3. Solutions to obstacles:
a. _____
b. _____
c. _____
d. _____
4. When to implement proposed actions:
a. _____
b. _____
c. _____
d. _____
5. Follow-up:
a. _____
b. _____
c. _____
d. _____

Figure 4.6 Action plan.

Table 4.1 Useful questions to be asked to the patient during Step 2 of the consensual role-play (CRP), assuming that the emotions are negative (e.g., fear, anxiety, shame)

1	What do you think carries more weight in your decision to . . . (action): the advantages or the disadvantages?	What do you think carries more weight in your decision to . . . (action): the advantages or the disadvantages?
	Answer: The disadvantages.	Answer: The advantages.
2	When you say, the weight of the disadvantages is greater, are you thinking emotionally or rationally?	When you say, the weight of the advantages is greater, are you thinking emotionally or rationally?
	Answer: Emotionally.	Answer: Rationally.

(*Continued*)

Table 4.1 (Continued)

3	So, the disadvantages, emotionally speaking, seem to weigh more. How much more? Sixty, seventy, eighty, ninety, one hundred percent?	So, the advantages, rationally speaking, seem to weigh more. How much more? Sixty, seventy, eighty, ninety, one hundred percent?
	Answer: 75% (leaving 25% for advantages, emotionally speaking).	Answer: 80% (leaving 20% for disadvantages, rationally speaking).
4	And rationally speaking, what seems to weigh more, the advantages or the disadvantages?	And emotionally speaking, what seems to weigh more, the disadvantages or the advantages?
	Answer: The advantages.	Answer: The disadvantages.
5	How much? Sixty, seventy, eighty, ninety, one hundred percent?	How much? Sixty, seventy, eighty, ninety, one hundred percent?
	Answer: 90% (leaving 10% for the disadvantages, rationally speaking).	Answer: 70% (leaving 30% for the advantages, emotionally speaking).

Case Illustration

Merilyn, a 45-year-old female single dentist who presented for consultation because of symptoms of specific phobias (e.g., thunder, heights, planes, crowds) and major depression, complained of a long-lasting fear of planes and, more recently, sadness, lack of energy, fatigue, somnolence, and difficulty concentrating. In the past 5 years, she presented three low-mood episodes, but had never complied with the antidepressants prescribed by her psychiatrist, for fear of the side effects. She had recently started a new relationship with Jim, who lived in a different state. Jim visited her every two weeks, but she was unable to travel to visit him back. Merilyn's ATs ("Jim will leave me," "There is no hope"), UAs ("If I take the plane, it will crash, or at least I will lose control and go crazy up there"), and CBs ("I'm weak," "I'm a failure," "I'm not good enough") increased in frequency and intensity one month prior to consultation because Jim had difficulties visiting her as frequently as before since his job demands had increased. Her psychiatrist proposed a time-limited course of weekly TBCT sessions to deal with the fear of traveling and reluctance to take antidepressants. After introducing the cognitive model by means of the CCD, and educating her on the cognitive distortions, the psychiatrist was able to help her challenge the ATs by means of the Intra-TR, challenge the UAs with the CCSH and CRP (the latter was first used to help her decide to take the SSRI and then to take the plane to visit Jim), and restructure the negative CBs using trials I and II (see Chapters 5 and 10, respectively, in this manual to know how). In addition to being able to travel by plane 3 months after starting therapy, Merilyn was complying with the SSRI 6 months after treatment termination. Figure 4.7 illustrates one of her CRPs, and Figure 4.8 the corresponding action plan (Step 7), which helped her decide to take the antidepressant medication.

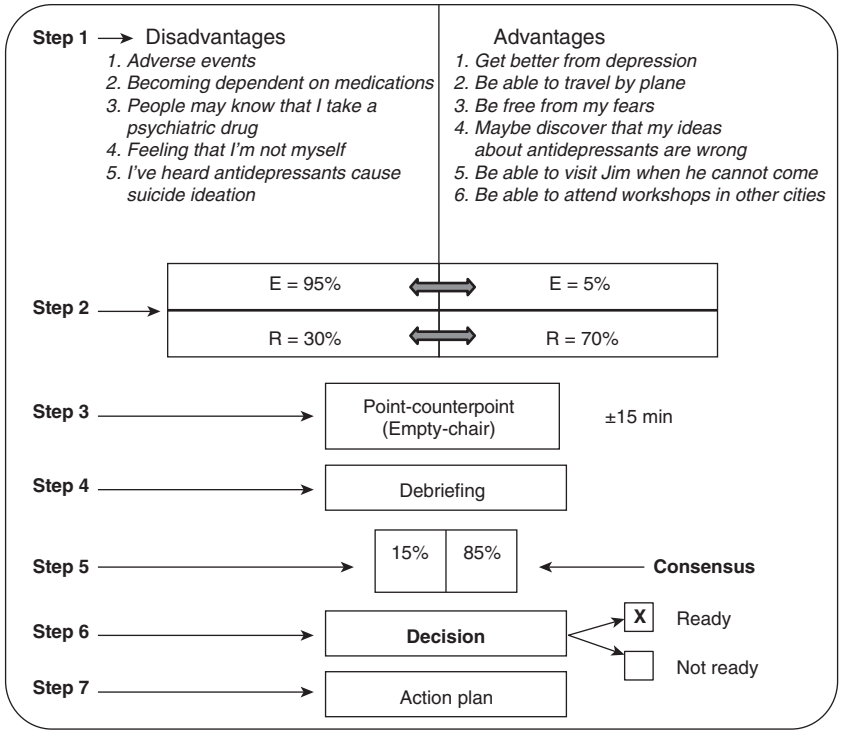


Figure 4.7 Merilyn's consensual role-play to help her comply with the antidepressant treatment.

CASE ILLUSTRATION DIALOGUE

Bridge from Session 3

T: Good morning, Leslie.
P: Good morning, Dr. de Oliveira.
T: How was your week?
P: My week was more or less calm. I looked at and filled in the material you gave me and I identified some situations.
T: Good, good. We will talk about all this and I am quite curious to know how you got through the week; I'd like you to tell me what our meeting last week represented to you. What do you remember that was important?
P: Dr. de Oliveira, you taught me how to use the Intra-TR. I really liked the way it helps us change our thoughts.
T: Today you arrived early and filled in the CD-Quest again. We will go over this in a little while. I asked you to fill in not only the CD-Quest but also the anxiety questionnaire. And I asked you to fill in another questionnaire that gives an idea of social phobia, and that you had already filled in at intake.
P: Right.

1. Proposed actions:
a. Read the brochure on depression and antidepressants given by my psychiatrist
b. Talk to Mary, my co-worker, about her antidepressant treatment (has been taking for years)
c. Start on low dose
d. Call my psychiatrist if I have any side effects

2. Possible obstacles to actions:
a. None
b. She might not be willing to talk about her treatment
c. Fear and anxiety
d. He might be busy and not be able to talk to me

3. Solutions to obstacles:
a. —
b. Tell her about my depression and my fear of medications (she has already told me about her treatment)
c. Fill in an Intra-TR
d. No evidence of this, as he has always replied or called me later

4. When to implement the proposed actions:
a. Tonight
b. Tomorrow, during lunch, after work
c. This Saturday (I'll be at my sister's home)
d. When and if necessary

5. Follow-up:
a. Done
b. Done. Mary was very receptive. She told me her side effects were mild and occurred only in the first weeks
c. Started on Saturday. Few side effects (slight nausea the first two or three days)
d. Not necessary

Figure 4.8 Merilyn's action plan to help her comply with the antidepressant treatment.

Setting the Agenda and Reviewing Homework

T: OK. So let's take a look at this. Is there something you would like to bring up today for the agenda?

P: Yes, Dr. de Oliveira. I have talked about my situation at work a lot, my anxiety about giving people assistance, the lawyers, about speaking to the judge, speaking to the other analysts, but maybe I haven't talked so much about another area of my life, which is the social area. So, I don't have many friends; on weekends I stay mostly at home; at the most I'll go to the mall to have a coffee. But I worry about the cup shaking and I always stay as hidden away as possible in the café. I don't have many friends, I've only had a few, and now I have the chance to go to a party.

T: Great, great! This is exactly what I was going to ask you, because it seems that you isolate yourself a lot, and making friends is a goal you included in your goals list when we started this therapy; do you remember that?

P: Yes, I do.

T: And what is interesting is that this is well represented in this scale that we filled in today, the social phobia scale.

P: I see.
T: Let's take one of these items to work on as the therapy advances. You have brought an example that we could put on the agenda. First, I'd like you to summarize the week, in terms of the homework you did. And I believe that our second item could be the decision related to the difficulty of attending the party, right?
P: Yes, of going to the party. Not only the difficulty in attending but also in knowing how I will behave there, if I decide to go.
T: Right. Naturally, you don't know how you will behave there.
P: I keep thinking about it.
T: Is there anything you would like to add, or are these items already enough for today?
P: These two, because, since we always work with this questionnaire, I always remember situations from work, when someone arrives at the office, when someone comments on my clothes, or if someone comes in and speaks with a co-worker and not me; so these are always the situations that make me uncomfortable or embarrassed.

Reviewing the Questionnaires

T: Great. But this we'll add to the agenda. That is, on today's agenda, we have three items that I'd like to review: the questionnaires that we've seen up to now, there is the reviewing itself of the homework, and there is this specific item, the decision about attending the party, due to this difficulty, right? In terms of the questionnaires, I'm very curious to see how you filled in the CD-Quest today. Did you notice any difference in filling in the CD-Quest? We have the results in our hands, right? What did you notice that was different when filling in the CD-Quest today?
P: It decreased a little, didn't it, Dr. de Oliveira?
T: Exactly. Last week you scored 45, and today I see that you only scored 40.
P: Perfect, that was it.
T: And some of these appear not to have decreased a lot in frequency, but I have the impression, from how you scored them, that at least the intensity as to how much you believed some of them was modified, right?
P: Yes.
T: What conclusion do you reach with this?
P: I reasoned that, knowing that these distortions exist I can understand the situation better and no longer imagine that it is true.
T: That is, you believe it less because you know it is a distortion; isn't that so?
P: Yes. There is also an interesting thing, Dr. de Oliveira: these unfair comparisons. I had never stopped and noticed how I make unfair comparisons, how much I put myself down.
T: Last week you scored 5 in this item and I can see today that you only scored 3.
P: Right, that's it.
T: And what is also interesting is that they happened more or less at the same frequency, but I notice that you decreased how much you believed them, right?

P: Yes.
T: Great.
P: And also, Dr. de Oliveira, when we talked about personalizing, I noticed that, by talking more about a distortion in here, I see an improvement in myself outside the sessions. And I start to pay more attention during the week.
T: Did you use that distortions sheet a lot? Did you learn about the distortions?
P: Yes, I did.
T: Great.
P: And I noticed that, on the days that I read the sheet, the result was better. I was able to visualize . . .
T: You were able to identify the distortions more.
P: Yes, because you told me that when I observed some inadequate behavior, or when I noticed that my emotion changed, I should use the list, and this was very important in helping me identify what was happening.
T: Great! That's right. The other thing we observed was that, besides the CD-Quest score having decreased, the anxiety score also decreased a little more, right? Do you confirm this? Is this what you feel?
P: Yes, it's what I feel.
T: Should we review homework now? How was it for you filling in the Intra-TRs?
P: I confess I did not succeed in doing the three you asked me to do, but I did two Intra-TRs. I don't know if I answered the questions correctly, but they helped me a lot, I felt better when I finished filling them in.
T: Excellent. Let's take some time reviewing them.

[The therapist and the patient take a few minutes to review the two Intra-TRs filled in by Leslie.]

Introducing Underlying Assumptions While Working on the Main Agenda Item, Facilitated by the Color-Coded Symptoms Hierarchy Card

T: Good, then. Leslie, today we've seen here the social phobia scale. Let's see the various items that you have that involve speaking in public, participating in small groups, getting along in public places, and so on . . . You scored high in several of these, and not only where you feel much fear or anxiety but also some things that you avoid. So, maybe we could, starting now, since you've brought something to our agenda—which is precisely going to a party—organize these symptoms according to the color-coded symptoms hierarchy (Fig. 4.3)? Looking at this card, would you please score them from 0 to 5?
P: Yes.
T: I can see that you scored 4, a dark gray symptom, in the item "going to a party." It means that this is something you expose yourself to only if really necessary.
P: I generally avoid this.
T: In these circumstances, I don't always ask this, first off, for you to do something that you feel so distressed doing, and at the same time, avoid so much—the

dark gray and black symptoms [4 and 5]—because we normally prefer to start with items that have a somewhat lower score—the medium gray ones [2 and 3]. So, I'll leave it up to you. For example, this issue of attending or not the party today: it seems that this is an opportunity that doesn't come very often.

P: Exactly.

T: So, can we learn more about this before you make the decision?

P: Yes, we can. I'd like to do this.

T: So, let's take this as an example here. Maybe you remember that, at our first session of cognitive therapy, I showed you that cognitive conceptualization diagram, do you remember?

P: Yes, I do.

T: Maybe we can take this opportunity for me to explain to you this second level (Fig. 4.1). This is what we're going to do today, here. So, I'll show you this and see if you remember . . . well, you saw how your thoughts interfered or, in some way, influenced the way you felt, and, consequently, many things you were doing at that time. At this second level, I'll show you that there are some ways that you behave very frequently that go on to be a habit for you. We call them safety behaviors. This is a technical term, but I believe that little by little you'll become familiar with these. Which behaviors do you repeat in order to feel more secure?

P: I avoid things.

T: How about writing down exactly that? Because this goes on to be a very routine behavior in your life, avoidance. What else?

P: I'm so nice all the time. I do what everybody wants, be nice.

T: If you're not nice all the time and don't do what people want, then . . .

P: They won't like me.

T: How about writing this as a type of underlying assumption? That is, if you're not nice all the time to people, they won't like you. Is this an underlying assumption you carry around?

P: Yes.

T: Let's write this here. You avoid things often, right? You avoid situations. If you don't avoid them, what happens?

P: If I don't avoid them, I'll fail doing them.

T: You'll fail. And this seems like a situation that causes you much suffering, right? So, why don't you also write that down as an underlying assumption?

P: If I try, I will fail.

T: Exactly. Is this an underlying assumption on which you always base yourself?

P: Yes. This is always present in my life.

T: OK. If you manage to change this assumption and find out that, in some way, it isn't necessary in most situations, only in some, what do you imagine will happen?

P: My life may change. But is this possible, Dr. de Oliveira?

T: That is what we will try to find out together during this therapy. So what do we need to do then, Leslie, to begin at least to check whether these assumptions are correct or not?

P: I need to change my strategies; I need to behave differently.
T: Exactly. Maybe you can try to act a little differently.
P: I'm afraid.
T: How could you try, even being afraid? Beginning with the most difficult ones or the easiest?
P: Beginning with the easiest.

Introducing the Consensual Role-Play as a Decision-Making Approach

T: Leslie, I like using this color-coded symptoms hierarchy card. Dark gray symptoms [4] are challenged only when really necessary. But, we have a decision to make today; there is a more difficult situation. And as I told you, generally I don't propose that the patient begin with the most difficult issues. But, going to the party today, is that important to you?
P: Yes, Dr. de Oliveira. It's very important, because I already don't have many friends. There is going to be a class reunion, of the school where I studied my whole childhood and adolescence. I haven't kept in touch with these people for 15 years. So I think that now it's time. It's been 15 years since I last saw them.
T: So why don't we do this? There is a technique that we use for this second level of cognition, which I will show you. We will use this technique that helps in decision making. For example, deciding if this is the time for you to attend the party or not. I'll explain it a little better to you. So, I'll get this form that we use for this, and who knows, this technique might help you make the decision, all right? So, Leslie, what is the decision you want to make at this time?
P: Go to the party, to the class reunion.
T: And beforehand, let me tell you that you are not obliged to make this decision. I would just like to present this diagram to try and see if this could help you decide, all right?
P: Right.
T: So, why don't you write down on your paper (Fig. 4.9) what you would like to be able to do, which is exactly to go to the party?
P: Yes, go to the party.
T: This is the decision that we'll see whether you are able to make today or not. Because it doesn't matter if you feel that today is not the day for you to go to the party. You won't go. You won't be forced to do it, all right?
P: All right.

Step 1: Identifying Decisional Balance

T: So, why don't you write here, beginning with the disadvantages of going to the party?
P: Disadvantages . . . I might not be able to communicate with people. I might get anxious.

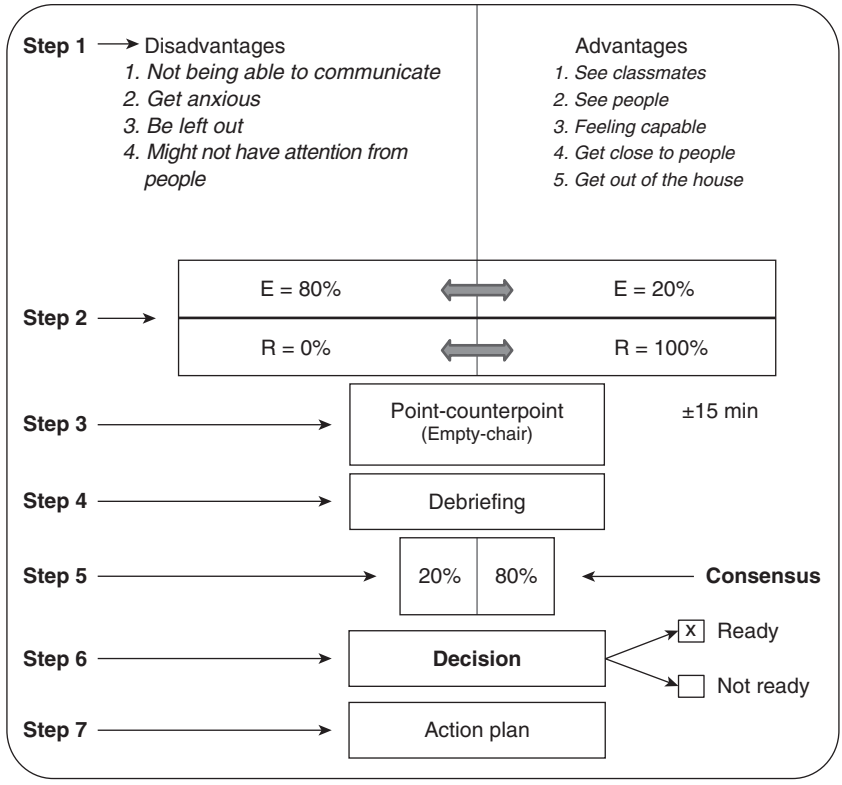


Figure 4.9 Leslie's CRP filled in during Session 4.

T: OK.
P: I might be left out.
T: Great! Anything else?
P: When I was in school, people didn't pay me a lot of attention.
T: So you fear that today this could happen again; that is, people might not pay you any attention. Why don't you write this down as a possible disadvantage?
P: People might not give me any attention.
T: Is this enough? Or is there anything else you would like to add as a disadvantage?
P: I think it's quite clear here.
T: Why don't we look now on the other side and you write down the advantages of going to this party, Leslie?
P: I can see my classmates again.
T: OK.
P: See people.
T: See other people, yes. Can you see other advantages for yourself in this process of going to the party today?
P: I can feel capable. Just the fact of going in itself would already be a victory. Regardless of what I could do there.

T: What else? Anything else?
P: I can get closer to people.
T: OK. Why don't you write that here?
P: Get out of the house.
T: Get out. This is something that you've had much difficulty with, isn't it?
P: Yes.
T: Is this enough?
P: Yes. I think it's good. I can see people again, see other people, I can feel capable, I can get closer to people, and get out of the house.

Step 2: Identifying Ambivalence by Weighing Advantages and Disadvantages According to the Rational and Emotional Selves

T: I'd like you to look at this question of advantages and disadvantages in the following way, Leslie. For example, at this time, what do you think carries more weight in your decision to go to the party: the disadvantages or the advantages?
P: I think the advantages do, Dr. de Oliveira.
T: When you say, the weight of the advantages is greater, are you thinking emotionally or rationally?
P: Rationally.
T: So, the advantages, rationally speaking, seem to weigh more. How much more? Sixty, seventy, eighty, ninety?
P: Rationally, I think the advantages of going to the party are 100%.
T: OK. Why don't you write here, 100%, regarding the advantages? And this means, therefore, rationally speaking, in terms of disadvantages, it is zero?
P: Right.
T: And emotionally, what seems to weigh more: the disadvantages or the advantages.
P: The disadvantages.
T: How much? Sixty, seventy, eighty, ninety, one hundred?
P: Emotionally, in terms of disadvantages, it must be around 80%.
T: OK. Why don't you write 80% there?
P: 80%.
T: This means that in terms of emotional weight, for the advantages, there is only 20% left. Can you write that down?
P: I understand now what you mean.
T: There seems to be a disagreement between what you think and what you feel.
P: Right.

Step 3: Resolving Ambivalence by Reaching a Consensus Between Rational and Emotional Selves with the Empty Chair Approach[1]

T: OK. What could we do then in order for reason and emotion to come to an agreement? Maybe we can continue a little more and you'll find out.

P: All right.

I: Good. Leslie, what I'll ask you to do now might seem a little weird, because I'm going to ask you to occupy three chairs. What I'll ask you to do now is to allow Leslie Reason and Leslie Emotion to talk with each other, while Leslie Consensus will pay close attention to this dialogue. Can you come to the Leslie Emotion chair? Therefore, probably, Leslie Emotion will be saying, "Look, Leslie Reason, you'd better not go to the party, because . . . " Why don't you continue?

P: Don't go to this party, Leslie Reason, because if you go, people won't treat you nicely. When you studied at that school, no one paid any attention to you.

T: OK. I hope you won't mind sitting in the other chair now. And I'd ask you then, while being Leslie Reason, for you to answer all that was said by Leslie Emotion now. We'll keep on with this dialogue for 10–15 minutes. Not less than this. Would you please sit over there? What does Leslie Reason answer?

P: Leslie Emotion, remember that you were a child, you behaved differently, maybe you didn't give people assistance or attention, maybe didn't talk so much with people. And now we are all adults. People are having this party for a reunion. They will treat you nicely.

T: OK. So you can use these same arguments that you wrote here in advantages and disadvantages, and keep going. So, you can see that the disadvantages are more on the emotional side, while the advantages are more on the rational one. Can you sit here and let your Leslie Emotion answer? How does she answer?

P: Leslie Reason, you will become anxious; you'll feel excluded, start feeling left out.

T: Sitting over there, what does Leslie Reason answer?

P: No, Leslie Emotion, you'll see people again, you can make friends, you're capable of carrying on conversations with people. Of course, if people invited you, this means that they want you to go. Your presence there matters to them. [Leslie Emotion replies] No, they don't care. They don't want to be near me; they never valued me. [Leslie Reason insists] Leslie Emotion, is it that they never valued you, or is it that you avoided them, you stepped back, you didn't give people the chance to be your friends? [Leslie Emotion replies] No, I don't think so. I think, in fact, people didn't like me; I'll feel left out at this party. I don't think the people wanted me to go to this party.

T: And what does Leslie Reason answer? Please, change your seat.

P: Leslie Emotion, people invited you too. Several people did. They might not have, but they did invite you. If they invited you, it's because they want to reunite with all the classmates. After all, the party is being set after 15 years. And people lead a different life now; they are more mature; they may want to know how you are, where you work, how your life is.

T: And Leslie Emotion, what does she say? Please, come to this chair.

P: But, if they meet me now, they will see that I am a failure, that I don't have many friends, that I don't have a boyfriend, that I don't have anyone.

T: And what does Leslie Reason answer?

P: [Changes chair] But Leslie Emotion, you've invested a lot in your professional life. You're a judicial analyst; you're important at the registrar's office. And you do so much there. You organize everything, the lawsuits; you make a big difference there. And now you are seeking help to improve your emotional side.

T: What does Leslie Emotion answer?

P: [Changes chair] I'm afraid. [Long silence]

T: Please, sit there. What does Leslie Reason say?

P: [Changes chair] You don't have to be afraid, Leslie Emotion. You can manage. Another thing, you can go to the party, and you can get there at the beginning. Because, in the beginning, the people who get there are the ones who will speak with you. You won't have to talk with people before that.

T: What does Leslie Emotion answer?

P: [Changes chair] Right. If I really get there earlier it'll be easier. I can sit down. I can look for a place to sit where it's more pleasant, or that will help me be more outgoing. This is a good idea: I can go early.

T: OK. So, maybe Leslie Reason could still present a few arguments to Leslie Emotion?

P: [Changes chair] Yes. Leslie Emotion, you can go to the party. You can feel calm. And you can set that you'll stay one hour at the party. And, in one hour, you need to talk with some people. If you feel good, you'll stay there; if you don't feel good, you'll think and evaluate why you're not feeling good. And, who knows, if you don't feel good (and you will feel good, yes), you can act as if you were feeling good, so you can feel less anxious.

T: What does Leslie Emotion answer?

P: [Changes chair] Maybe this is a good idea. Maybe I could go to the party. And maybe I can observe and be happy just from the fact that I attended the party. And if I don't go, I'll feel excluded like I always do.

T: OK. So what does Leslie Reason say, finally?

P: [Changes chair] You'll go to the party and there's a big chance that it'll end up fine. The objective is to go to the party. Everything will be all right. There, you'll manage to express yourself. Talk. As little as it may be, this will already be a good result.

Step 4: Debriefing Previous Steps and Assessing What Was Learned

T: OK. Let's stop now. Look here, the first thing I'd ask you to do (and what was done here was exactly this, you got Leslie Reason to speak with Leslie Emotion) is that you go to the Leslie Consensus chair and assess the impact and the importance of the advantages and disadvantages regarding the decision to go to the party. What have you learned here as Leslie Consensus? What evaluation can you make from this dialogue between Leslie Emotion and Leslie Reason?

P: What I learned from this dialogue was that if I go to the party, I won't lose very much. And I don't have to feel left out, unless I isolate myself. And I can

go earlier to feel more at ease, and that people may talk with me, and it can go well; I can also find out how everybody is. And it will come out all right, because I will see people again and they want to have the reunion.

Step 5: Assessing the Consensus Between Rational and Emotional Selves

T: It seems to me that they reached a consensus. If this is true, where is the greater impact? Here, without thinking in terms of emotion or reason, but simply what you, Leslie Consensus, consider . . .
P: Advantages. The advantages of going to the party have the greater impact.
T: How much would you put for the advantages here: sixty, seventy, eighty, ninety?
P: 80%.
T: 80%. This means that, for Leslie Consensus, 80% was given to advantages and 20% to disadvantages, right? Therefore, there is a tendency toward this.
P: Yes.

Step 6: Making the Decision

T: OK, Leslie, this was what you learned from this exercise. So, this is the moment to make the decision, and remember, you're not obliged now to make the decision to go. The question I ask you now is, Are you ready to make the decision? And the decision might be to go or not to go. You're free to do this according to what you really learned here. Are you ready to make this decision?
P: Yes, yes.
T: And what decision do you make in this case?
P: I'll go to the party.
T: OK. Great, great! How much do you believe this?
P: I believe it 90%.

Step 7: Helping the Patient Maintain the Decision with an Action Plan

T: This is really a strong thing and I'm happy that you've reached this conclusion, even knowing that this decision involves a dark gray symptom [4], something distressing for you, right? Could you, by any chance, have doubts and go back on your decision? It's extremely important to know this, because it might be worth it to devise an action plan now, in order to maintain this decision.
P: Dr. de Oliveira, I'm quite set on going to the party.
T: OK, great! So, you don't have any doubts about this. Maybe we could devise an action plan to help you maintain this decision and function at the party. What do you think?
P: That's great!
T: I'd like to propose this action plan for you. It can be done on several levels. First, to go to the party, which steps must you take in this regard? You have

several items: one of them is the plan itself, which involves the actions to be implemented; there is an item where you can write down the problems and obstacles that might happen; another one where we can predict some strategies and solutions if you anticipate obstacles; another one setting the schedule for implementation of the actions; and a final one to follow up the results.

P: Yes.

T: Shall we do this now? What are the actions in this action plan that you should take? What do you need to do? You have the letters *a, b, c, d* for each action, but you can add more letters (Fig. 4.10).

P: First, know where the house is, because it is in the suburbs. [**1a**]

T: OK.

P: Go to the party early—because the reunion is set for 7 p.m.—and I would not like to be late. I'd like to be there at 6:30 p.m. [**1b**]

1. Proposed actions:
- a. *Know where the house is*
- b. *Arrive at 6:30 pm*
- c. *Talk to my classmates*
- d.

2. Possible obstacles to actions:
- a. *None*
- b. *Get lost*
- c. *Anxious; sweaty hands; people might ask questions about my job and family*
- d.

3. Solutions to obstacles:
- a. *Google search*
- b. *Leave early*
- c. *Give short answers; ask questions about themselves*
- d.

4. When to implement the proposed actions:
- a. *This afternoon*
- b. *Tonight*
- c. *Tonight*
- d.

5. Follow-up:
- a. *Done*
- b. *Done*
- c. *Done*
- d.

Figure 4.10 Leslie's action plan.

T: Anything else? What do you plan to do there during the reunion?
P: I could try to socialize, talk with my classmates. I haven't seen them for many years. [**1c**]
T: Can you write this down? What else? Any other action?
P: No, that's it. But I'm worried about the party itself.
T: OK. I see you anticipate problems. What are the problems that could happen? We also have the corresponding letters *a, b, c, d* for this. What difficulties do you anticipate regarding knowing where the house is?
P: None. [**2a**]
T: And about going to the party early?
P: I get insecure about driving through places that I don't know yet. I could get lost. [**2b**]
T: Please, write it down here.
T: And about socializing, talking with your classmates?
P: This is the difficult part. Besides being anxious and have my hands sweaty, people might not talk to me very much. [**2c**]
T: This is what you anticipate could happen at the party, right? And you already predict that this would bother you a lot. What other problems do you anticipate? Anything else?
P: The real problem is when I will be there, anxious, and not knowing what to say to people.
T: What do you fear the most?
P: They will ask questions about my job and will want to know if I'm married or have children. They will know I didn't do well in my life. [**2c**] These are the problems I anticipate, and they already make me anxious right now.
T: Maybe we could find the solutions for these obstacles right away. What do you think?
P: Yes, I'd like that.
T: I see you don't anticipate any problem regarding the item *1a,* finding where the house is.
P: No, this is easy. A Google Maps search will help me. [**3a**]
T: Do you have anything that you already anticipate as a strategy to solve the obstacle: difficulty in finding the house or not getting lost?
P: A Google Maps search can also help me. I can print the map and follow it carefully. Regarding the other problem, the risk of arriving late because of the rush, I can solve it easily too. I will leave before the rush and will try to get there even before 6:30 pm. [**3b**]
T: We will have time to test all these thoughts, Leslie. But, by now, may I suggest a strategy to help you regarding this obstacle?
P: Yes, I'd really like that!
T: What about giving short answers, and asking questions about their lives? [**3c**] People usually like to talk about themselves, don't you agree?
P: Yes, I can do that.
T: Great. Therefore, having made this plan now, how do you evaluate it?
P: It will help me a lot.

Summarizing Session 4

T: OK. So, Leslie, it seems to me that, in terms of the agenda, we've covered practically everything today. Could you give a summary of everything we've seen so far?

P: Once more I thought it was interesting because we could see the CD-Quest. And also I saw my greatest needs—the ones that make me more anxious—and my desire to go to the party, to expose myself to the situations that bring me anxiety. And so, these techniques that you showed me today, the CCSH and the CRP, which I thought were very important because I was able to understand that part of me feels that it's easy, and another part of me feels that it's difficult. We were able to do the consensual role-play, where reason helped emotion to see that, in fact, going to the party would bring many more advantages than disadvantages. It was also interesting because we evaluated the situation, and I said I felt at ease because you didn't set the decision as an obligation.

T: Great.

P: You gave me the alternative of choosing and finding the best option. And we made the action plan that helped me broaden it a lot . . .

T: It seems to increase the odds of your managing not only to go but also of feeling good there. Let me just add to this excellent summary that you gave, Leslie, what we are looking at here, which is our cognitive conceptualization diagram. We've seen it several times (this one here), and so, in order to begin working at this second level, what we observed was that the assumptions you saw, of the type, "if I do such and such a thing, something will happen," also appear to influence these thoughts. Normally, while we change the assumptions and rules, it seems that you give yourself a chance to change, as well, the behaviors we call safety behaviors. For example, I don't know if you can see it: if you go to the party, you'll be, who knows, giving yourself a chance of changing this over here? [The therapist shows the second level of the conceptualization diagram.]

P: Right, right. For sure.

T: And if this happens, maybe you'll see that this second level will influence and help to change this. [The therapist points to the automatic thoughts box]. Is this how you see it?

P: Exactly, Dr. de Oliveira. That's right.

Assigning Homework and Concluding Session 4

T: OK. It appears that today's task, shall we say, comes down to this experiment of your going to the party. To balance this, our earlier experiment, the task of having the distortion sheet, I'll ask you to fill in three Intra-TRs: is that all right?

P: Yes.

T: Fine. Another possibility is exactly for you to write down some of these thoughts that came to mind in this experiment of attending the party today, and pay attention according to the distortion sheet.

P: OK.
T: Is that clear to you?
P: Yes, I understand it. And I think it'll help me a lot, Dr. de Oliveira.
T: All right. What feedback can you give me today? How was this session for you?
P: Dr. de Oliveira, I really liked it. Especially this technique you call consensual role-play. It made me feel more secure to attend the party, after we came to a consensus between my rational and emotional sides. I saw that there are many more chances of everything coming out fine than what I first thought about things not happening, that it was better to have a safety behavior. And then I also noticed that, as I change these strategies and behaviors, I can look at the social situations in a different way.
T: OK. This makes me really happy. I'm content. I'll be extremely curious to know how you'll be next week, all right?
P: Thank you, Dr. de Oliveira.

Note

1. *The patient moves from one chair to the other to role-play "reason," "emotion," and "consensus."*

5 Changing Negative Core Beliefs with Trial I

Outline

- Introduction
- Introducing the Third Level of Cognition to the Patient
- Description of the Trial-Based Thought Record (Trial I) Technique
  - *Step 1: Investigation (Table 5.1, Column 1)*
  - *Steps 2 and 3: Prosecutor and Defense Attorney's First Pleas (Table 5.1, Columns 2 and 3)*
  - *Step 4: Prosecutor's Second Plea (Table 5.1, Column 4)*
  - *Step 5: Defense Attorney's Second Plea (Table 5.1, Columns 5 and 6)*
  - *Step 6: Jury's Verdict (Table 5.1, Column 7)*
  - *Step 7: Preparation for the Appeal (Table 5.2)*
- Possible Obstacles to the Trial's Optimal Use

Case Illustration Dialogue

- Bridge from Session 4 and Setting the Agenda
- Reviewing Questionnaires
- Introducing CBs and Trial I While Working on the Main Agenda Item
  - *Step 1: Investigation (Table 5.3, Column 1)*
  - *Step 2: Prosecutor's Plea (Table 5.3, Column 2)*
  - *Step 3: Defense Attorney's Plea (Table 5.3, Column 3)*
  - *Step 4: Prosecutor's Second Plea (Table 5.3, Column 4)*
  - *Step 5: Defense Attorney's Second Plea (Table 5.3, Columns 5 and 6)*
  - *Step 6: Jury's Verdict (Table 5.3, Column 7)*
  - *Step 7: Preparation for the Appeal (Table 5.4)*
- Assigning Homework
- Summarizing
- Reviewing the CCD
- Concluding Session 5

Introduction

Several techniques have been developed to change dysfunctional core beliefs (CBs).[1] The trial-based thought record (TBTR; de Oliveira, 2008, 2011c) or, in short, "trial I," presented in this chapter was also developed to change CBs, and received its name for two reasons: On the one hand it involves a simulation of a court trial, and on the other hand, it was inspired by the work of the same name, *The Trial*, by the Czech writer, Franz Kafka (1925/1998). In Kafka's novel, the character, Joseph K., is arrested, convicted, and executed without ever being told for which crime he was accused (de Oliveira, 2011b).

It is possible that Kafka's intention was to propose self-accusation as a universal principle (de Oliveira, 2011b), which is often implicit and not conscious. Thus, it does not allow for an adequate defense. In cognitive therapy, such a self-accusation can be understood as the manifestation of an active negative CB. Therefore, the rationale for developing trial I would be to foster awareness on the patients' part of negative CBs regarding themselves. Thus, unlike what happens to Joseph K., the purpose of trial I is to stimulate patients to develop more positive and helpful CBs throughout the therapy.

A number of techniques used in CBT and other approaches, organized in a structured format and sequence, were incorporated in trial I: downward arrow (Beck, 1979; Burns, 1980; de Oliveira, 2011a), examining the evidence (Greenberger & Padesky, 1995), defense attorney (Freeman & DeWolf, 1992; Cromarty & Marks, 1995; Leahy, 2003), thought reversal (Freeman & DeWolf, 1992), upward arrow (de Oliveira, 2011a; Leahy, 2003), developing a more positive schema (Leahy, 2003), positive self-statement logs (J. S. Beck, 2012), and the empty-chair approach (Carstenson, 1955). Figure 5.1 illustrates how the chairs used by the therapist and the patient are placed during the trial I session.

Introducing the Third Level of Cognition to the Patient

The following extract of a session[2] and Figures 5.2 and 5.3 show how the third cognitive level is introduced to the patient.

T: Maria, at these times that you are thinking of this—that is, in how to talk to your husband about this, or even the issue of maybe disappointing him—what are the thoughts and ideas that have gone through your mind?
P: First, that I will disappoint him.
T: "I'll disappoint him." Has anything else gone through your mind about this?
P: He's going to think that I'm not that strong woman he met years back.
T: So he'll think that you aren't that strong woman he once knew.
P: Right.
T: And, if it's true (only when we start from the principle that this thought may be true), what does this mean about you?

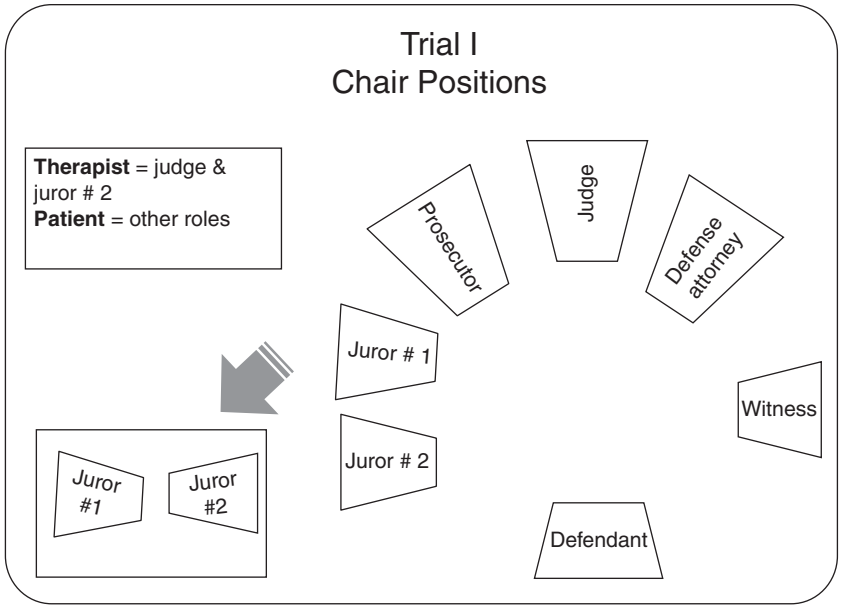


Figure 5.1 Suggested chair positions during trial I.

P: That in fact I am not strong anymore. I am weak.
T: OK. Is this an idea that goes through your mind once in a while?
P: Yes! Every time I think about the idea of leaving my position as a teacher, I get this idea that I'm being weak, that I could keep on trying . . .
T: That's interesting, Maria, because we have talked a lot during therapy, and since the beginning (when I showed you this psychotherapy model), you could see this cognitive conceptualization diagram that seems to have helped. And what is interesting is that many of these automatic thoughts that I explained to you, and that are at the first level, are often the result of the idea you have of yourself, of how you see yourself as a person. Do you remember what we call this?
P: Core belief.
T: Yes, core belief, you remember well. If we were to put this down as an activated core belief, and wrote down here "I'm weak," would this make sense to you? Can you see this as this arrow going up here [the therapist points to the arrow in the CCD], nurturing the automatic thoughts?
P: That makes sense.
T: Would it be worthwhile for us to work on this idea a bit, this concept of yourself that you are presenting here, which seems to return every now and then?
P: Yes.

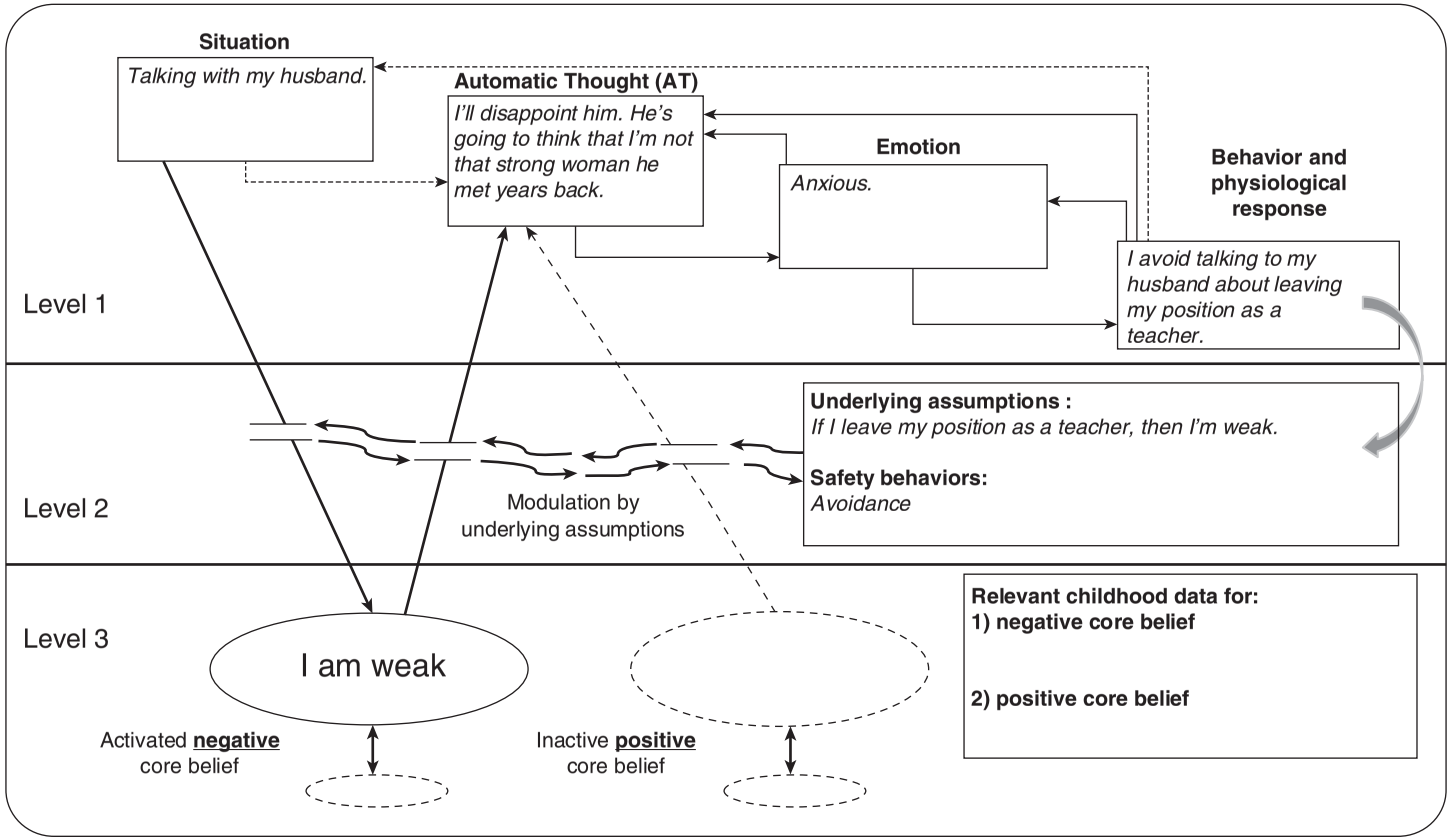


Figure 5.2 Cognitive conceptualization diagram (CCD) showing activation of the negative core belief "I'm weak" in level 3 by the situation "Talking to my husband."

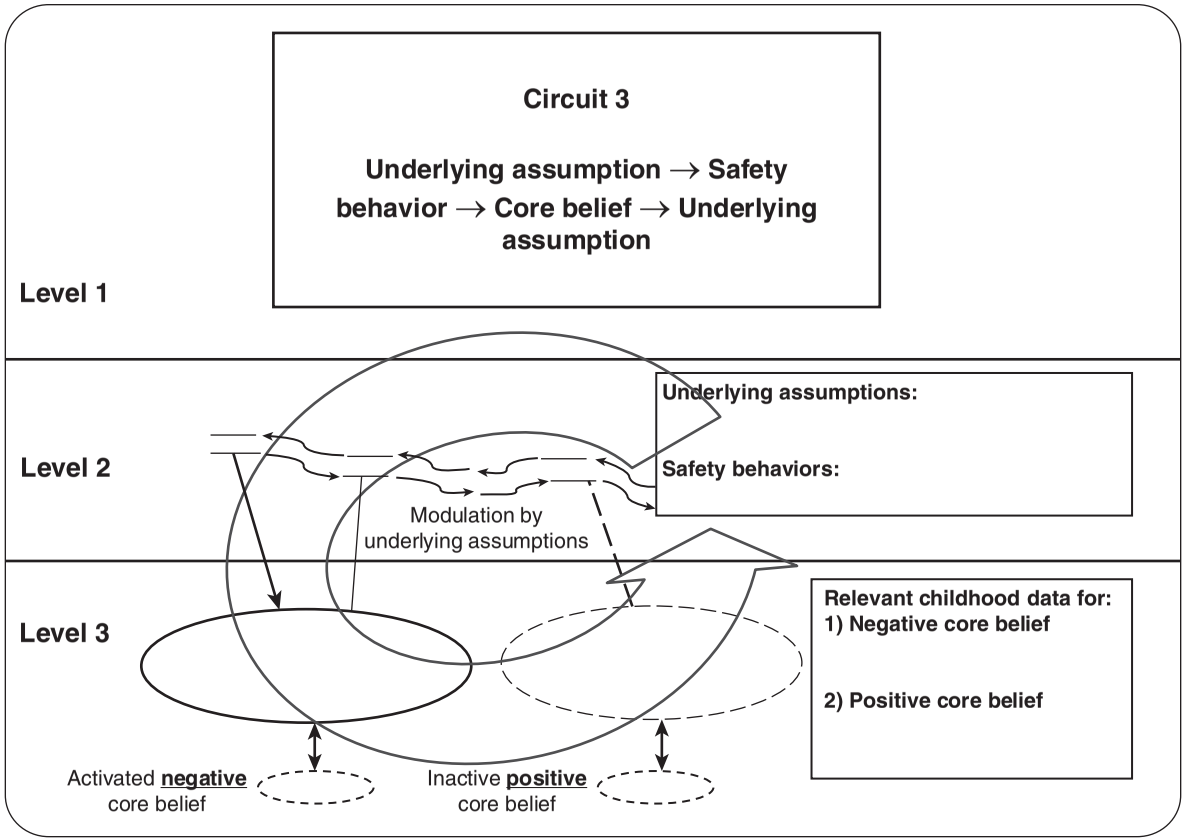


Figure 5.3 Cognitive conceptualization diagram (CCD) showing circuit 3, composed of the underlying assumption, safety behavior, and core belief.

Description of the Trial-Based Thought Record (Trial I) Technique

Step 1: Investigation (Table 5.1, Column 1)

First, the patient presents an uncomfortable situation or problem, usually corresponding to the main item on the agenda. The therapist asks what goes through the patient's mind when she observes a strong feeling or emotion. This stage of trial I is designed to track the automatic thoughts (ATs) connected to the emotional state presented by the patient and is recorded in column 1. To uncover the active negative CB (or one to be activated) responsible for the ATs and the current emotional state, the therapist uses the downward arrow technique (Burns, 1980; de Oliveira, 2011a). For instance, the therapist might ask what the ATs that were just communicated mean about the patient, assuming that they were true. The answer, normally expressed as "I am . . . " sentences, corresponds to the activated negative CB. In the example shown in Table 5.2, the patient expressed the belief "I am weak." The therapist then explains that column I of Trial I is similar to an investigation or inquiry and aims at uncovering the accusation (in this case, self-accusation) expressed as a negative CB. The therapist then asks how much the patient finds this belief to be true and what emotion(s) she feels. The percentages indicating how much the patient believes the negative CB and the corresponding emotion intensity are written down in the lower part of column 1, in the space where one reads "Initial." The space where one reads "Final" is to be filled in when the session is over, after the completion of the "Preparation for the appeal," and the activation of the positive CB (e.g., "I'm strong").

The credit the patient gives to the negative CB and the intensity of the corresponding emotion are recorded in the lower part of all the columns (with the exception of column 5).

Steps 2 and 3: Prosecutor and Defense Attorney's First Pleas (Table 5.1, Columns 2 and 3)

In columns 2 and 3, the patient places the information that supports (column 2) and also the information that does not support (column 3) the negative CB. Column 2 expresses the prosecutor's performance, where the patient presents all the evidence supporting the negative CB, articulated as a self-accusation. Here, the patient tends to produce cognitive distortions, rather than evidence. It is essential that the therapist not correct the patient in this case, because later on, during the jurors' phase (column 7), the patient will observe that the prosecutor produces mostly cognitive distortions rather than evidence. Also, the information collected and recorded in column 2 has the purpose of making evident the internal arguments that the patient uses to support the negative CBs.

Column 3 brings the defense attorney's plea; here the patient is actively encouraged to identify the evidence not supporting the negative CB. When the

therapist notices that the patient is expressing opinions, rather than evidence, he might subtly recommend that the patient give fact-based examples.

Step 4: Prosecutor's Second Plea (Table 5.1, Column 4)

Column 4 is the prosecutor's reply to the defense attorney's allegation, and is devoted to the "yes, but . . . " thoughts that the patient uses to disqualify or discount the evidence or fact-based thoughts expressed by the defense attorney in column 3, causing them to have less credit. In the example illustrated in Table 5.1, by using the conjunction "but," the therapist actively stimulates the expression of other dysfunctional ATs that maintain the negative emotional reactions and dysfunctional behaviors presented by the patient. The mood of the patient usually goes back to the level she presented in column 2, during the prosecutor's first plea.

Step 5: Defense Attorney's Second Plea (Table 5.1, Columns 5 and 6)

Columns 5 and 6 are the crucial aspects of this technique. In column 5 (defense attorney's response to the prosecutor), the patient is guided to invert the propositions of columns 3 and 4, once again connecting them with the conjunction "but." The therapist reads each sentence in column 4, adds the conjunction "but," and asks the patient to connect it to what was said by the defense attorney in column 3, copying it after the conjunction "but." The purpose is to cause the patient to reduce the force of the ATs by changing the situation's perspective to a more positive and realistic one. The patient is stimulated to record the new meaning in column 6, which is now positive. The therapist encourages the patient to go further by adding the adverb "therefore" and completing its meaning. As an example, in the dialogue between the therapist and Leslie (when she was playing the role of the defense attorney), after the therapist read, "She (Leslie) is anxious (column 4), but . . . ," Leslie came up with "At the party she acted in a normal manner" (column 3), which is copied in column 5. Then, she added in column 6: "She can act calmly; therefore, there is no reason for her to be afraid of rude lawyers."

Step 6: Jury's Verdict (Table 5.1, Column 7)

This is the analytical part of trial I and has the form of a jury's deliberation. Although many questions may be answered by the patient as juror number 1 (e.g., Who was most consistent? Who was most convincing? Who used more fact-based information? Was there intent on the part of the accused?), the main question to be considered is, Who made the least cognitive distortions? After the patients identify the cognitive distortions made by the prosecutor and notice that the defense attorney made no cognitive distortions, the patients acquit themselves of the accusation in virtually all cases.

Table 5.1 TBCT form (trial I)

Please, briefly describe the situation:

1. **Inquiry/Establishing the accusation (core belief).** What was going through your mind before you started to feel this way? Ask yourself what these thoughts meant about yourself, supposing they were true. The answer *"If these thoughts were true, it means I am . . ."* is the uncovered **self-accusation** (core belief).	2. **Prosecutor's plea.** Please, state all the evidence you have that **supports** the accusation/core belief that you have circled in column 1.	3. **Defense attorney's plea:** Please, state all the evidence you have that **does not support** the accusation/core belief that you have circled in column 1.	4. **Prosecutor's rebuttal to the defense attorney's plea.** Please, state the thoughts that question, discount, or disqualify each piece of positive evidence in column 3, usually expressed as "yes, but . . ." thoughts.	5. **Defense attorney's rejoinder to the prosecutor's plea.** Please, copy each thought of column 3, connecting them with the conjunction BUT, after reading each sentence in column 4. **Note:** columns 5 and 6 are filled in at the same time.	6. **Meaning of the response presented by the defense attorney to the prosecutor's plea.** Please, state the meaning you attach to each sentence in column 5.	7. **Juror's verdict.** Please, report cognitive distortions made by the prosecutor and the defense attorney and give the verdict.
Downward arrow technique: *If the thoughts above were true, what would they mean about you?* ↓ *I am*_____	*1)* *2)* *3)* *4)* *5)* *6)*	*1)* *2)* *3)* *4)* *5)* *6)*	**But . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**But . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**It means that . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**Cognitive distortions:** **Prosecutor 1** / **Defense 1** 1: / 1: 2: / 2: 3: / 3: 4: / 4: 5: / 5: 6: / 6: **Prosecutor 2** / **Defense 2** 1: / 1: 2: / 2: 3: / 3: 4: / 4: 5: / 5: 6: / 6: **Verdict:**
Now, how much (%) do you believe you are _____? **Initial:** **Final:** What emotion does this belief make you feel? _____ How strong (%) is it? **Initial:** **Final:**	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%		Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____now? _____%

Step 7: Preparation for the Appeal (Table 5.2)

Columns 6 and 7 of Table 5.1 allowed the patient to uncover or to activate the positive core belief, made possible by the positive meaning brought by the defense attorney. Thus, the therapist used the upward arrow technique (de Oliveira, 2007, 2011a), as opposed to the downward arrow technique (Burns, 1980) used in column 1. For this purpose, he asked, "Supposing that the defense attorney is right, what does this say about you?" In the example of Table 5.3, the patient brings up the new positive CB "I am normal."

Table 5.2 is the record that the patient will be asked to fill in during the session and to continue to fill it in as homework, being encouraged to gather on a daily basis, during the week, the facts, elements, and pieces of evidence that support the uncovered positive CB. This homework is assigned as a preparation for the appeal requested by the prosecutor when the patient acquits herself of the accusation, or rarely, it is demanded by the defense attorney, when the patient does not consider herself innocent. In this form, the patient also indicates on a daily basis how much she finds the new CB to be true in percentages.

The essential feature at this stage is that the patient take time outside the session to focus on the events that support the positive CBs, implying that the defense attorney is the one chosen as an ally, regardless of whether or not the patient has been considered innocent at the end of each trial I.

Table 5.2 Preparation for the appeal (one-belief form)

Positive new core belief: I am _____ (Please, write down here at least one piece of evidence supporting the new core belief. Also, write how much you believe it, daily, in the space between parentheses).

Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.
Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.
Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.
Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.

Possible Obstacles to the Trial's Optimal Use

In order to allow the trial-based thought record (TBTR or Trial I) to work optimally, therapists should act in a way to prevent the following obstacles:

- Sentences written by the therapist should be short so that the patient has no difficulty in understanding them after sentence reversal. A good strategy is to allow the patient to talk freely, but ask her to summarize what has just been said in a short sentence.
- The defense attorney's arguments should not be exclusively limited to responding to the prosecutor's arguments, because this would limit the patient's view of her positives; thus, during the defense attorney's plea, the therapist will encourage the patient to explore aspects other than those explored by the prosecutor.
- If the therapist does not succeed in finishing trial I during one session, he is encouraged not to interrupt trial I just after the prosecutor's plea; he should always end the session after the defense attorney's plea so that the patient can leave the therapy session feeling better than when she arrived.
- If the patient is not considered innocent at the end of a trial, which is an extremely rare event with experienced trial-based cognitive therapists, this should not be a problem, because the defense attorney then asks for an appeal. In this case, trial I should be repeated in the following session as an appeal regarding the same accusation/CB; homework will consist of the patient gathering evidence supporting the positive CB.
- Sometimes, during the trial, the prosecutor interrupts the defense attorney with "yes, but . . . " statements derived from negative ATs; the therapist should interrupt the patient and say that the prosecutor must wait for his or her turn. The therapist does this looking at the chair used by the prosecutor, now empty. Conversely, if the patient uses the defense arguments when role-playing the prosecutor, the therapist should also tell her, but gently, that this is the prosecutor's turn and that the defense attorney should wait for his or her turn.
- On some occasions, the negative CB is so strongly activated that, after reversal of the sentences, the patient does not succeed in seeing or admitting the positive side shown during the second defense attorney's plea at the time when she is looking for the meaning of the reversed sentence. Here, the therapist should ask her, "Who is speaking now?" Usually, the patient recognizes that the prosecutor is the one acting. The therapist turns to the empty chair supposedly occupied by the prosecutor and commands her to be quiet; then, he gently asks the patient (now role-playing the defense attorney) for the meaning of the reversed sentence in the defense attorney's perspective, reminding her that the defense attorney's commitment is to the accused.
- Sometimes, the patient does not find any evidence or argument as a prosecutor against the defense attorney's plea after the therapist reads the sentence and says "but . . . " Here, the therapist draws a line leaving an empty

space and, when reversing the sentences, copies what was stated by the defense attorney in the first plea and asks the patient for its meaning.

- Finally, in some severe axis I and some personality disorder patients, even when the defense attorney is repeatedly successful in acquitting the patient, self-accusations return, meaning that the CB is frequently and easily active; in this case, the therapist should use the trial-based metacognitive awareness (TBMA or trial II, described in Chapter 10 in this manual) technique. In this case, the patient sues the prosecutor, accusing her of incompetence (never won a lawsuit), abuse (pursues the patient everywhere), and harassment (humiliates the patient). Results tend to be more durable after trial II. In this step, the patient is trained to distance herself (metacognition) from her thoughts and beliefs. The prosecutor has much less or no more credibility for the patient at this stage of the therapy.

CASE ILLUSTRATION DIALOGUE

Bridge from Session 4 and Setting the Agenda

T: Hi, Leslie.
P: Hi, Dr. de Oliveira.
T: So, how was your week?
P: This week hasn't been very easy.
T: It appears that something unpleasant happened, is that it? Is it anything to do with the last session or the class reunion?
P: Two situations occurred that made me feel very anxious.
T: OK.
P: And last week I felt much more encouraged because I had gone to the party and everything had gone well. That guy had left me a message, John, and then he disappeared.
T: OK, so . . .
P: And so I started thinking that I'm ugly, and that I'm strange, that there's something wrong with me.
T: Shall we put this on our agenda then, for us to discuss now?
P: Sure.
T: Do you mind if we start going over the homework and the questionnaires, before working on the agenda items?
P: All right.
T: Tell me a little about what happened in terms of the experiments. Is this something you would like us to put aside, or . . . ?
P: No, it's fine, Dr. de Oliveira, the experiments worked. I asked some questions to unknown people and it wasn't so hard, and I felt less anxious about this. I also talked with a group of strangers, although during the conversation I started thinking I was strange, because a co-worker of mine commented on my clothes. So there were two situations that made me think I was strange, ugly . . .
T: Are you suggesting this for the agenda? First, there is the subject involving the fact that John didn't appear, is that it?

P: Yes.
T: And the other thing . . .
P: My co-worker commented on my clothes, as if I was wearing very old-fashioned clothes, you see?
T: And this made you think you were strange, right? OK, let's put this on the agenda.
P: Right. When I succeeded in going to the party, I began feeling better. I began to feel happy, I started to trust myself more, but then all this happened and everything started over again.

Reviewing Questionnaires

T: I'm looking over what you filled out earlier, the CD-Quest, and I'm under the impression that there actually was a small increase, wasn't there?
P: Yes, there was.
T: Which cognitive distortions did you notice?
P: Look here, Dr. de Oliveira, the mind reading. I started thinking that everybody thinks I'm ugly, strange. And I also think that things happen because of me: personalizing. So, when something goes wrong, I think it is my fault, I think that other people are more interesting than me.
T: And what did you notice regarding your anxiety? Do you see that the anxiety score increased?
P: Yes, I do.

Introducing CBs and Trial I While Working on the Main Agenda Item

T: OK. Well, Leslie, I have a new proposal for you today, and we are going to focus on our agenda. I propose that we take advantage of these events that occurred here. So, shall we turn to our cognitive conceptualization diagram? [Therapist shows the CCD to the patient.] I don't know which situation you would choose for us to work with now: the one of John or the one of your co-worker?
P: The situation of John. John didn't look me up anymore.

Step 1: Investigation (Table 5.3, Column 1)

T: Leslie, can you write this down here, "John didn't look me up anymore"? During the time that John did not look you up, what was going through your mind?
P: No one is interested in me.
T: Consequently, how did you feel?
P: I felt anxious.
T: And what did you do?
P: I started isolating myself more.
T: Let me ask you something, Leslie. Supposing that these thoughts are true, what do they mean about you?

P: That no one is interested in me, that I really am strange.
T: OK. So why don't you write exactly that here? I have the impression that you have just activated a core belief, which is "I am strange;" isn't that right?
P: Right.
T: Would this come as a type of accusation that you are charging yourself with?
P: That's right.
T: I would like to propose a technique for us to work with, in order for you to check whether this concept that you have of yourself now is true or not.
P: All right.
T: We don't know beforehand. And maybe it's important for you to check this out. Leslie, this may seem odd to you, but you will understand why in a minute. I will ask you to sit in this chair and be yourself. Please, sit here in the chair in front of me. [Patient goes to the defendant's chair.] Now, how much do you believe this, "I'm strange"?
P: 100%.
T: And how strong is your anxiety?
P: Also 100%.
T: Can we consider this as a self-accusation? What if we used this as a metaphor, and transformed this into a legal trial? You will be able to put yourself on the stand, so to speak, in order to decide whether or not you are strange. Sure, you believe this 100%. It's as if you had two characters inside you, and one is accusing you. Right now, it appears that this one is dominating, correct?
P: Yes.

Step 2: Prosecutor's Plea (Table 5.3, Column 2)

T: If we took the trial into consideration, which person would this character be?
P: Are you speaking about lawyers, these things?
T: Exactly. In that case, while you accuse yourself of being strange, who would this character be?
P: A prosecutor?
T: Exactly. Do you see this empty chair at my side?
P: Yes.
T: I would like to ask you to imagine the person who accuses you. Can you describe this person to me? Is it a man, a woman? What is he or she wearing? Can you tell me how he or she looks at you?
P: I see a woman who is wearing a black dress and looks at me with a severe gaze.
T: Now I will ask you to sit in this other chair here and be this person. [Leslie changes chairs.] How about stating the reasons that you put in motion, for us to know which arguments you use to say that Leslie is strange? What arguments do you have, Mrs. Prosecutor, to hold this up?
P: John didn't look her up.
T: OK.

P: Guys don't flirt with her.
T: Right.
P: Anna, her co-worker, said that she dresses in a strange way.
T: Yes.
P: She gets nervous in front of people.
T: OK.
P: Her hands sweat a lot.
T: Sweaty hands. It seems to me that you have several pieces of evidence that indicate that Leslie is strange; isn't that right?
P: Yes.
T: Would this be enough, or do you want to add any other element?
P: She's never had a boyfriend.
T: OK. I would like you to go back to that chair over there and be Leslie, the defendant. [Waits for her to sit in the defendant's chair] It seems to me that the prosecutor has several pieces of evidence that indicate that you are strange; isn't that right? While you have all these elements placed very clearly here by the prosecutor, who brings all these elements she has just presented to us—saying that John didn't look you up, guys don't flirt with you, Anna said that you dress in a strange way, you get nervous in front of people, your hands sweat a lot, and you have never had a boyfriend—how much do you believe this, "I'm strange"?
P: 100%.
T: Believing this 100%, how does it make you feel?
P: This makes me feel very anxious.
T: How anxious do you feel?
P: 100%.

Step 3: Defense Attorney's Plea (Table 5.3, Column 3)

T: Leslie, when you have this kind of self-accusation that we call core belief—which was already explained to you—do you sometimes give yourself the chance to mobilize an internal defense? If we continue to simulate a legal trial here, and we call upon your internal defense attorney, what would he or she say regarding this, "I am strange"? Please, look at this other chair here. I would like to ask you to imagine the person who defends you. Can you describe this person to me? Is it a man or a woman? What is he or she wearing? Can you tell me how he or she looks at you?
P: It is also a woman. She seems to be a nice woman and looks at me tenderly.
T: Please, come to this other chair here where the defense attorney is placed. I'd like you to be this person, your defense attorney. [Waits for her to sit in the defendant's chair] Can you bring the arguments in Leslie's defense?
P: All right. Leslie passed a qualifying exam.
T: Hmmmmm . . .
P: At the party, some guys flirted with her.
T: OK.

P: There are people at work who think she's efficient.
T: Yes . . .
P: At her job, some people prefer to have her assisting them.
T: OK.
P: At the party, she acted in a normal manner.
T: Any other argument?
P: She does the same things as other people do.
T: Great! Do you have any other evidence?
P: No, that's enough.
T: Can you go back to Leslie's chair? [Waits for her to sit in the defendant's chair] Leslie, listen to what the defense attorney says about you: you passed a qualifying exam; at the party, some guys flirted with you; there are people at work who think you're efficient; at your job, some people prefer to have you assisting them; at the party you acted in a normal manner; and you do the same things as other people do . . . When you listen to this from the defense attorney, how much do you believe this accusation, "I'm strange"?
P: Sixty percent.
T: And what happens to your anxiety?
P: It falls to 50.
T: OK, good! . . . Very good! Leslie, do you notice that depending on how you see this, either from the point of view of the prosecutor or the defense, you believe this accusation more, or you believe it less?
P: Yes, I do.

Step 4: Prosecutor's Second Plea (Table 5.3, Column 4)

T: What do you think will happen when you leave here? Will the prosecutor keep quiet or will she continue to bother you?
P: I think she will bother me.
T: And this is exactly why here, in this metaphor, we give the prosecutor a chance to speak again; that is, to give a retort, right? It seems that, strictly speaking, the prosecutor has already used all the arguments she has. So what will she probably do?
P: She will discount what the defense attorney said.
T: Is this what you normally do?
P: Yes.
T: And this usually happens by way of the conjunction "but;" isn't that right? Do you use this conjunction much?
P: I do.
T: OK, please, will you return to the prosecutor's chair? [Waits for her to sit in the prosecutor's chair] Let's take a look at this: "She passed the qualifying exam, but" . . .
P: A whole bunch of people pass.
T: "At the party, some guys flirted with her," but . . .

P: John didn't look her up any more.
T: "There are people at work who think she's efficient," but . . .
P: There are others who pay little attention to her.
T: "Some people prefer to have her assisting them," but . . .
P: Maybe this happens because she doesn't say no.
T: "At the party, she acted in a normal manner," but . . .
P: She's anxious.
T: "She does the same things as other people do," but . . .
P: She doesn't do other important things.
T: Can you please go back to Leslie's chair? [Waits for her to sit in the defendant's chair] While you listen to the prosecutor saying that a whole bunch of people pass the qualifying exams, that John didn't look you up any more, that people pay little attention to you, and that people prefer to have you assisting them because you don't say no, how much do you believe you're strange?
P: 90%.
T: So then it increases, right?
P: Right.
T: What happens to your anxiety?
P: It also increases to 90.
T: So, how do you feel when you pay attention to the prosecutor?
P: I feel more anxious.

Step 5: Defense Attorney's Second Plea (Table 5.3, Columns 5 and 6)

T: Exactly! What if now, Leslie, we give the defense another chance? This is what I am going to ask you to do now: call the defense. Can you come back to the defense attorney's chair? [Waits for her to sit in the defense attorney's chair] And it seems that you don't have any more arguments either. But I suggest that you use the exact same strategy as the prosecutor. Now, I will read here, in column 4, what the prosecutor said, Leslie, and add the conjunction "but . . . " I would also like you to copy what you said before, in column 3. "A whole bunch of people pass," but . . .
P: She passed the qualifying exam.
T: What does this mean about Leslie?
P: It means that she's good.
T: Can you write that here, in column 6? Would you please add "therefore" after this, and complete the sentence? So, "It means that she's good;" therefore . . .
P: Therefore there is no reason for her to be anxious.
T: Can you do the same for the other items?
P: Yes.
T: So, what do we have here? "John didn't look her up any more," but . . .
P: Some guys flirted with her at the party.
T: What does this mean about Leslie?

P: That sometimes she's interesting.
T: Please, write this down here: "Sometimes she's interesting;" therefore . . .
P: Other guys can be interested in her.
T: Could you do this with the other items? "There are other people who don't pay her any attention," but . . .
P: There are people at work who think she's efficient.
T: What does this mean?
P: That she is a good employee therefore she can do her job well.
T: Excellent! "Maybe this happens because she can't say no," but . . .
P: Some people prefer to have her assisting them.
T: What does this mean about Leslie?
P: That she's too nice . . .
T: From which of the two characters did this expression come?
P: From the prosecutor.
T: [Looking at the prosecutor's empty chair] Is this time for you to speak? Would you please be quiet and let the defense attorney finish her work, please?
P: Let me see. Some people prefer for her to be assisting them. It means that she's efficient; therefore she can continue assisting people and say no when necessary.
T: OK, so, from your point of view, as a defense attorney, this is what you write here; isn't that right?
P: Yes, she's efficient.
T: "She's anxious," but . . .
P: At the party she acted in a normal manner. This means that she can act calmly; therefore there is no reason for her to be afraid of rude lawyers.
T: And the last one. "She doesn't do other important things," but . . .
P: She does the same things as other people do, and this means that she can live in a normal manner; therefore she's not strange.
T: So, Leslie, please, can you sit there again? [Waits for her to sit in the defendant's chair] Now, listen to the defense attorney, who reaches conclusions of this kind: you passed a qualifying exam, meaning that you are good; therefore there is no reason for you to be anxious; at the party some guys flirted with you, meaning that sometimes you can be interesting; therefore other guys can be interested in you; there are people at work who think you are efficient, meaning that you are a good employee; therefore you can do your job well; some people prefer to have you assisting them, meaning that you're efficient; therefore you can continue assisting people and say no when necessary; at the party you acted in a normal manner, meaning that you can act calmly; therefore there is no reason for you to be afraid of rude lawyers; and you do the same things as other people do, meaning that you can live in a normal manner; therefore you're not strange. As you listen to these conclusions from the defense attorney, how much do you believe you're strange, Leslie?

P: 20%.
T: And how strong is your anxiety now?
P: Also 20%.
T: They decrease. You only believe it 20% and your anxiety is also at 20%; isn't that right? OK, let's take a look at this, Leslie, because we've had the accusation, the defense attorney speaking his piece, then the prosecutor's reply, and then the rebuttal of the defense, OK? What usually happens in a trial? What's the next step?
P: The jurors will assess whether I am innocent or guilty.

Step 6: Jury's Verdict (Table 5.3, Column 7)

T: Exactly. The jury convenes to give the verdict. Shall we move to those two chairs over there? I'll go from the judge's position and become juror number 2. You'll be juror number 1. We have to leave here with a unanimous decision. In our tribunal, it matters who distorted the facts more or who distorted them less. We'll evaluate in detail what was said by the prosecutor and by the defense attorney, and we'll see if there was any distortion of the facts. Let's identify and write down the distortions in this table. We'll call the prosecutor's first allegation P1, the defense attorney's first allegation D1, the prosecutor's reply P2, and the defense attorney's rejoinder D2.
P: OK, that's clear to me.
T: I'll read each sentence stated by the prosecutor and by the defense, and you try to identify whether there were any distortions in them, OK? To do this, you should consult your distortions sheet. [Therapist hands her the sheet of cognitive distortions.] Let's begin. The prosecutor said, "John didn't look her up." Can you find any distortion here, on the part of the prosecutor?
P: That's true; John didn't look her up.
T: Do I understand that juror number 1 considers that, since John did not look the defendant up that this means that she is strange?
P: No, that's not true; the prosecutor is taking an extreme stance. John could have had other reasons for not looking her up. That is dichotomous thinking.
T: OK. So, P1.1 = dichotomous thinking, right?
P: Right!
T: The prosecutor said, "Guys don't flirt with her." Is there any distortion on the part of the prosecutor?
P: I think she is discounting positives here. The fact that some guys didn't flirt with Leslie at the party does not remove her value as a person.
T: P1.2 = discounting positives.
T: The prosecutor said that Anna said that Leslie dresses in a strange way. Can you see any distortion there?
P: It's true. Anna did say that she dresses in a strange way.
T: Indeed, Anna did say this. However, the prosecutor is using this as an argument to prove that Leslie is strange. Is this sufficient to prove that Leslie is strange?

P: No. This is overgeneralization. The prosecutor is overgeneralizing by saying that Leslie is strange just because she dresses in a strange way. Besides, this is just Anna's opinion. Other people don't have the same opinion.
T: OK. P1.3 = overgeneralization. The prosecutor said that she gets nervous in front of people.
P: Hmm, in this case . . . I think it is overgeneralization, because she doesn't get nervous in front of everybody. This happens more at work.
T: Very good. P1.4 = overgeneralization. The prosecutor stated that Leslie's hands sweat a lot. Is there any distortion in this claim of the prosecutor's?
P: This is true. Her hands sweat a lot.
T: So, because her hands sweat a lot, according to the prosecutor, Leslie is strange. Isn't this what the prosecutor wants us to believe, with this argument?
P: I think the statement is exaggerated on the part of the prosecutor. Just because one's hands sweat a lot doesn't mean that the person is strange. I think that this, too, is overgeneralization.
T: OK. P1.5 = overgeneralization. Finally, the prosecutor affirmed that she's never had a boyfriend. What does juror number 1 think of this?
P: I think the prosecutor was somewhat heavy-handed. She wants one to think that, due to the fact that Leslie hasn't ever had a boyfriend, she never will. That is fortune telling.
T: OK. P1.6 = fortune telling. Now, let's go to the defense attorney's arguments. She states that Leslie passed a qualifying exam. Any distortion?
P: No, that's true.
T: OK. D1.1 = true. "At the party, some guys flirted with her." Is there any distortion here?
P: No, that's true.
T: D1.2 = true. "There are people at work who think she's efficient." Did the defense attorney carry out any distortion?
P: No, that's true.
T: D1.3 = true. The defense attorney affirmed that some people prefer to have her assisting them. Is there any distortion here?
P: No, that's also true.
T: Very good. D1.4 = true. "At the party, she acted in a normal manner."
P: This is true. Although anxious, she acted in a normal manner.
T: D1.5 = true. Finally, the defense attorney affirmed that she does the same things as other people do.
P: This is also true.
T: Going back to the prosecutor's rejoinder: "a whole bunch of people pass."
P: That isn't true. The prosecutor is discounting the fact that Leslie did pass her exam.
T: P2.1 = discounting positives. "John didn't look her up anymore."
P: I think this is personalizing. John may have other reasons for not looking her up.
T: P2.2 = personalizing. "There are others who pay little attention to her."
P: The prosecutor is clearly discounting her positive aspects and denying the fact that some people at work think she is efficient.

T: P2.3 = discounting positives. The prosecutor states that maybe this happens (some people preferring to have her assisting them) because she doesn't say no.
P: The prosecutor is discounting positives. The fact is that there are people who prefer that she assist them, and that's that. This is undeniable.
T: I'll write that down here. P2.4 = discounting positives. Following that, the prosecutor affirmed that Leslie is anxious.
P: This is labeling.
T: P2.5 = labeling. Finally, the prosecutor stated that she avoids doing other, more important things, regarding what was said by the defense attorney; that is, she does the same things as everyone else.
P: Clearly, discounting positives.
T: P2.6 = discounting positives. Let's move on to the defense attorney's rejoinder. The defense attorney reaffirmed all that had been said earlier. Let's see. She passed a qualifying exam, meaning that she's good; therefore there is no reason for her to be anxious.
P: This is true.
T: D2.1 = true. At the party, some guys flirted with her, meaning that sometimes she's interesting; therefore other guys can be interested in her.
P: This is also true.
T: D2.2 = true. There are people at work who think she's efficient, meaning that she's a good employee; therefore she can do her job well.
P: True.
T: D2.3 = true. Some people prefer to have her assisting them, meaning that she's efficient; therefore she can continue assisting people and say no when necessary.
P: True.
T: D2.4 = true. At the party, she acted in a normal manner, meaning that she can act calmly; therefore there is no reason for her to be afraid of rude lawyers.
P: True.
T: D2.5 = true. She does the same things as other people do, meaning that she can live in a normal manner; therefore she's not strange.
P: Also true.
T: D2.6 = true. What do you think happened during the rejoinder of the defense attorney? Can you please look here? Can you see any distortions from the defense attorney?
P: No. The defense attorney brought forth actual facts and reached true conclusions based on these facts.
T: What shall we decide, while we are jurors? Can you give your opinion?
P: As a juror, I think that the prosecutor made cognitive distortions in all her statements: dichotomous thinking, discounting positives, overgeneralization, fortune telling, personalizing, and labeling. On the other hand, the defense attorney stated the truth in all her affirmations and did not have any distortions. The prosecutor tried to mar what the defense attorney stated, using imprecision, exaggeration, and distortions; the defense attorney's words were based on true evidence.

T: So, what verdict have we reached?
P: Yes, not guilty.
T: OK. I'll go back to the judge's chair. Can I ask you, juror number 1, to stand in front of the judge and announce the verdict?
P: Your Honor, we've reached the conclusion that the accused is not guilty.
T: Would you please sit in the defendant's chair? [Leslie sits in the defendant's chair.] Now, Leslie, you've heard from the jury that you are not guilty of this accusation. So, how much do you believe this accusation, that you are strange?
P: 0%.
T: And your anxiety?
P: I'm fine: 0% too.

Step 7: Preparation for the Appeal (Table 5.4)

T: OK, Leslie, let's go back to our therapeutic setting. Once established as true that the jury acquitted you, and that the defense attorney, therefore, was right, what does this mean about you?
P: That I am a normal person.
T: This is very good, Leslie, because, in the next step, what we are going to do is exactly write down, "I am normal." Do you think the prosecutor is satisfied? Or will she, in some way, continue accusing you . . .
P: I think she will, that in some situations she will accuse me.
T: Therefore, does this mean that she is asking for an appeal? And as a matter of fact, the first question I would ask you is this: with whom have you worked more over the past years, with your prosecutor or with your defense?
P: With my prosecutor.
T: Would you like to change? Who would you like to work with from now on?
P: With my defense attorney.
T: Why are you choosing your defense attorney?
P: Because she might be more realistic, she might help me.
T: She may make you feel better, which was what you have seen demonstrated here; isn't that right? And what will a good defense attorney do when facing the possibility of an appeal from the prosecutor?
P: She will actually evaluate what the defendant has that can strengthen the assumption that he or she is innocent of the accusation.
T: Therefore, what she is going to do is exactly go in search of more evidence.
P: Yes, in search of proof.
T: And so, can you get prepared for this appeal along with your defense attorney?
P: Yes, I can.
T: How about if we start here, now?
[The therapist introduces Table 5.4, to be filled out by the patient as homework during the week, but starting in session.]

T: If you had to search today, what elements could you find already today? And I'm going to ask you to, on a daily basis, to really stay close to your defense attorney searching for evidence, like you are doing here, now with me.
P: I went to work.
T: Why don't you write this here? So, this is a piece of evidence that indicates that you are normal; isn't that right?
P: I assisted several people.
T: Good. Would you like to leave the third piece of evidence for later?
P: Yes, I would.
T: We have enough then. Based on what we have, how much do you believe "I am normal"?
P: 100%.
T: Good. I will ask you now how much you believe this initial accusation, "I am strange."
P: 0%.
T: And what about your anxiety?
P: I don't feel anxious: 0%.

Assigning Homework

T: OK, how would you put together all this information up to now?
P: I saw in what we worked through here that I tend to make things out to be very catastrophic.
T: And would it be true to think that you have an internal character that leads you to act and think this way?
P: Yes, it would.
T: And who would this internal character be?
P: My prosecutor.
T: OK. And after realizing this, what do you decide to do?
P: I should stop and work more closely with my defense attorney, and try to view situations in a more realistic way so that I can think of other possibilities.
T: OK. And can you do this on a daily basis?
P: Yes, I can.
T: In order for you to feel normal, do you need to do extraordinary things, or is it a matter of observing your day-to-day activities, the small things of your routine?
P: Dr. de Oliveira, I think this is meaningful, if I pay attention to what goes on day to day; I can see that I don't need to do different things.
T: OK. So, how about, in order for us to prepare for this appeal, at our next session, how about giving the defense attorney the possibility to speak again? One of the things that I would like you to always remember is to put down how much you believe that you are normal, as you are writing down these small examples and pieces of evidence.
P: Sure.

Summarizing

T: So, how would you summarize and give me a feedback of what happened here today, Leslie?

P: Today's session was very important because I arrived here very discouraged and frustrated, because my co-worker made a comment about my clothes and also because John didn't look me up. I didn't even stop to think of other possibilities. So then I'd already started using avoidance again, which confirmed that I was strange. As we carried out this simulation of a trial, where you helped me to think as a defense attorney and as a prosecutor, I could notice other things, that in reality I don't need to believe my thoughts so much, because they may be distortions.

Reviewing the CCD

T: OK, Leslie. We can then return to this chart. Let me ask you something: when you arrived here, which belief was this arrow strongly indicating? [Therapist shows cognitive conceptualization diagram.]

P: I am strange.

T: And with this belief being activated "I am strange," what kind of thoughts was it releasing for you here?

P: I won't manage.

T: Which left you feeling . . .

P: Anxious.

T: And you were actually presenting some types of behaviors that seemed to be more habitual.

P: Right.

T: In this case here, what would be your behavior?

P: I would avoid things.

T: You would avoid things, and this would also repeat itself as a safety behavior.

P: That's right.

T: OK. After we used this technique we call trial I, what happened? What belief do you see that you were able to activate?

P: That I am a normal person.

T: Why don't we write this here then, in this space, "I am normal"? [Patient writes "I am normal" in the positive core belief box in the CCD.]

P: Dr. de Oliveira, sometimes it also happens with my friends when guys flirt with them somewhere, and then they could end up not looking up the girls; that doesn't mean the girls are strange.

T: Exactly, but why are you arriving at this possibility of thinking like this, now? Where is this coming from?

P: From this new belief: "I am normal."

T: And thinking like this, "I am normal," what changes do you notice about your thoughts?

P: I see that these things can happen to any person.
T: OK. And what are you going to continue doing here in terms of this new intermediate level: do you see the need to continue using this safety behavior, avoidance?
P: No. I don't need to avoid so much.
T: So you should keep away from avoidance; isn't that right?
P: Yes.
T: OK.
P: I need to confront these situations more.
T: All right?
P: Yes.

Concluding Session 5

T: Great, I'm very pleased about this. So, what could we have as homework for this session?
P: You had asked me to work out some items of that social phobia scale and I liked it a lot.
T: OK. But I think I will be a little more lenient with you now. That is, you already have a task here. What is your task?
P: To use the preparation for the appeal.
T: Exactly, work with your defense attorney. How long did it take you to do this here with me?
P: Less than two minutes.
T: OK. And this is exactly the amount of time you will take every day until the next time we see each other. And during the day, while you pay attention to these things, what will become clear to you?
P: That I am normal.
T: And how are you feeling now?
P: Calmer, more relieved.
T: OK. We'll see each other next week then?
P: Yes. Thank you, Dr. de Oliveira. Goodbye.
T: Goodbye Leslie.

Table 5.3 Worksheet of Leslie's "trial I" (TBTR), filled in during Session **5**

Please, briefly describe the situation: In session, talking about my concerns.

1. **Inquiry/Establishing the accusation (core belief).** What was going through your mind before you started to feel this way? Ask yourself what these thoughts meant about yourself, supposing they were true. The answer "*If these thoughts were true, it means I am . . .*" is the uncovered **self-accusation** (core belief).	2. **Prosecutor's plea.** Please, state all the evidence you have that **supports** the accusation/core belief that you have circled in column 1.	3. **Defense attorney's plea:** Please, state all the evidence you have that **does not support** the accusation/core belief that you have circled in column 1.	4. **Prosecutor's rebuttal to the defense attorney's plea.** Please, state the thoughts that question, discount, or disqualify each piece of positive evidence in column 3, usually expressed as "yes, but . . ." thoughts.	5. **Defense attorney's rejoinder to the prosecutor's plea.** Please, copy each thought of column 3, connecting them with the conjunction BUT, after reading each sentence in column 4. **Note**: columns 5 and 6 are filled in at the same time.	6. **Meaning of the response presented by the defense attorney to the prosecutor's plea.** Please, state the meaning you attach to each sentence in column 5.	7. **Juror's verdict.** Please, report cognitive distortions made by the prosecutor and the defense attorney and give the verdict.
John didn't look me up anymore. *No one is interested in me.* **Downward arrow technique:** *If the thoughts above were true, what would they mean about you?* ↓ ***I am strange.*** **Emotion:** ***sadness***	1. *John didn't look her up.* 2. *Guys don't flirt with her.* 3. *Anna said that she dresses in a strange way.* 4. *She gets nervous in front of people.* 5. *Her hands sweat a lot.* 6. *She's never had a boyfriend.*	1. *She passed a qualifying exam.* 2. *At the party, some guys flirted with her.* 3. *There are people at work who think she's efficient.* 4. *Some people prefer to have her assisting them.* 5. *At the party, she acted in a normal manner.* 6. *She does the same things as other people do.*	**But:** 1. *A whole bunch of people pass.* 2. *John didn't look her up any more.* 3. *There are others who pay little attention to her.* 4. *Maybe this happens because she doesn't say no.* 5. *She's anxious.* 6. *She doesn't do other important things.*	**But:** 1. *She passed a qualifying exam.* 2. *At the party, some guys flirted with her.* 3. *There are people at work who think she's efficient.* 4. *Some people prefer to have her assisting them.* 5. *At the party, she acted in a normal manner.* 6. *She does the same things as other people do.*	**It means that:** 1. *She's good, therefore, there is no reason for her to be anxious.* 2. *Sometimes she's interesting, therefore, other guys can be interested in her* 3. *She is a good employee, therefore, she can do her job well.* 4. *She's efficient, therefore, she can continue assisting people and say no when necessary.* 5. *She can act calmly, therefore, there is no reason for her to be afraid of rude lawyers.* 6. *She can live in a normal manner, therefore, she's not strange.*	**Prosecutor 1** / **Defense 1** 1: DT / 1: True 2: DP / 2: True 3: OG / 3: True 4: OG / 4: True 5: OG / 5: True 6: FT / 6: True **Prosecutor 2** / **Defense 2** 1: DP / 1: True 2: P / 2: True 3: DP / 3: True 4: OG / 4: True 5: L / 5: True 6: DP / 6: True **Verdict:** *Not guilty*
Belief Initial: *100%* **Belief** *Final: 0%* **Emotion** Initial: *100%* **Emotion** *Final: 0%*	**Belief** *100%* **Emotion:** *100%*	**Belief** *60%* **Emotion:** *50%*	**Belief** *90%* **Emotion:** *90%*		**Belief** *20%* **Emotion:** *20%*	**Belief** *0%* **Emotion:** *0%*

DT = Dichotomous thinking; DP = Discounting positives; OG = Overgeneralization; FT = Fortune telling; L = Labeling; P = Personalizing.

Table 5.4 Leslie's preparation for the appeal (one-belief form)

Positive new core belief: *I am normal* (Please write down here at least one piece of evidence supporting the new core belief. Also, write how much you believe it, daily, in the space between parentheses).

Date (90%)	Date (%)	Date (%)
1. I went to work.	1.	1.
2. I assisted several people.	2.	2.
3.	3.	3.
Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.
Date (%)	Date (%)	Date (%)
1.	1.	1.
2.	2.	2.
3.	3.	3.

Notes

1. For a review of the more commonly used techniques developed to change dysfunctional core beliefs, see Wenzel (2012): http://www.intechopen.com/download/get/type/pdfs/id/31822.
2. See the complete presentation of this case in de Oliveira (2012b): http://www.intechopen.com/download/get/type/pdfs/id/31823.

6 Trial I in the Appeal Format

Outline

- Explaining Trial I in the Appeal Format

Case Illustration Dialogue

- Bridge from Session 5 and Setting the Agenda
- Reviewing Questionnaires and Homework
- Introducing the Appeal as the Agenda Item
  - *Step 1: Investigation*
  - *Step 2: Prosecutor's Plea*
  - *Step 3: Defense Attorney's Plea*
  - *Step 4: Prosecutor's Second Plea*
  - *Step 5: Defense Attorney's Second Plea*
  - *Step 6: Jury's Verdict*
  - *Step 7: Preparation for the Appeal*
- Assigning Homework

Explaining Trial I in the Appeal Format

Trial I in the appeal format is similar to trial I implemented in Session 5. The only differences are

1) There is no investigation, as the same core belief (accusation) will be worked on during the session.
2) The patient has already gathered new evidence as homework during the week so that the defense attorney will probably have more elements for his or her pleas.

The following extract of a session provides an idea of how the therapist may introduce the appeal to the patient:

T: Paul, I'm happy you brought this sheet we call "preparation for the appeal" containing the elements that indicate that you are competent. It will be very

useful in our session today. The idea is to help you become aware of your accomplishments and the events supporting the positive core belief "I'm competent" you brought to the last session.

P: Yes. It was not easy to find them. I'm used to finding those that show that I am incompetent.

T: Did the prosecutor prevent you from seeing the small pieces of evidence showing that you are competent?

P: Yes. The thought that my work was bad and that John didn't like it were just a few that came to mind again some of the time. Then I tried to activate my defense, asking questions like "What does my defense attorney say," as you had taught me.

T: Did you succeed?

P: I don't know, maybe sometimes. I continue telling myself that many things I do are just my duty, my obligation; they don't mean I'm competent.

T: Right. Did you ask yourself who was telling you this?

P: I know it was the prosecutor, but it was hard to remember that.

T: They came as automatic thoughts, didn't they? Let me propose something to you. In the last session, I told you about an appeal requested by the prosecutor, who lost the case; that is, the prosecutor would be given the chance to return and try to prove that you are incompetent.

P: Yes, I remember that.

T: So, can we start? I would now like you to sit in the defendant's chair again. We don't need an investigation, because the accusation is the same: "I'm incompetent." [The patient goes to the chair of the accused.] We will do the same as in the last session. Can you tell me how much you believe you are incompetent?

P: I believe less than last week, but it is still there: 50%.

T: It made you feel sad last week. How sad are you now?

P: About the same: 45–50%.

T: Now, would you please go to the prosecutor's chair and state all the elements supporting this accusation? But before sitting there, can you describe to me who you see in that chair?

CASE ILLUSTRATION DIALOGUE

Bridge from Session 5 and Setting the Agenda

T: Hi, Leslie.

P: Hi, Dr. de Oliveira.

T: I'm curious to know how your week went.

P: This week was better than the last one.

T: And why is that?

P: Although the same things happened at work, I think I was able to have a better reaction to them. I cared less about what people were thinking of me.

T: Did anything happen that you would like to include in our agenda?

P: No, nothing different happened.

T: Let me propose something to you, though. Do you remember I mentioned that the prosecutor requested an appeal last week? As she lost the case, we agreed that she would have the chance to return and prove that you were strange.
P: Yes, I remember that very well. That's why you gave me the task of helping my defense attorney by looking for elements that would show that I am normal.
T: Can the appeal be the main topic of our agenda? In this case, our agenda would involve reviewing the questionnaires and also reviewing the preparation for the appeal.
P: Yes, no problem.
T: Let's have a quick look at the questionnaires, all right?

Reviewing Questionnaires and Homework

T: I see your CD-Quest score is lower. Did you notice that?
P: Yes, I did. Although the same thoughts came up, I believed them less.
T: Great! Can you see that the scores of the other questionnaires have also decreased?
P: Yes, I felt much better this week.

[The therapist and the patient spend some time reviewing the questionnaires and homework.]

Introducing the Appeal as the Agenda Item

T: OK, let's start. Can I ask you to sit in the defendant's chair and tell me how much you believe you are strange? You will notice that we don't need the Investigation step, because the core belief is the same, "I'm strange."

Step 1: Investigation (Table 6.1, Column 1)

[Not necessary in the appeal]

T: How much do you believe you are strange?
P: 50%.
T: How strong is your anxiety now?
P: Also 50%.
T: Please, take the prosecutor's chair.

Step 2: Prosecutor's Plea

T: What arguments did you bring that will prove that Leslie is strange?
P: I did not bring different arguments, because I am convinced that she is strange for the same reasons. For instance, guys don't flirt with her, and when they flirt, they disappear. John disappeared, and it is still true that she's never had a boyfriend.
T: Anything else?
P: She still gets anxious in front of people.
T: OK.

P: She is permanently vigilant at work. When someone asks her for help, she's still anxious. That's it.
T: Would you please sit there? The prosecutor insists that you are strange because guys don't flirt with you, and when they flirt, they disappear; John disappeared, and you've never had a boyfriend. After hearing the prosecutor saying those things, how much do you believe this, "I'm strange"?
P: 60%.
T: And your sadness, how strong is it?
P: The same: 60%.

Step 3: Defense Attorney's Plea

T: Leslie, would you like the defense attorney to use the sheet with the preparation for the appeal? Please, sit in this chair at my left. Would you like to use the new pieces of evidence you have gathered during the week, proving that the prosecutor is wrong?
P: Of course.
P: She was praised by a lawyer who said that she was kind.
T: OK.
P: She went to work every day and did her job well.
T: OK.
P: She helped her boss solve a difficult problem.
T: Yes . . .
P: Same thing as last week: some people prefer to have her assisting them at work.
T: OK.
P: She's more natural in the way she's assisting people at work. Also, she could enter places where people observed her and feel more comfortable.
T: Great! Do you think this is enough?
P: Yes, this is enough.
T: Can you go back to Leslie's chair now? The defense attorney said that you were praised by a lawyer who said that you were kind; you went to work every day and did your job well; you helped your boss solve a difficult problem; some people prefer to have you assisting them at work; you're more natural in the way you're assisting people at work; and you could enter places where people observed you and feel more comfortable. After listening to what your defense attorney says, how much do you believe this accusation, "I'm strange"?
P: 30%.
T: Anxiety?
P: 35%.

Step 4: Prosecutor's Second Plea

T: Can we call the prosecutor again? Would you please sit here?
P: Yes.
T: Do you remember the prosecutor's role? What does she do?
P: She will disqualify what the defense attorney said.
T: So, "she was praised by a lawyer who said that she was kind," but . . .

P: He said that because he was interested in the lawsuit procedure.
T: "She went to work every day and did her job well," but . . .
P: This is nothing more than her duty.
T: "She helped her boss solve a difficult problem," but . . .
P: Many people can do that.
T: "Some people prefer to have her assisting them at work," but . . .
P: They know she can't say no.
T: "She's more natural in the way she's assisting people at work," but . . .
P: She's still anxious.
T: "She could enter places where people observed her and feel more comfortable," but . . .
P: Anyone can do this without anxiety.
T: Please, go back to Leslie's chair. Listening to the prosecutor saying that the lawyer said that because he was interested in the lawsuit procedure; going to work every day and doing your job well is nothing more than your duty; many people can help their bosses solve difficult problems; some people prefer to have you assisting them because you can't say no; you are still anxious in assisting people at work; and anyone can enter places without anxiety and feel comfortable, how much do you believe you're strange?
P: It goes back to 50%.
T: What happens to your anxiety?
P: It also increases to 50%.

Step 5: Defense Attorney's Second Plea

T: You know what to do now. Please, can you come back to the defense attorney's chair? I'll read what the prosecutor said, add the conjunction "but," and you will copy what you said before as the defense attorney, OK?
P: OK, I remember that.
T: "He said that because he was interested in the lawsuit procedure," but . . .
P: She was praised by a lawyer who said that she was kind.
T: What does it mean about Leslie?
P: She's competent.
T: Therefore . . .
P: She can do her job well.
T: "This is nothing more than her duty," but . . .
P: She went to work every day and did her job well. It means that she's a good employee; therefore, she's not strange.
T: "Many people can do that," but . . .
P: She helped her boss solve a difficult problem. It means that she does her job well; therefore, she's not strange.
T: "They know she can't say no," but . . .
P: Some people prefer to have her assisting them at work. It means that she's not strange; therefore, she can do her job well.
T: "She's still anxious," but . . .
P: She's more natural in the way she's assisting people at work. It means that she will be more and more natural in doing her job; therefore, she's not strange.

T: "Anyone can do this without anxiety," but . . .
P: She could enter places where people observed her and feel more comfortable. It means that she's normal; therefore, she has no reason to be anxious at work.
T: Leslie, can you sit there again, please? Listen to what your defense attorney just said: you went to work every day and did your job well. It means that you're a good employee; therefore, you're not strange. You helped your boss solve a difficult problem. It means that you do your job well; therefore you're not strange. Some people prefer to have you assisting them at work. It means that you're not strange; therefore, you can do your job well. You're more natural in the way you're assisting people at work. It means that you will be more and more natural in doing your job; therefore, you're not strange. You could enter places where people observed you and feel more comfortable. It means that you're normal; therefore, you have no reason to be anxious at work. As you listen to these conclusions from your defense attorney, how much do you believe you're strange, Leslie?
P: 10%.
T: And how strong is your anxiety now?
P: 10%.
T: Do you remember what the next step is?
P: The jurors now. They will decide whether I am innocent or not.

Step 6: Jury's Verdict

[After a detailed analysis of the pleas, looking for cognitive distortions . . .]

T: What do we decide as jurors about Leslie?
P: She's innocent of that accusation. She's a normal person.
T: Yes. I'll go back to the judge's chair. Can you stand up and announce the verdict to the court?
P: Your Honor, the jury's deliberation was that the defendant is not guilty.
T: [The therapist waits for Leslie to sit in the defendant's chair.] Now, Leslie, how much do you believe the accusation, that you are strange?
P: 0%.
T: And how's your anxiety?
P: 0% too.

Step 7: Preparation for the Appeal

T: OK, Leslie, let's go back to our therapeutic setting. What conclusion do you reach after this second experience of being accused?
P: Today, I'm more convinced that I am a normal person.
T: Very good. Would you find it useful to continue working with your defense attorney, and go on looking for more evidence that you're normal?
P: Yes, it helped me much more than paying attention to my negative thoughts.
T: This way, you will always be prepared if your prosecutor accuses you, won't you?
P: Yes, I will.

T: Do you have elements for today? I'll ask you to go on doing this, on a daily basis, helping your defense attorney by searching for evidence.
P: OK. I'll do that.
[After searching for more evidence for the day . . .]
T: How much do you believe you're strange?
P: 0%.
T: And your anxiety?
P: Also 0%.

Assigning Homework

T: Leslie, besides continuing to gather evidence to help your defense attorney, just in case the prosecutor requests another appeal, I have a new homework assignment to propose to you. Before that, however, and having learned how the prosecutor and the defense attorney operate, whom do you choose to have as your ally: the prosecutor or the defense attorney?
P: No doubt, the defense attorney who has clearly shown to be of more help!
T: In this case, it is important that you remember what the defense attorney concluded about you; don't you think so?
P: Sure.
T: I'd like you to take a look at this record we have just filled out during trial I. Can you please copy down all the pleas of the defense attorney from the fifth and sixth columns? The difference is that, instead of using "she," I will ask you to copy them in the first person. Please, write it down on this card [the therapist hands a card to Leslie].
P: [Copying] 1. I went to work every day and did my job well. It means that I am a good employee; therefore, I'm not strange.
T: Great! Can you please complete this card with the other sentences stated by the defense attorney? When you finish, I will ask you to read all the sentences to me. Also, this is something I will ask you to read as homework whenever you feel uncomfortable or distressed. Please, always carry this card (Fig. 6.1) with you. This is the best way you have to be aware of what your defense attorney would like you to remember.

I am normal

1. *I went to work every day and did my job well. It means that I'm a good employee, therefore I'm not strange.*
2. *I helped my boss solve a difficult problem. It means that I do my job well, therefore I'm not strange.*
3. *Some people prefer to have me assisting them at work. It means that I'm not strange, therefore I can do my job well.*
4. *I'm more natural in the way I'm assisting people at work. It means that I will be more and more natural in doing my job, therefore I'm not strange.*
5. *I could enter places where people observed me and felt more confortable. It means that I'm normal, therefore I have no reason to be anxious at work.*

Figure 6.1 Leslie's evidence-based meaning card homework assignment to be consulted when she feels uncomfortable or distressed.

Table 6.1 Worksheet of Leslie's "trial I" (TBTR), appeal format, filled in during Session 6

Please, briefly describe the situation: In session, talking about my concerns with the therapist

1. **Inquiry/Establishing the accusation (core belief).** What was going through your mind before you started to feel this way? Ask yourself what these thoughts meant about yourself, supposing they were true. The answer "*If these thoughts were true, it means I am . . .*" is the uncovered self-accusation (core belief).	2. **Prosecutor's plea.** Please, state all the evidence you have that **supports** the accusation/core belief that you have circled in column 1.	3. **Defense attorney's plea:** Please, state all the evidence you have that **does not support** the accusation/core belief that you have circled in column 1.	4. **Prosecutor's rebuttal to the defense attorney's plea.** Please, state the thoughts that question, discount, or disqualify each piece of positive evidence in column 3, usually expressed as "yes, but . . ." thoughts.	5. Defense attorney's rejoinder to the prosecutor's plea. Please, copy each thought of column 3, connecting them with the conjunction BUT, after reading each sentence in column 4. **Note**: columns 5 and 6 are filled in at the same time.	6. **Meaning of the response presented by the defense attorney to the prosecutor's plea.** Please, state the meaning you attach to each sentence in column 5.	7. **Juror's verdict.** Please, report cognitive distortions made by the prosecutor and the defense attorney and give the verdict.
[Not necessary in the appeal] **Downward arrow technique:** *If the thoughts above were true, what would they mean about you?* ↓ ***I am strange.*** **Emotion: *sadness***	1) *Guys don't flirt with her.* 2) *Her hands sweat a lot.* 3) *When guys flirt with her, they disappear.* 4) *She's never had a boyfriend.* 5) *She still gets anxious in front of people.* 6) *She is permanently vigilant at work.* 7) *When someone asks her for help, she's still anxious.*	1) *She went to work every day and did her job well.* 2) *She helped her boss solve a difficult problem.* 3) *Some people prefer to have her assisting them at work.* 4) *She's more natural in the way she's assisting people at work.* 5) *She could enter places where people observed her and felt more comfortable.*	**But:** 1) *This is nothing more than her duty.* 2) *Many people can do that.* 3) *They know she can't say no.* 4) *She's still anxious.* 5) *Anyone can do this without anxiety.*	**But:** 1) *She went to work every day and did her job well.* 2) *She helped her boss solve a difficult problem.* 3) *Some people prefer to have her assisting them at work.* 4) *She's more natural in the way she's assisting people at work.* 5) *She could enter places where people observed her and felt more comfortable.*	**It means that:** 1) *She's a good employee, therefore, she's not strange.* 2) *She does her job well, therefore she's not strange.* 3) *She's not strange, therefore, she can do her job well.* 4) *She will be more and more natural in doing her job, therefore, she's not strange.* 5) *She's normal, therefore, she has no reason to be anxious at work.*	**Prosecutor 1** / **Defense 1** *1: DT* / *1: True* *2: M* / *2: True* *3: OG* / *3: True* *4: DT* / *4: True* *5: True* / *5: True* *6: M* *7: DP* **Prosecutor 2** / **Defense 2** *1: DP* / *1: True* *2: DP* / *2: True* *3: DP/MR* / *3: True* *4: DP* / *4: True* *5: DP* / *5: True* **Verdict:** *Not guilty*
Belief Initial: *50%* **Belief** *Final: 0%* **Emotion** Initial: *50%* **Emotion** *Final: 0%*	**Belief** *60%* **Emotion:** *60%*	**Belief** *30%* **Emotion:** *35%*	**Belief** *50%* **Emotion:** *50%*		**Belief** *10%* **Emotion:** *10%*	**Belief** *0%* **Emotion:** *0%*

DT = dichotomous thinking; M = magnification/minimization; OG = overgeneralizing; MR = mind reading; DP = discounting positives.

Homework assignment. Preparation for the appeal: Supposing that the defense attorney's pleas are true, what does it mean about you (upward arrow technique)? **Positive core belief: *I am normal.***

7 Trial I to Change a Second Core Belief

Outline

- Explaining Trial I to Restructure a Second Core Belief
- Calling Witnesses to Court

Case Illustration Dialogue

- Introducing Trial I to Restructure a Second Core Belief
  - *Step 1: Investigation*
- Assigning Homework

Explaining Trial I to Restructure a Second Core Belief

There is no difference between the trial I implemented in Session 5 and the trial I implemented to restructure a second or third CB. However, as the patient is already familiar with the technique, the therapist can go further and ask the patient to add witnesses as new characters in trial I.

In the following extract, the therapist and the patient are working on a second negative CB: "I'm unlovable."

T: Paul, last session, you confirmed that you were a capable person, after the appeal requested by the prosecutor; wasn't that true?
P: Yes, that was true.
T: Anyhow, I'm happy you are succeeding in gathering elements in your daily life for the new positive core belief; that is, that you are competent.
P: Yes. It is easier to find small and even tiny pieces of evidence that I did not notice before. The evidence-based meaning card you asked me to read whenever I felt uncomfortable also helped me to remember that I am capable. All I was able to see before were the things that showed that I was incompetent. Now it seems to be a little different.
T: Do you have problems we should work on today? Why don't we set our agenda? Did anything bother you this week or is bothering you now?

P: You know, having understood how a core belief operates, as you explained to me in that diagram, I wonder whether other core beliefs are not making me have unpleasant automatic thoughts. I have the feeling that some of my colleagues at work avoid me sometimes.
T: Do you have a specific example? Did anything happen this week that made you feel this way?
P: Yes. After leaving work this Wednesday, I returned to pick up something I forgot. And I saw John, my boss, talking to and laughing with two of my co-workers. I don't know why; I just felt jealous. He never talks to me that way. And I thought that he does not like me as he likes my co-workers.
T: Can you picture that moment, as if it were happening now? What do you notice?
P: Thinking about this brings this unpleasant feeling again. It bothers me a little to feel this kind of jealousy.
T: What is going through your mind now?
P: I don't know. It is as though John preferred my co-workers.
T: Supposing this is true, that John prefers your co-workers: What does it mean to you?
P: That maybe John and my co-workers don't like me.
T: And what is so bad about that?
P: It's awful. It makes me feel as though I were being put aside.
T: And what does it mean about you, supposing this is true?
P: It means that I'm not accepted by my boss and by my co-workers as well.
T: Does it say anything about you?
P: Yes, that I'm unlovable.
T: Would you possibly consider that this core belief was activated when you saw your boss talking to your co-workers?
P: Yes, it's possible.
T: How much do you believe now that you're unlovable?
P: I believe it a lot: 90%.
T: What does it make you feel?
P: Although it made me feel jealous before, now I'm sad.
T: How much?
P: Also a lot: 80%.
T: We will consider this as a self-accusation, if you agree, as we have done these two past weeks. Do you think we could do another trial and see what you learn about this?
P: Yes. I'm willing to do that. This technique helped me regarding the idea I had that I was incompetent, and I was much more comfortable. I'm sure it will help me again.

Calling Witnesses to Court

In this session, after the prosecutor's and the defense attorney's pleas, the therapist has also the option of proposing to call witnesses to testify against

and in favor of the defendant. The idea is to make the patient aware of the role and impact some people have in her life, by giving both the prosecutor and the defense attorney the chance to call witnesses to testify. In this case, instead of role-playing internal characters (prosecutor, defense attorney, juror), the patient will be able to picture and role-play real persons in her environment.

T: Paul [still in the defendant's chair, after pleas of both the prosecutor and defense attorney], would you please go back to the prosecutor's chair please? [Paul moves to the prosecutor's chair.] Now, Mr. Prosecutor, I would like to ask you if you would like to call anyone to testify against Paul, to prove that he is incompetent.
P: Yes, Your Honor, I'd like to call John, Paul's boss.
T: Would you please go to the defense attorney's chair? Now, Mr. Defense Attorney, I would like to ask you if you would like to call anyone to testify in favor of Paul, to prove that he is not incompetent.
P: Yes, Your Honor, I'd like to call Karl, Paul's best friend, who knows him since he was a kid.

The trial I is completed exactly in the same way as in Session 5, with the therapist and patient role-playing the jurors, uncovering and labeling the cognitive distortions made by the prosecutor and the defense attorney, but this time taking into account the witnesses' testimonials when necessary.

CASE ILLUSTRATION DIALOGUE

[After having made the bridge from Session 6, set the agenda, and reviewed the questionnaires and homework]

Introducing Trial I to Restructure a Second Core Belief

T: OK, Leslie. I'm happy to know that you are feeling more at ease in your work, regarding the assistance you give to the lawyers. But you told me that you still have thoughts about not doing your job well.
P: Yes, Dr. de Oliveira, this is not so much in relation to being evaluated by the public, but something telling me that I am not good enough, as though I'm not competent.

Step 1: Investigation

T: Can you picture this as a kind of self-accusation? Which one mobilizes you more: I'm not good enough or I'm incompetent?
P: They are the same thing, but I'm not good enough seems to bother me more. This is an expression my mother repeated when I didn't have a good grade at school.

T: How much do you believe now that you are not good enough?
P: 95%.
T: What does it make you feel?
P: I'm sad: 90%.
T: Do you think the trial could help you understand more about this self-accusation, "I'm not good enough"?
P: Yes, Dr. de Oliveira.

[Except for homework, this session is similar to Session 5.]

Assigning Homework

T: Leslie, how much time do you think it will take you to gather evidence supporting your new core belief "I'm good enough"?
P: The same, because now I will pay attention to the evidence that I'm good enough, isn't it?
T: May I ask you to continue paying attention to the core belief "I'm a normal person" too? Do you think it will take longer to do your homework?
P: Yes, because now I have two new core beliefs.
T: Does it surprise you if I tell you that the time you will use for that is the same as for one core belief?
P: And how is that, Dr. de Oliveira? I heard you say that I will gather elements for the two beliefs.
T: Yes, you are right. However, the elements you could find for one may be good for the other. Please take a look at this form. [The therapist shows the two or more beliefs form (Table 7.1).] It is enough to search for just three pieces of evidence. This form is structured in such a way that one should search up to three pieces of evidence. If one piece of evidence supports the two beliefs, you just need to repeat it in the other column. Does this make sense to you?
P: Yes.
T: However, even if you do not find evidence for one belief one day, but find it for the other, I would like to ask you to mark how much you believe both core beliefs, all right?
P: Yes, no problem with that.

Table 7.1 Preparation for the appeal (form for two or more beliefs)

Positive new core beliefs. Please, write down at least one piece of evidence supporting the new core beliefs. Also, write how much you believe it (%) daily. Note that one piece of evidence may support one or more new core beliefs.

Date	*I am a normal person*	*I am good enough*	*I am. . .*	*I am. . .*
21/05/12	(60%)	(60%)	(%)	(%)
	1. *I went to the movies.*	1._____	1.	1.
	2. *John invited me to go out.*	2._____	2.	2.
	3._____	3. *I helped several clients at work.*	3.	3.
22/05/12	**Date:** (70%)	(65%)	(%)	(%)
	1. *I exercised this morning.*	1._____	1.	1.
	2. *Anna asked for advice.*	2. *Anna asked for advice*	2.	2.
	3. *I helped clients at work.*	3. *I helped clients at work.*	3.	3.
23/05/12	**Date:** (65%)	(60%)	(%)	(%)
	1. *I helped my mother to get dressed*	1._____	1.	1.
	2. *I exercised.*	2._____	2.	2.
	3. *I had lunch with Anna at the cafeteria.*	3._____	3.	3.
24/05/12	**Date:** (%)	(%)	(%)	(%)
	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

8 Trial I in the Appeal Format to Change a Second Core Belief

Outline

- Explaining Trial I to Restructure a Second Core Belief in the Appeal Format
- Assertive Letter to the Prosecutor

Case Illustration Dialogue

- Trial I in the Appeal Format to Restructure a Second Core Belief
- Assigning Homework

Explaining Trial I to Restructure a Second Core Belief in the Appeal Format

As in Session 6, in the following transcript, trial I is implemented in the appeal format.

T: Paul, I'm happy you are succeeding in gathering elements in your daily routine showing that you are competent, and now that you're lovable, contrasting the idea that you were incompetent and unlovable.
P: Yes. It is becoming easier to find elements and evidence showing that I am competent and also that I am lovable.
T: Why don't we set our agenda? What would you like to add to the agenda today?
P: I recall you told me that we could have another appeal requested by the prosecutor today. In fact, I had this in mind during the week. Although I had several pieces of evidence showing that I am lovable, I don't believe it much. There are always situations showing me the opposite, that I am unlovable.
T: Do you have something in mind, a specific example of something that might have happened this week?
P: Yes. This time, it was Martha. I called her to invite her to see a new play, and she apologized and said she was tired. My first thought was that she stopped loving me. I couldn't avoid this idea that maybe I am unlovable.

T: Good. Would you agree to test this idea here in session? Can we go back and give the prosecutor the chance to prove that you're unlovable?
P: Yes, we can do that.
T: Can you sit in the chair in front of me and, as a defendant, tell me how much you believe you're unlovable?
P: Not as before, but still a lot: 50%.
T: What does it make you feel?
P: Sad, the same as last week.
T: How much?
P: Also 50%.
T: We will take this as a self-accusation. Please, come to this chair beside me and, as a prosecutor, tell us why Paul is unlovable.

Assertive Letter to the Prosecutor

Having performed at least two trials I, the patient is now able to notice the bullying character of the prosecutor. The therapist proposes that the patient start becoming assertive against the prosecutor's abusive demands. A useful and sometimes very emotional approach is to ask the patient to formally write an assertive, respectful letter or e-mail to the prosecutor explaining that, from now on, he will not comply with the prosecutor's demands any more.

T: Paul, what did you notice about the prosecutor in the last trials and appeals we performed?
P: It is now clear that the prosecutor makes distortions of the facts all the time.
T: Do you agree that, in the absence of a competent defense attorney, you tended to comply with the prosecutor's demands?
P: I did not even know about the existence of a defense attorney.
T: It's funny that even knowing this, you still believe and obey the prosecutor; am I right?
P: Yes. It is a habit of many years. I'm not sure I'll succeed in changing it.
T: Just being aware of its existence has already changed something, don't you agree?
P: Yes, it has changed a little, but I would like it to be durable.
T: Let me propose something to you that might help you accomplish this. I'd like to ask you to write an assertive letter to the prosecutor. In this letter, or e-mail if you prefer, you will formally explain to the prosecutor why you will not comply with his demands any more.
P: And how should I do that? I don't know what to say.
T: You have now collected a lot of information on that. You have your copies of trial I forms filled in. It might be something like: "Dear Prosecutor, I know you have been trying to help me all these years, but now, I decided not to obey you any more. Here are the reasons: You have lost all the trials and appeals so far. In them, all the elements you presented were distortions. Instead of helping me, I now notice that you have paralyzed rather than

helped me." You can also state all the damages the obedience to the prosecutor caused to your life. What do you think?

P: I understand. It will be a long letter.

T: I am curious and will ask you to read it to me next session. OK?

P: OK.

CASE ILLUSTRATION DIALOGUE

[After having made the bridge from Session 7, set the agenda, and reviewed the questionnaires and homework]

Trial I in the Appeal Format to Restructure a Second Core Belief

T: OK, Leslie. I'm curious to know if this idea, a sort of self-accusation, "I'm not good enough," is still bothering you.

P: Yes, Dr. de Oliveira, although not as strong as before, this idea still comes to mind.

T: So, can we go on and give the prosecutor another chance to prove that this accusation is valid?

P: Yes, of course. I have much evidence. I took written notes during the week showing that this is not true. But, let's go give the prosecutor another chance.

Assigning Homework

[Same as last week. The therapist could also ask her to write an assertive letter to the prosecutor.]

9 Changing Multiple Negative Core Beliefs with Trial I

Outline

- Introducing Multiple Core Beliefs to the Patient

Case Illustration Dialogue

- Bridge from Session 8 and Setting the Agenda
- Introducing Multiple Core Beliefs and Trial I While Working on the Agenda Item
  - *Step 1: Investigation (Table 9.1, Column 1)*
  - *Step 2: Prosecutor's Plea (Table 9.1, Column 2)*
  - *Step 3: Defense Attorney's Plea (Table 9.1, Column 3)*
  - *Step 4: Prosecutor's Second Plea (Table 9.1, Column 4)*
  - *Step 5: Defense Attorney's Second Plea (Table 9.1, Columns 5 and 6)*
  - *Step 6: Jury's Verdict (Table 9.1, Column 7)*
  - *Step 7: Preparation for the Appeal (Table 9.2)*
- Reviewing the Cognitive Conceptualization Diagram and Concluding Session 9

Introducing Multiple Core Beliefs to the Patient

It is not infrequent that patients have two or more active CBs. This can be a partial explanation of why restructuring just one core belief is not enough to improve the patient's symptoms, as one negative CB may activate others. For instance, after having the CB "I'm incompetent" restructured during one session, Paul had his negative CB "I'm unlovable" activated by seeing his boss talking to his co-workers. Thus, in addition to strongly believing that he was unlovable, Paul had his negative CB "I'm incompetent" reactivated.

In TBCT, multiple negative CBs may be restructured in the same session. The following extract illustrates how the therapist may introduce the trial I for multiple beliefs to a patient.

T: OK, Maria. And at these times when you are thinking of how to talk to your husband about changing your job, what are the thoughts that have gone through your mind?
P: First, that he will be angry and that he will try to convince me not to do it.
T: Has anything else gone through your mind about this?
P: He's going to think that I'm not the same strong woman he met before.
T: And, if this thought is true, what does it mean about you?
P: It means that I am weak.
T: Is there any other adjective you use to qualify yourself is such situations?
P: Yes. I think that I am a failure and that my husband will reject me. So, I am unlovable.
T: Is it correct to say that we have three activated core beliefs here?
P: Yes, I think that I'm weak, that I'm a failure, and that I'm unlovable.
T: Right. Maybe we could put these three activated negative core beliefs on trial. What do you think?
P: Is that possible, Dr. de Oliveira?
P: Yes. It is possible and we can do it right now.

CASE ILLUSTRATION DIALOGUE

Bridge from Session 8 and Setting the Agenda

T: Good morning, Leslie.
P: Good morning, Dr. de Oliveira.
T: It would be interesting if you summarized what has been happening so that we can see in what way I can help you today.
P: Right. Well, Dr. de Oliveira, I have been feeling fine, and this therapy has helped me enormously. But lately, since the last session, I've been feeling lots of pressure. That is, I haven't been able to get back to my work routine, since this last week has been extremely complicated, because of my sister's problem with my parents. So it was an extremely difficult week because the situation between my sister and my parents got a lot worse, and automatically I got involved in the process, trying to help. But then, with all this, I became very stressed; it wore me out psychologically so much, because the situation became more serious, with threats to my parents—it became critical.
T: This is a new problem that hasn't come up into our therapy so far. I see you are going through a very stressful time, because now the circumstance does not involve only you, but your whole family, right?
P: Exactly. So, we'd been working on my difficulties regarding my social anxiety so that I could have normal contact with people, without feeling so anxious. It's just that I realized, during this past week, that if something like this happens, then I don't cope well with it. That is, I get into enormous psychological exhaustion. So I've been feeling exhausted because my life isn't normal.

Table 9.1 Leslie's TBCT form for multiple beliefs

1. **Inquiry/Establishing the accusations (cores beliefs).**	2. **Prosecutor's plea**	3. **Defense attorney's plea**	4. **Prosecutor's rebuttal or response to the defense attorney's plea**	5. **Defense attorney's rejoinder to the prosecutor's plea** **Note:** columns 5 and 6 are filled in at the same time.	6. **Meaning of the rejoinder presented by the defense attorney to the prosecutor's plea**	7. **Juror's verdict**
Accusations: *1) I'm strange* *2) I'm a failure* *3) I'm a fraud* *4) I'm bad* **Emotions:** *1) Anger* *2) Sadness* *3) Anxiety*	1) She's a person who does not learn. 2) She isn't capable of remaining stable when facing problems. 3) She isn't able to maintain a work routine. 4) She doesn't give the attention she should to a friend in need. 5) She blocks calls on her cell phone so she won't have to answer people's calls.	1) She is an extremely disciplined person (her planned activities are carried out). 2) She goes to her therapy sessions and does the homework correctly. 3) People say that she is extremely kind. 4) She is extremely supportive of her friends, and they all say this. 5) She is sought out by her friends and gives them advice.	**But:** 1) She always does what other people want. 2) Look at her, in utter suffering facing all the activated beliefs. 3) These people aren't with her all the time; only she knows. 4) She blocks her friends' calls and restricts her time. 5) She has set restrictions.	**But:** 1) She is an extremely disciplined person (her planned activities are carried out). 2) She goes to her therapy sessions and does the homework correctly. 3) People say that she is extremely kind. 4) She is extremely supportive of her friends, and they all say this. 5) She is sought out by her friends and gives them advice.	**It means that:** 1) She is a disciplined person; therefore, she is capable of leading a normal life. 2) This means that she is improving; therefore, she is going to get better. 3) She can be kind; therefore, people might be telling the truth. 4) She is not bad; therefore, she's a good person. 5) She is supportive; therefore, she is not a bad person.	**Cognitive distortions:** **Pros. 1** / **Def. att. 1** 1: L / 1: True 2: DT / 2: True 3: DT / 3: True 4: SS / 4: True 5: JC / 5: True **Pros. 2** / **Def. att. 2** 1: OG / 1: True 2: DP / 2: True 3: DP / 3: True 4: DP / 4: True 5: DP / 5: True **Verdict:** **NOT GUILTY**

(*Continued*)

Table 9.1 (Continued)

1. **Inquiry/Establishing the accusations (cores beliefs).**	2. **Prosecutor's plea**	3. **Defense attorney's plea**	4. **Prosecutor's rebuttal or response to the defense attorney's plea**	5. **Defense attorney's rejoinder to the prosecutor's plea** **Note:** columns 5 and 6 are filled in at the same time.	6. **Meaning of the rejoinder presented by the defense attorney to the prosecutor's plea**	7. **Juror's verdict**
% INITIAL % FINAL **Accusations:** 1) 100 0 2) 100 0 3) 100 0 4) 100 0 **Emotions:** 1) 100 0 2) 100 0 3) 100 0	**Accusations:** 1) 100 2) 100 3) 100 4) 100 **Emotions:** 1) 100 2) 100 3) 100	**Accusations:** 1) 80 2) 80 3) 80 4) 80 **Emotions:** 1) 80 2) 80 3) 70	**Accusations:** 1) 90 2) 100 3) 100 4) 90 **Emotions:** 1) 90 2) 90 3) 90		**Accusations:** 1) 65 2) 70 3) 70 4) 65 **Emotions:** 1) 60 2) 60 3) 60	**Accusations:** 1) 0 2) 0 3) 0 4) 0 **Emotions:** 1) 0 2) 5 3) 5

L = labeling; DT = dichotomous thinking; SS = should statement; JC = jumping to conclusions; OG = overgeneralization.

Introducing Multiple Core Beliefs and Trial I While Working on the Agenda Item

Step 1: Investigation (Table 9.1, Column 1)

T: Leslie, which negative core belief do you think is active now? What does this new situation you are going through mean about you?
P: It means that I'm strange.
T: But I suspect that this is not the only core belief being activated. It seems to me that there is a circle being closed, where a belief like "I'm strange" is active, but it also seems to activate other core beliefs.
P: How is that, Dr. de Oliveira?
T: You can clearly see that this belief "I'm strange" has been activated, but I have the impression that, from everything you've said, it's like other negative beliefs were also activated. What does this lead you to think? I am . . .
P: I also believe, Dr. de Oliveira, that I'm a failure, that I'm a fraud, and that I'm bad.
T: I will write this down here, Leslie, but I'm going to propose to you that we work today a little differently from the way we have done before. That is, we've always worked with one belief.
P: Yes.
T: You've just told me that you are strange. Shall we transform "I'm strange" into an accusation? But it looks to me that your prosecutor isn't only accusing you of this today, but of several things.
P: Yes, several beliefs.
T: So, I'm going to write here in the negative core belief box of the cognitive conceptualization diagram [the therapist shows her the CCD]: "I'm strange," "I'm a failure," "I'm a fraud," and "I'm bad."
P: Yes.
T: Can you see that we're able to, at the same time, work on several beliefs?
P: Yes, Dr. de Oliveira.
T: We've never done this before; this is the first time we'll try to work on several negative core beliefs at the same time. You said "I'm strange." How much do you believe this now, Leslie?
P: I believe it 100%.
T: I'll write down 100%. How much do you believe, now, that you're a failure?
P: Oh, the same, Dr. de Oliveira: 100%.
T: How much do you believe you are a fraud"?
P: 100%.
T: And how much do you believe you are bad?
P: 100%.
T: So it is easy to see how high, now, with all these accusations, your level of suffering must be . . .
P: There are several accusations.
T: And, by believing all these things, how does this make you feel, if we take the most important emotions?

P: Oh! I'm angry at myself, I'm feeling sad, and I'm also feeling anxiety.
T: So let's write down anger, sadness, and anxiety. What is the amount of your anger right now?
P: I'm really angry, 100% angry.
T: What is the amount of your sadness right now?
P: It's also 100%.
T: This can also be seen by your tears; right now you are crying. And what is the amount of your anxiety at this time, Leslie?
P: It's also 100%, Dr. de Oliveira. I need to get away from this bunch of beliefs.
T: Leslie, what if we did another trial now? I think we can put all these beliefs that you've just mentioned here on trial. I'd like us to transform this into a tribunal. I'd like you to take the chair of the defendant at this time, because we're going to begin this trial and you'll be charged, but first I want you to get the feeling of being in the defendant's chair, for this accusation to be formalized.
P: Right.
T: Could you go sit over there, Leslie? [Patient goes to the defendant's chair.] OK, so you are in the tribunal, seated in the defendant's chair, and you are being accused of being strange, of being a failure, of being a fraud, and of being bad, all of these at the same time. Do you believe all this 100%, like you just told me?
P: Yes, I do.
T: OK. And this causes anger, sadness, and anxiety 100%, right?
P: 100%.

Step 2: Prosecutor's Plea (Table 9.1, Column 2)

T: The man or woman formalizing this accusation is the prosecutor. I'd like you to look over at this chair, because there is a person seated here. Describe this person to me, Leslie. Is it a man? Is it a woman? How is he or she dressed? How does he or she look at you?
P: It's a woman. She is dressed in black. She is very cruel. She has a very mean face. But the worst part is that I know that what she is saying is true. That is what is painful in her expression, because she appears to be saying the truth.
T: So, you know the prosecutor perfectly well, because she's been a part of your life, and you see her here, in this chair.
P: Yes, I can see her.
T: OK, I'd like you to come and sit over here; could you do that?
P: Sure.
T: You are now this person, you are the prosecutor. And as the prosecutor, you are accusing the defendant, Leslie, of being strange, a failure, a fraud, and bad. What are the elements that you have to prove all these accusations?
P: She's a person who does not learn . . .
T: Yes.
P: She isn't capable of remaining stable when facing problems . . . . She isn't able to maintain a work routine.

T: So, she can't maintain a routine.
P: No, she can't. She's unable to. She can't keep up her work routine, and help people with their requests without much anxiety, while maintaining stability.
T: OK, is there any other element you'd like to point out to prove all these things?
P: She doesn't give due attention to her sister and to her parents that she should. She's the kind of person who is unable to give the attention she should, for example, to a friend in need. She makes up stories. She says she's somewhere else, and blocks calls on her cell phone so she won't have to answer people's calls.
T: So she blocks calls on her cell phone . . .
P: Yes, she is totally bad. She is a fraud. She pretends everything is 100%, that she is someone who is available to give other people advice, to help her sister and her parents, but she can't do any of these.
T: OK. So, if we could stop now, I'd like you to go back over there. [Patient sits in the defendant's chair.] Leslie, see what you've just heard from the prosecutor.
P: Right.
T: The prosecutor accuses you of being strange, a failure, of being a fraud, of being bad, and there are arguments to back her up. The arguments she brought up are that you are unbalanced because you are unable to remain stable. You can't maintain a work routine. You don't give due attention to your sister and to your parents that you should. And you block calls on your cell phone so your friends can't call you. Finally, the prosecutor says that you pretend to be available, but don't manage to be available to your friends. When you hear this, Leslie, how much do you believe these accusations?
P: 100%.
T: All of them?
P: All.
T: OK, so tell me something, how strong are the anger, sadness, and anxiety?
P: For sure, 100%.
T: You mean all three?
P: Yes.

Step 3: Defense Attorney's Plea (Table 9.1, Column 3)

T: OK, Leslie, I'd like to ask you to pay attention to that other chair, and I'd like you to look at it and visualize very clearly who is seated there. And at this point you know the person seated there is the one who will defend you, right?
P: Right.
T: So, describe this person to me, Leslie.
P: He's a tall, dark-haired man, who has a docile appearance, who looks agreeable and who looks at me with compassion. He looks at me with kindness: I see this in this person.

T: All right. So, I'd like you to come here and assume the identity of the defense attorney. [Patient sits in the defense attorney's chair.] So you are seated here to defend Leslie against several accusations. Leslie has just been accused, and not only accused of all this but we also just heard all the elements pointed out by the prosecutor to prove this. I'd like you to assume your role by way of defending Leslie against these accusations.

P: Leslie is an extremely disciplined person.

T: And maybe you could give an example.

P: As an example I could cite her activity. When she schedules things, she always follows through; any commitment she has, including her therapy sessions, she follows it just right, goes to the sessions, does the homework correctly. She is a very disciplined person. And, as testimony, the people who are always around her focus on this characteristic of hers: that she is extremely kind.

T: OK, so I am hearing you say that people say that she is kind.

P: Yes. Another thing is that she shows her friends a lot of support.

T: She is quite supportive of her friends.

P: This is also always said by her friends, so much so that she is very sought after to advise people. People seek her out, she gives people advice, she talks with them.

T: OK. Maybe you could return to that chair, and now we will have Leslie as defendant. [Patient goes to the defendant's chair.] So, Leslie, you have just heard from the defense, and the defense attorney doesn't agree with these accusations that you are strange, a failure, a fraud, and bad. He uses several arguments for this, and I'd like you to listen to the arguments used by the defense attorney. He says that you are extremely disciplined and shows as an example your activity calendar that is carried out. The defense attorney says that you go to the therapy sessions and do the homework correctly. The defense attorney states here that people say you are extremely kind. Besides, he gives as an example that you are extremely supportive of your friends, and states that they say this about you. The defense attorney, disagreeing with these accusations, says that your friends seek you out, and that you give them advice, which they started to ask you for. When you hear all this, how much do you believe you're strange, Leslie?

P: 80%.

T: How much do you believe you're a failure?

P: 80%.

T: How much do you believe you're a fraud?

P: 80% also.

T: How much do you believe you're bad?

P: I'll put 80% as well, for now.

T: OK, how does this leave then, Leslie, the amount of anger?

P: By listening to the defense attorney, I feel a little relief. So I'll decrease the anger to 80% also.

T: Where does this leave the sadness?

P: I'll decrease the sadness to 80%.
T: How about the anxiety?
P: I'll decrease the anxiety to 70%, because it went down a little more than the anger and sadness.

Step 4: Prosecutor's Second Plea (Table 9.1, Column 4)

T: OK. Leslie, of course now it is time for the rebuttal, and I'd like you to come here and visualize again the person who is the prosecutor, whom you saw a while back. Please sit here in this chair. [The patient moves to the other chair.] Now you will be this person.
P: I am the prosecutor.
T: So, Madam Prosecutor, the defense says that "Leslie is an extremely disciplined person (her planned activities are carried out)," but . . .
P: She always does what other people want.
T: The defense says that "Leslie goes to her therapy sessions and does her homework correctly," but . . .
P: Look at her, in utter suffering, facing all the activated beliefs.
T: The defense states that "people say she is extremely kind" but . . . .
P: These people aren't with her all the time. Only she knows.
T: OK. The defense says that "she is extremely supportive of her friends, and they all say this," but . . .
P: But she blocks the calls, she sets a limit.
T: The defense attorney says that "her friends seek her out and she gives them advice," but . . .
P: But she's been restricting this.
T: OK. Could you go back over there, please? [The patient moves to the defendant's chair.] Leslie, the prosecutor maintains all these accusations. She insists that you are strange, a failure, a fraud, bad, and the arguments stated by the prosecutor are that you have not passed any examination. She goes on to say, "Look at her, in utter suffering facing all the activated beliefs!" The prosecutor even used these points to prove all these accusations—in this case referring to those who say you are disciplined—saying that these people aren't with you all the time, and that only you know. The prosecutor insists that you block calls from your friends and set time limits. And, finally, regarding the fact that you are sought out by friends, it was said that you have been restricting this. When you hear all this, Leslie, I'd like you to tell me how much you believe you are strange.
P: 90%.
T: How much do you believe you are a failure?
P: Oh, I think I'll put 100%.
T: How much do you believe you are a fraud?
P: 100% also.
T: How much do you believe you are bad?
P: 90%.

T: How much anger is there?
P: 90%.
T: How much sadness is there?
P: 90%.
T: And how much anxiety is there?
P: It also goes up to 90%.

Step 5: Defense Attorney's Second Plea (Table 9.1, Columns 5 and 6)

T: Can you see the defense attorney here beside me again?
P: Yes.
T: Are you visualizing him?
P: Yes, I am.
T: Is the person's image clear to you?
P: Yes, it's clear.
T: Because I'd like you to come here and assume the person of the defense attorney. So, again you have the floor to defend Leslie against these accusations. What I'd like you to do, after I read the arguments used by the prosecutor and add the "*but*," is for you to copy down what was previously said by you. So, "she always does what other people want," but . . .
P: She is an extremely disciplined person; her planned activities are carried out.
T: What does this say about Leslie, who is over there?
P: This means that Leslie is a disciplined person.
T: So write that down here, she is . . .
P: She is a disciplined person.
T: Therefore . . .
P: . . . she is capable.
T: Why don't you write that down? She is capable.
P: She is capable of leading a normal life.
T: So you can continue using the same strategy. "Look at her, in utter suffering facing all the activated beliefs," but . . .
P: She goes to her therapy sessions and does her homework correctly.
T: What does this say about Leslie?
P: This means that she is improving.
T: Therefore . . .
P: . . . she is going to get better.
T: "These people aren't with her all the time, only she knows," but . . .
P: People say that she is extremely kind.
T: What does this say about her?
P: It means that she can be kind; therefore, people might be telling the truth.
T: "She blocks her friends' calls and restricts her time," but . . .
P: She is extremely supportive of her friends, and they all say this.
T: What does this mean regarding Leslie?
P: This means that she is supportive; therefore she isn't bad. So, she is . . . I won't say that she is good, because she . . .

T: Let me tell you something. You are in fact here as the defense attorney. There are things that might not be necessary and that could be used by the prosecutor. Do you maintain, or would you like to rephrase what you just said?
P: Right, so, she's good. She's a good person.
T: "She has set restrictions," but…
P: She is sought out by her friends and gives them advice.
T: What does this mean about Leslie?
P: This means that she is supportive; therefore . . . she is not a bad person.
T: OK. So, if you would please go over there. [The patient sits in the defendant's chair.] So, Leslie, you've just heard from the defense attorney, who not only repeats all the arguments stated beforehand but also comes to conclusions about you. The defense attorney just stated that you are extremely disciplined—that is, you carry out your planned activities—meaning that you are capable of having a normal life.
P: Right.
T: The defense attorney says that you go to your therapy sessions and do the homework, meaning that you are improving; therefore, you are going to get better.
P: Exactly.
T: The defense attorney states that people say you are extremely kind, meaning that you can be a kind person; therefore, people might be telling the truth. The defense says that you are extremely supportive of your friends, and they all say this, meaning that you are a good person.
P: Right.
T: And finally, the defense says that yours friends seek you out and you give them advice, meaning that you are supportive; therefore, you are not a bad person. When you hear all this, Leslie, how much do you believe you are strange?
P: 65%.
T: How much do you believe you are a failure?
P: I believe it 70%.
T: How much do you believe you are a fraud?
P: Also 70%.
T: How much do you believe you are bad?
P: Now I believe it 65%.
T: Where does this leave your anger, Leslie?
P: 60%.
T: How about your sadness?
P: 60%.
T: And how about your anxiety?
P: Also 60%.

Step 6: Jury's Verdict (Table 9.1, Column 7)

T: OK. With this, Leslie, you can see that we are finished with the participation of the prosecutor and defense attorney.
P: Right.

T: What we'll do now is go to the jury. So I'd like us to enter this other space.
P: Right.
T: I'd like you to come over here. And in this room you are not Leslie. It is very clear that our role here is, in fact, of absolutely neutral people.
P: Right.
T: And as neutral people, you being juror number 1 and myself juror number 2, all we have to do here is to see exactly what was said by the prosecutor and then by the defense attorney. So, this is our document [the therapist hands her the cognitive distortions sheet], and with this document we'll go through item by item and see what was said by one side and the other, because our objective is to see who distorted the facts or who presented the facts truthfully. Is this fine?
P: Sure.
T: Beginning with the prosecutor, she said that Leslie, who is outside this room, is a person who doesn't learn.
P: Actually, she is labeling, in my opinion.
T: The prosecutor stated that she isn't capable of remaining stable when facing problems.
P: I think that here she is using all or nothing; that is dichotomization, right? And also labeling, right?
T: I'd say that it's more like dichotomous thinking, because, strictly speaking, it seems to me that Leslie, based on the information we have, at certain times is very well and manages to get things done. So it looks like the prosecutor is dichotomizing.
P: Exactly. Dichotomous thinking.
T: The prosecutor said that she isn't able to maintain a study routine.
P: I think that here it's more a case of labeling, isn't it?
T: I'm not sure. I think it might be dichotomous thinking, because, strictly speaking, it appears that when things are going reasonably well and when she doesn't get interrupted by any daily issues, then Leslie can; consequently, it seems that these are more like the type of all-or-nothing thoughts; isn't that right?
P: You are right.
T: The prosecutor stated that she doesn't give the attention she should to a friend in need.
P: Actually, it's also dichotomy and a "should statement," right?
T: The prosecutor said she blocks calls on her cell phone so she won't have to answer people's calls.
P: I think the prosecutor is telling the truth here.
T: It appears that this is true, but is blocking calls sufficient for her to deserve the accusation of being strange, a failure, a fraud, and bad?
P: No, no. I think it is, in fact, jumping to conclusions. There are certain times that we need to isolate ourselves.
T: Yes. Shall we move on to the defense? The defense attorney said that Leslie is extremely disciplined, she carries out her planned activities; that is, she gets things done.
P: Yes, it's true. We can bring witnesses forward to confirm this.

T: OK. "Leslie goes to the consultations and does the homework correctly."
P: I don't see any distortion there either; we can prove it, right?
T: The defense attorney affirms that people say that she is disciplined.
P: There too, I don't see any distortion; people say this, they testify, right?
T: Yes. The defense attorney says that she is extremely supportive of her friends, and that they all say this.
P: So it's the same case, I guess. I don't see any distortion here either.
T: And the defense attorney says that she is sought out by her friends and that she gives them advice.
P: I can't see any distortions there either.
T: OK. If we go back to the prosecutor, then secondly, the prosecutor said that she always does what other people want.
P: It's overgeneralization.
T: The prosecutor said: "Look at her, in utter suffering facing all the activated beliefs!" It seems to me that this is total discounting positives, don't you think?
P: Yes, totally discounting positives.
T: Even done in a mocking way, right?
P: Exactly.
T: The prosecutor said that the people who spoke for the defense aren't with Leslie all the time. Only she knows.
P: Yes. I also think that here she is discounting positives.
T: And the prosecutor said that she blocks her friends' calls and restricts her time, which is true.
P: Yes, this is true.
T: Tell me something: the fact that she blocks her friends' calls, isn't this discounting what was stated by the defense attorney—that she is extremely supportive of her friends?
P: Yes. It's discounting.
T: OK. Let's write it down here as discounting positives. And finally, the prosecutor said that she limits the fact that people seek her out and she gives them advice. It appears to be discounting positives as well, doesn't it?
P: Yes.
T: OK. When the defense attorney addressed the court for the second time, he repeated exactly what had been said and drew some conclusions. So, the defense attorney said that Leslie is extremely disciplined, she carries out her planned activities, and that this shows how disciplined she is; therefore, she is capable of leading a normal life.
P: Exactly. I don't see any distortion there.
T: He said that she goes to the consultations and does her homework correctly, which means that she is improving, and since she is improving, the conclusion is she is going to get better.
P: Exactly.
T: The defense attorney affirmed that people state she is extremely kind, which means that she can be kind; therefore, people might be telling the truth.
P: Right. I don't see any distortion there.

T: The defense attorney said that she is extremely supportive of her friends, and they all say this, meaning that she is not bad; therefore, she is a good person.
P: I agree. I don't see any distortion.
T: And the defense attorney said that she is sought out by her friends and she gives them advice, which means that she is supportive; therefore, she is not a bad person.
P: I can't see, I can't visualize any cognitive distortion.
T: It looks to me that everything that was stated here is true.
P: That's right; it's all true.
T: OK. What we have here is the record (Table 9.1), where the prosecutor's analysis is in the first sub-column of column 7, and the defense attorney's is in the second one. What do you, juror number 1, suggest?
P: Really, there isn't anything to question here. Actually, we can leave this room clearly seeing how the prosecutor used distortions in all the pieces of evidence presented during the trial. That is, she discounted positives, she labeled, she used dichotomous thinking, while the defense attorney always tried to use true evidence . . .
T: OK. Shall we return to the tribunal?
P: Let's.
T: So now, I'll again take the chair of the judge. And I'd like you to, formally and before the judge, state what the result is from what was discussed by us as jurors.

[Therapist moves to the judge's chair. Leslie stands up before the judge.]

P: Well, Your Honor, we, as jurors, discussed and came to our conclusions. In fact, the prosecutor used distortions in all the evidence that was presented. That is, in each piece of evidence presented by the prosecutor we were unable to prove any of the facts. We found labeling, dichotomous thinking, and other distortions; she always discounted positives in all the phases of this trial. Before all this, and at the same time evaluating what the defense attorney said, we verified and validated each piece of evidence presented by him. Therefore, we state that the defendant is not guilty.
T: OK. Would you please sit over there? [Patient moves to the defendant's chair.] OK, Leslie, you've just heard the verdict stated by juror number 1, and saw all the reasons that show you are acquitted of these accusations. According to the record I have here in my hands, and from what was stated by juror number 1, we can clearly see that the prosecutor used several distortions. I can distinctly see discounting positives several times, while the defense attorney stated the truth, with no distortions at all. I would now like you to reassess how much you believe all these accusations against you. How much do you believe you are strange?
P: 0%.
T: How much do you believe you are a failure?
P: 0% as well.
T: How much do you believe you are a fraud?

P: 0% also.
T: And how much do you believe you are bad?
P: 0%.
T: OK. Insofar as you believe all these statements 0%, what is the level of your anger?
P: I'm not angry. 0%.
T: What is the level of your sadness, Leslie?
P: I'm still feeling a bit sad from the whole trial. Just a little. I'll say 5%.
T: What is the level of your anxiety?
P: I'll say 5% also.

Step 7: Preparation for the Appeal (Table 9.2)

T: So, Leslie, by being acquitted of all this and not believing these accusations, it appears to me that you are now free to come and go. So, I'd like us to go back to our therapy setting. Leslie, I think it would be worthwhile for us to evaluate this. I am curious to know how you feel and how you'd describe it all.
P: I am so relieved.
T: For a very simple reason: this is the first time we worked in this way, with all the beliefs as a set.
P: Oh, Dr. de Oliveira, I'm feeling much lighter, I arrived here so overburdened. And when we began to discuss all the beliefs as a set, it was overwhelming at first. Actually, the feeling I got was that I wouldn't even be able to go through the trial.
T: Well, what happened when you sat in the defendant's chair, over there, and heard in a clear and merciless way what the prosecutor said?
P: I thought that what was being said was the absolute truth and that I wouldn't overcome all that, because so many things were activated at the same time.
T: Every time we had our sessions before and did the trials, they were always about one accusation, one belief. Now, we worked on several beliefs at the same time. And it was very emotional, wasn't it?
P: Yes, very emotional. That position, of the defendant, carries a lot of emotion at the same time. Because you feel each one, and in this case, I had several beliefs activated at the same time: "I'm strange," "I'm a failure," "I'm a fraud," and "I'm bad."
T: This explains, Leslie, why at first you would get rid of one belief, but it wouldn't go down to 0% because maybe the other activated beliefs would still be feeding some other beliefs . . .
P: Now the connection is very clear, Dr. de Oliveira. When I listen to the prosecutor, all of the statements are linked together: "I'm strange, I'm a failure, I'm a fraud, I'm bad," all these beliefs come at the same time, and are very real and connected. When I listen to the jurors going over each piece of evidence, one by one, and all are proved to be distortions made by the prosecutor, then, I become convinced that I'm not strange. On the contrary, I'm a normal person. I don't feel I'm a failure. On the contrary, I'm a successful person. I'm not a fraud; I'm

Table 9.2 Leslie's preparation for the appeal (form for two or more beliefs)

Positive new core beliefs. Please, write down at least one piece of evidence supporting the new core beliefs. Also, write how much you believe it (%) daily. Note that one piece of evidence may support one or more new core beliefs.

Date	*I am a normal person*	*I am good enough*	*I'm successful*	*I'm an honest person*
23/06	(100%)	(100%)	(100%)	(100%)
	1. *I called to ask about Jane.*	1. ----------	1. ----------	1. *I called to ask about Jane.*
	2. *I traveled a long distance to therapy.*	2. ----------	2. *I traveled a long distance to therapy.*	2. ----------
	3. ----------	3. ----------	3. ----------	3. ----------
24/06	**Date:** (100%)	(90%)	(80%)	(95%)
	1. *I exercised this morning.*	1. ----------	1. ----------	1. ----------
	2. *Anna asked for advice.*	2. *Anna asked for advice.*	2. ----------	2. ----------
	3. *I helped clients at work.*	3. *I helped clients at work.*	3. *I helped clients at work.*	3. ----------
25/06	**Date:** (90%)	(85%)	(85%)	(95%)
	1. *I helped my mother to get dressed.*	1. ----------	1. ----------	1. ----------
	2. *I exercised.*	2. ----------	2. ----------	2. ----------
	3. *I had lunch with Anna at the cafeteria.*	3. *I had lunch with Anna at the cafeteria.*	3. ----------	3. ----------
26/06	**Date:** (90%)	(90%)	(80%)	(100%)
	1. *I told my husband that I love him.*	1. ----------	1. ----------	1. *I told my husband that I love him.*
	2. ----------	2. *I prepared lunch for my husband.*	2. ----------	2. ----------
	3. ----------	3. ----------	3. ----------	3. ----------
27/06	1. ----------	(80%)	(85%)	(95%)
	2. ----------	1. ----------	1. ----------	1. ----------
	3. ----------	2. ----------	2. ----------	2. ----------
		3. ----------	3. ----------	3. ----------

honest. And I do not believe I'm a bad person. On the contrary, I'm a good person. I was able to resolve a set of beliefs all at the same time.

T: What can we understand that your defense attorney wanted to prove about you, Leslie?

P: That I was normal, successful, honest, and a good person.

T: Exactly. Leslie, now I would like to give you this document, which will allow you to keep a diary of several positive beliefs at the same time. I would like you to keep on with it.

P: All right.

T: You have the possibility of evaluating all these beliefs at the same time, of following each one, and I'd like you to leave here today putting this down exactly, which is: what did the defense attorney want to tell you? And you yourself can write everything that was said by the defense in each item here, and follow this daily—bringing one, two, or three pieces of evidence showing that you are normal, successful, honest, and good.

P: OK, Dr. de Oliveira. It's funny, I leave here with everything: I'm normal, I'm successful, I'm honest and a good person.

T: If we were to begin the preparation for an appeal today, specifically, you'll see that we'll only bring three elements proving all these positive beliefs. If you had to bring three elements from your day now, what happened today that proves one or more of these beliefs?

P: For "I'm normal?"

T: Actually, you don't need to look for, specifically, "I'm normal." Tell me something that happened today that fits any one of these.

P: Right. A friend of mine is sick, and, before coming here, I remembered to call her to ask if she was feeling better today. So I think that this proves that I'm a good person, right?

T: Yes. Were you pretending when you did this?

P: No.

T: So, wouldn't that prove you are honest as well?

P: Oh, that's true!

T: You can see perfectly well how the same example fit in two beliefs.

P: That's true.

T: Can you describe to me anything else that happened today that might feed one or more of these beliefs?

P: Yes, I can. Before coming here I bought a book on the subject I'm studying, for an examination; I needed it because I'm not sure whether this subject will be tested or not, so, I'm a normal person.

T: So, basically, these two things.

P: Exactly.

T: So, you seem to understand what I'm asking you to do.

P: Yes, I do.

T: Therefore, although this diary is something you are quite accustomed to filling in, you can see that today it has a somewhat different aspect, which is exactly to bring elements that will help your defense attorney to prove all

these positive core beliefs. So, let me take the time now to ask how much you believe you are normal?

P: 100%.

T: How much do you believe you are successful?

P: 100%.

T: How much do you believe you are honest?

P: 100%.

T: And how much do you believe you are a good person?

P: Also 100%.

T: So, we had already evaluated these points here, where you started out with 100% for each one of the negative core beliefs and it seems to me that you ended with 0% in all of them. Do you confirm this?

P: Yes, I do.

T: And about your emotions, how are they?

P: Actually, they are all at zero.

T: And, insofar as you brought them all to zero, can you see that each one of these beliefs feeds the other one?

P: I can see it clearly now.

T: Can you also see that one positive core belief also activates other positive core beliefs?

P: Sure. This is very clear to me now.

Reviewing the Cognitive Conceptualization Diagram and Concluding Session 9

T: Leslie, would you take a look at this conceptualization diagram and describe to me what you saw taking place during this session? [The therapist shows her the CCD, phase 2 (Fig 11.2).]

P: At first I thought that the only core belief that would be activated was "I'm strange." But, actually, I had a set of negative core beliefs that were activated: I'm strange, I'm a failure, I'm a fraud, and I'm bad. Consequently, I managed to, through trial I, produce positive core beliefs. So, now this arrow points over here, activating these items, which are the positive beliefs.

T: Now that the upward arrow isn't coming from here [the therapist points to the negative core beliefs box], but coming from these activated positive beliefs [the therapist points to the positive core beliefs box], what are the thoughts that appear here in the automatic thoughts box [the therapist points to the AT box]?

P: Since I activated my positive core beliefs and deactivated the negative ones, I now have other kinds of automatic thoughts, like these: "Wow, Leslie, you are a normal person; you've been doing things as well as possible. You have been disciplined, when you needed to be disciplined. There are times when any normal person would be discouraged with a family situation that you've been facing." So, all these good thoughts come to mind, inside the automatic thoughts box.

T: What happens here in the emotional reaction box, about the emotions?
P: Everything decreased to zero.
T: Exactly. What do you think will happen now, Leslie, with your behaviors?
P: Now, I have a set of active positive core beliefs, which fostered automatic thoughts that were extremely favorable, with my emotional reactions decreasing to zero. Automatically, I won't have any need to avoid people or isolate myself.
T: Leslie, these behaviors, in fact, had become habitual, and you saw that, at this second level, we call them safety behaviors.
P: Exactly.
T: And you remember that they are safety behaviors because they make you feel good. When you avoid people, this gives you relief, because, if you don't, what happens?
P: I'm strange.
T: You are strange. So you can see this here as an underlying assumption.
P: Exactly.
T: In fact, you obey the underlying assumption through this behavior. And if you obey this assumption through this behavior, are you trying to deactivate or get rid of anything?
P: Maybe of my negative core beliefs. And I can clearly see that I still had a cognition behind this, which is the underlying assumption: if I don't avoid people, then this shows that I'm strange and I'll suffer a lot . . . . And now it's quite clear to me that I have no obligation to obey this underlying assumption.
T: And even if, eventually, it comes back by force of habit, what will you do with it?
P: I'll remember my set of positive core beliefs . . . . I'll remind myself that I'm normal, I'm successful, I'm honest, and I'm a good person.
T: And there is much to prove this, which is the daily evidence accumulated. OK? How are you feeling now, Leslie?
P: I'm feeling very good, Dr. de Oliveira, really quite well! I'm impressed with the result we achieved!

10 Trial-Based Metacognitive Awareness (Trial II)

Outline

- Introduction
- Description of the Trial-Based Metacognitive Awareness (Trial II) Technique
  - *Step 1: Investigation*
  - *Step 2: Charge Against the Prosecutor*
  - *Step 3: Patient's Attorney Formalizes Patient's Accusation Against the Prosecutor*
  - *Step 4: Prosecutor's Defense Attorney Defends the Prosecutor*
  - *Step 5: Patient's Attorney Replies to the Prosecutor's Defense Attorney*
  - *Step 6: Prosecutor's Defense Attorney Replies to the Patient's Attorney's Plea*
  - *Step 7: Jury's Verdict*
  - *Step 8: Judge's Sentence*
- Explaining Metacognitive Awareness to the Patient

Case Illustration Dialogue

- Bridge from Session 9 and Setting the Agenda
  - *Step 1: Investigation*
  - *Step 2: Charge Against the Prosecutor*
  - *Step 3: Patient's Attorney Formalizes Patient's Charge Against the Prosecutor*
  - *Step 4: Prosecutor's Defense Attorney Defends the Prosecutor*
  - *Step 5: Patient's Attorney Replies to the Prosecutor's Defense Attorney*
  - *Step 6: Prosecutor's Defense Attorney Replies to the Patient's Attorney's Plea*
  - *Step 7: Jury's Verdict*
  - *Step 8: Judge's Sentence*
- Debriefing
- Summary and Feedback
- Explaining Metacognitive Awareness to the Patient
- Assigning Homework and Concluding Session 10

Introduction

Cognition includes the whole range of variables involved in the processing of information and meaning (Alford & Beck, 1997). Metacognition is defined as a range of interrelated factors in cognitive processes that involve the interpretation, monitoring, or control of cognition (Wells, 2009).

Metacognitive knowledge incorporates beliefs and theories that people hold about their own thinking, and this knowledge may comprise beliefs about specific types of thoughts as well as beliefs about the efficiency of one's memory or powers of concentration (Wells, 2009).

In this session, I introduce and explain this concept to the patient by means of the trial metaphor. The patient is stimulated to confront thoughts produced by the internal character represented by the prosecutor who accuses her. Here, the patient learns how to reverse the roles in which she, instead of being controlled by the prosecutor's accusations, gains the power of accusing and sentencing the prosecutor.

Description of the Trial-Based Metacognitive Awareness (Trial II) Technique

The therapist will play a different role in this session. In trial I the therapist role-played the judge, and here he becomes the narrator. This technique is also implemented in the empty chair format. Figure 10.1 illustrates how the chairs

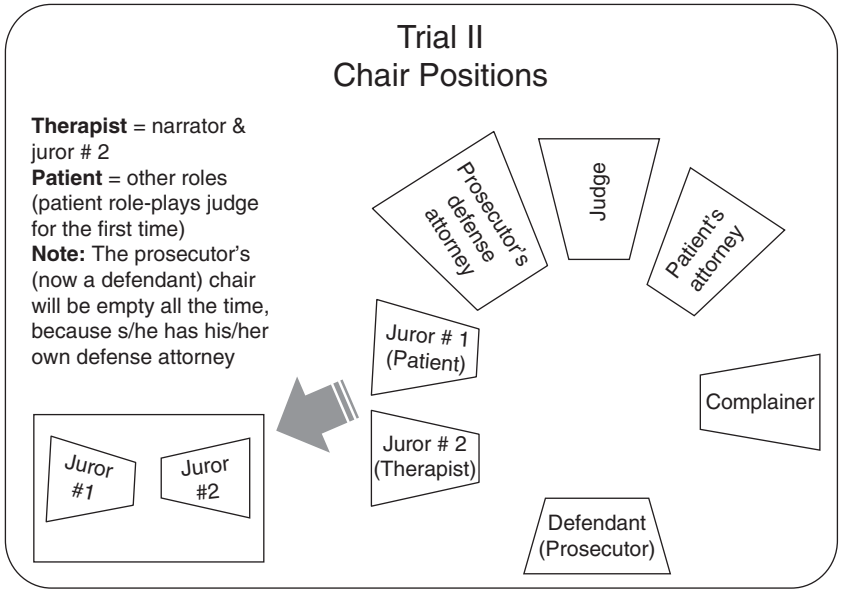


Figure 10.1 Suggested chair positions during trial II.

used by the patient (as a narrator, the therapist does not have a chair for himself, except in the jury phase) are placed during a trial II session.

Step 1: Investigation

In trial I, the therapist used the downward arrow technique to uncover negative core beliefs, presented as self-accusations. Similarly, in trial II, the therapist asks a series of questions that will uncover the fragility demonstrated by the prosecutor in trial I. Such questions lead the patient to conclude that the prosecutor is abusive and incompetent, and practices harassment. During this step, the therapist asks three groups of questions:

- Group 1: questions about the prosecutor's competence;
- Group 2: questions about damages and losses suffered by the patient;
- Group 3: questions leading to the accusations against the prosecutor.

Step 2: Charge Against the Prosecutor

The patient is encouraged to verbalize all the damages and losses she considers that negative thoughts and beliefs credited to the prosecutor's excessive accusations caused in her life. Such damages are symptoms, problems, and limitations the patient brings to therapy.

Step 3: Patient's Attorney Formalizes Patient's Accusation Against the Prosecutor

Here the patient goes to the chair reserved to her attorney and repeats all the above complaints, this time playing the role of her attorney. This is a way of externalizing the same speech content. The internal character who defended her in trial I will now accuse the prosecutor of abuse, harassment, and incompetence. The therapist introduces this topic to the patient, suggesting that she formalize the accusation against the prosecutor to the judge.

Step 4: Prosecutor's Defense Attorney Defends the Prosecutor

The patient is asked to sit down in the same chair previously occupied by the prosecutor. However, here a new character is introduced: a defense attorney for the prosecutor. The rationale is that in the law system it is not usually accepted that the accused—in this case, the prosecutor—defends him or herself. Interestingly and almost invariably, the prosecutor's defense attorney, instead of using arguments to justify and defend the prosecutor's behavior, tends to continue accusing the patient. After allowing the patient to do that for a short time, the therapist (narrator) interrupts her (prosecutor's defense attorney) and reminds her that her role is not to accuse the patient. He also reminds this character that the patient was considered not guilty in several

trials. So, the prosecutor's defense attorney is denied the right to use arguments accusing the patient.

Step 5: Patient's Attorney Replies to the Prosecutor's Defense Attorney

The patient, role-playing her own attorney, will confront the arguments elicited by the prosecutor's defense attorney.

Step 6: Prosecutor's Defense Attorney Replies to the Patient's Attorney's Plea

As in any criminal trial, the one who is being accused has the right to have the last word, and the logical procedure here is to continue this way. What is frequently seen is that the patient (placed in the prosecutor's defense attorney's place) has no arguments to defend the prosecutor, and will say it explicitly or will repeat the previous arguments.

Step 7: Jury's Verdict

Similarly to what occurs in trial I, the therapist helps the patient to decide, by asking careful Socratic questions, the verdict. The patient will be juror number 1 and the therapist juror number 2. However, the discussion is free, and unlike in trial I, there will be no pleas to be read. Using Socratic questions, the therapist helps the patient to understand the bullying character of the prosecutor, who will be considered guilty of incompetence, harassment, and abuse.

Step 8: Judge's Sentence

This step symbolizes the most important moment in the therapy process. Here the patient occupies, for the first time, the judge's chair and gives the sentence. There will be a huge contrast between the power she assumes to establish the sentence given to the prosecutor and the fact that the latter is not allowed to speak during the entire session (the prosecutor's chair remained empty during the whole trial). Indeed, from this session on, the prosecutor will be allowed to speak only when she is considered retrained and rehabilitated. And the power to decide this is given to the patient, when she is occupying the judge's chair.

Explaining Metacognitive Awareness to the Patient

Metacognitive awareness may be explicit (declarative—it is verbally expressed) or implicit (procedural—it is not directly verbally accessible) (Wells, 2009). This stage in TBCT envisages delivering such knowledge to the patient's conscious awareness by means of the trial metaphor. The following extract of a session illustrates how the therapist explains metacognitive awareness to the patient.

T: Paul, now that trial II is over, I'd like us to go back to our therapeutic setting. I'd like to give you some additional information that will help you understand the work we did today. Maybe you have never heard of the word "metacognition."
P: No, I haven't.
T: Although it is a technical term used by cognitive therapists, I like to teach it to my patients. Metacognitive awareness is the capacity that only humans possess. It means that we can think about our thoughts. We can assess our own thinking process. Why do you think I am explaining this to you?
P: Is this anything to do with the prosecutor and the accusations he has against me?
T: Can you see these accusations as a thinking process that you are able, in a certain measure, to evaluate and choose to accept or not, to obey or not?
P: Yes, I can see that clearly now. Although I know I can't control my negative thoughts, I can examine them and choose to do nothing about them.
T: Exactly.

CASE ILLUSTRATION DIALOGUE

Bridge from Session 9 and Setting the Agenda

T: Good morning, Leslie.
P: Good morning, Dr. de Oliveira.
T: I'd like to know how you've been since last session.
P: It was fine for me. This work seems to have helped me very much, although, Dr. de Oliveira, these disturbing thoughts come to me very often. I haven't been able to stop them or to get free from them.
T: Would you say that, if we want to continue using our tribunal metaphor, it is as though your internal prosecutor continues acting, saying the same things, bringing the same accusations?
P: That's right.
T: How about setting our agenda?
P: That's fine.
T: What would you like us to discuss today?
P: Although I am much better than last week, these accusations are still important and bother me a lot. I still have the ideas that I'm ugly, that I'm strange, and that there's something wrong with me.
T: Are you telling me that these ideas are still bothering you and that you don't know what to do?
P: Yes.
T: Let me propose that we go over the homework and the questionnaires, and then take the ideas of being ugly, strange, and that there's something wrong with you as the main agenda item. These are not concrete and specific topics like the items we have been working on, but this poses no problem for my proposal for today.
P: All right.
T: Going back to the questionnaires, the CD-Quest scores have changed a lot since the beginning of therapy, don't you agree? Even though you had a

difficult time last week, with multiple negative core beliefs bothering you, its score is 20 now, almost the same as we have found in medical and psychology students. Assuming that these people are normal [the therapist laughs], your score is almost there.

P: This is great! [Leslie also laughs.]

T: And both the anxiety and the social phobia scale decreased significantly, didn't they? Do you see the difference, compared with the beginning of the therapy?

P: Certainly, Dr. de Oliveira. I feel much less anxious, and I do a lot of things I was not able to do before this therapy.

T: Great, Leslie. Our goal, working together, is that this becomes long-lasting, isn't it?

P: Yes, of course.

Step 1: Investigation

T: Let me ask you a few questions. You've been judged in a tribunal five times here under the accusations, first that you were strange, and then that you were not good enough—each time twice if we take the appeals into account. Last week, the accusations came in kind of a pack, four at once.

P: Exactly.

T: So, here are my questions [First group questions—prosecutor's competence]: how many times did the prosecutor win?

P: None. She has never won.

T: How many times did the prosecutor ask for the appeal and was given a chance to prove that she was right?

P: Twice for the accusations and twice for the appeals. And once more last week.

T: How many times did the prosecutor succeed in proving that you were strange or not good enough?

P: Never.

T: How many times did the prosecutor stay calm and was convinced that she was wrong?

P: Never. She goes on accusing me all the time.

T: How many times did the prosecutor distort the facts during the trials?

P: Almost all of her arguments were false accusations; almost all of them were distortions.

T: On the other hand, how many times did the defense attorney bring false pieces of evidence to court?

P: None. They were all true with no exception at all.

T: But you still give much credit to what the prosecutor says and not to what the defense attorney says. Why is that?

P: I don't know. The prosecutor seems more convincing because she is always sure of what she says, and she's very persistent. On the other hand, the defense attorney, although always saying the truth, seems not to be credible enough.

The prosecutor has been following me during my whole life, has always been present in my life; and only recently I seem to have become aware of the defense attorney's existence. It has only been one month. I'm not used to her yet.

T: Exactly. Let me ask you a few more questions [Second group questions—damages and losses]. What are the damages and losses you've had that can be credited to the prosecutor's accusations?

P: I have had too many losses: professional, social, and personal losses. The prosecutor has damaged my life.

T: Why don't you sue her?

P: What?

T: Why don't you sue her?

P: What do you mean?

T: Why don't you sue the prosecutor for the damages and losses she produced in your life, for all the suffering and distress you've had to undergo because of her?

P: Is that possible, Dr. de Oliveira?

T: Not only possible, but you can do it right here and now, in this session.

P: Please tell me how.

T: [Third group questions—accusations] First, what are you going to accuse the prosecutor of? For instance, if she never won, how would you consider her as a professional?

P: Certainly incompetent!

T: Exactly. And if she accuses you anywhere, anyhow, anytime; if she accuses you during holidays, day and night, what do you consider this to be?

P: Harassment, of course!

T: Would you add abuse of power, considering that a prosecutor is an authority figure?

P: Certainly.

T: OK. We have several chairs in this room. I propose that we come back to the tribunal. Would you please sit here? [Leslie goes to the defendant's chair.] No, no, Leslie, not in this chair. Don't you see that you're not the defendant? Today the defendant is the prosecutor. Please, sit here, beside your attorney. [The therapist gently points to another chair.] Today, we'll do it differently. From now on I leave this chair, the judge's chair, and I become a narrator. I'm not the judge any more.

P: And who's going to be the judge?

T: You'll see for yourself. Now, sitting where you are, you are Leslie. I'll ask you to bring the charges against the prosecutor. Please, bring your complaints against the prosecutor. There are several characters in this room. In the chair you are occupying right now, you are yourself. As a narrator, I'll be moving around, anywhere in this room. The attorney, who was previously your defense attorney, will accuse the prosecutor, after you bring your complaints. The judge will sit over here, in the central and bigger chair; here, in this other chair, we have the prosecutor herself, who is now the defendant, and in this other chair we have a new character, the prosecutor's defense attorney.

Step 2: Charge Against the Prosecutor

T: I'd like you to bring up the charge now.
P: I don't know what to say.
T: Nothing more than your complaints. You know them well.
P: What do I call a judge?
T: Your Honor, I think. It doesn't matter.
P: Your Honor, I'm here today to complain against the prosecutor's excesses, which have brought many damages and losses to my life. I'd like to bring my charges against her because she has been excessive, she has practiced actions that are beyond her duties, she has done her work outside and beyond what should be her professional role. She has accused me outside working hours, outside her place of work, and not in the way such accusations should be made.
T: So, Leslie, I'd like you to formalize these charges, and this should be done by the competent party. Now, would you please sit in the attorney's chair and formalize the charges against the prosecutor?

Step 3: Patient's Attorney Formalizes Patient's Charge Against the Prosecutor

P: Your Honor, I'm here representing my client, Leslie, in this courtroom, to formally begin the suit against the prosecution. She has had an abusive and excessive attitude against my client. She has caused my client much suffering, as you know. Her false and distorted accusations have brought many damages and incalculable losses to my client that disturbed her life, and this should not be the job of the prosecution; this is not her role. The prosecution should act within normal standards. In the case of my client, the prosecutor has exceeded them. So, I'm here to bring formal charges, so that the prosecutor will stop her excessive and abusive accusations against my client.

Step 4: Prosecutor's Defense Attorney Defends the Prosecutor

T: Leslie, would you please go to that chair over there, beside the prosecutor, and be her defense attorney, and defend the prosecutor who is now the accused?
P: Yes, Dr. de Oliveira.
T: OK, go on please, and make the prosecutor's defense.
P: Your Honor, I'm here as the prosecutor's defense attorney, and I feel at ease because my client didn't do anything wrong. Her job is to accuse; this is her duty. So of course she's here to accuse: that is her function, that's what she's prepared for, in order to reach correct verdicts; I don't see in the charge brought by Leslie's attorney any shift on the part of my client. First it has always been like this in the history of this prosecution. Leslie has always been aware of the accusations and complied with them. I would even say that she

has encouraged my client, the prosecutor, to do so [to make those accusations]. She has been very active in this regard. In fact, it seems to me that she is really strange and not good enough.

T: Stop please. As a narrator, I would like to interrupt you and remind you that you are not here to accuse Leslie. This is not your job today. You are here to defend your client, the prosecutor. I would like to remind you that Leslie has been considered not guilty in five trials. So, please, I'd like to ask you to limit yourself to the defense of your client, the prosecutor, who is the defendant here today. Please go on and don't forget this.

P: As I said, the prosecutor has always acted like this; it has always been this way. Therefore, the charges brought against my client are not valid. The prosecutor exists to accuse, and there was consent on the part of the accuser. She has always lived with the prosecutor. So, there is no excess, and my client is doing her job honestly and in a legal manner.

Step 5: Patient's Attorney Replies to the Prosecutor's Defense Attorney

T: Leslie, can you go back and sit in the attorney's chair? What will she say?

P: She will reply to what the prosecutor's defense attorney has pleaded now.

T: Exactly.

P: Your Honor, in this reply, I'd like to say to the prosecutor's defense attorney that the fact that she's acted in this way during many years of my client's life does not give her the right to make excessive accusations, or that these excesses are legitimate. It doesn't mean that the prosecutor has the right to act whatever way she wants. She's been acting this way because of my client's lack of awareness; my client didn't know what the role of the prosecutor was; she didn't even know that these accusations came from a prosecutor; therefore, she allowed the prosecutor to grow larger and exceed her functions. Using the argument that it has always been this way is not acceptable. Certainly, if it has always been this way, it has always been wrong, it has always been excessive, and it has always been outside any good prosecutor's ethical standards. In this way, the words of the prosecutor's defense serve only to reinforce the arguments of my client, since the prosecutor's defense said that she, prosecutor, has always acted like this. So, she has always acted in excess. My request, Your Honor, is that the prosecutor be considered guilty of incompetence, harassment, and abuse of power.

Step 6: Prosecutor's Defense Attorney Replies to the Patient's Attorney's Plea

T: Now we should give the word to the prosecutor's defense attorney, because the last word is always given to the accused, and then the verdict will be given by the jurors.

P: OK. In my last instance in the trial, Your Honor, I'd like only to strengthen my position by saying that the prosecution exists to accuse. This is the duty

of my client. Once again I reiterate, and say these words so that it'll be clear that at no time did the prosecutor step out from her purpose. She accuses, and seeks to promote the smooth pace of the trial. There is nothing proving that my client's actions are contrary to how a prosecutor's work should be run. What I'd like to make clear here, at this time, is that there was no excessive behavior on the part of my client. To the contrary, she always acted within her function; that is, to bring forth accusations in order for those who are in error to be charged and condemned.

Step 7: Jury's Verdict

T: At this time, the jury takes its place. I will leave my narrator's role now and sit with you as a juror. You're juror number 1 and I am juror number 2. [The therapist and the patient sit in the jurors' chairs.] The jurors should now analyze the propositions, and according to what is brought forth, they decide so that the decision will be unanimous. So we are here again in this room as jurors, this time to decide if the prosecutor is guilty or not guilty. What do you think?

P: I think that, based on what we saw here, the client's attorney brings factual elements that the prosecutor directly interferes excessively in the life of her client. And at no time was it verified that acting as a prosecutor gives one the right to exceed, to bring to the life of the one being accused more than what is expected from him or her. In this way, the action of a prosecutor is legitimate as long as it stays within what is normal and ethical, and this was not what we saw regarding the prosecutor. So I think the verdict should be guilty.

T: OK. I agree with you and this is our role here: having a unanimous verdict. Let's go back and take this verdict to the judge. Would you please announce the verdict to the court?

P: Your Honor, the jury considers the prosecutor guilty of incompetence, harassment, and abuse of power.

Step 8: Judge's Sentence

T: Leslie, let me ask you to sit in the judge's chair. Now, for the first time you will be able to take this place. Please sit here. I return to my narrator's role. The jurors have just brought the verdict: guilty. Your role as a judge is to pronounce the sentence. But, as a narrator, I would like to call your attention to the importance of a prosecutor in our lives, be it in the external judicial system or be it in our internal judicial system. Prosecutors are important. So, may I suggest that you give the prosecutor a chance to retrain her knowledge as a professional, and consider that maybe she is mentally disturbed and so give her the chance of rehabilitation? Please, the decision is yours as the major authority in this room. You are the judge.

P: My decision is to give the prosecutor the following sentence: she must be submitted to specialized treatment in order to change her conduct and

attitudes; and she must retrain her knowledge so that she can work efficiently and within the legal standards as a prosecutor.

Debriefing

T: So, in this case the jury session is closed, right? We are finished and the jury terminates. After dissolving the jury, I'd like to hear from you, Leslie—still within the courtroom, returning to your initial position—on how you feel about the court's decision, still within this dramatization.

P: I feel more relieved because being in this process brought me an understanding of my worlds and of the things I am going through. To me it's a relief to know that the prosecutor will become more suitable, that she will stay in her proper place; I am very happy about the sentence given. Knowing that she will be treated and looked after makes me feel more capable of verifying that the prosecutor, in the way she is placed here, has to act within normal standards.

Summary and Feedback

T: What we can do now, Leslie, is to return to our therapeutic setting. I'd ask you to give me some feedback, now as Leslie undergoing therapy.

P: It was very good for me because in a simple but objective way, I was able to examine who really are the characters of this intricate situation. For me as a patient, when I started this treatment, I didn't believe this was real. I didn't believe that techniques such as this one could bring me health. And today I can verify *in loco* how this is possible. I have this core belief, an accusation that I am strange. You gave me the task of raising my defense every day, with the homework of writing down and aiming at the things that say that I am a normal person. I've been seeking the little things that bring these elements to prove, along with my defense attorney, that I am normal. So, from the moment I start raising the smallest things that affirm I am normal, this brings elements that strengthen my defense, since I've lived my whole life making accusations to myself.

T: I am quite pleased with this, Leslie. I can even feel your present sense of security. For example, what you are able to do now is different from what you could do some time ago. A while ago, you weren't able to talk to lawyers looking at their faces.

P: No, I was not.

Explaining Metacognitive Awareness to the Patient

T: And now that you gave life to these characters, you can now distance yourself from them. It is something we call metacognition. You don't need to retain this technical term, but I would like you to understand what it means. This is something only human beings can do, to think about their own thoughts

and take a step back. You can just pay attention to your thoughts and, at the same time, not follow them, not obey them, even when you believe them. While this character who is undergoing treatment, the prosecutor who is in rehabilitation, might say something, what can you do?

P: Today I'm able to use mechanisms when she accuses me. I use all the elements I learned here, such as "you're distorting, you're catastrophizing, you're overgeneralizing." I give her objective answers: "Look, all the evidence I have shows that I am normal. I don't need to believe what you say."

T: This is very interesting because maybe now you can go on to the next step. Did you notice that today the prosecutor didn't have the right to speak, that she remained quiet? How do you see this prosecutor silent here in this court?

P: It is something that speaks volumes to me. Because having her quiet, having her only in a secondary role and not as the main character is something which clears up, at least in my point of view, what her situation should be. That is, seeing her quiet, silenced, and only being able to manifest herself through a third party, tells me that today I have the power to resist her when she is excessive.

T: So, what is interesting now is that you don't even have to justify yourself to the prosecutor.

P: No, I don't.

T: Now, when the prosecutor says something, you simply place yourself at a distance, what we call metacognition, and say what?

P: I can simply tell her: "Be quiet and stay in your place. I don't need to believe you at this time, because you are in rehab."

T: Exactly. And consequently she doesn't deserve credit, right?

P: Right. Today I can see this clearly.

T: Isn't what we want from now on, really to retrain the prosecutor?

P: Yes. To put her in her place.

T: And from the moment when she is rehabilitated—that is, when you will be seated in the judge's chair and tell her, "You are rehabilitated"—from then on you'll be able to believe her, won't you?

P: Yes, because she'll be cured.

T: Consequently, what she will say will deserve credit.

P: Yes, she'll deserve credit.

T: Meanwhile, what do you plan to do?

P: Only give her this standby time. I still think she is excessive. I still think there is no possibility, right now, of hearing her and giving her words credit.

Assigning Homework and Concluding Session 10

T: OK, then. Great! I hope you will be able to use what you learned here today. This is your homework assignment: continue practicing metacognitive awareness.

P: Yes. I'll keep doing this.

T: However, there is something else you can do to help improve your metacognitive awareness. You have just arrived at the conclusion that the prosecutor needs help, and that she needs rehab. Maybe you might want to write a compassionate letter to her.

P: And how is that?

T: Differently from the assertive letter you wrote a few weeks ago, now you know that a healthy prosecutor is helpful and necessary to one's life. So, maybe you might want to write a letter informing that you understand her point of view, that you accept her, that you are sorry that she was considered guilty, and that you are ready to listen to her, help her get better, although you are not ready to accommodate to her demands; that you know that her demands are made with good intention, but this is because she did not learn how to do otherwise. Do you see the difference?

P: Yes, it is clear to me.

T: I'll be curious to read your letter. See you next week.

11 Relaxation and the Sailboat Metaphor

Outline

- Explaining the Sailboat Metaphor to the Patient
- Relaxation
- Sailboat Metaphor

Case Illustration Dialogue

- Relapse Prevention and Ending Treatment

Explaining the Sailboat Metaphor to the Patient

It is difficult to know how long the sailboat metaphor has existed. You have probably heard this saying many times: "We can't control the wind, but we can adjust the sail." Or you may even have listened to the song recorded by Ricky Scaggs "Can't Control the Wind," easily found on YouTube by just writing the song's title. The sailboat is a powerful metaphor, used to enhance resilience and encourage people to endure difficult situations.

I use this metaphor during relaxation exercises with patients. To my knowledge, this is the first time this metaphor is being used in therapy, at least in cognitive therapy, to explain the nature of metacognition. I compare thoughts with the wind, emotions with the waves, and behavior with the rudder. Lowering or hoisting the sail is my idea of metacognitive awareness. We do not have to pay attention to our thoughts when we are well (hoisted sail), but we can access our thoughts, evaluate them, and choose not to follow them in tempestuous moments (lowered sail). In the following extract I propose a relaxation exercise with the sailboat metaphor to a patient.

T: Mary-Ann, you seem to be impressed by the notion that you do not have to obey your thoughts and emotions. You had a clearer idea of this when we talked about metacognition during the trial II session last week.

P: Indeed, I was impressed by the image of a quiet and silenced prosecutor during the session and how I was able to listen to her during the week and not be forced by what she wanted me to do. It was funny because, before I took the elevator to my gynecologist's office, I listened to the prosecutor saying, "It's dangerous. You'd rather take the escalators. You're weak." I immediately replied, "Shut up. You have no credibility. I don't believe what you say. You are in rehab." [Patient laughs.]

T: And, of course, I assume you took the elevator.

P: Sure.

T: Great, Mary-Ann. I'd like to propose something to you today that might help you be even more aware of the prosecutor's accusations when she becomes excessive, and you have no need to justify yourself to her, only to pay attention. It is a relaxation exercise, the same we used a few weeks ago to help you decrease your anxiety. However, I'd like to use relaxation differently today. I'd like to add a metaphor in the middle of it, when you will be relaxed, so that you become even more aware of your unhelpful thoughts, like those elicited by the prosecutor.

P: OK.

Relaxation[1]

T: Let's begin the relaxation process. I'd like you to choose a comfortable position. Close your eyes and take a deep breath. Hold the air briefly. // Now, let it all the way out. I'd like to ask you to continue breathing this way, deeply, for a moment. / While breathing, I'd like to draw your attention to your stomach. Let your stomach rather than your chest move. /// Breathe totally in. /// Now let it all the way out. /// Repeat this movement for a while. /// Feel your stomach moving up as you inhale and moving down as you let the breath out. /// In a moment you will notice your body going limp and your muscles in a comfortable and completely relaxed state. /// Continue paying attention to your breath. Feel your stomach moving up and down as you breathe in and out. /// Now I will ask you to close your right hand tightly, balling it into a fist. Feel the tension in your right fist. Squeeze your fingers together. /// Now let them go. // Relax your right hand. Let your right hand go limp, / let your fingers relax, / and feel the difference between a tensed up and relaxed state. /// Now repeat the same process with your left hand. Close it tightly, balling it into a fist. Squeeze your left fingers together. // Let them go. // Relax your left hand. Let your left hand go limp, / let your fingers relax. / Can you feel the difference between tension and relaxation? /// Now contract your right arm bringing it next to your body, with your elbow digging into your waist. Hold the tension for a while. // Now relax. / Let it go. // Relax your right lower arm, and then your right upper arm. /// Repeat it with the left arm and bring it next to your body, with your elbow digging into your waist. Hold the tension for a while. // Relax. / Let it go. // Relax your left lower arm, and then your left upper arm. /// Take advantage of each

expiration movement and let your muscles go limp, completely relaxed. Let your muscles relax each time you let the breath out. /// Pay attention now to your toes. Squeeze them together. Hold them for a bit. // Relax. Let them go. Can you feel the difference between tension and relaxation? Please, repeat the process. Squeeze your toes together. Hold them. /// Let them go. Once more you'll notice the difference between tension and relaxation. // Relax your feet now as much as you can. Let them go limp. // Now, keep your feet well planted on the floor and press your legs against it. Maintain the pressure just a little more. // Relax. Let your legs relax. Let your calves relax and then the upper part of your legs. Let them go. // Can you feel the difference between tension and relaxation? /// Now contract your buttocks. Keep them tensed up for a while. // Relax. /// Now, pay attention to your shoulders. Hunch them toward your neck. Hold them for a while. Just a little more. // And now relax. Allow your shoulders to fall. / Feel the muscles loosen. / Let all the muscles in this area—back, lower back, upper back, shoulder blades, neck . . . let them relax. /// Now contract your jaw. // Make a grimace so that your lips are tightened across your teeth. // Keep this tightness for a bit. // Now let them go. Relax. Relax your jaws . . . let them come apart and your tongue collapse in the floor of your mouth. Your whole face is completely relaxed. / Your forehead is completely smooth. Your cheeks, your forehead, and your scalp are now totally relaxed. /// Take this opportunity to let all your body muscles go. Relax; let them go as you breathe out.

Sailboat Metaphor

After the patient is clearly relaxed, the therapist adds something like in the following extract of a session.

T: Now I want you to think of what I told you regarding metacognition last week after the trial II session. Remember that the prosecutor was accused of incompetence, abuse, and harassment; the prosecutor is in rehab and has no more credibility, at least temporarily, until you decide otherwise. /// Imagine now that you are on a sailboat, in a beautiful bay. / The sea is calm and the wind is pleasant. / The day is sunny. You feel the pleasantness of the wind touching your skin. / You can feel the pleasant sensation of the sun warming your body. // Stay a moment like this, feeling the pleasantness of being in communion with Nature. /// Keep this image in your mind for a minute and take strength from it. /// Now imagine the wind becoming a little stronger. // The clouds are becoming dark. / You look at the skyline and wonder whether you'll have time to go back home in safety. / No. You are far from the shore. You'd better be ready to face a storm if it comes. / You have faced many storms before. This will be just one more in your life. / The wind becomes stronger and stronger, / and the waves start to shake the boat. // You don't know what to do. / After a moment of doubt, you decide to lower the sail. / This is the way of protecting the boat from the strength of the wind and of the waves. // You lower the sail and wait. / You have nothing more to do but wait. // Wait. /// Wait. /// Just watch the

wind go by. /// Now, I'd like you to imagine that the wind is like your thoughts, / the waves like your emotions, / and the rudder like your behavior. // You can't control the wind; neither can you control your thoughts. // You can't control your emotions nor control the waves. // Now, the wind is tempestuous, so you have nothing to do but keep the sail lowered and hold the rudder of the boat as firmly as you can so it does not overturn. // Do not follow the wind. // Do not follow your thoughts. They are tempestuous now. /// You can't control the waves. / You can't control your emotions either. So, try not to control your emotions, but just stay firm, holding the rudder, / holding your behavior. Just wait. Just observe. Don't judge the wind as good or bad. It's just the wind. Don't judge your thoughts as good or bad. They're just thoughts. // Don't try to get rid of your emotions. They are just the product of your thoughts, as the waves are the product of the wind. // Wait for the tempestuous thoughts and emotions to go by, to calm down. Just let them go. /// Now you look at the skyline and notice the blue sky. You also notice that, maybe, the wind and the sea are calming down. // Relieved, you notice the day becoming sunny and pleasant again. In a minute you will be able to hoist the sail and go on sailing again. /// This is the way you can understand what metacognition is. They are just thoughts. You are not obliged to follow them. They are just emotions. // You are not obliged to obey them. /// You have just hoisted the sail. // The sea is calm again and the wind is pleasant, calm. // The day is sunny. // You feel again the pleasantness of the wind touching your skin. / You can feel the pleasing sensation of the sun warming your body. /// And now you are sailing back home, to the shore. // You start listening to the growing noise of cars and voices. /// . . . /// Now you are ready to wake up. I will count to five and then you will open your eyes:// one, // two, // three, // four, // and five. / Please open your eyes.

CASE ILLUSTRATION DIALOGUE

[After having made the bridge from Session 10, set the agenda, reviewed questionnaires, introduced relaxation with the sailboat metaphor, and asked for a summary and feedback, the therapist and the patient conclude this session by revisiting the CCD, phase 3.]

Relapse Prevention and Ending Treatment

T: Leslie, this therapy seems to have helped you in many aspects, hasn't it?
P: Yes, Dr. de Oliveira, I feel much better now.
T: Do you think we could review your therapy goals and see if we can prepare for the ending of your treatment?
P: Yes. Although I think I did not reach all the goals, I know I have a lot of resources to deal with my problems.
T: Do you remember your problems and therapy goals?
P: Sure. There were not many, but they were important and made me suffer a lot. How could I forget them?

T: What were your therapy goals?
P: Speak with people without much anxiety, be able to say no without anxiety, find myself capable at work, talk with people naturally, without the anxiety symptoms, go out more, and also socialize more.
T: They were not so specific, but they were clearly represented by the symptoms in that social phobia scale whose score is now normal. We used the social phobia scale items as specific goals, do you remember?
P: That's it. And now I score low in all those items.
T: How do you think you succeeded? What do you think helped you the most in this therapy?
P: Knowing that my difficulties in dealing with people came from my safety behaviors was very important. Both the color-coded symptoms hierarchy and the consensual role-play helped me a lot. They gave me courage to expose myself to unpleasant situations. However, the trial I was essential. It helped me uncover my negative core beliefs and develop more positive ones, like "I am normal" and "I am good enough." Finally, the trial II was amazing. Things became much clearer.
T: Maybe we could review the conceptualization diagram and try to understand what happened, according to it.
P: Yes.
T: Maybe you could give me a summary of the therapy so far, while using the diagram.
P: When I started therapy, I was unable to do simple things like go to a restaurant without feeling anxious. The first thing I thought was important was to understand that anxiety was a normal emotion and that physical reactions like sweating and blushing were the result of a wrong way of thinking, a wrong way of viewing and understanding reality. You gave me a list of cognitive distortions and knowing them helped me believe less in my anxious thoughts. This was the first level. [Leslie points to level 1 of the diagram in Figure 11.1.]
T: This is a nice summary of the first level.
P: After that, we went to the second level, that of the underlying assumptions and the safety behaviors. Knowing this helped me in the exposures you asked me to do. Then you showed me the third level, the one of the negative and positive core beliefs.
T: Maybe this diagram (Fig. 11. 1) could help you summarize it.
P: We tested the core belief "I am strange," taken as a self-accusation. So, we went through the trial facing the prosecutor and her demands; I brought forth my defense attorney, but the most important thing was the homework you assigned of strengthening my defense every day, with the task of writing down and focusing on the tiny things that said that I was a normal person. So, after raising these issues, we went on to examine this system through the dramatization also by means of the empty chair, causing the prosecutor to become suitable, and stay in her place.
T: I am quite pleased and impressed by your summary, Leslie. I can even feel your present sense of security. For example, what you do today is very

different from what you were able to do some time ago. A while ago, you weren't able to go to a party.

P: No, I wasn't.

T: You weren't able to go to a restaurant without anxiety.

P: I couldn't say no to a salesperson. [She laughs.]

T: And what are you able to do today?

P: Well, today, I can do everything in that list of the social phobia scale.

T: So all this was accomplished in 10 sessions, today being our 11th session.

P: Yes.

T: Already during the first session, I was able to show you the conceptualization diagram, and you could understand thoughts, emotions, and behaviors more clearly and, in Session 4, how your behaviors became habitual because of your underlying assumptions. Such safety behaviors protected you from what?

P: They protected me from seeing myself as strange and not good enough.

T: Exactly. And at these times you gained at least a bit of security.

P: Right, right.

T: And already in the fifth session I could bring about a trial where you were able to raise the issue, "I'm strange." And you easily came to the conclusion that this wasn't really true, that you were normal. We were able to return to the appeal, during Session 6, where this became even clearer, after you began to put together the elements that showed you were . . .

P: A normal person.

T: And really, after this, all we did was to reinforce this knowledge. That is, as the internal prosecutor continued, in a way, to accuse you, we finally arrived at trial II in Session 10, when you learned about metacognitive awareness. So that you can give me the final word as to how you are feeling today, what do you imagine will come next?

P: I think I can live with self-confidence because I know I'm normal and good enough. My life has an increase in possibilities now. Today, my condition is one of freedom.

T: And, above all, while you can give life to these characters such as the prosecutor, defense attorney, judge, etc., you can now distance yourself from them as well. This is something you learned which we call metacognition. You can now think about this, and when the prosecutor—who is undergoing retraining and rehabilitation—might say something, what do you do?

P: Today I have resources. When she accuses me, I use all the elements I learned here, such as "you are catastrophizing, you're overgeneralizing." I give her objective answers: "Look, I've already done so many things I couldn't do before and now I can do them normally."

T: And from the moment when she is rehabilitated—that is, when you are seated in the judge's chair and tell her: "You are rehabilitated"—from then on you'll be able to believe her, won't you?

P: I think so.

T: How do you explain this phase in the diagram? What do you think was happening when you came here for the first time?

P: This strong arrow going down indicated that the situations activated my negative core belief "I'm strange." [Fig. 11.1]

T: Exactly, it's as if it were here in this space. [Therapist points to the negative core belief box in level 3 of Figure 11.1.] Do you see this arrow going up and demonstrating that, since you are strange, your thoughts correspond to these anxious thoughts in the AT box? What if we looked at this other diagram, would you say that what happened here was this? What happened to this arrow? [Therapist shows her Figure 11.2.]

P: It doesn't activate my negative core belief "I am strange;" it directly activates the belief that I am normal.

T: What do you imagine will happen from now on, now that you have these positive core beliefs more frequently activated: "I am normal" and "I'm good enough"?

P: These beliefs stay activated longer and more often now.

T: And having these beliefs activated more often now, what thoughts would you say will be produced, in this space of automatic thoughts? [Therapist points to the AT box in Figure 11.2.]

P: This is what happens now. I socialize and meet people normally, without anxiety. I have anxious thoughts less frequently.

T: And how do you explain it according to this diagram? [Therapist shows her Figure 11.3.]

P: This is what I expect this therapy to prepare me to do: find a balance between my positive and negative thoughts, because there will be a balance in the activation of my positive and negative core beliefs. But, Dr. de Oliveira, I do not understand why the line indicating the positive core belief is stronger than the negative one. Shouldn't there be a balance?

T: You are right. But in this case, the balance means that you have your positive core beliefs more frequently activated and that your negative core beliefs will be ready to be activated whenever necessary. It is a state of normal vigilance. Negative core beliefs should be activated whenever something really goes wrong, like, for instance, when you decide to do something not approved socially. You need that internal voice telling you, "Be careful Leslie. If you take this object that does not belong to you, you'll be charged. I'm here to remind you that. I am your prosecutor."

Note

1. / = short, // = medium, and /// = longer pauses.

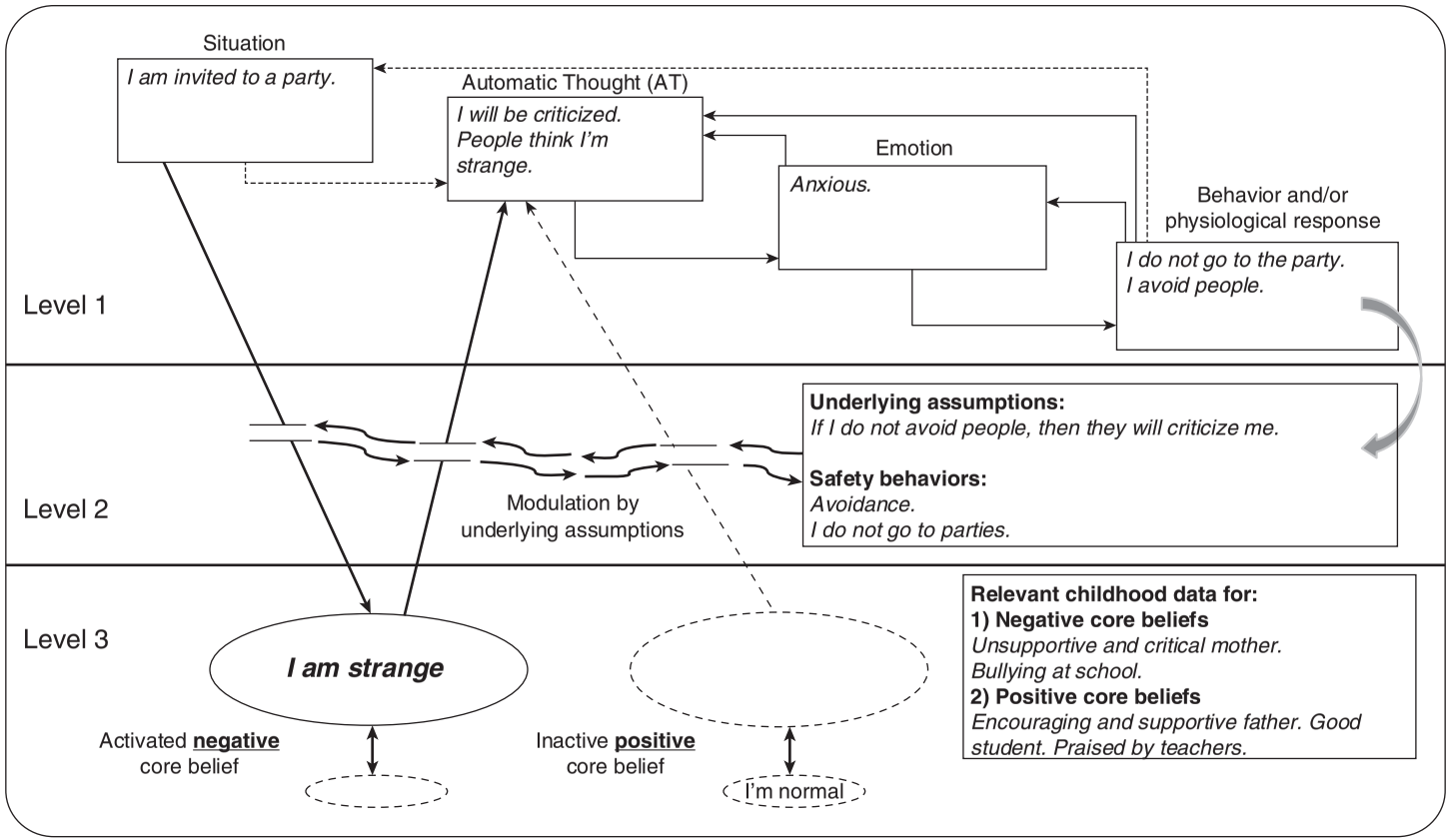


Figure 11.1 Leslie's conceptualization diagram before and in the beginning of therapy (Phase 1).

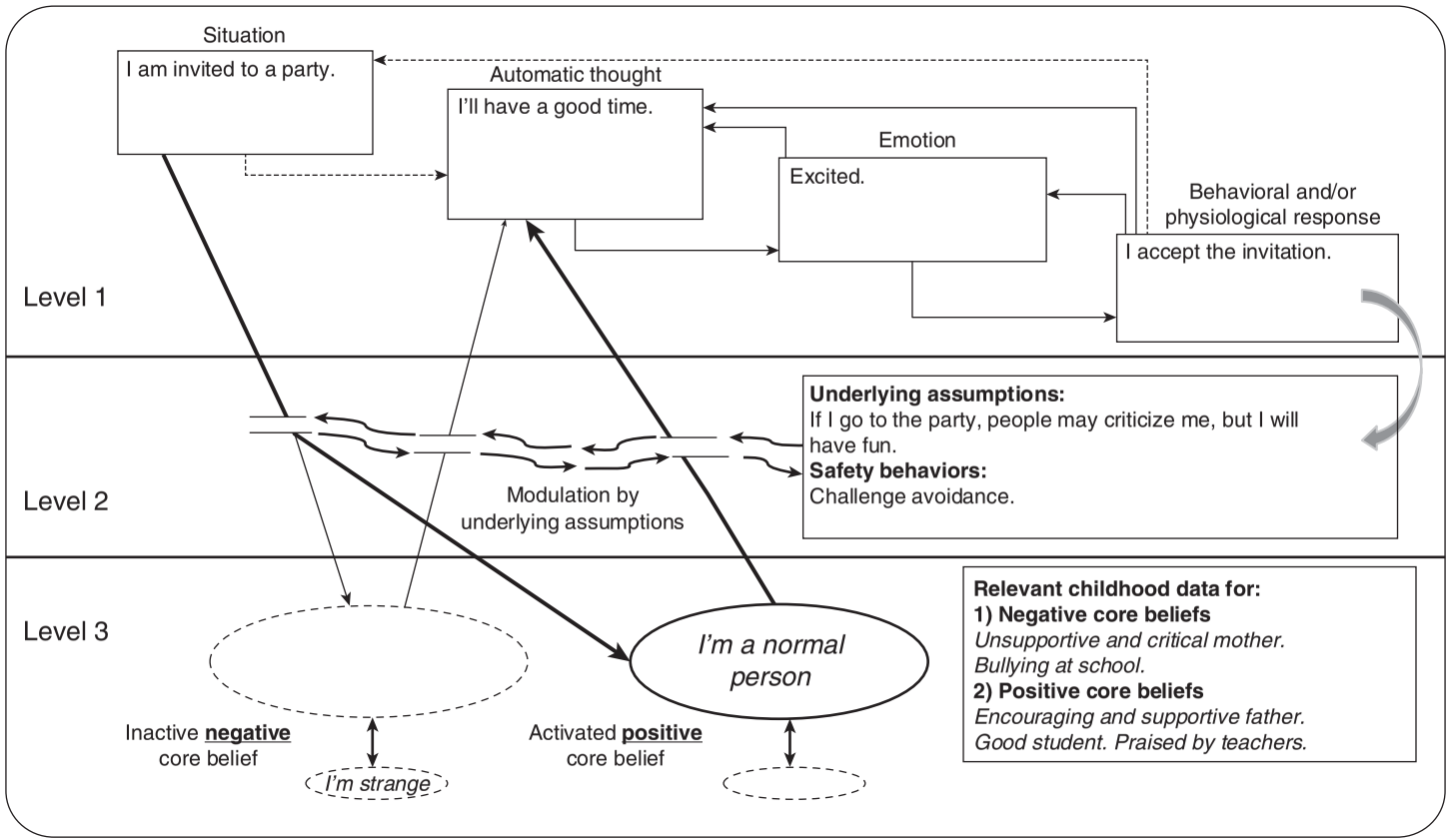


Figure 11.2 Leslie's conceptualization diagram during therapy (Phase 2).

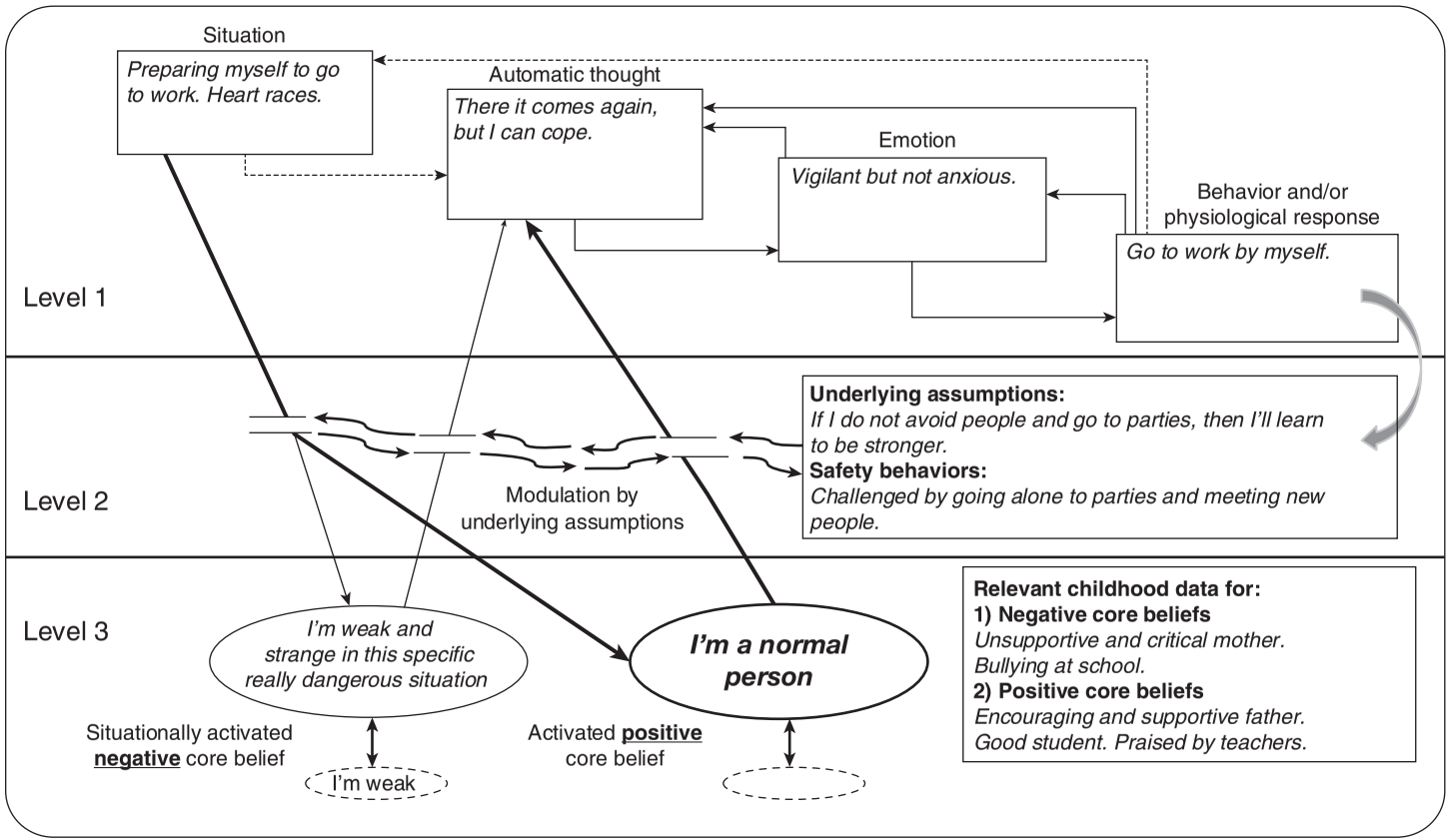


Figure 11.3 Leslie's conceptualization diagram at the end of therapy (Phase 3).

12 Trial-Based Participation Assessment (Trial III)

Outline

- Trial-Based Participation Assessment (TBPA) or Trial III
- Case Illustration

Trial-Based Participation Assessment (TBPA) or Trial III

The TBPA (trial III) or the participation grid is a modification of the responsibility pie (Greenberger & Padesky, 1995). Although both are very similar procedures, in my experience, the participation grid seems to allow a more progressive exposure to the avoided or shameful situation. Additionally, it can be particularly useful for the patients who do not like or feel uncomfortable when asked to draw. The TBPA usually brings a surprise element when the patients calculate the sum of all percentages given to the circumstances and people who have participated in the event, and patients become less guilty or ashamed on discovering that their own participation or responsibility is minimal or inexistent.

The participation grid may be used earlier in therapy, especially when guilt is a clear complaint. For instance, a patient felt she was guilty of being raped, because she concluded that she should not have walked home alone from work late in the evening. Moreover, she had not accepted her boss's offer to drive her home. With such patients, this approach may be used earlier in therapy, as a preparation, but also as a complement to trial I.

However, to evaluate guilt feelings, before the participation assessments, the therapist asks the patient how much she believes she is guilty about something that has happened. Then, in the participation assessments, the patient is encouraged to think of other people, phenomena, or circumstances that could have had any "participation" in the event. When guilt is transformed into participation, the patient accepts thinking about other people or circumstances. Her participation is assessed last, after she calculates the sum of other participants. I use the word "participation," because it may be intentional or non-intentional. For a religious patient, concluding that God's participation was important may change dramatically her guilt feelings. One patient said, "It is such a relief to

accept that this could be God's will, and that I could do nothing to avoid it." For the first participation assessment, I suggest that the therapist ask questions in as vague and less detailed a manner as possible. One should pay attention to avoidance and the patient's mood. Sometimes, even small reductions in guilt of 5% or 10% may be surprising for the patient. Each assessment becomes progressively more detailed, specific, and concrete. Sometimes, it takes up to five assessments for the patient to have a real benefit the patient to have a real benefit. The assessments are conducted in the same session.

Case Illustration

A 60-year-old married man tormented himself for more than 30 years feeling guilty over his mother's death. He said, "I killed my mother." When I asked him how much he believed that, he said 100%. He had driven her to the bus station and she died in a road accident. For years, he avoided thinking about this.

See in Table 12.1 how this man reassessed his participation and finally his guilt. Believing at first that he was 100% guilty for his mother's death, after the participation assessments, his guilt decreased dramatically to 5%.

After the therapist conducted a careful Socratic questioning about other people and events possibly contributing to the event the patient felt guilty for, the patient gave these reasons for his guilt feelings:

- His mother had decided to travel to be with her younger daughter who was undergoing elective surgery. He said he had tried to dissuade her, but she didn't listen to him.
- His father did nothing to prevent his mother from going.
- His sister's surgery was simple and did not need his mother's presence. His sister did not try to dissuade her from going to be with her.
- His mother's driver was sick and could not take her to the bus station, which was the reason why she asked him to drive her.
- The bus driver must have had some participation because it was raining and maybe he was not careful enough.
- It was raining, so the weather was also a participant.

Table 12.1 Trial-based participation assessment (TBPA, or trial III)

I believe *100%* I am guilty for *my mother's death.*

Participation assessment	*1st evaluation*	*2nd evaluation*	*3rd evaluation*	*4th evaluation*	*5th evaluation*
Myself	30	15	5		
My mother	10	20	20		
My father	10	15	20		
My sister	20	20	20		
My mother's driver	10	10	10		
The bus driver	15	15	20		
The weather	5	5	5		
Total percentage	100	100	100	100	100

I believe 5% I am guilty for *my mother's death.*

Conclusion

TBCT Is a Flexible Approach

The therapist may start therapy using any of its techniques from any cognitive level described in the TBCT cognitive conceptualization diagram (CCD) seen in Chapter 1 (Fig. 1.2). TBCT can be tailored to the patients and should fit their present difficulties. Table C.1 depicts the TBCT techniques.

TBCT may be described as an assimilative integrative approach (Messer, 1992), with cognitive therapy as the main theoretical model and techniques from other approaches being incorporated and assimilated.

Although this manual describes TBCT use in 12 sessions, this description should not be taken literally. On the contrary, one typical session may be repeated once or twice, sometimes even more if necessary. For instance, if the patient does not clearly understand or is unable to use one technique independently (e.g., intrapersonal thought record [Intra-TR]), the therapist should encourage her to continue practicing its use until she feels confident and skillful. On the other hand, some TBCT techniques do not seem to resonate with one particular patient's problems or do not appear to please her. In this case, the therapist should choose another one, provided that the rationale is offered to the patient before moving to a different technique. For instance, for some patients, identifying automatic thoughts (ATs) and restructuring cognitions in the first level (explained in Chapter 1) are particularly difficult. In these cases, I suggest that the therapist go to level 2 and use behavior experiments with the aid of the color-coded symptoms hierarchy (CCSH) card and the consensual role-play (CRP) (shown in Chapter 4) in order to challenge and change dysfunctional underlying assumptions. Sometimes, the therapist and the patient have a limited number of sessions such as when the patient is hospitalized for a short period of time. It is not infrequent that the therapist and the patient have only one appointment, and in this case, depending on the educational level of the patient, her difficulties may be approached immediately with trial I—the main TBCT technique—which is ordinarily used after a one-month, four-session preparation.

In short, although TBCT has a logical sequence, with a beginning, a middle, and an end, the circular nature of cognitions allows that therapy be started anywhere in the cognitive circuits in the three cognitive levels shown in Chapter 1.

Table C1 Summary of trial-based cognitive therapy (TBCT) techniques, diagrams, and forms. Columns 2 and 3 show in which sessions and cognitive levels they are usually used.

Techniques/Diagrams/Forms	*Sessions*	*Cognitive level*
TBCT conceptualization diagram	All sessions	1, 2, and 3
Cognitive distortions questionnaire (CD-Quest)	Every session from Session 2 on	1
Intrapersonal thought record (Intra-TR)	Any from Session 2 or 3 as needed	1
Interpersonal thought record (Inter-TR)	Any from Session 2 or 3 as needed	1
Color-coded symptoms hierarchy (CCSH)	Any from Session 3 or 4 as needed	2
Consensual role-play (CRP)	Any from Session 3 or 4 as needed	2
Trial-based thought record (TBTR or trial I)		3
First use:	Usually from Session 5 on	
In the appeal format:	After first use	
For multiple beliefs simultaneously:	Usually after restructuring 2 or 3 individual beliefs	
Trial-based metacognitive awareness (TBMA or trial II)	Usually from Session 7 on	3
Trial-based participation assessment (TBPA or trial III)	Any session (as needed) for guilt/shame	1, 2, and 3
Relaxation with the sailboat metaphor	Usually from Session 7 on	1, 2, and 3

Appendix

Blank Diagrams and Forms to Be Used with and by Patients

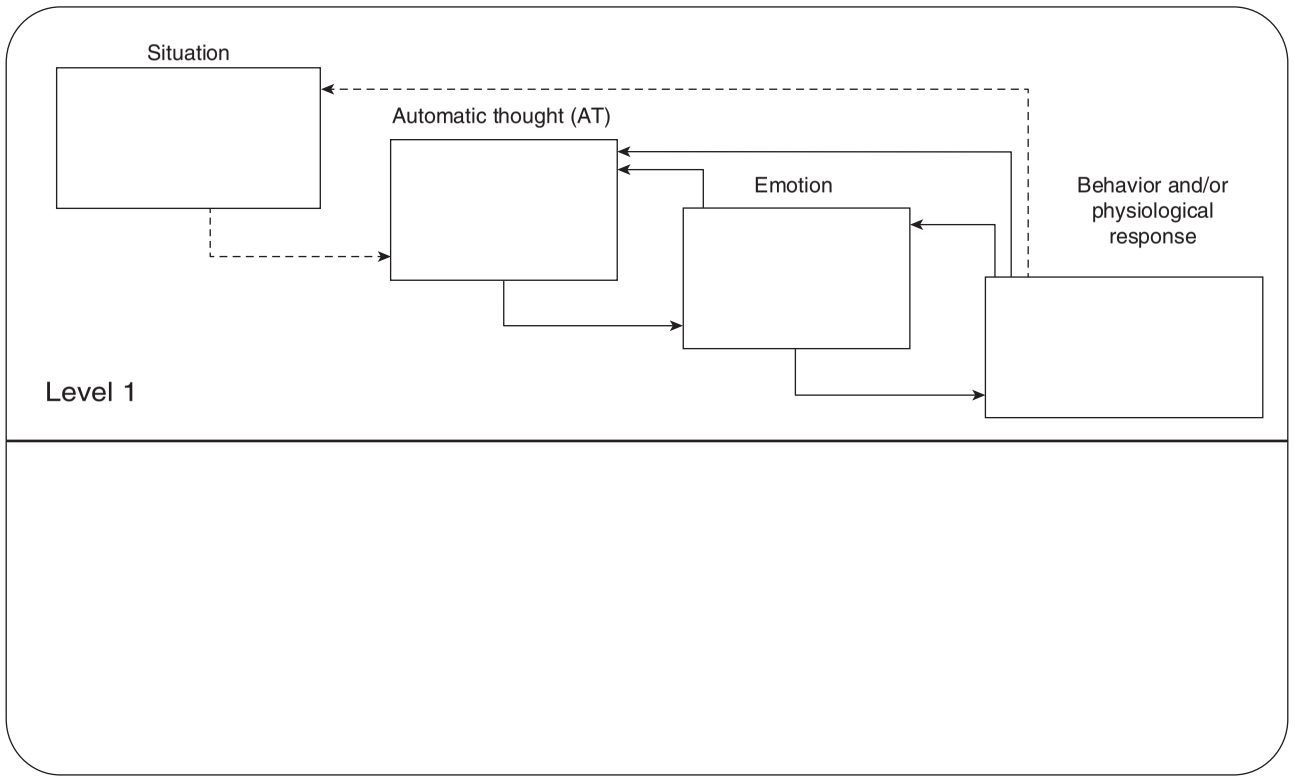


Figure A1 TBCT conceptualization diagram (phase 1, level 1).

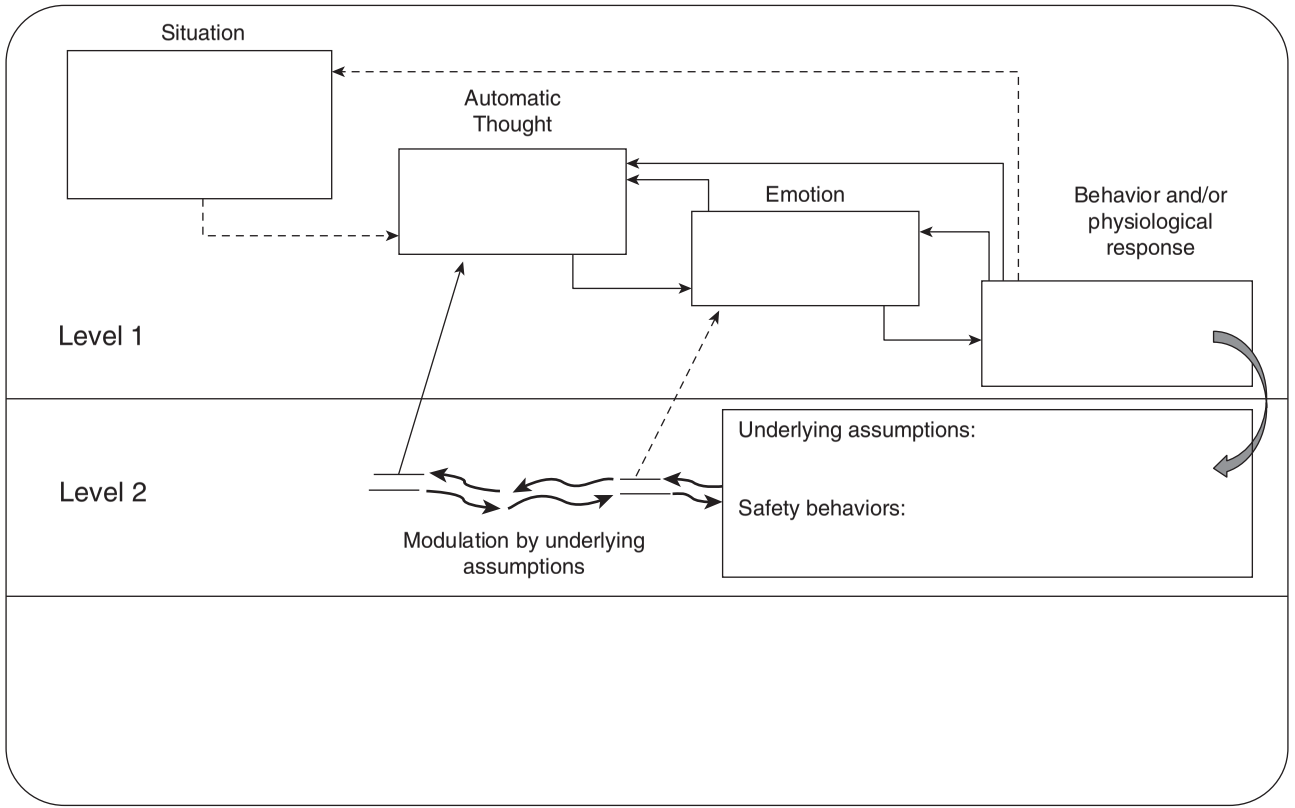


Figure A2 TBCT conceptualization diagram (phase 1, levels 1 and 2).

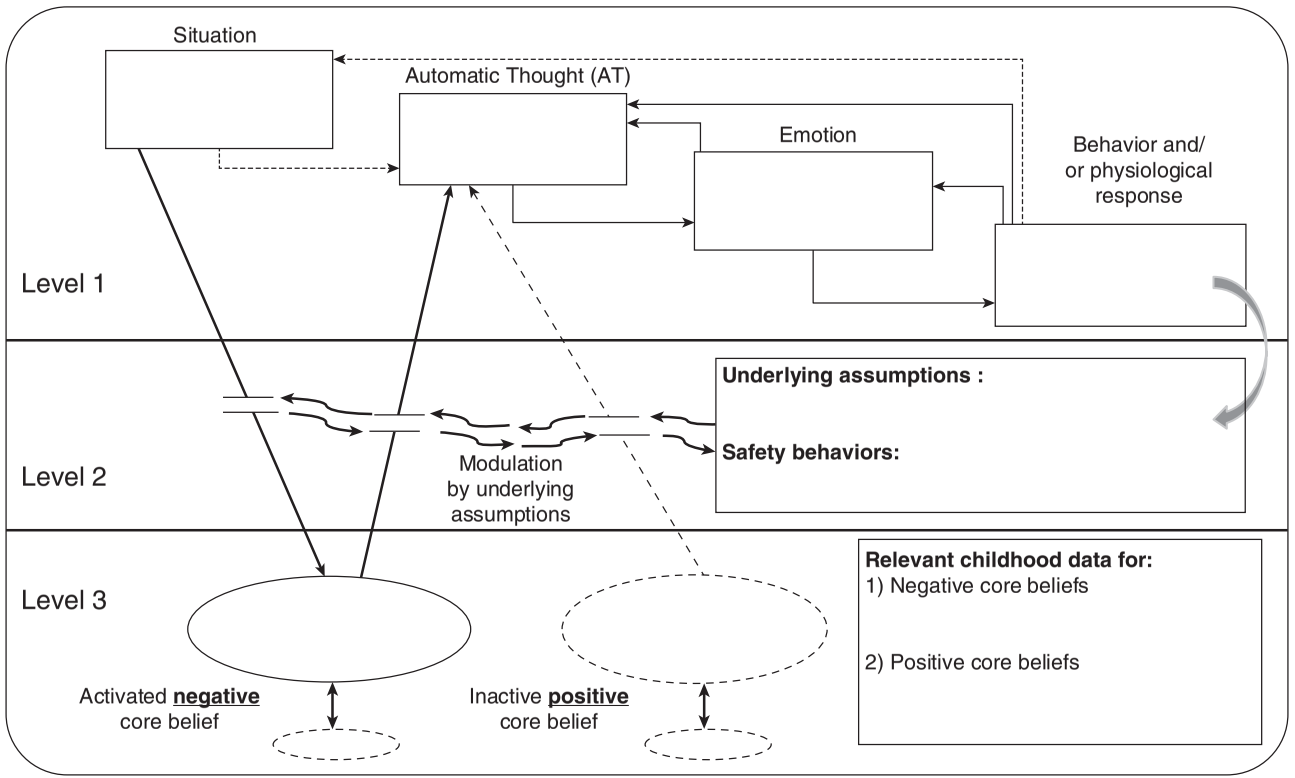


Figure A3 TBCT conceptualization diagram (phase 1, levels 1–3).

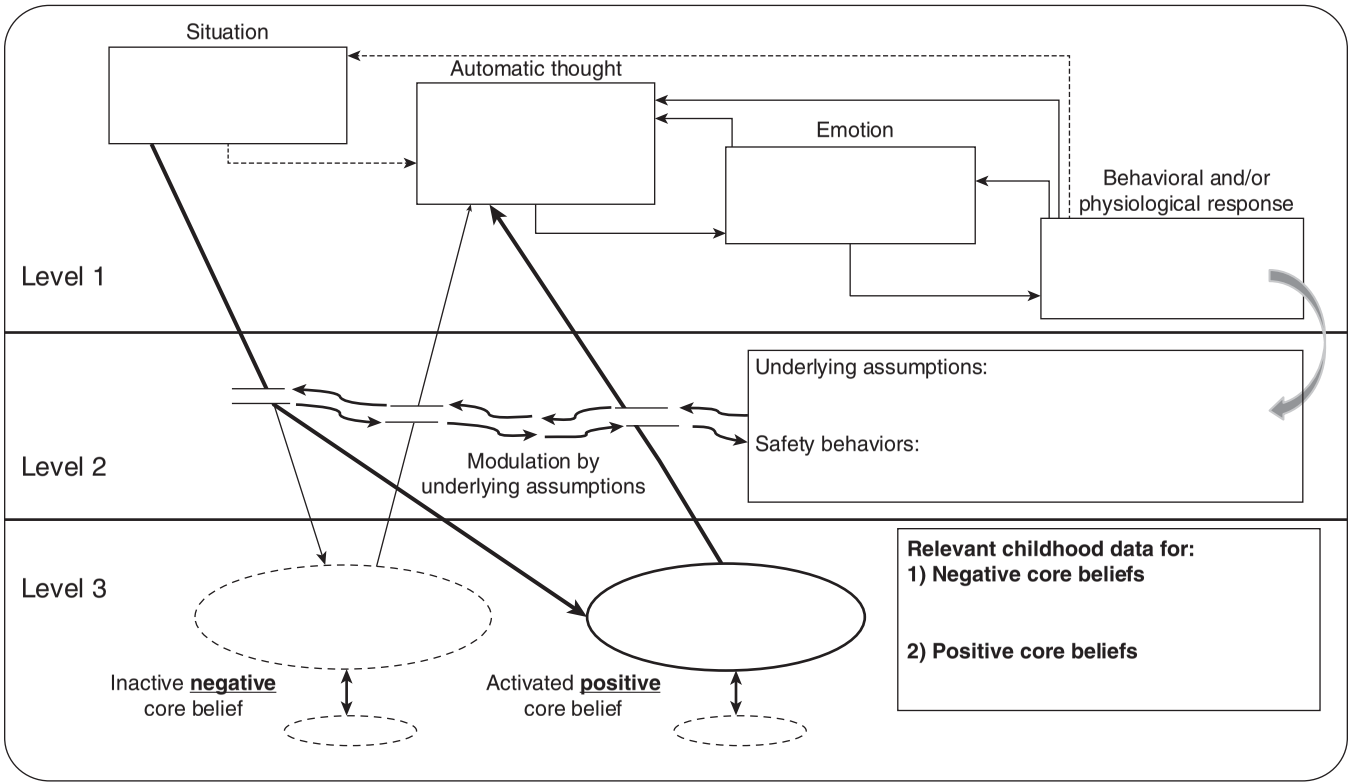


Figure A4 TBCT conceptualization diagram (phase 2, levels 1–3).

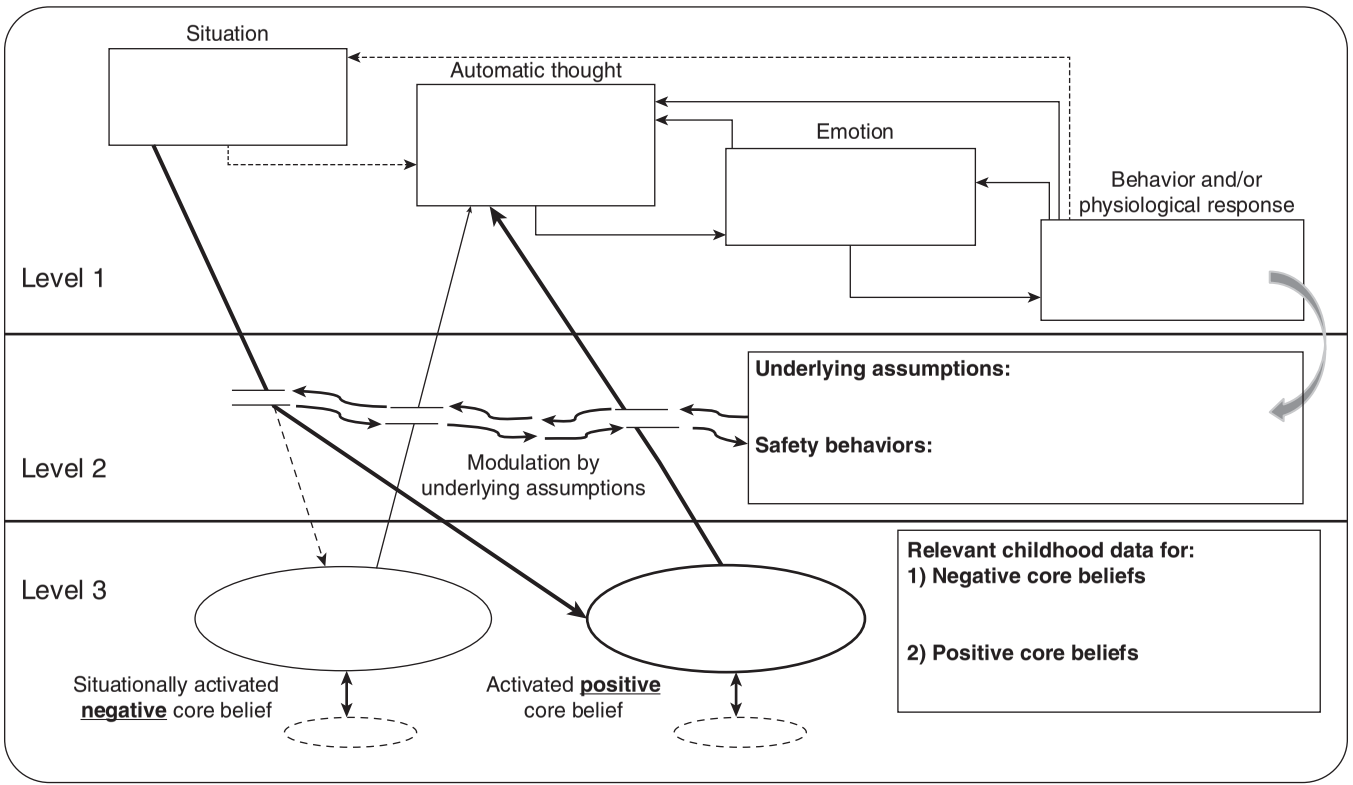


Figure A5 TBCT conceptualization diagram (phase 3, levels 1–3).

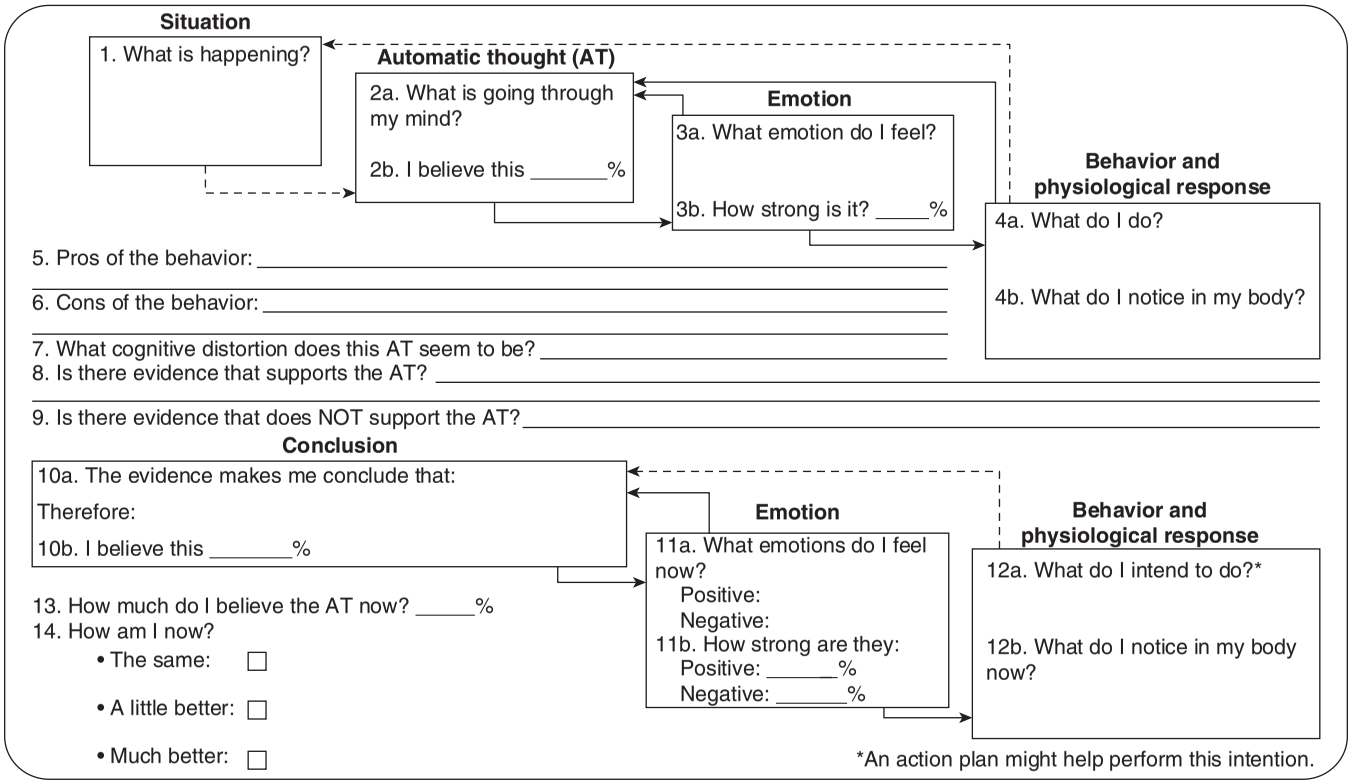


Figure A6 TBCT intrapersonal thought record (Intra-TR).

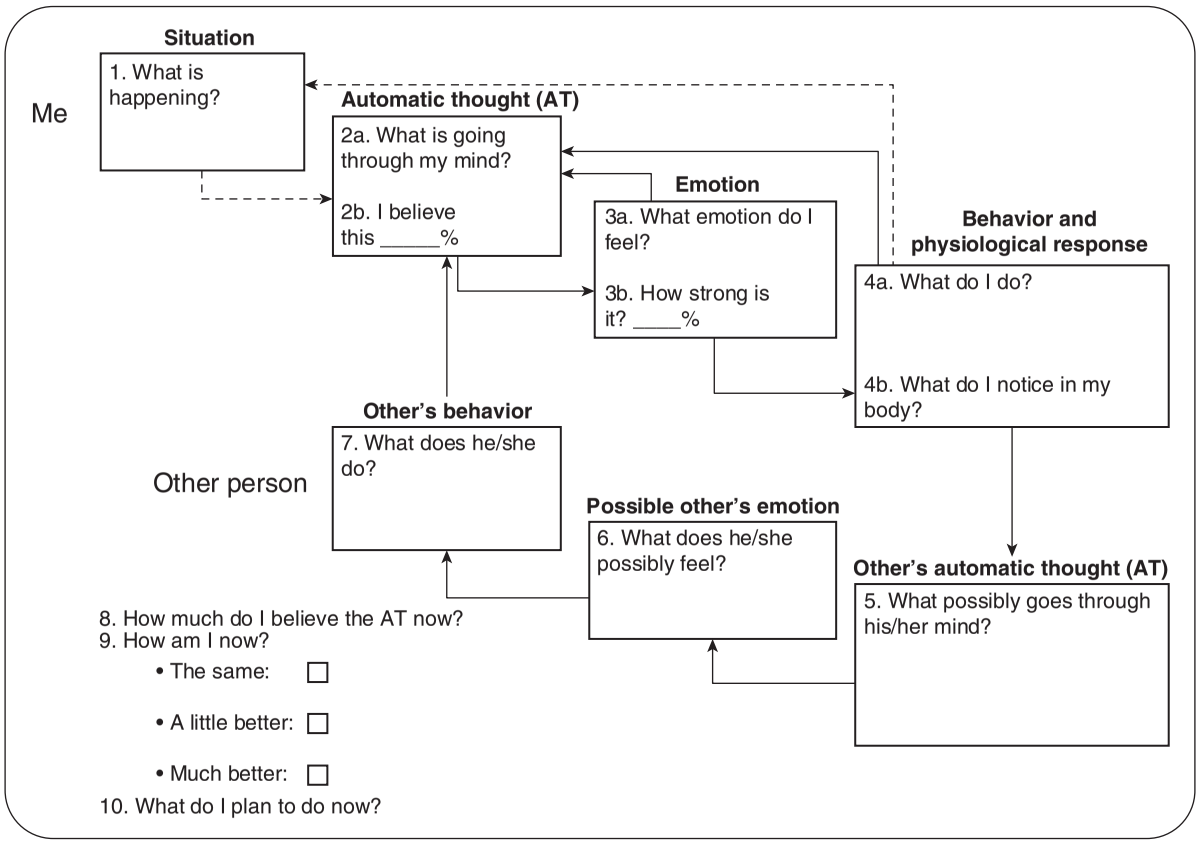


Figure A7 TBCT interpersonal thought record (Inter-TR).

0	Exposure is comfortable or indifferent
1	Exposure is a little uncomfortable
2	Exposure is uncomfortable
3	Exposure is very uncomfortable
4	Exposure is so distressful that I do it only if really necessary
5	Exposure is so distressful that I cannot imagine myself doing it

- *Light gray symptoms (0 and 1) are not a reason for concern*
- *Medium gray symptoms (2 and 3) should always be challenged*
- *Dark gray symptoms (4) are challenged in session or with the therapist's help*
- *Black symptoms (5) are NEVER challenged*

Figure A8 Color-coded symptoms hierarchy (CCSH) card to facilitate exposure implementation.

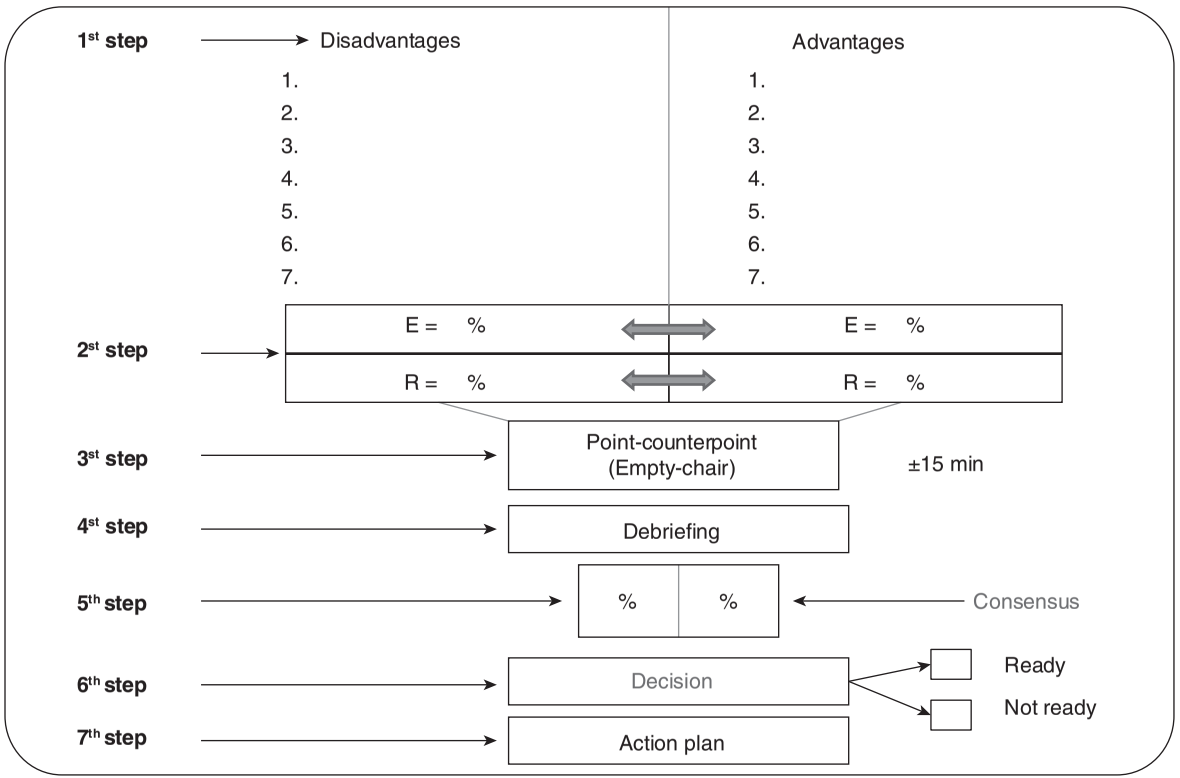


Figure A9 Consensual role-play (CRP), a decision-making approach.

1. Proposed actions:
   a. _____
   b. _____
   c. _____
   d. _____
2. Possible obstacles to actions:
   a. _____
   b. _____
   c. _____
   d. _____
3. Solutions to obstacles:
   a. _____
   b. _____
   c. _____
   d. _____
4. When to implement proposed actions:
   a. _____
   b. _____
   c. _____
   d. _____
5. Follow-up:
   a. _____
   b. _____
   c. _____
   d. _____

Figure A10 Action plan.

Table A1 Cognitive distortions list and CD-Quest

Please read the list of definitions and examples of cognitive distortions below, so that you can learn to identify your own examples. Write down these examples in column 4, under "My examples."

Cognitive distortion	*Definition*	*Examples*	*My examples*
1. Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking)	I view a situation, a person, or an event only in all-or-nothing terms, fitting them into only two extreme categories instead of on a continuum.	"I made a mistake; therefore I'm a failure." "I ate more than I planned, so I blew my diet completely."	
2. Fortune telling (also called catastrophizing)	I predict the future in negative terms and believe that what will happen will be so awful that I will not be able to stand it.	I will fail and this will be unbearable." "I'll be so upset that I won't be able to concentrate for the exam."	
3. Discounting or disqualifying the positive	I disqualify and discount positive experiences or events, insisting that they do not count.	"I passed the exam, but I was just lucky." "Going to college is not a big deal; anyone can do it."	
4. Emotional reasoning	I believe my emotions reflect reality and let them guide my attitudes and judgments.	"I feel she loves me, so it must be true." "I am terrified of airplanes, so flying must be dangerous."	
5. Labeling	I put a fixed, global label, usually negative, on myself or others.	"I'm a loser." "He's a rotten person." "She's a complete jerk."	
6. Magnification / minimization	I evaluate myself, others, and situations magnifying the negatives and/or minimizing the positives.	"I got a B. This proves how inferior I am." "I got an A. It doesn't mean I'm smart."	

7. Selective abstraction (also called mental filter and tunnel vision)	I pay attention to one or a few details and fail to see the whole picture.	"My boss said he liked my presentation, but since he corrected a slide, I know he did not mean it." "Even though the group said my work was good, one person pointed out an error so I know I will be fired."	
8. Mind reading	I believe that I know the thoughts or intentions of others (or that they know my thoughts or intentions) without having sufficient evidence.	"He's thinking that I failed." "She thought I didn't know the project." "He knows I do not like to be touched this way."	
9. Overgeneralization	I take isolated cases and generalize them widely by means of words such as "always," "never," "everyone."	"Every time I have a day off from work, it rains." "You only pay attention to me when you want sex."	
10. Personalizing	I assume that others' behaviors and external events concern (or are directed to) me without considering other plausible explanations.	"I felt disrespected because the cashier did not say thank you to me" (not considering that the cashier did not say thank you to anyone). "My husband left me because I was a bad wife" (not considering that she was his fourth wife).	
11. Should statements (also "musts," "oughts," "have tos")	I tell myself that events, people's behaviors, and my own attitudes "should" be the way I expected them to be and not as they really are.	"I should have been a better mother." "He should have married Ann instead of Mary." "I shouldn't have made so many mistakes."	

(Continued)

Table A1 (Continued)

Cognitive distortion	*Definition*	*Examples*	*My examples*
12. Jumping to conclusions	I draw conclusions (negative or positive) from little or no confirmatory evidence.	"As soon as I saw him I knew he had bad intentions." "He was looking at me, so I concluded immediately he thought I was responsible for the accident."	_____ _____ _____ _____
13. Blaming (others or oneself)	I direct my attention to others as sources of my negative feelings and experiences, failing to consider my own responsibility, or conversely, I take responsibility for others' behaviors and attitudes.	"My parents are the ones to blame for my unhappiness." "It is my fault that my son married a selfish and uncaring person."	_____ _____ _____ _____
14. What if?	I keep asking myself questions such as "what if something happens?"	"What if my car crashes?" "What if I have a heart attack?" "What if my husband leaves me?"	_____ _____ _____ _____
15. Unfair comparisons	I compare myself with others who seem to do better than I do and place myself in a disadvantageous position.	"My father always preferred my elder brother because he is much smarter than I am." "I am a failure because she is more successful than I am."	_____ _____ _____ _____

Cognitive Distortions Questionnaire* CD-Quest

Irismar Reis de Oliveira, MD, PhD
Department of Neurosciences and Mental Health
Federal University of Bahia, Brazil

All of us have thousands of thoughts a day. These thoughts are words, sentences, and images that pop into our heads as we are doing things. Many of these thoughts are accurate, but many are distorted. This is why they are called cognitive errors or cognitive distortions.

For example, Paul is a competent journalist who had his 10-page work assessed by John, the editor of an important local newspaper. John amended one paragraph and made a few other suggestions of minor importance. Although John approved Paul's text, Paul became anxious and found himself thinking: "This work is not good at all. If it were good, John wouldn't have made any correction."

For Paul, either the work is good or it is bad. This kind of thinking error is sometimes called dichotomous thinking. As this thought returned to Paul's mind several times from Friday to Sunday (3 days), and Paul believed it at least 75%, he made a circle around number 4 in the fourth column of the grid below.

1. **Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking)**: I view a situation, a person, or an event in "either-or" terms, fitting them into only two extreme categories instead of on a continuum.

EXAMPLES: "I made a mistake; therefore my performance was a failure." "I ate more than I planned, so I blew my diet completely"
Paul's example: *This work is not good at all. If it were good, John wouldn't have made any correction.*

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (Up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (More than 70%)		3	④	5

Please, turn the page and assess your own thinking style.

Cognitive Distortions Questionnaire
CD-Quest
Irismar Reis de Oliveira, MD, PhD

Name: _____ **Date:** _____

Please, make a circle around the number corresponding to each option below, indicating cognitive errors or distortions that you have made *during this past week.* When assessing each cognitive distortion, please, indicate *how much* you believed it in the exact moment it occurred (not how much you believe it now), and *how often* it occurred during this past week. Please, give your own examples in the items you mark 3 or more.

DURING THIS PAST WEEK, I FOUND MYSELF THINKING THIS WAY:

1. **Dichotomous thinking (also called all-or-nothing, black-and-white, or polarized thinking)**: I view a situation, a person, or an event in "either-or" terms, fitting them into only two extreme categories instead of on a continuum.

EXAMPLES: "I made a mistake; therefore my performance was a failure." "I ate more than I planned, so I blew my diet completely."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

2. **Fortune telling (also called catastrophizing)**: I predict the future in negative terms and believe that what will happen will be so awful that I will not be able to stand it.

EXAMPLES: "I will fail and this will be unbearable." "I'll be so upset that I won't be able to concentrate for the exam."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

3. **Discounting the positive**: I disqualify positive experiences or events insisting that they do not count.

EXAMPLES: "I passed the exam, but I was just lucky." "Going to college is not a big deal, anyone can do it."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

4. **Emotional reasoning**: I believe my emotions reflect reality and let them guide my attitudes and judgments.

EXAMPLES: "I feel she loves me, so it must be true." "I am terrified of airplanes, so flying must be dangerous." "My feelings tell me I should not believe him."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

5. **Labeling:** I put a fixed, global label, usually negative, on myself or others.

EXAMPLES: "I'm a loser." "He's a rotten person." "She's a complete jerk."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

6. **Magnification/minimization**: I evaluate myself, others, and situations placing greater importance on the negatives and/or placing much less importance on the positives.

EXAMPLES: "I got a B. This proves how bad my performance was." "I got an A. It means the test was too easy."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

7. **Selective abstraction (also called mental filter and tunnel vision)**: I pay attention to one or a few details and fail to see the whole picture.

EXAMPLES: "Michael pointed out an error in my work. So, I can be fired" (not considering Michael's overall positive feedback). "I can't forget that a small piece of information I gave during my presentation was wrong" (not considering its success and the audience's great applause).

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

8. **Mind reading**: I believe that I know the thoughts or intentions of others (or that they know my thoughts or intentions) without having sufficient evidence.

EXAMPLES: "He's thinking that I failed." "She thought I didn't know the project." "He knows I do not like to be touched this way."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

9. **Overgeneralization**: I take isolated negative cases and generalize them, transforming them in a never-ending pattern, by repeatedly using words such as "always," "never," "ever," "whole," "entire," etc.

EXAMPLES: "It was raining this morning, which means it will rain during the whole weekend." "What a bad luck! I missed the plane, so this will interfere with my entire vacation." "My headache will never stop."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

10. **Personalization**: I assume that others' behaviors and external events concern (or are directed to) myself without considering other plausible explanations.

EXAMPLES: "I thought I was disrespected because the cashier did not say thank you to me" (not considering that the cashier did not say thank you to anyone). "My husband left me because I was a bad wife" (not considering that she was his fourth wife).

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

11. **Should statements (also " musts," "oughts," "have tos"**): I tell myself that events, people's behaviors, and my own attitudes "should" be the way I expected them to be and not as they really are.

EXAMPLES: "I should have been a better mother." "He should have married Ann instead of Mary." "I shouldn't have made so many mistakes."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

12. **Jumping to conclusions (also called arbitrary inference)**: I draw conclusions (negative or positive) from little or no confirmatory evidence.

EXAMPLES: "As soon as I saw him I knew he would do lousy work." "He looked at me in a way that I immediately knew he was responsible for the accident."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

13. **Blaming (others or oneself)**: I direct my attention to others as sources of my negative feelings and experiences, failing to consider my own responsibility, or conversely, I take responsibility for others' behaviors and attitudes.

EXAMPLES: "My parents are the only to blame for my unhappiness." "It is my fault that my son married a selfish and uncaring person."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

14. **What if?**: I keep asking myself questions such as "what if something happens?"

EXAMPLES: "What if my car crashes?" "What if I have a heart attack?" "What if my husband leaves me?"

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

15. **Unfair comparisons:** I compare myself with others who seem to do better than I do and place myself in a disadvantageous position.

EXAMPLES: "My father always preferred my elder brother because he is much smarter than I am." "I can't stand that she is more successful than I am."

Frequency:	**No** (It did not occur)	**Occasional** (1–2 days during the past week)	**Much of the time** (3–5 days during the past week)	**Almost all of the time** (6–7 days during the past week)
Intensity: I believed it . . .	0			
A little (up to 30%)		1	2	3
Much (31% to 70%)		2	3	4
Very much (more than 70%)		3	4	5

Table A2 TBCT form (trial I). Please, briefly describe the situation:

1. **Inquiry/Establishing the accusation (core belief).** What was going through your mind before you started to feel this way? Ask yourself what these thoughts meant about yourself, supposing they were true. The answer *"If these thoughts were true, it means I am a . . ."* is the uncovered **self-accusation** (core belief).	2. **Prosecutor's plea**. Please, state all the evidence you have that supports the accusation/ core belief that you have circled in column 1.	3. **Defense attorney's plea:** Please, state all the evidence you have that does not support the accusation/core belief that you have circled in column 1.	4. **Prosecutor's rebuttal to the defendant's plea**. Please, state the thoughts that question, discount, or disqualify each piece of positive evidence in column 3, usually expressed as "yes, but . . ." thoughts.	5. **Defense attorney's rejoinder to the prosecutor's plea**. Please, copy each thought of column 3, connecting them with the conjunction BUT, after reading each sentence in column 4. Note: columns 5 and 6 are filled in at the same time.	6. **Meaning of the response presented by the defense attorney to the prosecutor's plea.** Please, state the meaning you attach to each sentence in column 5.	7. **Juror's verdict**. Please, report cognitive distortions made by the prosecutor and the defense attorney and give the verdict.

(Continued)

Table A2 (Continued)

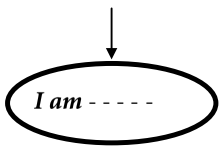
Downward arrow technique: *If the thoughts above were true, what would they mean about you?* 	*1)* *2)* *3)* *4)* *5)* *6)*	*1)* *2)* *3)* *4)* *5)* *6)*	**But . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**But . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**It means that . . .** *1)* *2)* *3)* *4)* *5)* *6)*	**Cognitive distortions:** **Prosecutor 1** / **Defense 1** 1: / 1: 2: / 2: 3: / 3: 4: / 4: 5: / 5: 6: / 6: **Prosecutor 2** / **Defense 2** 1: / 1: 2: / 2: 3: / 3: 4: / 4: 5: / 5: 6: / 6: **Verdict:**
Now, how much (%) do you believe you are _____? **Initial:** **Final:** What emotion does this belief make you feel? _____ How strong (%) is it? **Initial:** **Final:**	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____now? _____%		Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____ now? _____%	Now, how much (%) do you believe you are _____? _____% How strong (%) is your _____now? _____%

Table A3 Preparation for the appeal (one-belief form)

Positive new core belief: I am ____________________ (Please write down here at least one piece of evidence supporting the new core belief. Also write how much you believe it, daily, in the space between parentheses.)

Date	(%)	Date	(%)	Date	(%)
1.		1.		1.	
2.		2.		2.	
3.		3.		3.	
Date	(%)	Date	(%)	Date	(%)
1.		1.		1.	
2.		2.		2.	
3.		3.		3.	
Date	(%)	Date	(%)	Date	(%)
1.		1.		1.	
2.		2.		2.	
3.		3.		3.	
Date	(%)	Date	(%)	Date	(%)
1.		1.		1.	
2.		2.		2.	
3.		3.		3.	

Table A4 Preparation for the appeal (form for two or more beliefs)

Positive new core beliefs. Please write down at least one piece of evidence supporting the new core beliefs. Also write how much you believe it (%) daily. Note that one piece of evidence may support one or more new core beliefs.

Date	*Belief 1:*	*Belief 2:*	*Date*	*Belief 1:*	*Belief 2:*
	(%)	(%)		(%)	(%)
…../…../……	1.	1.	…../…../……	1.	1.
	2.	2.		2.	2.
	3.	3.		3.	3.
	(%)	(%)		(%)	(%)
…../…../……	1.	1.	…../…../……	1.	1.
	2.	2.		2.	2.
	3.	3.		3.	3.
	(%)	(%)		(%)	(%)
…../…../……	1.	1.	…../…../……	1.	1.
	2.	2.		2.	2.
	3.	3.		3.	3.
	(%)	(%)		(%)	(%)
…../…../……	1.	1.	…../…../……	1.	1.
	2.	2.		2.	2.
	3.	3.		3.	3.

Table A5 Preparation for the appeal (form for three or more beliefs)

Positive new core beliefs. Please write down at least one piece of evidence supporting the new core beliefs. Also write how much you believe them (%) daily. Note that one piece of evidence may support one or more new core beliefs.

Date	*Belief 1:*	*Belief 2:*	*Belief 3:*	*Belief 4:*
	(%)	(%)	(%)	(%)
…../…../……	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.
	(%)	(%)	(%)	(%)
…../…../……	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.
	(%)	(%)	(%)	(%)
…../…../……	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.
	(%)	(%)	(%)	(%)
…../…../……	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

Table A6 Participation grid

I believe _____% I am guilty for _____.

Participation assessment	*1st evaluation*	*2nd evaluation*	*3rd evaluation*	*4th evaluation*	*5th evaluation*
Myself					
Total percentage	100	100	100	100	100

I believe _____% I am guilty for _____.

Note

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