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Core Beliefs Psychotherapy: Theory and Preliminary Research

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Abstract

This article introduces Core Beliefs Psychotherapy (CBP), a structured psychological intervention that incorporates elements of cognitive-behavioral, psychodynamic, and humanistic therapy in relatively novel ways. The theoretical foundations and specific techniques of CBP are described. The theory and technique are applied to two actual cases. Standardized measures were used to track the clients' progress in therapy and their treatment outcomes. Both clients showed marked improvements in the course of therapy such that their standardized scores shifted from the dysfunctional range to the non-patient normal range. A small group of therapists (n = 8) were surveyed about their experiences using CBP. In addition to commenting on clients that benefit least and most from CBP, they reported that CBP is at least as effective (if not more effective) than other commonly practiced modalities (e.g., cognitive behavior therapy). We conclude that CBP is a promising intervention for a variety of common clinical problems (e.g., depression, anxiety, and relationship difficulties). Yet, in recognition of the limitations of this initial report, we recommend further formal investigation.

Core Beliefs Psychotherapy: Theory and Preliminary Research

Core Beliefs Psychotherapy (CBP) is a structured, potentially brief psychological intervention for adults developed by Alice Brown, M.A (Brown, 2004). Clinical experience suggests that CBP can be highly effective in treating clients with depression, low self-esteem, panic disorder, codependency, compulsive overeating, and/or relationship difficulties especially when these complaints can be credibly linked to childhood experiences. CBP is generally not recommended for clients who are struggling with intense anger, impulsiveness, and destructive behaviors. CBP is an approach that not only integrates ideas from other forms of therapy but also may be integrated *within* other forms of therapy. In the present article, we describe the theory behind CBP and the specific techniques used in a typical course of CBP. In addition, we describe two cases treated with CBP and provide outcome data supporting the efficacy of this approach. We also present results of a survey of a small group of CBP practitioners attesting to the usefulness of CBP. Our goals are to introduce this therapy to people who are unfamiliar with it and to provide preliminary evidence of its potential effectiveness. We hope that this article encourages further investigation of this promising method of ameliorating psychological distress.

General Theoretical Overview

Though novel in many respects, CBP includes and integrates well-established cognitive, psychodynamic, and humanistic principles and techniques. In agreement with cognitive theorists such as Beck et al. (1979) and Ellis (1973), CBP views dysfunctional beliefs as major pathogens contributing to a client's presenting concerns. In agreement with psychodynamic theorists such as Freud (1933/1965) and Kohut (1977), CBP assumes that there is a need to directly and regularly address childhood memories and experiences during the course of therapy. Finally, in

agreement with humanistic theorists such as Rogers (1965) and Perls (1969), CBP recognizes that people can develop "false selves" in compliance with environmental demands. Therefore, CBP aims to help clients to discover their "real selves" by engaging in structured experiential exercises.

In CBP, the pathogenic cognitions are *mistaken core beliefs* (MCBs) directed at the self. Typical MCBs include: I am – inadequate, bad, selfish, unlovable, unimportant, unworthy, inferior, stupid, lazy, boring and ugly. They are "core beliefs" because they are thought to develop and solidify before the age of seven, a time when a person is particularly vulnerable to *egocentric thinking* (e.g., the tendency to see one's self as responsible for all salient environmental events; Piaget, 1929/1960). Thus, when a child is raised in an environment in which her needs are unmet or in which her parents are distressed, the child is at risk of assuming blame and developing mistaken core beliefs to explain her negative circumstances. For example, "I must be unlovable if my parents do not love me" or "I must be bad if my parents are unhappy." These beliefs are theorized to lead the child to conceal her "real self" (which has been judged to be problematic) in favor of a "coping self" that behaves in compliance with the MCBs. These MCBs and negative coping patterns are assumed to play a major role in the psychological and relational problems that bring people to therapy. MCBs are pathogenic not only because they are incorrect but also because they form a type of "mental prism" that fundamentally distorts all of one's perceptions throughout his lifespan. CBP assumes that all experiences are filtered through these distorted core beliefs. Therefore, the beliefs become self-reinforcing and more and more resistant to change. They also tend to prevent long lasting change by seducing clients to return to old dysfunctional habits.

Core Beliefs Psychotherapy also makes the humanistic assertion that there are "healthy" and "accurate" core beliefs, which include: every person is unique, important, worthwhile, valuable, lovable, and worthy of respect. One major goal of CBP is to replace mistaken core beliefs with these accurate core beliefs. It is important to underscore, however, that the aim is to change "core" beliefs that have persisted for a lifetime. This is not a matter of the more superficial task of correcting recently learned, basic cognitive distortions, such as negative interpretations about the world developed in the aftermath of a single traumatic event in adulthood. When the MCBs are corrected, the coping self should no longer be necessary and the real self can be rediscovered and nurtured back to life. It is assumed that the problems that necessitated psychotherapy will be more easily addressed after MCBs are refuted.

Practicing Core Beliefs Psychotherapy

Core Beliefs Psychotherapy was designed to access and correct mistaken core beliefs at the core level. This means that the aim is to help the client to achieve more than an intellectual understanding of her mistaken core beliefs and more than just education about accurate core beliefs. Thus, rather than engaging in Socratic questioning or interpretation (as cognitive or psychodynamic therapists might), CBP provides clients with a corrective psychotherapy experience. Moreover, rather than providing this experience only in the context of the relationship between the client and therapist as some psychodynamic theorists recommend (Weiss, 1993), CBP uses a mode of intervention that has more in common with Gestalt therapy (Perls, 1969), namely, teaching clients how to enact in-session dialogues with disowned aspects of themselves.

CBP uses the metaphor of the inner-child (IC) to capture this disowned aspect of self. The IC is the client's reconstruction of himself or herself as a five or six-year old child. This so-

called “inner-child” (IC) is literally asked to engage in the therapy process. However, the therapist’s interventions are not aimed directly at the IC. Instead, the therapist “coaches” the adult client on how to speak to his or her inner-child during the sessions. This is done in a highly structured way in which the therapist tells the adult client exactly what to say to his or her inner-child. The therapist never speaks for the inner-child. Only the adult client speaks for the inner-child.

Inner-child work proceeds in a specific sequence that comprises Core Beliefs Psychotherapy. Yet, before CBP can begin, it is important to assess whether the client is appropriate for CBP. Appropriate clients are those that present with the kind of problems described in the beginning of this article and those who seem ready and willing to participate in the experiential activities required by CBP. It is not unusual to begin working with a client using a different intervention model (e.g., cognitive behavior therapy) and then to add CBP only if the client (and the timing) seems appropriate. It is also not unusual to interrupt CBP and return to a traditional model of therapy if the client finds the CBP work to be too intense or too awkward. Many clients who interrupt CBP will eventually choose to return to it after a greater sense of safety has been established.

Like any psychotherapy, effective CBP requires a strong working alliance between the therapist and client. Not only should the therapist and client establish the usual emotional bond and agreement on the tasks and goals of therapy that has been shown to reliably predict successful outcomes (Horvath & Luborsky, 1993) but there are also a few other relationship elements that seem to be particularly helpful in CBP: (a) starting the session on time, (b) avoiding self-disclosure, and (c) moving at the client’s pace (Brown, 2004). Beginning sessions on time is thought to convey basic care and respect for the clients, which should be helpful in

dispelling their mistaken core belief that they do not deserve care and respect. Self-disclosure may divert the client's attentions from her own needs to the therapist's needs. This is especially contraindicated for typical CBP clients, who are overly attentive to the needs of others at their own expense. Finally, following the client's pace also helps the client to feel cared for and respected, and experientially disputes the mistaken core beliefs.

When an appropriate client has been identified and the therapy relationship is sufficiently secure, the rationale behind CBP is explained to the client and potential mistaken core beliefs are identified. If the client agrees to try CBP, the therapy proceeds through seven stages: (1) establishing rapport and safety, (2) telling and believing the story, (3) relinquishing blame, (4) processing anger, (5) grieving losses, (6) self discovery and nurturance, and (7) changing behaviors. In each stage (described in detail below), CBP sessions include the following six components: (1) opening, (2) getting rolling, (3) reflective responses, (4) challenging mistaken beliefs, (5) affirmations, and (6) closing (Table 1).

Establishing Rapport and Safety. In addition to establishing an alliance between the client and therapist, there is also a need to establish a trusting relationship with the inner-child. The therapist coaches the client on how to initiate safe contact with his or her IC. The client is first asked to imagine herself at age five or six and her experiences with important caretakers. Once the client has a clear mental picture of herself as a child, IC work is "opened" by specific introductory words first spoken by the therapist and then repeated by the client to her inner-child. The IC is usually called by the client's name preceded by the word "little" (e.g., a client named Jane would call her IC "little Jane"). The IC is informed that the therapist is in the room in order to establish that these dialogues will occur in a safe environment. The IC work "gets rolling" by the therapist coaching the client to ask the IC superficial questions (e.g., "What is your favorite

color?"). Questions are kept superficial to avoid upsetting the IC and with the goal of fostering safety. The client is trained to engage in Rogerian "reflective responses" (Rogers, 1965). For example, if the IC answers, "My favorite color is blue" then the therapist coaches the client to say, "Your favorite color is blue." These simple reflective responses help the IC to feel understood and listened to and they help the client to gain familiarity with the conventions of CBP. Reflective dialogue between client and IC continues through all stages of CBP. Mistaken core beliefs are not directly challenged in this stage of therapy but they are indirectly challenged by treating the client and IC with respect, care, and compassion. This behavior negates the MCBs that the client is not worthy of respect, care, and compassion. Each session is ended with an affirmation. For example, the therapist coaches the client to tell her IC that she enjoyed being with her. The IC is also told to expect that they will talk again in the future when they meet with the therapist. Because many clients initially find this process unnatural, awkward, and even "hokey," the therapist may need to normalize these feelings and encourage the client to continue with the process despite her discomfort. However, if clients exhibit extreme reluctance to try more inner-child work, the therapist should discontinue CBP until such time that the client seems interested and ready to proceed.

Telling and Believing the Story. Once the IC begins to share more details about the childhood circumstances that contributed to her MCBs, she has entered the "telling the story" phase. IC work in this stage opens with the same introduction that was described in the prior stage. However, the "getting rolling" process is facilitated by reminding the IC about what she talked about in the previous session and by asking her how she would like to spend the time. The therapist coaches the client to respond reflectively to the IC's statements. Eventually this is not necessary because clients will spontaneously engage in reflective responding without coaching.

MCBs are not challenged at this stage unless the IC or client expresses doubt about whether her childhood experiences were as negative as she is remembering them. In which case, the therapist will coach the client to validate the ICs feelings, thoughts, perceptions, and needs and to tell the IC that she is not to blame for wanting her basic needs attended to. Sessions close with the same affirmations described in the initial stages.

Relinquishing Blame. Once a clear picture has emerged about the circumstances that generated the client's MCB and the client seems ready to accept the veracity of her story, the next step is to actively challenge the MCBs. The key objective in this phase is to help the IC to abandon the childish idea that she caused her negative experiences. Moreover, the client is helped to understand (and accept) the "accurate" belief that children are entitled to love, respect, and appropriate attention. CBP operates under the assumption that once these cognitive changes are made at a core level then the client will abandon her coping self in favor of her real self and also show improvement in symptoms. Sessions are opened in this phase just as they were in the previous stages. However, once the IC dialogue "gets rolling," the therapist should anticipate that clients might resist changing their MCBs. This is to be expected if these beliefs have really organized much of the client's life experience. The therapist challenges MCBs at this stage by coaching the client with statements such as "it was not your fault," and offering rational alternatives to irrational beliefs, while continuing to provide the corrective emotional experience of acceptance, love, and validation. For example if the IC blames himself for making his parent unhappy, the therapist coaches him to tell the IC, "it is a parent's responsibility to get help if they are depressed, and help is available, children do not make their parents happy or unhappy, it wasn't your fault." When the therapist encounters resistance, interventions become less direct

and instead revert to reflective responses. Sessions in this stage end with the same affirmations that characterized earlier stages.

Processing Anger. As the client begins to let go of the blame for earlier injustices, she will begin to feel anger toward those who were actually responsible (e.g., her parents). The therapist helps the client to understand that anger is a normal and healthy emotion under these circumstances. The therapist also helps the client to process the anger in a healthy way. This is done by helping the IC to express her anger directly in role-play confrontations. Sessions are ended by congratulating the IC for bravely expressing anger and by affirming that the IC is still acceptable and lovable even when she is expressing anger. Clients are not encouraged to actually confront their parents. They are warned that during this stage of the therapy they may feel irritable outside of session and are advised to caution others in their lives about this possibility and to schedule extra sessions as needed to process excessive anger.

Grieving Losses. The end of the anger phase is marked by reductions in the client's anger. On the other hand, there is often a brief period of elevated sadness and grief. This grief is addressed by validating the IC's feelings using reflective statements that are oriented to raising the client's consciousness about grief and loss such as, "it is so sad that you were treated that way, your life could have been so different." Grief is also addressed in CBP by reinforcing the relationship between the client and the IC. The goal is to help the client to replace their lost attachment to their parents with a new healthy attachment to themselves. The client is also taught how to "hug" their inner-child. Because this can be awkward and seem weird to the client, the therapist can normalize and model the practice by hugging "their own inner-child."

Self Discovery and Nurturance. The task in this stage is to help the client to abandon unhealthy coping mechanisms and to foster the emergence of the real self. For the first time in

the therapy, the client is given a regular homework assignment. She is instructed to conduct daily "check-ins" with her IC outside of therapy in a manner similar to what she has been doing in her therapy sessions. The client is to determine what her IC is feeling and needing in what is called a "feeling/needing exercise." The theory behind this practice is that the client's needs and feelings were frequently ignored when she was a child and thus the client has learned to ignore herself. This exercise is designed to help the client to develop a new habit of self-awareness and self-responsiveness. This process will also help to clarify the goals and desires of the real self, which may have been obscured by the coping self.

Changing Behaviors. One of the basic premises of CBP is that many maladaptive behaviors are maintained by MCBs. It is assumed that maladaptive behaviors will be difficult to change while MCBs are still present. Yet, even after MCBs are changed, maladaptive behaviors may persist out of habit. The last stage of CBP is devoted to systematically changing maladaptive behaviors, which can be done by employing standard psychotherapy techniques such as clarifying, exploring, summarizing, and educating. The client is encouraged to continue daily IC check-ins outside of session both for the remainder of therapy and for at least six months to a year. Then they can maintain the practice of self-awareness and self-care by simply checking in with "themselves," without needing to use the IC construct. It is assumed that this practice will solidify healthy core beliefs and foster healthy nurturing.

Case Examples

We will now describe two cases treated with CBP and present evidence that the clients improved while in CBP treatment. Two different certified CBP therapists treated one male and one female client. The first case will be described in more detail than the second. In both cases, CBP was embedded within other therapeutic modalities including psychoeducation and cognitive

behavioral therapy but we will focus on the CBP aspects of the treatments. The clients were instructed to complete self-report measures of psychological distress following every fourth session of therapy for the first 20 sessions of therapy. Specifically, the clients completed: (a) the *Rosenberg Self Esteem Scale* (Rosenberg, 1965), (b) the *Symptom Checklist-90-Revised* (Derogatis & Savitz, 2000), and (c) the *Inventory of Interpersonal Problems* (Horowitz et al., 1988). All of these measures are both reliable and valid and all have been widely used in previous rigorous research to assess change in psychotherapy. Thus, we used responses to these questionnaires as preliminary evidence of client improvement in CBP. To facilitate comparison between the therapy process and progress on the standardized measures, we will describe the therapy process in blocks of four sessions.

Case #1: The Case of MB

MB was a 35-year-old male who presented tearfully with sad mood and anxiety. The precipitating event for his negative affect and for the therapy was that his wife of 13 years requested a marital separation citing a need for "space." As the therapist probed for relevant background information MB revealed that his wife had been frequently verbally and physically abusive toward him. Sometimes his young daughters witnessed the abuse, which upset MB to the point of tears as he related this information to his therapist. Concealing family conflict was important to MB because he recalled that the constant turmoil in his own family of origin was actively hidden from their surrounding highly religious community. Making a good impression in public was very important in his family. MB described his mother as "out of control" and his father as "playing the victim." He reported that he lived in "constant fear and anxiety" that his family's dysfunction would be revealed to the community. From a CBP perspective, this family environment was seen as fertile soil for the development of mistaken core beliefs. MB's

presenting problems were framed as originating in mistaken core beliefs developed in childhood and the strategies that he adopted to survive in that environment. At intake, MB met DSM-IV criteria for anxiety disorder NOS (300.02) and adjustment disorder with depressed mood (309.00).

In the first four sessions of the treatment, the therapist conducted an assessment of the client's chief complaints and his broader social history. The therapist also attended to developing their therapeutic alliance. CBP was introduced to the client in the second session. He showed some insight into the ways that his passivity with his wife, his feeling of being victimized by her, his anxiety about how his marital problems affected his young children, and his questions about his own worth, were repetitions of his childhood experiences. In particular, MB readily acknowledged that his core beliefs were preventing him from responding effectively to his marital crisis. However, when asked about his childhood home environment, MB reported that he was "loved" by both of his parents and that all of his "needs were met." The first IC work (establishing rapport) was implemented in the third session. MB readily engaged in this work with minimal awkwardness. He easily picked up the rhythm of reflecting his IC's responses. In fact, he became immediately tearful when introduced to his inner-child. He described his inner-child as "very outgoing, articulate, likeable, mature, responsible and wanting to please" but also "lonely and estranged." MB reported surprise at the memories and images that arose during his inner-child work. CBP interventions continued during the fourth session. The dialogue with the IC focused on his relationship with his parents. The IC was able to eagerly and enthusiastically describe what he enjoyed doing with his father but he became tearful when asked what he enjoyed doing with his mother. He said, "I wish that I could play with her. I think she thinks other things are more important." Outside of therapy, MB's wife

informed him that she wanted the separation to be permanent. Therefore, MB moved out of his home.

During the following four sessions (5-8), the patient relocated to a serene cabin in the woods. He reported feeling "in touch" with himself, relieved, and happy. His children enjoyed visiting him there. CBP work continued in the fifth session, focusing on his relationship with his mother. He recalled that his mother constantly drilled him on lessons from the Bible and from school, which the patient found frustrating. He remembered having little choice about how he spent his time with his mother. He also remembered that his mother was sad a lot because of her ongoing fights with MB's father. He recalled that his mother had been "vicious" towards his father. CBP work continued in session seven when the IC first revealed that he believed that he was the cause of his mother's unhappiness. The therapist challenged this MCB by coaching the client to tell the IC, "It's not your job to make mommy happy. It's mommy's job to make you happy." The therapist also worked toward helping the client to see that his childhood problems were not his fault. In the following session, the IC acknowledged that his mother's unhappiness might not be his fault. By this point in the therapy, MB expressed great enthusiasm about the CBP work. He noted that he was beginning to be less compliant in his relationships with his wife and mother. His relationship with his daughters remained close and, contrary to his worries, their lives were not "ruined" by his separation from his wife.

In the next four sessions (9-12), the client began a new relationship with a female coworker and established healthier communication patterns with his wife. CBP work continued in the 10th session at the patient's request but did not occur in sessions 9, 11, or 12. The CBP work focused on "believing the story" and "relinquishing blame" stages. MB's inner-child revealed that he was worried that he was not smart enough for his mother to enjoy being with

him. Outside of therapy, MB noted that his current relationship with his mother was improving and that he was gaining increasing awareness of his tendency to take on a caretaker role in his relationships including his new romantic relationship.

After a session of traditional therapy and a month lost because of the patient's business travel, CBP resumed in session 14 at MB's request. His IC revealed that he believed that his mother was acting like the victim but that he was worried that his mother would "fall apart" if he were honest with her about this assessment. He also admitted that despite his love for his father, he felt that he could not count on him. Anger and grief emerged in this phase and the therapist worked to help the IC feel safe enough to confront his parents in role-plays. The therapist coached the client to emphasize that MB's parents' problems were not the IC's fault.

During sessions 17 through 20, the IC admitted to underlying feelings of shame and the belief that he was unworthy of love. Outside of therapy, MB reported feeling guilt about being away from his daughters for long durations when he had to travel for business. In session 18, CBP resumed. The IC confronted his father with anger but was still afraid to confront his mother. Thus, CBP at this stage of treatment was devoted to processing the anger. The therapist explored the forces making it difficult for him to confront his anger at his mother and stressed that core beliefs would remain until the IC faced his anger and confronted her. By session 20, the client was very pleased with himself regarding the relationships he was creating with his daughters and with his new girlfriend.

Though self-report measures were only obtained for the first 20 sessions, the CBP treatment continued for an additional 22 sessions (which will be described in less detail). This period was marked by frequent disruption in the CBP work due to the patient's work-related travel, stressors related to his divorce, another relocation, and various issues that required focus

on his current relationships with his daughters, girlfriend, and parents. CBP work was done in session 21 but was then put on hold until session 35. In sessions 37 and 41, he confronted his mother with his anger and in session 42 he grieved his losses and comforted his inner-child.

By the end of the treatment, MB still met DSM-IV diagnostic criteria for anxiety disorder NOS (300.02) but his adjustment disorder was entirely resolved. According to the therapist, CBP made a central and important contribution to the client's recovery. It helped to identify MB's conflict between his wish for approval and his feeling of not deserving approval. CBP revealed that the strategy he employed as a young child was to try to make his mother happy and he repeated this pattern in his relationship with his ex-wife and his other significant relationships. Additionally, CBP was seen as helpful because its experiential nature blocked MB's tendency to obsess and intellectualize.

The therapist was asked to identify specific psychological problems assessed by the self-report measures that were particularly relevant to this case. The problems that she picked: low self-esteem, depression, anxiety, interpersonal sensitivity, excessive responsibility, overly expressive, and overly nurturing are tracked over time in Figures 1 through 3. The data shows that over the first 20 sessions of treatment, MB reported: (a) improved self-esteem (Figure 1); (b) reduced depression, anxiety, and interpersonal sensitivity (Figure 2); and (c) reduced excessive responsibility, expressiveness, and nurturance (Figure 3). All of these measures were in the normal range by the end of treatment.

Case #2: The Case of CV

CV was a 55-year-old female who sought therapy for "overwhelming fear and anxiety" exacerbated by her brother's death, which occurred two months prior to beginning treatment. Her recent history included going on short-term disability from her stressful job in response to her

brother's death. Her anxiety was triggered by the responsibilities associated with becoming executor of her brother's estate. She reported great difficulty making even simple decisions and noted that she was facing considerable hostility from her brother's family. She reported feelings of depression and anxiety when attempting to set boundaries with them and others. At intake, she met DSM-IV criteria for anxiety disorder NOS (300.00), major depression (296.32), and bereavement (V62.82). She had been taking Lexapro (20 mg) prior to treatment and during the initial phases of treatment. CV reported being neglected and both emotionally and physically abused by her parents in childhood. Prior to beginning the current therapy, CV had been briefly exposed to CBP both through a single session of IC work and via information on the Core Beliefs Psychotherapy website (www.core-beliefs-psychotherapy.com). The client believed that CBP would be helpful to her. The therapist concurred that CBP could be effective at helping CV to set appropriate boundaries, to monitor her internal states more clearly, and to alleviate her depression and anxiety.

During the initial four sessions, the therapist conducted a diagnostic assessment and life history interview. The client was referred for medication consultation and was prescribed Gabapentin (300mg) and Lorazepam (1 mg) in addition to the Lexapro that she had been taking prior to treatment. Formal CBP began in the second session with an introduction to the rationale behind CBP and an identification of the client's likely MCBs. In particular, the therapist believed that the client suffered from MCBs that she was "inadequate, unimportant, inferior, untrustworthy, boring, and stupid." CV seemed very comfortable the IC work. Perhaps this was because of her prior experience with CBP.

During sessions 5-8, the therapist worked to facilitate her return to work and focused on helping CV to set appropriate boundaries with her co-workers and her deceased brother's family.

CBP inner-child work proceeded through the fifth, sixth, and seventh sessions. The CBP sessions focused on "telling and believing the story" and "relinquishing blame." Though CV continued to cooperate with the CBP procedures, she experienced some difficulty believing that she was not to blame for her negative childhood experiences.

The next four sessions (9-12) also focused on helping CV to achieve appropriate boundaries with her brother's family and in her other relationships. The client discontinued Lexapro between the 9th and 10th sessions and began taking Effexor XR (75 mg). CBP techniques were used in sessions 9, 10, and 12. The client seemed to accept the idea that she was not to blame for the abuse that she experienced in childhood. Therefore, the remaining sessions were devoted to helping her to process anger. The client reported difficulty expressing anger toward her parents. Consequently, the therapist helped her to role-play expressing anger while imagining that her parents were behind a glass wall with one-way speakers. This seemed to help her to effectively process her anger toward her parents.

Boundary setting continued to be a major goal in the next four sessions (13-16). The client also increased her Effexor XR dose to 150 mgs. CBP inner-child work continued in sessions 13, 14, and 15 aimed at helping CV to grieve her losses and to discover and nurture her real self. The client reported difficulty with the check-in procedure because her IC did not "know what she needed." Outside of sessions, the client showed marked improvement in boundary setting as evidenced by deciding to let her brother's family handle his estate.

In the next phase (sessions 17-20), the therapy focused on helping the client to improve in identifying her feelings and needs and in being able to make those needs known to others. CBP work continued in the 17th and 19th sessions with an emphasis on teaching the client how to accomplish check-ins in order to identify her internal needs. Though the client initially reported

difficulty remembering to do check-ins and frustration in not knowing what she needed, she eventually became skilled at identifying her internal needs. The CBP was completed within 20 sessions but the treatment continued for an additional seven sessions while she consolidated her gains. The therapist reported that "CBP was very effective in decreasing the anxiety and depression [that the client] felt when unable to set boundaries with anyone."

The therapist identified the following problems as particularly important to track on the standardized measures: low self-esteem, depression, anxiety, interpersonal sensitivity, trouble with intimacy, excessive responsibility, overly controlling, and overly nurturing. As with the other case, CV completed self-report measures at the end of every fourth session for the first 20 sessions. In addition, measures were obtained at the end of treatment (session 27). Figures 4 through 6 show CV's progress on these symptoms during the 27 sessions of therapy. CV's evidenced low self-esteem in the early part of her treatment (Figure 4). Her depression, anxiety, and interpersonal sensitivity scores were all higher than the scores of the average female outpatient (Figure 5). All of her interpersonal problems were similar to or more severe than outpatient norms in the early phase of treatment (Figure 6). In general, CV showed improvement on all of these measures over the course of treatment. Specifically, as therapy proceeded: (a) CV's self esteem increased, (b) her depression, anxiety, and interpersonal sensitivity decreased, and (c) her intimacy problems, excessive responsibility, excessive control, and excessive nurturance of others decreased. By the end of treatment all of her scores were within the normal range.

Survey of CBP Therapists

We surveyed eight "certified" (i.e., fully trained and experienced) Core Beliefs psychotherapists about their experiences using this form of therapy. Seven are female and one is

male. Six are Masters level therapists and two are Doctoral level therapists. Their average age was 54.7 years old with a range of 50 to 60 years. At the time of their participation in the present study, they had been fully licensed practitioners for an average of 13.8 years with a range of 6 to 22 years. Their caseloads comprised an average of 21.7 clients per week with a range of 8 to 37 clients. Most of the therapists learned about CBP at a seminar and then sought formal CBP training and certification.

In addition to providing information about their demographics and prior training, therapists were asked to answer several questions about CBP. They reported an average of 3.3 years of experience using CBP (range 1.8 to 10 years) and said that they had treated an average of 44 clients with CBP (range 9 to 220 clients). They were also asked to rate the "usefulness of CBP as a therapeutic tool" using a 5-point Likert type scale ranging from 1 = poor to 5 = excellent. The mean rating was 4.7 (range 4 to 5). They also estimated the percentage of their CBP clients who showed a "positive outcome" following treatment. The mean rating was 80.6% (the range was 70 to 90%). One respondent remarked, "I cannot imagine practicing psychotherapy without CBP, it is an excellent therapeutic tool."

What Kind of Clients Were Treated with CBP? The respondents reported that they had used CBP to treat clients with: major depression, dysthymia, generalized anxiety, panic, obsessive/compulsive, separation anxiety, posttraumatic stress disorder, bipolar disorder, adjustment disorder, low self-esteem, attention deficit disorder, intermittent explosive disorder, sexual trauma, alcoholism, self injury, marital and relational conflicts, eating disorders, and personality disorders. Among these, CBP was most frequently used in the treatment of major depression (n = 7), anxiety disorder NOS (n = 5), dysthymic disorder (n = 3), eating disorders (n = 3), and relationship problems (n =3).

What Kind of Clients Respond Best to CBP? According to the therapists, the problems that responded best to CBP were: major depression, dysthymia, generalized anxiety disorder, panic disorder, adjustments disorders, low self-esteem, bipolar disorder, separation anxiety disorder, self-injury, and couples/relationship issues. Among these, there was some consensus that depression (n = 4) and Anxiety NOS (n =3) were particularly responsive to CBP.

What Kind of Clients Yielded Poor Responses to CBP? Some therapists reported that CBP was inappropriate for some clients with: narcissistic, paranoid, and borderline personality disorders; alcoholism; intermittent explosive disorder, and attention deficit disorder. However, there was no strong consensus among respondents about which problems were not appropriate for CBP. In fact, one therapist noted that the underlying constructs and concepts from CBP could be incorporated into treatments with patients who are inappropriate for formal CBP.

How Does CBP Compare with Other Forms of Therapy? Therapists were asked to indicate what other forms of therapy they were trained in using. Respondents reported expertise in using cognitive behavior therapy (n = 7), behavior therapy (n = 1), systems centered therapy (n = 1), solution focused therapy (n = 1), interpersonal therapy (n = 1), theophostics (n = 1), psychodrama (n = 1), client centered therapy (n = 1), psychodynamic (n = 1), dialectical behavior therapy (n = 1), emotional freedom technique (n = 1), neurolinguistic programming (n = 1), and motivational enhancement therapy (n = 1). Therapists were also asked to compare CBP with other forms of therapy in which they had been trained using a 5-point scale (1 = CBP is much less effective, 2 = CBP is less effective, 3 = CBP is just as effective, 4 = CBP is more effective, and 5 = CBP is much more effective). The responses ranged from 3 to 5 with a mean rating of 3.75, which is closest to a rating of “CBP is more effective” than other forms of therapy.

What are the major strengths of CBP? The therapists noted that CBP "gets to the root" of the issues quickly and effectively. Consequently, clients are able to learn, change, and grow more expeditiously than they might in other forms of psychotherapy. For example, it quickly dismantles inaccurate and negative self-talk. It seems to directly access the often crippling issues of shame and guilt. It encourages cathartic expression including the processing of childhood rage. It teaches clients to validate and care for themselves. One therapist observed that it heals low self-esteem in many clients who have had many years of prior therapy with no change in self-esteem. CBP was seen as "excellent at empowering compliant victims of abuse to set boundaries and stop allowing themselves to be abused." Its experiential nature was found to move clients from intellectualizing into the realm of feelings and connection with their authentic selves, which consequently strengthens the integration of the self. At a more superficial level, the structured approach has the advantage of reducing anxiety about "what" will happen in therapy, "where" the therapy is going and "why." This keeps clients engaged and hopeful and probably contributes to the overall alliance. Indeed, it seems to provide hope to patients who feel hopelessly stuck. An additional advantage of CBP is that the client is always in control of the pacing, which fosters safety in the process. Finally, one therapist noted that CBP is flexible enough so that its underlying constructs can be incorporated into therapies that do not include "formal CBP."

What are the major weaknesses of CBP? The responding therapists only generated a few weaknesses with CBP. These included: (a) clients are hesitant to enter such an intense process, (b) clients report (almost universally) that the process feels awkward, especially in the beginning stages, and (c) low functioning clients seem to have greater difficulty tolerating the process and

must be introduced to it slowly, with great care, and only after establishing a significant level of trust in the therapeutic relationship.

Discussion

Core Beliefs Psychotherapy (CBP) is a novel approach to treating a range of complaints that challenge psychotherapists. Though there is much new and potentially unfamiliar in CBP (e.g., IC work), the skeptical reader can take some comfort in the fact that its key theoretical propositions and techniques are grounded in time-tested clinical wisdom. As noted above, CBP borrows ideas and procedures found in cognitive behavior therapy, psychodynamic therapy, and humanistic therapy. For example, in cognitive behavior therapy, the active disputing of dysfunctional cognitions has been found to be an effective way of changing them (Ellis, 1973). Person-centered therapy pioneered reflective responding as a means to convey empathy and to help clients deepen their experience of themselves (Rogers, 1965). Finally, some psychodynamic therapies emphasize in-session corrective emotional experiences as their central mutative factor to correct the effects of negative childhood experiences (Weiss, 1993).

Furthermore, students of psychotherapy may recognize that in addition to incorporating specific techniques found in other forms of psychotherapy, CBP contains a number of "common factors" long thought to be important in effective psychotherapy (Frank & Frank, 1991). In addition to depending on a traditional therapeutic *relationship*, CBP likely enhances the congruence between therapist and client through its "coaching" technique in which therapists and clients literally speak the same words. CBP also contains a number of *rituals* such as the opening and closing words of each IC dialogue. These rituals are a predictable part of CBP that help the client to experience the therapeutic encounter as a healing event in much the same way that the use of a stethoscope signals healing in a physician's office.

It should be acknowledged, however, that CBP contains some elements that may raise doubts and concerns in some practicing clinicians. For example, some may feel uncomfortable with using the metaphor of the "inner-child" because of its connection with faddish pop psychology of yesteryear. Though we believe that this term provides a straightforward and accessible characterization of the concept, it is certainly not necessary for clinicians to use this term in order to use the techniques outlined in this article. A second area of concern may arise from the assumption in CBP that negative childhood experiences reported by clients actually happened. It is well known that all memories are to some extent reconstructed (Loftus, 2003) and it is now recognized that clinicians may unwittingly lead clients to reconstruct memories that never occurred (Geraerts et al., 2008). Though we advise all clinicians to be very careful not to impose memories on clients, our clinical experience suggests that the typical CBP patient is more likely to have the opposite problem. That is, they are more likely to deny past injustices because they feel guilty about thinking critical thoughts about their parents or caretakers. Furthermore, CBP does not aim to excavate specific "repressed" memories. Instead, it aims to achieve an accurate assessment of the general environment in which the client grew up. It is presumed that the client can be generally accurate at that level of abstraction. A final potentially unsettling feature of CBP is its highly directive nature. Clinicians from the psychodynamic or client-centered traditions may find themselves fundamentally opposed to telling clients exactly what to say in therapy (as CBP coaching requires them to do). Even cognitive behavioral therapists, who are generally more comfortable with being didactic and directive, may find themselves challenged by providing such detailed structure. In response to this, we note that most forms of therapy require therapists to engage in behaviors that may at first seem unnatural. Many psychodynamic therapists are reluctant to offer their first transference interpretation (e.g., telling

a patient that she is being seductive in therapy like she was seductive with her father). Many client-centered therapists have difficulty refusing their first client's direct request for advice (especially when the therapist had a clear opinion on the subject). Thus, we see CBP as yet another set of teachable clinical skills that can become second nature to clinicians who wish to incorporate these techniques into their practice.

As a treatment conceived and developed in the arena of clinical practice, CBP has not heretofore been subjected to formal empirical scrutiny. We provided preliminary empirical evidence in the form of standardized assessment on two cases and a modest survey of clinicians about their satisfaction with CBP. We believe that the case examples showed how CBP can be used in conjunction with other approaches to address problems that are typically seen in private practice settings. The case examples suggest that clients treated with CBP can show marked improvement in self-esteem, depression, anxiety, interpersonal sensitivity, and other interpersonal problems. Moreover, in most cases, these improvements shifted clients from the clinically distressed range to functioning consistent with the non-patient population. The survey showed a great deal of consensus among experienced CBP practitioners that CBP can be a highly useful clinical tool that appears to be at least as effective (or more effective) than other commonly practiced modalities (e.g., cognitive behavior therapy). Moreover, these clinicians have found CBP to be most effective with clients presenting with depression or unspecified anxiety. Other problems were cited as being less amenable to CBP treatment but there was little consensus about specific diagnoses. In general, the problems that were judged to be less appropriate for CBP were those that involved impulsivity or acting out. Such clients may misuse CBP to justify their maladaptive behavior as someone else's fault. Finally, several strengths and

a few weaknesses were articulated about CBP, which argued forcefully for its inclusion in these clinician's tool kits.

Taken together, these findings suggest that CBP shows promise as a powerful and effective therapeutic approach. Yet, further investigation is warranted because of major limitations of the data presented in this article. Case studies are inherently limited in that one cannot assume that positive results in a few cases will necessarily generalize to other cases (Pole, 2001; Pole et al., 2002; Pole et al., 2008; Serralta et al., in press). In addition, the nature of CBP is such that the techniques are often embedded within other therapeutic interventions. For example, in both cases, the clients received CBT interventions in addition to CBP interventions. In one of the cases (CV), the client was taking psychoactive medication while receiving CBP. Thus, we cannot conclude that the changes that were observed in the treatments were due to the CBP interventions. Future controlled studies will hopefully address this area of ambiguity.

The therapist survey is limited by its small sample size and the fact that all respondents were interested enough in CBP to seek training and certification. It is not clear whether these results would generalize to a larger sample of therapists randomly assigned to learn CBP. Also, several of the survey questions (e.g., those pertaining to the diagnoses that were most responsive to CBP) allowed open-ended responses. Thus, respondents had to rely on recall rather than recognition in making their responses. Respondents who were less motivated would likely produce less detailed responses. Some conclusions drawn from the survey are also limited because they rely on clinician opinion rather than gathering of controlled data. For example, just because several respondents believed that CBP is as effective as cognitive behavior therapy does not make it so.

Despite these limitations, we believe that this article makes important and necessary contributions. It provides a detailed introduction to a form of therapy that will be unfamiliar to many readers and thus offers new ideas to clinicians seeking to expand their repertoire. It also lays the groundwork for more rigorous empirical investigations. We recognize and endorse the goals of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). Consequently, we recognize that many types of evidence can contribute to that goal. Case studies and surveys of clinicians are an important start. More controlled case studies, randomized trials, and effectiveness studies will be critical next steps. Ultimately, science and knowledge progress slowly and incrementally. One must crawl and walk before she or he can run and leap. We are delighted to have taken these first empirical steps for Core Beliefs Psychotherapy with you.

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Table 1

*Stages and Components of Core Beliefs Psychotherapy (CBP)**

Stage	Opening	Getting rolling	Reflective responding	Challenging mistaken core beliefs (MCBs)	Affirmations	Closing
Establishing rapport and safety	Coach client to imagine self at 5 or 6. Review childhood environment and mistaken core beliefs.	Coach the client to ask IC superficial questions (e.g., "What is your favorite color?").	Teach reflective listening; demonstrate reflective responses.	MCBs are indirectly challenged by treating the client and IC with respect, care, and compassion.	End session with affirmations (e.g., coach the client to tell her IC that she enjoyed being with her).	Process IC dialogue with the client; normalize feels of awkwardness or discomfort.
Telling and believing the story	Coach client to say, "Hi __ , we're here with (therapist) how would you like to spend our time?"	Coach client to remind IC about last session's dialogue.	If necessary, remind client to respond reflectively to the IC's statements.	If client or IC doubts her own memory, coach the client to validate the ICs feelings, thoughts, perceptions, and needs.	Same as above.	Same as above.
Relinquishing blame	Same as above	Same as above.	Same as above.	Actively challenge MCBs; coach the client with statements such as "it was not your fault" and continuously coach (and provide) acceptance, love,	Same as above.	Same as above.

				and validation		
Processing anger	Same as above.	Remind the IC about the anger discussed in previous session.	Same as above.	Facilitate role-plays in which those who neglected/abused them are confronted.	Same as above.	Coach the client to tell IC that she is proud of her for expressing her anger.
Grieving losses	Same as above.	Same as above.	Coach reflective statements to raise the client's consciousness about grief and loss.	Reinforce the healthy relationship between the client and the IC	Same as above.	Same as above.
Self discovery and nurturance	Same as above.	Same as above.	Help client determine what her IC is feeling and needing in what is called "a feeling/needing exercise."	Help the client abandon unhealthy coping mechanisms and foster the emergence of the real self.	Same as above.	First homework assignment: conduct daily "check-ins" with her IC outside of therapy
Changing behaviors	Same as above.	Same as above.	Same as above.	Use clarifying, exploring summarizing, and education to change maladaptive behavior.	Same as above.	Encourage daily IC check-ins to foster healthy core beliefs.

Note. Core Beliefs Psychotherapy proceeds through seven stages each of which generally follows six components outlined above.

*Discontinue CBP if client expresses extreme reluctance or distress.

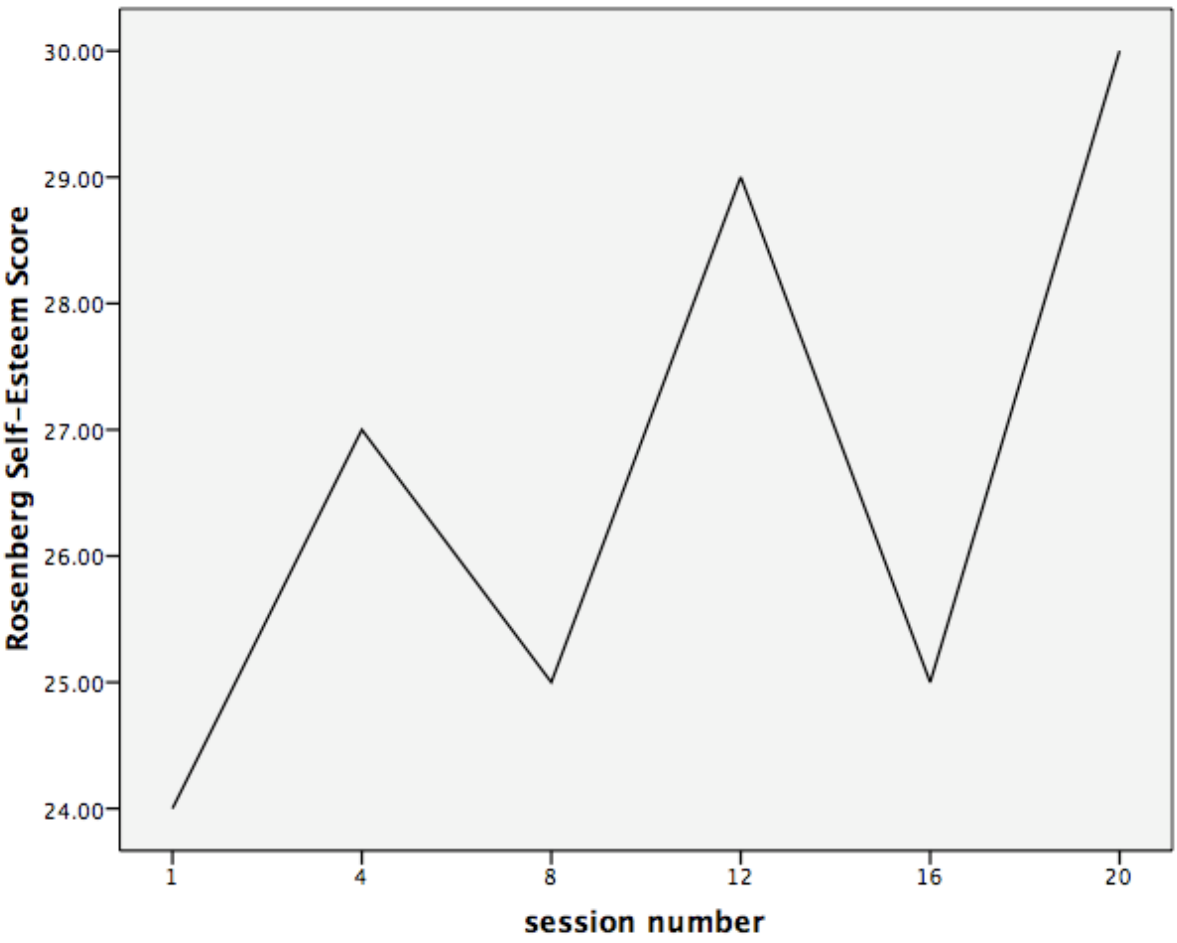

Figure 1. Changes in self-esteem over time in Case #1 (MB). Self-esteem is measured using the *Rosenberg Self-Esteem Scale*. Scores range from 0 to 30. Scores below 15 suggest clinically low self-esteem (Rosenberg, 1965).

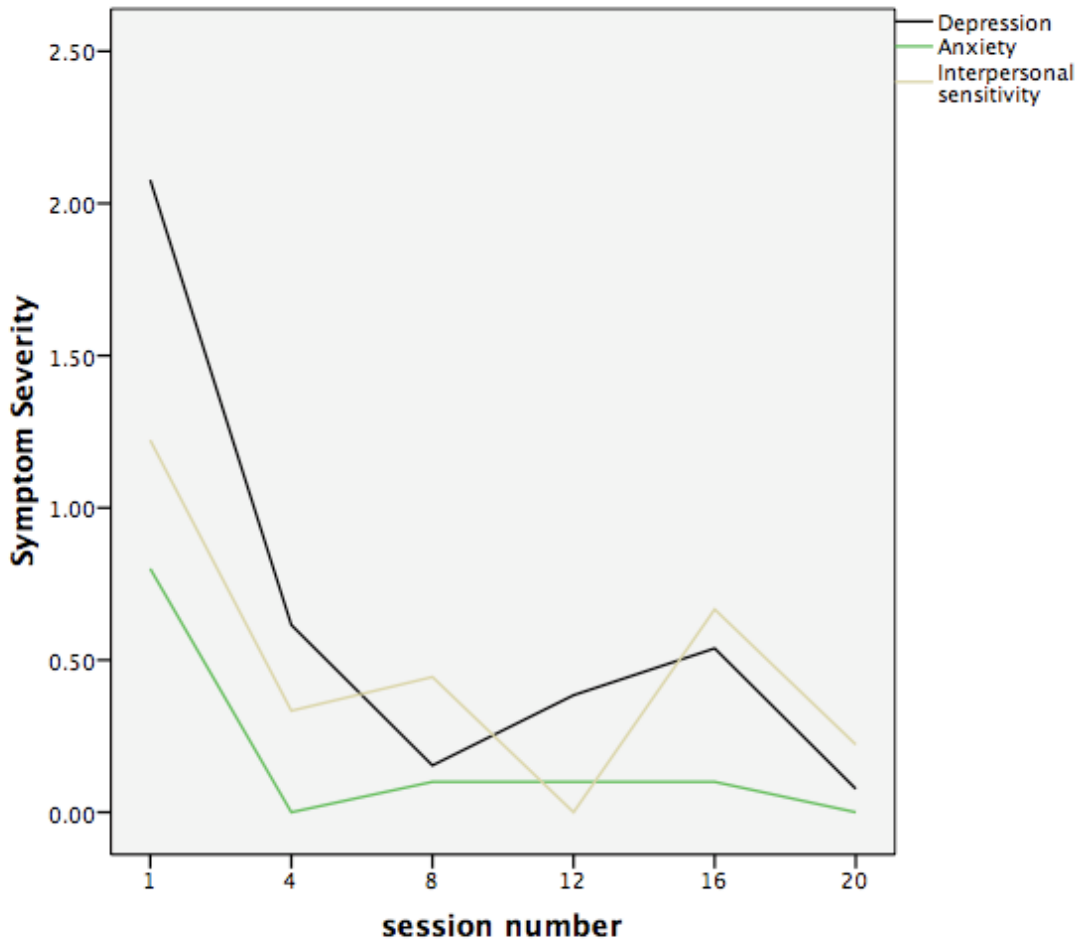

Figure 2. Changes in psychiatric symptoms over time in Case #1 (MB). Psychiatric symptoms (depression, anxiety, interpersonal sensitivity) are measured using the *Symptom Checklist-90-Revised*. Scale scores range from 0 to 4. Normative data suggest the following average scores for male outpatients beginning psychotherapy: depression (M = 1.59, SD = .92), anxiety (M = 1.30 SD = .83), and interpersonal sensitivity (M = 1.36, SD = .90). Males in the nonpatient population normatively report the following average scores: depression (M = .28, SD = .31), anxiety (M = .22 SD = .27), and interpersonal sensitivity (M =.25, SD = .31) (Derogatis, 1994).

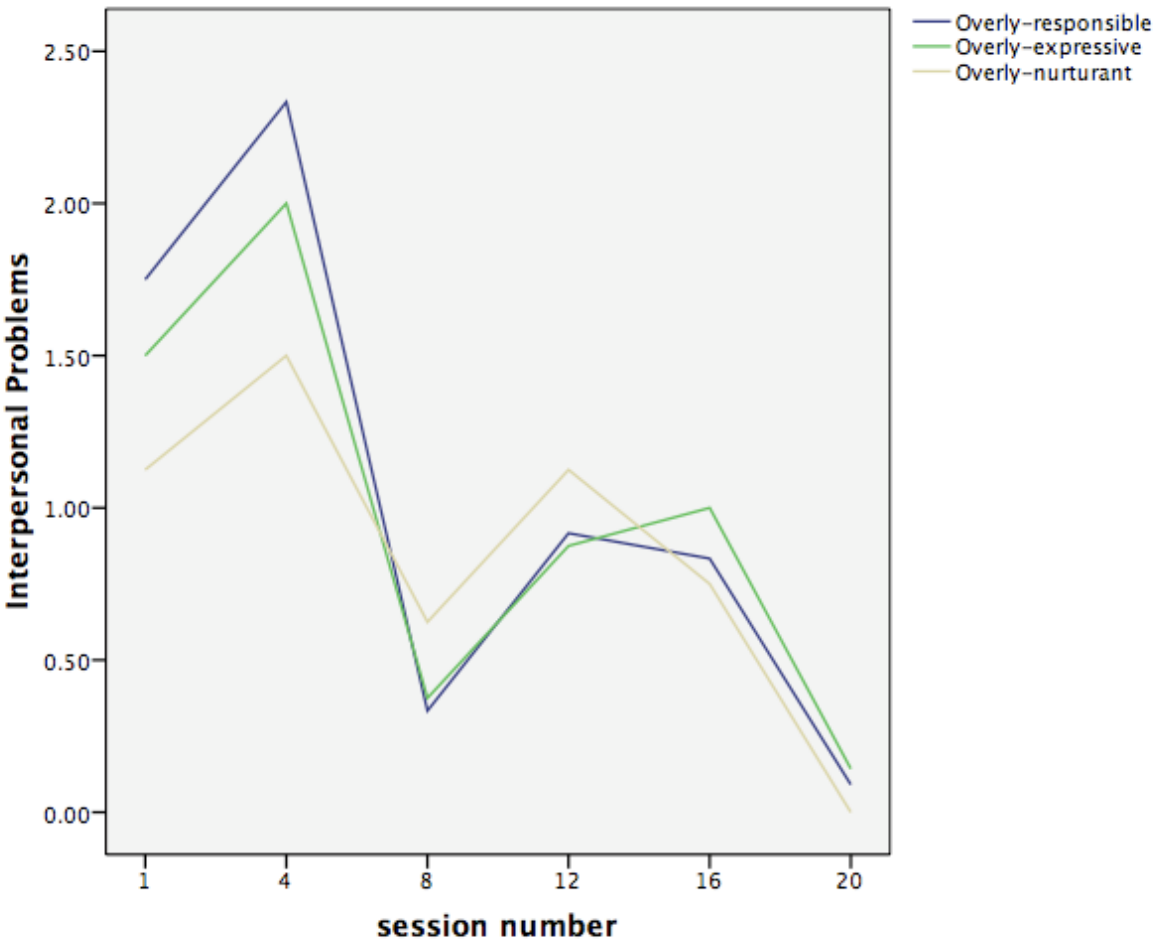

Figure 3. Changes in interpersonal problems over time in Case #1 (MB). Interpersonal problems (overly-sensitive, overly-expressive, and overly-nurturant) are measured using the *Inventory of Interpersonal Problems*. Scale scores range from 0 to 4. Normative data suggest the following average scores for outpatients beginning psychotherapy: overly-responsible (M = 1.81, SD = .80), overly-expressive (M = 1.78, SD = .72), overly-nurturant (M = 1.50, SD = .75). Normal scores in the non-patient population are as follows: overly-responsible (M = 1.48, SD = .59), overly-expressive (M = 1.52, SD = .59), overly-nurturant (M = 1.25, SD = .60) (Horowitz et al.,1988).

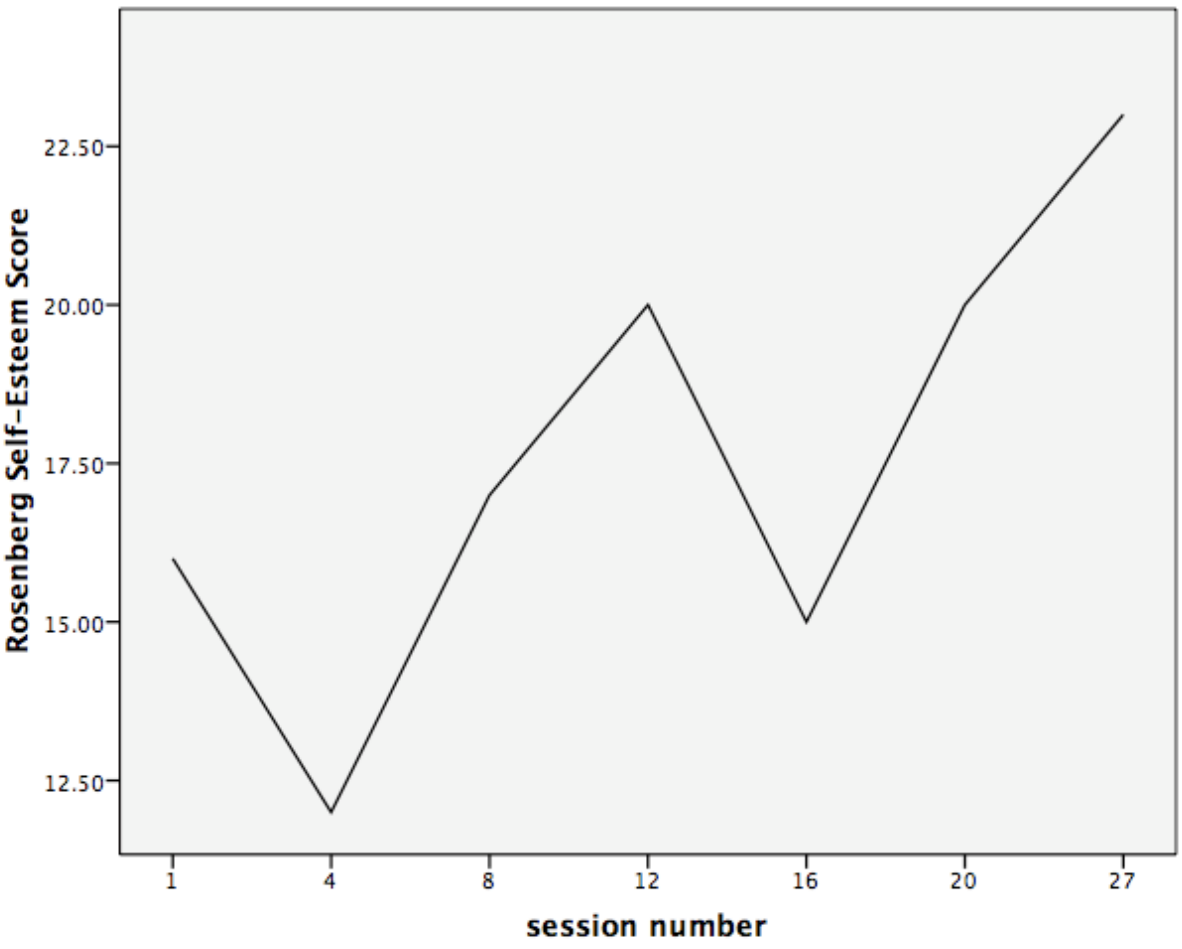

Figure 4. Changes in self-esteem over time in Case #2 (CV). Self-esteem is measured using the *Rosenberg Self-Esteem Scale*. Scores range from 0 to 30. Scores below 15 suggest clinically low self-esteem (Rosenberg, 1965).

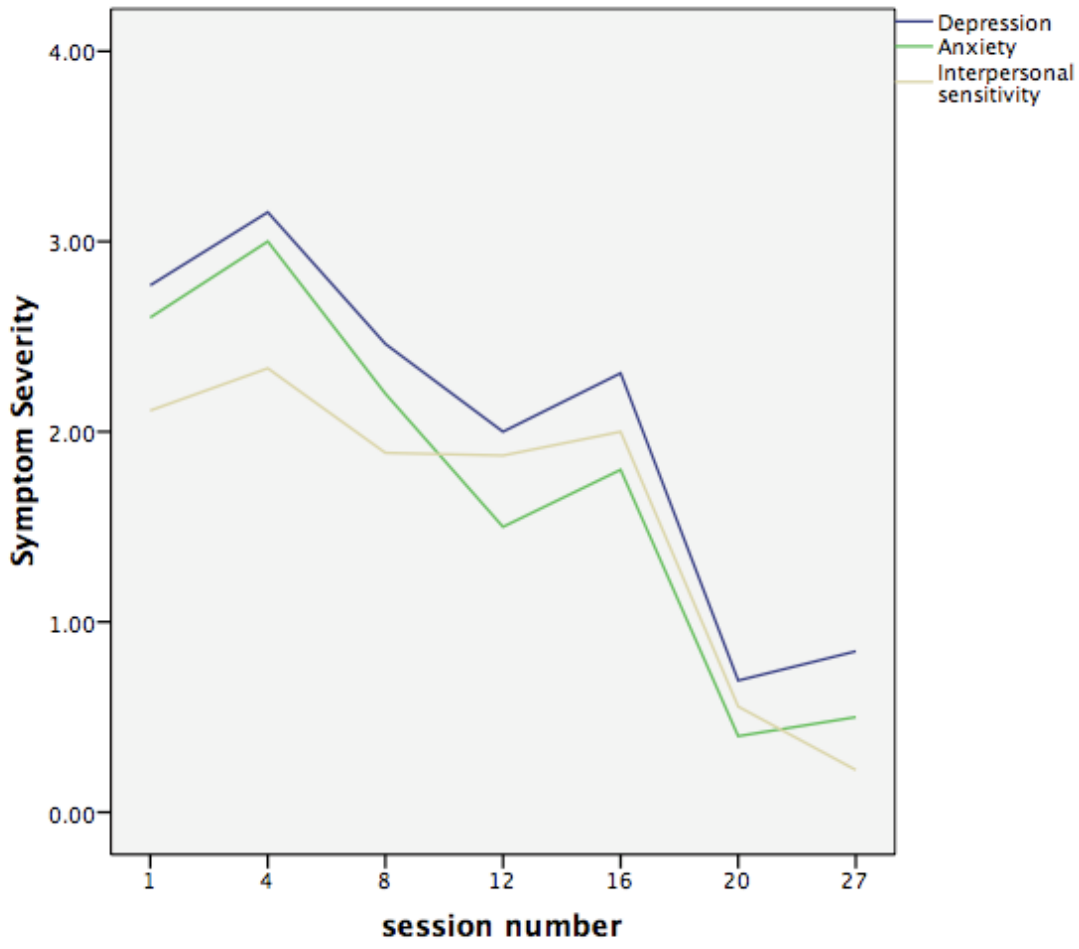

Figure 5. Changes in psychiatric symptoms over time in Case #2 (CV). Psychiatric symptoms were measured using the *Symptom Checklist-90-Revised*. Scale scores range from 0 to 4. Normative data suggest the following average scores for female outpatients beginning psychotherapy: depression (M = 1.94, SD = .93), anxiety (M = 1.59 SD = .90), and interpersonal sensitivity (M = 1.44, SD = .88). Females in the nonpatient population normatively report the following average scores: depression (M = .46, SD = .52), anxiety (M = .37, SD = .43), and interpersonal sensitivity (M =.35, SD = .43) (Derogatis, 1994).

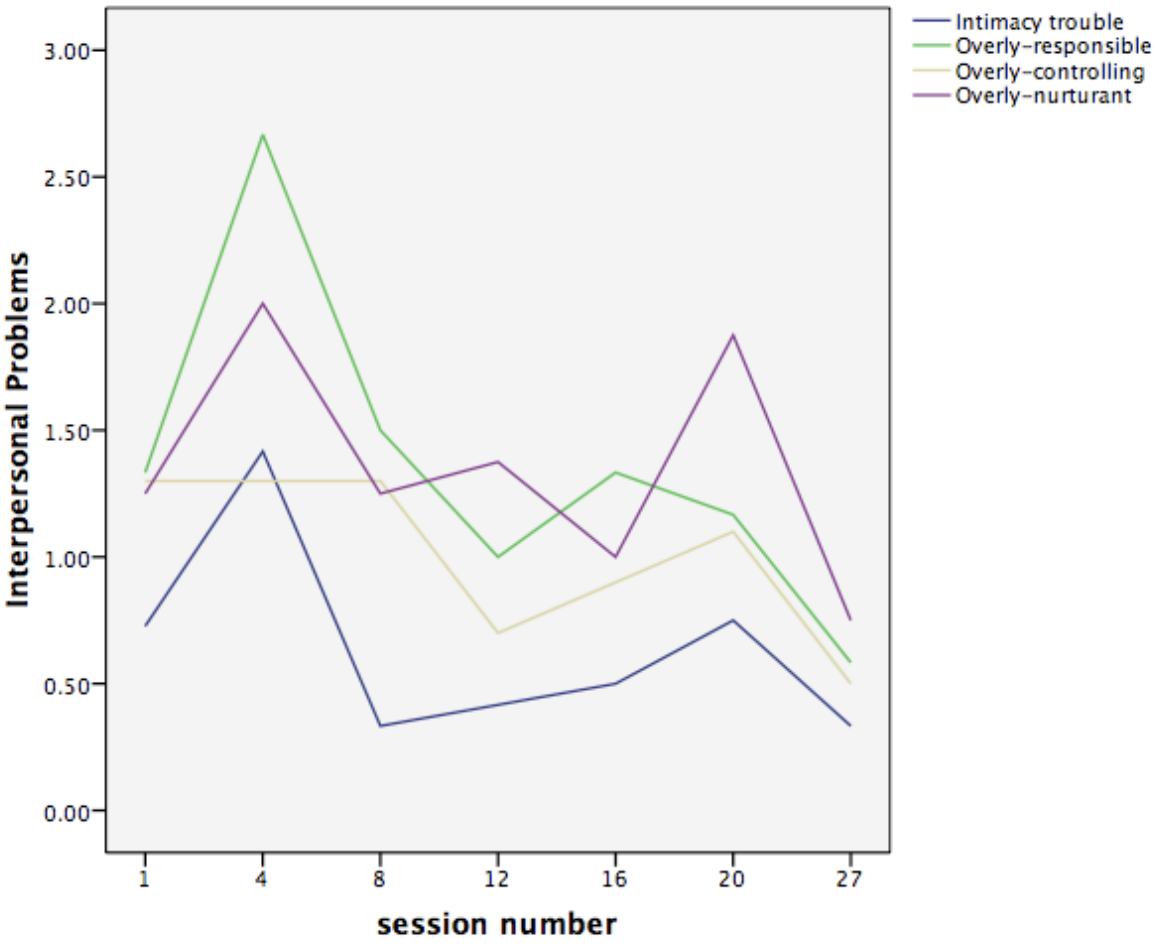

Figure 6. Changes in interpersonal problems over time in Case #2 (CV). Interpersonal problems were measured using the *Inventory of Interpersonal Problems*. Normative data suggest the following average scores for outpatients beginning psychotherapy: intimacy trouble (M = 1.02, SD = .76), overly-responsible (M = 1.81, SD = .80), overly-controlling (M = .98, SD = .69), overly-nurturant (M = 1.50, SD = .75). Normal scores in the non-patient population are as follows: intimacy trouble (M = .82, SD = .44), overly-responsible (M = 1.48, SD = .59), overly-controlling (M = .93, SD = .54), overly-nurturant (M = 1.25, SD = .60) (Horowitz et al.,1988).