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Modification of Core Beliefs in Cognitive Therapy

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1. Introduction

As has been seen in this volume thus far, a great deal of work in cognitive therapy is geared toward the identification, evaluation, and modification of situational thoughts (i.e., *automatic thoughts*) that patients experience on particular occasions and that are associated with an increase in an aversive mood state. Although they usually obtain significant relief from their mood disturbance using this *cognitive restructuring* process, many patients who focus only on these situational cognitions find that they continue to experience the same thoughts, over and over again, even if they have increased their ability to cope with them. One explanation for this is that these patients continue to hold unhelpful core beliefs, which facilitate the activation of these situational thoughts.

Core beliefs are defined as fundamental, inflexible, absolute, and generalized beliefs that people hold about themselves, others, the world, and/or the future (J. S. Beck, 2011; K. S. Dobson, 2012). When a core belief is inaccurate, unhelpful, and/or judgmental (e.g., "I am worthless"), it has a profound effect on a person's self-concept, sense of self-efficacy, and continued vulnerability to mood disturbance. Core beliefs typically center around themes of lovability (e.g., "I am undesirable"), adequacy ("I am incompetent"), and/or helplessness (e.g., "I am trapped"). I propose that the greatest amount of change, and the best prevention against relapse, results when patients identify unhelpful core beliefs and work with their therapists, using cognitive therapy strategies, to develop and embrace a healthier belief system.

Core beliefs are much more difficult to elicit and modify in cognitive therapy sessions, relative to situational automatic thoughts. They usually develop from messages received, over time, during a person's formative years, oftentimes during childhood but sometimes during times of substantial stress during adulthood. For example, consider the case of a female patient, "Cori," who was told repeatedly by her parents during childhood that she was worthless because the pregnancy was unwanted, her parents only married one another because it was the "right thing to do" once the pregnancy was discovered, and they viewed themselves as miserable ever since then. Not surprisingly, this woman was characterized by the core belief, "I'm worthless." Other patients receive messages from their peers that they are unwanted when they are teased and bullied. There are still other patients who had

adaptive, healthy belief systems develop during childhood and adolescence, only to experience horrific events as an adult that had a profound impact on their core beliefs (e.g., a young man who joins the military and engages in combat returns home with the belief, "The world is cruel"). Identification of the pathway by which core beliefs develop can provide multiple points for intervention and evaluation.

It is important to understand the core belief construct's place in light of cognitive theory, as this knowledge will allow clinicians to understand and articulate to their patients the mechanism of change by which they expect therapeutic work on core beliefs to exert its desired effect. Figure 1 displays the central cognitive constructs in cognitive theory. The core belief construct is embedded in the larger construct of the *schema*. According to Clark and Beck (1999), schemas are "relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized" (p. 79). In other words, schemas not only influence *what* we believe (i.e., cognitive contents), but also *how* we process information that we encounter in our daily lives (i.e., information processing). Core beliefs, then, are the cognitive contents that are indicative of a person's schema. When a schema and its corresponding core belief(s) are activated, people process information in a biased manner, such that they attend to, assign importance to, encode, and retrieve information that is consistent with the schema, and they overlook information that is inconsistent with the schema. Thus, there is a bidirectional relation between information processing biases and core beliefs, such that information biases strengthen a person's core beliefs, and that core beliefs strengthen information processing biases. It is not difficult to imagine, for example, that a person with an unhelpful schema characterized by depressogenic core beliefs (e.g., "I'm a failure") will attend to information that reinforces those beliefs at the expense of neutral or contrary evidence, entrenching that person further in his or her depression.

Schemas and their corresponding core beliefs give rise to what Judith Beck has termed *intermediate beliefs* (J. S. Beck, 2011), which are defined as conditional rules, attitudes, and assumptions, often unspoken, that play a large role in the manner in which people live their lives and respond to life's challenges and stressors. In many instances, they are worded as "if-then" conditional statements that prescribe certain rules that must be met in order for the person to protect him- or herself from a painful core belief. For example, a person with an "I'm a failure" core belief might live by the rule, "If I get all As, then I'm successful," which is viewed as a positive intermediate belief because it specifies a path toward a positive outcome. However, that same person might also live by a negative intermediate belief, "If I get anything less than all As, then I'm a failure." Intermediate beliefs that do not use conditional language are often expressed as heavily valenced attitudes (e.g., "It would be terrible to get anything less than an A.") or assumptions about the way the world works (e.g., "Successful people should get all As in their classes."). The problem with these rules and assumptions is that they are rigid and inflexible, usually prescribing impossible standards to which one should live his or her life and failing to account for life's unexpected events and challenges that invariably affect one's ability to achieve these standards. As with core beliefs, they exacerbate information processing biases that reinforce unhelpful core beliefs, and conversely, information processing biases strengthen the rigidity of these rules and assumptions.

It is not surprising, then, that schemas and their associated core beliefs, intermediate beliefs, and information processing biases create a context for certain automatic thoughts to arise under particular circumstances. Continuing with the example in the previous paragraph, if a person is characterized by a failure core belief and carries rigid rules about the meaning of grades he receives in school, then receiving a "D" on a test might be associated with the automatic thoughts, "I'm never going to get into medical school; My life will be meaningless." However, consider another person who has the core belief "I'm unlovable" and who carries rigid rules about the meaning of her accomplishments on the degree to which others value her. In this case, receiving a "D" on a test might be associated with the automatic thoughts, "I have nothing to contribute to anyone; why should anyone care about me?" This comparative illustration demonstrates that two people in similar situations can report very different automatic thoughts, and the explanation for those different thought patterns is that these people are characterized by different sets of core beliefs and intermediate beliefs. Information processing biases only serve to further increase the likelihood that patients will experience negative automatic thoughts in stressful or otherwise challenging situations, and when the thoughts are activated, they feed back into those biases.

A final cognitive construct in this model is that of the mode, captured in the upper right-hand corner of Figure 1. According to A. T. Beck (1996), a *mode* is an interrelated set of schemas. Thus, several systems of schemas, core beliefs, intermediate beliefs, automatic thoughts, and information processing biases can be assimilated into a larger mode. A. T. Beck proposed three types of modes: (a) those that are primal in nature, which influence basic and immediate necessities such as preservation and security; (b) those that are constructive in nature, which influence the ability to have effective relationships and build life satisfaction; and (c) those that are minor in nature, which influence daily activities such as reading, writing and driving. As anyone who has treated a psychiatric patient has undoubtedly seen, unhelpful belief systems have the potential to severely limit patients' functioning in all three of these modal domains.

I propose that core beliefs play a central role in cognitive theory and that modification of core beliefs will play a fundamental role in modifying the other layers of cognition in the cognitive model. The adoption of a healthy belief system is hypothesized to add flexibility and even a sense of kindness to patients' rules and assumptions by which they live their lives, which is proposed to, in turn, decrease the likelihood that unhelpful situational thoughts will be activated automatically in stressful or challenging situations. A healthy belief system might to decrease the weight that unhelpful schemas carry when people function in various modes. I also hypothesize that the adoption of a healthy belief system will decrease the extremity of unhelpful information processing biases, as patients will begin to widen the scope of the information to which they attend to and process in their environment. I acknowledge that other cognitive behavioral approaches to treatment focus primarily on the modification of other constructs in this model, such as Nader Amir's attentional modification program that uses a computer task to train patients' attention away from stimuli that reinforces their pathology (Amir, Beard, Burns, & Bomyea, 2009; Amir, Beard, Taylor, et al., 2009). Nevertheless, I believe that an intentional focus on core beliefs during the course of cognitive therapy has the greatest potential to help patients create a healthy belief system, which will in turn increase functioning in many domains of their lives.

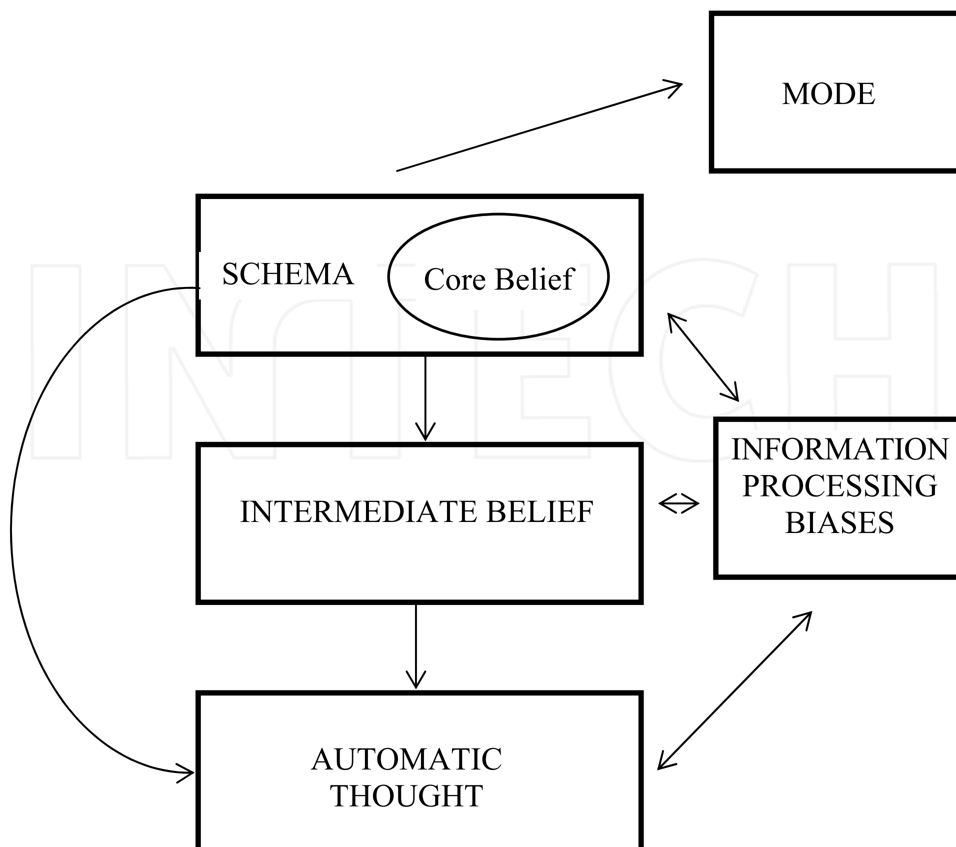

Fig. 1. Central Cognitive Constructs in Cognitive Theory.

In this chapter, I describe strategies for identifying and modifying unhelpful core beliefs. Throughout this chapter, I illustrate the application of these strategies with cases that I have seen or supervised in my practice, taking care to remove and modify any identifying information. I conclude the chapter with a discussion of challenges that can arise when working with core beliefs and directions for future research.

2. Identification of core beliefs

The first step in working with patients' core beliefs is for the therapist and patient to, collaboratively, identify them. Some patients present in the first session with a clear understanding of their core beliefs; for example, a patient, "Karen," articulated in her first session that the main issue she wanted to address was her belief that she is inferior to those whom she perceives as more accomplished than her. It is more common, however, for patients to need some time before they can identify and are ready to work with core beliefs. For example, some patients have difficulty identifying the cognitions that are related to aversive mood states, so they require practice with the more-easily-accessible automatic

thoughts before they have a sense of their underlying core beliefs. Other patients, early in therapy, find articulation of their core beliefs to be overly threatening and painful, and working with situational automatic thoughts allows them to develop a comfort level in working with their cognitions before they begin to focus on their most fundamental beliefs (K. S. Dobson, 2012). For these reasons, most cognitive therapists work with situational automatic thoughts earlier in the course of treatment and with core beliefs later in the course of treatment.

When therapists opt to work with patients across several sessions, focusing first on situational automatic thoughts, they can be vigilant for the presence of core beliefs through several means. For example, automatic thoughts that provoke a great deal of affect have the potential to be core beliefs in and of themselves, or be a direct manifestation of a core belief. Patients who systematically track their automatic thoughts across several sessions (e.g., through the use of Dysfunctional Thoughts Record) can begin to identify themes in the thoughts that they identify, which may provide a clue about the nature of the underlying core belief. When patients spontaneously report recurrent experiences that remind them of another experience, the therapist can take the opportunity to identify the threads that link these experiences together and the messages they internalized from them—both of which could reflect their core beliefs (D. Dobson & Dobson, 2009).

Perhaps the most commonly recognized strategy for identifying core beliefs is the *Downward Arrow Technique*, first mentioned by A. T. Beck, Rush, Shaw, and Emery (1979) and subsequently elaborated upon by Burns (1980). Therapists who use this strategy ask repeatedly about the meaning of situational automatic thoughts until they arrive upon a core belief, whose meaning is so fundamental that there is no additional meaning associated with it. Take, for instance, a socially anxious patient, "Gary," who was treated with 12 sessions of cognitive therapy. This patient's presenting concern was excessive blushing and blotchiness, for which he perceived that others would judge him negatively. In describing a social situation in which he was convinced that he was becoming red, he identified the automatic thought, "Others are going to see that I am red." Figure 2 displays the application of the downward arrow technique for this case. It is evident that this exercise elicited a pair of powerful core beliefs, "I am weak" and "I am less than a man."

Many therapists administer self-report inventories to assess identify cognitions that have the potential to be core beliefs. These questionnaires include: (a) the Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1980); (b) the Sociotropy-Autonomy Scale (SAS; Bieling, Beck, & Brown, 2000; D. A. Clark & Beck, 1991);(c) the Personality Belief Questionnaire (PBQ; A. T. Beck & Beck, 1991; A. T. Beck et al., 2001), and (d) the Young Schema Questionnaire (YSQ; http://www.schematherapy.com/id49.htm). Advantages of administering inventories of this nature are that core beliefs can be identified in a relatively short period of time and that an extensive range of possible beliefs can be considered. This allows the therapist to develop a richer case conceptualization than he or she might otherwise develop on the basis of interview and observational information alone. However, it is important to regard core beliefs identified via self-report inventories as hypotheses to be tested using the "data" that are obtained by the therapeutic work that takes place across sessions. As stated previously, early in the course of treatment, many

patients are not aware of their core beliefs. This lack of awareness could influence the manner in which they respond to these inventories, such that they minimize the operation of one or more beliefs. Moreover, core beliefs are idiosyncratic to each individual, so there is always the possibility that a salient core belief is not assessed on the inventory that is administered. D. Dobson and Dobson (2009) have recommended that self-report inventories of core beliefs should be administered after patients' immediate distress has been addressed, so that their distress does not affect their responses to items on the inventory, but not so late in treatment that their beliefs have already shifted.

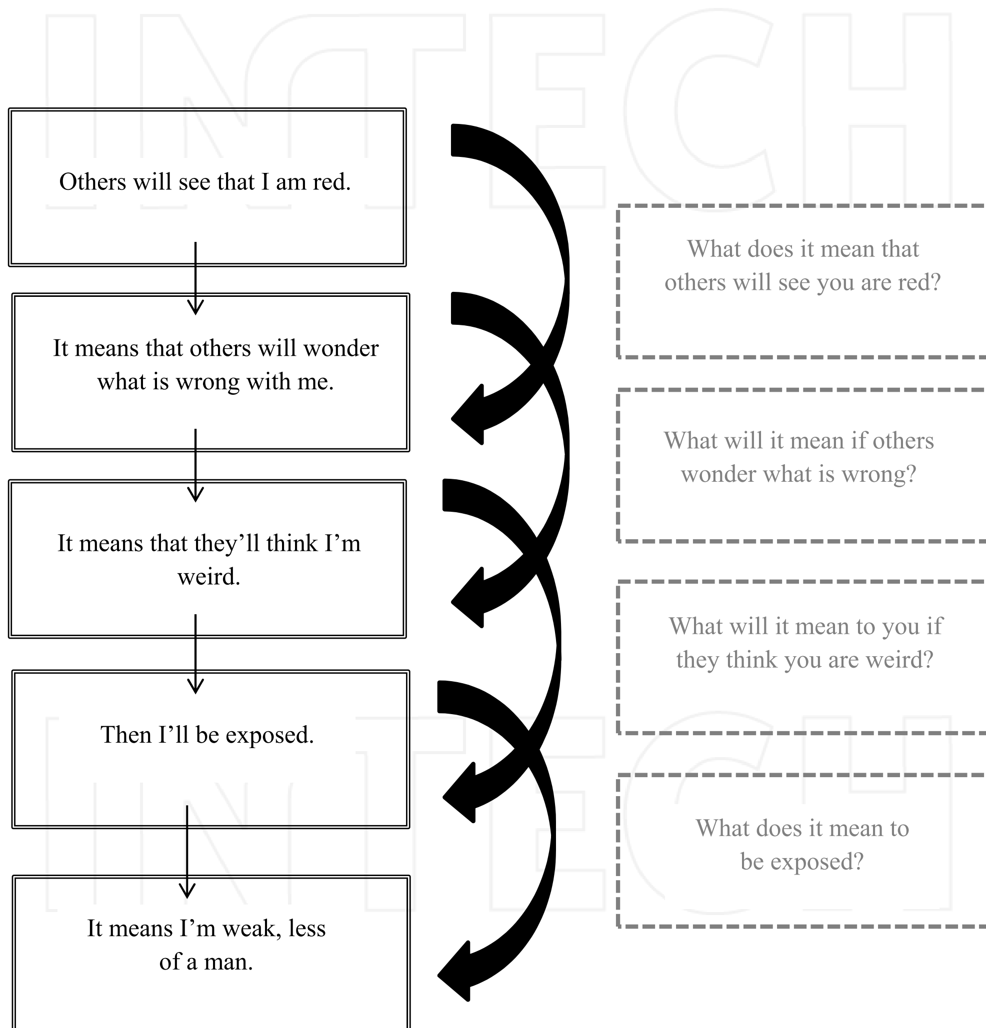

Fig. 2. Application of the Downward Arrow Technique.

3. Modification of core beliefs

Because they are so entrenched, core beliefs are almost never modified after only one session of cognitive therapy. More typically, once core beliefs are identified, the therapist and patient work together, collaboratively, to decrease the degree to which the patient believes the old, unhelpful core belief and increase the degree to which the patient believes a new, healthier belief. In this section, I describe some common strategies for the modification of core beliefs. Most therapists use a creative combination of the strategies described in this session (as well as other strategies) to achieve core belief modification with their patients.

3.1 Defining the core belief

In most cases, core beliefs are so global that they pervade all aspects of a patient's life (e.g., "I'm a failure," "I'm worthless."). However, patients take these excessive judgments as fact without taking the time to operationalize the components that comprise them. When patients are faced with identification of the components that make up successfulness, worth, lovability and so on, they often realize that they are basing their judgment on one or two areas of their lives that are not going well for them and failing to acknowledge the other areas of their lives that contribute to these constructs are going rather well. Thus, a first step I take in modifying core beliefs is to work with patients to define their components so that we know, more precisely, what is driving the belief, so that we can gain perspective on the belief, and so that we can identify specific points of intervention.

One straightforward way to define the components of core beliefs is to use a pie chart. Figure 3 displays a pie chart for a depressed and angry patient, "Marco," who had the core belief, "I'm not as good as others." He divided his pie into components that he believed contributed to a person's ability to, indeed, be as good as others. As can be seen in Figure 1, Marco put the greatest weight on his career, the second greatest amount of weight on a romantic relationship, the third greatest amount of weight on major possessions, and an equal amount of weight on relationships with his children and recreational pursuits. Notice that some of these components required definitions, themselves. For example, Marco was encouraged to identify the most important aspects of his career that would help him to adopt the new core belief, that he is as good as other people. He also identified the number of recreational pursuits that would reinforce this new core belief, as well as the types of possessions he would have that would, in his view, be manifestations of being as good as other people.

There may be aspects of the components of a patient's core belief that the therapist views as concerning. For example, it appears that Marco is one whose self-worth is driven, at least to some degree, by money, status, and possessions. Therapists must remember that it is not their place to judge patients' priorities and values, but rather to help them identify discrepancies between their current life situation and their beliefs, values, and aspirations. Regardless, defining the components of Marco's core belief in this manner allowed Marco and his therapist to examine his functioning in five different domains, evaluate the degree to which his view of his functioning in these five domains is accurate and helpful, and to identify action plans for improving functioning in these five domains.

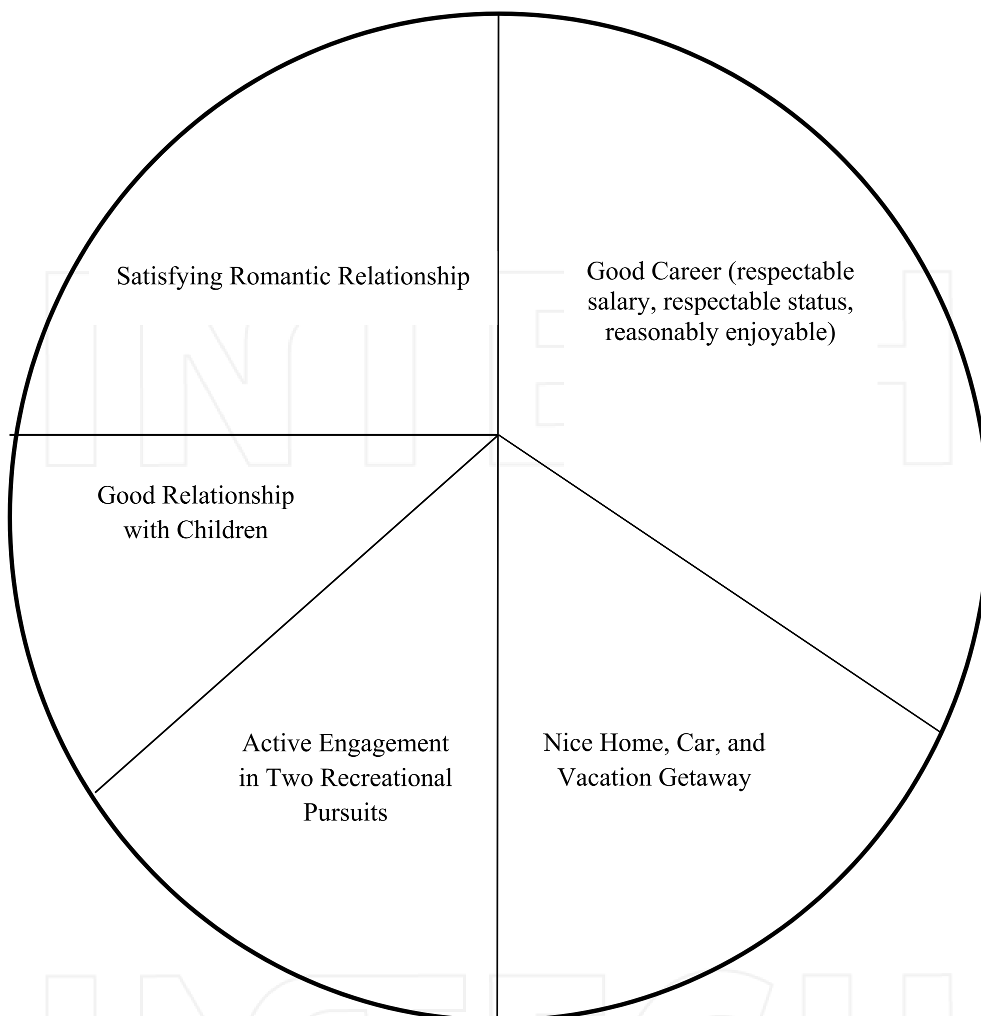

Fig. 3. Sample Pie Chart to Define "Being As Good As Others".

3.2 Examining evidence

A common strategy for modifying core beliefs is to critically examine the evidence that supports the old, unhelpful core belief and that which supports a new, healthier core belief. The goal is for, over time, the patient to accumulate an increasing amount of evidence that supports the new core belief, which in turn is expected to be associated with an increase in the degree to which the patient believes the new belief and a decrease in the degree to which the patient believes the old core belief. When the patient identifies evidence that supports the old core belief, the therapist works with the patient to use cognitive restructuring strategies to reframe it. Judith Beck (2011) has created a *Core Belief Worksheet* to achieve this

goal. Other therapists do not use a formal worksheet, but instead have their patients keep track of this evidence over time on a *Positive Data Log* (D. Dobson & Dobson, 2009).

Recall the patient, Cori, introduced earlier in the chapter. She carried the core belief, "I'm worthless" throughout her adult life on the basis of consistent, negative messages that she received from her parents during childhood. Until she participated in cognitive therapy, she ignored positive feedback that she received from others, which could very well have implications for her belief of worthlessness. When she participated in cognitive therapy, she agreed to keep a Positive Data Log, writing down the feedback that she received from others that suggest that others see her as having a great deal of worth. After completing this exercise, she could not deny that others—her children, her co-workers, and people at church—valued her highly, and she concluded that she had some worth. Of course, it, ultimately, is important that Cori can view herself as having worth even without positive feedback from others. However, this exercise was the catalyst in putting a significant dent in her belief that she is worthless, allowing her and her therapist to develop creative strategies to help her, on her own, acknowledge that she has worth. Without the Positive Data Log, she would have rejected this notion.

Marco, on the other hand, drew a different conclusion after examining the evidence that contributed to his core belief that he is not as good as other people. He determined that he was not where he would like to be in all five areas that he believed contributed to being "good enough"—career, possessions, romantic relationship, relationship with his children, and consistent engagement in meaningful and enjoyable recreational activities. On the basis of this conclusion, he and his therapist used graded task assignment (Wenzel, Brown, & Karlin, 2011) to break each of these areas into smaller pieces and used problem solving to begin to make positive changes in his life, with the idea that each positive change will bring him closer to living his life consistent with the new, healthier core belief, "I'm as good as other people."

These case illustrations demonstrate that, although examination of the evidence that supports new, healthier core beliefs is a central activity that occurs in cognitive therapy, it is usually not a strategy that is an end in and of itself. Rather, it allows the patient and therapist to begin to modify the belief so that the patient is able to tolerate other creative therapeutic interventions that will solidify the shift in beliefs.

3.3 Advantages-disadvantages analysis

The *advantages-disadvantages analysis* is a versatile strategy that can be used for many purposes in cognitive therapy, such as evaluating potential solutions to problems or for weighing the pros and cons of decisions that patients face in their daily lives. It can also be used during core belief modification to help patients draw conclusions about the utility of their core beliefs after examining their advantages and disadvantages. To conduct the advantages-disadvantages analysis, patients draw a 4 X 4 quadrant, with the old core belief and the new core belief listed across the top, and "advantages" and "disadvantages" listed down the side. Then, patients record the advantages and disadvantages of each belief.

The advantages-disadvantages analysis can be used for a patient like Gary, who, after examining the evidence that supported and refuted the beliefs that he is weak and less than a man, still held onto his unhelpful beliefs. Specifically, he continued to believe that turning

red and blotchy in social situations made him weak and less than a man, reasoning that other men did not have to deal with such a “flaw” and that he could not even do what other men take for granted. His therapist turned to the advantages-disadvantages analysis to examine the degree to which holding on to such beliefs were working for him or working against him. Figure 4 displays Gary’s advantages-disadvantages analysis. After completing this exercise, Gary recognized that holding this core belief is likely to significantly increase the probability that he would, indeed, turn red and blotchy in social situations. He also concluded that it was keeping him from addressing more central issues in his life, such as a lack of fulfillment in his career.

	“I’m weak, I’m less than a man.”	“I’m just as much of a man as other guys.”
Advantages	• I keep working on overcoming my problems. • I protect myself from people seeing how red and blotchy I get.	• Maybe I would get less red and blotchy. • Maybe I would attend more social events and feel more relaxed. • I’d look more confident to women I want to date. • I would feel better about myself. • This problem would stop taking up so much time and energy. • I could move on and address some other areas of my life (e.g., getting my career on track).
Disadvantages	• When these beliefs are activated, I get even more anxious, red, and botchy. • They keep me from taking social risks (e.g., asking someone out on a date). • I avoid social activities that used to be a lot of fun. • When I do attend social events, I am preoccupied with whether I am turning red and blotchy. • I feel badly about myself. • They are keeping me from moving forward in my life (e.g., applying for a new job). • I’m not where I want to be in life.	• It seems hard to believe right now. • I could get red and blotchy, be rejected, and be devastated.

Fig. 4. Sample Advantages-Disadvantages Analysis.

As can be seen in this illustration, the advantages-disadvantages analysis usually provides a complex perspective on the core belief, as valid reasons for maintaining the unhelpful core belief are acknowledged. Unhelpful core beliefs can often be conceptualized as being understandable and associated with many advantages at the time they developed, but that, in the present, they are no longer associated with those advantages and now serve to exacerbate emotional distress. In addition, patients may view the adoption of new core beliefs as being associated with significant short-term disadvantages (e.g., discomfort), but also being associated with significant advantages in the long-term (D. Dobson & Dobson, 2009). In fact, K. S. Dobson (2012) has developed an expanded version of the advantages-disadvantages analysis, such that advantages and disadvantages of the old and new core beliefs are considered from short- and long-term time perspectives.

3.4 Behavioral experiments

Some patients find that they believe the results from strategies designed to modify core beliefs "intellectually" but that they still believe their old, unhelpful core belief "emotionally." In my experience, one explanation for this is that the verbal and written strategies described in the chapter to this point are not potent enough to provide a vivid demonstration that their core belief is inaccurate or unhelpful. *Behavioral experiments* are powerful experiential exercises that patients implement in their own lives, outside of session, to test aspects of core beliefs. In essence, a behavioral experiment requires the patient to formulate a prediction on the basis of a core belief and then gather "data" to support or refute that prediction. Patients "see for themselves" the degree to which their predictions and beliefs are warranted.

The implementation of a behavioral experiment is demonstrated with the patient described earlier in this chapter, Cori. Because she believes that she is worthless, Cori predicted that others would dismiss her contribution at her monthly book club meeting. In the past, she had refrained from sharing her comments and observations at these meetings, which further reinforced the belief that she is worthless because she believed she had nothing meaningful to share. To implement the behavioral experiment, Cori's therapist worked with her to (a) identify what she hoped to communicate about that month's book club selection, (b) practice articulating it, and (c) objectively observe others' reactions to her. At the subsequent session, Cori reported that there was no evidence that others rejected her contribution, and in fact, that two others in her book club noted that they had similar observations. Cori and her therapist discussed the manner in which her worthlessness core belief might be revised in light of this experience.

Many behavioral experiments involve, at least in part, an observation of others' reactions (e.g., the other members of Cori's book club). It is important for therapists to be mindful of the fact that they cannot control others' reactions and that there is a possibility that others will respond in a manner that inadvertently reinforces the patient's old, unhelpful core belief. Thus, behavioral experiments must be developed thoughtfully and thoroughly in session, in a manner that gives the patient an opportunity to have a "win-win" situation. In the previous example, Cori's therapist took the time to work with her on formulating the thoughts she hoped to share with the group and practicing effective communication skills. Cori's therapist also helped her to approach the experiment as if she were testing two

competing predictions that contributed to her worthlessness belief. Cori predicted that other members of the book club would dismiss or reject her contribution, which, to her, was another indicator that she is worthless. Although Cori's therapist was confident of Cori's communication abilities and doubted that would occur, they also prepared for the worst case scenario (i.e., that the others would indeed dismiss or reject her contribution), which was associated with a related belief, "I'm so worthless that I can't cope with rejection." They developed specific coping skills for managing distress associated with a rebuff, and Cori's therapist framed Cori's use of these coping skills as evidence that she has worth because she is able to weather adversity.

3.5 Acting "as if"

At times, patients continue to engage in engrained and self-defeating behavioral patterns that reinforce their old, unhelpful core beliefs. *Acting "as if"* is a specific type of behavioral experiment in which patients behave in a manner consistent with a new, healthier belief (even if they are not fully invested in the new belief) and evaluate the effects of this new behavioral set. Questions patients can consider after acting "as if" include: (a) What were the effects on my mood (e.g., happier?, less anxious?); (b) How did others respond to me?, (c) What negative consequences came from my acting "as if"?; and (d) What positive consequences came from my acting "as if"? In most instances, patients see that acting according to a new, healthier belief frees them from their unhelpful core beliefs, allows them to let go of emotional distress, and elicits positive reactions from others.

Gary used acting "as if" to modify the belief that others would react negatively to him if he were to become red and botchy in a social situation, thereby exposing himself as being weak. When he first entered therapy, he presented with a submissive posture, not wanting anyone to notice him and comment on his appearance. His therapist hypothesized that this behavior actually increased the likelihood of negative reactions from others (e.g., by making others uncomfortable around him), thereby reinforcing his old, unhelpful core beliefs. His therapist encouraged Gary to act "as if" he did not care that he had a propensity to become red and blotchy and to carry himself with confidence. Gary implemented this assignment in the time in between sessions, and at his subsequent session, he reported that he had had dates with two different women that he had met at social engagements. As a result of this experiment, Gary began to see that he was overstating the implications of his propensity to turn red and blotchy and that, by carrying himself in a manner consistent with the core belief "I am just as much of a man as other guys," members of the opposite sex found him to be attractive and were interested in dating him.

3.6 Cognitive continuum

The *cognitive continuum* is a strategy for critically examining, and ultimately modifying, all-or-nothing core beliefs, such as "I'm a failure." Patients are asked to draw a horizontal line representing the full continuum of their core belief from 0% to 100%. For example, a patient with a core belief of "I'm a failure" might write the word "Failure" under the anchor for 0% and the word "Successful" under the anchor for 100%. The patient is asked to provide an initial rating of where on the continuum he or she falls, as well as the point on the continuum in which the negative core belief begins (e.g., failure begins at 20%). As the

exercise progresses, the patient considers the full spectrum of people who would lie on the continuum and lists some of these people as anchors (e.g., people who would be considered at 10%, 20%, et cetera, through 80% and 90%). Concurrently, the patient continually revises where he or she stands on the basis of these anchors. In most instances, when patients consider the full spectrum of people who could be included on this continuum (which could range from world leaders to people who are in prison and homeless), they generally conclude that they compare favorably to many others and that they are doing no better or worse than most people.

It is important for therapists who use the cognitive continuum to be vigilant for distorted or inaccurate beliefs that fuel the location at which they place themselves on the continuum. Recall the patient, Karen, who was introduced earlier in the chapter. Karen was a physician's assistant and worried a great deal about being "found out" as incompetent, which contributed to her perception that she was inferior to others. Using the cognitive continuum, she initially rated herself as 30% on a continuum from competent (100%) to incompetent (0%) and estimated that incompetence started at 30%. She made her estimate on the basis of questionable reasoning; for example, she believed that she consulted her medical books much more frequently than other health care providers and interpreted that as a sign of incompetence. Thus, during the cognitive continuum exercise, Karen's therapist also worked with her to evaluate whether consulting her medical books was equal to being incompetent and whether there are other ways to view the consultation of her medical books (e.g., she cares deeply for her patients and wants to provide optimal care). In addition, during the exercise Karen's therapist learned that Karen was ignoring one of her major strengths as a health care provider—her sensitive and compassionate bedside manner. At first, Karen rejected this characteristic as having anything to do with competence. However, using Socratic questioning, Karen's therapist worked with her to see that a compassionate bedside manner might increase the likelihood that her patients would comply with their treatment regime, which would very much speak to her competence as a health care provider. At the end of the exercise, Karen decided that her compassionate bedside manner indeed contributes to her competence as a health care provider, and she re-rated herself at 70% on the competence-incompetence continuum.

3.7 Historical tests

Historical tests of unhelpful core beliefs allow patients to understand the pathway by which such beliefs developed, to examine evidence that supports and refutes the core beliefs at various periods of time in their life (e.g., elementary school years, middle school years, high school years, and so on), to reframe the evidence that they view as supportive the core beliefs, and to draw a more balanced conclusion that has direct implications for the core beliefs (J. S. Beck, 2011). This strategy was used with Gary, who distinctly remembered giving a presentation to his fourth grade class, when a classmate blurted out, "What's wrong with Gary? His face is all red." Gary identified the evidence that supported the core beliefs that he is weak and less than a man for several periods of his life, including elementary school, middle school, high school, college, and post-college. Gary identified several instances during each of these time periods that he viewed as supporting the unhelpful core beliefs, all of which involved becoming red and blotchy when he made presentations or asked young women out on dates. However, he also described many other

accomplishments that had nothing to do with getting red and blotchy, such as being the captain of his high school soccer team and being accepted into a prestigious fraternity in college. He concluded that although he has had the propensity to turn red and blotchy throughout most of his life, he has received much recognition in his life that someone who is weak and less than a man would likely not have gotten.

3.8 Restructuring early memories

Therapists can use imagery and role-playing techniques in order to elicit affect associated with and restructure painful memories of events that shaped unhelpful core beliefs (J. S. Beck, 2011). Not only does completion of this exercise demonstrate to patients that their beliefs are understandable in light of their formative experiences, it also allows them to consider other explanations that might account for the unfortunate life events that contributed to them. Many approaches for implementing this strategy can be selected. In one application of this strategy, patients who present with distress about a current situation can think back to the first time they experienced similar distress and play the role of the person delivering the negative message in order to identify other explanations for that person's behavior. For example, Karen recalled that her father criticized her when she was in first grade because the neighbor boy got higher grades on his report card than she did, which gave her the message that she was inferior. Her therapist encouraged her to play the role of her father, and the therapist played the role of Karen when she was in first grade, responding to her "father" in a balanced manner. After completion of the role play, Karen realized that her father recognized her potential and wanted her to succeed because she was quite capable, rather than inferior.

Another application of this strategy involves a role-play between the patient at his or her current age and the patient at the age began to receive messages that contributed to the development of an unhelpful core belief. Such a role-play often begins with the therapist playing the role of the patient at that younger age, and the patient playing the role of the current him- or herself. The patient applies the cognitive restructuring skills that have been acquired in previous sessions to appraise the negative messages in a more balanced manner. Cori's therapist used this approach, inviting Cori to "show" her younger self that she has worth. Specifically, Cori's therapist made statements such as, "Well I am worthless. That's what Mommy and Daddy tell me. Cuz I always mess up things." In the context of the role-play, the adult Cori asked the younger Cori questions, such as, "Aren't kids allowed to mess up once in a while? How will you learn if you don't try? Does messing up something you are trying for the first time have to mean that you are worthless?" Later in the role-play, Cori assumed the role of her younger self, and her therapist played the role of her mother, telling her she was worthless. In her new role, the "young" Cori was encouraged to respond to her mother in a healthy, balanced manner, in which she stated, "Mommy, I'm just trying my best. Trying makes me worthwhile, not worthless." By "reliving" this experience, Cori was able to experience the intense affect associated with her mother's treatment of her and begin the reframe the hurtful message that she had internalized.

3.9 Defining the "new self"

Earlier in the chapter, I emphasized the importance of defining components of unhelpful core beliefs so that patients have an operational definition for their many components. In a

similar manner, patients can define the precise operational components of their "new self" (D. Dobson & Dobson, 2009). In many instances, patients can translate their work on defining the unhelpful core belief to paint a picture of their "new self," developing goals they would like to achieve for each component. However, in other instances, patients are at a loss when they are asked to describe the person they would like to become and the associated healthy belief system. Thus, in these latter cases, patients can identify role models from biographies, movies, or the media and adopt the beliefs that these role models seem to expose.

For example, Marco's belief that he is not as good as other people often led him to "explode" at others when he perceived that he was being disrespected, which further reinforced his unhelpful core belief because he would chastise himself for not remaining "cooler" in challenging situations. He perceived the actor, George Clooney, to embody a healthy belief system that would, in turn, facilitate calm and centered responding in situations characterized by interpersonal conflict. Thus, he kept a mental image of George Clooney when he was faced with challenges, and when he successfully used this image to avert self-defeating behavior, his therapist helped him to use the experiences to reinforce his new, healthier belief that he is just as good as others.

3.10 Soliciting social support and consensus

Patients can also mobilize their social support system to help define and reinforce a new set of healthier core beliefs. Specifically, they can obtain feedback from others about the degree to which their old, unhealthy core beliefs are accurate, as well as about the proposed new, healthy set of core beliefs (D. Dobson & Dobson, 2009). Cori used this approach to address an intermediate belief, her attitude that being shy is perceived as a character defect (which, in turn, fueled her core belief that she is worthless). She constructed a questionnaire that she distributed to eight family members and friends, which was designed to solicit their feedback on the degree to which her shyness made a negative impact on her personality and behavior. She was shocked at the responses she received—although the family members and friends indeed acknowledged that they viewed her as shy, they, uniformly, did not regard her shyness as a character defect. Instead, they gave her the feedback that her quiet nature made her a good listener, and as a result, she was one of the first people they would go to when they needed support. Not only did this exercise refute the attitude that shyness was "bad," but it also refuted her core belief of worthlessness because she obtained evidence that other people valued her opinion.

3.11 Time projection

An approach for solidifying the adoption of a new, healthy belief system is *time projection*, in which patients create vivid images and descriptions of what life will be like at specific time periods in the future as a result of their new core beliefs. Creative ways to achieve time projection include having patients imaging writing a memoir at the end of their lives or a eulogy that captures how they would like to be remembered (D. Dobson & Dobson, 2009). These images and descriptions can then serve as a template to guide patients' appraisals of and behavior in new challenges that they face in their every day lives, such they are responding in a manner consistent with their new core beliefs, and more generally, the

person they aspire to be. Toward the end of therapy, Gary used this approach to solidify his new core belief that he is a confident man with something to offer. He wrote a eulogy characterizing himself as a warm, funny, personable individual who had a wide social circle that valued and respected him. When he experienced the occasional twinge of anxiety about become red and blotchy while interaction with strangers, he recalled the spirit of the eulogy and was mindful that his warm interpersonal style was more salient than his redness and blotchiness, and that discontinuing the interaction would be contrary to the person by whom he wanted to be remembered.

4. Challenges and future directions

Many therapists find that working with core beliefs is quite rewarding, as it allows the therapist and patient to harness their creativity, it is intellectually stimulating, and it has the potential to facilitate lasting change in the patient. With those rewards, however, come potential challenges. Unhelpful core beliefs are often quite painful for patients to acknowledge, and sustained attention to core beliefs in session may be associated with an escalation of negative affect and agitation. Not only, then, is it important for the therapist to be comfortable in affective expression of this nature, but it is also imperative that the patient has coping skills in place to deal with the "side effects" of work with core beliefs (James & Barton, 2004). Because core beliefs are not modified fully after only one session, the patient may experience a temporary increase in symptoms in between sessions. Therapists should anticipate this and should work with patients to develop a specific cognitive behavioral coping plan to manage this affect.

In addition, there is no step-by-step procedure for working with core beliefs, in contrast to some cognitive therapy protocols that address situational automatic thoughts and behavioral coping skills. This is undoubtedly frustrating for the therapist-in-training who is learning how to administer cognitive therapy. In collaboration with their patients, therapists incorporate a variety of core belief modification strategies on the basis of the conceptualization of the patient's presenting problem, the factors that maintain or reinforce the core belief, and the patient's preferences. It is crucial for the therapist to keep in mind cognitive behavioral mechanisms of change, clearly map out the intended mechanism of the proposed strategy in light of this theory, and assess the degree to which the strategy achieved its anticipated outcome along the way. This approach reflects a true "scientist-practitioner" model of psychotherapy, such that relevant theory guides the choice of intervention, and the therapist collects "data" about the intervention to ensure that it is effective.

Although the efficacy and effectiveness of cognitive therapy, as a *treatment package*, have been evaluated in countless randomized controlled trials (Butler, Chapman, Forman, & Beck, 2006), rarely is research conducted to evaluate the effectiveness of particular cognitive therapy *strategies*. In fact, the research data have little to say about whether core belief work with patients even increases the efficacy of treatment above and beyond initial work with situational automatic thoughts, unhelpful behavioral patterns, and behavioral coping skills (D. Dobson & Dobson, 2009; see De Oliveira et al., in press, and Chapter 3 of this volume for an example of an exception). Thus, a much-needed direction for future research is to evaluate the efficacy of specific cognitive therapy strategies in reducing psychiatric

symptoms, improving functioning, and improving quality of life. Such research would involve the time-series analysis of standardized assessments completed at the beginning and end of each therapy session, across the course of multiple sessions. Although it would be labor-intensive, such research would elucidate, more precisely, the short- and long-term effects of specific cognitive therapy strategies; clarify, more precisely, mechanisms of change; and speak to the ideal points in the course of cognitive therapy that specific strategies might be introduced. In other words, such research would move the field beyond the question of "Does cognitive therapy work" and toward the question of "How does cognitive therapy work?"

In conclusion, it is my speculation that work done early in the course of cognitive therapy, when therapists work with situational automatic thoughts, unhelpful behavioral patterns, and behavioral coping skills, is associated with substantial symptom reduction and increased motivation to make additional changes in therapy. For many patients, this is sufficient, and they are considered "treatment successes." However, it is also my speculation that the work done in the later sessions in therapy, when therapists work with core beliefs, is associated with enhanced consolidation of learning and relapse prevention, as well as shifts in cognitive and behavioral tendencies that underlie unhelpful personality styles. Although core belief work can be challenging for both the therapist and patient, it also can be some of the most gratifying work done in cognitive therapy due to its highly individualized and creative approach and its potential in creating lasting cognitive change in patients.

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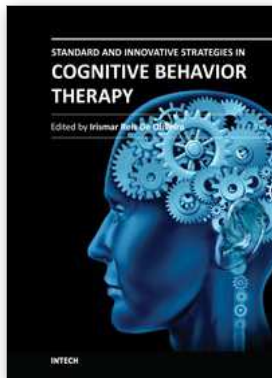

Standard and Innovative Strategies in Cognitive Behavior Therapy

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Cognitive-behavioral therapy (CBT) is the fastest growing and the best empirically validated psychotherapeutic approach. Written by international experts, this book intends to bring CBT to as many mental health professionals as possible. Section 1 introduces basic and conceptual aspects. The reader is informed on how to assess and restructure cognitions, focusing on automatic thoughts and underlying assumptions as well as the main techniques developed to modify core beliefs. Section 2 of this book covers the cognitive therapy of some important psychiatric disorders, providing reviews of the recent developments of CBT for depression, bipolar disorder and obsessive-compulsive disorder. It also provides the latest advances in the CBT for somatoform disorders as well as a new learning model of body dysmorphic disorder. Two chapters on addiction close this book, providing a thorough review of the recent phenomenon of Internet addiction and its treatment, concluding with the CBT for substance abuse.

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