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Original article

Sentence-reversion-based thought record (SRBTR): a new strategy to deal with "yes, but…" dysfunctional thoughts in cognitive therapy ☆

Enregistrement de pensées fondé sur la réversion de sentences : nouvelle stratégie pour travailler les pensées automatiques du type « oui, mais » en thérapie cognitive

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Abstract

The Dysfunctional Thought Record (DTR) is an effective and useful worksheet, widely used in cognitive therapy (CT), to help patients respond to automatic thoughts (ATs) and to change negative mood states. Some clients, however, seem not to improve with the use of the original DTR proposed by Beck et al. (1979). Padesky and Greenberger (1995) added two evidence columns to the original five-column DTR in order to generate more balanced alternative thoughts. In this paper, I present a case report and propose a modified thought record to deal especially with "yes, but…" dysfunctional thoughts.

Résumé

L'enregistrement de pensées dysfonctionnelles est une fiche effective et utile, largement utilisée en thérapie cognitive, dont le but est celui d'aider les patients à répondre aux pensées automatiques (PA) et de modifier leurs états d'humeur négatifs. Quelques patients, cependant, ne sont pas aidés par l'utilisation de la fiche originale proposée par Beck et al. (1979). Padesky et Greenberger (1995) ont ajouté deux colonnes, celles des évidences, à la fiche originale à cinq colonnes, pour générer de pensées alternatives plus balancées. Je présente dans cet article un cas clinique et propose une fiche modifiée pour travailler spécialement les pensées automatiques dysfonctionnelles du type « oui, mais… »

Keywords: Automatic thought; Cognitive therapy; Core belief; Mode; Schema; Sentence-reversion; SRBTR; Thought record

Mots clés : Pensée automatique ; Thérapie cognitive ; Croyance centrale ; Mode ; Schéma ; Réversion de sentence ; Fiche d'enregistrement de pensées

1. Introduction

According to cognitive therapy (CT), stressful states such as depression, anxiety and anger are often maintained or exacerbated by exaggerated or biased cognitions (Leahy, 2003). Aaron Beck, the founder of CT, proposed that the activation of certain underlying dysfunctional beliefs represented the core problem in depression and could be assigned a primary role in the production of the various cognitive, affective, and behavioral symptoms (Beck, 1996). In CT, the clinician helps the patient to understand and modify dysfunctional thoughts, maladaptive emotional expressions and maladaptive core beliefs.

Beck's CT model came from his clinical experience with depressed patients (Beck, 1976). He noticed that these patients presented three main types of negative thoughts concerning themselves, the others and the future, 'the cognitive triad'. These thoughts were labeled "automatic thoughts" (ATs) because they seemed to arise automatically and without any effort or attention. When asked 'What is going through your

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Table 1
SRBTR worksheet filled in by Mrs. A

1. Please, briefly describe the situation	2. How did you feel (sad, anxious, etc.) and how strong was/were your emotion(s) (%)?	3. What was going through your mind before you started to feel this way and how much (%) did you believe these thoughts? Ask yourself what they meant about yourself, supposing they were true. The answer "If these thoughts were true, it means I am a·····.." is the uncovered core belief. How much (%) do you believe it?	4. Please, state all the evidence you have that ***does not*** support the core belief that you have circled in column 3. How much (%) do you believe each statement below?	5. Please, state the thoughts that question, discount or disqualify each positive evidence in column 4, usually expressed as "yes, but…" thoughts. How much (%) do you believe them? What logic distortions do you see?	6. Please, copy each thought of column 5 **first**, and **then** each corresponding evidence in column 4, connecting them with the conjunction BUT. How much (%) do you believe each of them now?	7. Now, assess how much (%) you believe the core belief and how strong is/are your emotion(s): (i) after filling in column 4;(ii) after filling in column 5;(iii) after filling in column 6
During therapy session, talking about my husband's decision to quit his job in another state to be able to help me	*Sadness (100)* *Anxiety (100)*	*I am good for nothing (100)* *I do not know how to deal with this situation (90)* *If I die, everything will be solved and nobody will suffer anymore (100)* **Downward arrow technique** *If the thoughts above were true, what would they mean about you?* ↓ *I am a failure (100)*	*1. I have helped my husband in difficult situaltions before, as when he lost his job (100)* *2. I am trying hard to do the right thing. So, I have already started to read the papers for my thesis (90)* *3. I am trying to resume my Master's degree course. So, I contacted my supervisor who is willing to help me (70)* *4. It is my desire to resume work as soon as I can and I am trying hard. My boss said I will be accepted when I feel better (100)*	*1. …but he does not need me now (100)* *- discounting positives* *2. …but I have not succeeded yet, and it took me too long to start therapy (95)* *- discounting positives* *3. …but it is still going to take long to finish it (80)* *- fortune telling,* *4. …but I am not able to do it yet (100)* *- discounting positives*	*1. My husband does not need help now, BUT I have helped him in difficult situations before, as when he lost his job (100)* *2. I have not succeeded to do the right thing yet, and it took me too long to start therapy BUT I am trying hard. So, I have already started to read the papers for my thesis (100)* *3. It is still going to take long to finish my Master's degree course, BUT I am trying to resume it and I contacted my supervisor who is willing to help me (100)* *4. I am not able to resume work yet, BUT it is my desire to do it as soon as I can and I am trying hard. My boss said I will be accepted when I feel better (95)*	**(i) Core belief:** *80* **Emotion(s):** sad: *80* anxious: *90* **(ii) Core belief: 95** **Emotion(s):** sad: *90* anxious: *95* **(iii) Core belief:** *40* **Emotion(s):** sad: *35* anxious: *30* **Homework assignment:** Complete at least three SRBTRs until next session

Table 2
Coping card derived from column 6 of the SRBTR filled in by Mrs. A

Sentence-reversal:	New meaning derived from sentence-reversal (*upward arrow technique*):
1. My husband does not need help now, BUT I have helped him in difficult situations before, as when he lost his job (100)	*I can not help my husband now but I might be able to help him in the future, when I feel better. This is more optimistic*
2. I have not succeeded yet, and it took me too long to start therapy BUT I am trying hard to do the right thing. So, I have already started to read the papers for my thesis (100)	*Although I took long to start this therapy, I am more successful in my attempts to read the articles necessary to write my thesis. It means it is not too late to finish my Master's degree course*
3. It is going to take a long time to finish my Master's degree course, BUT I am trying to resume it and I contacted my supervisor who is willing to help me (100)	*Even if it takes long to complete my Master's degree course, it is better than not completing it at all*
4. I am not able to resume work yet, BUT it is my desire to do it as soon as I can and I am trying hard. My boss said I will be accepted when I feel better (95)	*Not being able to resume work now does not mean I will never be able to do it. So, I should keep trying*
If the thoughts above are true, what do they mean about you? How much (%) do you believe them? *I am not a failure. I am a reliable person (70)*	

mind now?', a depressed patient might respond: 'I shall not be able to finish this work. My boss is not satisfied with me. He is planning to fire me.'

Subsequently, Beck described other kinds of cognitions that he called intermediate and core beliefs. Core beliefs are beliefs held by persons about themselves and others as absolutely true to the point that they do not question them. They consider such ideas about themselves as part of the way they are or the way things are. These core beliefs may be inactive most of the time and be activated when the person becomes depressed. Examples are: 'I am incompetent' or 'I am unlovable'. Dysfunctional core beliefs are the sources of dysfunctional ATs. Core beliefs arise in early developmental stages when children organize their experiences and interactions with other people and the world. They are global, rigid and over-generalized cognitions. On the other hand, ATs are words or images going through one's mind during a specific situation. They correspond to the most superficial levels of cognition. Between core beliefs and ATs are intermediate beliefs consisting of rules and attitudes such as 'If I work as hard as I can, maybe I will be able to do what most people can easily do' (Beck, 1995).

Beck et al. (1979) developed the Dysfunctional Thought Record (DTR) as a worksheet to help patients respond to ATs more effectively, thereby modifying negative mood states. As ATs are quick and evaluative thoughts that are not the result of deliberation or reasoning and seem to come up automatically, they are most likely accepted uncritically as true by the person (Beck, 1995).

An important and common problem is that a straightforward use of the DTR does not help alleviate negative mood in all sufferers. Even though many patients use the DTR quite consistently, for some other patients adaptive, alternative, rational thoughts generated in response to ATs may not have enough credibility. So, Padesky and Greenberger (1995) proposed the addition of two other columns (the evidence columns) to the original five-column DTR designed by Beck et al. (1979) in order to deal with the problem. Adding evidence that supports and evidence that does not support the ATs might permit the patient to generate more balanced alternative thoughts, reducing, therefore, the intensity of their affect and corresponding behavior.

One important reason for the lack of credibility of the new, generated, rational alternative responses is that temporarily-activated or long-term activated schemas—defined as cognitive structures containing a set of related core beliefs that filter, code, integrate and attach meaning to events (Beck et al., 2004)—, produce and maintain the so called "yes, but…" disqualifying thoughts.

The purpose of this report is to propose a thought record—the sentence-reversion-based thought record (SRBTR)—, as an additional strategy to deal with "yes, but…" dysfunctional thinking. Although thought reversal has already been proposed as a useful technique to deal with some forms of "yes, but…" thinking (Freeman and DeWolf, 1992), as far as I know, sentence-reversion has not been incorporated into a thought record sheet.

2. Method

2.1. Procedure

SRBTR is presented as a worksheet in Table 1, taking data from Mrs. A, the patient described in the clinical vignette below.

The first two columns of the SRBTR are used as originally proposed by Beck et al. (1979). The first column is dedicated to briefly describing, in a few sentences, the situation that generated the affect. It is easily done by asking the client what happened, how, when, where and with whom. In the second column, the patient is asked to state his/her emotion, which may usually be described in one word: sad, anxious, jealous, angry, etc. Then, he/she is asked to rate how strong the emotion(s) is/are (0–100%).

In order to elicit the ATs connected to the mood state(s) to be registered in column 3, the therapist asks the patient what is/was going through his/her mind when he/she notices(d) a strong affect. The therapist might use the downward arrow technique (Burns, 1980) in order to uncover the activated core belief responsible for ATs and the present mood state. For instance, in column 3, the therapist asked the client the meaning of the ATs and what they meant about her, supposing they were true, before she said "*I am a failure*".

Column 4 deals exclusively with the core belief circled in column 3. We encourage the patient to identify the evidence

that does not support it. However, there may be little or no change in the corresponding affect, because of lack of credibility of the positive evidence generated to challenge the core belief. Often the client will say he/she believes such positive evidence only intellectually.

Column 5 deals with the dysfunctional ATs that usually disqualify, minimize or discount the evidence or rational thoughts generated in column 4 and, therefore, make them less credible. Such "yes, but…" thoughts are responsible for preserving other ATs and, consequently, maintaining maladaptive emotions and behavior. They are elicited when the therapist asks the client to use the conjunction *but*, as seen in Table 1. The therapist notices a new shift in mood, back to or close to the previous state the patient presented before improving with the positive evidence of column 4. These upward (column 4) and downward (column 5) shifts in emotion may be used by the therapist to explain the cognitive model; i.e. mood states depend on the way the situation is cognitively processed (positively or negatively) by the client. For example, in depression, events that are either ambiguous or irrelevant may be interpreted in a negative way. They involve primal thinking, such as selective abstraction, dichotomous inferences, and over-generalization (Beck, 1967, 1995). Such logical distortions may subsequently be explained, and the patient should be taught how to identify them and register them in column 5.

Column 6 is the central aspect of the strategy proposed here. The client is asked to copy each sentence of column 5 followed by each corresponding evidence in column 4, and to connect them with the conjunction *but* (sentence-reversion) in order to invert the proposition contained in both sentences. The rationale is to allow him/her to disqualify the negative instead of the positive and, therefore, notice the situation from a more positive and realistic perspective.

As shown in column 7 of Table 1, assessing how much the client believes the core belief (circled in column 3), and how strong the emotions are, may be repeated after completion of columns 4, 5 and 6 for affect shift demonstration to the client during the therapy session. However, when the client is instructed to practice SRBTR as homework on a daily basis, assessment of core belief and emotions should be done only after completion of column 6.

Sentence-reversion may also be registered separately in a coping card to be read by the patient in crises situations. During session, the client is asked to write down the new positive meaning derived from sentence-reversion, as shown in the second column of Table 2. This technique might be used to activate the corresponding positive core belief: "*I am reliable*", as described in Table 2.

2.2. Case report

I present below a clinical vignette in order to illustrate this strategy. This is a rather complex case in which the client fulfills diagnostic criteria for borderline personality disorder (BPD). Although complex cases are not always suitable for the presentation of new clinical tools, it illustrates how long-term activated schemas might be challenged by the SRBTR use.

Mrs. A is a 31-year-old married female who described herself as a previously preoccupied and perfectionistic person. Three years earlier, she started to feel excessively anxious and this anxiety increased greatly, often leading her to be verbally aggressive. Difficulty in dealing with her subordinates (she was a manager in a computer enterprise) made her ask for temporary dismissal. Depressive symptoms installed themselves progressively, and she could no longer resume work. She made several impulsive suicide attempts, explaining that they were due to her incapability of dealing with the pain provoked by her intense anxiety. Her psychiatrist prescribed different antidepressants and very high doses of benzodiazepines (i.e. diazepam 100 mg/day during 1 year, replaced by bromazepam 24 mg/day) without any success in significantly decreasing her anxiety levels, which sometimes led her to self-mutilation. She also gave up activities as a Master's degree student.

She was referred to me for pharmacotherapy and CT 6 months ago and seemed to rapidly understand and accept the cognitive model. Since then, Beck's standard CT has been employed on a weekly basis, simultaneously with an attempt to progressively taper benzodiazepine, replacing it with low-dose quetiapine (50–100 mg/day), an atypical antipsychotic. At the same time, I dealt with her core beliefs (such as "I am a failure", "I am incompetent", "I am inadequate", etc.) using techniques as evidence that supported and did not support them and the *continuum* (James and Barton, 2004). Although her level of anxiety decreased significantly in intensity and frequency (and the benzodiazepine dose was tapered to half the previous dose), she still presented a sort of hypersensitivity to external events, when her schemas seemed to be highly charged and she would mutilate herself again. One of the first uses of SRBTR with Mrs. A is shown in Table 1. Practicing it on a daily basis as homework helped her decrease anxiety and sadness to an acceptable level in about one and a half months.

3. Discussion

Although the conventional DTR is an effective and useful worksheet, widely used to help patients respond to ATs, it does not help all sufferers. The SRBTR presented in this paper might be used, together with other strategies such as role-plays and repeated behavioral experiments, especially when "yes, but…" thinking discounts newly-generated rational responses. With this record, stimulating upward and downward shifts in emotions, we give the patient, in the same session, the opportunity to be in contact with what is the most basic principle of CT: the way one thinks about the situation regulates one's moods. In the case example presented in this paper, using the SRBTR may have helped reactivate the patient's core belief "I am a failure" and the negative emotions attached to it, afterward reducing its charge with the evidence that did not support it. As seen in Table 2, Mrs. A, through this intervention, reframed the situation into a more positive and flexible one. One

of the advantages of this strategy may be its capacity to help patients improve in the session after stimulating upward and downward shifts in emotions.

Beck (1996) proposes that CT be an intervention aimed at discharging and modifying the modes, conceived as structural and operational units of personality that serve to adapt an individual to changing circumstances. So, by repeatedly using SRBTR in session and as homework, dysfunctional modes might be de-activated, modified in structure and content, and, finally, neutralized by the incorporation of a more credible explanation and by the activation of more adaptive modes.

SRBTR results might also be explained from the perspective of the Interacting Cognitive Subsystems (ICS) (Teasdale, 1996; Teasdale and Barnard, 1993). In the ICS view, the main goal of treatment is to replace the synthesis of the depressogenic schematic models that maintain depression with the synthesis of alternative, non-depressogenic models, something that is possible only if one achieves change at the level of higher-order meanings. In the example given by Teasdale (1996) (page 36), making small changes like "The man said 'GO ON'" vs. "The man said 'NO GO'" (and thus changing a small part of a total pattern of the implicational code) might be enough to radically change the high-level meaning represented. Still according to Teasdale (1996), "the effect of changing a thought and its related specific meaning may, by changing a discrete corresponding section of an affect-eliciting, implicational code pattern, be sufficient to change emotional response". In SRBTR, this is what might happen by inverting the sentences in columns 4 and 5 of Table 1, resulting in the entirely modified representational meaning seen in Table 2.

It is desirable, before introducing SRBTR to the patient, that he/she learn to identify ATs and, also, to make the distinction between thoughts and emotions. This approach should not be used before the patient understands the cognitive model and a good therapeutic alliance exists between patient and therapist. As it was also designed to deal with core beliefs, the therapist should be familiar with the downward arrow technique to be applied in the AT column (third column of Table 1), except when a core belief is spontaneously expressed by the patient. This is often the case in depressed and chronically anxious patients, as well as those with personality disorders, whose depressed and anxious modes are continuously charged. Then, other standard techniques used in CT, like behavioral experiments and the *continuum*, may be used.

This brief, preliminary clinical report has limitations. One such limitation is the use of SRBTR itself, which is more complicated than the original DTR proposed by Beck et al. (1979) and modified by Padesky and Greenberger (1995). It may take one entire 50-min session to be completed; however, after sufficient training, patients become progressively able to use it as homework completed in a few minutes.

A fundamental difference between SRBTR and the DTR proposed by Padesky and Greenberger (1995) is that column 5 of SRBTR deals with ATs that are actively elicited (in session or as homework) by the use of the conjunction *but*. The purpose is to find first the evidence that does not support the "hot thought" (column 4), and then find the argument used by the patient to disqualify or minimize such evidence (column 5). The aim of sentence-reversion in column 6 is to give preponderance to the evidence that does not support the hot thought over the elicited negative ATs. In Greenberger and Padesky's DTR, both columns 4 and 5 contain sentences summarizing the evidence on both sides. Because of this, some patients, especially when in highly charged emotional states, still consider that the evidence supporting the hot thought is stronger than the one not supporting it.

Although this report is limited by the presentation of only one case, in order to illustrate the use of SRBTR, this method has been successfully used in my clinical experience with several different patients and disorders in the last 2 years. However, it should be empirically validated by case series and randomized trials comparing it with other interventions before one could conclude that it is effective.

In summary, although widely used and effective, the conventional DTR is not effective in all patients, such as when they discount the meaningfulness of their rational responses to hot cognitions, and instead remain under the influence of other disqualifying ATs. Padesky and Greenberger (1995) have made changes to the DTR so as to help clients work through such difficulties, but some clients seem bound to such "hot cognitions". In response to this important and common problem, I propose an additional strategy, the SRBTR, as a way to booster the effects of rational responding. This strategy involves having the client add two other columns to the original DTR, one in which new ATs that discount the newly-generated responses are written, and another in which the conjunction "but" is used to connect the reversed sentences composed by the negative disqualifying thoughts and the positive alternative responses. The rationale is to change "disqualifying the positive" into "disqualifying the negative". In other words, the client learns to use the negative thoughts that would otherwise nullify the positive responses as a new starting point, leading to their own minimization by pairing them with the positive response. So, the therapist uses the patient's shift in affect back and forth to demonstrate and teach the cognitive model.

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