Abstract

Objective: Beliefs about the unacceptability of experiencing or expressing negative emotions have been noted in individuals with a range of problems, including chronic fatigue syndrome (CFS), irritable bowel syndrome, somatization disorder, depression, eating disorders, social phobia, posttraumatic stress disorder, and borderline personality disorder. These beliefs are likely to have implications for emotion regulation and processing, and are addressed explicitly or implicitly within many therapies including cognitive behavior therapy (CBT), mindfulness-based cognitive therapy (MBCT), and Acceptance and Commitment Therapy (ACT). This article describes the development, validation, and internal reliability of the Beliefs about Emotions Scale (BES), a self-report questionnaire to assess such beliefs. Methods: The new scale was completed by people with CFS (n=121) and healthy controls (n=73). Twenty-two individuals with CFS completed the scale before and after CBT. Results: People with CFS had significantly higher scores on this new questionnaire than healthy controls. Principal components analysis identified one factor, and the scale had high internal consistency (0.91). Scores on the BES were most highly correlated with a measure of negative perfectionism (r=0.59) and also showed significant correlations with measures of dysfunctional attitudes, self-sacrifice, depression, anxiety, and fatigue. When completed before and after CBT for CFS, the questionnaire was sufficiently sensitive to detect a significant reduction in endorsement of unhelpful beliefs about emotions. Conclusion: The new Beliefs about Emotions Scale showed good internal reliability, validity and sensitivity to change. © 2010 Elsevier Inc. All rights reserved.

Keywords: Beliefs; Chronic fatigue syndrome; Cognitive behavior therapy; Emotions; Questionnaire; Perfectionism

Introduction

Beliefs about the unacceptability of experiencing negative emotions, or the adverse consequences of expressing such feelings, have been reported in individuals with a range of different problems, including chronic fatigue syndrome [1], irritable bowel syndrome [2], somatization disorder [3], eating disorders [4], social phobia [5], depression [6,7], posttraumatic stress disorder [8], and borderline personality disorder [9]. It has been suggested that such beliefs are more likely to develop in individuals who have grown up in an environment where the reporting of difficulties or negative feelings was met with a lack of sympathy or punishment [1,9].

Cognitive behavioral models propose that beliefs about the unacceptability of experiencing or expressing negative thoughts and emotions can play a central role in the development and maintenance of clinical problems [1] and can be associated with a poorer prognosis or treatment outcome [4]. Such beliefs may contribute to difficulties in a range of ways. For example, these beliefs may lead to unwanted feelings being ignored, which could retard the development of self-awareness and self-understanding and, hence, the ability to look after oneself appropriately [10]. If emotionally distressing thoughts are actively suppressed, this is likely to have a counterproductive effect, as there is substantial evidence that such suppression can result in the maintenance of distress [11]. It has also been suggested that
in individuals who are already emotionally vulnerable, inhibiting one’s feelings can contribute to feelings of numbness, emptiness and an absence of a strong sense of identity [9]. Furthermore, believing that it is unacceptable to express one’s feelings is also likely to cause interpersonal problems, for example, by causing relationship difficulties to remain unresolved [9].

Believing that the expression of emotions or distress will be evaluated negatively by others can lead to safety-seeking behaviors to try to prevent this feared outcome, which can inadvertently maintain unhelpful beliefs and distress. For example, people who are concerned about appearing anxious can use strategies to try to hide their anxiety such as avoidance of eye contact, saying very little or over-rehearsing speech, which can actually increase their social anxiety and/or impair social performance [5]. People who are feeling depressed may attempt to hide their low mood from others by avoiding social interaction, but the resulting reduced opportunity for positive reinforcement can lead to even lower mood and passivity [12].

In cognitive behavioral models of medically unexplained symptoms, it has been suggested that beliefs about the unacceptability of negative emotions lead to people trying to hide their feelings and not asking for help, which in turn can lead to increases in distress and associated mental and physical effects such as fatigue, concentration/memory problems, bowel disturbance, and so on [1,2]. Believing that psychological distress is unacceptable may also lead these individuals to favor a physical disease explanation for their symptoms [1]. Such attributional preferences should be viewed within the context of a culture in which psychological difficulties and distress continue to be stigmatized [13].

It could be argued that beliefs about the unacceptability of negative emotions are a form of excessively high standards or perfectionism regarding one’s emotional experience and expression. In problems such as chronic fatigue syndrome (CFS) and anorexia nervosa, in addition to such attitudes to emotions, it has been noted that more general perfectionist beliefs also tend to occur [1,14]. These may be apparent across different domains, with the individual believing that failure to meet high standards indicates failure as a person or unacceptability to others. This type of conditional acceptance belief has been described as a form of negative perfectionism [15]. It has also been noted that individuals with CFS often have high standards about moral conduct, including the importance of putting other people before themselves, sometimes described as ‘self-sacrifice’ [16]. In the present study it was predicted that beliefs about the unacceptability of negative emotions would be associated with negative perfectionist beliefs and self-sacrificial beliefs, in individuals with CFS.

Negative beliefs about emotions are addressed in many different therapies. Most involve psychoeducation and the expression of emotions, which may help to modify such unhelpful beliefs, but different forms of therapy also have specific methods to address these beliefs. For example, in cognitive behavior therapy (CBT), unhelpful beliefs about emotions may be addressed as a form of dysfunctional assumption, using behavioral experiments. In Mindfulness-Based Cognitive Therapy (MBCT) [17], the repeated practice of bringing non-judgmental awareness and acceptance to feelings, thoughts and sensations, and the group discussion of this, may reduce unhelpful beliefs about emotions. Similarly, in Acceptance and Commitment Therapy (ACT) [18], participants are encouraged to feel emotions fully and without defense, as an alternative to experiential avoidance. Dialectical Behavioral Therapy (DBT) [9] also includes components likely to modify beliefs about emotions, including mindfulness, distress tolerance, and emotional regulation methods.

Given that many different therapies are likely to impact on unhelpful beliefs about emotions, and that various clinical problems are thought to involve these beliefs, it is surprising that no questionnaire to assess such beliefs can be identified in the existing literature. Although there are measures to assess behaviors that may be linked to underlying unhelpful beliefs about emotions, such as suppression or avoidance, the authors were not able to identify a questionnaire to assess the beliefs themselves. Such a questionnaire could be helpful as a research tool or a clinical assessment/outcome measure.

This study aimed to develop a measure of beliefs about experiencing and expressing negative thoughts and feelings (the Beliefs about Emotions Scale; BES) and examined the internal reliability and validity of the new scale. The underlying unhelpful beliefs about emotions, and that various clinical measures to assess behaviors that may be linked to these beliefs also have undergone a course of CBT.

Given that many different therapies are likely to impact on unhelpful beliefs about emotions, and that various clinical problems are thought to involve these beliefs, it is surprising that no questionnaire to assess such beliefs can be identified in the existing literature. Although there are measures to assess behaviors that may be linked to underlying unhelpful beliefs about emotions, such as suppression or avoidance, the authors were not able to identify a questionnaire to assess the beliefs themselves. Such a questionnaire could be helpful as a research tool or a clinical assessment/outcome measure.

This study aimed to develop a measure of beliefs about experiencing and expressing negative thoughts and feelings (the Beliefs about Emotions Scale; BES) and examined the internal reliability and validity of the new scale. The internal consistency, factor structure and the relationship between scores on the BES and sociodemographic factors were investigated. Participants with CFS were selected because cognitive models have suggested that such beliefs tend to be common in this group. The following hypotheses were investigated:

1. Supporting the validity of the BES, participants with CFS will report more negative beliefs about the acceptability of experiencing and expressing negative thoughts/feelings than healthy controls. It is assumed that elevated levels of these beliefs will lead to increases in distress, so that when adjusting for depression and anxiety, there will no longer be a significant group difference.

2. As further evidence for the validity of the scale, scores on the BES will correlate most highly with measures of negative perfectionism and high standards about putting others before oneself (“self-sacrifice”), but will also correlate significantly with other unhelpful attitudes and depression, anxiety and fatigue.

3. The BES will be sufficiently sensitive to detect change in beliefs about emotions after participants with CFS have undergone a course of CBT.
Methods

Part 1: Internal reliability, validity, and dimensionality

Participants

Participants were individuals attending a specialist CFS unit (n=121) and healthy controls (n=73). All the patients had been assessed by a physician or cognitive behavior therapist with experience in the diagnosis of CFS and had a range of tests to exclude other medical causes for the fatigue as suggested in diagnostic guidelines [19]. Patients met the Oxford [19] criteria for chronic fatigue syndrome. The sociodemographic and medical/psychological characteristics of the two groups are shown in Table 1.

Procedures and assessments

The study was approved by the local ethics committee and participants had the opportunity to ask questions before giving informed consent. Participants were then asked to complete the questionnaires and post them back in a prepaid envelope or bring them to the CFS Unit. The questionnaire pack included questions about their age, sex, relationship status, employment, educational background, and ethnicity. In the CFS group, duration of illness was recorded. In addition, participants completed the questionnaires described below.

Beliefs about Emotions Scale

This new scale developed for the present study has 12 items: see Table 3 for the items or contact the corresponding author for a copy of the scale. The item content was selected to represent the types of beliefs about the unacceptability of experiencing and expressing emotions that have been specified in clinical reports and cognitive models [1,4]. Seven columns are presented to the right of the item list, showing seven response options from left to right: “Totally agree,” “Agree very much,” “Agree slightly,” “Neutral,” “Disagree slightly,” “Disagree very much” and “Totally disagree.” Responses are scored 6, 5, 4, 3, 2, 1, and 0, respectively. Instructions are as follows: “Please tick the column that best describes how you think. Please note that because people are different, there are no right or wrong answers to these statements. To decide whether a given answer is typical of your way of looking at things, simply keep in mind how you think most of the time.”

Chalder Fatigue Scale

The Chalder Fatigue Scale is an 11-item questionnaire measuring fatigue-related symptoms over the past month, which has good reliability and validity [20]. The Likert scoring method was used (0–3) with a maximum total score of 33.

Hospital Anxiety and Depression Scale

The Hospital Anxiety and Depression Scale (HADS) [21] measures anxiety and depression in people with physical health problems, excluding items related to somatic symptoms that are higher in these populations. It has been shown to be reliable and valid [22].

Young Schema Questionnaire, self-sacrifice subscale

The Self-Sacrifice 16-item Subscale of the Young Schema Questionnaire [23] is designed to assess the tendency to put other peoples’ needs before one’s own. There is some evidence to support the reliability and validity of this scale [24].

All of the healthy participants and a subset of the CFS group (n=67) also completed the questionnaires listed below. (Some of the CFS group were not asked to complete the entire questionnaire set because they were also participating

Table 1

<table>
<thead>
<tr>
<th></th>
<th>CFS participants (n=121)</th>
<th>Healthy controls (n=73)</th>
<th>Group comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>76.0% female</td>
<td>67.1% female</td>
<td>(\chi^2=1.8)</td>
</tr>
<tr>
<td>Age: mean years (S.D.)</td>
<td>38.8 (11.9)</td>
<td>37.6 (11.7)</td>
<td>(t_{188}=0.7, P=.51)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>76.9 %</td>
<td>76.7 %</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>14.9 %</td>
<td>19.2 %</td>
<td>(\chi^2=1.8, P=.43)</td>
</tr>
<tr>
<td>Not given</td>
<td>8.3 %</td>
<td>4.1%</td>
<td></td>
</tr>
<tr>
<td>Relationship status:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single/separated/divorced</td>
<td>51.7%</td>
<td>24.7%</td>
<td>(\chi^2=14.4, P=.001)</td>
</tr>
<tr>
<td>Married/living with partner</td>
<td>48.3%</td>
<td>75.3%</td>
<td></td>
</tr>
<tr>
<td>Further education qualification</td>
<td>45.5%</td>
<td>79.5%</td>
<td>(\chi^2=17.2, P&lt;.0005)</td>
</tr>
<tr>
<td>In paid employment</td>
<td>42.0%</td>
<td>86.3%</td>
<td>(\chi^2=36.6, P&lt;.0005)</td>
</tr>
<tr>
<td>Mean (S.D.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of CFS in months</td>
<td>78.6 (68.6)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chalder Fatigue Scale</td>
<td>21.0 (8.3)</td>
<td>11.7 (3.2)</td>
<td>(t_{154.3}=10.7, P&lt;.0005)</td>
</tr>
<tr>
<td>HADS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>10.5 (5.1)</td>
<td>5.2 (3.3)</td>
<td>(t_{1897}=8.6, P&lt;.0005)</td>
</tr>
<tr>
<td>Depression</td>
<td>8.3 (4.4)</td>
<td>2.3 (2.6)</td>
<td>(t_{1897}=11.8, P&lt;.0005)</td>
</tr>
</tbody>
</table>
in another questionnaire study, and it was judged inappropriate to burden them with a large number of questionnaires).

**Dysfunctional Attitudes Scale 24**

The Dysfunctional Attitudes Scale 24 (DAS-24) [25] is designed to measure maladaptive attitudes, with three subscales. “Achievement” measures perfectionist beliefs (e.g., If I fail partly, it is as bad as being a complete failure) and “Dependency” measures beliefs about interpersonal relationships (e.g., “If others dislike you, you cannot be happy”). The “Self-control” scale includes two items about controlling emotions (e.g., “I should be happy all the time”) but the other items cover a range of issues. The DAS-24 has exhibited good construct validity and reliability [26].

**Perfectionistic self-belief scales**

Perfectionism was assessed using Campbell and Di Paula’s Perfectionistic Self-belief Scales [15], which are based on a factor analysis of Hewitt and Flett’s Multidimensional Perfectionism Scale [27]. There are four factors: Conditional Acceptance (e.g., “Although they may not show it, other people get very upset with me when I slip up”), Perfectionist Striving (e.g., “I strive to be the best at everything I do”), Others’ High Standards (e.g., People expect nothing less than perfection from me”), and Importance of being Perfect (e.g., “It is very important that I am perfect in everything I attempt”). This perfectionism measure was chosen because the Conditional Acceptance subscale corresponds well to the types of beliefs that have been hypothesized as characteristic of people with CFS [1]. A previous study [15] found that high scores on the Conditional Acceptance scale were associated with lower academic performance, less effective pursuit of goals, increased psychological distress and low self-esteem, and this subscale may be seen as a measure of negative perfectionism. Others’ High Standards scores were correlated with lower agreeableness, and The Importance of Being Perfect subscale was correlated with conscientiousness and lower self-esteem. Perfectionist Striving was associated with mainly positive outcomes including higher self-esteem, goal stability and conscientiousness, and lower levels of depression and anxiety, and may be seen as a measure of positive perfectionism.

**Part 2: Sensitivity to clinical change**

To examine the sensitivity of the BES to change after treatment, 22 individuals with CFS completed the questionnaire before and after twelve sessions of CBT. The mean age of the participants was 33.9 years (S.D.=10.2). Nineteen of the participants were Caucasian, one was Black British, and one was of mixed ethnic background. The mean duration of the CFS was 5.8 years (S.D.=5.0). The CBT was conducted by clinical psychologists and cognitive behavior therapists at a specialist CFS unit. Subscales (Concern about Mistakes, Doubts about Actions, Parental Expectations and Parental Criticism) from the Frost Multidimensional Perfectionism Questionnaire [28] thought to measure unhealthy perfectionism [29] were also administered at the same time points.

**Statistical analyses**

Statistical analyses were conducted using SPSS for Windows and included Cronbach’s alphas, paired and independent t tests, Pearson’s correlations, and principal components analysis.

**Results**

**Internal consistency**

The Cronbach’s alpha for the BES, 0.91, indicated very good reliability. The Cronbach’s alphas for the scale if each item was separately deleted were also calculated. The only item that would lead to an increase in the Cronbach’s alpha if deleted was Item 7, which would result in an increase of 0.003. This was such a small increase that it was not considered necessary to delete the item on this basis. For the CFS sample alone, the Cronbach’s alpha was 0.91, and for the healthy controls, the Cronbach’s alpha was 0.88.

**Dimensionality**

Principal components analysis extracted only one factor, which accounted for 50.1% of the variance. Principal components analyses were also repeated for the two samples separately and this did not change the findings significantly; in both cases, a main factor accounting for over 50% of the variance was extracted (Table 2).

**Relationship of BES scores with sociodemographic variables**

An independent t-test indicated that there was no significant difference between males (mean=30.1, S.D.=13.2) and females (mean=33.2, S.D.=13.8) on the total BES score.
[192]=1.4, P=0.16. An independent $t$ test comparing BES scores between individuals with further (post-school) educational qualifications (mean=33.8, S.D.=14.9) and those without further qualifications (mean=32.0, S.D.=13.3) indicated no significant difference \( t_{(190)}=0.75, P=0.45 \). A $t$ test comparing BES scores between Caucasian (mean 32.9 S.D. 13.3) and non-Caucasian participants (mean=33.7, S.D.=15.5) indicated no significant difference \( t_{(179)}=0.27, P=0.79 \).

A Pearson correlation coefficient indicated that there was a significant negative correlation between total BES score and age \( r_{(190)}=-0.18, P=0.014 \). This was repeated covarying for HADS anxiety and depression scores, and the association was still significant \( r_{(181)}=-0.20, P=0.008 \). In order to explore this result further, correlational analyses were performed between age and the other measures relating to high standards. Results indicated significant negative associations between age and the subscale Others High Standards \( r_{(128)}=-0.20, P=0.017 \), and there was a marginal nonsignificant negative association with Perfectionist Striving \( r_{(136)}=-0.16, P=0.071 \), but age was not significantly correlated with the subscales Conditional Acceptance or Importance of Being Perfect, or the self-sacrifice scale from the Young Schema Questionnaire.

**Construct validity**

An independent $t$ test was used to compare the responses of participants with CFS and healthy controls on the BES. As predicted, there was a significant group difference \( t_{(178.8)}=3.8, P<0.0005 \), with the CFS group reporting more negative beliefs about emotions (mean=35.0, S.D.=14.3) than the healthy controls (mean=27.9, S.D.=11.3). The means and standard deviations for individual items for both groups are shown in Table 3, together with the results of exploratory independent $t$ tests.

Univariate analyses of variance was undertaken comparing the CFS and control group while covarying for HADS anxiety and HADS depression scores. When controlling for anxiety, the group difference was no longer significant \( F_{(1,190)}=0.491, P=0.485 \) and similarly when controlling for depression the group difference was no longer significant \( F_{(1,189)}=0.697, P=0.405 \).

Table 4 shows the Pearson’s correlation coefficients for the BES and other questionnaire measures. For the whole sample, the BES correlated significantly with all the measures, and most highly with a measure of negative perfectionism—the Conditional Acceptance subscale of Perfectionistic Self-Beliefs Scales. This remained the case when adjusting for multiple comparisons using Bonferroni’s correction, with an alpha level of $P<0.0045$. The correlations were also repeated for the CFS participants and the non-CFS participants separately (see Table 4).

**Sensitivity to change**

For the 22 participants with CFS who underwent CBT, the mean score on the BES beforehand was 37.7 (S.D.=15.2) and, afterwards, was 28.8 (S.D.=16.2). A paired $t$ test indicated that this was a significant decrease \( t_{(21)}=4.6, P<0.0005 \). Changes in BES scores correlated significantly with changes on the Doubt about Actions subscale of the Frost Multidimensional Perfectionism Scale \( r_{(22)}=0.66, P=0.001 \).

**Discussion**

The results indicate that the BES may be a useful addition to the field. The construct validity is supported by the finding that participants with CFS have higher scores on the scale than healthy participants, consistent with clinical reports and a cognitive model suggesting that people with CFS have negative beliefs about experiencing and expressing negative emotions [1]. The BES also has very good internal consistency. Furthermore, BES scores decreased significantly after CFS participants underwent CBT, indicating that the scale may be a sensitive measure of change in beliefs.

Table 3

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean (S.D.)</th>
<th>Mean (S.D.)</th>
<th>$t$ tests</th>
<th>Results of independent $t$ tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It is a sign of weakness if I have miserable thoughts</td>
<td>2.5 (1.7)</td>
<td>1.8 (1.4)</td>
<td>$t_{(171.0)}=2.6, P=0.007$</td>
<td></td>
</tr>
<tr>
<td>2. If I have difficulties I should not admit them to others.</td>
<td>2.0 (1.6)</td>
<td>1.4 (1.3)</td>
<td>$t_{(176.4)}=2.7, P=0.008$</td>
<td></td>
</tr>
<tr>
<td>3. I should be able to control my emotions.</td>
<td>3.1 (1.8)</td>
<td>2.3 (1.6)</td>
<td>$t_{(192.0)}=3.1, P=0.003$</td>
<td></td>
</tr>
<tr>
<td>4. If I am having difficulties it is important to put on a brave face.</td>
<td>3.6 (1.6)</td>
<td>3.3 (1.7)</td>
<td>$t_{(192.0)}=1.2, P=0.214$</td>
<td></td>
</tr>
<tr>
<td>5. If I lose control of my emotions in front of others, they will think less of me</td>
<td>3.5 (1.6)</td>
<td>3.1 (1.3)</td>
<td>$t_{(188.2)}=2.8, P=0.003$</td>
<td></td>
</tr>
<tr>
<td>6. I should not let myself give in to negative feelings.</td>
<td>4.5 (1.2)</td>
<td>3.3 (1.5)</td>
<td>$t_{(124.3)}=5.4, P&lt;0.0005$</td>
<td></td>
</tr>
<tr>
<td>7. I should not let myself give in to negative feelings.</td>
<td>3.0 (1.7)</td>
<td>2.4 (1.6)</td>
<td>$t_{(192.0)}=2.2, P=0.029$</td>
<td></td>
</tr>
<tr>
<td>9. To be acceptable to others, I must keep any difficulties or negative feelings to myself.</td>
<td>2.3 (1.7)</td>
<td>1.7 (1.2)</td>
<td>$t_{(187.1)}=3.4, P=0.001$</td>
<td></td>
</tr>
<tr>
<td>10. It is stupid to have miserable thoughts.</td>
<td>2.2 (1.9)</td>
<td>1.7 (1.5)</td>
<td>$t_{(174.1)}=2.2, P=0.029$</td>
<td></td>
</tr>
<tr>
<td>11. It would be a sign of weakness to show my emotions in public.</td>
<td>3.1 (1.7)</td>
<td>2.3 (1.5)</td>
<td>$t_{(192.0)}=3.1, P=0.002$</td>
<td></td>
</tr>
<tr>
<td>12. Others expect me to always be in control of my emotions.</td>
<td>3.1 (1.7)</td>
<td>3.0 (1.5)</td>
<td>$t_{(192.0)}=0.4, P=0.771$</td>
<td></td>
</tr>
<tr>
<td>Total BES score:</td>
<td>35.0 (14.3)</td>
<td>27.9 (11.3)</td>
<td>$t_{(192.0)}=3.8, P=0.0005$</td>
<td></td>
</tr>
</tbody>
</table>
The association between BES scores and fatigue was significant but only small/moderate. This is in line with multifactorial approaches to CFS which propose that a number of contributory factors are likely to be involved. As expected, when controlling for anxiety and depression, there was no longer a significant difference between the CFS and control groups. This is consistent with the hypothesis that believing that emotions are unacceptable will lead to responses (e.g., attempts at suppression and failure to seek social support) which have a counterproductive effect and lead to increased distress. It has been suggested that this increased distress will in turn contribute to elevated levels of fatigue [1].

The finding that scores on the BES correlated significantly with fatigue, depression, and anxiety are consistent with the suggestion that these beliefs do not have a specific association with a particular form of distress or symptom. Instead, these beliefs may represent a transdiagnostic vulnerability factor that could contribute to a range of different problems. However, it is important to note that the association between beliefs about emotions and distress may operate in the opposite direction (or be due to a third unmeasured causal variable). It is plausible that people with emotional difficulties may have experienced a lack of sympathy or negative reactions from others and subsequently developed these negative beliefs about emotions as a consequence of these experiences. If this is the case then these beliefs about emotions may still act to maintain the person’s symptoms or impaired functioning even if they did not play a part in the initial development.

Scores on this new questionnaire do not appear to be simply reflecting current mood, as the size of correlation coefficients between the BES and the depression/anxiety measures were only moderate. Correlations between the BES and perfectionism measures were stronger, as had been predicted. Scores on the BES were most highly correlated with a measure of negative (but not positive) perfectionism, the subscale of the DAS measuring perfectionist-type beliefs, and the self-sacrifice scale, which assesses high standards about putting the needs of other people before oneself. These associations support the notion that the beliefs assessed in this new questionnaire could be viewed as a form of unhelpful perfectionism concerning emotions.

Principal components analysis for the whole sample extracted only one factor. All items showed reasonable factor loadings on this factor except for Item 7 (“I should not let myself give in to negative feelings”). This item also showed the largest difference between the two groups and it is possible that the CFS group show unusual responding to this question. Removing the item would only have increased the Cronbach’s alpha by a marginal amount (.003). Therefore, the item was retained in the scale, but this issue will need to be investigated in future research.

Scores on the BES were significantly lower after CFS participants underwent CBT, with post-treatment scores almost reaching the mean score of healthy participants. This is interesting because the CBT had focused mainly on reducing fatigue and disability and there was not necessarily a focus on addressing unhelpful beliefs about emotions unless this seemed important in the individual formulation. However, perfectionism would typically have been addressed, so it is possible that addressing perfectionism in other areas generalized to attitudes towards emotions. This would be consistent with the finding that reductions in BES scores correlated significantly with reductions in scores on a subscale of the Frost Multidimensional Perfectionism Scale. Of course, discussing one’s feeling with a therapist may have helped modify unhelpful beliefs about emotions indirectly.

Cognitive models of various different disorders have proposed that unhelpful beliefs about emotions may play a contributory role to distress or impairment. This new
questionnaire may be a useful brief screening instrument that could be used in clinical settings. It is easy to score, and as the items are stated in the form of beliefs, it is easy to make direct links between the endorsement of individual items and the addressing of such beliefs within therapy.

Questionnaires to measure behavioral responses (e.g., emotional suppression) which may be associated with underlying unhelpful beliefs about emotions already exist. However, there are potential advantages of assessing the beliefs that may be driving behavioral responses rather than only attempting to assess the behaviors themselves. Beliefs may be easier for people to access and self-report than the behavioral responses. For example, individuals may not be aware of the extent to which they are suppressing emotions if this has become an over-learned, relatively automatic strategy. Furthermore, it may be clinically useful to assess the underlying beliefs as these can then be addressed directly in therapy. It could be argued that without addressing the beliefs it will be more difficult to modify the associated maladaptive behavioral responses or may leave the individual vulnerable to developing alternative unhelpful responses.

One limitation is that only 22 participants with CFS underwent the CBT, and without a control group, it is not possible to conclude that CBT was responsible for the observed significant reduction in scores on the BES. The effectiveness of CBT in addressing unhelpful beliefs about emotions, and the sensitivity of this new questionnaire to detect change in such beliefs needs to be examined in the context of a randomized controlled trial. Another limitation is that participants with only one type of clinical problem were included. A study is being undertaken that includes this new questionnaire with people with eating disorders, for whom it has also been hypothesized that there is an increased tendency for negative beliefs about emotions [30].

In conclusion, the study found evidence supporting the validity and internal reliability of the new BES. Consistent with cognitive behavioral models, people with CFS report more negative beliefs about the experience and expression of emotions than healthy controls. There is also evidence that the scale may be sensitive to reductions in negative beliefs about emotions occurring after a course of CBT. This new questionnaire may fill a gap in the existing range of assessment tools, in that it aims to assess the unhelpful beliefs about emotions that may be driving problematic behaviors (e.g., avoidance or suppression), rather than the behaviors themselves. The utility of this questionnaire should now be investigated in other research contexts and with different clinical populations and forms of psychotherapy.

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