Socratic dialogue and thought records

How CBT works with thoughts: questions instead of arguments, a worksheet instead of pep talks, and what the evidence honestly says

DRAFT this text has not yet been approved by the author and may change.

18 chapters ~49 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **Socratic dialogue is not a way to win an argument with a thought.** It is a series of questions that lets a person reach a new conclusion from their own information. In 1993 Christine Padesky contrasted two styles: "changing minds" (the therapist already knows the answer and steers towards it) and "guiding discovery" (the therapist genuinely doesn't know).
- **Padesky's model has four stages:** informational questions, listening, summarising, and a synthesising question. The most common mistake is to stop before the fourth.
- **A thought record is the same dialogue on paper.** Situation, emotions rated 0–100, the "hot" thought, evidence for and against, a balanced thought, and a re-rating. A good outcome is a drop of roughly 10–50% in the emotion, not a drop to zero.
- **CBT is not positive thinking.** The aim is an accurate thought, not a pleasant one. In lab experiments, people with low self-esteem felt worse after repeating "I'm a lovable person".
- **The evidence is honestly mixed.** CBT as a whole works well for depression. In one observational study, more Socratic questioning was linked to a bigger drop in symptoms by the next session. But direct evidence for the method is thin, and component studies have not shown that the thought-challenging part adds much.
- **The strongest case for the skill is protection after therapy ends.** People who learned cognitive therapy skills well and used them on their own were less likely to relapse into depression over the following year.

- **It matters not only whether homework is done, but how well.** Both the amount and the quality of homework completion are linked to therapy outcomes.
- **Most "CBT apps" are not thought records.** Of 36 apps presented as cognitive restructuring tools, 21 had no step for writing an alternative thought.

Timeline

How the techniques for working with thoughts took shape, and how they were tested. Details and sources are in the chapters below.

1979

Beck, Rush, Shaw and Emery, "Cognitive Therapy of Depression": the Daily Record of Dysfunctional Thoughts, forerunner of the thought record

COGNITIVE LINE

1980

David Burns, "Feeling Good": cognitive therapy reaches a mass audience

COGNITIVE LINE

1983

Padesky's seven-column thought record: "rational response" becomes "balanced thought"

COGNITIVE LINE

1993

Padesky's London address: "changing minds or guiding discovery?" and the four stages

COGNITIVE LINE

1994

Padesky describes core-belief work: the continuum, the positive data log, the historical test

COGNITIVE LINE

1995

First edition of Greenberger and Padesky's "Mind Over Mood"

COGNITIVE LINE

1996

Jacobson and colleagues: behavioural activation alone does as well as full cognitive therapy

EVIDENCE

2000

Kazantzis and colleagues' first meta-analysis of homework

EVIDENCE

2003

Bennett-Levy: behavioural experiments feel more convincing than thought records

EVIDENCE

2007

Longmore and Worrell: "Do we need to challenge thoughts?"; Strunk and colleagues: CT skills and relapse risk

EVIDENCE

2009

Wood and colleagues: positive self-statements and low self-esteem

EVIDENCE

2015

Clark and Egan: no direct evidence for the method; Braun and colleagues: first data linking questions to symptom change

EVIDENCE

2016

Kazantzis and colleagues' meta-analysis: both quantity and quality of homework matter

EVIDENCE

2019

Padesky in Berlin: "Socratic dialogue" rather than "Socratic questions"; a review finds 110 different thought record forms

COGNITIVE LINE

2022

App review: 21 of 36 "restructuring tools" lack an alternative-thought step

EVIDENCE

How to read these notes: evidence labels

Every claim here carries a label that tells you how solid it is.

The label comes first in brackets, followed by the source. **Proven by research** means trials, meta-analyses or other empirical studies (we say so when it is a single, small or observational study). **Clinical consensus** means professional standards, manuals and accepted CBT practice. **The author's own account** is what the creator of a method says; it has not been independently checked. **Documented fact** covers dates, publications and names. **Interpretation** is a reading of the facts, or a point still under debate. **Sources disagree** means both versions are given. **Not verified** means we could not open the primary source, so treat it with care. All dialogue and thought record examples here are composites, not stories of real people.

> Important This is education, not therapy or diagnosis. The techniques are described as they are used in therapy, not as a substitute for it. These notes mention thoughts of not wanting to live. If you need support now, see If you need help now.

What cognitive techniques are and where they fit in CBT

Before you can change a thought you have to find it, and before you find it you need to agree who looks for it, and how.

Earlier episodes in the series covered the cognitive model (episode 2), cognitive distortions (episode 3) and how a therapist builds a picture of the case and structures a session (episode 4). This one is about the next step: what you do with a thought once you have noticed it.

Cognitive techniques are the part of CBT that works with the content of thoughts. That means automatic thoughts (quick phrases that flash through the mind in response to an event: "I've ruined everything"), intermediate beliefs (rules and assumptions: "if I make a mistake, people will stop respecting me") and core beliefs (broad conclusions about oneself, other people and the world: "I'm incompetent"). The umbrella term is **cognitive restructuring**: thoughts are explored, evaluated and, where useful, replaced with more accurate ones **clinical consensus; Clark, 2014, cited in Erhardt et al., 2022**.

It helps to separate two things.

- **The process: how the therapist talks.** In CBT this is **guided discovery**, where the person reaches a new view on their own, using their own information. Its main vehicle is **Socratic dialogue**. It is the style through which everything else is done, not a separate technique.

Guided discovery and Socratic questioning are part of the CBT competence framework used to train therapists in the UK clinical consensus; UCL CORE, Roth & Pilling.

- **The tools: what is done on paper and in life.** Thought records, rating scales, evidence for and against, alternative explanations, the double standard, decatastrophising, the downward arrow, the responsibility pie, the continuum, behavioural experiments.

Behind both sits **collaborative empiricism**: a thought is treated as a hypothesis that therapist and client test together. The therapist is a co-investigator, not a judge deciding whether the person thinks correctly clinical consensus; Padesky, 1993; UCL CORE.

> Example Someone is late for a meeting and thinks, "I'm irresponsible." An argument would sound like: "No, you're responsible." Collaborative empiricism sounds like: "Let's look. How often are you late? What happened today? What would your colleagues say about you?" Neither person knows in advance how the check will turn out.

Experts disagree on whether the Socratic method is the heart of CBT. In a survey of 15 CBT researchers, some called it a central feature of therapy and others a helpful but optional extra (interpretation; Clark & Egan, 2018). We come back to this in the chapter on evidence.

Changing minds or guiding discovery: Padesky's four stages

The best question a therapist can ask is one they don't know the answer to.

Two conversations with the same thought

Imagine someone says, "I'm a failure."

In the first conversation the therapist replies: "But you have a job, a family, a degree. Could a failure do all that? So you're not a failure." The person nods. The thought has been "disproved" in three moves.

In the second, the therapist asks: "When did you last think that? What happened then? What does 'failure' mean to you?" They don't know where this will lead, and a few minutes later the person says something the therapist didn't expect.

The psychologist Christine Padesky (later co-author of the self-help book "Mind Over Mood", 1995) built a keynote address at the European Congress of Behavioural and Cognitive Therapies in London on 24 September 1993 around this difference documented fact; Padesky, 1993. She called the first style **changing minds**: the therapist already has a conclusion and leads the client there in a "one-two-three-aha!" pattern. The second is **guiding discovery**: helping the person see what they already know but haven't noticed the author's own account; Padesky, 1993.

Her working rule: "If you are not truly curious to know the answer, don't ask the question" **the author's own account; Padesky, 1993**. And from the same talk: "We are not simply fixing problems but also teaching ways of finding solutions" **the author's own account; Padesky, 1993**.

Why does this matter beyond the therapy room? Because it is how we talk to ourselves. When the inner voice says "I've ruined it", we usually either believe it or argue back: "No, you're doing great." Both are attempts to change a mind. The third way is to question the thought as if you really don't know the answer.

Myth vs fact **Myth:** the Socratic method means asking questions until the client admits they're wrong. **Fact:** that is exactly what Padesky calls changing minds. In guided discovery the therapist doesn't know the answer in advance, and the person draws the conclusion themselves **the author's own account; Padesky, 1993**. The CBT competence framework says explicitly that therapists should refrain from imposing a point of view through debate, persuasion, "lecturing" or "cross-examining" the client **clinical consensus; UCL CORE**.

What makes a question Socratic

In Padesky's definition, Socratic questions are questions that **the author's own account; Padesky, 1993**:

1. the client **has the knowledge** to answer;
2. draw attention to relevant information that is currently out of focus;
3. generally move from the concrete to the more abstract;
4. help the client apply the new information to re-evaluate an earlier conclusion or build a new one.

The four stages

Stage	What the therapist does	Example question (composite)	Why
1. Informational questions	Asks questions the person can answer; turns the general into the specific	"When was this? What did you see? What else was going on that day?"	Brings into view information the person has but isn't attending to
2. Listening	Catches unexpected words, metaphors, emotional reactions	"You said 'again'. What does 'again' mean?"	Avoids missing what doesn't fit the therapist's expectations
3. Summarising	Every few minutes, sums up in the client's words	"Let me pull together what I've heard, and you correct me"	Shows the whole picture and checks understanding
4. Synthesising (analytical) question	Asks the person to connect the new information to the original thought	"How does all this fit with the thought that you 'always mess things up'?"	The person puts the new conclusion into words

The stage names come from Padesky's 1993 address **documented fact; Padesky, 1993**.

Stage 1 usually starts by getting specific. "I always mess things up" is a label; "yesterday at 4:40 pm I sent a report with a mistake in a table" is a situation you can work with.

Stage 2 is not a pause before the next question; it is work in its own right. A client's unexpected word often matters more than the therapist's plan. Padesky warns that "if you are too confident of where you are going, you only look ahead and miss detours" **the author's own account; Padesky, 1993**.

Stage 3, according to Padesky, is where one of the most common mistakes happens: therapists summarise too rarely **the author's own account; Padesky, 1993**.

Stage 4 is the point of the whole exercise. Padesky notes that therapists often "stop short of this critically important final stage": the facts are gathered, but the person is never invited to link them back to the original thought **the author's own account; Padesky, 1993**.

Common mistakes

According to Padesky **the author's own account; Padesky, 1993**:

- asking questions the person cannot answer (for example, "what are you feeling right now?" to someone who struggles to identify emotions; asking about body sensations may work better);
- "building a case": waiting for answers that confirm a planned conclusion and not hearing unexpected ones;
- summarising too little;
- stopping before synthesis.

The psychologist Scott Waltman adds a mistake he calls **provided discovery**: the therapist simply tells the client the conclusion they are "supposed" to reach. He also warns against using thought records to prove to someone that their thinking is distorted **the author's own account; Waltman, 2020**.

What changed 25 years later

In 2019, at the Ninth World Congress of Behavioural and Cognitive Therapies in Berlin, Padesky revisited the model **documented fact; Padesky, 2019**. The main updates **the author's own account; Padesky, 2019**:

- **"Socratic dialogue" rather than "Socratic questions"**, to stress that it is a joint process.
- **Information can be created through action, not only asked for.** She highlights four kinds: interactive writing, behavioural experiments, imagery and role play.
- **Summaries in the client's own words.** The therapist should be a "humble parrot", using only the client's exact words, metaphors and images. Written summaries help.
- **The synthesising question need not be about testing a thought.** It can be "How would you like to be?" or "What are the next steps you could take?"
- **Silence is an intervention too.** The therapist needs the courage to stay silent while the person searches for a meaningful answer.

Padesky herself notes that we don't yet know whether the four-stage model makes therapists' learning easier; that hasn't been tested **the author's own account; Padesky, 2019**.

Another version of the same steps

Waltman describes a similar sequence **the author's own account; Waltman, 2020**:

1. **Targeting**: pick the thought most tied to the person's difficulties and underlying beliefs, rather than working through everything.
2. **Understanding their view**: grasp why the belief makes sense from where the person stands; this is the basis for validation (acknowledging that the experience is

understandable).

3. **Curious exploration**: what might the person be missing, including because of avoidance?
4. **Integration**: bring both sides together into a balanced thought, then plan how to test it in daily life.

Waltman stresses that there are no "silver bullet" questions that disprove any and every belief, and calls Socratic questioning among the hardest skills for a psychotherapist to learn **the author's own account; Waltman, 2020**.

What it looks like in practice: "I never finish anything"

A composite example: what each question does, and how it differs from an argument.

A composite client; let's call her Lana. The theme is everyday self-criticism about abandoned projects. This is not a real person's story. The right-hand column shows Padesky's stage and what the question is doing.

#	Line	Stage and what the question does
1	**T:** You said, "I never finish anything." When did that thought come up today?	Stage 1: from a label to a specific situation
2	**C:** This morning. I opened my laptop and saw my English course — I dropped it after lesson four.	
3	**T:** How much do you believe that thought right now, from 0 to 100? And what are you feeling, in a word or two?	Stage 1: ratings give a baseline so change can be seen later
4	**C:** Ninety. Shame, about 70. And irritation with myself.	
5	**T:** Let's gather some data. What have you started in the last year or two — both what you dropped and what you finished? I'll write it in two columns.	Stage 1: a question the client can answer. The therapist doesn't argue or suggest items
6	**C:** Dropped the course. Dropped running. Finished the bathroom renovation, though two months late. Handed in the annual report. Got my driving licence — on the second attempt.	
7	**T:** I notice that each time you mention something you finished, you add "though late" or "on the second attempt". What do those additions mean to you?	Stage 2: listening for the client's unexpected words. The observation is offered as a question, not a verdict
8	**C:** Well... if it's late, it sort of doesn't count. Finishing means doing it straight away, with no hiccups.	A rule surfaces: "only flawless counts"
9	**T:** Let me sum up in your words, and you correct me. Of five things, you finished three and dropped two. And you don't count the finished ones if	Stage 3: a summary in the client's words

#	Line	Stage and what the question does
	there were delays along the way. Is that right?	
10	**C:** Yes. When you say it out loud, it sounds odd.	
11	**T:** What do you think sets the finished things apart from the dropped ones?	Looking for a pattern: the client, not the therapist, finds the explanation
12	**C:** The finished ones were for someone else or had a deadline. The renovation — I'd agreed it with my husband; the report — deadline; the licence — I needed it for work. The course and running were just for me, and nobody was waiting.	
13	**T:** How does all that fit with the thought "I never finish anything"? And how much do you believe it now?	Stage 4: synthesising question plus re-rating
14	**C:** "Never" isn't true. I finish things when there's a deadline or another person involved. I drop the things that are just for me. I believe it… maybe forty percent. Less shame; the irritation's still there — I want to do something about it.	The client states a balanced conclusion herself. The emotion dropped, but not to zero
15	**T:** What could you test this week?	Moving to action: "what's the next step?"
16	**C:** Maybe go back to the course, but with an outside deadline — arrange to study with a friend on Tuesdays. See if it works.	A hypothesis for a behavioural experiment (more in episode 6)

Notice what is missing. The therapist never says "that's overgeneralisation" and never lists Lana's achievements. The strongest discoveries — the rule "only flawless counts" and the link "I finish when there's an outside deadline" — came from her. The therapist couldn't have suggested them, because they didn't know.

How not to do it

The same situation in a changing-minds style (composite):

> Example **T:** But you finished the renovation and handed in the report! So "I never finish anything" is irrational — it's overgeneralisation. **C:** Yes, but the renovation is different… and it was late anyway. **T:** Being late doesn't cancel the result. Can you see you're wrong? **C:** I suppose… (She believes the thought as much as before, and now also feels ashamed of "thinking wrong".)

What went wrong:

- the therapist knows the answer in advance and is "building a case" (Padesky, 1993);
- the therapist states the conclusion, which is provided discovery (Waltman, 2020);
- the "yes, but…" is pushed past rather than explored, so the rule "only flawless counts" never surfaces;
- there is no summary and no synthesis in the client's words;
- the label "irrational" turns the conversation into a contest about who is right.

Cheat sheet: what each question does

Function	Example
Get specific	"When was this? What did you see?"
Measure	"How much do you believe it, 0 to 100? How strong is the feeling?"
Gather data	"What did you start, and how did it end?"
Hear the word	"You said 'though late'. What does that mean to you?"
Summarise	"If I've understood correctly…"
Find a pattern	"What sets one apart from the other?"
Synthesise	"How does this fit with the original thought?"
Move to action	"What could you test this week?"

Does the Socratic method work? What we actually know

It is called a cornerstone of CBT, but testing started late and the data are still thin.

An awkward review

In 2015 the Australian researchers Gavin Clark and Sarah Egan published a review of the Socratic method in CBT. Their conclusion: the method is described as an important part of CBT, but no empirical case for it has been made, and **no direct evidence shows that it is beneficial in CBT** (interpretation; Clark & Egan, 2015). A year earlier, a published expert panel that included Padesky herself acknowledged that even the definition and purpose of Socratic dialogue remain unresolved **documented fact; Kazantzis et al., 2014**.

The first supporting data

The same year, Daniel Strunk's team at Ohio State University published a study **proven by research, a single observational study; Braun et al., 2015**:

- 55 adults with major depressive disorder, 16 weeks of cognitive therapy;
- video recordings of the first three sessions were rated by independent observers on a five-item scale built for the study (inter-rater agreement ICC = 0.77, where 1 would be perfect agreement);
- the therapists were four graduate students with one to two years of clinical experience.

The result: after sessions in which the therapist used more Socratic questioning than usual for that client, depressive symptoms fell more by the next session. A one-standard-deviation increase corresponded to a score about 1.5 points lower on the BDI-II depression scale (which runs from 0 to 63). The link held after accounting for the therapeutic alliance (the quality of the working relationship). There was no difference between clients, though: those who on average received more questioning did not do better overall.

The authors list the limits themselves: without an experimental manipulation, causation can't be established; only early sessions were studied; the findings apply to cognitive therapy for depression; and the mechanism — whether questions change thoughts or simply increase engagement — was not tested **documented fact; Braun et al., 2015**.

Using the same sample, a later analysis looked at who benefits more. The link with symptom change was stronger in people who made especially gloomy predictions about the future and in those not taking antidepressants; the effects were small **proven by research, a single study; Vittorio et al., 2021**. A further paper by the same group, judging by its title, describes cognitive change as a mediator of this effect; we did not access its data (not verified; Vittorio et al., 2022, *Behaviour Research and Therapy, 150*, 104035 — only the bibliographic record was available).

Experiments outside the clinic

- In an analogue experiment (a model of therapy, not real therapy), 144 people watched videos of "sessions". The Socratic style was rated higher than a didactic (explaining) one: the questions seemed more helpful, people felt more supported in their autonomy and were more willing to do the tasks. Part of the effect was explained by alliance and empathy **proven by research, an analogue study; Heiniger et al., 2018**.
- In an online experiment with 69 participants, a 15-minute "Socratic" presentation changed a common irrational belief more than a control reading did, but not more than a standard explanation (psychoeducation) **proven by research, a small analogue study; Harrison et al., 2018**.

What follows

Claim	What there is	How solid
Socratic questions are linked to a drop in depressive symptoms by the next session	Braun et al., 2015	One observational study, 55 people
Questions help some people more than others	Vittorio et al., 2021	One study, small effects
A Socratic style is perceived better than an explaining one	Heiniger et al., 2018	Analogue, not clinical
A Socratic style changes beliefs more than explanation does	Harrison et al., 2018	Not supported in a small experiment
No direct evidence for the method's benefit in CBT	Clark & Egan, 2015	A review's conclusion
Experts disagree on whether the method is essential	Clark & Egan, 2018	Survey of 15 experts

An honest summary: Socratic dialogue is an accepted CBT style with a plausible rationale and some encouraging early data, but it is not a proven "main mechanism" of therapy (interpretation; based on the sources above).

Thought records: the same dialogue on paper

A worksheet is a way to ask yourself the same questions when no therapist is in the room.

Padesky writes that most of the worksheets in "Mind Over Mood" guide clients through a Socratic dialogue with themselves **the author's own account; Padesky, 2019**. The thought record is the central one.

Where it came from

- **1979.** Beck and colleagues' manual "Cognitive Therapy of Depression" introduces the Daily Record of Dysfunctional Thoughts **documented fact; Beck et al., 1979**. It is usually described as five columns: situation, emotions, automatic thoughts, rational response, outcome. We give this layout from secondary descriptions; we did not consult the book **not verified**.
- **1983.** Padesky creates a seven-column thought record and replaces "rational response" with "alternative/balanced thought". According to Padesky and Greenberger, Beck later described "rational response" as a misstep because it risked making cognitive therapy look dogmatic **the author's own account; Padesky & Greenberger, 2020, as cited by Psychology Tools**.
- **1995 and 2016.** The first and second editions of Greenberger and Padesky's self-help book "Mind Over Mood", in which the thought record is a core tool **documented fact; Guilford Press**.

Myth vs fact **Myth:** there is one "correct" thought record form from Beck. **Fact:** researchers collected 110 different forms from classic CBT texts and from certified CBT therapists. They boiled down to 55 unique combinations of elements: practitioners use far more variations than the textbooks describe **proven by research, a review of forms; Waltman et al., 2019**. Which version works best for which problem has not yet been studied.

What it is made of

Most versions include five core elements: the situation that triggered distress; named emotions; automatic thoughts; an adaptive alternative thought; and an assessment of the outcome, i.e. how much the distress changed **clinical consensus; Erhardt et al., 2022**.

The seven-column version spells this out in more detail. Below is the logic of the columns in our own words **clinical consensus; based on Padesky & Greenberger as cited by Psychology Tools**. The layout and text of published worksheets are copyrighted, so we don't reproduce them.

Column	What goes in it	Tip
1. Situation	What, where, when, with whom	Like camera footage: no judgements
2. Emotions	Each in one word, with strength 0–100	"Anxiety 85", not "I feel bad"
3. Automatic thoughts	Everything that went through your mind; mark the "hot" one	The hot thought is the one most tied to the emotion
4. Evidence for	What supports the hot thought	Only what's observable, not interpretations
5. Evidence against	What doesn't fit the hot thought	Facts, not reassurance
6. Balanced thought	A conclusion that holds both columns; belief 0–100%	Often uses "and": "there are edits, and that doesn't mean I'm incompetent"
7. Emotions now	Re-rate the same emotions	Compare with column 2

How seven columns differ from five: evidence for and against gets its own columns, and "rational response" becomes "balanced thought" **clinical consensus; Psychology Tools, after Padesky & Greenberger, 2020**. In the first weeks, short three-column forms (situation — emotion — thought) are often used: learn to notice first, then test **clinical consensus**.

Using the ratings

- **Emotion strength** is rated to give a baseline for measuring change **clinical consensus; Psychology Tools**. In CBT a 0–100 scale is typical.
- **Belief in the new thought** is rated from 0 to 100% **clinical consensus; Psychology Tools**.
- **Order.** Recent formats often name and rate emotions **before** writing automatic thoughts, since a strong feeling leads more easily to the hot thought **clinical consensus; Psychology Tools** .
- **What to expect.** When a thought record goes well, shifts of 10–50% are typical **clinical consensus; Psychology Tools, citing Padesky & Greenberger, 2020, and Waltman et al., 2021**. The goal is relief, not zero emotion.
- **If very little changes,** possible reasons include: the analysis was too superficial or too directive; the new thought wasn't credible enough; another distressing thought remains;

or the original thought reflects a core belief that needs deeper work clinical consensus; Psychology Tools.

Apps: recording is not the same as processing

In a 2022 review, researchers found 246 apps by keyword search and narrowed them to 36 that fit the description of cognitive restructuring tools. Twenty-one of them had no step for writing an alternative thought: they only logged situations, emotions or thoughts. Of the 15 apps in the final analysis, 7 included all five core elements. The authors found no study directly testing whether these apps help proven by research, a review of apps; Erhardt et al., 2022.

The practical takeaway: if an app has no step where you test the thought and write a new one, it is a mood diary, not a thought record.

A completed thought record: "Let's discuss tomorrow at 10"

A composite example following the seven-column logic, with a breakdown and common mistakes.

Mira, 32, works in marketing (a composite example). She sent her manager the quarterly report. An hour later the reply came: "Let's discuss tomorrow at 10." No "thanks", no emoji.

Column	Mira's entry
1. Situation	Tuesday, 4:40 pm, at my desk. Sent the quarterly report. Manager's reply an hour later: "Let's discuss tomorrow at 10."
2. Emotions (0–100)	Anxiety 85 · Shame 60 · Irritation with myself 40
3. Automatic thoughts	"He didn't like it." · "I've missed something again." · **"I've botched the report and now he thinks I'm incompetent" (belief 90%)** — the hot thought. · "If this carries on, I'll be fired."
4. Evidence for	The reply is short, with no "thanks", though he usually thanks me. · Last month he sent back one of my presentations with edits. · There was a section in the report I wasn't sure about.
5. Evidence against	He sets up a meeting for every quarterly report — mine and my colleagues'. · Two weeks ago he asked me to lead a new project. · Last month's edits were to one slide out of thirty. · He writes short replies from his phone between meetings. · "Let's discuss" is not a verdict; I don't yet know what the conversation will be about. · If a friend got this reply, I'd tell her: "It's just an invitation to a meeting."
6. Balanced thought (belief 0–100%)	"A short reply means there'll be a conversation, not that the report has failed. There may be questions or edits on the section I'm unsure about; edits are a normal part of work, not a verdict on my competence. Tomorrow I'll find out the specifics" — **75%**
7. Emotions now	Anxiety 45 · Shame 20 · Irritation with myself 15 · Belief in the hot thought now 35%

After the record. Mira prepares three questions about the section she's unsure of. She also sets up a small experiment: at the start of the meeting she will ask what matters most to her manager in the report, and write down what he actually says. Before the meeting she records her prediction: "he'll say it's all bad" — belief 60%. This is how a thought record turns into a real-life test; behavioural experiments are covered in episode 6.

What was done well

- **Emotions came before thoughts**, each in one word and rated.
- **The hot thought is not the first one but the most charged:** about incompetence, not "he didn't like it".

- **The "for" column was filled in honestly.** Without it, the balanced thought would sound like self-persuasion.
- **The "against" column holds facts, not reassurance.** Not "it'll be fine" but "he meets about every report". The last item is the double standard (see below).
- **The balanced thought allows for likely edits.** "I'm great and the report is perfect" would be positive thinking, and fragile.
- **The emotions dropped, but not to zero** (anxiety 85 → 45). Some anxiety before a meeting with your manager is normal.
- **It ends in action**, not just a conclusion on paper.

Common mistakes when filling one in

Mistake	What it looks like	Better
An emotion instead of a thought	"Thought: I feel anxious"	Emotion goes in column 2; the thought is what you tell yourself: "I'll be fired"
A question instead of a thought	"What if he didn't like it?"	Rephrase as a statement and rate it: "He didn't like it" — 70%
An interpretation in "for"	"He doesn't respect me"	Only what's observable: "the reply had no thanks"
Reassurance in "against"	"Everything will be fine"	A fact: "he meets about every report"
A positive thought instead of a balanced one	"I'm the best in the department"	A conclusion that accounts for both columns
Aiming for zero emotion	"It didn't work, I'm still anxious"	A 10–50% drop is already a result
Writing it "later, this evening"	A day later the details have faded	Write columns 1–3 straight away, the rest later

Why rephrase questions: thoughts phrased as questions ("what if?") are hard to test against evidence, so they are first turned into statements **clinical consensus; Psychology Tools, "What to Try When CBT Thought Records Don't Work"**.

CBT is not positive thinking

The aim is an accurate thought, not a pleasant one. And sometimes the accurate thought confirms that the problem is real.

When people hear "CBT works with thoughts", they often take it to mean "swap bad thoughts for good ones". It doesn't.

	Cognitive restructuring	Positive thinking and affirmations
Aim	An accurate, useful thought	Feeling good
Approach to the negative	Tested; may turn out partly true	Replaced or ignored
Result	A balanced thought that reflects both columns	A positive statement
Who words it	The person, from their own data	Often a ready-made phrase from outside

The affirmation experiment

In 2009 the psychologist Joanne Wood and colleagues ran a series of experiments with the phrase "I'm a lovable person". Among people with low self-esteem, repeating it — or thinking about why it was true — left them in a **worse** mood than skipping the statement or considering both how it was and wasn't true. Among people with high self-esteem, mood improved, but only a little. The authors concluded that positive self-statements may help some people but backfire for the very people who seem to need them most **proven by research; Wood et al., 2009**.

A caveat: these were lab experiments with non-clinical samples. They don't show that affirmations harm everyone. But they illustrate why CBT isn't built on positive phrases. Waltman makes the same point from clinical practice: purely positive reframes can be brittle if they don't fit the reality of the person's life **the author's own account; Waltman, 2020**.

Myth vs fact **Myth:** CBT replaces negative thoughts with positive ones. **Fact:** the aim is a balanced thought that takes account of evidence on both sides. According to Padesky and Greenberger, Beck himself came to see even the word "rational" on the worksheet as a misstep: therapy shouldn't look like a set of "correct" thoughts **the author's own account; Padesky & Greenberger, 2020, as cited by Psychology Tools**.

What if the thought is true?

A balanced thought isn't always "softer". If the facts confirm a problem — the person really is facing injustice, a threat, discrimination or abuse — restructuring must not turn into "it's all in your head". The conversation moves to problem-solving: what can be done, who can help, what is needed for safety **clinical consensus**. Clumsy "challenging" risks sounding like "you're thinking wrong", which is invalidation: dismissing the person's experience **clinical consensus; Waltman, 2020**.

Tools for evaluating a thought

A short set of techniques a therapist chooses to fit the situation. Not all at once, and not all for working on your own.

The double standard

Most people judge themselves more harshly than they would a close friend in the same situation. The therapist makes the gap visible: "Would you say that to a friend?" **the author's own account; Burns, 2018**.

David Burns, author of "Feeling Good", says he first saw the technique in the 1970s, during his residency at the University of Pennsylvania, used by Dr Maultsby, and later adapted it **the author's own account; Burns, 2018**. So it is fair to say Burns popularised the technique rather than invented it.

Burns also has a **paradoxical version**: the therapist plays the client's friend and describes the client's problem as their own; the client responds with a compassion they don't give themselves; then together they check whether that response is true, and the client writes it down. Burns says it works when there is good empathy and the person really does hold a double standard, and rarely works for people who hate both themselves and other people **the author's own account; Burns, 2018**.

Alternative explanations

"How else could this be explained? If this happened to a friend, how would you explain it?" The person lists three to five possibilities and, if useful, estimates how likely each is **clinical consensus**.

> Example A friend hasn't replied to a message. First thought: "She's upset with me." Other explanations: she's busy at work; she read it and forgot; she's waiting until she has time to reply properly; something has happened on her side. None of them is proven yet — including the first.

Decatastrophising

"What if the worst happens?" The term is linked to Albert Ellis and his idea of catastrophising, and the technique was also developed within Beck's cognitive therapy **not verified; based on a secondary source**. The steps **clinical consensus**:

1. Name the worst-case scenario specifically.
2. Estimate how likely it is.
3. "If it happens, how would I cope? Who and what would help? What would it look like in a week, a month, a year?"
4. Name the best and the most likely scenarios.
5. Make a plan for the most likely one.

A limitation: in generalised anxiety disorder, working through the content of one worry often triggers the next, so therapy there focuses more on the worry process itself **clinical consensus; Psychology Tools**.

The downward arrow

A technique for finding the belief beneath an automatic thought **clinical consensus; Neenan & Dryden**:

1. Take the automatic thought.
2. Provisionally accept it as true. It isn't challenged along the way, or the underlying belief won't surface.
3. Ask: "If this were true, what would it mean for me? What's the worst part of it?"
4. Repeat until the answer becomes a general statement about yourself, others or the world.
5. Then work with each link.

The technique was first mentioned by Beck and colleagues (1979) and elaborated by Burns in "Feeling Good" (1980) (documented fact; Wenzel, 2012, in *Standard and innovative strategies in cognitive behavior therapy*, InTech). Burns calls his version the "Individual Downward Arrow Technique" and says he developed it **the author's own account; Burns, Feeling Good blog, 2017**. We did not check the book's text for the name "vertical arrow" **not verified**.

> Important The downward arrow quickly reaches painful core beliefs such as "I'm worthless". In therapy it is done within a safe frame, with time left to close the conversation. It is not an exercise to take all the way on your own.

The responsibility pie

When someone blames themselves "one hundred percent", they are asked to list **all** the factors that affected the outcome: other people, circumstances, chance, information that

wasn't available at the time. Each factor gets a slice of the circle, and **their own share goes in last**. Then they discuss what they see and re-rate their responsibility clinical consensus; Psychology Tools. The technique has roots in cognitive therapy for obsessive-compulsive disorder, where an inflated sense of responsibility is considered a key mechanism documented fact; van Oppen & Arntz, 1994. We could not establish who first devised the "pie" itself.

The goal is a realistic share of responsibility, not zero: legitimate responsibility isn't removed clinical consensus; Psychology Tools.

> Example A work project falls through, and the project lead thinks: "This is entirely my fault, 100%." The circle fills up: a supplier who delayed the data; the client's changing requirements; a key colleague's illness; a tight deadline set from above; her own decision not to raise the alarm earlier. Her own share at the end is, say, 25%. That isn't "it had nothing to do with me" but "this part is mine, and I can work with it". Using the responsibility pie around bereavement, trauma or abuse is work for therapy only.

The continuum

Beliefs like "I'm a failure" live in a black-and-white world: either a failure or perfect. A continuum turns this into a scale, which makes room for doubt clinical consensus; James & Barton, 2004. The person names the ends of the scale themselves, often on a line about 10 cm long clinical consensus; James & Barton, 2004.

Padesky suggests several moves the author's own account; Padesky, 1994:

- rate yourself on a scale of the **new**, desired belief (for example, 0–100% "I'm lovable") rather than the old one, so any shift is easier to see;
- **criteria continua**: break a global idea ("a successful person") into specific qualities and rate each — often it turns out the person's rules never let them rise above zero;
- a **positive data log**: write down, every day, even small observations that support the new belief; this may take at least six months;
- a **historical test**: gather evidence for and against the belief across different periods of life.

The continuum and core-belief work are a step beyond working with automatic thoughts. They are done after case conceptualisation and when the person is stable clinical consensus; James & Barton, 2004.

Do we even need to challenge thoughts?

The most awkward question in the topic, and the answer may lie in what stays with you after therapy.

"I get it in my head, but I don't feel it"

A common complaint: it makes sense, but the anxiety is the same. The psychologist James Bennett-Levy asked trainee therapists to try thought records and behavioural experiments on themselves. They rated the experiments as more powerful and convincing for changing beliefs. His explanation draws on the Interacting Cognitive Subsystems model (Teasdale and Barnard): a thought record works more at the level of "I understand", action at the level of "I feel" **proven by research, one small study of trainees; Bennett-Levy, 2003**. Hence the practice of ending a thought record with "how can I test this in real life?" It has been reported that in an experiment with a non-clinical sample, a behavioural experiment changed belief immediately while a thought record did so only after a week, but we could not open the original paper **not verified; McManus et al., 2012**.

The 1996 component study

Neil Jacobson and colleagues randomly assigned 150 outpatients with major depression to three groups **proven by research, RCT; Jacobson et al., 1996**:

1. **behavioural activation** only — work on activities and daily schedule;
2. behavioural activation plus skills for modifying automatic thoughts;
3. full cognitive therapy, including work on core beliefs.

The full therapy was no better at the end of treatment or at six-month follow-up. Behavioural activation without thought work changed negative thinking as effectively as full cognitive therapy. One detail adds weight: all groups were treated by four experienced cognitive therapists, and the authors note a clear allegiance in favour of cognitive therapy **documented fact; Jacobson et al., 1996**. A limitation: this is a single trial in depression and shouldn't be generalised to every disorder.

A critical review

In 2007 Richard Longmore and Michael Worrell published a review with the blunt title "Do we need to challenge thoughts in cognitive behavior therapy?" Their conclusion: component studies offer little evidence that cognitive interventions add benefit, and there is little evidence that changing thoughts is what causes improvement (interpretation; Longmore & Worrell, 2007). This position has been contested, and the debate continues.

The case on the other side

Daniel Strunk and colleagues followed 35 people who had responded to cognitive therapy for depression. A lower risk of relapse over the next year was predicted by their cognitive therapy coping skills and by in-session signs that they were applying its principles on their own. This held after accounting for symptom severity at the end of treatment. General self-esteem did not predict relapse risk **proven by research, small sample; Strunk et al., 2007**.

The bottom line

CBT for depression works overall: in a meta-analysis of 409 trials (52,702 patients), the effect against control conditions was g = 0.79, while the difference from other bona fide psychotherapies was close to zero, g = 0.06 **proven by research; Cuijpers et al., 2023**. How much the thought work itself contributes is an open question (interpretation; Jacobson et al., 1996; Longmore & Worrell, 2007). Perhaps the value of cognitive techniques lies less in relieving symptoms faster and more in a skill that stays after therapy ends (interpretation; based on Strunk et al., 2007). That echoes Padesky's 1993 point: therapy teaches ways of finding solutions.

Myth vs fact **Myth:** it's proven that Socratic questions and challenging thoughts are CBT's main mechanism. **Fact:** there are early data linking questions to improvement (Braun et al., 2015), but direct evidence is thin (Clark & Egan, 2015), and component studies in depression have not shown an advantage for the cognitive part (Jacobson et al., 1996; Longmore & Worrell, 2007).

Homework: what happens between sessions

If a thought record is a dialogue without the therapist, it happens between sessions. Here the data are fairly consistent.

Study	What was included	What was found
Kazantzis et al., 2000	27 studies, 1,702 participants	Effect of homework on outcome r = 0.36; link between compliance and outcome r = 0.22
Mausbach et al., 2010	23 studies, 2,183 participants	Compliance–outcome link r = 0.26 (95% CI 0.19–0.33), the same for depression and anxiety; size depended on how compliance was measured
Kazantzis et al., 2016	17 studies, 2,312 clients	Quantity completed: g = 0.79 at post-treatment (15 studies), g = 0.51 at follow-up (7). Quality of completion: g = 0.78 at post-treatment and g = 1.07 at follow-up — but from only 3 studies, with very wide confidence intervals

All three are meta-analyses **proven by research; Kazantzis et al., 2000; Mausbach et al., 2010; Kazantzis et al., 2016**. The coefficient r shows the strength of a relationship (0 = none, 1 = perfect); g shows the size of a difference (0.2

is usually considered small, 0.5 medium, 0.8 large). An important caveat: these are mostly correlations. It may be that people who are already improving do their homework better.

The practical point: what matters is not just "done or not done" but **how** it was done — whether the person grasped the process. That is why in CBT homework is reviewed at the start of the next session clinical consensus.

What good homework looks like clinical consensus: designed together; linked to the session's goal; specific — when, where, how much; started as a trial run in the session; obstacles discussed in advance; undone homework is data, not failure.

The limits of the method, and how to recognise a good CBT therapist

The thought record is a strong tool, but not a universal one, and not a substitute for help.

When the method needs adapting or adding to

- **Cognitive load.** A thought record requires writing, concentration and abstract thinking. With severe depression, with children or with cognitive impairment, it is simplified (three columns, spoken, by voice) or therapy starts with behavioural activation clinical consensus.
- **Not every thought is testable.** Questions ("what if?"), statements about feelings and truisms don't lend themselves to weighing evidence; they are rephrased first clinical consensus; Psychology Tools.
- **Real problems.** If the thought is true, what's needed is not restructuring but problem-solving, safety and validation clinical consensus.
- **The head–heart gap.** Behavioural experiments, imagery work and attention to the tone of the inner voice can help clinical consensus; Psychology Tools.
- **Cultural context.** Where people expect advice from a specialist ("just tell me what's right"), questions can feel like evasion. It helps to explain why the therapist asks rather than tells: a conclusion the person reached themselves usually holds better than one handed to them (interpretation; the author's observation, no sources gathered).
- **Other approaches.** Third-wave therapies (ACT, metacognitive therapy) suggest not testing the content of thoughts but changing one's relationship to them, or working with the worry process; they are covered in episode 13 clinical consensus.

Important A thought record is no substitute for in-person help. If your thoughts are heavy, come back every day, get in the way of work and life, or include thoughts of not wanting to live, that is a reason to see a psychotherapist or psychiatrist, not to reach for a worksheet. See If you need help now.

How to tell whether a CBT therapist works in the spirit of the method

These pointers come from descriptions of the method and the competence framework clinical consensus; Padesky, 1993; UCL CORE:

- they ask more than they explain;
- they summarise in your words and ask you to correct them;
- they don't say "you're thinking wrong" and don't argue;
- they don't rush to a conclusion, and let you put the new thought into words yourself;
- they end with a question about the next step or a real-life test.

Warning signs are being argued with, lectured, or led to an answer decided in advance. The CBT competence framework explicitly says to avoid debate, persuasion, "lecturing" and "cross-examining", and to create doubt in place of certainty clinical consensus; UCL CORE.

Myths: a quick check

All the myths from these notes in one table.

Myth	Fact	Label
CBT means replacing negative thoughts with positive ones	The aim is an accurate, balanced thought; in experiments, affirmations worsened mood in people with low self-esteem	**Proven by research (lab experiments)**
The Socratic method means asking questions until the client admits they're wrong	That is "changing minds"; in guided discovery the therapist doesn't know the answer in advance	**The author's own account (Padesky, 1993)**
A good thought record takes the emotion to zero	A typical shift is 10–50%	**Clinical consensus**
There is one correct form from Beck	110 different forms, 55 combinations of elements	**Proven by research (review)**
A diary app is CBT	21 of 36 "restructuring tools" have no alternative-thought step; benefit untested	**Proven by research (review)**
It's proven that questioning and challenging thoughts is CBT's main mechanism	The data are preliminary; component studies are mixed	**Interpretation**
Homework is a formality	The amount and quality of completion are linked to outcome	**Proven by research (meta-analyses, correlational)**
If you understand it, it worked	The head–heart gap is common; experiments feel more convincing	**Proven by research (one small study)**
The responsibility pie is for stopping self-blame	The aim is a realistic share, not zero	**Clinical consensus**
Burns invented the double standard	He says he saw it used by Dr Maultsby and adapted it	**The author's own account (Burns, 2018)**

Test yourself

1. **How does "changing minds" differ from "guiding discovery"?** In the first the therapist knows the answer and steers towards it; in the second they genuinely don't know, and the person draws the conclusion.
2. **Name the four stages of Padesky's model.** Informational questions, listening, summarising, synthesising question.
3. **What did Braun and colleagues (2015) find, and why isn't it proof of cause?** After sessions with more Socratic questioning, depressive symptoms fell more by the next session, even after accounting for alliance. But it was one observational study of 55 patients without an experimental manipulation.
4. **How does a seven-column thought record differ from a five-column one?** Evidence for and against the hot thought has separate columns, and "rational response" is replaced by "balanced thought".
5. **Anxiety was 85 and after the thought record it's 50. Is that failure?** No. A typical shift is 10–50%; the goal is relief, not zero.
6. **Why isn't the thought challenged during the downward arrow?** Otherwise the core belief won't surface.
7. **What did Jacobson's component analysis (1996) show?** Behavioural activation without thought work did as well as full cognitive therapy and changed negative thinking just as much.
8. **What case for cognitive skills do Strunk's data (2007) make?** People who learned the skills and used them on their own had a lower risk of relapse over the next year.

Key takeaways

- Socratic dialogue is curiosity, not argument: questions the person can answer, careful listening, summaries in their words, and a question that ties it all back to the original thought.
- A thought record is the same dialogue on paper. Name emotions before thoughts, fill in the "for" column honestly, and put facts rather than reassurance in the "against" column.
- A balanced thought is not a positive one. If the facts confirm a problem, the job is to solve the problem.
- A 10–50% drop in an emotion is already a result.
- The science is honest about it: CBT works overall, while the contribution of individual cognitive techniques is still being worked out. The strongest case for them is a skill that stays after therapy and is linked to a lower risk of relapse.

- A thought record ends in action: the next step is to test the conclusion in real life (episode 6).
- Heavy, daily thoughts, or thoughts of not wanting to live, are a reason to see a professional, not to reach for a worksheet.

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If you need help now

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