ORIGINAL ARTICLE

Trial-Based Thought Record (TBTR): preliminary data on a strategy to deal with core beliefs by combining sentence reversion and the use of analogy with a judicial process

Registro de Pensamentos com Base no Processo (RPBP): dados preliminares de uma estratégia para lidar com crenças nucleares, combinando reversão de sentenças e analogia com o processo jurídico

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Abstract

Objective: *To propose the Trial-Based Thought Record, a modified, 7-column thought record addressing core beliefs by sentence reversion and the analogy to a trial.* ***Method:*** *Clients (n = 30) participated in a simulation of a trial and exhibited shifts in their adherence to core beliefs and in the intensity of corresponding emotions after each step (investigation, prosecutor's plea, defense attorney's plea, prosecutor's second plea, defense attorney's second plea, and jury verdict) during a session.* ***Results:*** *Significant mean reductions existed between percent values after investigation (taken as baseline) and defense attorney's plea ($p < 0.001$), and after the jury's verdict, either in beliefs ($p < 0.001$) or in intensity of emotions ($p < 0.001$). Significant differences also emerged between the defense attorney's first and second pleas ($p = 0.009$) and between the defense attorney's second plea and jury's verdict concerning core beliefs ($p = 0.005$) and emotions ($p = 0.02$).* ***Conclusion:*** *Trial-Based Thought Record may at least temporarily help patients constructively reduce attachment to negative core beliefs and corresponding emotions.*

Descriptors: *Cognitive therapy; Core belief; Schema; Kafka; Trial-based thought record*

Resumo

Objetivo: *Propor o Registro de Pensamentos com Base no Processo, versão modificada, com sete colunas, para lidar com as crenças nucleares por meio da combinação da reversão de sentenças e a analogia com um processo jurídico.* ***Método:*** *Os clientes (n = 30) participaram da simulação de um júri e exibiram mudanças na adesão às crenças nucleares e na intensidade das emoções correspondentes após cada passo durante uma sessão (investigação, alegação do promotor, alegação do advogado de defesa, réplica do promotor, tréplica do advogado de defesa e veredicto do júri).* ***Resultados:*** *Reduções médias significantes foram observadas entre os valores percentuais após a investigação (tomada como valor basal), a alegação da defesa ($p < 0,001$) e o veredicto do júri, tanto das crenças ($p < 0,001$) quanto da intensidade das emoções ($p < 0,001$). Diferenças significantes foram também observadas entre as primeira e segunda alegações da defesa ($p = 0,009$) e entre a segunda alegação da defesa e o veredicto do júri no que diz respeito às crenças nucleares ($p = 0,005$) e às emoções ($p = 0,02$).* ***Conclusão:*** *O Registro de Pensamentos com Base no Processo pode, pelo menos temporariamente, ajudar os pacientes, de forma construtiva, a reduzirem a adesão às crenças nucleares negativas e emoções correspondentes.*

Descritores: *Terapia cognitiva; Crença nuclear; Esquema; Kafka; Registro de pensamentos com base no processo*

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Introduction

A tenet of cognitive therapy (CT) is that exaggerated or biased cognitions often maintain or exacerbate stressful states such as depression, anxiety, and anger.[1] It has been proposed that activation of certain underlying dysfunctional beliefs could play the primary role in the manifestation of various cognitive, affective, and behavioral symptoms because this activation represents the core problem in depression and other psychological disorders.[2] A clinician practicing CT helps the patient to understand and modify these dysfunctional thoughts and maladaptive emotional expressions and core beliefs.

Automatic thoughts (ATs) are rapid, evaluative thoughts that do not arise from deliberation or reasoning; as a result, the person is likely to accept them as true, without analysis.[3] Beck et al.[4] developed the Dysfunctional Thought Record (DTR) as a worksheet to help patients respond to ATs more effectively, thereby modifying negative mood states. This approach works for many patients who use the DTR consistently. However, for some patients, the alternative thoughts generated through DTR and intended to be perceived as adaptive and rational may still lack credibility. To address this issue, Padesky and Greenberger[5] have proposed expanding the original 5-column DTR designed by Beck et al.[4] to seven columns. The two additional columns are evidence columns, allowing the patient to include evidence that does and does not support the ATs, giving the patient the opportunity to generate more balanced thoughts and thus reducing their intensity and ameliorating associated behavior.

One problem with the newly generated, rational, alternative responses is that they leave open the possibility of disqualifying "yes, but…" thoughts about self and others. These "yes, but…" thoughts arise from schemas (cognitive structures comprising a set of related core beliefs that filter, code, integrate, and attach meaning to events) that are either temporarily activated or of long-term activation. When hypervalent, these idiosyncratic schemas displace or inhibit other schemas that may be more adaptive or more appropriate for a given situation and consequently introduce a systematic bias into information processing. Accordingly, a person predisposed to overreact to the more commonplace kinds of rejection in childhood may develop a negative self-image that, with repetition, becomes structuralized as a core belief.[6]

Core beliefs are those held by persons about themselves and others as absolutely true to the point that they do not question them; to the believer, these global, rigid, and over-generalized cognitions about self are just the way things are. These beliefs typically arise early in development as children organize experiences and interactions with other people and their environment. Although, generally, these core beliefs may be inactive, they can be activated during periods of depression or anxiety.[3] These are beliefs that people have held for much of their lives and that are activated across a wide range of situations, having a profound influence on how people feel, appraise situations, and see themselves and the world.[7]

The purpose of this report is to propose a thought record as an additional and structured strategy to deal with core beliefs, especially those that manifest as "yes… but" thinking. This paper expands a thought record that was previously proposed by this author[8] and modifies it by means of an analogy with Law, in which the therapist engages the client in a simulation of the judicial process. Inspiration for the latter came from the surreal novel by Franz Kafka, *The Trial*;[9] in this book, the character Joseph K., for reasons never revealed, is arrested and ultimately convicted without even knowing the crime of which he was accused. The rationale for proposing the TBTR is that it could be useful in making patients aware of their core beliefs about themselves (self-accusations) and, differently from Joseph K.'s process, engaging them in a constructive trial to develop more positive and functional core beliefs.

Method

1. Patients

Charts of all patients with any psychiatric diagnoses for whom this sequence of techniques was used in my private practice from January to June 2006 were consulted and information from the first use of TBTR was used. This publication was approved by the ethics committee of the Universidade Federal da Bahia (Maternidade Climério de Oliveira).

2. Description of TBTR

A case example of a panic disorder patient is presented as a worksheet in Table 1. TBTR was used only after the patient was familiar with the cognitive model and after interoceptive exposure had helped her decrease panic attacks.

First, the patient describes, in one or two sentences, the unpleasant situation. For column 1, the therapist asks what is in the patient's mind when she/he notices a strong affect; this technique is designed to elicit the ATs connected to (a) particular mood state(s), which will be registered in column 1. To elucidate the activated core belief that elicited the ATs and the present mood state, the therapist can, for example, use the downward arrow technique.[10] For instance, in column 1 of Table 1, the therapist asked what the ATs meant about the client, supposing they were true, and the client's response was, "I'm vulnerable." The therapist explains that this procedure may be considered analogous to an inquiry or investigation to uncover the self-accusation or core belief the patient maintains about him/herself. After uncovering or activating the core belief, the therapist asks the client how much she/he believes it and what emotion it makes him/her feel. Percents are written down in the row at the bottom of column 1.

Columns 2 and 3 of this thought record are designed to help gather information that supports and information that does not support the core belief. Column 2 deals exclusively with the core belief circled in column 1. Playing the role of a prosecutor, the patient is encouraged to identify all the evidence that supports the belief, taken as a self-accusation. This information is aimed mainly at uncovering the internal arguments the patient uses to maintain the core belief. Although TBTR was not used with suicidal patients in this practice, therapists working with severely depressed patients should be careful to limit prosecutor items to just a few, only the necessary amount of evidence to make the patient aware of the arguments she/he uses to maintain the core belief.

In column 3 (defense attorney), the patient is encouraged to actively identify evidence that does not support the core belief. Although the patients usually improve after concluding column 3, for some there may be little or no change in the corresponding affect because of the lack of credibility of the positive evidence generated to challenge the core belief. Often the client will say she/he believes such positive evidence only intellectually.

Column 4 (prosecutor's response to the defense attorney's plea) is devoted to the "yes, but…" thoughts that disqualify, minimize, or discount the evidence or rational thoughts generated in column 3, making them less credible. As the case example in Table 1 illustrates, by using the conjunction "but," the therapist actively elicits these thoughts that lead to preservation of other ATs and thus act to maintain maladaptive emotions and behavior. The therapist can note that the mood shifts back to or near the state of emotion the patient presented for column 2 (upward) (see Figure 1). The therapist can then use these shifts to explain that mood depends on how the client processes the situation, either positively or negatively. An example would be the way depression elicits a negative interpretation of events that are really ambiguous or irrelevant. These responses involve primal thinking, such as selective abstraction, dichotomous inferences, and over-generalization.[3,11]

Table 1 - Worksheet of a "trial" filled in during a session with a patient

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

1. **Inquiry/Establishing the accusation (core belief).** What was going through your mind before you started to feel this way? Ask yourself what these thoughts meant about yourself, supposing they were true. The answer "*If these thoughts were true, it means I am a ...*" is the uncovered self **accusation** (core belief).	2. **Prosecutor's plea.** Please, state all the evidence you have that **supports** the accusation/core belief that you have circled in column 1.	3. **Defense attorney's plea:** Please, state all the evidence you have that **does not support** the accusation/core belief that you have circled in column 1.	4. **Prosecutor's response to the defendant's plea.** Please, state the thoughts that question, discount, or disqualify each piece of positive evidence in column 3, usually expressed as "yes, but..." thoughts.	5. **Defense attorney's response to the prosecutor's plea.** Please, copy each thought of column 4 **first**, and **then** each corresponding evidence in column 3, connecting them with the conjunction BUT.	6. **Meaning of the response presented by the defense attorney to the prosecutor's plea.** Please, state the meaning you attach to each sentence in column 5.	7. **Juror's verdict.** Please, make a succinct report, considering the questions: Who was more convincing? Who presented more evidence? Whose evidence was more based on facts? Who made fewer (cognitive) distortions? Who was more concerned about defendant dignity?
I have several chronic diseases that can lead to sudden death. *A psychological disorder may evolve to a physical disease.* **Downward arrow technique:** *If the thoughts above were true, what would they mean about you?* ↓ ***I am vulnerable.***	*My grandfather died suddenly.* *I have a genetic predisposition, and I can also die.* *My sister had an infarction when she was 13, due to a viral infection.* *I have panic disorder.*	*1) I have gone through many difficult situations, and I always survived.* *2) I have never had a serious disease; to the contrary, I am always the last to become ill.* *3) As a human being, I have resources to deal with life.* *4) My eating habits are healthy, I do physical exercises, and I visit the doctor regularly.*	*1) ...BUT I can go through a worse situation and not survive.* *2) ...BUT I may have a physical disease.* *3) ... BUT human beings die.* *4) ...BUT I may have a genetic predisposition to a physical disease.*	*1) I can go through a worse situation and not survive, BUT I have gone through many difficult situations and I always survived.* *2) I may have a physical disease, BUT I have never had a serious disease; to the contrary, I am always the last to become ill.* *3) Human beings die, BUT as a human being, I have resources to deal with life.* *4) I may have a genetic predisposition to a physical disease, BUT my eating habits are healthy, I do physical exercises, and I visit the doctor regularly.*	**It means that:** *1) ... the expression "I can" is abstract. Indeed, I always survived.* *2) ... the expression "I may" is just an assumption and, in fact, I have never had a serious disease.* *3) ...I have resources.* *4) ...I have always behaved in the most careful and preventive way.*	*The defense attorney seems more convincing and presented more evidence based on facts. The prosecutor tends to make more distortions as discounting positives and catastrophic thinking.* **Veredict:** *I am innocent of the accusation.*
Now, how much (%) do you believe you are *vulnerable*? *70%* What emotion does this belief make you feel? *Sadness* How strong (%) is it? *50%*	Now, how much (%) do you believe you are *vulnerable*? *90%* How strong (%) is your *sadness* now? *80%*	Now, how much (%) do you believe you are *vulnerable*? *50%* How strong (%) is your *sadness* now? *20%*	Now, how much (%) do you believe you are *vulnerable*? *90%* How strong (%) is your *sadness* now? *80%*	—	Now, how much (%) do you believe you are *vulnerable*? *0%* How strong (%) is your *sadness* now? *0%*	Now, how much (%) do you believe you are *vulnerable*? *0%* How strong (%) is your *sadness* now? *0%*

Homework assignment. Preparation for the appeal: Supposing that the defense attorney's pleas are true, what does it mean about you (upward arrow technique)?
Positive core belief: ***I am a strong person*** (Please, state how much you believe in this new core belief, daily, after writing down at least three pieces of evidence that support it).

Columns 5 and 6 are central aspects of the strategy proposed in this paper. In column 5 (defense attorney's response to the prosecutor's second plea), the client is asked to invert the propositions in columns 3 and 4, again connecting them with the conjunction "but." The client copies each sentence from column 4 and connects it with the corresponding evidence in column 3 with the conjunction; the idea is that this approach allows the client to disqualify the negative, rather than the positive. As a result, the client will have a view of the situation from a more positive and realistic perspective. The client is asked to read each of the reversed sentences in column 5 and to write down the new positive meaning derived from them in column 6.

Column 7 should contain the analytical part of TBTR and is performed in the form of a jury's deliberation. The client answers a series of questions concerning the prosecutor and defense attorney's performance; for example: Who was more convincing? Who presented more evidence? Whose evidence was more based on facts? Who made fewer (cognitive) distortions? Who was more concerned with defendant dignity? This is also the moment to consider what Leahy[12] highlights as the importance of legal and moral theory to develop distinctions about moral responsibility and negligence responsibility. According to Leahy,[12] negligence responsibility (consider possible cause and obligation, proximate cause, contributory negligence) and rational responsibility are to be considered by answering the following questions: 1) Did a behavior actually result in a negative outcome? 2) What would a reasonable person know or do in the same situation ("reasonable man doctrine" in the law)? 3) What are the contractual obligations with another person? 4) What are the conventional expectations? 5) Was there a malicious intent (*mens rea*)? 6) Can responsibility be shared in determining the assignment of blame? 7) Is the cause something that is ordinarily not present? Discussing and answering these questions when the client is playing the role of the juror should help him decenter or refocus from one possible cause (the self) to other possible, more probable causes that are relevant to responsibility.[12]

Assessment of how much the client believes the core belief (circled in column 1) and of how strong the main emotion is may be repeated after completion of columns 1 to 7 (except column 5) to demonstrate a shift in affect to the client during the therapy session.

Finally, TBTR is used to activate the corresponding positive core belief derived from the upward-arrow technique,[8] described in the footnote of Table 1. The therapist asks the client: "Supposing that the defense attorney is right, what does it mean about you?" In the case example in Table 1, the patient came up with the new positive core belief: "It means that I am a strong person."

As daily homework that should be started in session, the client gathers two or three pieces of evidence from that day in support of the new core belief, as a preparation for the appeal, indicating how much he or she believes the new core belief.

3. Statistics

Friedman's one-way analysis of variance was used to assess the global difference both for the percentage of credit in the self-accusation/core belief and the intensity of the main emotion between baseline (after the uncovering of the self-accusation/core belief, described in column 1 of Table 1) and each intervention (prosecutor's plea, defense attorney's plea, prosecutor's second plea, defense attorney's second plea, and the jury's verdict, described respectively in columns 2 to 7 of Table 1). The Wilcoxon signed-rank test was used to compare the results of each intervention with baseline and among them.

Results

Table 2 provides detailed information regarding diagnoses, gender, and age, as well as the percentage of belief in the core beliefs and intensity of emotions derived from the first application of the TBTR to each patient (n = 30). Raw values correspond to how much patients believe in their core beliefs and the main emotion expressed in each step of TBTR. Figure 1 shows that there was a shift respectively in how much the patients believed in their self-accusation/core belief and the intensity of the corresponding emotion after each procedure (investigation: 76.1% and 67.5%; prosecutor: 80.2% and 72.8%; defense attorney: 40.7% and 39.3%; prosecutor's second plea: 67.8% and 58.2%; defense attorney's second plea: 32.8% and 30.5%; and verdict by the juror: 26.8% and 25.8%). There was a significant global difference ($p < 0.001$), as demonstrated by the Friedman's test. There were also significant differences between values after investigation (taken as baseline) and after defense attorney's pleas (T3 and T5), and after the jury's verdict ($p < 0.001$), either in patients' beliefs and in the intensity of their emotions. Statistically significant differences were also shown between the defense attorney's first and second pleas (T3 and T5; $p = 0.009$) and between the defense attorney's second plea and jury's verdict (T5 and T6; $p = 0.005$ regarding the belief and $p = 0.02$ regarding the emotion).

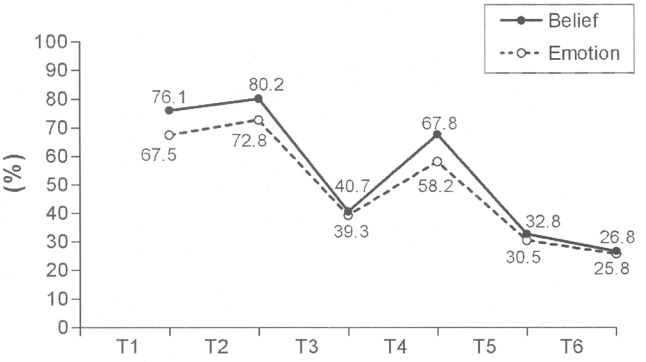

Figure 1 - Mean percentage values (n = 30) after investigation (T1), prosecutor's plea (T2), defense attorney's plea (T3), prosecutor's second plea (T4), defense attorney's second plea (T5), and jury's report and verdict (T6). The solid line indicates how much clients believe in their core belief, and the dotted line indicates intensity of emotion.

Discussion

In this manuscript, I address a common clinical moment: the patient has accumulated considerable alternative evidence pertaining to a negative interpretation, but it is dismissed because of discounting and/or minimizing "but" statements that are driven by putative core beliefs and assumptions. I introduce here a clinical strategy, a revised dysfunctional thought record approach, mirroring the steps of a legal trial – investigation, prosecutor's plea, defense attorney's plea, prosecutor's second plea, defense attorney's second plea, and jury's report and verdict. TBTR is aimed to have patients address the evidence supporting and not supporting the "but" statements, essentially "butting the buts". Overall, the idea is to address core beliefs in a structured format.

So, the strategy presented in this paper might be used especially when "yes, but…" thinking discounts newly generated rational responses. With this thought record, in stimulating upward (columns 2 and 4) and downward (columns 3 and 5) shifts in emotions, we give the patient, in the same session, the chance to engage with the most basic principle of CT: a person's thoughts about a situation regulate mood. By means of TBTR, patients may reactivate their core beliefs and associated negative emotions, afterward reducing their effect with evidence

Table 2 - Characteristics of the patients and raw percentage values during the first application of TBTR

						Investigation		Prosecutor 1st plea		Defense attorney 1st plea		Prosecutor 2nd plea		Defense attorney 2nd plea		Jury	
No	Gender	Age	Primary diagnosis	Core belief	Emotion	B 1	E 1	B 2	E 2	B 3	E 3	B 4	E 4	B 5	E 5	B 6	E 6
1	M	40	Alcohol dependence	I am too limited	Sadness	100	50	50	25	25	10	10	2	0	0	0	0
2	F	34	OCD	I am imperfect	Guilt	100	100	100	100	75	75	85	85	60	60	45	45
3	M	40	Hypochondriasis	I am a sick person	Anxiety	70	90	60	70	60	60	70	80	55	55	55	55
4	F	17	Anorexia nervosa	I am ugly	Sadness	90	90	100	100	70	70	100	100	60	60	60	60
5	F	27	Panic disorder	I am vulnerable	Sadness	70	50	90	80	50	20	90	80	0	0	0	0
6	M	24	OCD	I am a bad person	Guilt	50	40	60	50	10	20	40	10	5	5	0	0
7	F	39	Depression	I am not good enough	Sadness	60	40	50	40	20	40	30	50	10	20	10	20
8	F	35	Depression	I am despisable	Sadness	99	80	100	80	20	40	90	80	30	60	30	60
9	F	22	Panic disorder	I am weak	Sadness	80	80	80	80	70	70	80	80	60	60	40	40
10	F	63	GAD	I have no faith	Fear	100	100	80	80	50	50	80	100	50	50	40	40
11	F	24	Depression	I am boring	Sadness	100	80	100	90	70	50	80	65	30	40	30	35
12	F	22	BED	I am not good enough	Sadness	10	20	50	50	10	40	40	40	10	30	10	40
13	M	32	Depression	I am weak	Sadness	90	80	90	80	60	60	90	80	60	60	40	30
14	F	33	Panic disorder	I am physically vulnerable	Insecurity	50	0	50	50	0	0	60	55	0	0	0	0
15	F	25	Social phobia	I am weird	Anxiety	40	30	70	60	5	10	50	30	5	5	5	5
16	M	36	Social phobia	I am a bad father	Guilt	80	90	95	100	55	80	95	100	70	75	60	70
17	M	32	Multiple phobias	I am vulnerable	Anxiety	85	60	95	75	80	60	95	65	60	55	40	30
18	M	34	OCD	I am weak of character	Shame	100	70	100	70	0	0	70	30	0	0	0	0
19	F	40	Hypochondriasis	I am weak	Sadness	60	60	60	50	30	20	50	50	30	30	30	30
20	F	22	Panic disorder	I am vulnerable	Fear [a]	80	0	80	0	50	0	80	0	50	0	20	0
21	F	24	Panic disorder	I am not intelligent enough	Sadness	40	90	90	100	20	20	30	30	10	0	10	0
22	M	32	ADHD	I am insecure	Sadness	50	80	50	80	25	35	40	40	30	30	30	30
23	F	31	Panic disorder	I am incompetent	Anxiety	80	80	100	90	40	60	80	80	30	40	25	20
24	F	36	Panic disorder	I am a failure	Anxiety	70	70	60	60	35	40	60	40	40	40	40	40
25	F	26	OCD	I am weak	Sadness	80	70	95	100	40	50	100	100	50	30	5	5
26	F	35	Depression	I am a failure	Sadness	80	100	80	100	50	50	70	40	50	30	50	40
27	F	28	Panic disorder	I am a failure	Fear	70	50	70	50	60	30	50	50	50	30	50	30
28	F	26	OCD	I am insecure	Sadness	100	75	100	75	0	10	100	85	0	10	0	10
29	M	22	OCD	I am a sick person	Sadness	100	100	100	100	70	50	70	50	50	30	50	30
30	F	67	OCD	I am a piece of fat shit	Sadness	100	100	100	100	70	60	50	50	30	10	30	10
					Mean	76.1	67.5	80.2	72.8	40.7	39.3	67.8	58.2	32.8	30.5	26.8	25.8

[a] *Patient explained that her fear did not change with changes in how much she believed her core belief because, although the belief "I am vulnerable" was strongly held, she felt safe during session. OCD: obsessive-compulsive disorder; GAD: generalized anxiety disorder; ADHD: attention deficit-hyperactivity disorder; BED: binge eating disorder. B: belief; E: emotion.*

that does not support them. As seen in the example shown in Table 1, the patient, through this intervention, re-framed a core belief (*I am vulnerable*) into a more positive and flexible one (*I am a strong person*). This ability to help patients improve in the same session after stimulation of upward and downward shifts of emotion may be one of the advantages of this strategy.

Once training is sufficient, repeated use of the TBTR strategy in session and as homework might result in deactivation of dysfunctional modes (defined by Beck[13] as structural and operational units of personality that aid an individual in adapting to change) and in modification of their structure and content. According to Beck,[13] CT should target discharging and modifying these modes. The ultimate outcome of the TBTR strategy might be neutralization of these modes as the more credible explanation is incorporated, accompanied by activation of more adaptive ones.

It is also possible to explain the TBTR results in the context of the Interacting Cognitive Subsystems (ICS),[14,15] which holds that replacing dysfunctional schematic models that maintain psychological disorder with alternative, non-dysfunctional models is the main goal of treatment. This goal can be achieved only if there is change at the level of higher-order meanings. Teasdale[14] gives an example: a small change, as in the sentences, "The man said 'GO ON'" vs. "The man said 'NO GO'" (which also alters part of a total pattern of the implicational mode) could effect a dramatic change in the high-level meaning represented. According to Teasdale,[14] "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." The inversion of columns 3 and 4 in the TBTR approach, as given in the example in Table 1, may well accomplish this goal, resulting in the modified sentence in column 5 and the representational meaning identified in column 6.

Before a patient can engage in TBTR, she/he must learn to identify ATs, to distinguish thoughts and emotions, and to understand the cognitive model, and there must be a good therapeutic alliance with the therapist. The therapist must be familiar with the downward-arrow technique illustrated in Table 1, except in cases in which the patient spontaneously expresses a core belief. The spontaneous expression may happen more often with patients who are depressed and chronically anxious or who manifest personality disorders in which these modes are continuously charged. The therapist can then turn to other CT techniques, such as behavioral experiments or the continuum technique.

In addition to the analogy with a judicial process, TBTR and DTR[5] differ fundamentally in the contents of column 4. In TBTR, column 4 addresses ATs that are brought to the fore by using the conjunction "but," with the goal of identifying evidence that supports the core belief (column 2) and that does not (column 3), and then pinpointing the patient's own rationale for disqualifying or dismissing the evidence (column 4). Inverting 3 and 4 to achieve the sentence reversion in column 5 allows the evidence that does not support the core belief to prevail over the negative ATs elicited during the session. Columns 4 and 5 under the DTR approach[5] summarize evidence for both sides, which can lead patients in extreme emotional states to still perceive and give credence only to the evidence that supports the negative core belief.

TBTR incorporates in a structured format and sequence several techniques already used in cognitive therapy: downward arrow technique,[10] examining the evidence,[1] defense attorney technique,[16] thought reversal,[16] upward arrow technique,[8] developing a more positive schema[1] and positive self-statement logs.[3]

This brief, preliminary clinical report has limitations. One such limitation is the use of the thought record itself, which requires some training by the therapist and by the client. It usually takes an entire one-hour session to be completed and, in a few cases, more than one session. However, due to its structured format, after a one-session video demonstration, therapists consider TBTR very user-friendly, and, after sufficient training, patients become progressively able to use it as homework.

This report is also limited by the presentation of a small sample size (n = 30) and should be empirically validated by randomized trials comparing it with other interventions before any conclusions about its effectiveness can be considered firm. The sample is heterogeneous, in that any diagnosis was accepted and TBTR was used in different stages of the treatment. This precluded any follow-up comparison. Future studies should resolve other limitations such as what specific populations may benefit from this intervention.

In summary, this strategy, based on the simulation of a trial, is intended to bolster the power of the rational response and involves the addition of two columns to the DTR construct. One column gives elicited, new ATs that discount the newly generated responses, and the other involves reversing the "yes, but…" concept by inverting the negative disqualifying thoughts and positive alternative responses with the conjunction "but." The ultimate goal is to have the patient recognize and change his or her disqualification of the positive into a disqualification of the negative. The client thus uses those negative thoughts to minimize themselves by pairing them with the positive response, reducing their capacity to render a positive response null. In this manner, the therapist demonstrates and teaches the cognitive model by using the patient's own back-and-forth shift in affect.[8] However, this new measure should be considered in future studies in relation to other measures that have been designed to address core beliefs (i. e., the continuum technique).

Some aspects are still open to debate and should be considered before accepting TBTR as a useful tool for addressing core beliefs. Although the standard thought record does not necessarily work for every patient, one of the issues to resolve is whether this is a function of the tool itself or the individual clinician who is using the tool. One problem with the typical thought record is that newly generated thoughts are open to disqualification via "yes-buts". If, however, the standard thought record is worked through with patients so that they become aware of the evidence both for and against their cognitive assumptions, and develop alternative beliefs that sufficiently incorporate both sides of the evidence (thereby making it credible), the probability of such disqualification would be far less likely. The clinician's job is to help patients to identify alternative beliefs that carry the weight of the evidence, are believable, and result in improvements in mood. However, TBTR should be considered as an additional alternative when this is not achieved.

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