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A cognitive conceptualization is the cornerstone of CBT. You'll be learning more about the various elements and the process of conceptualization throughout this book. In this chapter, you'll find the answers to the following questions: What is a cognitive conceptualization? How do you initiate the process of conceptualization? How do automatic thoughts help you understand clients' reactions? What are core beliefs and intermediate beliefs? What is a more complex cognitive model? What is Abe's conceptualization? How do you complete a Cognitive Conceptualization Diagram? INTRODUCTION TO COGNITIVE CONCEPTUALIZATION Your conceptualization provides the framework for treatment. It helps you • understand clients, their strengths and weaknesses, their aspirations and challenges; • recognize how it is that clients developed a psychological disorder with dysfunctional thinking and maladaptive behavior; COGNITIVE CONCEPTUALIZATION

• strengthen the therapeutic relationship; • plan treatment within and across sessions; • select appropriate interventions and adapt treatment as needed; and • overcome stuck points. An organic, evolving formulation helps you plan for efficient and effective therapy (Kuyken et al., 2009; Needleman, 1999; Persons, 2008; Tarrier, 2006). You begin to construct the conceptualization during your first contact with a client and refine it at every subsequent contact. It's important to understand the cognitive formulation for the client's diagnosis(es), the typical cognitions, behavioral strategies, and maintaining factors. But then you need to see whether the formulation fits your specific client. You continually collect data, summarize what you've heard, check out your hypotheses with the client, and modify your conceptualization as needed. For example, I didn't know in the first few sessions that Maria had a belief of worthlessness. It wasn't until she had a shouting match with her mother and sister that this belief came to light. You confirm, disconfirm, or modify your hypotheses as clients present new information. You continually ask yourself, "Is the new data I've just learned part of a pattern I've already identified—or is it something new?" If new, make a note to check in future sessions to see if these data are part of another pattern. You share your conceptualization and ask the client whether it "rings true" or "seems right." If your conceptualization is accurate, the client invariably says something like "Yes, I think that's right." If you're wrong, the client usually says, "No, it's not exactly like that. It's more like ." Eliciting the client's feedback strengthens the alliance and allows you to more accurately

conceptualize and conduct effective treatment. In fact, sharing your conceptualization can itself be therapeutic (Ezzamel et al., 2015; Johnstone et al., 2011). Abe felt better when I suggested that he really had only one problem: seeing himself as incompetent and a failure. “I think you believe this so strongly that you avoid doing things that seem hard. And when you’re depressed, almost everything seems hard. (pause) Do you think I could be right?” It’s important to put yourself in your clients’ shoes, to develop empathy for what they are experiencing, to understand how they are feeling, and to perceive the world through their eyes. Clients’ perceptions, thoughts, emotions, and behavior should make sense given their

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interpretation of past and current experiences, their strengths and vulnerabilities, their values and personal attributes, their biology, and their genetics and epigenetics. Your conceptualization also helps you understand and build on your clients’ positive attributes and skills. Helping clients become more aware of their strengths and resources can lead to better functioning and improved mood and resilience (Kuyken et al., 2009). It also helps you understand how and why obstacles to achieving their goals have arisen and been maintained. INITIATING THE PROCESS OF CONCEPTUALIZATION There are many questions you should keep in mind throughout treatment to develop and refine your conceptualization. See Chapter 5 for a description of the evaluation session, in which you’ll start to collect a great deal of information: clients’ identifying information; chief complaint, major symptoms, mental status, and diagnosis; current psychiatric medications and concurrent treatment; significant relationships; best lifetime functioning; and various aspects of their history. You’ll continue to gather data throughout treatment. AUTOMATIC THOUGHTS HELP EXPLAIN CLIENTS’ REACTIONS CBT is based on the cognitive model, which hypothesizes that people’s emotions, behaviors, and physiology are influenced by their perception of events (both external, such as failing a test, and internal, such as distressing physical symptoms). Situation/event Automatic thoughts Reaction (emotional, behavioral, physiological) It’s not a situation in and of itself that determines what people feel and do but rather how individuals construe a situation (Beck, 1964; Ellis, 1962). Imagine, for example, a situation in which several people are reading a basic text on CBT. They have quite different emotional Cognitive Behavior Therapy: Basics and Beyond

and behavioral responses to the same situation, based on what is going through their minds as they read. • Reader A thinks, “This really makes sense. Finally, a book that will really teach me to be a good therapist!” Reader A feels mildly excited and keeps reading. • Reader B, on the other hand, thinks, “This approach is too simplistic. It will never work.” Reader B feels disappointed and closes the book. • Reader C has the following thoughts: “This book isn’t what I expected. What a waste of money.” Reader C is disgusted and discards the book altogether. • Reader D thinks, “I really need to learn all this. What if I don’t understand it? What if I never get good at it?” Reader D feels anxious and keeps reading the same few pages over and over. • Reader E has different thoughts: “This is just too hard. I’m so dumb. I’ll never master this. I’ll never make it as a therapist.” Reader E feels sad and turns on the television. The way people feel emotionally and the way they behave are associated with how they interpret and think about a situation. The situation itself does not directly determine how they feel or what they do. PEOPLE’S REACTIONS ALWAYS MAKE SENSE ONCE WE KNOW WHAT THEY’RE THINKING. You will be particularly interested in the level of thinking that may operate simultaneously with a more obvious, surface level of thinking. As

you’re reading this text, you may notice these two levels. Part of your mind is focusing on the information in the text; that is, you are trying to understand and integrate factual information. At another level, however, you may be having some quick, evaluative thoughts about the situation. These cognitions are called automatic thoughts and are not the result of deliberation or reasoning. Rather, these thoughts seem to spring up spontaneously; they are often quite rapid and brief. You may barely be aware of these thoughts; you are far more likely to be aware of the emotion or behavior that follows. Even if you are aware of your thoughts, you most likely accept them uncritically, believing they are true. You don’t even think of questioning them. You can learn, however, to identify your automatic thoughts

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by attending to your shifts in affect, behavior, and/or physiology. Ask yourself, “What was just going through my mind?” when • you begin to feel dysphoric, • you feel inclined to behave in a dysfunctional way (or to avoid behaving in an adaptive way), and/or • you notice changes in your body or mind that distress you (e.g., shortness of breath or racing thoughts). Having identified your automatic thoughts, you can, and probably already do to some extent, evaluate the validity of your thinking. For example, when I have a lot do, I sometimes have the automatic thought “I’ll never get it all finished.” But I do an automatic reality check, recalling past experiences and reminding myself, “It’s okay. You know you always get done what you need to.” When people find their interpretation of a situation is erroneous and correct it, they probably discover that their mood improves, they behave in a more functional way, and/or their physiological arousal decreases. In cognitive terms, when dysfunctional thoughts are subjected to objective reflection, one’s emotions, behavior, and physiological reaction generally change. But where do automatic thoughts spring from? What makes one person interpret a situation differently from another person? Why may the same person interpret an identical event differently at one time from another? The answer has more to do with enduring cognitive phenomena: beliefs. THE THEMES IN PEOPLE’S AUTOMATIC THOUGHTS ALWAYS MAKE SENSE ONCE WE UNDERSTAND THEIR BELIEFS. BELIEFS Beginning in childhood, people develop certain ideas about themselves, other people, and their world. Their most central or core beliefs are enduring understandings so fundamental and deep that they often do not articulate them, even to themselves. Individuals regard these ideas as absolute truths—just the way things “are” (Beck, 1987). Well- adjusted individuals primarily hold realistically positive beliefs much of the time. But we all have latent negative beliefs that can become Cognitive Behavior Therapy: Basics and Beyond

partially or fully activated in the presence of thematically related vulnerabilities or stressors. Adaptive Beliefs Many clients, like Abe, had been predominantly psychologically healthy before the onset of their disorder; they were reasonably effective, had basically good relationships, and lived in environments that were mostly safe. If so, they most likely developed flexible, helpful, reality--based beliefs about themselves, their worlds, other people, and the future (Figure 3.1). They probably saw themselves as reasonably effective, likeable, and worthwhile. They had accurate and nuanced views about other people, seeing many of them as basically benign or neutral and only some as potentially hurtful (but they most likely believed they could reasonably protect themselves). They saw their world realistically too as composed of a mixture of predictability and unpredictability, safety and danger (but believed they could cope with most things that came their way). They perceived their future as having positive, neutral, and negative experiences (believing

they could cope with misfortune—sometimes with the help of other people—and that they would be okay in the end). FIGURE 3.1. Adaptive (positive) core beliefs about the self. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania. EFFECTIVE CORE BELIEFS • “I am reasonably competent, effective, in control, successful, and useful.” • “I can reasonably do most things, protect myself, and take care of myself.” • “I have strengths and weaknesses [in terms of effectiveness, productivity, achievement].” • “I have relative freedom.” • “I mostly measure up to other people.” LOVABLE CORE BELIEFS • “I am reasonably lovable, likeable, desirable, attractive, wanted, and cared for.” • “I am okay, and my differences don’t impair my relationships.” • “I am good enough [to be loved by others].” • “I am unlikely to be abandoned or rejected or end up alone.” WORTHY CORE BELIEFS • “I am reasonably worthwhile, acceptable, moral, good, and benign.”

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The latent negative counterparts to these beliefs might temporarily surface when these clients negatively interpret a setback related to their effectiveness, an interpersonal problem, or an action they took that was contrary to their moral code. But they probably reverted back to their more reality-based core beliefs after a short period of time— that is, unless they developed an acute disorder. When this happens, they may need treatment to help them reestablish their primarily adaptive beliefs. The situation is different for other clients, though, especially those with personality disorders, like Maria. Their positive, adaptive beliefs may have been fairly weak or actually nonexistent when they were growing up and on into adulthood, and they usually need treatment to help them develop and strengthen adaptive beliefs. Note that some clients hold overly positive beliefs, especially if they’re manic or hypomanic. They may see themselves, others, the world, and/or the future in an unrealistically positive light. When these beliefs are dysfunctional, they may need help in viewing their experiences more realistically, which is in a negative direction. Dysfunctional Negative Beliefs People who have a history of being less psychologically healthy, or who live in more dangerous physical or interpersonal environments, tend to function more poorly; they may have troubled relationships, and they may hold core beliefs that are more negative. These beliefs may or may not have been realistic and/or helpful when they first developed. In the presence of an acute episode, however, these beliefs tend to be extreme, unrealistic, and highly maladaptive. Negative core beliefs about the self tend to fall into three categories (Figure 3.2): • helplessness (being ineffective—in getting things done, self- protection, and/or measuring up to others); • unlovability (having personal qualities resulting in an inability to get or maintain love and intimacy from others); and • worthlessness (being an immoral sinner or dangerous to others). Clients may hold beliefs in one, two, or all three of these categories, and they may hold more than one belief in a given category. Case Example Reader E, who thought she was too unintelligent to master this text, frequently has a similar concern when she has to engage in a new Cognitive Behavior Therapy: Basics and Beyond

task (e.g., renting a car, figuring out how to put together a bookcase, or applying for a bank loan). She seems to have the core belief “I’m incompetent.” This belief may operate only when she is in a depressed state; it may be active some or much of the time; or it may be fairly dormant. When this core belief is active, Reader E interprets situations through the lens of this belief, even though the interpretation may, on a rational basis, be patently invalid. Reader E tends to selectively focus on information that confirms her core belief, disregarding or discounting information to the contrary.

For example, Reader E did not consider that other intelligent, competent people might not fully understand the material in their first reading. Nor did she entertain the possibility that the author had not presented the material well. She didn't recognize that her difficulty in comprehension could be due to a lack of concentration, rather than a lack of brainpower. She forgot that she often had difficulty initially when presented with a body of new information but later had a good track record of mastery. Because her incompetence belief was activated, she automatically interpreted the situation in a highly HELPLESS CORE BELIEFS • "I am ineffective in getting things done." • "I'm incompetent, ineffective, helpless, useless, and needy; I can't cope." • "I am ineffective in protecting myself." • "I am powerless, weak, vulnerable, trapped, out of control, and likely to get hurt." • "I am ineffective compared to others." • "I am inferior, a failure, a loser, defective, useless." • "I'm not good enough [in terms of achievement]; I don't measure up." UNLOVABLE CORE BELIEFS • "I am unlovable, unlikeable, undesirable, unattractive, boring, unimportant, and unwanted." • "[I won't be accepted or loved by others because] I am different, a nerd, bad, defective, not good enough, have nothing to offer, and there's something wrong with me." • "I am bound to be rejected, abandoned, and alone." WORTHLESS CORE BELIEFS • "I am immoral, morally bad, a sinner, worthless, and unacceptable." • "I am dangerous, toxic, crazy, and evil." • "I don't deserve to live." FIGURE 3.2. Dysfunctional core beliefs about the self.

negative, self-critical manner. In this way, her belief is maintained, even though it's inaccurate and dysfunctional. It is important to note that she's not purposely trying to process information in this way; it occurs automatically. Figure 3.3 illustrates this distorted way of processing information. The circle with a rectangular opening represents Reader E's schema. In Piagetian terms, the schema is a hypothesized mental structure that FIGURE 3.3. Information processing diagram. This diagram demonstrates how negative data are immediately processed, strengthening the core belief, while positive data are discounted (changed into negative data) or unnoticed. – Difficulty reading text – Thinking of applying for a bank loan – But it's because she's so eager to please me – But it took me so long + Sessions with a client went well + Finished reading text + Finished paperwork + Figured out ambiguous diagnosis "I'm incompetent" Cognitive Behavior Therapy: Basics and Beyond

organizes information. Within this schema is Reader E's core belief: "I'm incompetent." When Reader E is exposed to a relevant experience, this schema becomes active, and the data, contained in negative rectangles, are immediately processed as confirming her core belief— which makes the belief stronger. But a different process occurs when Reader E encounters an experience in which she does well. Positive data are encoded in the equivalent of positive triangles, which cannot fit into the schema. Her mind automatically discounts the data. ("Yes, the session with my client went well, but that's because she was so eager to please me.") These interpretations, in essence, change the shape of the data from positive triangles to negative rectangles. Now the data fit into the schema and, as a result, strengthen the negative core belief. There are also positive data that Reader E just doesn't notice. She doesn't negate some evidence of competence, such as paying her bills on time or helping a friend with a problem. But had she failed to take these actions, she probably would have interpreted her inaction as supporting her dysfunctional core belief. Though she doesn't discount the positive data, she doesn't seem to notice or process the positive data as being relevant to her core belief; this kind of data bounces off the schema. Over time, Reader E's core belief of incompetence becomes stronger and stronger. Abe, too, has a core belief

of incompetence. Fortunately, when Abe is not depressed, a different schema (which contains the core belief “I’m reasonably competent”) is active most of the time, and his belief “I’m incompetent” is latent. But when he’s depressed, the incompetence schema predominates. One important objective of treatment is to help Abe view his experiences (both positive and negative) in a more realistic and adaptive way. INTERMEDIATE BELIEFS: ATTITUDES, RULES, AND ASSUMPTIONS Core beliefs are the most fundamental level of belief; when clients are depressed, these beliefs tend to be negative, extreme, global, rigid, and overgeneralized. Automatic thoughts, the actual words or images that go through a person’s mind, are situation specific and may be considered the most superficial level of cognition. Intermediate beliefs exist between the two. Core beliefs influence the development of this intermediate class of beliefs, which consists of (often unarticulated) attitudes, rules, and assumptions. Note that many attitudes indicate clients’ values. Reader E, for example, had the following intermediate beliefs:

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• Attitude: “It’s terrible to fail.” • Rule: “I should give up if a challenge seems too great.” • Assumptions: “If I try to do something difficult, I’ll fail. If I avoid doing it, I’ll be okay.” These beliefs influence her view of a situation, which in turn influences how she thinks, feels, and behaves. The relationship of these intermediate beliefs to core beliefs and automatic thoughts is depicted below. Core beliefs Intermediate beliefs (rules, attitudes, assumptions) Automatic thoughts How do core beliefs and intermediate beliefs arise? People try to make sense of their environment from their early developmental stages. They need to organize their experience in a coherent way to function adaptively (Rosen, 1988). Their interactions with the world and other people, influenced by their genetic predisposition, lead to certain understandings: their beliefs, which may vary in their accuracy and functionality. Of particular significance to the CBT therapist is that dysfunctional beliefs can be unlearned, and more reality- based and functional new beliefs can be developed and strengthened through treatment. The quickest way to help clients feel better and behave more adaptively is to help them identify and strengthen their more positive adaptive beliefs and to modify their inaccurate beliefs. Once this is accomplished, clients tend to interpret current and future situations or problems in a more constructive way. In most cases we can work both directly and indirectly on positive beliefs from the beginning of treatment. But we usually need to work indirectly on negative core beliefs at first and more directly later on. Even the identification of negative core beliefs can trigger significant negative affect that can lead clients to feel unsafe. A MORE COMPLEX COGNITIVE MODEL The hierarchy of cognition, as it has been explained to this point, can be illustrated as follows: Cognitive Behavior Therapy: Basics and Beyond

Core beliefs Intermediate beliefs (rules, attitudes, assumptions) Situation Automatic thoughts Reaction (emotional, behavioral, physiological) It’s important to note that the sequence of the perception of situations leading to automatic thoughts that then influence people’s reactions is an oversimplification at times. Thinking, mood, behavior, and physiology can affect one another. Core beliefs Intermediate beliefs (rules, attitudes, assumptions) Trigger Situation Automatic thoughts Emotion Behavior There are also many different kinds of internal and external triggering situations about which clients have automatic thoughts: • Discrete events (such as failing to get a job offer) • A stream of thoughts (such as thinking about being unemployed) • A memory (such as getting fired from a job) • An image (such as the disapproving face of a boss) • An emotion (such as noticing how intense one’s dysphoria is) • A behavior (such as staying in bed) • A physiological

or mental experience (such as noticing one’s rapid heartbeat or slowed-down thinking)

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Individuals may experience a complex sequence of events with many different triggering situations, automatic thoughts, and reactions. (See Chapter 12, pp. 217–218, for an example of an extended cognitive model.) CONCEPTUALIZATION OF ABE At intake, it’s clear that Abe is suffering from persistent sadness, anxiety, and loneliness. I diagnose him with major depression, severe, with anxious distress. I ask some specific questions to help me develop an initial conceptualization. For example, I ask Abe when he generally feels the worst—which situations and/or times of day. He tells me that he pretty much feels the same all day long, but perhaps a little worse in the evenings. Then I ask him how he felt the previous evening. When Abe confirms that he was as depressed as usual, I ask, “What was going through your mind?” Right from the beginning, I obtain a sample of important automatic thoughts. Abe reports that he often thinks, “There’s so much I should be doing but I’m so tired. If I even try [to do things like cleaning up the apartment], I’ll just do a bad job” and “I feel so down. Nothing will make me feel better.” He also reports an image, a mental picture that had flashed through his mind. He saw himself, sometime in the indeterminate future, sitting in the dark, feeling utterly hopeless and helpless. I also look for factors that maintain Abe’s depression. Avoidance is a major problem. He avoids cleaning up his apartment, doing errands, socializing with friends, looking for a new job, and asking others for help. Therefore, he lacks experiences that could have given him a sense of mastery, pleasure, or connection. His negative thinking leads to his being inactive and passive. His inactivity and passivity reinforce his sense of being helpless and out of control. As a child, Abe tried to make sense of himself, others, and his world, learning from, for example, his experiences, interactions with others, and direct observation. His perceptions were also undoubtedly influenced by his genetic inheritance. Early experiences within the family laid the groundwork for his core belief of competence and incompetence. Abe was the oldest of three boys. When he was 11, his father left the family and never returned. His mother, a single parent, worked two jobs and relied heavily on him. Once his father left, she often asked Abe to do things that were quite difficult—for example, keeping the house clean, doing the laundry, and taking care of his younger brothers. Abe had a strong value of being a good son, accomplishing Cognitive Behavior Therapy: Basics and Beyond

what was asked of him and helping others. He expected himself to be able to do everything his mother asked, but he was often not up to the task. He had thoughts such as “I should be doing this [task] better”; “I should be helping Mom more”; and “I should be able to make them [his brothers] behave.” On the few occasions when he asked his mother what he should do to control his brothers’ behavior better, she said irritably, “Figure it out for yourself.” Not all youth in this kind of situation perceive themselves as lacking. Some youth, for example, blame their mothers for expecting too much. Abe’s mother did, in fact, expect too much of him, for his age and developmental level. She criticized him when she came home and saw his brothers “running wild” or found the kitchen messy. At these times, she became upset and told Abe, “You can’t do anything right. You’re letting me down.” Abe thought what she said was true, and he felt distressed. He then often retreated to his room and ruminated over his shortcomings. Abe’s Core Beliefs Over time, Abe’s belief that he was reasonably competent began to erode, in the specific context of his home life. He began to notice what he considered to be his failures. Even when he saw he was doing a good job, he tended to discount his accomplishments. “I cleaned up

the kitchen, but the living room is still messy"; "I got them [brothers] to do their homework, but I couldn't make them stop fighting." No wonder Abe began to feel incompetent. The result of putting too much weight on his perceived weaknesses and discounting or failing to notice his strengths led to the development of his core belief: "I'm incompetent." Abe's negative belief was fairly circumscribed to "failures" at home. He received average grades at school, as did his friends. His teachers and mother generally seemed satisfied with his performance, so he was satisfied too. He was an above-average athlete and received praise and support from his coaches. So Abe saw himself as reasonably competent in the context of school and sports. He also saw himself as reasonably likeable and worthwhile. Abe's beliefs about his world and other people were, for the most part, realistically positive and adaptive. He generally believed that many people were benign—or would be benign as long as he performed well. He saw his world as relatively safe. Influenced by his father's abandonment of the family, he saw the world as potentially unpredictable, but he also thought he'd be able to cope with most circumstances. He viewed his future as unknown but potentially pretty good. Abe was at his best when he finished high school, became employed, and moved into an apartment with a friend. During this

time, his adaptive core beliefs were mostly active. He did well on the job, socialized often with good friends, exercised and kept himself in good shape, and started saving money for the future. He was honest, forthright, responsible, and a hard worker. He was pleasant to be around, often helping family and friends without being asked. He married at age 23, a year after meeting his wife. Although she tended to criticize him, he nevertheless saw himself as basically competent, worthwhile, and likeable. But he had an underlying vulnerability of viewing himself as incompetent when he didn't live up to his self- imposed high expectations. This vulnerability developed primarily as a result of negative interactions with his mother when he was a youth. Abe became more stressed once his children were born, and he sometimes criticized himself for not spending enough time with them. His wife was stressed too and became more critical of him. But he didn't become depressed at this point. He continued to function well as long as he perceived that he was performing at a high level at work and at home. His related belief was "If I perform highly, it means I'm okay." A problem arose when he perceived himself as functioning at a lower level, associated with his belief "If I don't perform highly, it shows I'm incompetent." It wasn't until he put a very negative meaning on his difficulties at work and on the dissolution of his marriage that his previously latent negative core beliefs became strongly activated. In addition, he saw himself as helpless and out of control (which he described as related to incompetence/failure). Abe's Intermediate Beliefs and Values Abe's intermediate beliefs were somewhat more amenable to modification than his core beliefs. These attitudes (such as "It's important to work hard, be productive, be responsible, be reliable, be considerate to others, honor commitments, do the right thing, and give back to others") reflected his values and his behavior, as did his rules (e.g., "I should work hard"). They developed in the same way as core beliefs, as Abe tried to make sense of his world, of others, and of himself. Mostly through interactions with his family, and to a lesser degree with others, he developed the following assumptions: "If I work hard, I'll be okay (but if I don't, I'll be a failure)." "If I figure things out for myself, I'll be okay (but if I ask for help, it will show I'm incompetent)." Abe had not fully articulated these intermediate beliefs or values before therapy. But they nevertheless influenced his thinking and guided his behavior. Cognitive Behavior Therapy: Basics and Beyond

Abe’s Behavioral Strategies Beginning in adolescence, Abe developed certain patterns of behavior, which were mostly quite functional, to live up to his values and to avoid the activation of his core belief (and the emotional discomfort connected with it). He worked hard when he was at home, when playing sports, and when he got his first job. He set high standards for himself at work and went out of his way to help other people. On the other hand, Abe rarely asked for help, even when it was reasonable to do so. He feared others would criticize him and view him as incompetent. He felt vulnerable at times and tried to make up for what he saw as his weaknesses. While Abe’s assumptions were fairly inflexible, he nevertheless got along well in life—until he perceived himself as incompetent and not living up to his values. Sequence Leading to Abe’s Depression Throughout his life, Abe regularly had some negative thoughts about himself, particularly in situations in which he perceived his performance was subpar. “I should have done that better” was a common thought he had had growing up and later at work and at home, especially after he married and had children. The thoughts usually led to mild dysphoria, but when he resolved to put in more effort, he generally felt better. These kinds of automatic thoughts became fairly frequent and intense preceding the onset of Abe’s depressive episode, in the context of work, marriage, and home life. He had a new boss, Joseph, a man 15 years younger than he. Joseph changed Abe’s work responsibilities. Abe had been in charge of customer service at a lighting company. He enjoyed working with customers and interacting with the two employees whom he supervised. But Joseph moved him over to inventory management, which entailed little interaction with others and required him to use a software program with which he was unfamiliar. Abe started making mistakes and became highly self-critical. He had thoughts such as “What’s the matter with me? This shouldn’t be so hard.” He interpreted his difficulties with his new responsibilities as due to his own incompetence. He became dysphoric and anxious. But he didn’t become depressed— not yet. Abe finally asked for help, but Joseph growled at him, saying that Abe should be able to figure out what to do. Instead of continuing to ask for help, Abe tried harder, but he still couldn’t understand how to fulfill some of his new responsibilities. When he even considered asking for help again, he thought, “Joseph will think less of me. What if he says I’m incompetent? I could get fired.” His beliefs of incompetence and vulnerability became stronger.

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Soon his negative emotions started to spill over at home, as he ruminated over his perceived failures. When he developed symptoms of depression (especially a depressed mood and great fatigue), he changed his activities. He started to withdraw from others, including his wife. At dinner, he would sit almost silently, despite his wife’s efforts to get him to open up. After dinner, instead of doing household tasks, he mostly sat in his armchair, ruminating over his perceived failings. On weekends, he sat on the couch for hours at a time, watching television. His wife became very impatient with him when he was reluctant to make social plans, when he helped much less around the house, and when he spoke little to her. She began to nag and criticize him much more than before. His own self-critical thoughts became more and more intense too. His avoidance led to few opportunities for him to feel competent, in control, productive, and connected to others—crucial values of his—and to a dearth of pleasurable or enjoyable activities that could have lifted his mood. As he developed stronger symptoms of depression, he started avoiding additional tasks he thought he wouldn’t do well, for example, paying bills and doing yard work. He had many automatic thoughts across situations about the likelihood that he would fail. These thoughts led him to feel sad, anxious, and hopeless. He viewed his difficulties as due to an innate flaw and not as the result

of encroaching depression. He developed a generalized sense of incompetence and helplessness and curtailed his activities further. His relationship with his wife became quite strained, and they started having significant conflict. He interpreted the conflict as meaning he was failing in the marriage, that he was incompetent as a husband. Over the course of several months, Abe's problems at work became even worse. Joseph became quite critical of Abe and downgraded him at his yearly performance review. Abe's depression intensified significantly when his wife filed for divorce. He became preoccupied with thoughts of how he had let her and his children and his boss down. He felt like (that is, he had a belief that he was) an incompetent failure. He felt (believed he was) at the mercy of his sad and hopeless feelings ("I'm out of control") and thought there was nothing he could do to feel better ("I'm helpless"). And then he lost his job. This sequence of events illustrates the diathesis–stress model. Abe had certain vulnerabilities: very strong and rigid values of productivity and responsibility, biased information processing, a tendency to see himself as incompetent, and genetic risk factors. When these vulnerabilities were exposed to relevant stressors (loss of job and marriage), he became depressed. Abe's depression became maintained by the following factors or mechanisms: Cognitive Behavior Therapy: Basics and Beyond

• An ongoing negative interpretation of his experiences • Attentional bias (noticing everything he wasn't doing well or not doing at all) • Avoidance and inactivity (which resulted in few opportunities for pleasure, a sense of accomplishment, and connection) • Social withdrawal • Increased self-criticism • Deterioration of problem-solving skills • Negative memories • Rumination over perceived failures • Worrying about the future These factors negatively affected Abe's self-image and helped maintain his depression. They became important targets in treatment. Abe's Strengths, Resources, and Personal Assets Even though Abe was severely depressed when he first came to see me, his life wasn't unremittingly negative. His children and their spouses offered him support. His mood lifted somewhat when he interacted with his grandchildren, especially around sports. He was still doing very basic self-care. Although his funds were dwindling, he had some money in savings. He was able to do a minimal amount of housework and meal preparation. Historically, he had been a highly responsible, hardworking husband, father, and employee. He had learned many skills on the job that were potentially transferable to other jobs. He had good common sense and had been a good problem solver. To summarize, Abe's belief that he was incompetent stemmed from childhood events, especially through interaction with his critical mother, who kept telling him that he was doing a poor job (at tasks beyond his abilities) and that he was letting her down. Nonetheless, he had neutral or relatively positive school experiences, and his dominant core belief was that he was okay. Years later, significant stress at work and at home contributed to the activation of his core belief of incompetence and to his use of maladaptive coping strategies, most notably avoidance, which triggered his belief of helplessness. He avoided asking for help, he withdrew from his wife and friends, and he sat on the couch for hours instead of being productive. In addition, he became highly self-critical. Ultimately, Abe became depressed, and his maladaptive core beliefs became fully active.

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Abe's beliefs made him vulnerable to interpreting events in a negative way. He didn't question his thoughts but rather accepted them uncritically. The thoughts and beliefs by themselves did not cause the depression. (Depression is undoubtedly caused by a variety of psychosocial, genetic, and biological factors.) Abe may have had a genetic predisposition for depression; however, his

perception of and behavior in the circumstances at the time undoubtedly facilitated the expression of a biological and psychological vulnerability. Once his depression set in, these negative cognitions strongly influenced his mood and helped maintain the disorder. THE COGNITIVE CONCEPTUALIZATION DIAGRAMS It's important to develop both strengths-based and problem--based conceptualizations. Cognitive Conceptualization Diagrams (CCDs) help you organize the considerable amount of data you get from clients. You can start filling out these diagrams (between sessions) as soon as you identify relevant information during the evaluation and first session. You'll continue to look for pertinent data throughout treatment. Most clients, like Abe, provide you with negative data at the beginning of treatment, so it's important to ask questions to elicit positive information. It's also important to be continually on the lookout for positive data that clients overlook or discount. The Strengths-Based Cognitive Conceptualization Diagram The Strengths--Based Cognitive Conceptualization Diagram (SB-CCD; Figure 3.4) helps you pay attention to and organize the client's patterns of helpful cognitions and behavior. It depicts, among other things, the relationship among • important life events and adaptive core beliefs, • adaptive core beliefs and the meaning of the client's automatic thoughts, • adaptive core beliefs, related intermediate beliefs, and adaptive coping strategies, and • situations, adaptive automatic thoughts, and adaptive behaviors. Figure 3.5 contains the questions you should ask yourself to fill it out. You'll elicit relevant data at the evaluation (e.g., when you ask clients to describe the best period in their life) for the top of the diagram Cognitive Behavior Therapy: Basics and Beyond

RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): People described Abe as "a good kid." Some positive interactions with family, maternal uncle, and coaches growing up. Took father's abandonment in stride. Tried hard when given age-inappropriate responsibilities at home at age 11. Good friends, average grades, above-average athlete, high school diploma. Likeable, a "good family man"; good relationships with children/grandchildren, a cousin, two male friends; made a reasonable living; always budgeted and saved money. STRENGTHS, ASSETS: Strongly motivated, good sense of humor, liked by most people. Sees two grown children and four grandchildren often, helps them out, close relationships with them, a cousin, and several male friends. Had made a reasonable living; always budgeted and saved money. Highly motivated. Excellent work history; many interpersonal, organizational, and supervisory skills; reliable and responsible. Good problem-solver and good common sense. ADAPTIVE CORE BELIEFS (prior to onset of current difficulties): "I'm responsible, considerate, competent, self-reliant, helpful, a good person, likeable, resourceful. Most people are neutral or benign. The world is potentially unpredictable but relatively safe and stable. I can cope (if bad things happen)." ADAPTIVE INTERMEDIATE BELIEFS: RULES, ATTITUDES, ASSUMPTIONS (prior to onset of current difficulties): "Family, work, and community are important. It's important to work hard, be productive, self-reliant, responsible, and reliable, honor commitments, consider others' feelings, do the right thing; do what I say I'm going to do. I should figure things out for myself. If I persist on a difficult task, I'll probably succeed. If I perform highly, it means I'm competent; I'm okay." ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties): Sets high standards for himself, works hard, tries to increase his competence, perseveres and solves problems himself; is kind and considerate to others, honors his commitments, does what he sees as "the right thing," helps others. SITUATION 1: Thinking about meeting buddies for breakfast SITUATION 2: Fixing neighbor's car SITUATION 3: Surfing the Web AUTOMATIC THOUGHT(S): "I'm really tired, but I don't want to disappoint them." AUTOMATIC THOUGHT(S): "I don't know if I can get it to run." AUTOMATIC THOUGHT(S): "I'd like a better TV, but I have to cover my bills."

EMOTIONS: Neutral EMOTIONS: Neutral EMOTIONS: Mild disappointment BEHAVIOR: Goes to breakfast BEHAVIOR: Keeps trying BEHAVIOR: Doesn't order TV FIGURE 3.4. Abe's SB-CCD. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

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and additional data for the whole diagram throughout treatment. The list in Figure 3.6 (adapted from Gottman & Gottman, 2014) can help specify their positive qualities. The SB-CCD is too complex to present to many clients. If you do, show them a blank copy. You can fill it out together, choosing historical (premorbid) situations in which they had adaptive automatic thoughts and behaviors. Or you can wait until the clients are currently perceiving themselves and their experiences more realistically and are engaging in helpful coping strategies. RELEVANT LIFE HISTORY (including accomplishments, strengths, personal qualities, and resources prior to current difficulties): What experiences contributed to the development and maintenance of the adaptive core belief(s)? What have the client's strengths, skills, personal and material assets, and positive relationships been like? What are the client's skills, strengths, and positive qualities? What internal and external resources does the client have? ADAPTIVE CORE BELIEFS (prior to onset of current difficulties): What are the client's most central adaptive beliefs about him/herself? Others? The world? ADAPTIVE INTERMEDIATE BELIEFS: RULES, ATTITUDES, ASSUMPTIONS (prior to onset of current difficulties) What general assumptions, rules, attitudes, and values does the client have? ADAPTIVE PATTERNS OF BEHAVIOR (prior to onset of current difficulties): What adaptive coping strategies and behaviors does the client display? SITUATION 1: What was the problematic situation? SITUATION 2: SITUATION 3: AUTOMATIC THOUGHT(S): What went through the client's mind? AUTOMATIC THOUGHT(S): AUTOMATIC THOUGHT(S): EMOTIONS: What emotions were associated with the automatic thought? EMOTIONS: EMOTIONS: BEHAVIOR: What did the client do that was helpful? BEHAVIOR: BEHAVIOR: FIGURE 3.5. The SB-CCD: Questions. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania. Cognitive Behavior Therapy: Basics and Beyond

The (Traditional) Cognitive Conceptualization Diagram The traditional (i.e., problem-based) CCD (Figure 3.7) organizes the maladaptive information you collect about clients. You'll gather data at the evaluation and throughout treatment. Begin filling it out as soon as you begin to see patterns in the themes of clients' automatic thoughts or unhelpful behaviors. This CCD depicts, among other things, the relationship among • important life events and core beliefs, • core beliefs and the meaning of clients' automatic thoughts, • core beliefs, intermediate beliefs, and dysfunctional coping strategies, and • trigger situations, automatic thoughts, and reactions. FIGURE 3.6. List of positive qualities. Adapted with permission from Gottman and Gottman (2014). Copyright © 2014 J. Gottman and J. S. Gottman. 1. Loving 2. Sensitive 3. Brave 4. Intelligent 5. Thoughtful 6. Generous 7. Loyal 8. Truthful 9. Strong 10. Energetic 11. Sexy 12. Decisive 13. Creative 14. Imaginative 15. Fun 16. Attractive 17. Interesting 18. Supportive 19. Funny 20. Considerate 21. Affectionate 22. Organized 23. Resourceful 24. Athletic 25. Cheerful 26. Coordinated 27. Graceful 28. Elegant 29. Gracious 30. Playful 31. Caring 32. A great friend 33. Exciting 34. Thrifty 35. Planful 36. Committed 37. Involved 38. Expressive 39. Active 40. Careful 41. Reserved 42. Adventurous 43. Receptive 44. Reliable 45. Responsible 46. Dependable 47. Nurturing 48. Warm 49. Virile 50. Kind 51. Gentle 52. Practical 53. Lusty 54. Witty 55. Relaxed 56. Beautiful 57. Handsome 58. Rich 59.

Calm 60. Lively 61. A great partner 62. A great parent 63. Assertive 64. Protective 65. Sweet 66. Tender 67. Powerful 68. Flexible 69. Understanding 70. Totally silly 71. Shy 72. Vulnerable

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FIGURE 3.7. (Traditional) CCD. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania. SITUATION 1: Thinking about bills RELEVANT LIFE HISTORY and PRECIPITANTS: CORE BELIEF(S) (during current episode): INTERMEDIATE BELIEFS: CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES (during current episode): COPING STRATEGIES (during current episode): Father leaves family when Abe is 11 years old. He never sees him again. Mom is overburdened, very critical when he can't meet her unrealistic expectations. Precipitants to current disorder: Abe struggles and then loses his job and undergoes divorce. “I'm incompetent/a failure.” “It’s important to be responsible, competent, reliable, and helpful.” “It’s important to work hard and be productive.” During depression: (1) “If I avoid challenges, I’ll be okay, but if I try to do hard things, I’ll fail.” (2) “If I avoid asking for help, my incompetence won’t show, but if I do ask for help, people will see how incompetent I am.” Avoids asking for help and avoids challenges. AUTOMATIC THOUGHT(S): “What if I run out of money?” MEANING OF A.T.: “I’m a failure.” EMOTIONS: Anxious BEHAVIOR: Continues to sit on couch; ruminates about his failures SITUATION 2: Thinking of asking son for help in revising resume AUTOMATIC THOUGHT(S): “I should be able to do this on my own.” MEANING OF A.T.: “I’m incompetent.” EMOTIONS: Sad BEHAVIOR: Avoids asking son for help SITUATION 3: Memory of being criticized by boss AUTOMATIC THOUGHT(S): “I should have tried harder.” MEANING OF A.T.: “I’m a failure.” EMOTIONS: Sad BEHAVIOR: Ruminates about what a failure he was Cognitive Behavior Therapy: Basics and Beyond

Figure 3.8 presents questions to help you fill out the CCD. When you start, regard your first efforts as tentative; you have not yet collected enough information to determine the extent to which the automatic thoughts clients have expressed are typical and important. The completed diagram will mislead you if you choose situations in which the themes of clients’ automatic thoughts are not part of an overall pattern. You share your partial conceptualization with clients verbally at every session as you summarize their experiences in the form of the FIGURE 3.8. (Traditional) CCD: Questions. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania. SITUATION 1: What was the problematic situation? RELEVANT LIFE HISTORY and PRECIPITANTS: CORE BELIEF(S) (during current episode): INTERMEDIATE BELIEFS: CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES (during current episode): COPING STRATEGIES (during current episode): Which experiences contributed to the development and maintenance of the core belief(s)? What are the client’s most central dysfunctional beliefs about him/herself? Other people? The world? Which assumptions, rules, and beliefs help him/her cope with the core belief(s]? Which dysfunctional behaviors help him/her cope with the belief(s)? AUTOMATIC THOUGHT(S): What went through his/her mind? MEANING OF A.T.: What did the automatic thought mean to him/her? EMOTIONS: Which emotion(s) were associated with the automatic thought(s)? BEHAVIOR: What did the client do then? SITUATION 2: AUTOMATIC THOUGHT(S): MEANING OF A.T.: EMOTIONS: BEHAVIOR: SITUATION 3: AUTOMATIC THOUGHT(S): MEANING OF A.T.: EMOTIONS: BEHAVIOR:

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FIGURE 3.9. Adapting the CCD for additional emotions. Automatic Thought: “What if there’s something wrong?” Automatic Thought: “He probably doesn’t want to get together.” Emotion: Sadness Emotion: Anxiety Behavior: Sits on couch and ruminates. Behavior: — Situation: Charlie cancels Sunday breakfast. cognitive model. At times, especially initially, you’ll illustrate your summary via a handwritten diagram of the cognitive model. Initially, you may have data to complete only the top box (important lifetime data) and the bottom of the diagram (three cognitive models). Leave the other boxes blank or fill in items you have inferred with a question mark to indicate their tentative status. You will check out missing or inferred items with the client at future sessions. Fill in the bottom half of the CCD, starting with three typical current situations related to the presenting problems in which clients became upset or behaved in an unhelpful way. If clients have one more theme in their automatic thoughts, make sure to choose situations that reflect those themes. Next, fill in the key automatic thoughts and the subsequent emotion, relevant behavior (if any), and physiological reaction (sometimes important for clients with intense anxiety). If clients experience more than one emotion in a given situation, make sure to have separate boxes for each key automatic thought, followed by the emotional and behavioral reaction to that thought (Figure 3.9). Early in treatment, you may avoid asking clients for the meaning of their negative thoughts because eliciting these deeper-level cognitions can evoke significant distress. You can hypothesize about the meanings, but include a question mark next to your hypotheses, to remind you that you need to confirm their accuracy with clients at some point. The meaning of the automatic thought box in Figure 3.8 is below the automatic thought box because you identify the automatic thought first. In actuality, the core belief becomes activated and triggered (actually, the

schema containing the core belief becomes activated) in a particular situation and gives rise to automatic thoughts (see Chapter 17). When appropriate, usually a little later in treatment, you’ll ask clients directly about the meaning of their thoughts, using the “downward arrow” technique (pp. 291–292). The meaning of the automatic thought for each situation should be logically connected with one of the client’s core beliefs. Note that you don’t have to ask for the meaning of an automatic thought when the cognition is pervasive and overgeneralized (not just specific to only one or a few situations). Abe’s automatic thought “I’m a failure” was also a core belief because he didn’t believe he was a failure in just one situation (e.g., when he saw the pile of mail on the table); when he had that thought, he meant he was an overall failure as a person. To complete the top box of the diagram, ask yourself (and the client): • How did the core belief originate and become maintained? • What life events (often including those in childhood and adolescence, if any are relevant) did the client experience that might be related to developing and maintaining the beliefs? Typical relevant childhood data include such significant events as continual or periodic strife among parents or other family members; parental divorce; negative interactions with parents, siblings, teachers, peers, or others in which the child felt blamed, criticized, or otherwise devalued; serious medical conditions or disabilities; deaths of significant others; bullying; physical or sexual abuse; emotional trauma; and other adverse life conditions, such as moving frequently, experiencing trauma, growing up in poverty, or facing chronic discrimination, to name a few. The relevant data may, however, be more subtle: for example, youths’ perceptions (which may or may not have been valid) that they did not measure up in important ways to their siblings; that they were different from or demeaned by peers; that they did not meet expectations of parents, teachers, or others; or that their parents favored a sibling over them. Next ask yourself, “What are the client’s most important intermediate beliefs: rules, attitudes, and conditional assumptions?”

Unhelpful rules often start with “I should” or “I shouldn’t,” and unhelpful attitudes often start with “It’s bad to.” These rules and attitudes are often connected to client’s values, or they may serve to protect the client from the activation of the core belief. Clients’ broad assumptions often reflect their rules and attitudes and link their maladaptive coping strategies to the core belief. They are often phrased in this way:

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“If I [engage in the coping strategy], then [my core belief may not immediately come true; I’ll be okay for the moment]. However, if I [do not engage in my coping strategy], then [my core belief is likely to come true].” See Figure 3.10 for Reader E’s intermediate beliefs and coping strategies, the patterns of dysfunctional behaviors that are linked to clients’ intermediate beliefs. Note that most coping strategies are patterns of normal behaviors that everyone engages in at times. The difficulty clients experience is in the inflexible overuse of these strategies at the expense of more adaptive strategies in certain situations. At some point, usually in the middle part of treatment, you will share the information from both the top and the bottom of the CCD, when your goal for a session is to help the client understand the broader picture. Review the conceptualization verbally, draw a simplified diagram for your client (Figure 3.11), and elicit feedback. Occasionally, clients benefit from completing a blank CCD with you. (Don’t present a filled-out CCD to clients because it won’t be as good a learning experience.) But many clients would find it confusing (or demeaning if they interpret the diagram as your attempt to “fit” them into boxes). Ask clients questions to get the needed data to fill in the diagram. If you present a hypothesis, make sure to do so tentatively and ask clients whether it “rings true.” Correct hypotheses generally resonate well with the client. To summarize, the CCDs are based on data clients present, their actual words. You should regard your hypotheses as tentative until confirmed by the client. You will continually reevaluate and refine the diagrams as you collect additional data, and your conceptualization is not complete until the client terminates treatment. While you might not show the actual diagram to clients, you will verbally (and often on paper) conceptualize their experience from the first session on, to help them make sense of their current reactions to situations. At some point, you will present the larger picture to clients so they can understand • how their earlier experiences contributed to the development of their beliefs, • how they developed certain assumptions or rules for living, and • how these assumptions led to developing particular coping strategies or patterns of behavior.

Some clients are intellectually and emotionally ready to see the larger picture early on in therapy. You should wait to present it to others (especially those with whom you do not have a sound therapeutic relationship or who don’t fully grasp the cognitive model or accept it as true). As mentioned previously, whenever you present your conceptualization, ask the client for confirmation, disconfirmation, or modification of each part. FIGURE 3.10. Cognitive conceptualization of Reader E. CORE BELIEF(S) “I’m incompetent.” INTERMEDIATE BELIEFS: CONDITIONAL ASSUMPTIONS/ATTITUDES/RULES “It’s terrible to fail.” “I should give up if a challenge seems too great.” “If I set low goals for myself, I’ll be okay, but if I set high goals, I’ll fail.” “If I rely on others, I’ll be okay, but if I rely on myself, I’ll fail.” “If I avoid difficult tasks, I’ll be okay, but if I don’t, I’ll fail.” COPING STRATEGIES Developing low standards, relying on others, avoiding hard work SITUATION Reads CBT textbook AUTOMATIC THOUGHT(S) “This is just too hard. I’m so dumb. I’ll never master this. I’ll never make it as a therapist.” MEANING OF A.T. “I’m incompetent.”

EMOTIONS Sad BEHAVIOR Turns on the television

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Finally, an online course (beckinstitute.org/CBTresources) can help you master the complex process of conceptualization. And it’s often helpful to practice by conceptualizing characters in a movie or a novel. SUMMARY Conceptualizing clients in cognitive terms is crucial to determine the most effective and efficient course of treatment. It also aids in developing empathy, an ingredient that is critical in establishing a good therapeutic relationship. Conceptualization begins at the first contact and is an ongoing process, always subject to modification as new data are uncovered and previous hypotheses are confirmed or rejected. You base your hypotheses on the information you collect, using the most parsimonious explanations and refraining from interpretations and inferences not clearly based on actual data. You continually check out the conceptualization with clients for several reasons: to ensure that it is accurate, to demonstrate your accurate understanding to them, and to help them understand themselves, their experiences, and the meanings they put to their experiences. The ongoing process of conceptualization is emphasized throughout this book, as are techniques to present your conceptualization to clients. REFLECTION QUES TIONS How does an individual develop depression? Why is conceptualization so important? FIGURE 3.11. Simplified CCD. Core beliefs Intermediate beliefs (rules, attitudes, assumptions) Situation Automatic thoughts Reaction (emotional, behavioral, physiological) Cognitive Behavior Therapy: Basics and Beyond

PRACTICE EXERCISE Download a traditional CCD and start filling it out using Maria as the client. You’ll find information about her on pages 2, 27, and 32. Keep adding to it as you get additional information. Remember to put question marks next to anything you have inferred.

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