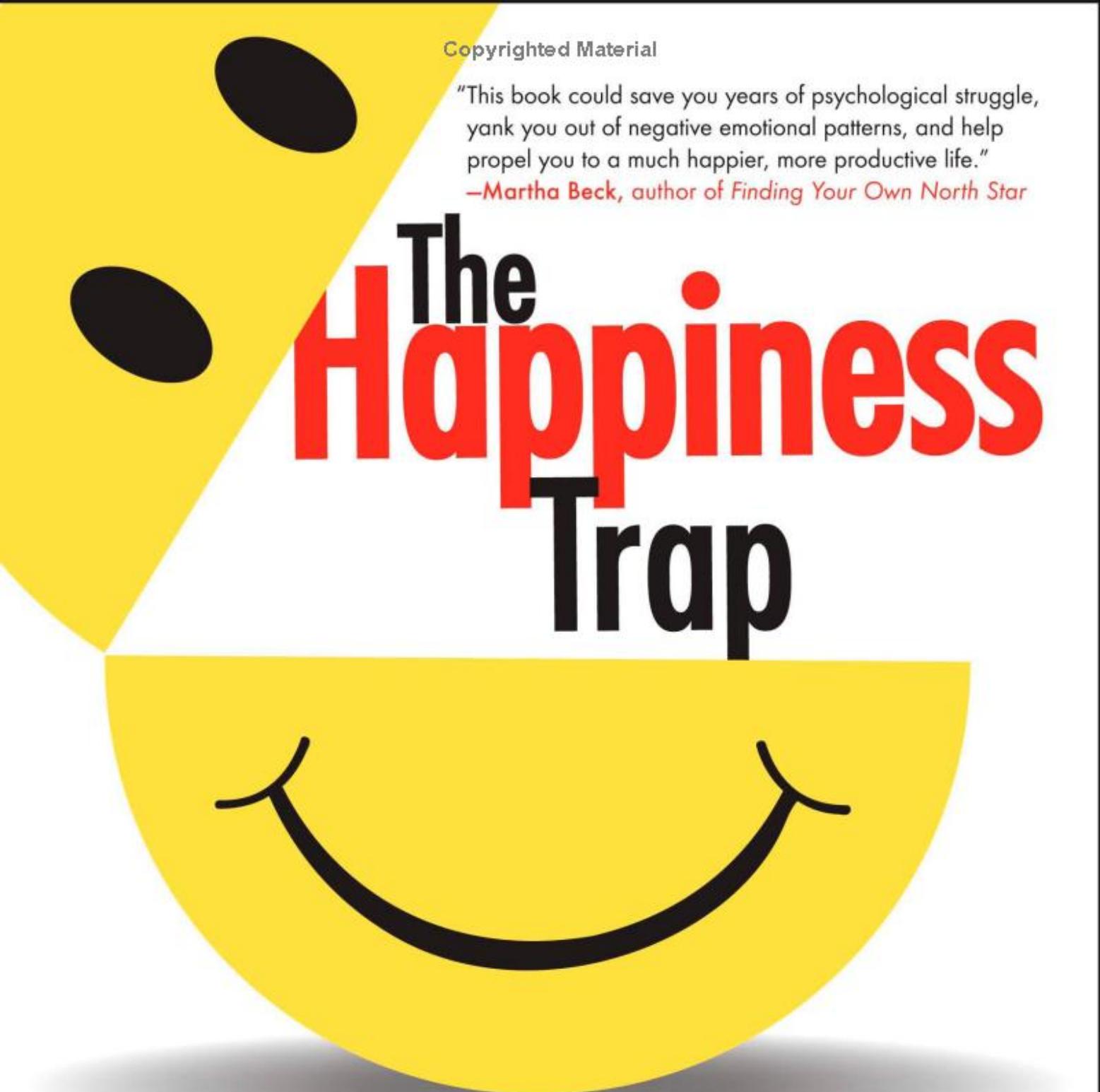


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"This book could save you years of psychological struggle, yank you out of negative emotional patterns, and help propel you to a much happier, more productive life."  
—Martha Beck, author of *Finding Your Own North Star*

# The Happiness Trap



## How to Stop Struggling and Start Living

A guide to ACT: the mindfulness-based program for reducing stress, overcoming fear, and creating a rich and meaningful life

**RUSS HARRIS**

FOREWORD BY  
Steven Hayes, PhD

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**A**re you, like millions of Americans, caught in the happiness trap? Russ Harris explains that the way most of us go about trying to find happiness ends up making us miserable, driving the epidemics of stress, anxiety, and depression. This empowering book presents the insights and techniques of ACT (Acceptance and Commitment Therapy), a revolutionary new psychotherapy based on cutting-edge research in behavioral psychology. By clarifying your values and developing mindfulness (a technique for living fully in the present moment), ACT helps you escape the happiness trap and find true satisfaction in life.

The techniques presented in *The Happiness Trap* will help readers to:

- Reduce stress and worry
- Handle painful feelings and thoughts more effectively
- Break self-defeating habits
- Overcome insecurity and self-doubt
- Create a rich, full, and meaningful life

"Carefully and creatively presents techniques that anyone can use to undermine struggle, avoidance, and loss of the moment. Harris systematically explores how we get into the 'happiness trap' and then shines a powerful beacon showing us another way forward."

—Steven Hayes, PhD, author of *Get Out of Your Mind and Into Your Life*

"Eminently practical and readable. This book reveals that when calibrating one's life according to acceptance and valued action, happiness is a pleasant sideshow in the larger carnival of an engaged and purposeful existence."

—Zindel Segal, PhD, author of *The Mindful Way through Depression*

"An exciting alternative to the usual approach of so many self-help books. Harris explains how we can work with ourselves as we are, rather than aggressively trying to alter ourselves. I'm impressed by the simple and effective methods of ACT."

—David Richo, PhD, author of *The Five Things We Cannot Change*

**RUSS HARRIS** is a physician, therapist, and speaker specializing in stress management. He travels nationally and internationally to train individuals and health professionals in the techniques of ACT. Born and educated in England, he now lives in Australia. For more information, visit [thehappinesstrap.com](http://thehappinesstrap.com).

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## **Dedication**

To my mother and father, for four decades of love, support, inspiration and encouragement. And to my wife Carmel, whose love, wisdom, and generosity has enriched my life and opened my heart in ways I would never have dreamed possible.

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# **Foreword**

There is a tremendous irony in happiness. It comes from a root word meaning ‘by chance’ or ‘an occurrence’, which in a positive sense connotes a sense of newness, wonder, and appreciation of chance occurrences. The irony is that people not only seek it, they try to hold on to it—especially to avoid any sense of ‘unhappiness’. Unfortunately, these very control efforts can become heavy, planned, closed, rigid and fixed.

Happiness is not just a matter of feeling good. If it were, drug abusers would be the happiest people on the planet. Indeed, feeling good can be a very unhappy pursuit. It is not by accident that drug users call their methods of doing so a ‘fix’—because they are chemically trying to hold something in place. Like a butterfly pinned to a table, however, happiness dies unless it is held lightly. Drug abusers are not the only ones. In the name of producing an emotional result we call happiness, most of us tend to engage in behaviour that is the exact opposite and then feel awful and inadequate with the inevitable result. Until we wise up, we are all generally trying to get a ‘fix’ on happiness.

This book is based on Acceptance and Commitment Therapy (ACT), which is an empirically supported approach that takes a new and unexpected tack in dealing with the issue of happiness and life satisfaction. Instead of teaching new techniques to pursue happiness, ACT teaches ways to undermine struggle, avoidance, and loss of the moment. Russ Harris has very carefully and creatively presented this approach in an accessible way. In 33 bite-sized chapters he systematically explores how we get into the ‘Happiness Trap’ and how mindfulness, acceptance, cognitive defusion, and values can release us from it.

The joyful message in these pages is that there is no reason to continue to wait for life to start. That waiting game can end. Now. Like a lion placed in a paper cage, human beings are generally most trapped by the illusions of their own mind. But despite the appearance the cage is not really a barrier that can contain the human spirit. There is another way forward, and with this book Dr Harris shines a powerful and loving beacon forward into the night, lighting that path.

Enjoy the journey. You are in excellent hands.

Steven C. Hayes  
Originator of ACT  
University of Nevada

# I JUST WANT TO BE HAPPY

Just suppose for a moment that almost everything you believed about finding happiness turned out to be inaccurate, misleading or false. And suppose that those very beliefs were making you miserable. What if your very efforts to find happiness were actually preventing you from achieving it? And what if almost everyone you knew turned out to be in the same boat—including all those psychologists, psychiatrists and self-help gurus who claim to have all the answers?

I'm not posing these questions just to grab your attention. This book is based on a growing body of scientific research that suggests we are all caught in a powerful psychological trap. We lead our lives ruled by many unhelpful and inaccurate beliefs about happiness—ideas widely accepted by society because ‘everyone knows they are true’. On the surface, these beliefs seem to make good sense—that’s why you encounter them again and again in nearly every self-help book you ever read. But these erroneous beliefs are both the cause of and the fuel for a vicious cycle, in which the more we try to find happiness, the more we suffer. And this psychological trap is so well hidden, we don’t even have a clue that we’re caught and controlled by it.

That’s the bad news.

The good news is there’s hope. You can learn how to recognise the ‘happiness trap’ and, more importantly, you can learn how to climb out of it—and stay out. This book will give you all the skills and knowledge you need to do it. It’s based on a revolutionary new development in human psychology: a powerful model for change known as Acceptance and Commitment Therapy (ACT).

ACT (pronounced as the word ‘act’) was created in the United States of America by psychologist Steven Hayes, and was further developed by a number of his colleagues, including Kelly Wilson and Kirk Stroshal. ACT has been astoundingly effective in helping patients with a wide range of problems: from depression and anxiety to chronic pain and even drug addiction. For example, in one remarkable study, psychologists Patty Bach and Steven Hayes used ACT with patients suffering from chronic schizophrenia and found that only four hours of therapy were sufficient to reduce hospital readmission rates by half! ACT has also proved highly effective for the less dramatic problems that millions of us encounter, such as quitting smoking and reducing stress in the workplace. Unlike the vast majority of other therapies, ACT has a firm basis in scientific research and, because of this, it is rapidly growing in popularity among psychologists all around the world.

The aim of ACT is to help you live a rich, full and meaningful life, while effectively handling the pain that inevitably comes your way. ACT achieves this through the use of six powerful principles, which are very different from the so-called commonsense strategies suggested in most self-help books.

## Is Happiness Normal?

In the western world we now have a higher standard of living than humans have ever known before. We have better medical treatment, more and better food, better housing conditions, better sanitation, more money, more welfare services and more access to education, justice, travel, entertainment and career opportunities. Indeed, today’s middle class lives better than did the royalty of not so long ago, and yet, human misery is everywhere.

The psychology and personal development sections of bookstores are growing at a rate never seen before, and the bookshelves are groaning under the strain. The titles cover depression, anxiety, anorexia nervosa, overeating, anger management, divorce, relationship problems, sexual problems, drug addictions, alcoholism, low self-esteem, loneliness, grief, gambling—if you can name it, there’s a book on it. Meanwhile, on the television and radio, and in magazines and newspapers, the

‘experts’ bombard us daily with advice on how to improve our lives. This is why the numbers of psychologists, psychiatrists, marriage and family counsellors, social workers and ‘life coaches’ are increasing with every year. And yet—now, think about this—with all this help and advice and worldly wisdom, human misery is not diminishing but growing by leaps and bounds! Isn’t there something wrong with this picture?

The statistics are staggering: In any given year almost 30 per cent of the adult population will suffer from a recognised psychiatric disorder. The World Health Organization estimates that depression is currently the fourth biggest, costliest and most debilitating disease in the world, and by the year 2020 it will be the *second biggest*. In any given week, one-tenth of the adult population is suffering from clinical depression, and one in five people will suffer from it at some point in their lifetime. Furthermore, one in four adults, at some stage in their life, will suffer from drug or alcohol addiction, which is why there are now over twenty million alcoholics in the United States of America alone!

But more startling and more sobering than all those statistics is that almost one in two people will go through a stage in life when they seriously consider suicide and will struggle with it for a period of two weeks or more. Scarier still, one in ten people will at some point actually attempt to kill themselves.

Think about those numbers for a moment. Think of the people in your life: your friends, family and co-workers. Consider what those figures imply: that of all the people you know, almost half of them will at some point be so overwhelmed by misery that they seriously contemplate suicide. And one in ten will attempt it! In the past two centuries we have doubled the span of the average human life. But have we doubled the richness, the enjoyment, the *fulfilment* of that life? These statistics give us the answer, loud and clear: happiness is not normal!

## Why Is It So Difficult To Be Happy?

To answer this question, we need to take a journey back in time. The modern human mind, with its amazing ability to analyse, plan, create and communicate, has largely evolved over the last hundred thousand years, since our species, *Homo sapiens*, first appeared on the planet. But our minds did not evolve to make us feel good, so we could tell great jokes, write sonnets and say ‘I love you’. Our minds evolved to help us survive in a world fraught with danger. Imagine that you’re an early human hunter-gatherer. What are your essential needs in order to survive and reproduce?

There are four of them: food, water, shelter and sex, but none of these things mean much if you’re dead. So the number one priority of the primitive human mind was to look out for anything that might harm you and avoid it! In essence, the primitive mind was a ‘Don’t get killed’ device, and it proved enormously useful. The better our ancestors became at anticipating and avoiding danger, the longer they lived and the more children they had.

With each generation the human mind became increasingly skilled at predicting and avoiding danger. And now, after a hundred thousand years of evolution, the modern mind is still constantly on the lookout for trouble. It assesses and judges almost everything we encounter: Is this good or bad? Safe or dangerous? Harmful or helpful? These days, though, it’s not sabre-toothed cats or 200 kilogram wolves that our mind warns us about. Instead it’s losing our job, being rejected, getting a speeding ticket, not being able to pay the bills, embarrassing ourselves in public, upsetting our loved ones, getting cancer, or any of a million and one other common worries. As a result we spend a lot of time worrying about things that, more often than not, never happen.

Another essential for the survival of any early human is to belong to a group. If your clan boots you out, it won't be long before the wolves find you. So how does the mind protect you from rejection by the group? By comparing you with other members of the clan: Am I fitting in? Am I doing the right thing? Am I contributing enough? Am I as good as the others? Am I doing anything that might get me rejected?

Sound familiar? Our modern-day minds are continually warning us of rejection and comparing us against the rest of society. No wonder we spend so much energy worrying whether people will like us! No wonder we're always looking for ways to improve ourselves or putting ourselves down because we don't 'measure up'. A hundred thousand years ago we had only the few members of our immediate clan to compare ourselves with. But these days we can open any newspaper or magazine, switch on any television, tune in to any radio, and instantly find a whole host of people who are smarter, richer, taller, slimmer, sexier, stronger, more powerful, more famous, more successful, or more admired than we are. What's the fastest way to make a teenage girl depressed? Show her a fashion magazine. When she compares herself to all those air-brushed, collagen-enhanced, digitally altered supermodels, she is guaranteed to feel inferior or downright unattractive. And the rest of us are not that different. Thanks to evolution, our minds are now so sophisticated they can even dream up a fantasy of the person we'd like to be—and then compare our 'real' self to that impossible standard. What chance have we got? We will always end up feeling not good enough!

Now, for any Stone Age person with ambition, the general rule for success is: the more, the better. The more sophisticated your weapons (and the more of them you have), the more food you can kill. The more plentiful your food stores, the better your chances are for living through times of scarcity. The more substantial your shelter, the safer you are from weather and wild animals. The more children you have, the better the chance that some of them will survive into adulthood. No surprise then, that our modern mind continually looks for more: more money, more status, more love, more job satisfaction, a newer car, a younger-looking body, a younger-looking partner, a bigger house. And if we succeed, if we actually get more money or a newer car or a better job, then we're satisfied—*for a while*. But sooner or later (and usually sooner), we end up wanting more.

Thus, evolution has shaped our minds so that we are almost inevitably destined to suffer psychologically: to compare, evaluate and criticise ourselves; to focus on what we're lacking; to be dissatisfied with what we have; and to imagine all sorts of frightening scenarios, most of which will never happen. No wonder humans find it hard to be happy!

## **What Exactly Is 'Happiness'?**

We all want it. We all crave it. We all strive for it. Even the Dalai Lama has said: 'The very purpose of life is to seek happiness.' But what exactly is this elusive thing we are looking for?

The word 'happiness' has two very different meanings. Usually it refers to a feeling: a sense of pleasure, gladness or gratification. We all enjoy happy feelings, so it's no surprise that we chase them. However, like all our other feelings, feelings of happiness don't last. No matter how hard we try to hold on to them, they slip away every time. And as we shall see, a life spent in pursuit of those feelings is, in the main, unsatisfying. In fact, the harder we pursue pleasurable feelings, the more we are likely to suffer from anxiety and depression.

The other meaning of happiness is 'a rich, full and meaningful life'. When we take action on the things that truly matter deep in our hearts, when we move in directions that we consider valuable and worthy, when we clarify what we stand for in life and act accordingly, then our lives become rich and full and meaningful, and we experience a powerful sense of vitality. This is not some fleeting feeling—it is a profound sense of a life well lived. And although such a life will undoubtedly give us many pleasurable feelings, it will also give us uncomfortable ones, such as sadness, fear and anger. This is only to be expected. If we live a full life, we will feel the full range of human emotions.

In this book, as you've probably guessed by now, we are far more interested in the second meaning of happiness than in the first. Of course, happy feelings are quite pleasant, and we should certainly make the most of them when they present themselves. But if we try to have them all the time, we are doomed to failure.

The reality is, life involves pain. There's no getting away from it. As human beings we are all faced with the fact that sooner or later we will grow infirm, get sick and die. Sooner or later we all will lose valued relationships through rejection, separation or death. Sooner or later we all will come face-to-face with a crisis, disappointment and failure. This means that in one form or another, we are all going to experience painful thoughts and feelings.

The good news is that, although we can't avoid such pain, we can learn to handle it much better—to make room for it, rise above it and create a life worth living. This book will show you how to do so. There are three parts to this process.

In Part 1 you will learn how you create and get stuck in the happiness trap. This is an essential first step, so please don't skip it—you can't escape the trap if you don't know how it works.

In Part 2, rather than trying to avoid or eliminate painful thoughts and feelings, you will learn how to fundamentally transform your relationship with them. You will learn how to experience painful thoughts and feelings in a new way that will lessen their impact, drain away their power, and dramatically decrease their influence over your life.

Finally, in Part 3, instead of chasing happy thoughts and feelings, you will focus on creating a rich and meaningful life. This will give rise to a sense of vitality and fulfilment that is both deeply satisfying and long lasting.

## **The Journey Ahead**

This book is like a trip through a foreign country: much will seem strange and new. Other things will seem familiar yet somehow subtly different. At times you may feel challenged or confronted, at other times excited or amused. Take your time on this journey. Instead of rushing ahead, savour it fully. Stop when you find something stimulating or unusual. Explore it in depth and learn as much as you can. To create a life worth living is a major undertaking, so please take the time to appreciate it.

## PART 1

# How You Set The Happiness Trap

## Chapter 1

### FAIRYTALES

What's the last line of every fairytale? You got it: '...and they lived happily ever after.' And it's not just fairytales that have happy endings. How about Hollywood movies? Don't they nearly always have some sort of feel-good ending where good triumphs over evil, love conquers all, and the hero defeats the bad guy? And doesn't the same hold true for most popular novels and television programs? We love happy endings because society tells us that's how life should be: all joy and fun, all peace and contentment, living happily ever after. But does that sound realistic? Does it fit in with your experience of life? This is one of four major myths that make up the basic blueprint for the happiness trap. Let's take a look at these myths, one by one.

#### **Myth No.1: Happiness Is The Natural State For All Human Beings**

Our culture insists that humans are naturally happy. But the statistics quoted in the introduction clearly disprove this. Remember, one in ten adults will attempt suicide, and one in five will suffer from depression. What's more, the statistical probability that you will suffer from a psychiatric disorder at some stage in your life is almost 30 per cent! Not exactly great odds, are they?

And when you add in all the misery caused by problems that are not classified as psychiatric disorders—loneliness, divorce, sexual difficulties, work stress, midlife crisis, relationship issues, domestic violence, social isolation, bullying, prejudice, low self-esteem, chronic anger and lack of meaning or purpose in life—you start to get some idea of just how rare true happiness really is. Unfortunately, many people walk around with the belief that everyone else is happy except for them. And—you guessed it—this belief creates even more unhappiness.

#### **Myth No.2: If You're Not Happy, You're Defective**

Following logically from Myth 1, western society assumes that mental suffering is abnormal. It is seen as a weakness or illness, a product of a mind that is somehow faulty or defective. This means that when we do inevitably experience painful thoughts and feelings, we often criticise ourselves for being weak or stupid. Health professionals contribute to this process by readily slapping on labels such as, 'You're depressed', and these labels merely confirm how defective we are.

Acceptance and Commitment Therapy is based on a dramatically different assumption. ACT proposes that the normal thinking processes of a healthy human mind will naturally lead to psychological suffering. You're not defective—your mind's just doing its job; the thing it *evolved* to do. Fortunately, ACT can teach you how to adapt to this in such a way that your life will be powerfully transformed.

#### **Myth No.3: To Create A Better Life, We Must Get Rid Of Negative Feelings**

We live in a feel-good society, a culture thoroughly obsessed with finding happiness. And what

does that society tell us to do? To eliminate ‘negative’ feelings and accumulate ‘positive’ ones in their place. It’s a nice theory and on the surface it seems to make sense. After all, who wants to have unpleasant feelings? But here’s the catch: the things we generally value most in life bring with them a whole range of feelings, both pleasant and unpleasant. For example, in an intimate long-term relationship, although you will experience wonderful feelings such as love and joy, you will also inevitably experience disappointment and frustration. There is no such thing as the perfect partner and sooner or later conflicts of interest will happen.

The same holds true for just about every meaningful project we embark on. Although they often bring feelings of excitement and enthusiasm, they also generally bring stress, fear and anxiety. So if you believe Myth 3, you’re in big trouble, because it’s pretty well impossible to create a better life if you’re not prepared to have some uncomfortable feelings. However, in Part 2 of this book, you will learn how to handle such feelings altogether differently, to experience them in such a way that they bother you a whole lot less.

### **Myth No.4: You Should Be Able To Control What You Think And Feel**

The fact is, we have much less control over our thoughts and feelings than we would like. It’s not that we have no control; it’s just that we have much less than the ‘experts’ would have us believe. However, we do have a *huge* amount of control over our actions. And it’s through taking action that we create a rich, full and meaningful life. (That’s why we say ACT as the word ‘act’, rather than as the initials A.C.T.)

The overwhelming majority of self-help programs subscribe to Myth 4. For example, many approaches teach you to identify negative thoughts and replace them with more positive ones. Other approaches encourage the repetition of positive affirmations such as, ‘Everything that happens is for my highest good and greatest joy’, or ‘I am strong, able and capable at all times’. Still other approaches encourage you to visualise what you want, to vividly imagine yourself the way you want to be, living the life you dream of. The basic theme of all these approaches is this: if you challenge your negative thoughts or images and, instead, repeatedly fill your head with positive thoughts and images, you will find happiness. If only life were that simple!

I’m willing to bet that you’ve already tried countless times to think more positively about things and yet those negative thoughts keep coming back again and again. As we saw in the last chapter, our minds have evolved over a hundred thousand years to think the way they do, so it’s not likely that a few positive thoughts or affirmations will change them all that much! It’s not that these techniques have *no* effect; they can often make you feel better temporarily. But they will not get rid of negative thoughts over the long term.

The same holds true for ‘negative’ feelings such as anger, fear, sadness, insecurity and guilt. There are multitudes of psychological strategies to ‘get rid of’ such feelings. But you’ve undoubtedly discovered that even if they go away, after a while they’re back. And then they go away again. And then they come back again. And so on and so on. The likelihood is, if you’re like most other humans on the planet, you’ve already spent a lot of time and effort trying to have ‘good’ feelings instead of ‘bad’ ones—and you’ve probably found that as long as you’re not too distressed, you can, to some degree, pull it off. But you’ve probably also discovered that as your level of distress increases, your ability to control your feelings progressively lessens. Sadly, Myth 4 is so widely believed that we tend to feel inadequate when our attempts to control our thoughts and feelings fail.

These four powerful myths provide the basic blueprint for the happiness trap. They set us up for a struggle we can never win: the struggle against our own human nature. It is this struggle that builds the trap. In the next chapter we will look at this struggle in detail, but first let’s consider why these myths are so entrenched in our culture.

## The Illusion Of Control

The human mind has given us an enormous advantage as a species. It enables us to make plans, invent things, coordinate actions, analyse problems, share knowledge, learn from our experiences and imagine new futures. The clothes on your body, the shoes on your feet, the watch on your wrist, the chair beneath you, the roof over your head, the book in your hands—none of these things would exist but for the ingenuity of the human mind. The mind enables us to shape the world around us and conform it to our wishes, to provide ourselves with warmth, shelter, food, water, protection, sanitation and medicine. Not surprisingly, this amazing ability to control our environment gives us high expectations of control in other arenas as well.

Now, in the material world, control strategies generally work well. If we don't like something, we figure out how to avoid it or get rid of it, and then we do so. A wolf outside your door? Get rid of it! Throw rocks at it, or spears, or shoot it. Snow, rain or hail? Well you can't get rid of those things, but you can avoid them by hiding in a cave, or building a shelter. Dry, arid ground? You can get rid of it by irrigation and fertilisation, or you can avoid it by moving to a better location.

But what about our internal world? I'm talking here about thoughts, memories, emotions, urges, mental images and physical sensations. Can we simply avoid or get rid of the ones we don't like? In the outer world, we can do so fairly easily, so shouldn't it be the same with our inner world?

Here's a little experiment. As you keep reading this paragraph, try not to think about ice cream. Don't think about the colour or the texture or the taste of it. Don't think about how it tastes on a hot summer's day. Don't think about how good it feels as it melts inside your mouth. Don't think about how you have to keep licking around the edges to stop it from dripping on your fingers.

How'd you do?

Exactly! You couldn't stop thinking about ice cream.

Here's another little experiment. Recall something that happened in the past week. Any memory will do, whether it's a conversation you had, a movie you watched or a meal you ate. Got one? Good. Now try to get rid of it. Totally obliterate it from your memory so it can never come back to you, ever again.

How did you go? If you think you succeeded, just check again and see if you can still remember it.

Now, tune in to your mouth. Notice how your tongue feels. Run it over your teeth, your gums, your cheeks and the roof of your mouth. Now try to get rid of those sensations. Try to turn your mouth totally numb, as if you just had a shot of novocaine from the dentist. Were you able to forget the sensations?

Now consider this hypothetical scenario for a moment. Suppose someone put a loaded gun to your head and told you that *you must not feel afraid*; that if you should feel even the slightest trace of anxiety, they will shoot you. Could you stop yourself feeling anxious in this situation, even though your life depended on it? (Sure you could try to act calm, but could you truly feel it?)

Okay, one last experiment. Stare at the star below then see if you can stop yourself from thinking for 60 seconds. That's all you have to do. For 60 seconds, prevent any thoughts whatsoever from coming into your mind—especially any thoughts about the star! (Figure 1)

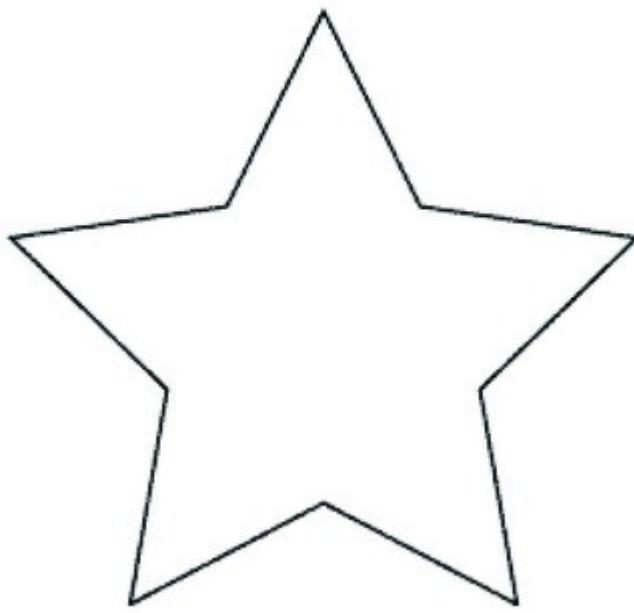


Figure 1

Hopefully by now you're getting the point that thoughts, feelings, physical sensations and memories are just not that easy to control. It's not that you have *no* control over these things; it's just that you have much less control than you thought. Let's face it, if these things were that easy to control, wouldn't we all just live in perpetual bliss? Of course, there are a few self-help gurus who claim to live in such a state all the time. Such people often get really rich, their books sell by the million and they attract huge followings of people desperate for 'the answer'. My guess is that many readers of this book will have already gone down that path and been sadly disappointed.

## How We Learn About Control

From a young age, we are taught that we should be able to control our feelings. When you were growing up, you probably heard a number of expressions like, 'Don't cry, or I'll give you something to cry about', 'Don't be so gloomy; look on the bright side', 'Take that frown off your face', 'You're a big boy now. Big boys don't cry', 'Stop feeling sorry for yourself', 'Don't worry, there's no need to be frightened.'

With words such as these, the adults around us sent out the message, again and again, that we ought to be able to control our feelings. And certainly it appeared to us as if they controlled theirs. But what was going on behind closed doors? In all likelihood, many of those adults weren't coping too well with their own painful feelings. They may have been drinking too much, taking tranquillisers, crying themselves to sleep every night, having affairs, throwing themselves into their work or suffering in silence while slowly developing stomach ulcers. However they were coping, they probably didn't share those experiences with you.

And on those rare occasions when you did get to witness their loss of control, they probably never said anything like, 'Okay, these tears are because I'm feeling something called sadness. It's a normal feeling and you can learn how to handle it effectively.' But then, that's not too surprising; they couldn't show you how to handle your emotions because they didn't know how to handle theirs!

The idea that you should be able to control your feelings was undoubtedly reinforced in your school years. For example, kids who cried at school were probably teased for being 'cry-babies' or 'sissies'—especially if they were boys. Then, as you grew older, you probably heard phrases (or even used them yourself) such as, 'Get over it!' 'Shit happens!' 'Move on!' 'Chill out!' 'Don't let it

bother you!' 'Don't be such a chicken!' 'Snap out of it!' and so on.

The implication of all these phrases is that you should be able to turn your feelings on and off at will, like flicking a switch. And why is this myth so compelling? Because the people around us seem, on the surface, to be happy. They seem to be in control of their thoughts and feelings. But 'seem' is the key word here. The fact is that most people are not open or honest about the struggle they go through with their own thoughts and feelings. They 'put on a brave face' and 'keep a stiff upper lip'. They are like the proverbial clown crying on the inside; the bright face paint and chirpy antics are all we see. It's common in therapy to hear clients say things like, 'If my friends/family/colleagues could hear me now, they'd never believe it. Everyone thinks I'm so strong/confident/happy/independent...'

Penny, a 30-year-old receptionist, came to see me six months after the birth of her first child. She was feeling tired and anxious and full of self-doubt about her mothering skills. At times she felt incompetent or inadequate and just wanted to run away from all the responsibility. At other times she felt exhausted and miserable and wondered if having a child had been a huge mistake. On top of that, she felt guilty for even having such thoughts! Although Penny attended regular mothers' group meetings, she kept her problems a secret. The other mothers all seemed so confident, she feared that if she told them how she was feeling, they would look down on her. When Penny eventually plucked up the courage to share her experiences with the other women, her admission broke a conspiracy of silence. The other mothers had all been feeling the same way to one degree or another, but they'd all been putting on the same act of bravado, hiding their true feelings for fear of disapproval or rejection. There was a huge sense of relief and bonding as these women opened up and got honest with one another.

To make a gross generalisation, men are much worse than women at admitting their deepest concerns because men are taught to be stoic: to bottle up their feelings and hide them. After all, big boys don't cry. In contrast, women learn to share and discuss their feelings from a young age. Nonetheless, many women are reluctant to tell even their closest friends that they are feeling depressed or anxious or not coping in some way, for fear of being judged weak or silly. Our silence about what we are really feeling and the false front we put on for the people around us simply add to the powerful illusion of control.

So the question is: How much have you been influenced by all these control myths? The questionnaire on the following pages will help you find out.

## CONTROL OF THOUGHTS AND FEELINGS QUESTIONNAIRE

This questionnaire has been adapted from similar ones developed by Steven Hayes, Frank Bond and others. When the term 'negative thoughts and feelings'

is used, it refers to a whole range of painful feelings (such as anger, depression and anxiety), and painful thoughts (such as bad memories, disturbing images, and harsh self-judgments). For each pair of statements, please select the one that most accurately fits how you feel. The answer you choose doesn't have to be absolutely 100 per cent true for you all the time; just pick the answer which seems to be more representative of your general attitude.

- 1a.** I must have good control of my feelings in order to be successful in life.
- 1b.** It is unnecessary for me to control my feelings in order to be successful in life.
- 2a.** Anxiety is bad.
- 2b.** Anxiety is neither good nor bad. It is merely an uncomfortable feeling.
- 3a.** Negative thoughts and feelings will harm you if you don't control or get rid of them.
- 3b.** Negative thoughts and feelings won't harm you, even if they feel unpleasant.

**4a.** I'm afraid of some of my strong feelings.

**4b.** I'm not afraid of any feelings, no matter how strong.

**5a.** In order for me to do something important, I have to get rid of all my doubts.

**5b.** I can do something important, even when doubts are present.

**6a.** When negative thoughts and feelings arise, it's important to reduce or get rid of them as fast as possible.

**6b.** Trying to reduce or get rid of negative thoughts and feelings frequently causes problems. If I simply allow them to be, then they will change as a natural part of living.

**7a.** The best method of managing negative thoughts and feelings is to analyse them; then utilise that knowledge to get rid of them.

**7b.** The best method of managing negative thoughts and feelings is to acknowledge their presence and let them be, without having to analyse or judge them.

**8a.** I will become 'happy' and 'healthy' by improving my ability to avoid, reduce or get rid of negative thoughts and feelings.

**8b.** I will become 'happy' and 'healthy' by allowing negative thoughts and feelings to come and go of their own accord, and learning to live effectively when they are present.

**9a.** If I can't suppress or get rid of a negative emotional reaction, it's a sign of personal failure or weakness.

**9b.** The need to control or get rid of a negative emotional reaction is a problem in itself.

**10a.** Having negative thoughts and feelings is an indication that I'm psychologically unhealthy or 'I've got problems'.

**10b.** Having negative thoughts and feelings means I'm a normal human being.

**11a.** People who are in control of their lives can generally control how they feel.

**11b.** People who are in control of their lives do not need to try to control their feelings.

**12a.** It is not okay to feel anxious and I try hard to avoid it.

**12b.** I don't like anxiety, but it's okay to feel it.

**13a.** Negative thoughts and feelings are a sign that there is something wrong with my life.

**13b.** Negative thoughts and feelings are an inevitable part of life for everyone.

**14a.** I have to feel good before I can do something that's important and challenging.

**14b.** I can do something that's important and challenging even if I'm feeling anxious or depressed.

**15a.** I try to suppress thoughts and feelings that I don't like by just not thinking about them.

**15b.** I don't try to suppress thoughts and feelings that I don't like. I just let them come and go of their own accord.

To score your test, count the number of times you selected option 'a' or 'b'. (Please keep a record of your score. At the end of this book, I'll ask you to come back and do this test again.)

The more times you selected option 'a', the greater the likelihood that control issues are creating significant suffering in your life. How so? Well, that's the subject of the next chapter.

## Chapter 2

### VICIOUS CYCLES

Michelle has tears streaming down her eyes. ‘What’s wrong with me?’ she asks. ‘I have a great husband, great kids, a great job. I’m fit; I’m healthy. We have a lovely house. We’re well off. We live in a beautiful area. So why aren’t I happy?’

It’s a good question. Michelle seems to have everything she wants in life, so what’s going wrong? We’ll come back to Michelle later in this chapter, but for now let’s take a look at what’s happening in your life.

#### What’s Your Problem?

Presumably, if you’re reading this book, there’s room for your life to work better than it does. Maybe your relationship is in trouble, or you’re lonely or heart broken. Maybe you hate your job, or maybe you’ve lost it. Maybe your health is deteriorating. Maybe someone you love has died, or rejected you, or moved far away. Maybe you’re having a midlife crisis. Maybe you have low self-esteem or no self-confidence or feelings of inadequacy. Maybe you have drug or alcohol problems or other addictions. It could be financial or legal difficulties, or that you just feel stuck and don’t know *what* you want. Maybe you’re suffering from depression or anxiety, or you could just be bored with life or feel that it lacks any meaning.

Whatever the problem is, it undoubtedly gives rise to unpleasant thoughts and feelings—and you’ve probably spent a lot of time and effort trying to escape them or blot them out. But suppose those attempts to get rid of your bad thoughts and feelings are actually lowering the quality of your life? In ACT we have a saying for this: ‘The solution is the problem!’

#### How Does A Solution Become A Problem?

What do you do when you have an itch? You scratch it, right? And usually this works so well you don’t even think about it: scratch the itch and it goes away. Problem solved. But suppose one day you develop a patch of eczema (a common skin condition). The skin is very itchy, so naturally you scratch it. However, the skin cells in this region are already inflamed and therefore highly sensitive, and when you scratch them, they release chemicals called histamines, which are highly irritating. And these histamines inflame the skin even further. So after a little while the itch returns—with a greater intensity than before. And, of course, if you scratch it again, it gets even worse! The more you scratch, the worse the eczema and the bigger the itch.

Scratching is a good solution for a fleeting itch in normal, healthy skin. But for a persistent itch in abnormal skin, scratching is harmful: the ‘solution’ becomes part of the problem. This is commonly known as a ‘vicious cycle’. And in the world of human emotions, vicious cycles are common. Here are a few examples:

- Joseph fears rejection, so he feels overly anxious in social situations. He doesn’t want those feelings of anxiety, so he avoids socialising whenever possible. He doesn’t accept invitations to parties. He doesn’t pursue friendships. He lives alone and stays home every night. This means that on the rare occasion when he does socialise, he’s more anxious than ever because he’s so out of practice. Furthermore, living alone with no friends or social life just serves to make him feel completely rejected, which is the very thing he fears!

- Yvonne also feels anxious in social situations. She copes with this by drinking heavily. In the short term, alcohol reduces her anxiety. But the next day she feels hung-over and tired and she often regrets the money she spent on alcohol or worries about the embarrassing things she did while under the influence. Sure, she escapes anxiety for a little while, but the price she pays is a lot of other unpleasant feelings over the long term. And if she ever finds herself in a social situation where she can't drink, her anxiety is greater than ever, because she doesn't have alcohol to rely on.
- Danielle is overweight and hates it, so she eats some chocolate to cheer herself up. For the moment, she feels better. But then she thinks about all the calories she's just consumed and how that will add to her weight—and ends up feeling more miserable than ever.
- Ahmed is out of shape. He wants to get fit again. He starts working out, but because he's unfit, it's hard work and it feels uncomfortable. He doesn't like the discomfort, so he stops working out. Then his fitness level slides even lower.
- There's a lot of built-up tension between Andrew and his wife, Sylvana. Sylvana is angry at Andrew because he works long hours and doesn't spend enough time with her. Andrew doesn't like those feelings of tension in the house, so in order to avoid them, he starts working longer hours. But the more hours he works, the more dissatisfied Sylvana gets—and the tension in their relationship steadily increases.

You can see that these are all examples of trying to get rid of, avoid or escape from unpleasant feelings. We call these ‘control strategies’ because they are attempts to directly control how you feel. The table on the following page shows some of the most common control strategies. I’ve organised them into two main categories: fight strategies and flight strategies. Fight strategies involve fighting with or trying to dominate your unwanted thoughts and feelings. Flight strategies involve running away or hiding from those unwelcome thoughts and feelings. (Table 2.1)

#### COMMON CONTROL STRATEGIES

Flight Strategies		Fight Strategies
Hiding/Escaping		Suppression
You hide away or escape from situations or activities that might bring up uncomfortable thoughts or feelings. For example, you drop out of a course or avoid going to a social function, in order to prevent feelings of anxiety.		You try to directly suppress unwanted thoughts and feelings. You forcefully push unwanted thoughts from your mind, or you push your feelings ‘deep down inside’.
Distraction		Arguing
You distract yourself from your thoughts and feelings by focusing on something else. For example, you’re feeling bored or anxious, so you smoke a cigarette or eat some ice cream or go shopping. Or you’re worried about some important issue at work, so you spend all night watching television to try to keep your mind off it.		You argue with your own thoughts to try to disprove them rationally. For example, if your mind says, ‘You’re a failure’, you may argue back, ‘Oh, no, I’m not—just look at everything I’ve achieved in my work.’ Or you may argue against reality, protesting that, ‘It shouldn’t be like this!’
Zoning Out/Numbing		Taking Charge

You try to cut off from your thoughts and feelings by zoning out or making yourself numb, most commonly through the use of medication, drugs or alcohol. Some people do their zoning out by sleeping excessively or simply ‘staring at the walls’.	You try to take charge of your thoughts and feelings. For example, you may tell yourself things like, ‘Snap out of it!’ ‘Stay calm!’ or ‘Cheer up!’ Or you try to replace negative thoughts with positive ones, or to force yourself to be happy when you’re not.
	Self-bullying

Table 2.1

## The Problem With Control

What’s the problem with using methods like these to try to control your thoughts and feelings? The answer is nothing, if:

- you use them only in moderation
- you use them only in situations where they can work
- using them doesn’t stop you from doing the things you value.

If you’re not too distressed or upset—if you’re just dealing with run-of-the-mill, everyday stress—then deliberate attempts to control your thoughts and feelings aren’t likely to be a problem. In some situations distraction can be a good way of dealing with unpleasant emotions. If you’ve just had a row with your partner and you’re feeling hurt and angry, it could be helpful to distract yourself by going for a walk or burying your head in a book until you calm down. And sometimes zoning out can be beneficial. For example, if you’re stressed and drained after a gruelling day’s work, falling asleep on the couch may be just the ticket to help you rejuvenate.

However, control methods become problematic when:

- you use them excessively
- you use them in situations where they can’t work
- using them stops you from doing the things you truly value.

## Using Control Excessively

To varying degrees, every one of us uses control strategies. I mean, who wouldn’t prefer to do without some of the less enjoyable thoughts and feelings that crop up from time to time? And as we’ve seen, used in moderation, such attempts at control are no big deal. For instance, when I’m

feeling particularly anxious, I sometimes eat a bar of chocolate or some biscuits. This is basically a form of distraction; an attempt to avoid some unpleasant feeling by focusing on something else. But because I don't do it excessively, it doesn't create a major problem in my life—I maintain a healthy weight, and I don't give myself diabetes. Now, when I was in my early twenties it was a different story. Back then I ate a truckload of cakes and chocolates to try to avoid my anxiety (on a bad day I could go through five whole packets of TimTams), and as a result I became seriously overweight and developed high blood pressure. It was exactly the same control strategy, but when I used it excessively, it clearly had serious consequences.

If you're worried about upcoming exams, you may try to distract yourself from the anxiety by watching television. Now, that's fine if you're only doing it every now and then, but if you do it too much, you'll spend all your evenings watching television and you won't get any studying done. This, in turn, will create more anxiety as your studies lag further and further behind. Therefore, as a method for anxiety control, distraction simply can't work in the long run. And then there's the obvious: dealing with your anxiety in this way prevents you from doing the one thing that would be genuinely helpful—studying.

The same goes for zoning out with alcohol or drugs. Moderate drinking or taking the occasional tranquilliser isn't likely to have serious long-term consequences. But if such control methods become a crutch, it can easily lead to addiction, which then creates all sorts of complications, giving rise to even more painful feelings.

Notice that there is considerable overlap between these control strategies. Watching television instead of studying can be not only a distraction but also a hiding/escaping strategy (hiding or escaping from your studies). And television can also be used for zoning out: some people may sit in front of the telly for hours on end, watching without any genuine interest.

## Trying To Use Control In Situations Where It Can't Work

If you love somebody deeply and you lose that relationship—whether through death, rejection or separation—you will feel pain. That pain is called grief. Grief is a normal emotional reaction to any significant loss, whether a loved one, a job or a limb. There's no way to avoid or get rid of it—it's just there. And, once accepted, it will pass in its own time.

Unfortunately, many of us refuse to accept grief. We will do anything rather than feel it. We may bury ourselves in work, drink heavily, throw ourselves into a new relationship 'on the rebound' or numb ourselves with prescribed medications. But no matter how hard we try to push grief away, deep down inside it's still there. And eventually it will be back.

It's like holding a football underwater. As long as you keep holding it down, it stays beneath the surface. But eventually your arm gets tired and the moment you release your grip, the ball leaps straight up out of the water.

Donna was 25 years of age when her husband and child died in a tragic car crash. Naturally, she felt an enormous sense of loss: an explosion of painful feelings, including sadness, anger, fear, loneliness and despair. But Donna could not accept those painful feelings and she turned to alcohol to push them away. Getting drunk would temporarily soothe her pain, but once she sobered up, her grief returned with a vengeance—and then she'd drink even more to push it away again. By the time Donna came to see me six months later, she was knocking back two bottles of wine a day, as well as some Valium and sleeping tablets. The single biggest factor in her recovery was her willingness to stop running away from her pain. Only when she opened herself to her feelings, and accepted them as a natural part of the grieving process, was she able to come to terms with her terrible loss. This enabled her to grieve effectively for her loved ones and channel her energy into building a new life. (Later in the book, we'll look at how she accomplished that.)

## **When Using Control Stops Us From Doing What We Value**

What do you cherish most in life? Health? Work? Family? Friends? Religion? Sport? Nature? It's no surprise that life is richer and more fulfilling when we actively invest our time and energy in the things that are most important or meaningful to us. Yet all too often our attempts to avoid unpleasant feelings get in the way of doing what we truly value.

For example, suppose you are a professional actor and you love your work. Then one day, quite out of the blue, you develop an intense fear of failure just as you are due to appear onstage. So you refuse to go on (a malady commonly known as 'stage fright'). Refusing to go onstage may well reduce your fear temporarily, but it also stops you from doing something you truly value.

Or suppose you've just gone through a divorce. Sadness, fear and anger are all natural reactions, but you don't want to have these unpleasant feelings. So you try to lift your mood by eating junk food, getting drunk or chain-smoking cigarettes. But what does this do to your health? I've never met anyone who didn't value their health, and yet many people use control strategies that actively damage their physical bodies.

## **How Much Control Do We Actually Have?**

The degree of control we have over our thoughts and feelings depends largely on how intense they are—the less intense the feelings, the more we can control them. For instance, if we're just dealing with the typical everyday stresses, a simple relaxation technique can make us feel calmer right away. However, the more troubling our thoughts and feelings are, the less effective our attempts at control will be. If you're terrified, no relaxation technique known to humanity will calm you.

We also have more control over our thoughts and feelings when the things that we're avoiding aren't too important. For example, if you're avoiding cleaning your messy garage or your car, then it's probably fairly easy to take your mind off it. Why? Because in the larger scheme of things, it's simply not that important. If you don't do it, the sun will still rise tomorrow and you will continue to draw breath. All that will happen is that your garage or car will remain messy. But suppose you suddenly developed a large, suspicious-looking black mole on your arm and you avoid going to the doctor. Would it be easy to take your mind off it? Sure, you could go to a movie, watch television or surf the Internet and maybe, for a little while, you could stop thinking about it. But in the long term, you will inevitably start thinking about that mole, because the consequences of not taking action are potentially serious.

So, because many of the things we avoid are not that important, and because many of our negative thoughts and feelings are not that intense, we find that our control strategies can often make us feel better—at least for a little while. Unfortunately, though, they can give us a false sense of confidence; that is, we start to believe that we have much more control than we actually do. And this false sense of control is only compounded by the myths we encountered in the last chapter.

## **What Has Control Got To Do With The Happiness Trap?**

The happiness trap is built through ineffective control strategies. In order to feel happy, we try hard to control what we're feeling. But these control strategies have three significant costs:

1. They take up a lot of time and energy and are usually ineffective in the long run.
2. We feel silly, defective, or weak-minded because the thoughts/feelings we're trying to get rid of keep coming back.

3. Many strategies that decrease unpleasant feelings in the short-term actually lower our quality of life over the long term.

These unwanted outcomes lead to more unpleasant feelings, and thus even more attempts to control them. It's a vicious cycle. Psychologists have a technical term for this inappropriate or excessive use of control strategies: 'experiential avoidance'. Experiential avoidance means the tendency to keep trying to avoid, change or get rid of your unwanted thoughts and feelings—even when doing so is harmful, costly, useless or destructive. Experiential avoidance is a major cause of depression, anxiety, drug and alcohol addiction, eating disorders and a vast number of other psychological problems. So here is the happiness trap in a nutshell: to find happiness, we try to avoid or get rid of bad feelings—but the harder we try, the more bad feelings we create. It's important to get a sense of this for yourself, to trust your own experience rather than simply believing what you read. So with this in mind, take a moment to complete the following sentence: The thoughts/feelings I'd most like to get rid of are...

Once you've got your answer, take a few minutes to write a list of every single thing you've tried in order to avoid, change or get rid of these unpleasant thoughts or feelings. Try to remember every single strategy you have ever used, whether deliberately or by default. Don't try to edit or troubleshoot your answers. The goal is to come up with as many examples as possible, such as avoiding situations where the feeling occurs, using drugs or alcohol, taking prescription medications, criticising or chastising yourself, going into denial, blaming others, using visualisation or self-hypnosis, reading self-help books, seeing a therapist, using positive affirmations, procrastination, praying, talking it through with friends, writing in your diary, smoking cigarettes, eating more, eating less, sleeping more, sleeping less, putting off important changes or decisions, throwing yourself into work/socialising/hobbies/exercise, or telling yourself 'It will pass.'

Once you've done that, go through your list and for each item, ask yourself:

1. Did it get rid of my painful thoughts and feelings in the long term?
2. What did it cost me in time, energy, money and health and vitality?
3. Did it bring me closer to a rich, full and meaningful life?

You probably discovered four things while doing this exercise:

1. You've put a lot of time and effort into trying to change, get rid of or escape from unpleasant thoughts and feelings.
2. Most of the control strategies you've tried have not lessened your painful thoughts and feelings in the long term.
3. Many of these control strategies have taken a toll.
4. Many of these control strategies have actually taken you further away from the life you would ideally like to have.

Feeling a bit dazed, confused or disturbed? If so ... good! This is a major shift in your reality, one that challenges many deeply entrenched beliefs. Strong reactions are quite normal.

Of course, if your control strategies have *not* had significant costs, or if they *have* brought you closer to the life you want, then they are not problematic and we don't need to focus on them. In ACT we are only concerned about the control strategies that put a drag on your quality of life in the long run.

'Wait a moment,' I hear you say. 'Why haven't you talked about things like giving to charity, or working diligently, or caring for your friends? Isn't giving to others supposed to make people happy?' Good point. Bear in mind that it's not just the things you do that matter; it's also your motivation for doing them. If you're giving to charity to push away thoughts that you're selfish, or you're throwing yourself into work to avoid feelings of inadequacy, or you're caring for your friends to counteract fears of rejection, then chances are, you won't get much satisfaction out of those activities. Why not? Because when your primary motivation is the avoidance of unpleasant thoughts and feelings, this drains the joy and vitality from what you are doing. For example, recall the last time you ate something rich and tasty to try to stop feeling stressed, or bored, or unhappy. Chances are, it wasn't all that satisfying. However, did you ever eat that very same food, not to get rid of bad feelings, but purely and simply to enjoy it and appreciate its taste? I bet you found that much more fulfilling.

Great advice about how to improve your life comes at you from all directions: find a meaningful job, do this great workout, connect with friends and family, get out in nature, take up a hobby, join a club, contribute to a charity, learn new skills, get involved in your community and so on. And all these activities can be deeply satisfying if you do them because they are genuinely important and meaningful to you. But if these activities are used mainly to dodge unpleasant thoughts and feelings, chances are, they won't be very rewarding. It's hard to appreciate life when you're running away from something threatening.

Remember Michelle, who seems to have everything she wants in life and yet she's not happy? Michelle's life is driven by avoiding feelings of unworthiness. She is plagued by thoughts like, 'I'm a lousy wife', 'Why am I so inadequate?' and 'Nobody likes me', along with all the accompanying feelings of guilt, anxiety, frustration and disappointment.

Michelle works hard to make those thoughts and feelings go away. She pushes herself to excel at her job, frequently working late to accommodate others; she dotes on her husband and kids and caters to their every whim; she tries to please everyone in her life, always putting their needs in front of her own. The toll this takes on her is enormous. And does it get rid of those upsetting thoughts and feelings? You guessed it. By continually putting herself last and working so hard to win others' approval, she merely reinforces her sense of unworthiness. She is well and truly stuck in the happiness trap.

## How Do I Escape The Happiness Trap?

Increasing your self-awareness is the first step. Notice all the little things you do each day to dodge, change or blot out unpleasant thoughts and feelings. And when you find yourself using these control strategies, notice the consequences.

Keep a journal, or spend a few minutes each day reflecting on this. The faster you can recognise when you're stuck in the trap, the faster you can lift yourself out of it. Does this mean you just have to put up with bad feelings and resign yourself to a life of pain and misery? Not at all. In Part 2 of this book you will learn a radically different way of handling unwelcome thoughts and feelings. You'll discover how to take away their power so they can't hurt you, how to rise above them instead of getting crushed by them. You'll learn how to let them go rather than struggle with them. And you will learn how to see them in a new light, so they cease to be the frightening phantoms of old.

But don't rush. Before reading on, take a few days. Notice your attempts at control and how they

are working for you. Learn to see the trap for what it is. And look forward to the changes soon to come.

## PART 2

# Transforming Your Inner World

### Chapter 3

## THE SIX CORE PRINCIPLES OF ACT

Acceptance and Commitment Therapy is based upon six core principles which work together to help you achieve two main goals: a) to effectively handle painful thoughts and feelings, and b) to create a rich, full and meaningful life. Part 2 of this book is mainly concerned with the first of these goals: transforming your inner psychological world. Part 3 of the book is mainly concerned with the second goal: creating a life worth living. As we progress through the book, we will work through these six core principles, one by one, but first let's take a very brief look at all of them.

### PRINCIPLE 1: DEFUSION

Defusion means relating to your thoughts in a new way, so they have much less impact and influence over you. As you learn to defuse painful and unpleasant thoughts, they will lose their ability to frighten, disturb or depress you. And as you learn to defuse unhelpful thoughts, such as self-limiting beliefs and harsh self-criticisms, they will have much less influence over your behaviour.

### PRINCIPLE 2: EXPANSION

Expansion means making room for unpleasant feelings, sensations and urges, instead of trying to suppress them or push them away. As you open up and make space for these feelings, you will find they bother you much less, and they 'move on' much more rapidly, instead of 'hanging a round' and disturbing you. (The official ACT term for this principle is 'Acceptance'. I have changed it because the word 'acceptance' has so many different meanings, and can easily be misunderstood.)

### PRINCIPLE 3: CONNECTION

Connection means living in the present; focusing on and engaging fully in whatever you're doing. Instead of dwelling on the past, or worrying about the future, you are deeply connected with what is happening right here, right now. (The official ACT term for this principle is 'Contact With The Present Moment'. I have changed the term in this book purely for ease of communication.)

### PRINCIPLE 4: THE OBSERVING SELF

The Observing Self is a powerful aspect of human consciousness, which has been largely ignored by western psychology until now. As you learn how to access this part of yourself, it will enable you to further transform your relationship with unwanted thoughts and feelings.

## **PRINCIPLE 5: VALUES**

Clarifying and connecting with your values is an essential step for making life meaningful. Your values are reflections of what is most important in your heart: what sort of person you want to be; what is significant and meaningful to you; and what you want to stand for in this life. Your values provide direction for your life, and motivate you to make important changes.

## **PRINCIPLE 6: COMMITTED ACTION**

A rich and meaningful life is created through taking action. But not just any action. It happens through *effective* action, guided by and motivated by your values. And in particular, it happens through *committed* action: action that you take again, and again, and again, no matter how many times you fail, or go off track. So ‘committed action’ is shorthand for ‘committed, effective, valued action’.

It’s important to remember that while these six basic principles can transform your life in many positive ways, they aren’t the Ten Commandments! You don’t *have* to follow them. You can apply them if and when you choose to. So play around with them. Experiment. Test them out in your life, and see how they work for you. And don’t believe they’re effective just because I say so; give them a go and trust your own experience.

I should also warn you that as you work through this book, there is one key point I’ll be repeating again and again: you won’t change your life simply by *reading* this book. To do that, you will have to *take action*. It’s like reading a travel guide about India: by the end of it, you have a lot of ideas about where you’d like to visit—but you still haven’t been there. To truly experience India, you have to make the effort to get up and go there. Similarly, if all you do is read this book and think about the contents, then by the end, you will have a lot of ideas about how to create a rich, full and meaningful life—but you won’t actually be living one. In order to actually *live* a better life, you will need to follow through on the exercises and suggestions within these pages. So, are you eager to begin? Then read on...

## Chapter 4

### THE GREAT STORYTELLER

This morning I held a fresh lemon in my hands. I ran my fingers over the bright yellow skin, noting all the little dimples. I lifted it to my nose and inhaled the delicious aroma. Then I placed it on a cutting board and sliced it in half. Picking up one of the pieces, I opened my mouth and squeezed a drop of fresh lemon juice onto the tip of my tongue.

What happened as you read about that lemon? Perhaps you ‘saw’ its shape and colour. Or maybe you ‘felt’ the texture of the skin. You may have ‘smelled’ the fresh, lemony scent. You may even have found your mouth watering. However, there was no lemon in front of you, only words *about* a lemon. Yet once those words entered your head, you reacted to them almost as you would to a real lemon.

The same thing happens when you read a great thriller. All you have in front of you are words. But once those words enter your mind, interesting things start to happen. You may ‘see’ or ‘hear’ the characters and experience powerful emotions. When those words describe a character in a dangerous situation, you react as if someone really were in danger: your muscles tense, your heartbeat speeds up, your adrenaline rises. (That’s why they’re called thrillers!) And yet, all you are dealing with in reality are little black marks on a page. Fascinating things, words! But what exactly are they?

### Words And Thoughts

Humans rely heavily on words. Other animals use physical gestures and facial expressions and a variety of sounds to communicate—and so do we—but we are the only animal that uses words. Words are basically a complex system of symbols. (And a ‘symbol’ means something that stands for or refers to something else.) So, for example, the word ‘dog’ in English refers to a certain type of animal. In French, *chien* refers to the same animal, as does *cane* in Italian. Three different symbols, all referring to the same thing.

Anything that we can sense, feel, think about, observe, imagine or interact with can be symbolised by words: time, space, life, death, heaven, hell, people who died thousands of years ago, places that never existed, current events and so on. And if you know what a word refers to, then you know its meaning and you can understand it. But if you don’t know what a word refers to, then you don’t understand it. For example, ‘axillary hyperhidrosis’ is a medical term that most of us don’t understand. It means ‘sweaty armpits’. And now that you know what ‘axillary hyperhidrosis’ refers to, you understand the words.

We use words in two different settings: in public, when we’re talking, listening or writing; and in private, when we’re thinking. Words on a page, we call ‘text’; words spoken out loud, we call ‘speech’; and words inside our head, we call ‘thoughts’.

It’s important not to confuse thoughts with the mental pictures or physical feelings that often accompany them. To clarify the difference, here’s a little experiment. Take a few moments to think about what you’re going to fix for breakfast tomorrow morning. Then, as you’re thinking about it, close your eyes and observe your thoughts as they happen. Notice what form they take. Close your eyes and do this for about half a minute.

Okay, what did you notice? You may have noticed ‘pictures’ in your mind; you ‘saw’ yourself cooking or eating, as on a television screen. We’ll call these mental pictures ‘images’. Images are not thoughts, although they often occur together. You may also have noticed feelings or sensations

in your body, almost as if you were actually preparing or eating breakfast. These, too, are not thoughts; they are sensations. You also probably noticed some words passing through your head, almost like a talking voice. Those words may have described what you intend to eat: ‘I’ll have toast with peanut butter.’ Or they may have said something like, ‘I don’t know what I’ll have.’ These words in our heads are what we call ‘thoughts’. Therefore:

*Thoughts*=words inside our heads

*Images*=pictures inside our heads

*Sensations*=feelings inside our bodies.

It’s important to remember this distinction, because we deal with these internal experiences in different ways. We’ll be focusing on images and sensations later in the book. For now, we’re going to look at thoughts.

Humans rely a lot on their thoughts. Thoughts tell us about our life and how to live it. They tell us how we are and how we should be, what to do and what to avoid. And yet, they are nothing more than words—which is why, in ACT, we often refer to thoughts as stories. Sometimes they are true stories (called ‘facts’) and sometimes they are false. But most of our thoughts are neither true nor false. Most of them are either stories about how we see life (called ‘opinions’, ‘attitudes’, ‘judgements’, ‘ideals’, ‘beliefs’, ‘theories’ and ‘morals’) or about what we want to do with it (called ‘plans’, ‘strategies’, ‘goals’, ‘wishes’ and ‘values’). In ACT, our main interest in a thought is not whether it’s true or false, but whether it’s helpful; that is, does it help us create the life we want?

## The Story Is Not The Event

Imagine that a police officer catches an armed bank robber in a dramatic shoot-out. The next day we read about it in the newspapers. One particular newspaper may give a totally accurate account of what happened. It may have all the facts correct: the name of the police officer, the location of the bank, maybe even the precise number of shots fired. Another newspaper may give a less accurate account of what happened. It may exaggerate some of the details for the sake of drama or just get the facts wrong. But whether the story is totally accurate or false and misleading, it’s still just a story. And when we read that story, we aren’t actually present at the event. There is no shooting actually taking place before our eyes; all we have in front of us are words. The only people who can truly experience this event are those who are present when it happens: the ‘eyewitnesses’. Only an eyewitness actually hears the sound of the shots or sees the officer tackle the robber. No matter how much detail there is in the description, the story is not the event (and vice versa).

Of course, we know that newspaper stories are biased. They don’t give us *the absolute truth*; they give us an *angle* on what happened, which reflects the editorial viewpoint and attitude of the newspaper. (And let’s face it, some newspapers are far more sensationalistic than others.) We also know that at any point we wish, we can stop reading. If we’re not getting anything useful out of the story, we can put down the newspaper and walk outside.

Now, this may be obvious when it comes to stories in newspapers, but it’s not nearly so obvious when it comes to the stories in our minds. All too often we react to our thoughts as if they are the absolute truth, or as if we must give them all our attention. The psychological jargon for this reaction is ‘cognitive fusion’.

## What Is Cognitive Fusion?

‘Cognition’ is the technical term for a product of the mind, such as a thought, image or memory. ‘Fusion’ means a blending or melding together. ‘Cognitive fusion’ means that the thought and the thing it refers to—the story and the event—become blended. Thus, we react to words about a lemon

as if a lemon is actually present; we react to words in a crime novel as if someone really is about to be murdered; we react to words like ‘I’m useless’ as if we actually are useless; and we react to words like ‘I’m going to fail’ as if failure is a foregone conclusion. In a state of cognitive fusion, it seems as if:

- Thoughts are *reality*—as if what we’re thinking were actually happening.
- Thoughts are the *truth*—we completely believe them.
- Thoughts are *important*—we take them seriously and give them our full attention.
- Thoughts are *orders*—we automatically obey them.
- Thoughts are *wise*—we assume they know best and we follow their advice.
- Thoughts can be *threats* —some thoughts can be deeply disturbing or frightening.

Remember Michelle, who is plagued by thoughts such as, ‘I’m hopeless’, ‘I’m a lousy mother’ and ‘Nobody likes me’? In her state of cognitive fusion, those thoughts seemed to be the gospel truth. As a result, she felt terrible. ‘That’s not surprising’, you might think. ‘With thoughts like that, anyone would feel upset.’ Certainly that’s what Michelle believed—*at first*. But she soon discovered that she could instantly reduce the impact of such unpleasant thoughts by applying the simple technique described below. Read through the instructions first, then give it a go.

### **‘I’M HAVING THE THOUGHT THAT...’**

To begin this exercise, first bring to mind an upsetting thought that takes the form ‘I am X’, for example, ‘I am dumb’, ‘I am such a loser’ or ‘I’m so incompetent.’ Preferably pick a thought that often recurs and that usually bothers or upsets you when it does. Now hold that thought in your mind and believe it as much as you can. Focus on it for several seconds. Notice how it affects you.

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Now take that thought and, in front of it, insert this phrase: ‘I’m having the thought that...’ Now run that thought again, this time with the phrase attached. Think to yourself, ‘I’m having the thought that I am X.’ Notice what happens.

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Did you do it? Remember, you can’t learn to ride a bike just by reading about it—you actually have to get on the bike and pedal. And you won’t get much out of this book if you just read the exercises. To change the way you handle your painful thoughts, you actually have to *practise* some new skills. So if you haven’t done the exercise, *please* go back and do it now.

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So what happened? You probably found that inserting the phrase, ‘I’m having the thought that...’ instantly gave you some distance from the actual thought itself; it helped you step back and observe it. (If you didn’t notice any difference, try it again with another thought.)

You can use this technique with any unpleasant thought. For instance, if your mind says, ‘Life sucks!’ then simply acknowledge, ‘I’m having the thought that life sucks!’ If your mind says, ‘I’ll never get over this!’ then simply acknowledge, ‘I’m having the thought that I’ll never get over this!’

If your mind says, ‘My bum looks huge in this!’ then simply acknowledge, ‘I’m having the thought that my bum looks huge in this!’

Using this phrase makes you aware of the process of thinking. This means you’re less likely to take your thoughts literally. Instead, you can step back and see those thoughts for what they are: words passing through your head and nothing more. We call this process ‘cognitive defusion’, or simply ‘defusion’. Cognitive *fusion* tells us that thoughts are *the truth* and *very important*. Cognitive *defusion* reminds us that thoughts are just words. In a state of defusion, we recognise:

- Thoughts are merely sounds, words, stories or bits of language.
- Thoughts may or may not be true; we don’t automatically believe them.
- Thoughts may or may not be important; we pay attention only if they’re helpful.
- Thoughts are definitely not orders; we certainly don’t have to obey them.
- Thoughts may or may not be wise; we don’t automatically follow their advice.
- Thoughts are never threats; even the most negative of thoughts is not deeply disturbing or frightening.

In ACT we have many different techniques to facilitate defusion. Some of them may seem a bit gimmicky at first, but think of them like training wheels on a bicycle: once you can ride the bike, you don’t need them anymore. So try out each technique as we come to it and see which works best for you. Remember as you use the techniques, the aim of defusion is not to get rid of a thought, nor to make you like it or want it. The aim is simply to see the thought for what it really is—a string of words—and to let it be there without fighting it.

The technique that follows will call on your musical abilities. But don’t worry, no one will be listening but you.

## MUSICAL THOUGHTS

Bring to mind a negative self-judgement that commonly bothers you when it comes up, for example, ‘I’m such an idiot.’ Now hold that thought in your mind and really believe it as much as you can for about ten seconds. Notice how it affects you.

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Now imagine taking that same thought and singing it to yourself to the tune of ‘Happy Birthday’. Sing it silently inside your head. Notice what happens.

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Now go back to the thought in its original form. Once again, hold it in your mind and believe it as much as you can, for about ten seconds. Notice how it affects you.

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Now imagine taking that thought and singing it to the tune of ‘Jingle Bells’. Sing it silently inside your head. Notice what happens.

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After doing this exercise, you probably found that by now you're just not taking that thought quite so seriously; you're just not buying into it as much. Notice that you haven't challenged the thought at all. You haven't tried to get rid of it, debated whether it's true or false, or tried to replace it with a positive thought. So what has happened? Basically, you have 'defused' it. By taking the thought and putting it to music, you have realised that it is just made up of words, like the lyrics of a song.

## The Mind Is A Great Storyteller

The mind loves telling stories; in fact, it never stops. All day, every day, it tells you stories about who you are, what you're like, what you should be doing with your life, what other people think of you, what's wrong with the world, what will happen in the future, what went wrong in the past, and so on. It's like a radio that never stops broadcasting.

Unfortunately, a lot of these stories are really negative—stories such as, 'I'm not good enough', 'I'm stupid', 'I'm so fat', 'I hate my thighs', 'My life is terrible', 'There's no hope for the future', 'Nobody likes me', 'This relationship is doomed', 'I can't cope', 'I will never be happy', and so on.

There's nothing abnormal in this. As mentioned earlier, research shows that about 80 per cent of our thoughts have some degree of negative content. But you can see how these stories, if taken as the absolute truth, can readily feed into anxiety, depression, anger, low self-esteem, self-doubt and insecurity.

Most psychological approaches regard negative stories as a major problem and make a big fuss about trying to eliminate them. Such approaches will advise you to try to:

- make the story more accurate by checking the facts and correcting any errors
- rewrite the story, making it more positive
- get rid of the story by repeatedly telling yourself a better one
- distract yourself from the story
- push the story away
- argue with the story, and debate whether it's true or not.

But haven't you already tried methods like these? The reality is, such control strategies simply *will not work* in the long run.

In ACT the approach is very different. Negative stories are not seen as a problem in their own right. It's only when we 'fuse' with them, when we react as if they were the truth and give them our full attention, that they become problematic.

Since childhood you've heard, 'Don't believe everything you read.' When we read about celebrities in the tabloids, we know that many of the stories are false or misleading. Some are exaggerated for effect, others are made up entirely. Now some celebrities take this in their stride; they accept it as part of being famous and don't let it get to them. When they notice ridiculous stories about themselves, they just shrug it off. They certainly don't waste their time reading, analysing and discussing them! Other celebrities, though, get very upset about these stories. They read them and dwell on them, rant and complain, and lodge lawsuits (which are stressful and eat up a lot of time, energy and money).

Defusion allows us to be like the first set of celebrities: the stories are there, but we don't take them seriously. We don't pay them much attention, and we certainly don't waste our time and energy trying to fight them. In ACT we don't try to change, avoid or get rid of the story. We know how ineffective that is. Instead we simply acknowledge: 'This is a story.'

## NAMING YOUR STORIES

Identify your mind's favourite stories, then give them names, such as the 'loser!' story, or the 'my life sucks!' story, or the 'I can't do it!' story. Often there will be several variations on a theme. For example, the 'nobody likes me' story may show up as 'I'm boring', the 'I'm undesirable' story as 'I'm fat', and the 'I'm inadequate' story as 'I'm stupid'. When your stories show up, acknowledge them by name. For example, you could say to yourself, 'Ah yes. I recognise this. That old favourite, the "I'm a failure" story.' Or 'Aha! Here comes the "I can't cope" story.' Once you've acknowledged a story, that's it—just let it be. You don't have to challenge it or push it away, nor do you have to give it much attention. Simply let it come and go as it pleases, while you channel your energy into doing something you value.

Michelle, whom we met earlier, identified three major stories: the 'I'm worthless' story, the 'I'm a bad mother' story, and the 'I'm unlovable' story. Acknowledging her thoughts by these names made her far less likely to get caught up in them. But Michelle's handsdown favourite technique was Musical Thoughts. Whenever she caught herself buying into the 'I'm so pathetic' story, she would put the words to music and watch them lose all their power. And she didn't just stick to 'Happy Birthday' and 'Jingle Bells'. She experimented with a wide variety of tunes, from Beethoven's Fifth Symphony to the Beatles' 'Penny Lane'. After a week of practising this technique repeatedly throughout the day, she found she was taking those thoughts a lot less seriously (even without the music). They hadn't gone away, but they bothered her much less.

Now you're no doubt brimming with all sorts of questions. But be patient. In the next few chapters we're going to cover defusion in much more detail, including how to use it with mental images. In the meantime, practise using the three techniques we've covered so far: I'm Having the Thought that..., Musical Thoughts and Naming the Story.

Of course, if you don't like a particular technique, you can leave it. And if you have a favourite, you can stick to it. Use these techniques regularly with distressing thoughts, at least ten times a day when starting. Any time you're feeling stressed, anxious or depressed, ask yourself: 'What story is my mind telling me now?' Then once you've identified it, defuse it.

It's important not to build up great expectations at this point. At times defusion occurs easily; at other times it may not happen at all. So play around with these methods and notice what happens—but don't expect instant transformation.

If all this seems too difficult, just acknowledge, 'I'm having the thought that it's too difficult!' It's okay to have the thought that 'It's too hard', or that 'This is stupid', or that 'It won't work.' They're all just thoughts, so see them for what they are and let them be.

'That's all fine,' you may say, 'but what if the thoughts are true?'

Good question...

## Chapter 5

### TRUE BLUES

In ACT, whether a thought is true is not that important. Far more important is whether it's *helpful*. Truthful or not, thoughts are nothing more than words. If they're helpful words, then it's worth paying attention to them. If they're not helpful, then why bother?

Suppose I am making some serious mistakes in my work and my mind tells me, 'You are incompetent!' This is not a helpful thought. It doesn't tell me what I can do to improve the situation; it just belittles me. It doesn't inspire me to improve; it's merely demoralising. If I really am making mistakes, then putting myself down is quite pointless. Instead, what I need to do is to take action: brush up on my skills or ask for help.

Or suppose I'm overweight and my mind says, 'You're a lump of lard! Just look at that belly—it's disgusting!' This thought is not helpful; it does nothing but blame, disparage and demoralise. It doesn't inspire me to eat sensibly or exercise more; it just makes me feel lousy.

You can waste a lot of time trying to decide whether your thoughts are actually true; again and again your mind will try to suck you into that debate. But although in some instances this can be important, the vast majority of the time it is totally irrelevant. What's more, it wastes a lot of energy.

The more pragmatic approach is to ask, 'Is this thought *helpful*? Does it help me take action to create the life I want?' If it is helpful, then pay attention. If it's not, then defuse it. But, I hear you ask, what if that negative thought actually is helpful? What if telling myself, 'I'm fat' actually prompts me to lose some weight? Well if a negative thought does actually motivate you, then by all means make use of it. But almost always, self-critical thoughts of this nature do not motivate you to take effective action. Usually such thoughts, if taken literally, just make you feel guilty, ashamed, depressed, frustrated or anxious. And usually people with weight problems react to these unpleasant emotions by eating more, in a futile attempt to feel better! In ACT we place great emphasis on taking effective action to improve your quality of life. In later chapters we'll look at how to do this. For now, suffice to say, thoughts that criticise you, insult you, judge you, put you down or blame you are likely to lower your motivation rather than increase it. So when troublesome thoughts pop into your head, it may be useful to ask yourself one or more of the following questions:

- Is this thought in any way useful or helpful?
- Is this an old thought? Have I heard this one before? Do I gain anything useful from listening to it again?
- Does this thought help me take effective action to improve my life?
- What would I get for believing this thought?

At this point you may be wondering, how can you tell whether a thought is helpful or not? If you're not sure, you can ask yourself:

- Does it help me to be the person I want to be?
- Does it help me to build the sort of relationships I'd like?

- Does it help me to connect with what I truly value?
- Does it help me to make the most of my life as it is in this moment?
- Does it help me to take effective action to change my life for the better?
- Does it help me, in the long term, to create a rich, full and meaningful life?

If the answer to any of these questions is yes, then the thought is helpful. If the answer to all of them is no, then it's probably not helpful.

## **Thoughts Are Just Stories**

In Chapter 4, I discussed the concept that thoughts are basically just ‘stories’—a bunch of words strung together to tell us something. But if thoughts are just stories, then how do we know which ones to believe? There are three parts to this answer. First, be wary of holding on to any belief too tightly. We all have beliefs, but the more tightly we hold on to them, the more inflexible we become in our attitudes and behaviours. If you’ve ever tried having an argument with someone who absolutely believes they are right, then you know how pointless it is—they will never see any point of view other than their own. We describe them as being inflexible, rigid, narrow-minded, blinkered or ‘stuck in their ways’.

Also, if you reflect on your own experience, you’ll recognise that your beliefs change over time; that is, the beliefs that you once held tightly, you may now find laughable. For instance, at some point you probably used to believe in Santa Claus, the Easter bunny, the tooth fairy or dragons, goblins and vampires. And almost everyone changes some of their beliefs about religion, politics, money, family or health at some point, as they grow older. So by all means, have your beliefs—but hold them lightly. Keep in mind that all beliefs are stories, whether or not they’re ‘true’.

Second, if a thought helps you to create a rich, full and meaningful life, then use it. Pay attention to it, and use it for guidance and motivation—and at the same time remember that it is still just a story; a bit of human language. So use it, but don’t clutch it too tightly.

Third, one of the core principles of ACT involves learning to pay careful attention to what is *actually happening*, rather than just automatically believing what your mind says. For example, you may have heard of the ‘impostor syndrome’. This is where someone who does his job competently and effectively believes that he’s just an impostor; that he doesn’t really know what he’s doing. The impostor thinks of himself as a fraud, a fake, a charlatan, bluffing his way through everything, always on the verge of being ‘found out’. In the impostor syndrome, people are not paying enough attention to their direct experience; to the clearly observable facts that they are doing their job effectively. Instead they are paying attention to an overcritical mind that says, ‘You don’t know what you’re doing. You’re screwing up. Sooner or later everyone will see through you because you’re a fake.’ High-profile examples of people who have experienced the impostor syndrome, even while being phenomenally successful in their careers, include the rock star Robbie Williams and the Oscar-winning actress Renée Zellweger.

In my early years as a doctor I used to suffer from it, too. If one of my patients said, ‘Thank you. You’re a wonderful doctor’, I used to think, ‘Yeah, right. You wouldn’t say that if you knew what I’m *really* like.’ I could never accept such compliments, because I was convinced that deep down I was totally incompetent. In reality I did my job very well, but my mind kept telling me I was useless, and I believed it.

Whenever I made a mistake at work, no matter how trivial, two words would automatically blaze into my head: ‘I’m incompetent.’ At first I used to take the words quite seriously. I’d get really upset, believing they were the *absolute truth*. Then I’d start doubting myself and stressing out about all the decisions I’d made. Had I misdiagnosed that stomach-ache? Had I prescribed the wrong antibiotic? Had I overlooked something serious?

Sometimes I would argue with the thought. I’d point out that everyone makes mistakes, including doctors, and that none of the mistakes I made was ever serious, and that overall I did my job very well. At other times I would run through lists of all the things I did well, and remind myself of all the positive feedback I’d had from my patients and work colleagues. Or I’d repeat positive affirmations that I was, indeed, highly competent. But none of that got rid of the negative thought or stopped it from bothering me.

These days the same two words still often pop up when I make a mistake, but the difference is now they don’t bother me—because I don’t take them seriously. I know that those words are just an automatic response, like the way your eyes shut whenever you sneeze. The fact is, we don’t choose most of the thoughts in our head. We do choose a small number of them, when we’re actively planning or mentally rehearsing or being creative, but most of the thoughts in our head just ‘show up’ of their own accord. We have many thousands of useless or unhelpful thoughts every day. And no matter how harsh, cruel, silly, vindictive, critical, frightening or downright weird they may be, we can’t prevent them from popping up. But just because they appear doesn’t mean we have to take them seriously.

In my case, the ‘I’m incompetent’ story was there long before I became a doctor. In many different aspects of my life, from learning to dance to using a computer, any mistake I’ve made has triggered the same thought: ‘I’m incompetent.’ Of course, it’s not always those exact words. Often it’s variants on the same theme, such as: ‘Idiot!’ or ‘There you go, screwing up again!’ or ‘Can’t you do anything right?’ But these thoughts are not a problem as long as I see them for what they really are: just a few words that popped into my head. Basically, the more tuned in you are to your direct experience of life (rather than to your mind’s running commentary), the more empowered you are to take your life in the direction you truly want. In later chapters you will learn how to develop this ability.

## The Stories Never Stop

The mind never stops telling stories—not even when we’re asleep. It is constantly comparing, judging, evaluating, criticising, planning, pontificating and fantasising. And many of the stories it tells are real attention grabbers. Time and time again we get lost in these stories—a process for which we have many different expressions. We speak of ‘indulging a thought’, ‘entertaining a thought’, ‘struggling with a thought’, ‘flirting with a thought’, ‘buying into a thought’, ‘being wrapped up in thoughts’, ‘lost in thought’ and being ‘carried away by thoughts’ to name but a few.

All these expressions point to how thoughts occupy our time, energy and attention. Most of the time we tend to take our thoughts far too seriously and give them far too much attention. The following exercise demonstrates the difference between attaching importance to a thought and not taking a thought seriously.

### Not Taking A Thought Seriously

Bring to mind a thought that normally upsets you; that takes the form ‘I am X’ (for example, ‘I am inadequate’). Hold that thought in your mind and notice how it affects you.

Now bring to mind the thought, ‘I am a banana!’ Hold it in your mind and notice how it affects you. What did you notice? Most people find that the first thought bothers them but the second thought

makes them grin. Why? Because you don't take the second thought seriously. But if the words following 'I am...' are 'a loser', 'a failure', 'a fat pig' or 'a boring person', instead of 'a banana', we tend to attach far more importance to them. And yet, they are all just words. One simple way of taking your thoughts less seriously is to try...

## THANKING YOUR MIND

This is a simple and effective defusion technique. When your mind starts coming up with those same old stories, simply thank it. You could say to yourself (silently) things like, 'Thank you, Mind! How very informative!' or 'Thanks for sharing!' or 'Is that right? How fascinating!' or simply, 'Thanks, Mind!'

When thanking your mind, don't do it sarcastically or aggressively. Do it with warmth and humour, and with a genuine appreciation for the amazing ability of your mind to produce a never-ending stream of thoughts. (You could also combine this technique with Naming the Story: 'Ah yes, the "I'm a failure" story. Thanks so much, Mind!')

Below is another technique that will help you take your thoughts less seriously. Read through the instructions first and then give it a go.

## THE SILLY VOICES TECHNIQUE

This technique is particularly good with recurrent negative self-judgements. Find a thought that upsets or bothers you. Focus on the thought for ten seconds, believing it as much as possible. Notice how it affects you.

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Then pick an animated cartoon character with a humorous voice, such as Mickey Mouse, Bugs Bunny, Shrek or Homer Simpson. Now bring the troubling thought to mind, but 'hear' it in the cartoon character's voice, as if that character were speaking your thoughts out loud. Notice what happens.

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Now get the negative thought back in its original form, and again believe it as much as possible. Notice how it affects you.

Next pick a different cartoon character or a character from a movie or television show. Consider fantasy characters such as Darth Vader, Yoda, Gollum or someone from your favourite sitcom, or actors with distinctive voices, such as Arnold Schwarzenegger or Eddie Murphy. Once again bring the distressing thought to mind and 'hear' it in that voice. Notice what happens.

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After doing this exercise and then repeating it, you've probably found that you're not taking that negative thought quite so seriously. You may even have found yourself grinning or chuckling. Notice that you haven't tried to change the thought, get rid of it, argue with it, push it away, debate whether it's true or false, replace it with a more positive thought or distract yourself from it in any way. You have merely seen it for what it is: a bit of language. By taking that segment of language and hearing it in a different voice, you become aware that it is nothing more than a string of words—and thus, it loses its impact. (This may remind you of a rhyme we learned as children: 'Sticks and stones may break my bones, but words can never hurt me.' Unfortunately, as children we couldn't put this into practice all that well, because no one ever taught us defusion skills.)

A client of mine—we'll call her Jana—who suffered from depression, found this method extremely helpful. She had grown up with a verbally abusive mother who constantly criticised and insulted

her. The insults that had once come from her mother had now turned into recurrent negative thoughts: ‘You’re fat’, ‘You’re ugly’, ‘You’re stupid’, ‘You’ll never amount to anything ... nobody likes you.’ When these thoughts came to mind during our sessions, Jana would often start crying. She had spent many years (and thousands of dollars) in therapy, trying to get rid of these thoughts, all to no avail.

Jana was an avid fan of the comedy troupe Monty Python, and the character she picked was from their film *The Life of Brian*. In the film, Brian’s mother, played by the male actor Terry Jones, is always criticising Brian in a ridiculously high-pitched, screeching voice. When Jana ‘heard’ her negative thoughts in the voice of Brian’s mother, she couldn’t take them seriously. The thoughts did not immediately disappear, but they quickly lost their power over her, and this contributed significantly to lifting her depression.

But what if a thought is both true and serious? For instance, if you are dying from cancer and have the thought: ‘I’ll be dead soon.’

From an ACT perspective, we are far more interested in whether a thought is helpful than whether it’s true or false, serious or ridiculous, negative or positive, optimistic or pessimistic. The bottom line is always the same: does this thought help you make the most out of life? Now, if you only have a few months to live, it’s really important to reflect on how you want to spend them. What loose ends do you need to tie up? What do you want to do, and whom do you want to see before you die? So a thought like, ‘I’ll be dead soon’ could be helpful if it motivates you to reflect and take effective action. If that’s the case, you wouldn’t try to defuse such a thought. You would pay attention to it and use it to help you do what you need to do. But suppose that thought becomes an obsession and you keep playing it over and over in your head. Would it be helpful to spend your last weeks of life thinking all day long, ‘I’ll be dead soon’, giving all your attention to that thought instead of to the loved ones around you?

Now, for some people the Silly Voices technique may seem inappropriate for a thought like this, because it might seem to be trivialising something quite serious. If that’s how it feels to you, don’t use it. But it’s important to note that defusion is not about trivialising or making fun of genuine problems in your life. Defusion is aimed at freeing us from oppression by our minds; freeing up our time, energy and attention so we can invest it in meaningful activities rather than dwelling uselessly on our thoughts. So if ‘I’ll be dead soon’ keeps showing up and taking up all your attention, thus preventing you from connecting with your loved ones, then you could defuse it in a number of different ways. You could acknowledge, ‘Aha! Here’s the “imminent death” story’ or ‘I’m having the thought that I’ll be dead soon’ or you could simply say, ‘Thanks, Mind!’

And don’t think you are going to have to spend the rest of your life thanking your mind or hearing your thoughts in ditties and silly voices. These methods are merely stepping stones. Down the line you can expect to defuse your thoughts instantly, without the need for such contrived techniques (although there will always be times when it’s useful to pull them out of your psychological toolkit).

When practising defusion, it’s important to keep the following things in mind:

- The aim of defusion is *not* to get rid of unpleasant thoughts, but rather to *see them for what they are*—just words—and to let go of struggling with them. At times they will go away and at times they won’t. If you start expecting them to go, you are setting yourself up for disappointment or frustration.
- *Don’t expect* these techniques to make you feel good. Often when you defuse a troublesome thought, you will feel better. But this is just a beneficial byproduct, not the main goal.

The main goal of defusion is to free you from the tyranny of your mind, so you can focus your

attention on more important things. So when defusion does make you feel better, by all means enjoy it. But don't expect it to. And don't start using it to try to control how you feel; otherwise, you're stuck right back in the happiness trap.

- Remember that you're human, so there will be plenty of times when you forget to use these new skills. And that's okay, because the moment you realise you've been reeled in by unhelpful thoughts, you can instantly use one of these techniques to unhook yourself.
- Remember that no technique is foolproof. There may be times when you try them and defusion doesn't happen. If so, simply observe what it's like to be fused with your thoughts. Merely learning to tell the difference between fusion and defusion is useful in its own right.

Defusion is like any other skill: the more you practise, the better you get. So add the Thanking Your Mind and Silly Voices techniques to your repertoire, and aim to use them between five and ten times each day.

At this point, don't expect any dramatic changes in your life. Simply notice what happens as you incorporate these practices into your daily routine. And if you're having any doubts or concerns, make a note of them. In the next chapter we'll look at common problems people have with defusion and, more importantly, we'll learn how to overcome them.

## Chapter 6

### TROUBLESHOOTING DEFUSION

‘Defusion doesn’t work!’ snapped John.

‘What do you mean?’ I asked.

‘Well,’ he said, ‘I had to give this presentation at work in front of about 50 people. My mind kept telling me I was going to screw up and make a fool of myself, so I tried those defusion techniques, but they did nothing.’

‘You mean, you kept buying into the story that you’d screw up?’

‘No, it helped with that—I stopped taking it seriously.’

‘Then why do you say defusion doesn’t work?’

‘Because I still felt anxious.’

‘John,’ I said, ‘I’ve been giving talks in public for over twenty years, and I still feel anxious every time I get up there. I’ve met hundreds of people who speak to audiences as part of their profession, and I’ve always asked them, “Do you get anxious when you give a talk?” So far, almost every single person has said yes. The point is, if you’re going to put yourself in any sort of challenging situation, if you’re going to take any significant risk, then anxiety is a normal emotion. It will be there. And defusing negative thoughts is not going to get rid of it.’

Many of us, when we first encounter defusion, fall into the same trap as John; we start trying to use defusion as a control strategy. Remember:

- A control strategy is any attempt to change, avoid or get rid of unwanted thoughts and feelings.
- Control strategies are problematic when they are used excessively or in situations where they can’t work, or when using them reduces our quality of life in the long term.

Defusion is the very *opposite* of a control strategy; it’s an acceptance strategy. In ACT, rather than attempting to change, avoid or get rid of unpleasant thoughts and feelings, our aim is to *accept* them. Acceptance doesn’t mean you have to like your uncomfortable thoughts and feelings; it just means you stop struggling with them. When you stop wasting your energy on trying to change, avoid or get rid of them, you can put that energy into something more useful instead. This is best explained with an analogy.

Imagine you live in a small country that shares a border with a hostile neighbour. There is long-standing tension between the two countries. The neighbouring country has a different religion and a different political system, and your country sees it as a major threat. There are three possible scenarios for how your country can relate to its neighbour.

The worst-case scenario is war. Your country attacks and the other one retaliates (or vice versa). As both countries get pulled into a major war, the people of both nations suffer. Think of any major war and the huge costs involved in terms of life, money and wellbeing.

Another scenario, better than the first but still far from satisfactory, is a temporary truce. Both countries agree to a cease-fire, but there is no reconciliation. Resentment seethes beneath the surface, and there is the constant underlying threat that war will break out again. Think of India and Pakistan, with the constant threat of nuclear war, and the intense hostility between Hindus and Muslims.

The third possibility is genuine peace. You acknowledge your differences and allow them just to be. This doesn't get rid of the other country, nor does it mean that you necessarily like it or even want it there. Nor does it mean that you approve of its politics or religion. But because you're no longer at war, you can now use your money and resources to build up the infrastructure of your own country, instead of squandering them on the battlefield.

The first scenario, war, is like the struggle to get rid of unwanted thoughts and feelings. It's a battle that can never be won and it consumes a huge amount of time and energy.

The second scenario, a truce, is definitely better, but it's still a long way from true acceptance. It's more like a grudging tolerance; there's no sense of moving forward to a new future. Although there is no active warfare, the hostility remains, and you are resigned to the ongoing tension. A grudging tolerance of thoughts and feelings is better than an outright struggle, but it leaves you feeling stuck and somewhat helpless. It's a sense more of resignation than of acceptance, of entrapment rather than freedom, of being stuck rather than moving forward.

The third scenario, peace, represents true acceptance. Notice that in this scenario your country doesn't have to like the other country, approve of its being there, convert to its religion or learn to speak its language. You simply make peace with them. You acknowledge your differences, you give up trying to change their politics or religion, and you focus your efforts on making your own country a better place to live in. It's the same when you truly accept your uncomfortable thoughts and feelings. You don't have to like them, want them or approve of them; you simply make peace with them and let them be. This leaves you free to focus your energy on taking action—action that moves your life forward in a direction you value.

## **The True Meaning Of Acceptance**

Acceptance does not mean 'putting up with' or resigning yourself to anything. Acceptance is about embracing life, not merely tolerating it. Acceptance literally means 'taking what is offered'. It doesn't mean giving up or admitting defeat; it doesn't mean just gritting your teeth and bearing it. It means fully opening yourself to your present reality—acknowledging how it is, right here and now, and letting go of the struggle with life as it is in this moment.

But what if you want to improve your life and not just accept it as it is? Well, that's the whole purpose of this book. But the most effective way to make changes in your life is to start by fully accepting it. Suppose you are walking across ice. In order to safely take the next step, you first need to find a firm foothold. If you try moving forward without doing that, then you're likely to fall flat on your face.

Acceptance is like finding that firm foothold. It's a realistic appraisal of where your feet are and what condition the ground is in. It doesn't mean that you like being in that spot, or that you intend to stay there. Once you have a firm foothold, you can take the next step more effectively. The more fully you accept the reality of your situation—as it is, here and now—the more effectively you can take action to change it.

The Dalai Lama exemplifies this beautifully. He fully accepts that China has invaded Tibet and that he is forced to live in exile from his own country. He doesn't waste time and energy in wishful thinking, getting outraged or dwelling morosely on what he's lost. He knows that won't help. Nor does he admit defeat or throw the whole issue into the 'too-hard basket'. Instead he acknowledges that right now this is the way it is and at the same time he does everything in his power to help. He actively campaigns all around the world to increase public and political awareness of Tibet's predicament and to raise financial support for its people.

In another example, let's consider the case of domestic violence. If your partner is physically violent, the first step is to accept the reality of the situation: that you are in danger and you need to take action to protect yourself. The next step is to take action: get some professional help, take legal

action and/or leave the relationship. In order to take this action, you will need to accept the anxiety, guilt and other painful thoughts and feelings that are likely to rise. So this is what ACT is all about: acceptance and action, side by side. The core philosophy of ACT is neatly encapsulated in the Serenity Challenge:

*Develop the courage to solve those problems that can be solved, the serenity to accept those problems that can't be solved, and the wisdom to know the difference.*

If your life isn't working for you, the only sensible thing is to take action to change it. That action will be far more effective when you start from a place of acceptance. All the time and energy that you waste on struggling with thoughts and feelings could be far more usefully invested in taking action—the right action. A rich, full and meaningful life comes about through accepting your thoughts and feelings instead of fighting them, and taking effective action, guided by your deepest values.

So what are the costs of non-acceptance? What happens in the long run when you try to avoid or get rid of unpleasant thoughts and feelings? Do your control strategies work? Are they giving you the life you want? Acceptance is a powerful alternative to control. You've already discovered that many unpleasant thoughts are far less painful when defused, and in later chapters you'll discover similar transformations with negative feelings.

## How To Use Defusion

Now let's return to John's comment that 'defusion doesn't work'. John was trying to use defusion to get *rid* of his anxiety. No wonder it 'didn't work'! Defusion is not some clever way to control your feelings. It's simply an acceptance technique. True, defusing unhelpful thoughts will often reduce feelings of anxiety, but that's just a beneficial byproduct; a bonus—it's not the main thing. If you try to use defusion to control anxiety—or any unpleasant feeling, for that matter—sooner or later you'll end up frustrated.

But what if you've defused a thought and it's still there? Again, defusion isn't about getting rid of thoughts. It's about seeing them for what they really are and making peace with them; allowing them to be there without fighting them. Sometimes they will go away with very little fuss, other times they will hang around for quite a while, and sometimes they'll go away and then come back again. The point is, once you allow them to be there without a struggle, you can put your energy and attention into activities you value. But if you expect that defusing your thoughts will make them go away, you're setting yourself up for disappointment; you're falling back into the agenda of control—the happiness trap. The aim is to accept your thoughts, not to get rid of them.

And remember, you don't have to like a thought in order to accept it. You can accept it purely out of pragmatism: the thought is already there whether you like it or not, and struggling with it just takes up your time and energy without any long-term benefit. Acceptance frees up your energy for life-enhancing activities.

It's okay to want to get rid of an unpleasant thought. In fact, it's expected, given that that's what you've been trying to do your whole life. But wanting to get rid of something is quite different from *actively struggling* with it. For example, suppose you have an old car that you no longer want. And suppose you won't have an opportunity to sell it for at least another month. You can want to get rid of the car and simultaneously accept that you still have the car. You don't have to try to smash the car up, make yourself miserable or get drunk every night just because you still have that old car.

So if you do find yourself struggling with a negative thought, just notice it. Pretend that you're a scientist observing your own mind; notice the different ways in which you struggle. Do you challenge your thoughts, trying to disprove or invalidate them? Do you judge them as good or bad, true or false, positive or negative? Do you try to push them away or replace them with 'better'

ones? Do you enter into a debate with your mind? Observe your struggle with interest and notice what it accomplishes.

Of course, some stories are more persistent than others: they come back again and again. Remember my ‘I’m incompetent’ story? I’ve had that story for as long as I can remember. It visits me much less often now, but it still pops in to my mind from time to time. The difference is, now I don’t believe it. But if a helpful thought shows up like, ‘I just stuffed up; how can I learn from this?’ then I certainly do pay attention.

It’s important to let go of any expectation that your stories will go away or show up less frequently. As it happens, very often they will go away. But if you’re defusing them to make them go away, then by definition you’re not truly accepting them. And you know where that leads.

But, I hear you ask, aren’t positive thoughts better than negative thoughts? Not necessarily. Remember, the most important question is: ‘Is this thought helpful?’ Suppose an alcoholic brain surgeon thinks to himself, ‘Hey, I’m the greatest brain surgeon in the world. I can do brilliant surgery even if I’ve been drinking.’ It’s a positive thought, but surely not a helpful one. Most people convicted of drink driving have had positive thoughts of a similar nature.

The same applies to neutral thoughts. In this book I mostly talk about negative thoughts, simply because they’re the ones we most often have problems with. But anything that applies to negative thoughts also applies to neutral and positive thoughts. The bottom line is not whether a thought is positive or negative, true or false, pleasant or unpleasant, optimistic or pessimistic, but whether it helps you create a fulfilling life.

So should you believe *any* of your thoughts? Yes, but only if they’re helpful—and hold those beliefs lightly. And even while you’re holding them, know that they are nothing more than language.

As time goes on and you work through the rest of this book, you will learn to defuse unhelpful thoughts quickly and easily. But it’s important to remember: cognitive fusion is not the enemy.

Making plans for the future, brainstorming solutions for your problems, mentally rehearsing your actions, getting lost in a book, engaging in a conversation, reading music, writing a letter, telling someone you love them: all these activities involve cognitive fusion. So cognitive fusion is not the enemy; it’s an essential part of being human.

Negative thoughts are not the enemy, either. Because of the way our minds have evolved, many of our thoughts are negative to some extent, so if you consider them to be the enemy, you’re always going to be battling with yourself. Thoughts are merely sounds, words, symbols or bits of language, so why declare war on them? Our aim here is to increase our self-awareness; to recognise when we’re fusing with our thoughts, and to catch ourselves when it happens. Once we have that awareness, we then have a much greater choice as to how we act. If thoughts are helpful, make use of them; if they are unhelpful, then defuse them.

Keep in mind that the defusion techniques we’ve covered so far are like those inflatable armbands young children use in swimming pools: once you can swim, you don’t need them anymore. The idea is that later on, as you incorporate the other ideas within this book, you can defuse your thoughts without giving them too much attention; you can be thoroughly engaged in your work, a conversation, or any other meaningful activity, and when an unhelpful thought pops into your head you can instantly see it for what it is, and let it come and go without it distracting you.

This will be much clearer after the next chapter, in which we explore an immensely powerful aspect of human consciousness, a resource within us that has been so overlooked by western society that there isn’t even a common word for it in the English language.

But don’t turn the page straightaway. Why not wait a few days before reading on, and in the meantime practise your defusion skills? And if your mind says, ‘It’s all too hard; I can’t be bothered’, simply thank it.



## Chapter 7

### LOOK WHO'S TALKING

Have you ever noticed some strange or disturbing thought pop into your head and wondered, ‘Where did that come from?’ Have you ever been chided for not paying attention and said, ‘Sorry, I was somewhere else’? Do you ever suddenly realise that your mind has ‘wandered’?

If we look more closely at these expressions, we can see that they point to something rather curious. Where *did* that thought come from? And where *did* it go? And if you were ‘somewhere else’, then where were you? And how did you get back from there?

ACT answers these questions by teaching you to recognise two different parts of yourself: the ‘thinking self’ and the ‘observing self’. The thinking self is the part of you that thinks, plans, judges, compares, creates, imagines, visualises, analyses, remembers, day dreams and fantasises. A more common name for it is ‘the mind’. Popular psychological approaches such as positive thinking, cognitive therapy, creative visualisation, hypnosis and neuro-linguistic programming all focus on controlling the way your thinking self operates. This is all great in theory and it appeals to our commonsense, but as we have seen, the thinking self is just not that easy to control. (Again, it’s not that we have *no* control—after all, throughout this book we look at many ways to think more effectively—it’s just that we have much less control than the ‘experts’ would have us believe.)

The observing self is fundamentally different from the thinking self. The observing self doesn’t think; it is the part of you that is responsible for focus, attention and awareness. While it can observe or pay attention to your thoughts, it can’t produce them. Whereas the thinking self thinks about your experience, the observing self *registers* your experience directly.

For example, if you are playing baseball, cricket or tennis and you are truly focused, then all your attention is riveted on that ball coming towards you. This is your observing self at work. You are not *thinking* about the ball; you are *observing* it.

Now, suppose thoughts start popping into your head like, ‘I hope my grip is correct’, ‘I’d better make this a good hit’ or ‘Wow, that ball is moving fast!’ That is your thinking self at work. And of course, such thoughts can often be distracting. If your observing self pays too much attention to those thoughts, then it is no longer focused on the ball, and your performance will be impaired. (How often have you been focused on a task, only to be distracted by a thought such as, ‘I hope I don’t screw this up!’?)

Or suppose you’re watching a magnificent sunset. There are moments when all you are doing is looking at it. Your mind is quiet; there are no thoughts running through your head, you’re simply registering the many colours of the spectacle before you. This is your observing self at work: observing, not thinking.

Then your thinking self kicks in: ‘Wow, look at all those colours! This reminds me of that sunset we saw on holiday last year. I wish I had my camera. It’s so beautiful; this looks like something out of a movie.’ The more attention your observing self pays to the running commentary of the thinking self, the more you lose direct contact with that sunset.

Although we all understand words such as ‘awareness’, ‘focus’ and ‘attention’, most of us in the western world have little or no concept of the observing self. As a result, there is no common word for it in the English language. We only have the word ‘mind’, which is generally used to denote both the thinking self and the observing self, without distinguishing between the two. To reduce confusion, whenever I use the word ‘mind’ in this book, I am referring only to the thinking self. When I use terms like ‘attention’, ‘awareness’, ‘observing’, ‘noticing’ and ‘direct experience’, I’m referring to various aspects of the observing self. As this book progresses, you will learn how to

tune in and use this amazingly potent part of you. Let's begin right now with a simple exercise.

## Thinking Versus Observing

Close your eyes for one minute and simply notice what your mind does. Stay on the lookout for any thoughts or images, as if you were a wildlife photographer waiting for an exotic animal to emerge from the undergrowth. If no thoughts or images appear, keep watching; sooner or later they will show themselves—I guarantee it. Notice where those thoughts or images seem to be located: in front of you, above you, behind you, to one side of you, or within you? Once you've done this for a minute, open your eyes again.

That's all there is to it. So read through these instructions once again; then put down the book and give it a go.

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What you experienced were two distinct processes going on. First there was the process of thinking—in other words, some thoughts or images appeared. Then there was the process of observing; that is, you were able to notice or observe those thoughts and images. It's important to experience the distinction between thinking and observing, because as the book goes on, we'll be using each process in different ways. So just try the above exercise once more. Close your eyes for about a minute, notice what thoughts or images appear, and notice where they seem to be located.

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Hopefully, this little exercise gave you a sense of distance between you and your thoughts: thoughts and images appeared, then disappeared again, and you were able to notice them come and go. Another way of putting this is that your thinking self produced some thoughts, and your observing self observed them.

Our thinking self is a bit like a radio, constantly playing in the background. Most of the time it's the *Radio Doom and Gloom Show*, broadcasting negative stories 24 hours a day. It reminds us of bad things from the past, it warns us of bad things to come in the future and it gives us regular updates on everything that's wrong with us. Once in a while it broadcasts something useful or cheerful, but not too often. So if we're constantly tuned in to this radio, listening to it intently and, worse, believing everything we hear, then we have a sure-fire recipe for stress and misery.

Unfortunately, there's no way to switch off this radio. Even Zen masters are unable to achieve such a feat. Sometimes the radio will stop of its own accord for a few seconds (or even—very rarely—for a few minutes). But we just don't have the power to make it stop (unless we short-circuit it with drugs, alcohol or brain surgery). In fact, generally speaking, the more we try to make this radio stop, the louder it plays.

But there is an alternative approach. Have you ever had a radio playing in the background, but you were so intent on what you were doing that you didn't really listen to it? You could hear the radio playing, but you weren't paying attention to it. In practising defusion skills, we are ultimately aiming to do precisely that with our thoughts. Once we know that thoughts are just bits of language, we can treat them like background noise—we can let them come and go without focusing on them and without being bothered by them. This is best exemplified by the Thanking Your Mind technique (see Chapter 5): an unpleasant thought appears, but instead of focusing on it, you simply acknowledge its presence, thank your mind, and return your attention to what you're doing.

So here's what we're aiming for with all these defusion skills:

- If the thinking self is broadcasting something unhelpful, the observing self need not pay attention. The observing self can instead focus its attention on what you are doing here and now.

- If the thinking self is broadcasting something useful or helpful, then the observing self can tune in and pay attention.

This is very different from approaches such as positive thinking, which are like airing a second radio show, *Radio Happy and Cheerful*, alongside *Radio Doom and Gloom*, in the hope of drowning it out. It's pretty hard to stay focused on what you're doing when you have two radios playing different tunes in the background.

Notice, too, that letting the radio play on without giving it much attention is very different from actively trying to ignore it. Have you ever heard a radio playing and tried not to listen to it? What happened? The more you tried *not* to hear it, the more it bothered you, right?

The ability to let thoughts come and go in the background while you keep your attention on what you are doing is very useful. Suppose you're in a social situation and your mind is saying, 'I'm so boring! I have nothing to say. I wish I could go home!' It's hard to have a good conversation if you're giving all your attention to those thoughts. Similarly, suppose you're learning to drive and your thinking self is saying, 'I can't do it. It's too hard. I'm going to crash!' It's hard to drive well if your observing self is focused on those thoughts rather than on the road. The following technique will teach you how to let your thoughts 'pass on by' while you keep your attention on what you're doing.

## TEN DEEP BREATHS

Take ten deep breaths, as slowly as possible. (You may prefer to do this with your eyes closed.) Now focus on the rise and fall of your rib cage, and the air moving in and out of your lungs. Notice the sensations as the air flows in: your chest rising, your shoulders lifting, your lungs expanding. Notice what you feel as the air flows out: your chest falling, your shoulders dropping, the breath leaving your nostrils. Focus on completely emptying your lungs. Push out every last bit of air, feeling your lungs deflate, and pause for a moment before breathing in again. As you breathe in, notice how your tummy gently pushes outward.

Now let any thoughts and images come and go in the background, as if they were cars passing by outside your house. When a new thought or image appears, briefly acknowledge its presence, as if you were nodding at a passing motorist. As you do this, keep your attention on the breath, following the air, as it flows in and out of your lungs. You may find it helpful to silently say to yourself, 'Thinking', whenever a thought or image appears. Many people find this helps them to acknowledge and let go of the thought. Give it a go and if it's helpful, keep doing it.

From time to time a thought will capture your attention; it will 'hook you' and 'carry you away', so that you lose track of the exercise. The moment you realise you've been hooked, take a second to notice what distracted you; then gently 'unhook' yourself and refocus on your breathing.

Now read through the instructions once more, then put the book down and give this a go.

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How did you go? Most people get hooked up and carried away by their thoughts several times during that exercise. This is how thoughts typically affect us: they reel us in, pulling our attention away from what we're doing. (So although we may say that our mind wanders, this is not accurate. In reality, it's our attention that wanders.)

By regularly practising this technique, you will learn three important skills:

1. How to let thoughts come and go without focusing on them.
2. How to recognise when you've been hooked by your thoughts.

### 3. How to gently unhook yourself from thoughts and refocus your attention.

When practising this technique, notice the distinction between your thinking self and your observing self. (The observing self focuses on the breath, while the thinking self chatters away in the background.) Notice also that this is an acceptance strategy, not a control strategy. We aren't trying to change, avoid or get rid of unwanted thoughts; we're simply allowing them to be there, to come and go as they please.

Fortunately, this is an easy technique to practise, because you can do it anytime, anywhere. Therefore aim to practise this exercise throughout the day while you're stuck at traffic lights, waiting in line at a store, while you're on hold on the telephone, waiting for someone to get ready, during television commercial breaks, when you're having your morning tea or coffee, and in bed last thing at night or before you get up. Basically, try it anytime you have a moment to spare. (If you don't have time for the full ten breaths, even three or four can be useful.) In particular, try it anytime you realise that you're all caught up in your thoughts.

Remember when you're doing this technique, it doesn't matter how many times you get hooked. Each time you notice it and unhook yourself, you're getting more proficient at a valuable skill.

When doing this technique, let go of any expectations; simply notice what effect it has when you do it. Many people find it quite relaxing, but please don't regard it as a relaxation technique. When relaxation occurs, remember, it's merely a beneficial byproduct, not the main aim. (Obviously, enjoy it when it does occur, but don't come to expect it, or sooner or later you're bound to be disappointed.)

I've designed the above brief exercises for busy people who say they 'don't have enough time in the day' to do formal defusion practice. However, 'not enough time' is just another story. So here's a challenge for you: if you really want to get good at this, then as well as doing all those brief exercises, put aside five minutes twice a day to practise focusing on your breath. For example, you may do five minutes first thing in the morning and five minutes during your lunchbreak. During these times, keep your attention totally on your breath, while letting your thoughts come and go in the background; and each time you notice your attention has wandered, gently bring it back. Also, if you haven't already tried it, then try silently saying to yourself, 'Thinking', whenever a thought or image appears. Some people find this very helpful as a way of acknowledging the thinking process without getting caught up in it. (However, if you don't find it helpful, then don't bother with it.)

## Realistic Expectations

Defusion skills are essential for escaping the happiness trap. If you can see your thoughts for what they are—just words—and let them come and go without focusing on them, then you can put your time and energy into more important things, such as taking action to create the life you want. Your mind will never stop telling you unpleasant stories (at least, not for long)—that's just what minds do. So let's be realistic. The fact is, you will get hooked up and reeled in by these stories again and again.

That's the bad news.

The good news is, you *can* make dramatic improvements. You *can* learn to get hooked much less often. You *can* learn to recognise much faster when you have been hooked, and you *can* learn to get much better at unhooking yourself! All these abilities will help to keep you out of the happiness trap.

As for the observing self, we've only just begun to scratch the surface. The observing self is a very powerful ally in transforming your life and we'll return to it many times in later chapters. Meanwhile, we now come to the final chapter on defusion, in which we learn how to deal with ...

scary pictures!

## **Chapter 8**

### **SCARY PICTURES**

Roxy trembled. Her face was pale and drawn, her eyes teary.

‘What’s the diagnosis?’ I asked her.

‘Multiple sclerosis,’ she whispered.

Roxy was a 32-year-old lawyer, dedicated to her profession. One day at work she noticed a weakness and numbness in her left leg, and within a few days she was diagnosed with multiple sclerosis or MS. MS is a disease in which the nerves in the body degenerate, creating all sorts of physical problems. In the best-case scenario, you may have one fleeting episode of neurological disturbance from which you fully recover, never to be bothered again. In the worst case, the MS steadily worsens and your nervous system progressively deteriorates, until you are severely physically disabled. Doctors have no way of predicting how it will affect a patient.

Not surprisingly, this was extremely distressing news for Roxy: a frightening diagnosis, with no way of predicting the outcome. Roxy’s mind had always had a tendency to imagine the worst. This is a useful trait for lawyers, because it allows them to anticipate every possible problem in a criminal or civil case. But now this trait became a hindrance as Roxy kept imagining herself in a wheelchair, her body horribly deformed, her mouth twisted and drooling. Every time this image popped into her head, it terrified her. She tried telling herself all the usual commonsense things: ‘Don’t worry ... it will probably never happen to you’, ‘Your chances are excellent ... cross that bridge if and when you come to it’, ‘What’s the point of worrying about something that may never happen?’ Friends, family and doctors also tried to reassure her with similar advice. But did that get rid of this scary image? Not in the least.

Roxy found she could sometimes push the image out of her head, but it wouldn’t stay away for long, and when it returned it seemed to bother her even more than before. This commonly used, but ineffective, control strategy is known as ‘thought suppression’. Thought suppression means actively pushing distressing thoughts or images out of your head. For example, each time an unwanted thought or image appears, you might say to yourself, ‘No, don’t think about it!’ or ‘Stop it!’ or you might just mentally shove it away. Research shows that although this method often gets rid of distressing thoughts or images in the short term, after a while there is a rebound effect: the negative thoughts return in greater numbers and intensity than before.

Most of us have a tendency to conjure up frightening images of the future. How often have you ‘seen yourself’ failing, being rejected, making a fool of yourself, losing your job, getting sick, growing old and weak or getting into trouble of some kind? In a state of cognitive fusion, these mental pictures seem incredibly real, as if what we’re imagining were actually taking place, here and now. Naturally, this can create a lot of fear. To paraphrase Mark Twain, we live through many frightening experiences in our lifetime, and most of them never happen.

Unpleasant or unnerving images will pop up again and again whenever we are faced with challenges in life, and we can waste a lot of precious time dwelling on them or trying to get rid of them. Moreover, if we completely fuse with these images, they may seem so frightening that they scare us away from doing the things we value. For example, many people avoid air travel because their minds conjure up images of the plane crashing. In cognitive fusion, we:

- take these images seriously

- give them all our attention

- react to them as if they are actually happening
- treat them as if they are an accurate prediction of the future.

In cognitive *defusion* we:

- recognise that images are nothing more than pictures
- pay attention to them only if they are helpful.

The defusion techniques we use with images are very similar to the ones we use with thoughts. Initially, we need to focus on these images in order to practise defusing them. But the ultimate aim is to be able to let these images come and go without giving them much attention at all. (It's like having the television on in the background, without really watching it.)

Defusion techniques help us to see these images for what they are: nothing more than colourful pictures. Once we recognise this, we can let them be there without fighting them, without judging them and without trying to avoid them. In other words, we can accept them. Acceptance means we no longer have to fear them. Acceptance means we no longer waste our precious energy on struggling with them. And ultimately, acceptance means we can focus on something more constructive.

Before trying out the following techniques, it's important to say a few words about painful memories. We store memories with all five senses: sight, sound, smell, taste and touch. The techniques that follow are often helpful with visual memories, that is, memories which have been stored primarily as images. In cognitive fusion, we:

- give these memories all our attention
- react to them as if they are happening here and now
- react to them as if they are dangerous or harmful.

In cognitive *defusion* we:

- recognise these memories are nothing more than pictures
- know that they happened in the past and can no longer hurt us
- pay attention to them only if they are helpful.

However when working with memories, you need to be careful. While the techniques in this chapter are helpful for coming to terms with many unpleasant memories, such as times you have failed, screwed up, been rejected, humiliated or embarrassed, they may not be appropriate for more traumatic memories. If you are deeply distressed by traumatic memories of rape, torture, child abuse, domestic violence or other serious incidents, I don't recommend you use these methods by yourself. Instead, you should learn how to defuse such memories with an appropriately trained therapist.

## **Defusing Unpleasant Images**

No technique known to humanity is 100 per cent reliable and defusion techniques are no exception. If you find that a particular technique doesn't work, just notice what it's like to be fused and move on to a different one. For each technique first read through the instructions, then bring to mind a troublesome image that tends to recur. If it's a moving image, condense it into a ten-second 'video clip'. Next put the book down and try the technique. If any technique seems inappropriate, don't do it.

### **TELEVISION SCREEN**

Bring an unpleasant image to mind and notice how it's affecting you. Now imagine there's a small television screen across the room from you. Place your image on the television screen. Play around with the image: flip it upside down; turn it on its side; spin it around and around; stre-e-e-etch it sideways. If it's a moving 'video clip', play it in slow motion. Then play it backwards in slow motion. Then play it forwards at double speed; then reverse it at double speed. Turn the colour down, so it's all in black-and-white. Turn the colour and brightness up until it's ridiculously lurid (so the people have bright orange skin and the clouds are hot pink). The idea is not to get rid of this image but to see it for what it is: a harmless picture. You may need to do this for anything from ten seconds to two minutes, until you really defuse it. If at the end of two minutes it's still bothering you, then try the next technique.

### **SILLY SUBTITLES OR VOICE-OVERS**

Keeping that image on the television screen, add a humorous subtitle or voice-over to it, such as 'The Ultimate Disaster! premieres on Channel 4, Friday, 7.30pm' or 'Now showing at a movie theatre near you: *I Got Rejected By My Lover!*' If this image is linked to a story that you've already named, then use that name on the subtitle or voice-over. For example, an image of you failing might be subtitled: 'The "Failure" Story'. If it's still bothering you at the end of another 30 seconds, try the next technique.

### **MUSICAL SOUNDTRACK**

Keeping that image on the television screen, add a musical soundtrack of your choice. Experiment with a few different soundtracks: jazz, hip-hop, classical, rock or your favourite movie themes. If the image is still bothering you, try the next technique.

### **SHIFTING LOCATIONS**

Visualise this image in a variety of different locations. Stay with each scenario for twenty seconds before shifting to a new one. Visualise your image on the T-shirt of a jogger or a rock star. Visualise it painted on a canvas, or on a banner, flying behind an aeroplane. Visualise it as a bumper sticker, as a magazine photo, or as a tattoo on someone's back. Visualise it as a 'pop-up' on a computer screen or as a poster in a teenager's bedroom. Visualise it as the image on a postage stamp or as a drawing in a comic book. Use your imagination with this; the sky's the limit.

If you're still fused with the image after all this—that is, if it's still upsetting you, frightening you or taking up all your attention whenever it appears—then I would suggest you practise running through some or all of the above exercises every single day for at least five minutes. This is what I asked Roxy to do, and within a week that image of herself in a wheelchair was no longer bothering her. It still appeared from time to time, but it no longer frightened her, and she was able to let it

come and go while she stayed focused on more important things. Paradoxically, the less she tried to push this image away, the less often it appeared. This was not the intention, but it's something that often happens as a positive side effect. It makes sense when you think about the rebound effect, which so often occurs when you try to push thoughts and images away.

For less troublesome images, you can easily adapt other defusion techniques. Instead of 'I'm having the thought that...' you can acknowledge, 'I'm having the image of...'. For example, 'I'm having the image of screwing up the interview.' If the image is a memory, you could try, 'I'm having the memory of...' You could even think, 'My mind's showing me a picture of...'

Instead of Naming the Story, you can Name the Picture. For example, 'Aha! The "lonely and miserable" picture!' You can even Name the Memory—'Aha! The "nasty rejection" memory!' And you can always say, 'Thanks, Mind!' for whatever picture it sends you. And here's one final technique for troublesome images:

## CHANGING GENRES

This is most useful with moving images. First convert the image into a short 'video clip', then visualise it on a television screen. Now try playing that 'clip' in different film genres. For example, imagine it as a gangster movie, a Western, a trashy soap opera, a sci-fi thriller, a Disney cartoon or a musical. Each time you switch genres, change the clothes, sets and acting styles, but don't try to alter what actually happens. Keep the basic story exactly the same. Play it over and over in different genres until you can truly see that this is just a moving picture and nothing more.

Remember, defusion is all about acceptance. The idea is not to get rid of these images but to let go of struggling with them. *Why* should you accept them? Because the reality is, for the rest of your life, in one form or another, scary pictures will appear. Remember, your mind evolved from a 'don't get killed' device. It saved your ancestors' hides by sending them warnings: an image of a bear sleeping in the back of that cave, or of a hungry sabre-toothed tiger crouched on that rock. So after a hundred thousand years of evolution, your mind is not suddenly going to say, 'Oh, hang on a minute. All the wolves and bears have disappeared now—I don't need to keep sending out these warnings anymore.' Sorry, but minds don't work like that.

Again, don't believe this just because I say so—check your own experience. Despite everything you've tried over the years, isn't it a fact that your mind still produces unpleasant pictures? So we need to learn how to live with these things—to pay them attention if they're helpful, or let them come and go if they're not.

And once again, I have to prepare you. When you practise these techniques your unpleasant images will often disappear, or at least reduce in frequency, and you will often feel much better. But remember, these outcomes are merely beneficial byproducts, not the main aim. If you start defusing thoughts or images with the aim of *getting rid* of them, then you're not truly accepting them. Rather, you're trying to use an acceptance strategy as a control strategy—and ultimately, that will backfire. So use the techniques in the way they were intended, and for the right reasons, and they'll help keep you free of the happiness trap.

## Chapter 9

### DEMONS ON THE BOAT

Imagine you're steering a ship far out at sea. Below the deck, out of sight, lies a vast horde of demons, all with enormous claws and razor-sharp teeth. These demons have many different forms. Some of them are emotions such as guilt, anger, fear or hopelessness. Some are memories of times you've failed, screwed up or been hurt. Others are thoughts like, 'It's too hard', 'I'll make a fool of myself' or 'I'll fail.' Some of them are mental images in which you see yourself performing badly or getting rejected; others are strong urges to drink too much, smoke, harm yourself or overeat. And still others are unpleasant sensations such as tightness in your chest or a knot in your stomach.

Now, as long as you keep that ship drifting out at sea, the demons will stay below. But as soon as you start steering toward land, they clamber up from below deck, flapping their membranous wings, baring their fangs and generally threatening to tear you into little pieces. Not surprisingly, you don't like that very much, so you cut a deal: 'If you demons stay out of sight, down below, I'll keep the ship drifting out at sea.' The demons agree and everything seems okay—for a while.

The problem is, eventually you get fed up of being at sea. You get bored and lonely, miserable, resentful and anxious. You see plenty of other ships heading into shore, but not yours. 'What sort of life is this?' you think. 'That land over there—that's where I want to be heading.' But the demons down below aren't particularly interested in what you want. They want to stay out at sea and that's final! So the moment you start heading for land, they swarm up onto the deck and start threatening you again.

The interesting thing is, although these demons threaten you, they never actually cause you any physical harm. Why not? Because they can't! All they can do is growl and wave their claws and look terrifying—physically they can't even *touch* you. And once you realise this, you're free. It means you can take your ship wherever you want—as long as you're willing to accept the demons' presence. All you have to do to reach land is accept that the demons are above deck, accept that they're doing their level best to scare you, and keep steering the ship toward shore. The demons may howl and protest, but they're powerless, because their power relies totally on your belief in their threats.

But if you're not willing to accept these demons, if you've got to keep them below deck at all costs, then your only option is to stay adrift, at sea. Of course, you can try to throw the demons overboard, but while you're busy doing that no one is steering the ship, so you run the risk of crashing into rocks or capsizing. Besides that, it's a struggle you could never win, because there's an infinite number of those demons in the hold.

'But that's horrible!' you may well protest. 'I don't want to live surrounded by demons!' Well, I'm sorry to be the bearer of bad news, but you already are. And those demons will keep showing up, again and again, as soon as you start to take your life in a valued direction. Why so? Again, it all stems back to evolution. Remember, the mind of our ancestors had one overriding imperative: 'Don't get killed!' And an important factor in not getting yourself killed is to get to know your environment. The better you know the terrain and the local wildlife then, obviously, the safer you are; whereas venturing into unknown territory exposes you to all sorts of exotic dangers. So if one of our ancestors decided to explore a new area, his mind would go into a state of red alert. 'Look out!' 'Be careful!' 'Could be a crocodile in that pond or a leopard in the bushes!' And thanks to evolution, our modern minds do the same, only far more extensively.

Thus, as soon as we start to do something new, our mind will start warning us: 'You might fail', 'You might make a mistake', 'You might get rejected.' It warns us with negative thoughts, with disturbing images or bad memories, and with uncomfortable feelings and sensations. And all too

often we let these warnings stop us from taking our lives in the direction we really want. Rather than sail for shore, we drift at sea. Some people call this ‘staying in your comfort zone’, but that’s not a good name for it because the comfort zone is definitely not comfortable. It should be called the ‘misery zone’ or the ‘missing-out-on-life zone’.

In later chapters, when we start focusing on your values and on taking action to change your life for the better, these demons are going to challenge you. Depending on the nature of your current problems, you may choose to pursue a new career, start a new relationship, make some new friends, improve your physical fitness, or engage in some challenging project like writing a novel, taking a course or enrolling in higher education—and what I guarantee you is this: whatever meaningful changes you start to make in your life, those demons will rear their ugly heads and try to discourage you.

That’s the bad news.

Now here’s the good news: if you keep steering your ship toward shore (no matter how much the demons threaten you), many of them will realise they’re having no effect and will give up and leave you alone. As for the ones that remain, after a while you’ll get used to them. And if you take a good, long look at them, you’ll realise they’re not nearly as scary as they first appeared. You’ll realise they’ve been using special effects to make themselves look a lot bigger than they really are. Sure, they’ll still look ugly—they won’t turn into cute, fluffy bunny rabbits—but you’ll find them much less frightening. And more importantly, you’ll find that you can let them hang around without being bothered by them. Furthermore, if you keep sailing towards that shore, you won’t just have demons for company; you’ll soon encounter angels and mermaids and dolphins.

So one of my main aims in this book is to help you see through the special effects of your demons: to see them as they really are, so that they no longer intimidate you and no longer dictate where you steer your ship. We’ve already started to do this with thoughts and images, and next we’re going to do it with emotions. But before moving on, take a few moments to think about the changes you’d like to make in your life. Ask yourself:

1. How would I act differently if painful thoughts and feelings were no longer an obstacle?
2. What projects or activities would I start (or continue) if my time and energy weren’t consumed by troublesome emotions?
3. What would I do if fear were no longer an issue?
4. What would I attempt if thoughts of failure didn’t deter me?

Please take at least ten minutes to think about these questions. Better yet, write down your answers for future reference.

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When you contemplate these four questions, what trouble some thoughts and images come to mind? Do you visualise yourself getting hurt in some way? Does your thinking self tell you, ‘It’s hopeless’ or ‘It’s too hard’ or that you can’t make these changes because you are too weak/inadequate/depressed/anxious/stupid/unlovable?

Write a list of these troublesome thoughts and images, and once you’ve done it, set aside five minutes a day to practise defusing them. (And when your mind makes up some excuse for not practising, please remember to thank it!) As I’ve said several times before, practice is the key to success. The more you can see these thoughts for what they are—nothing more than words and

pictures—the less influence they will have over your life.

Defusion is a big topic, and we'll be coming back to it at later stages. For now we will focus on painful emotions (which most people find the scariest demons of all). In the next chapter we'll look at emotions from a scientific perspective, discover how they are created, and explode a few myths about them. And after that you'll learn how to fundamentally transform the way you handle them.

## Chapter 10

### HOW DO YOU FEEL?

If you were trekking through the Alaskan wilderness and you suddenly came face-to-face with a huge grizzly bear, what would you do? Scream? Call for help? Run away? We'll return to that question a bit later, after we've answered: What are emotions?

Scientists have a hard time reaching any kind of consensus on what emotions actually are, but most experts agree on three things:

1. Emotions originate from the middle layer of the brain, known as the 'midbrain'.
2. At the core of any emotion is a complex series of physical changes throughout the body.
3. These physical changes prepare us to take action.

Physical changes in the body may include alterations in heart rate, blood pressure, muscle tone, circulation and hormone levels, as well as the activation of different parts of the nervous system. We notice these changes as sensations, such as 'butterflies' in the stomach, a 'lump' in the throat, watering eyes or clammy hands. We also notice them as urges to act in a particular way, such as to cry, laugh or hide.

Emotions influence us to act in different ways. For example, under the influence of any strong emotion, we commonly make changes to our voice, facial expression, body posture, and behaviour. The likelihood that we will act in a particular way when experiencing a particular emotion is known as an 'action tendency'. But notice the key word here: 'tendency'. A tendency means we have the *inclination* to do something; it doesn't mean we *have* to do it, that we have *no* choice. It doesn't mean we are forced or compelled to act in a particular way; it just means we *tend* to act that way. So, for example, if you're anxious about running late, you may have the *tendency* to drive above the speed limit, but you can still *choose* to drive legally and safely if you wish. Or if you're angry with someone, you may have a *tendency* to yell at them, but you can *choose* to talk calmly if you wish.

To understand what constitutes an emotion, let's take a look at anxiety. The experience of anxiety varies from person to person (as does any emotion), but it may include some or all of the following:

- Physical changes such as raised blood pressure, increased heart rate, increased sweating, extra blood flow to the legs or a faster rate of breathing.
- Sensations such as tightness in the chest, racing heart, churning stomach, trembling legs, shaking hands or sweaty palms.
- Urges such as an urge to run away or to quit what you're doing.
- Action tendencies such as a tendency to fidget, talk rapidly, or pace up and down. (People often notice this action tendency as an 'urge'—the urge to fidget etc.)

Emotions are closely tied up with thoughts, memories and images. For instance, when you're feeling afraid, you may have thoughts about what might go wrong, memories of other times you've

felt afraid or mental images of anything from a car crash to a heart attack. One particular type of thought process is so intimately linked to our emotions that some experts consider it a core component. This is the process of ‘making sense of’ or ‘giving meaning to’ our experience. For example, with sadness you have a sense of loss, and with fear you have a sense of danger.

The word ‘emotion’ is derived from the Latin *emovere*, meaning to ‘move out’ or ‘excite’, and many of the names we give to our emotions are derived from ancient words for physical sensations. For example, ‘anguish’, ‘angst’, ‘anger’ and ‘anxiety’ all stem from the Latin *angere*, which means ‘to choke’—a reference to the tightness in the throat often associated with such emotions. For the sake of clarity, whenever I use the terms ‘emotions’ and ‘feelings’, I am referring primarily to the physical sensations and urges that we experience, rather than to the meanings or thoughts associated with them.

## Do Our Emotions Control Our Behaviour?

The answer to this is, quite simply, no! Our emotions definitely do not control our behaviour. For example, you can feel angry but act calmly. You may have the *tendency* to shout, grimace, clench your fists or lash out physically or verbally, but you don’t *have to*. You can, if you *choose*, speak slowly and calmly, maintain a look of serenity on your face, and hold your body in an open, relaxed posture.

I’m sure that at some point in your life you have felt afraid, yet you persisted in the face of that fear even though you felt like running away. In other words, you had a *tendency* to run, but you *chose* not to. We all have experienced this, for instance, when sitting for an exam, asking someone for a date, going for a job interview, speaking before a group or partaking in a dangerous sport.

You already know that whenever I give a speech in public I experience anxiety. And yet, when I reveal this to my audience (as I usually do), they are always amazed. ‘But you look so calm and confident,’ they say. That’s because even though I’m feeling anxious (racing heart, churning stomach, sweaty palms), I am not *acting* anxious. Anxiety typically gives us the *tendency* to fidget, breathe rapidly or talk fast; yet I do the very opposite of these things. I consciously *choose* to talk slowly, breathe slowly and move slowly. The same is true for virtually all public speakers: even after years of experience, they still commonly *feel* anxious, but you’d never know it, because they *act* calm.

Think of the poker player who keeps his face deadpan even when he’s feeling intense emotions. Think of the professional actor who can bring to life all the facial expressions, physical gestures and vocal changes of sheer panic, even though the actor himself may be feeling quite calm. (Method actors, obviously, are a different story.) Think of the times you’ve ‘put on a happy face’ even though you were feeling terrible. In all these cases, the actions are distinct from the emotions.

Now let’s return to the opening scenario of this chapter: you’re trekking through the Alaskan wilderness and you meet a grizzly bear. Obviously, you will feel intense fear and undoubtedly you’ll feel the urge to turn and run. But if you have read your survival manual, you’ll know that’s about the worst thing you could possibly do. If you turn and run, you will incite the bear’s pursuit instinct. It will chase after you and easily outrun you within seconds. After that, you’re bear fodder. Now, although there’s some discussion among the experts about the best response, they tend to agree that a good rule is to back away *slowly*, without any sudden moves or loud noises, and never turn your back on the bear.

Many people have survived by following this advice. They all felt terrible fear—that much was out of their control—but they were able to control *how they acted*. So here’s the point I’m trying to hammer home: although you don’t have much direct control over your feelings, you can directly control your actions. This realisation will have important practical applications later because when it comes to making important changes in your life, it’s far more useful to focus on

what you can control rather than on what you can't.

Of course, there are some reflex reactions that can't be controlled. For example, if I go to poke you in the eye, your eyelids will instantly close. You can't control that. Even if I offered you one million dollars, you wouldn't be able to keep your eyelids from closing. But such reflexes are the exception. The vast majority of our actions can be controlled, provided we are *consciously aware* of them.

The idea that emotions control your actions is a very powerful illusion. Psychologist Hank Robb compares this illusion to that of a sunset. When we watch a sunset, the sun appears to be sinking below the horizon. But in fact, the sun is not moving at all. It's the earth that's moving, rotating on its axis so that we're actually moving away from the sun. And even though we've all learned this at school, it's so easy to forget! When you're watching that sunset, it's almost impossible to believe that the sun is stationary and that it's actually the ground you're standing on that is moving.

When we're feeling strong emotions we may do all sorts of things we later regret. We may smash things, shout, abuse people, drink excessively or engage in any number of destructive behaviours. And it *seems* as if the emotion were *causing* us to do this. But actually, it's not. We're only acting this way because we've developed bad habits. But if we *consciously* bring our awareness to how we are feeling, and *consciously* observe how we're behaving, then no matter how intense our emotions are, we can still control our actions. Even when you're furious or terrified, you can stand up or sit down, close your mouth, drink a glass of water, answer the telephone, go to the toilet or scratch your head. You can't stop yourself from *feeling* angry or afraid, but you certainly *can* control how you behave.

The problem is, our society perpetuates the myth that emotions control our behaviour. For example, we talk about being 'driven by fear', 'seized by anger' or 'overwhelmed by guilt'. We justify our behaviour by saying things like, 'I was so angry, I couldn't help it!' or 'I was too depressed to do anything.' And we use expressions like, 'My fear got the better of me' or 'My anger took over.' So when we grow up hearing people talk this way, we readily come to believe that our emotions control us—and it's a powerful illusion to shake.

What about those cases where people get paralysed by fear? It's true that in very rare instances, when people find themselves in a genuinely life-threatening situation, they may become temporarily 'paralysed' by fear, rather like a rabbit frozen in the headlights. But 99.9 per cent of the time when we talk about being 'paralysed by fear', it isn't the literal truth. It's just a metaphor; a colourful turn of phrase. The person is not truly physically incapable of taking action; he or she is simply choosing not to.

## Emotions Are Like The Weather

Emotions are like the weather—they're always present and constantly changing. They continually ebb and flow, from mild to intense, pleasant to unpleasant, predictable to utterly unexpected. A 'mood' refers to the general tone of emotion across a period of time. A 'feeling' refers to a discrete episode of emotion with distinctive, recognisable characteristics. In our weather analogy, a 'bad mood' is akin to an overcast day, whereas a feeling of anger or anxiety is akin to a storm. We're always experiencing emotion of some sort, just as there is always weather of some sort—although sometimes it isn't strong enough or distinct enough for us to describe it easily, or perhaps even to notice it. At such times, if someone asks us how we're feeling, we might say 'fine' or 'I'm not feeling anything in particular.'

Some people are very much 'in touch' with their emotions while others are, to varying degrees, 'disconnected' from them. Likewise, some people are very good at talking about their feelings, while others have great difficulty doing so and may be limited to simple expressions such as 'I feel good', 'I feel bad', or 'I feel funny.' Although we may say someone has 'no feelings', the truth is, such people don't exist. Everyone has emotions and feelings, regardless of whether they are 'in

touch' with them or able to express them in words.

## The Three Phases Of Emotion

There are three phases in the creation of an emotion.

### PHASE ONE: A SIGNIFICANT EVENT!

An emotion is triggered by some sort of significant event. This event may happen inside your body (a distressing memory, a painful sensation or a disturbing thought) or it may happen in the world around you (something you can see, hear, smell, taste or touch). Your brain notices this event and alerts you that it's important.

### PHASE TWO: GET READY FOR ACTION!

The brain starts to evaluate this event: 'Is it good or bad? Beneficial or harmful?' At the same time, the brain starts to arouse the body for action: either to approach or to avoid the event. In this phase there is no distinctive 'feeling' in the usual sense of the word. If the brain judges the event as harmful, the 'fight-or-flight response' is triggered, and our body prepares to either attack or escape. If the brain judges the event as potentially helpful, our body prepares to approach and explore it. And as our body gets ready for action, we experience a variety of sensations and urges.

### PHASE THREE: THE MIND GETS INVOLVED

In the third phase, our mind starts attaching words, ideas and meanings to the changes happening in our body. For example, the mind may give our sensations and urges a label such as 'frustration' or 'joy', or 'feeling lousy'. And what our mind tells us about these sensations has a significant impact on how we relate to them. For example, imagine two people on a rollercoaster. One of them is terrified; the other is exhilarated. Both are experiencing the same physical changes (raised adrenaline levels, increased blood pressure), the same physical sensations (churning stomach, pounding heart), and the same urges (to scream), but their subjective experiences are very different, depending on what their minds tell them. One mind says, 'This is fun!', the other mind says, 'This is dangerous!' Guess who feels exhilarated and who feels frightened. In the same way, one performer's 'stage fright' can be another performer's 'adrenaline rush'. Both performers experience the same sensations (racing heart, shaking legs and so on), but their minds interpret those sensations very differently.

## The Fight-or-Flight Response

The fight-or-flight response is a primitive survival reflex that originates in the midbrain. It has evolved on the basis that if something is threatening you, your best chance of survival is either to run away (flight) or to stand your ground and defend yourself (fight). Your heart rate speeds up, your body floods with adrenaline, blood shunts to the large muscles of your arms and legs and your breathing increases to give you more oxygen, all of which primes you to flee or else stay and fight.

So whenever we perceive a threat, the fight-or-flight response immediately activates. In prehistoric times, this response was lifesaving. When a woolly mammoth charged you, if you couldn't escape, your only hope was to kill it or at least fight it off. However, in this modern age, most of us rarely find ourselves in life-threatening predicaments, and the fight-or-flight response is often triggered in situations where it is of little or no use to us.

Once again, evolution is the culprit here. Our mind, trying to make sure we don't get killed, sees potential danger almost everywhere: in a moody spouse, a controlling boss, a parking ticket, a new job, a traffic jam, a long line at the bank, a big mortgage, an unflattering reflection in the mirror—you name it. The threat may even come from the mind itself, in the form of a disturbing thought or image. Obviously, none of these things are actually life-threatening, but our brain and body react as if they were.

If our brain judges an event as harmful, the fight-or-flight response is triggered and it rapidly evolves into an unpleasant feeling such as fear, anger, shock, disgust or guilt. If our brain judges the event as 'good' or beneficial, we rapidly develop a pleasant feeling such as calm, curiosity or happiness. The former feelings, we tend to describe as 'negative'. The latter feelings, we tend to describe as 'positive'. But actually, they're neither positive nor negative—they're all simply feelings.

'Well,' you may be saying, 'they may be simply feelings, but I much prefer the positive ones to the negative ones.' Of course you do; so does everybody—it's human nature. But unfortunately, this preference often becomes so important to us that it leads to serious problems, contributing to something I call the 'struggle switch'. Care to find out more? Then keep reading.

## Chapter 11

### THE STRUGGLE SWITCH

Have you ever seen one of those old movies where the bad guy falls into a pool of quicksand and the more he struggles, the faster it sucks him under? If you should ever fall into quicksand, struggling is the worst thing you can possibly do. What you're supposed to do is lie back, spread your arms and lie as still as possible, floating on the surface. (Then whistle for your horse to come and rescue you!) Acting effectively in this situation is tricky, because every instinct tells you to try to escape; but if you don't stop struggling, pretty soon you'll sink beneath the surface. Sure, it's not exactly fun to be floating on quicksand, but it beats the hell out of *drowning* in it!

The same principle applies to difficult feelings: the more we try to fight them, the more they smother us. Now, why should this be? Well, imagine that at the back of your mind is a switch—we'll call it the 'struggle switch'. When it's switched on, it means we're going to struggle against any physical or emotional pain that comes our way; whatever discomfort we experience, we'll try to get rid of it or avoid it.

For instance, suppose the emotion that shows up is anxiety. If our struggle switch is ON, then that feeling is completely unacceptable. So we could end up with anger about our anxiety: 'How dare they make me feel like this!' Or sadness about our anxiety: 'Not again! This is tragic!' Or anxiety about our anxiety: 'This can't be good for me. I wonder what it's doing to my body.' Or guilt about our anxiety: 'I shouldn't let myself get so worked up! I should know better. Once again, I'm acting like a child.' Or maybe even a mixture of all these feelings at once! What all these secondary emotions have in common is that they are unpleasant, unhelpful and a drain on our energy and vitality. And then we get angry or anxious or depressed about that! Spot the vicious cycle?

Now imagine what happens if our struggle switch is OFF. In this case, whatever emotion shows up, no matter how unpleasant, we don't struggle with it. Thus, when anxiety shows up, it's not a problem. Sure, it's an unpleasant feeling and we don't like it, but it's nothing terrible. With the struggle switch OFF, our anxiety levels are free to rise and fall as the situation dictates. Sometimes they'll be high, sometimes low, and sometimes there will be no anxiety at all. But more importantly, we're not wasting our time and energy struggling with it.

Without struggle, what we get is a natural level of physical and emotional discomfort, depending on who we are and the situation we're in. In ACT, we call this 'clean discomfort'. There's no avoiding 'clean discomfort'; life serves it up to all of us in one way or another. But once we start struggling with it, our discomfort levels increase rapidly. And all that additional suffering, we call 'dirty discomfort'.

Our struggle switch is like an emotional amplifier—switch it ON and we can have anger about our anxiety, anxiety about our anger, depression about our depression, or guilt about our guilt. We could even have guilt about our anger about our anxiety—and then depression about that!

But it doesn't stop there. With our struggle switch ON, we are completely unwilling to accept the presence of these uncomfortable feelings, which means, not only do we get emotionally distressed by them, we also do whatever we can to get rid of them, or distract ourselves from them. For some people, this means turning to drugs or alcohol, which then leads to addictions, relationship issues and a whole host of other messy problems. Others may turn to food as a distraction, which can then lead to obesity or eating disorders. Humans find an almost infinite number of ways to try to avoid or get rid of unpleasant feelings: from smoking and sex, to shopping and surfing the Internet. As we saw earlier, most of these control strategies are no big deal, as long as they're used in moderation, but any of them is problematic if used excessively. For example, I've had clients who developed huge credit card debts from excessive shopping, and others who destroyed their relationships by

making unreasonable sexual demands. All these secondary problems, and the painful feelings associated with them, fall under the heading ‘dirty discomfort’.

With the struggle switch OFF:

- Our emotions are free to move.
- We don’t waste time and energy fighting or avoiding them.
- We don’t generate all that ‘dirty discomfort’.

With the struggle switch ON:

- Our emotions are stuck.
- We waste a huge amount of time and energy struggling with them.
- We create a lot of painful and unhelpful ‘dirty discomfort’.

Take the case of Rachel, a 43-year-old legal secretary. Rachel suffers from panic disorder, a condition characterised by sudden episodes of overwhelming fear: so-called panic attacks. During a panic attack the sufferer has an intense feeling of impending doom, associated with distressing sensations such as breathlessness, chest pain, a thumping heart, choking, dizziness, tingling in the hands and feet, hot and cold flushes, sweating, faintness and trembling. This is a common disorder, affecting up to 3 per cent of the population in any given year.

Rachel’s major problem is actually her intense dislike of anxiety. She thinks anxiety is something terrible and dangerous, and she will do anything possible to avoid it. This means that as soon as she feels any sensation that remotely resembles anxiety, such as a racing heart or tightness in the chest, that sensation will itself trigger further anxiety. Then, as her anxiety level rises, those unwanted sensations grow even stronger. This in turn triggers even more anxiety, until soon she is in a state of full-blown panic.

Rachel’s world is steadily shrinking. She now avoids drinking coffee, reading thrillers, watching scary movies or doing any physical exercise. Why? Because all these things make her heart beat faster, which can then set off the whole vicious cycle. She also refuses to ride in elevators or aeroplanes, drive on busy roads, visit crowded shopping centres or attend large social gatherings because she fears she might feel anxious in those situations, and that might lead her to have a panic attack, which is something she wants to avoid at any cost!

Rachel’s case is an extreme example, but to a lesser extent we all do the same thing. All of us, at times, avoid challenges in order to escape the stress or anxiety that goes with them. And as I’ve said before, in moderation this is not a problem. But the more habitual that avoidance becomes, the more we start to suffer in the long run.

‘Yes, that all makes sense,’ I hear you say, ‘but how can I stop struggling with difficult feelings when they feel so bad?’ The answer is by using a simple technique called ‘expansion’. But before we come to that, there’s an interesting bit of history we need to explore.

## **Chapter 12**

### **HOW THE STRUGGLE SWITCH DEVELOPED**

As you read through the emotions listed below just notice, without thinking too hard about it, which ones you automatically judge as ‘good’ or ‘positive’, and which you automatically judge as ‘bad’ or ‘negative’:

- fear
- anger
- shock
- disgust
- sadness
- guilt
- love
- joy
- curiosity.

You have just read a list of the nine basic human emotions, from which all others are derived by combination. (At least, this is what many scientists believe—it’s still the subject of considerable debate.) Most people tend to automatically judge the first six emotions as ‘bad’ or ‘negative’ and the last three as ‘good’ or ‘positive’. Why is this so? It’s largely because of the stories we believe about emotions.

Our thinking self loves to tell us stories, and we know how they affect us when we fuse with them. Here are some of the many unhelpful stories that our thinking self may tell us about emotions:

- Anger, guilt, shame, fear, sadness, embarrassment and anxiety are ‘negative’ emotions.
- Negative emotions are bad, dangerous, irrational and a sign of weakness.
- Negative emotions mean I am psychologically defective.
- Negative emotions will damage my health.
- People should hide their feelings.

- Expressing feelings is a sign of weakness.
- Strong emotions mean I'm out of control.
- Women shouldn't feel angry.
- Men shouldn't feel afraid.
- I must keep my emotions under tight control.
- If I don't control my emotions, something bad will happen.
- Negative emotions mean there's something wrong with my life.

You may agree with some or all of the above, or you may have beliefs that are quite different; it depends largely on your upbringing. If you grew up in a family where 'positive' emotions were freely expressed but 'negative' emotions were frowned upon, then you quickly learned that the 'negative' ones were to be avoided. If your family tended to suppress or hide their feelings, then you learned to keep your feelings bottled up. If your parents believed in 'getting anger off your chest', you may have learned that it's good to express anger. But if you were frightened by a parent's display of anger, you may have decided that anger is 'bad' and should therefore be suppressed or avoided.

## **What Was Your Childhood Programming?**

It's a useful exercise to spend some time thinking about your childhood programming regarding emotions. This can often give you an insight into how and why you struggle with certain feelings. Please take some time to write some answers (or at least think about them) to the following questions:

- As you were growing up, what messages were you given about emotions?
- Which emotions were you told were desirable or undesirable?
- What were you told about the best way to handle your emotions?
- What emotions did your family freely express?
- What emotions did your family suppress or frown on?
- With what emotions was your family comfortable?
- With what emotions was your family uncomfortable?

- How did the adults in your family handle their own ‘negative’ emotions?
- What emotional control strategies did they use?
- How did the adults in your family react to your ‘negative’ emotions?
- What did you learn from observing all this as you grew up?
- As a result of all this programming, what ideas are you still carrying around today about your emotions and how to handle them?

## Judging Our Emotions

One reason we tend to judge emotions as ‘bad’ or ‘negative’ is because they feel unpleasant; they create uncomfortable sensations in our bodies. We don’t like those sensations, so we don’t want them. On the other hand, we do like pleasant sensations, so naturally, we want more of them.

If you judge an emotion as ‘good’, you’ll probably try hard to get more of it; and if you judge it as ‘bad’, you’re apt to try even harder to get rid of it. Thus, judging sets you up for a struggle with your feelings.

In ACT we encourage you to let go of judging your feelings altogether and to see them for what they are: a stream of constantly changing sensations and urges, continuously passing through your body. Just because some of these sensations and urges are uncomfortable doesn’t mean they’re ‘bad’. For example, if you grew up in a family where people didn’t openly express love and affection, then you may find loving feelings uncomfortable. Does that mean they’re ‘bad’? And isn’t it interesting that many people judge fear a ‘bad’ emotion, yet they will pay good money to watch a horror movie or read a thriller, precisely to experience that very feeling! So no emotion is in itself ‘bad’. ‘Bad’ is just a thought: a judgement made by our thinking self. But if we fuse with that thought—if we literally believe that the feeling is ‘bad’—then, naturally, we will struggle with it all the harder. (And we know where that leads.)

Any defusion strategy can help you deal with unhelpful thoughts about your feelings. For example, suppose your mind says, ‘I can’t stand this feeling.’ You could then acknowledge, ‘I’m having the thought that I can’t stand this feeling.’ Or, more simply, you could reply, ‘Thanks, Mind!’

One strategy for dealing with judgements specifically is to label them as such. Suppose your mind says, ‘This anxiety is terrible.’ You could then acknowledge, ‘I’m making the judgement “This anxiety is terrible”.’ Or suppose your mind says, ‘This guilt is awful.’ You could then acknowledge, ‘I’m making the judgement “This guilt is awful”.’

Using this phrase makes you aware of the process of judging. Then you have a choice in how much you buy into those judgements. Alternatively, each time you notice a judgement you can silently say to yourself, ‘Judging...’ and let it be.

Notice that I said the aim is to let go of judging; I didn’t say to *stop* judging. Your thinking self is an expert at judging, and it’ll never stop doing it for long. But you can learn to let go of those judgements more and more, simply by defusing them, as in the above examples.

But what if the feeling really is awful? Then we come back to the pragmatic approach: is this thought helpful? If you fuse with the thought, ‘This feels awful!’, will that help you deal with your emotions or does it simply make you feel worse?

## **How The Mind Adds To Our Emotional Discomfort**

Judging is one of the most common ways that our mind adds to our emotional discomfort, however, there are plenty of others. Below is a list of common questions the mind asks, or comments that it makes, which often stir up or intensify unpleasant feelings.

### **‘WHY AM I FEELING LIKE THIS?’**

This question sets you up to run through all your problems one by one, seeing if you can pinpoint what caused your feelings. Naturally, this just makes you feel worse, because it creates the illusion that your life is nothing but problems. It also leads to a lot of time lost in unpleasant thoughts. (And does this process help you in any practical way? Does it help you take action to change your life for the better?)

### **‘WHAT HAVE I DONE TO DESERVE THIS?’**

This question sets you up for self-blame. You rehash all the ‘bad’ things you’ve done, so you can figure out why the universe decided to punish you. As a result, you end up feeling worthless, useless, ‘bad’ or inadequate. (And again, does this help you in any practical way?)

### **‘WHY AM I LIKE THIS?’**

This question leads you to search through your entire life history looking for the reasons why you are the way you are. Frequently this leads to feelings of anger, resentment and hopelessness. And it very often ends in blaming your parents. (And does this help you in any practical way?)

### **‘WHAT’S WRONG WITH ME?’**

This is another great question for setting you up to spend hours sifting through all your faults, flaws and defects. (And how do you usually feel as a result?)

### **‘I CAN’T HANDLE IT!’**

Variations on this theme include ‘I can’t stand it’, ‘I can’t cope’, ‘It’s too overwhelming’, ‘I can’t take it anymore’, ‘I’m going to have a nervous breakdown’, and so on. Your mind is basically feeding you the story that you’re too weak to handle this, and something bad is going to happen if you keep feeling this way. (And is this a helpful story to pay attention to?)

### **‘I SHOULDN’T FEEL LIKE THIS.’**

This is a classic! Here your mind picks an argument with reality. The reality is this: the way you are feeling right now is the way you are feeling. But your mind says, ‘Reality is wrong! It’s not supposed to be this way! Stop it! Give me the reality I want!’ (And is this effective? Does it change anything? Can you ever win an argument with reality?)

### **‘I WISH I DIDN’T FEEL LIKE THIS!’**

Wishful thinking: one of the mind’s favourite pastimes. (‘I wish I felt more confident.’ ‘I wish I didn’t feel so anxious.’) This can keep us wrapped up in second-guessing ourselves for hours, imagining how our lives could be so much better if only we felt differently. (And does this help us

deal with the life we have now?)

And the list could go on and on. Suffice it to say, the thinking self has lots of ways either to directly intensify our bad feelings or else to get us to waste a huge amount of time uselessly brooding on them. So, from now on, intend to catch your mind in the act when it tries to hook you with these questions and comments. Then simply refuse to play the game. Thank your mind for trying to waste your time, and focus instead on some useful or meaningful activity. You may find it helpful to say something to yourself like, ‘Thanks, Mind, but I’m not playing today.’

## The Struggle Switch Revisited

Now you can see how the struggle switch got there. Our thinking self created it by telling us that uncomfortable feelings are ‘bad’ or ‘dangerous’, that we can’t cope with them, that we are defective or damaged for having them, that they will take over or overwhelm us, that they are ruining our life or that they will hurt us in some way. If we fuse with these stories, the switch goes ON and we perceive uncomfortable emotions as a threat. And how does our brain respond to a threat? It activates the fight-or-flight response, which then gives rise to a whole new set of unpleasant feelings!

To draw an analogy, suppose a distant relative shows up on your doorstep. You’ve never met this relative before, but you’ve been told a lot of stories about her. You’ve been told that she’s bad, that she’s dangerous, that no one can stand her, that the only relationships she has are with defective or damaged people, and that she always ends up hurting or damaging those people or taking control of them and ruining their lives.

If you truly believed those stories, what would your attitude be toward this relative? Would you want her in your house? Would you want her *anywhere* near you?

Of course not. You’d do anything you could to get rid of her as fast as possible. But what if all those stories were false or exaggerated? What if this relative were actually an okay person who had just been the victim of malicious gossip?

The only way you’d ever find out would be to spend some time with her, put aside all the gossip and slander, and check her out for yourself. You’ve probably already experienced something like this in your own life. Perhaps there was once someone at school or at work whom you’d heard a lot of bad things about. Then you spent some time with them and discovered they were nowhere near as bad as their reputation.

You may also have experienced the opposite. You may have heard a lot of great stories about someone and then finally met them, only to discover they’re not all they’re cracked up to be. In both cases the lesson is the same: your own direct experience is more reliable than all the stories you’ve been told.

And so it is in learning to handle unpleasant emotions; what you need to do is have a direct experience of them, to connect with them directly via your observing self, rather than automatically believing the stories of your thinking self. When you do this, you’ll discover that those feelings are nowhere near as ‘bad’ as you thought and you’ll realise they can’t possibly hurt you or overwhelm you.

One thing that will help you in this process is more defusion practice. Therefore, you should use the following techniques several times a day, whenever you find yourself getting caught up in unhelpful judgements. (And as always, don’t have any great expectations—just try them and notice what happens.) If you have a judgemental thought such as ‘X is bad’, then simply acknowledge, ‘I’m making the judgement “X is bad”.’ Alternatively, if you notice an unhelpful judgement, then acknowledge its presence, and silently note it as ‘Judging...’

Sometimes when I tell people that their emotions can’t hurt them, they mention the research which

shows that chronic anger and depression can have bad effects on your physical health. However, the key word here is ‘chronic’, which means ongoing, over a long period of time. Painful emotions become chronic only when you struggle with them. Once you stop struggling, they are free to move and they generally do so fairly quickly (although not always). So when you respond to your emotions with acceptance, they don’t become chronic, and therefore they don’t hurt you. Acceptance breaks the vicious cycle of struggle and frees you to invest your time and energy in life-enhancing activities.

And guess what? In the next chapter you’ll learn how to do this.

## Chapter 13

### STARING DOWN DEMONS

How would you feel if the two people you loved most in the world suddenly died? Hard to imagine, isn't it? Even to *think* about such things feels pretty uncomfortable.

Earlier I mentioned Donna, whose husband and only child both died in a car crash. Most of us can't even begin to imagine her pain, but we can certainly understand her desire to avoid feeling it. When Donna came to see me six months after the accident, she was trying to avoid her pain by any means possible. This included drinking two bottles of wine each day, as well as taking a lot of Valium. Yet her pain was only increasing. Her 'clean discomfort' (the natural pain of loss and grief) was compounded by a lot of 'dirty discomfort' (all the additional suffering caused by her alcohol and drug problems). Learning the skill of 'expansion' was an essential part of her recovery from this trauma.

So why the term 'expansion'? Well consider some of the words we commonly use to describe feeling bad; words such as 'tension', 'stress' and 'strain'. If you look up these terms in a dictionary, you'll find they are all interlinked:

- Tension is a state of being stretched or strained.
- Stress is to subject to strain or pressure.
- Strain is to stretch beyond the proper point or limit.

All these words imply that our feelings are too big: they are pulling us apart and stretching us beyond our limits. Contrast these terms with 'expand': to increase in extent, size, volume, scope; to spread, unfold or develop.

Basically, expansion means making room for our feelings. If we give unpleasant feelings enough space, they no longer stretch us or strain us. Typically, when unpleasant emotions arise, we 'tense up'; that is, our muscles tighten and contract. It's as if we were trying to squeeze these feelings out, to push them out of our body by sheer brute force.

With expansion, we're intending the very opposite. Instead of squeezing down, we're opening up. Instead of increasing tension, we're releasing it. Instead of contracting, we're expanding.

We also commonly talk about being 'under pressure'. And then we talk of needing 'room' or 'breathing space'. It's exactly the same when it comes to our own feelings: if we feel 'pressure' building, we need to give them space. Fighting or avoiding our feelings does not create room for them—expansion does.

When you hear the term 'expanse of water' or 'expanse of sky', what comes to mind? Most people imagine a vast, open space. This is what we are aiming for in expansion: to open up to our feelings and make plenty of room for them. This will ease the pressure, lighten the tension and free those feelings to move. Sometimes they will move very rapidly; sometimes they will move more slowly. But as long as we make room for them, they will move. And more importantly, expansion frees us to invest our energy in creating a better life, rather than wasting it in useless struggles.

'Hang on a minute,' you may say, 'if I make room for these emotions, they'll ride roughshod over me—I'll lose control!'

Though this is a common fear, it isn't based in fact. Remember, ACT has been proven effective

with a wide range of psychological problems, from anxiety and depression to addiction and even schizophrenia. So if your thinking self is telling you scary stories ... simply thank it.

## The Two Selves Revisited

The process of expansion primarily involves the observing self, not the thinking self, so let's just take a moment to recap their differences.

The thinking self is responsible for thinking, in the broadest sense of the word; it produces all our thoughts, judgements, images, fantasies and memories; and is commonly called 'the mind'.

The observing self is responsible for awareness, attention and focus; it can observe thoughts, images, memories etc., but cannot produce them; and it has no commonly used word to describe it. (The closest term in the English language is 'awareness'.)

The following exercise will help distinguish these two distinct parts of you and will also give you a sense of something called 'body awareness' (a key factor in expansion).

### Body Awareness

As you keep reading, simply notice the following:

- Where are your feet?
- What position are your legs in?
- What is the position of your spine? Is it leaning forward or backward? Where does it curve?
- How are you breathing? Shallowly or deeply? Rapidly or slowly?
- As you breathe in, does your tummy move inward or outward?
- Is your back resting against something? If so, notice that area where your back is in contact with the supporting surface.
- What is the shape of that area?
- What are the positions of your arms?
- What can you feel in your neck and shoulders? Any tension or discomfort?
- What is your body temperature? Hot, cold or comfortable?
- Which part of you feels the warmest? Which part of you feels the coolest?
- Can you notice the air on your skin?

- How does the inside of your mouth feel: wet, dry, warm, cool? Where is your tongue resting? Is it touching your teeth?
- Now take twenty seconds to scan your body from head to toe and notice if there's any stiffness, tension, pain or discomfort anywhere.
- Take another twenty seconds to scan your body from head to toe and notice if there are any pleasant or comfortable sensations.
- Do you feel any urge to change your position even slightly, such as by shifting a leg or an arm or even just a finger? If so, notice that urge, but don't act on it yet; just notice which part of your body you want to move. Then move it and notice how it feels.
- Are you noticing any urge to eat, sleep, rest, drink, scratch, stretch or skip this bit and get to the point?

Hopefully, during that exercise you experienced that *awareness* of the body is very different from *thinking* about it. The thoughts you had while you did the exercise came from your thinking self. But the *awareness* of your body—the noticing of the different sensations, urges, movements and positions—came from your observing self.

If you didn't experience this distinction, do the above exercise again. And notice that while the thinking self is talking away, the observing self is simply paying attention to your body. Notice, too, that there are brief moments (which may last less than a second) when the thinking self shuts up and the observing self can observe without any distraction.

Once you have experienced that distinction, it's time to move on to...

## **Expansion**

In practising expansion, we need to sidestep the thinking self—to put aside its unhelpful comments—and connect with our emotions through the observing self. This enables us to experience our emotions directly, to see them as they actually are, rather than as the thinking self says they are. According to the thinking self, ‘negative’ emotions are giant, dangerous demons, but the observing self reveals them for what they are: relatively small and harmless.

So in practising expansion, the aim is to *observe* your emotions, not to think about them. There's just one problem: the thinking self never shuts up! (At least, not for more than a few seconds at a time.) This means that while you practise expansion, your thinking self will continually try to distract you. It may pass judgements on your feelings or try to analyse them, or tell you scary stories about them or claim that you can't handle them, or insist that it's all too hard. Or it may say, ‘Don't bother with these exercises; reading about them is enough.’ It may even suggest that you ‘do them later’, knowing full well that you probably won't.

But none of this needs to be a problem. Just allow those thoughts to be there and let them come and go as they please. Acknowledge their presence, but don't focus on them. Treat them as if they were cars driving past your house—you know they're there, but you don't have to peer out the window each time one goes by. And if a thought does hook you (in the same way that screeching tyres might distract you), then the moment you realise it, gently refocus your attention on what you are doing.

This is essentially the same defusion skill as you learned in the Ten Deep Breaths technique in Chapter 7. If you haven't been regularly practising that exercise, then *please*, start right now! Read through the instructions and give it a go. Then practise that exercise at least ten times a day for five days *before* you read on any further. Remember, there's no great rush to 'get through' this book. Think of it like a holiday—you get more out of it if you take your time, rather than trying to see all the sights in one day.

So, when practising expansion, let your thoughts come and go in the background, and keep your attention focused on your emotions. And remember:

- The essence of an emotion is a set of physical changes in the body.
- We primarily notice these changes as physical sensations.

Expansion starts with noticing what we're feeling in our body (body awareness) and observing precisely where those sensations are located; it then progresses to studying those sensations in more detail. This is the first of three basic steps, outlined below.

## The Three Steps Of Expansion

The three basic steps of expansion are: observe your feelings, breathe into them, and allow them to come and go. Sounds simple doesn't it? That's because it is. It's also effortless. However, that does not mean it's easy! Remember the quicksand scenario? Lying back and floating on quicksand is simple and effortless, yet it's far from easy. Why? Because every instinct in your body tells you to *struggle*. But don't worry. If you fell into quicksand several times a week, you'd soon be a pro at lying back and floating. And the same is true for expansion: the more you practise, the easier it gets.

So let's take a look at these steps in a bit more detail, and then it's practice time. Whenever you're struggling with an unpleasant emotion of any sort, follow these three steps:

### STEP 1: OBSERVE

'Observe' means bring your awareness to the sensations in your body. Take a few seconds to scan yourself from head to toe. Notice what you're feeling, and where. As you do this, you will probably notice several uncomfortable sensations. Look for the one that bothers you the most. For example, it may be a lump in your throat, a knot in your stomach, tightness in your chest or a teary feeling in your eyes. (If your entire body feels uncomfortable, then just pick the area that bothers you the most.) Focus your attention on that sensation. Observe it with curiosity, like a scientist who has discovered some interesting new phenomenon. Observe it carefully. Notice where it starts and where it ends. If you had to draw a line around this sensation, what would it look like? Is it on the surface of the body or inside you or both? How far inside you does it go? Where is it the most intense? Where is it the weakest? How is it different in the centre from around the edges? Is there any pulsing or vibration within it? Is it light or heavy? Still or in motion? Warm or cool?

### STEP 2: BREATHE

'Breathe' means you breathe into and around the sensation, as if making extra space for it. Begin with a few deep breaths—the slower the better—and make sure you fully empty your lungs before breathing in. Slow, deep breathing is important because it lowers the level of tension in your body. It won't get rid of your feelings, but it will provide a centre of calm within you. It's like an anchor in the midst of an emotional storm; the anchor won't get rid of the storm, but it will hold you steady until it passes. So breathe slowly and deeply, and imagine that you are breathing directly into the

sensation. Feel your breath flowing into and around it, as if you are somehow creating extra space within your body. Loosen up around this sensation. Give it some ‘room to move’.

### STEP 3: ALLOW

‘Allow’ means you allow the sensation to be there, even though you don’t like it or want it. In other words, you ‘let it be’. When your mind starts commenting on what’s happening, just say, ‘Thanks, Mind!’ and come back to observing. Of course, you may find this difficult. You may feel a strong urge to fight with it or push it away. If so, just acknowledge this urge without giving in to it. (Acknowledging is like nodding your head in recognition, as if to say, ‘There you are; I see you.’) Once you’ve acknowledged that urge, bring your attention back to the sensation itself. Don’t try to get rid of the sensation or alter it. If it changes by itself, that’s okay. If it doesn’t change, that’s okay too. Changing or getting rid of it is not the goal. The goal is to make peace with it; to let it to be there, even if you don’t like it or want it.

You may need to focus on this sensation for anywhere from a few seconds to a few minutes, until you completely give up the struggle with it. Be patient; take as long as you need. You’re learning a valuable skill. Once you’ve done this, scan your body again and see if there’s another sensation that’s bothering you. If so, repeat the procedure with this one, too. You can do this with as many different sensations as necessary. Keep going until you have a sense of no longer struggling with your feelings. As you practise this technique one of two things will happen: either your feelings will change or they won’t. It doesn’t matter either way, because this technique is not about changing your feelings—it’s about accepting them.

### A Session With Donna

To give you a better idea of how expansion works, I’ve included a transcript of a session I did with Donna. This transcript is from our fourth session, by which time Donna was already well-practised at defusion skills. As this session begins, Donna is sitting opposite me with tears welling up in her eyes.

**Russ:** You look very upset. What are you feeling right now?

**Donna:** Sadness. (*She sobs quietly.*)

**Russ:** (*Nods.*) Anything else?

**Donna:** Fear.

**Russ:** What are you afraid of?

**Donna:** I can’t take it anymore.

**Russ:** So you’re having the thought that you can’t take it anymore?

**Donna:** Yes.

**Russ:** Well, thank your mind for that one. (*Donna smiles through her tears.*) Anything else your mind is telling you right now?

**Donna:** I’ll fall to pieces.

**Russ:** Your mind doesn’t have much confidence in you, does it?

**Donna:** Not usually, no.

**Russ:** Okay. Well, thank it again for its valuable contributions. (*Donna smiles again.*) Now, remember that struggle switch I was talking about? How when it’s ON it amplifies your emotions and makes them into a big, dirty mess?

**Donna:** Yes.

**Russ:** Well, what we're going to do now is turn that switch OFF. I'm going to ask you to sit with your emotions and experience them fully, without struggling.

**Donna:** I can't do it.

**Russ:** Well, of course your mind will tell you that you can't. So thank it again, and let's give it a go. (*Donna sighs heavily, then nods her head.*) Okay. Now, I want you to scan your body from head to toe and notice what physical sensations you can feel. And as you're doing that, take a few very slow, very deep breaths.

**Donna:** Okay. (*She closes her eyes and takes a few slow, deep breaths.*)

**Russ:** What do you notice?

**Donna:** There's a big lump, up here, in my throat.

**Russ:** Anything else?

**Donna:** A pressure, here. (*She places a hand on her chest.*) Like a heavy weight.

**Russ:** Okay. Anything else?

**Donna:** A queasy feeling in my stomach.

**Russ:** Which of those sensations bothers you the most?

**Donna:** My chest!

**Russ:** Okay. Now, I want you to focus on that sensation and observe it as if you're a friendly scientist, who has never seen anything like this before. Just keep breathing slowly and observe it.

**Donna:** Okay. (*Twenty seconds of silence.*)

**Russ:** Now, study that sensation carefully; learn as much about it as you can. Where does it start and stop? Where are its edges? If you had to draw an outline, what shape would it have?

**Donna:** It's like a circle, in the centre of my chest.

**Russ:** How deep inside you does it go?

**Donna:** Right through the centre.

**Russ:** So it's more like a sphere or a cylinder?

**Donna:** It's like a rock.

**Russ:** Okay. So it's shaped like a rock. And it's heavy?

**Donna:** Very!

**Russ:** Temperature?

**Donna:** It's cold.

**Russ:** Is it moving or still?

**Donna:** Still.

**Russ:** Any vibration or pulsation within it?

**Donna:** It's tingling a bit.

**Russ:** Okay. So it's like a cold, heavy, tingling rock, right in the centre of your chest. Now, I want you to breathe into it. Imagine your breath is flowing into it and around it.

**Donna:** Okay. (*She nods her head and takes a long, deep breath.*)

**Russ:** And as that happens, it's as if you are in some sense expanding. You're opening up and

making some room for this feeling.

**Donna:** I don't want to. I want to get rid of it.

**Russ:** Okay. Well, acknowledge that urge to get rid of it and just keep going, observing and breathing into it. I'm not asking you to like this feeling, or want it, or approve of it in any way. Just see if you can allow it to be there, without fighting it.

**Donna:** I can't. It's too hard.

**Russ:** Thank your mind for that thought and come back to observing. Remember, I'm not asking you to think about this sensation; I'm asking you to observe it. You've been living with this feeling for six months now. A little bit longer won't hurt you.

**Donna:** Okay. I'll try. (*She takes another long, deep breath. Then 30 seconds of silence.*)

**Russ:** Now, as you're observing it, breathe into it. Let your thoughts come and go. Stay with it. Stop trying to squeeze it out. Give it some room. You don't have to like it—just let go of fighting it.

**Donna:** Okay. (*Thirty seconds of silence.*)

**Russ:** Have you got a sense of that yet? Of allowing it to be there without a struggle?

**Donna:** Yes.

**Russ:** And what's that like?

**Donna:** Peaceful. (*She smiles.*)

**Russ:** Peaceful?

**Donna:** Yes. It's weird. It's sort of ... I don't know ... calming.

**Russ:** Is that rock still there in your chest?

**Donna:** Yes.

**Russ:** But you're not fighting it?

**Donna:** No.

**Russ:** So the pain is still there, but now the struggle switch is OFF?

**Donna:** Yes.

**Russ:** And that's peaceful?

**Donna:** Yes. It's weird. It's like, it still hurts ... but ... I don't know ... It's like I'm not frightened by it anymore.

**Russ:** Isn't that interesting? Your mind tells you that you can't handle it; you'll fall to pieces; it's too overwhelming. Yet your direct experience shows you that you can make room for it. Which are you going to believe: your mind or your experience?

**Donna:** My experience. (*She smiles.*)

**Russ:** Glad to hear it.

**Donna:** It doesn't feel good, though.

**Russ:** I'm sure it doesn't. How could it? The pain you must be feeling, I can only imagine. But this pain means something, doesn't it?

**Donna:** What do you mean?

**Russ:** Well, if you hadn't deeply loved your family, you wouldn't be feeling what you're feeling. This sadness is directly connected to your love. You can't have one without the other. Now, let's suppose I could give you a choice here. (*Russ holds out both his hands for Donna to pick from.*) If

you pick the left hand, you will get to have meaningful and loving relationships with the people in your life—and you will also get the sadness and loss and grief when those relationships end. If you pick the right hand, then you will never have to feel this sadness and loss—but you will have to give up any sort of loving or meaningful relationships. Which hand do you pick?

**Donna:** That one. (*She picks the left hand: both love and sadness.*)

**Russ:** Are you sure? (*Donna nods.*) Good. Because although this sadness is painful, it's an important part of you. It's directly connected to your ability to love deeply.

**Donna:** I hadn't thought about it like that.

**Russ:** So the question is, are you willing to make room for it? To let this sadness be there, without running from it?

**Donna:** I wasn't before, but ... I am now.

**Russ:** Are you sure?

**Donna:** Yes. (*She smiles.*) I'm sure.

Of course, that was by no means the end of the process for Donna. But it was a valuable learning experience for her. It was the start of a very different approach to dealing with her emotions: one of acceptance rather than resistance or avoidance.

## Now It's Your Turn!

So at last we come to the practical part of this chapter. Now, in order to practise expansion, you'll need to have some uncomfortable feelings to deal with. So bring to mind something that's currently a problem, something that worries, disturbs or stresses you—the sort of problem that prompted you to pick up this book in the first place. Once you've thought of such a problem, focus on it until you feel uncomfortable.

'What!' you're probably yelling. 'Are you *crazy*? I don't want to feel that discomfort!'

Well, join the club. I don't know anyone who *wants* to feel discomfort. The idea here is to be *willing* to feel it. *Wanting* something means you actively *like* it. *Willingness* simply means that you're *allowing* it.

Why develop willingness? Because throughout your life uncomfortable feelings will arise. If you keep trying to avoid them, you'll simply create additional 'dirty discomfort'. By making room for your feelings and *willingly* feeling them (even though you don't want to), you'll change your relationship with them. They'll become much less threatening and will have much less influence on you. They'll take up much less time, energy and attention.

The more we turn away from our demons, the harder we try not to look at them, the bigger and scarier they seem. Menacing shapes half-glimpsed from the corner of our vision are far more disturbing than the things we can see clearly. That's why, in horror movies, they always film the monster lurking in darkness; if they brought it out into broad daylight, it wouldn't be nearly so scary.

'But isn't this all a bit masochistic?' you may ask.

Well, if you were feeling pain just for the sake of it, then yes, that would be masochism. And certainly in some types of therapy, people are encouraged to wallow in their feelings for no obvious benefit (at least, that I can see). This is not the case in ACT. We don't advocate exposing yourself to discomfort unless it is in the service of something important.

Suppose you get mild arthritis in your left ankle, so that from time to time it swells up and aches. And suppose your doctor offers to amputate your leg. There's no way you'd consent to that for

something so minor, is there? But suppose you developed bone cancer in that leg, and amputation became your only chance of survival. Then you would certainly do it. You would accept the discomfort of amputation because it's in the service of something important: your life!

It's the same with emotional discomfort. There's no point in wallowing aimlessly in it.

In ACT, accepting discomfort has only one purpose: to help you take your life forward in a meaningful direction. Thus, in bringing up discomfort to practise expansion, you are learning a valuable skill for transforming your life.

So enough of the talk, already! It's time to do something useful. Read through the detailed instructions in section "STEP 2: BREATHE" and "STEP 3: ALLOW" once again, then bring up some emotional discomfort as suggested above. Next practise the three steps of expansion: observe, breathe and allow. (This technique is one of several which I have recorded on CD, because many people find it's easier when a voice guides them through the process. You can find more details in the resources section at the end of this book.) When practising this technique, it's important to have no expectations. Instead, simply notice what happens, and if you have any problems, don't be concerned; in the next chapter you'll learn how to resolve them.

## Chapter 14

### TROUBLESHOOTING EXPANSION

I said it before and I'll say it again: to practise expansion may be simple, but it sure isn't *easy*. But then again, what meaningful challenge is? Raising kids, keeping fit, nurturing a relationship, developing a career, creating a work of art, caring for the environment: all these meaningful challenges involve some difficulty. So why should practising expansion be any different? Like any new skill, expansion is difficult to begin with, but as you continue to practise, it gets easier. Below you'll find answers to common concerns and problems about expansion.

#### Frequently Asked Questions About Expansion

**Q:** I tried to make room for the feeling, but it was too overwhelming. What should I do?

**A:** You're probably trying to do too much at once. Just pick *one* troublesome sensation and keep your focus on it. Aim to accept just that *one* sensation, even if it takes you several minutes. Once you've done that, go ahead and pick another one.

**Q:** It's hard to stay focused on one sensation.

**A:** Yes, sometimes it is hard—at first. But like any skill, it gets easier with practice. Try to keep your focus on one sensation at a time. If your attention wanders to another sensation, then as soon as you realise it, bring your focus back to the first sensation.

**Q:** But my thoughts keep distracting me.

**A:** Yes, this is the basic nature of the thinking self. It distracts you again and again, pulling you out of your experience. So when it starts chattering, just say, 'Thanks, Mind!' or silently say to yourself, 'Thinking!', then gently return your attention to the sensation. And whenever you notice that your attention has wandered, take a second to note what distracted you (a memory, a thought, an image); then gently refocus. Each time you do this, you are learning two valuable skills: first, to notice when you're all caught up in your thoughts (cognitive fusion); and second, to refocus your attention after it has wandered.

**Q:** That was fantastic. The moment I made room for my unpleasant feelings, they disappeared. Is this what I can expect every time?

**A:** No, no, no! When we practise expansion, unpleasant feelings often disperse rapidly. But (as with defusion techniques) this is merely a bonus, not the main intention. The aim with expansion is simply to make room for your feelings, to feel whatever you are feeling without a struggle. Often those feelings will move very rapidly, but sometimes they won't. So if you're expecting to 'feel good', then sooner or later you'll get disappointed and end up struggling again.

**Q:** The feelings disappeared at first, but then they came back again.

**A:** Many uncomfortable feelings will surface repeatedly. If someone you love has died, then waves of sadness may keep washing over you for many weeks or months. And if you've been diagnosed with cancer or some other serious illness, waves of fear will surge up again and again. As the saying goes, 'You can't stop the waves, but you can learn to surf.'

**Q:** I made room for my feelings, but they didn't change.

**A:** Sometimes feelings change quickly and sometimes they don't. You need to accept that they will change in their own good time, not according to your schedule.

**Q:** Okay. I've accepted my feelings. Now what?

**A:** Having accepted your emotions, choose an area of your life that is important to you and take effective action in line with your values.

**Q:** Why do you keep coming back to actions and values?

**A:** Actions are important because, unlike your thoughts and feelings, you can have direct control over them. Values are important because they can guide you and motivate you through situations where your feelings might lead you off course. Acting in accordance with your own deepest values is inherently satisfying and fulfilling—even though it often forces you to face your fears.

Pleasant feelings such as satisfaction, joy and love are natural byproducts of living by your values. But they aren't the only ones. Other byproducts include uncomfortable emotions such as fear, sadness, anger, frustration and disappointment. You can't have just the pleasant feelings without all the others. That's why it's important to learn how to accept all your feelings—pleasant, neutral and unpleasant.

**Q:** Lots of self-help approaches suggest that when we are feeling bad we should try things like having a hot bath, listening to music, reading a good book, savouring a hot chocolate, getting a massage, walking the dog, playing a sport we love, spending time with friends, and so on. Are you suggesting we shouldn't try such activities?

**A:** This is similar to a question I answered in Chapter 2. I'm sure you've had plenty of great advice from all sorts of sources about helpful activities to try when you're feeling 'bad'. And most of these activities can be deeply satisfying—as long as you genuinely value them; that is, as long as you engage in them out of a sense that they are truly meaningful to you. But if you do these activities mainly to run away from unpleasant feelings, they aren't likely to be all that rewarding—it's hard to appreciate life when you're on the run from something threatening.

Therefore, in ACT, acceptance always comes first. First you make room for your feelings and allow them to be exactly as they are. *Then* you ask, 'What can I do right now that is truly meaningful or important?' This is very different from asking, '*How* can I feel better?' Then, once you've identified an activity you truly value, go ahead and take action.

You can remember these three steps with a simple acronym:

A=Accept your internal experience.

C=Choose a valued direction.

T=Take action.

Of course, once you fully accept your unpleasant feelings and immerse yourself in valued activities, pleasant feelings will often start to emerge. But as I've said countless times before, this is just a bonus, not the main goal. The main goal is to engage in meaningful activities, no matter how you feel. It is this that, in the long run, makes life fulfilling.

**Q:** I did accept my feelings for a little while, but then I started struggling with them again.

**A:** This is common. We often need to accept, accept, and accept again. The word 'acceptance' is misleading, because it seems like a one-off action. In fact, acceptance is an ongoing process. A better word might be 'accepting'.

**Q:** What do I do if strong feelings come on when I'm at work, or in some other situation where I can't just sit down and practise expansion?

**A:** With practice, expansion can happen almost instantly. It takes only a couple of seconds to take a slow, deep breath, scan your body and make some room for what you're feeling. Once you've done that, focus your attention on effective action rather than getting caught up in your feelings.

**Q:** Is slow, deep breathing essential?

**A:** No, it's not. But most people find it very helpful. The other two steps, observing and allowing, are the only essential aspects of expansion.

**Q:** How can I accept my feelings when they have embarrassing side effects, such as making me blush!

**A:** In my days as a family doctor, I hated stitching up wounds on small children. The kids were usually terrified and they screamed and bawled as their parents held them down. I felt like such a sadist! Often I felt quite anxious and unfortunately my hands would start to shake. Now, obviously this was embarrassing, but if I got upset about it, they just shook all the more.

I didn't like my shaking hands, but I couldn't control them. It's just what my hands do when I get really nervous. (That's why I never became a bomb disposal expert!) So in these situations, the only sensible option was acceptance. I would say to the parents, 'When I start stitching in a moment, you may notice my hands shaking a little. You don't need to worry. It always happens when I stitch up young kids. It won't stop me from doing a good job.' Then, as I became involved in the stitching, my hands would gradually become steady. (Not always, mind you, but mostly. And even on those few occasions when they kept shaking, it was much easier to deal with once I'd accepted it.)

Our bodies can do all sorts of awkward things when we have strong feelings. We may start to blush, twitch, shake, sweat, develop stomach cramps, lose an erection, fail to reach an orgasm or even faint or vomit. Keep in mind that these reactions are often a result of the struggle switch being ON. With the switch ON, emotions are amplified (e.g. we get anxiety about our anxiety) and therefore the physical reactions in our body are greater. With the switch OFF, our emotions are smaller and change more rapidly, thereby causing less intense physical reactions. You're much better off if you accept these reactions than if you struggle with them. If you struggle, your feelings will intensify and your bodily reactions will worsen. However, often when we accept these reactions, they improve.

Remember, too, we're always talking about a twofold process: acceptance and action. So accepting these bodily reactions is the first step. Then, if something effective can be done about them, by all means do so. And if there is no effective remedy, acceptance is your best option.

**Q:** I'm starting to have my doubts about you. You sound like an anxious bundle of nerves.

**A:** In ACT, we place great emphasis on being 'up front'. ACT therapists don't go around pretending to be enlightened beings or to 'have it all together'. We freely admit we're human, and we fall into the same traps as everyone else. In fact, we often say to our clients something like this: 'I don't want you to put me on some kind of pedestal, to think I've got my life completely in order. It's more as if you're climbing your mountain over there and I'm climbing my mountain over here. And it's not as if I've reached the top and I'm having a rest. It's just that from where I am on my mountain, I can see obstacles on your mountain that you can't see. So I can point those out to you and maybe show you some alternative routes around them'.

So yes, you're absolutely right. I do experience a fair amount of anxiety in my life. But these days I generally handle it well. For example, when I am speaking publicly I fully accept my anxiety without a struggle. (I'm no keener than the next guy to experience such feelings, but I'm completely willing to have them in order to do something I value.) Just before I start speaking, my anxiety skyrockets. Then, as I become increasingly involved in my talk, one of two things happens: either it goes down or it doesn't. Usually, it goes down fairly quickly, but even if it doesn't, it's not a problem, because now I fully accept it.

When I look back on my life, I can see how acceptance has dramatically reduced my anxiety levels. As a junior doctor, I was often in a state of anxiety and as a consequence my hands were often sweaty. I then became increasingly anxious about my sweaty hands—and guess what happened? That's right. They became worse and worse until I developed a blistering sweat rash between my

fingers. Nowadays my hands still get sweaty at times—but not often, because I don’t worry about it. Looking back even further on my life, as a medical student I suffered terribly from social anxiety, and I drank extremely heavily to try to counteract it. As a consequence, I invariably got drunk and ended up doing stupid or outrageous things, and waking up with a terrible hangover. These days I still get anxious in some social situations, but because I accept the anxiety, it comes and it goes, and it doesn’t escalate in a vicious cycle. As a result, I get to enjoy social events without the unpleasant side effects of too much alcohol (which I now rarely drink).

Of course, there are times when I still handle my anxiety poorly, when I completely forget everything I’ve written in this book, and I pace up and down the house, worrying uselessly, or I wolf down an entire packet of TimTams. But as the years go by I do such things less and less frequently; I get better and better at catching myself and doing something more effective instead.

The same will undoubtedly be true for you. You’ll use these new skills at times and reap the rewards. And at other times you’ll forget all about them. Again and again and again throughout your life, you will get caught up in struggling with your feelings. That’s the bad news. The good news is, the very moment you realise this has happened, you can instantly respond far more effectively!

**Q:** I don’t really like all this acceptance stuff. Surely there must be easier ways of dealing with emotions.

**A:** You need to trust your own experience on this. ACT works particularly well with clients who have tried many different types of therapy or personal development programs. That’s because these people have experienced for themselves that control strategies are not effective in the long run. So you may need to go and try some of the more popular approaches—hypnosis, visualisation, affirmations, positive thinking and so on—and discover for yourself that they really are not effective in the long term. Perhaps only then will you be fully ready to take on this approach. But before you go off and do that, reflect back to Chapter 2. Consider again all the ways you’ve tried to control ‘negative’ thoughts and feelings and ask yourself, did those methods work in the long term? And did they bring you closer to the life you want?

**Q:** Do these principles apply to all emotions?

**A:** Yes. But most of us have no problem with neutral or pleasant emotions. We only tend to struggle with the uncomfortable ones.

**Q:** I don’t feel my emotions in my body. They’re all in my head.

**A:** Sometimes it seems as though you don’t feel emotions in your body, but everybody does. If you can’t readily feel them, it suggests you’re very disconnected from your body. If this is the case, practise the Body Awareness exercise (see Chapter 13). Practise it for three or four minutes, twice a day, especially when you’re feeling upset or stressed. Before long you’ll be able to locate your feelings in your body. There are usually some key areas where we feel most intensely. Common ones include the forehead, temples, jaw, neck, shoulders, throat, chest and abdomen.

**Q:** But I don’t feel anything when I’m deeply upset; I just go numb.

**A:** Then practise accepting your numbness. Find the part of your body that feels the most numb, and practise expansion around that. You’ll usually find that as you make room for that numbness other uncomfortable feelings will arise. Then you can practise expansion around those.

**Q:** Can the thinking self assist with expansion?

**A:** Yes, it can. Although your thinking self naturally sets you up to struggle, it can also help you accept unpleasant feelings. It can help in two ways: acceptance self-talk and acceptance imagery.

## ACCEPTANCE SELF-TALK

When practising expansion, some people find self-talk very helpful.

You may like to try saying things like:

- ‘I don’t like this feeling, but I have room for it.’
- ‘It’s unpleasant, but I can accept it.’
- ‘I’m having the feeling of...’
- ‘I don’t like it; I don’t want it; I don’t approve of it. But right here and now, I accept it.’

True acceptance is not a thinking process. It’s an attitude of openness, interest and receptiveness, which originates with the observing self. Therefore, silently saying things such as the above examples will not make you truly accept (any more than silently saying, ‘I’m happy’ will make you truly happy). But what these words can do is act as a prompt: they can *remind* us and *guide* us to accept.

## ACCEPTANCE IMAGERY

This is a variation on the three-step expansion technique. It is often helpful for people who are good at visualising. First scan your body and pick the sensation that bothers you the most. Observe it the way a curious scientist might. Now visualise that sensation as an object. What is the size and shape of it? Is it liquid, solid or gaseous? Is it transparent or opaque? What colour is it? Does the colour vary? What is its temperature? Is it light, heavy or weightless? How does the surface feel to the touch: rough, smooth, wet, dry, sticky, spiky, hot, cold? Is there any sound associated with it? Is there any vibration, pulsation or movement within it? Is its position fixed or shifting?

Take a few slow, deep breaths. Breathe into and around this object. Make some room for it. Allow this object to be there, to stay right where it is. Let go of trying to push it out. You don’t have to like it; just let it be. Don’t try to get rid of the object and don’t try to alter it. If it changes by itself, that’s okay. If it doesn’t change, that’s okay, too. The aim is to accept it, not get rid of it.

Repeat this with as many other sensations as you need to, until you have a sense of no longer struggling with these feelings.

**Q:** How much practice do I need to do?

**A:** Expansion is a very powerful acceptance skill, and obviously the more you practise, the better you get. So try it out with different feelings—both strong ones and mild ones. Use every opportunity. For example, if you’re stuck in traffic, caught in a slow-moving line or waiting for a friend who’s running late, use that time to practise expansion. Notice what you’re feeling in that moment: is it boredom, anxiety, irritation? Whatever it is, observe, breathe and allow—and if you wish, visualise. At least then you’ll be using your time constructively to develop a new skill, instead of merely struggling with your feelings.

**Q:** Isn’t it unhealthy to keep focusing on unpleasant feelings?

**A:** I ask you to focus on unpleasant feelings only so you can develop better acceptance skills. In everyday life, focusing too much on your feelings will just create problems; it will distract your attention from more important things. The ultimate aim of all this practice is:

- to be aware of your feelings but not preoccupied with them
- to accept them fully and allow them to come and go
- to focus on them *if and when they’re helpful*
- otherwise, to keep your focus on doing what you value.

**Q:** So far we’ve focused only on dealing with sensations. How do I deal with urges?

**A:** Through using a simple technique known as ‘urge surfing’. And yes, you guessed it: that’s what the next chapter is all about.

## Chapter 15

### URGE SURFING

Emotions prime your body to take action; that is, every emotion gives you the impulse to act in a certain way. We call that impulse an ‘urge’. In anger, we may feel the urge to shout, smash something (or someone), or just prove ‘I’m *right*, damn it!’ In sadness, the urge may make us want to lie down, cry, curl up into a ball or have someone cuddle us. In fear, the urge may be to run away and hide, stay really quiet, pace up and down or talk too fast.

And we experience all kinds of urges besides those mainly associated with emotions. We feel the urge to eat, drink, sleep, have sex or get some exercise. Addictions typically give rise to extremely powerful urges: to gamble, get high or get drunk. Eating disorders come with their own powerful urges, too: to eat, starve or induce vomiting.

And this one’s a little less obvious: when uncomfortable emotions arise we often feel strong urges to use control strategies. For example, whenever I’m anxious, I get a strong craving for chocolate or I want to go to the movies. In someone else, anxiety might trigger an urge to have a double scotch, smoke a cigarette or go for a run.

#### What Do Urges Feel Like?

You may not be aware of it, but your urges affect certain parts of your body far more than others—it all depends on which part of your body is preparing for action. If you pay attention to your body, you can feel these ‘preparations’ taking place. For example, when I have the urge to eat chocolate, I notice it first inside my mouth. First I feel my mouth watering, then my tongue gets fidgety and starts licking my lips. Then a vague tension starts in my jaws, as if they want to chew on something. Then, as the urge grows stronger, I may feel a sensation in my stomach—a sort of low-grade rumbling. As the urge grows stronger still, I may notice a restlessness in my legs: an impulse to get up and move (to wherever I can find some chocolate).

These sensations are all rather vague. Notice my use of terms such as ‘tension’, ‘restlessness’ and ‘fidgety’. These are hard sensations to describe because, primarily, they are impulses to take action. Still, we’ve all experienced just such sensations. And a key skill in dealing with urges is learning to be aware of them: to notice where they are happening and what they feel like. (Yes, this is more about body awareness!)

So the next time you feel an urge to eat, drink, smoke, yell or run away, take a moment to scan your body from head to toe and notice *where* you feel it. If you pay close attention, you’ll detect a variety of vague sensations. For example, if you focus in on ‘restless legs’, you’ll notice that some of the muscles feel tense or springy as they contract in readiness to move. You may also notice feelings of warmth or tingling, caused by increased blood flow and altered electrical activity in the nerves.

It takes a little practice (that word again!) to get really good at tuning in to your urges, but as you do, you’ll find that they have two main components:

1. Vague sensations that tell you your body is preparing for action.
2. Associated thoughts and images about the sort of action you want to take.

So, returning to my urge for chocolate, those sensations in my mouth, stomach and legs will be accompanied by thoughts and images about eating chocolate. Likewise, if you’re feeling anxious in

a social situation, you may have ‘restless’ sensations in your legs, coupled with thoughts or images about leaving early.

## To Act Or Not To Act?

You can deal with an urge in one of two ways: act upon it or not act upon it.

Therefore, once you are aware of a strong urge, you need to ask yourself: If I act on this urge, will I be acting like the person I want to be? Will it help take my life in the direction I want to go?

If the answer to either of these questions is yes, then it makes sense to act on that urge. For instance, if you’ve been nasty to someone and you’re feeling guilty about it, you may have an urge to apologise. If this is consistent with who you want to be and what you want to stand for, then it’s sensible to go ahead and apologise.

On the other hand, let’s suppose you’ve been mean to someone and you’re still feeling a lot of resentment toward them. In this case, rather than the urge to apologise, you may feel the urge to write them a nasty letter or say spiteful things about them to others. If this isn’t consistent with who you want to be or how you want to live your life, then it’s sensible not to act on it.

Now, let’s imagine a third scenario. You’re working or studying late to meet an important deadline when a friend calls and asks you to go for a drink. You turn down the offer because you need to get more work done. Your friend gets upset and tries to lay a guilt trip on you, telling you that she’s lonely and miserable and has no one else to go with. You tell her she can come and have a drink at your place, after you’ve done a few more hours of work. She’s upset and hangs up on you.

Different people will have very different emotional reactions to this situation. The emotional reaction you have will depend on your ‘learning history’; that is, everything you’ve ever learned, directly or indirectly, that relates to this event. This includes everything you’ve picked up from books, teachers, parents, television, movies, songs, video games, friends, family, co-workers and your own direct experiences of handling relationships, social etiquette, communication, negotiation and so on, plus every thing you’ve ever learned about how to relate to your own thoughts and feelings. This means that your emotional reaction in a given situation has been shaped by literally *millions* of learning experiences throughout your life. (Thus, it’s far too simplistic to say that your emotion is because of a certain thought, the way your parents treated you, or the chemical balance in your brain.)

There’s no right or wrong to how you should feel in any given situation. Your mind may tell you that you should feel this or that way, but that’s just your mind ‘mouthing off’. And other people may tell you how you should feel, but that’s just other people mouthing off. The reality is simply this: how you feel is how you feel. (And what do you get when you argue with reality?) The emotions you feel in any given situation are determined by three things:

1. The state of your physical body, including the structure and functioning of your brain and nervous system, your current state of health and wellbeing and the emotional state you were in right before the situation happened.
2. Your learning history; that is everything you’ve ever learned in your life, directly or indirectly, that relates even remotely to the situation.
3. The specifics of the situation you’re in.

Knowing this, it’s quite natural that in the scenario above, different people will have different emotional reactions. Those emotional reactions will in turn give rise to different urges. If you feel

angry with your friend, you may have the urge to call her back and yell at her. If you feel guilty, you may have the urge to call back and apologise and change your plans to accommodate her. If you feel anxious, you may have the urge to call someone else and ask for advice. If you feel sad, you may want to cry. If you feel pleased with the way you handled the whole event, and didn't buy into the guilt trip, you may have the urge to punch the air and shout, 'Yes!' If you feel distressed, you may have the urge to stop work and go and get some ice cream instead.

Whatever the urge, the first step is to notice it. (It often helps to acknowledge silently, 'I'm having the urge to do X.') The second step is to check in with your values: 'Will acting on this urge help me be the person I want to be? Will it help me take my life in the direction I want?' If the answer is yes, then go ahead and act, using that urge to guide you and give you momentum. But if the answer is no, then instead take some action that's more in line with your values.

To exemplify this, let's take a look at Lisa, a 21-year-old university student. Lisa values close relationships with her friends, and socialising with them regularly is an important part of her life. But when she feels depressed she has the strong urge to stay at home, all by herself. (This is a very common urge with depressed moods.) And here we have the setup for a major conflict of interest. Lisa's values are pointing her in one direction—socialising—but the urge is pointing her in another direction—staying home alone. Which action is likely to take Lisa's life in the direction she wants: to act on her urge and stay home, or to act in line with her values and go out and meet her friends?

Of course, it would be different if Lisa *truly valued* staying at home—if, for instance, she wanted to catch up on her studies for an important exam. If that were the case, staying home alone would be taking her life in the direction she wants, not away from it, so it would make sense to act on the urge.

## The Push And The Pull

So what do we do if an urge pushes us in one direction and our values pull us in another? We don't want to struggle with that urge because then it's hard to focus on effective action. So rather than try to resist, control or suppress it, the aim in ACT is to *make room* for it, to give it enough time and space to expend all its energy—in other words, to practise *expansion*. And one marvellously useful technique for this is known as 'urge surfing'.

Have you ever sat on the beach and watched the waves? Just noticed them coming and going? A wave starts off small and builds gently. Then gradually it gathers speed and grows bigger. It continues to grow and move forward until it reaches a peak, known as a crest. Then, once the wave has crested, it gradually subsides. The same happens with urges in your body. They start off small and then steadily increase in size (usually, that is—sometimes it can happen amazingly fast).

We often get into a struggle with our urges; that's why people talk of 'resisting' them or 'giving in' to them. In urge surfing, though, we aren't trying to resist or control our urges—we're just giving them space. If you give an ocean wave enough space, it will reach a crest and then harmlessly subside. But what happens if the wave encounters resistance? Well, ever seen a wave *crash* onto the beach or *smash* against the rocks? It's loud, messy and potentially destructive!

Urge surfing is a simple but effective technique in which we treat our urges like waves; that is, we surf them until they dissipate. The term was coined back in the 1980s by psychologists Alan Marlatt and Judith Gordon, as part of their groundbreaking work with drug addiction. The same principles they used with addictive urges can be applied to any urge we feel: whether it's an urge to stay in bed all day, to quit a course, to avoid some daunting challenge or to yell at someone we care about.

To surf an urge rather than be wiped out by it, all you need to do is pay careful attention and:

- Observe where in your body you feel the urge most strongly.

- Acknowledge, ‘I’m having the urge to ... X, Y, Z.’
- Just watch it rise and watch it fall.
- Don’t try to suppress it or get rid of it.
- Breathe into it; make room for it.
- When your mind starts judging or criticising this urge or telling you other unhelpful stories (such as ‘You can’t handle it’), just allow those thoughts to come and go without focusing on them.
- Some urges rise and fall rapidly; others linger. Allow your urge to rise and fall in its own sweet time.
- You may find it helpful to score the urge on a scale of 1 to 10. For example, ‘I’m having the urge to smoke and it’s a 7.’
- No matter how huge that urge gets, you have room for it. And eventually it will crest and then it will subside. So observe it, breathe into it and allow it.

That’s the essence of urge surfing, and below is a simple formula you can follow.

## The OBSERVE Acronym

Whenever you find yourself having troublesome urges, there’s a basic routine you can follow. You can remember it with the acronym OBSERVE:

**O**=Observe

**B**=Breathe

**S**=Surf

**E**=Expand

**R**=Refocus

**V**=Values

**E**=Engage

Let’s take a closer look.

OBSERVE means you observe this urge as if you were a curious scientist. Where do you feel it in your body? What does it feel like? Notice the associated thoughts and images and silently acknowledge the urge (e.g. ‘I’m having the urge to run away.’)

BREATHE means you take a few slow, deep breaths. Breathe into the urge and make room for it.

SURF means you treat the urge as if it were a wave that you were surfing. Notice where you feel it and how intense it is. Keep track of whether it’s growing, cresting or subsiding. You can score it on a scale of 1 to 10, and watch the numbers increase and decrease as it grows, crests and subsides.

Don't try to rush it. Allow it to rise and fall in its own sweet time.

EXPAND means you breathe into the urge and make more room for it. No matter how big this urge gets, you are bigger! Allow it to be; don't get into a fight with it. As long as you keep making room for it, sooner or later this urge will crest and then it will subside.

REFOCUS means you unhook yourself from any unhelpful thoughts, and you bring your attention back to what's happening, here and now.

VALUES means you take a moment to connect with what's important in your heart—with who you want to be and what sort of life you want to create. Then you choose an effective action, one that takes your life in a valued direction.

ENGAGE means you engage fully in whatever valued action you take. You let your thoughts and feelings come and go, and you give your full attention to your actions.

While I know that OBSERVE can be a wonderfully useful tool, I also know that plenty of readers will find it hard to remember. If this is the case for you, there's always a simpler acronym you can stick to—ACT:

Accept your internal experience.

Choose a valued direction.

Take action.

## A Balancing Act

We experience urges all day long, every day of our lives, and most of the time acting appropriately on them is no big deal. In ACT, we're concerned only with urges that get in the way of our living a meaningful life. For example, I act on my chocolate urges fairly regularly and it's not a problem. But if I acted on them all the time, I'd be the size of an elephant and that would not be in line with my values on health. On the other hand, if I never acted on them, I'd be unnecessarily depriving myself of a simple but satisfying pleasure.

All this means is, there needs to be a balance. Aim to find that balance over time. Don't put ridiculous expectations on yourself, deciding that you're never going to act on self-defeating urges ever again. Of course you will—you're human. You'll screw up again and again over the course of your life. But remember: the instant you are aware of what you're doing, you have a chance to do something more effective. And over time you'll get better and better at catching yourself earlier and earlier.

While urge surfing can be very helpful, like any skill, it requires practice. (Look, you had to know that was coming.) The best way to practise is to put yourself in a situation where you're likely to feel confronted by troublesome urges. But don't choose just any challenging situation; choose one that moves your life forward in a meaningful way.

During the next week, pick two or three difficult situations that naturally occur when you take your life in a valued direction. These situations could be anything: getting some exercise, attending a class, asking someone out on a date or attempting something new at work. Once you're in those situations, notice your urges, surf them and stay fully engaged in what you're doing.

Of course, staying engaged in what you're doing can be tricky, especially when the thinking self starts mouthing off. That's why in the following chapters we're going to look at a process called 'connection', which is all about engaging in and connecting with our experience (rather than getting caught up in our thoughts and feelings).

Connection builds on, and overlaps with, expansion and defusion. So if you're still struggling with thoughts and feelings, you'll find that connection skills will help you.

But before we get to that, we need to pay a very brief visit back to those demons on the boat...

## **Chapter 16**

### **MORE DEMONS**

So here we are again, back on the boat with all those creepy, scary demons. But hopefully, now you're starting to see them as they really are, starting to make peace with them, so you're free to steer the boat where you want. When you can see that your unpleasant emotions are nothing more than sensations and urges (with words and pictures attached, of course), you are able to relate to them differently. An unpleasant emotion arises and instead of struggling you can let it be and focus on doing something of greater value.

Naturally, at times those demons will steer you off course. (Why ‘naturally’? Because you’re a normal human being, not a saint or a guru.) But here’s the exciting thing: the moment you realise your boat is headed in the wrong direction, you can instantly turn it back around. Instantly! All it takes is awareness.

Of course, you may be a long way from shore at the time. And in fact, that very thought is often one of the demons: ‘I’m so far away from achieving what I want in my life, what’s the point in even trying?’ But the point is, the instant you turn that boat toward shore, you’re heading in the direction that you want—and that’s so much more rewarding than drifting aimlessly out at sea!

### **Getting To Know Your Demons**

In Chapter 9 you listed some of your main demons in terms of thoughts and images. Now it’s time to add emotions, sensations and urges to that list. The first step is to read through the seven questions below, noticing what thoughts and feelings automatically come to mind:

1. What are the major changes you’d like to make in your life?
2. How would you act differently if painful thoughts and feelings were no longer an obstacle?
3. What projects or activities would you start or continue if your time and energy were not consumed by troublesome emotions?
4. What would you do if fear were no longer an issue?

If unhelpful thoughts and unpleasant feelings did not deter you:

5. What sort of relationships would you build and with whom?
6. What improvements would you make in your health and fitness?
7. What changes would you make in your work?

In reading through your list, you have probably already noticed a variety of unhelpful thoughts and unpleasant feelings. If you’re experiencing those right now just by reading these questions, then you can be sure they’re going to confront you later, when we focus on taking action. So take a few minutes and write down the answers to these questions (or at least spend a few minutes thinking

about them):

- What demons can you expect to find clambering up on deck as you steer your boat in a valued direction?
- What feelings, urges and sensations might possibly act as obstacles?
- What thoughts and images might possibly act as obstacles?

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The next step is to make some time to practise defusion and/or expansion with these demons. What valued activities can you do in the next few days that will give you a chance to meet these demons, see them for what they are and make peace with them? Set yourself a few goals: specify the time, the place and the activity you'll do. Then engage yourself fully in that activity.

And if you have trouble with any of this, don't be discouraged. In the next few chapters you'll be learning another useful skill that will make a world of difference.

## Chapter 17

### THE TIME MACHINE

‘Where are you?’ asked my wife, startling me out of my reverie. We were halfway through a meal at a Japanese restaurant and for the past couple of minutes I hadn’t heard a word that she’d been saying. Or to be more accurate, I had *heard* the words but hadn’t consciously *listened* to them. ‘Where are you?’ was an appropriate question, because even though I was there physically, mentally I was miles away. I’d been completely ‘carried off’ by thoughts about a troublesome family matter.

We’ve all had this happen to us. We’re in a conversation, nodding and listening, but we’re not paying a bit of attention, because we’re ‘off in our heads’ thinking about what we’ve got to do later, or dwelling on something that happened earlier. Often we can get away with this ‘fake listening’, but sometimes, to our great embarrassment, we get caught. When someone asks, ‘Are you listening?’ we may try to bluff it out, saying, ‘Yes, of course.’ Or we may sheepishly confess, ‘No. Sorry, I was thinking about something else.’

The thinking self is constantly generating thoughts—after all, that’s its job. But all too often those thoughts distract us from where we are and what we’re doing in the moment. Ever been for a drive in a car and reached your destination with no real memory of the journey? Or thought you knew where you were going but ended up driving to the wrong place? That’s because your attention wasn’t on the road; it was on the activity of your thinking self (daydreaming, planning, worrying, problem-solving, remembering, fantasising and all the rest). And this is how we habitually go through most of our lives.

Take eating, for example. When we’re eating food we rarely, if ever, give it our full attention. We’re usually talking to someone, reading, watching television or even working at our desk. How often have you eaten a meal and focused on it completely, to the exclusion of all else? For most of us it’s a rare occurrence.

Have you ever been asked, ‘What did you do today?’ and not been able to remember? Do you ever find yourself snacking on something without even realising it? Or read an entire page of a book and realise you haven’t taken in a single word?

We say we were ‘lost in thought’, ‘distracted’ or ‘preoccupied’—all terms that mean our attention is fixed on the products of our mind instead of on what we are doing right here and now. That is, our observing self is distracted by our thinking self. We call this being ‘absent-minded’, but our mind is not absent at all; it’s our *attention* that’s busy elsewhere.

The thinking self is rather like a time machine: it continually pulls us into the future and the past. We spend a huge amount of time worrying about, planning for or dreaming of the future, and a huge amount of time rehashing the past. This makes perfect sense in terms of evolution. The ‘don’t get killed’ device needs to plan ahead and anticipate problems. It also needs to reflect on the past, to learn from it. But even when our mind is thinking about the here and now, it’s generally being judgemental and critical, struggling against reality instead of accepting it. And this constant mental activity is an enormous distraction. For a huge part of every day, the thinking self completely diverts our attention from what we’re doing.

Suppose you’re trying to have a conversation with someone and you’re giving most of your attention to thoughts like, ‘I’ve got nothing to say’, ‘He thinks I’m boring’, or ‘I’ve got to get my taxes done.’ The more attention you give to those thoughts, the less involved you are in the conversation. The same goes for every activity you ever do, whether you’re water-skiing or making love: the more you’re caught up in your thoughts, the less you’re engaged in the activity.

Of course, some activities require creative or constructive thinking as part of the process—playing chess, for instance, or doing a crossword puzzle. But even then thoughts can pull you away from what you’re doing. If you’re playing chess and carefully thinking through all your options, that’s fine; those thoughts keep you involved in the game. But if you’re giving your attention to thoughts like, ‘I’m going to lose’, ‘She’s so good, she must think I’m a dope’, or ‘I wonder if that new Steven Spielberg movie is out yet’, those thoughts will pull you out of the game.

Now, obviously there are times when being absorbed in thought is precisely what you *should* be doing—for example, if you’re dreaming up ideas for a new ad campaign, mentally rehearsing a speech, planning an important project or simply solving a crossword puzzle or philosophising about life. But too much of the time, we’re so absorbed in our thoughts that we aren’t fully engaged in our lives and aren’t in touch with the wondrous world around us. And when we’re like this, only half present with friends and family, we’re not even connected with ourselves!

## What Is ‘Connection’?

‘Connection’ is the process of making full contact with your experience in this moment.

‘Connection’ means being fully aware of your here-and-now experience and being interested, open and receptive to that experience.

In practising connection, we pull ourselves out of the past or the future and bring ourselves back to this moment, right here, right now, with openness, receptiveness and interest. Why do this? For three main reasons:

1. This is the only life you’ve got, so make the most of it. If you’re only half present, you’re missing out. It’s like watching your favourite movie with sunglasses on, listening to your favourite music wearing earplugs or eating your favourite food while your mouth’s still numb from a dentist’s needle. To truly appreciate the richness and fullness of life, you have to be here while it’s happening!
2. As Leo Tolstoy put it, ‘There is only one time that is important: NOW! It is the most important time because it is the only time when we have any power.’ To create a meaningful life, we need to take action. And the power to act exists only in this moment. The past has already happened and the future doesn’t exist yet, so we can only ever take action *here and now*.
3. ‘Taking action’ doesn’t mean just *any* old action. It must be *effective* action; action that helps us move in a valued direction. In order to act effectively, we need to be psychologically present. We need to be aware of what is happening, how we are reacting and how we wish to respond.

This means we need to add three extra words to the ‘A’ of ACT:

**A**=Accept your internal experience *and be present*.

**C**=Choose a valued direction.

**T**=Take action.

Connection is about waking up, noticing what’s happening, engaging with the world and appreciating the fullness of every moment of life. You’ve already experienced this many times in your life. Perhaps while on a walk in the countryside you feasted your eyes on the fields, the wildlife, the trees and flowers, enjoyed the touch of a balmy summer breeze, and listened to the songbirds. Or during an intimate conversation with the one you love, you hung on their every word, gazed into their eyes, and felt the closeness between you. Or while playing with a child or a beloved pet, you were so involved in the fun of it all, you didn’t have a care in the world.

As these examples suggest, connection often happens spontaneously in novel, intense, stimulating or pleasurable situations. Unfortunately, it rarely lasts for long. Sooner or later the thinking self pipes up and its comments, judgements and stories pull us out of the experience. And as for all those familiar, mundane or unpleasant situations that make up a sizeable part of even the most privileged life, connection is pretty well non-existent at those times.

## Connection And The Observing Self

Connection happens through the observing self. It involves bringing our full attention to what is happening here and now, without getting distracted or influenced by the thinking self. The observing self is by nature non-judgemental. It can't judge our experience, because judgements are thoughts and therefore a product of the thinking self. The observing self doesn't get into a struggle with reality; it sees things as they are, without resisting. It's only when we start judging things as bad or wrong or unfair that we resist them.

Our thinking self tells us that things shouldn't be as they are, that we shouldn't be as we are, that reality is in the wrong and we are in the right. It tells us that life would be better somewhere else or we would be happier if only we were different. Thus, the thinking self is like a pair of dark goggles that dims and obscures our view of the world, disconnecting us from reality through boredom, distraction or resistance.

The observing self, though, is incapable of boredom. It registers everything it observes with openness and interest. It's only the thinking self that gets bored, because boredom is basically a thought process: a story that life would be more interesting and more fulfilling if we were doing something else. The thinking self is easily bored because it thinks it already knows it all. It's been there, done that, seen the show and bought the T-shirt. Whether we're walking down the street, driving to work, eating a meal, having a chat or taking a shower, the thinking self takes it all for granted. After all, it's done all this stuff countless times before. So rather than help us connect with our present reality, it 'carries us off' to a different time and place. Thus, when the thinking self is running the show we spend most of our time only half awake, scarcely aware of the richness in the world around us.

The good news is that the observing self is always present and available. Through it we can connect with the vast length, breadth and depth of human experience, regardless of whether that experience is new and exciting or familiar and uncomfortable. The fascinating thing is that when, with an attitude of openness and interest, we bring our full attention to an unpleasant experience, the thing we dreaded often seems much less bothersome than before. Likewise, when we truly connect with even the most familiar or mundane experience, we often see it in a new and interesting light. To experience this for yourself, try the following exercise.

## Connecting With This Book

In this exercise the aim is to take a fresh look at the book in your hands, to see it with 'new eyes'. Therefore, imagine that you're an alien from another planet and you've never seen an object like this before. Pick up the book and feel the weight of it in your hands. Feel the cover against your palms. Run your finger down a page and notice the texture. Run your finger down the cover and notice that texture, too. Bring the open book up to your nose and smell the paper. Slowly turn a page and listen to the sound it makes. Turn several pages and, along with listening to the sound, also notice how the shadows change as the pages move. Grab about twenty pages between your index finger and thumb, and gently flip them all at once. Notice the feeling, the sound and the movement. Look at the front cover of the book. Notice how the light reflects off the surface. Notice the borders where one colour meets another. Notice the shapes of the spaces between the words. Then do the same with the back cover. Pick any page at random and notice the shapes made by the

white space.

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How did you find that ‘alien’ experience? You’ve been reading this book for quite a while now, and until now you’ve probably taken all these different aspects of it for granted. And the same is true for just about *every aspect of our life*. Over the next few chapters we’re going to focus on several different aspects of connection, particularly how to use it when dealing with painful experiences. For the rest of this chapter, though, we’re simply going to focus on ‘waking up’: on increasing our awareness of the world around us and refocusing whenever the thinking self distracts us.

## A Few Simple Connection Exercises

In each exercise that follows, you’ll be asked to connect with some experience, such as the sounds in your environment or the feelings in your body. When distractions in the form of thoughts and feelings occur:

- Let those thoughts and feelings come and go, and stay connected.
- When your attention wanders (and it will, I promise), the moment you realise it, acknowledge it.
- Silently say to yourself, ‘Thanks, Mind.’ Then gently bring your attention back to the exercise.

There are four short exercises, each lasting only 30 seconds, so there’s no excuse for not doing them. It’ll take two minutes to do them all!

### Connection With The Environment

Once you’ve finished reading this paragraph, put the book down and notice your surroundings. Notice as much as you can about what you can see, hear, touch, taste and smell. What’s the temperature? Is the air moving or still? What sort of light is there and where is it coming from? Notice at least five sounds you can hear, at least five objects you can see and at least five things you can feel against your body (such as the shirt touching your shoulders, the air on your face, your feet on the floor, your back against the chair). Put the book down now and do this for 30 seconds. Notice what happens.

### Awareness Of The Body

As you’re reading this paragraph, connect with your body. Notice where your legs and arms are and the position of your spine. Inwardly scan your body from head to toe; notice what you can feel in your head, chest, arms, abdomen, legs. Put the book down, close your eyes and do this for 30 seconds. Notice what happens.

### Awareness Of The Breath

As you’re reading this, connect with your breathing. Notice the rise and fall of your rib cage and the air moving in and out of your nostrils. Follow the air in through your nose. Notice how your lungs expand. Feel your abdomen push outward. Follow the air back out, as the lungs deflate. Put the book down, close your eyes and do this for 30 seconds. Notice what happens.

## Awareness Of Sounds

In this exercise, just focus on the sounds you can hear. Notice the sounds coming from you (from your breath and your movements), the sounds coming from the room and the sounds coming from outside the room. Put the book down now, close your eyes and do this for 30 seconds. Notice what happens.

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So what did you notice? Hopefully, two things:

1. That you are always in the midst of a sensory feast; you just don't usually realise it.
2. That it's very easy to get distracted by thoughts and feelings.

To improve your ability to stay present and notice what is happening around you, practise the following two exercises on a daily basis.

## Notice Five Things

This is a simple exercise to centre yourself and connect with your environment. Practise it a few times every day, especially whenever you find yourself getting caught up in your thoughts and feelings. You'll find that it brings you back to the here and now.

1. Pause for a moment.
2. Look around and notice five objects you can see.
3. Listen carefully and notice five sounds you can hear.
4. Notice five things you can physically feel.

You can develop this skill further by going for a daily walk and spending the whole time noticing what you can see, hear, smell and physically feel (and refocusing whenever you realise you've been 'disconnected').

## Connecting With Your Morning Routine

Pick an activity that's part of your daily morning routine, such as brushing your teeth, combing your hair or taking a shower. Totally focus on what you are doing, using all your five senses. For example, when you're in the shower notice the different sounds of the water: as it sprays out of the nozzle, as it hits your body, as it gurgles down the drain. Notice the temperature of the water and the feel of it in your hair. Notice the sensations of the water running down your back and legs. Notice the smell of the soap and the shampoo and how they feel against your skin. Notice the visual patterns of the water on the walls or curtain. Notice the clouds of steam billowing upward. Notice the movements of your arms as you scrub or shampoo.

When thoughts and feelings arise, acknowledge them, let them be and refocus on the shower. As soon as you realise that your attention has wandered off, thank your mind and refocus on the shower.

For starters, practise connecting with one part of your morning routine each day. Then, as your ability improves, extend it to other parts.

In the next three chapters we'll see how connection skills help us deal with painful life experiences. In the meantime, practise seeing the world through new eyes. And whenever you realise that the time machine has carried you off, bring yourself back to the here and now.

## Chapter 18

### THE DIRTY DOG

When Soula turned 33, her best friend organised a surprise birthday party in a local cafe. At first Soula was delighted, thrilled that all her closest friends and family had come together in her honour. But as the evening wore on she began to feel sad and lonely. When she looked around the room, her thinking self started telling her the ‘single and lonely’ story. ‘Look at all your friends. They’re all in long-term relationships, or married and having kids, and you haven’t even got a boyfriend! You’re 33 now, for heaven’s sake! Time’s running out ... Soon you’ll be too old to have kids ... Just look at them all, having so much fun ... It’s easy to have fun when you’ve got someone to share your life with. They don’t know what it’s like to go back to an empty apartment night after night, all by yourself ... What’s the point of celebrating your birthday? All you have to look forward to is being old, lonely and miserable ... or else marrying someone completely unsuitable out of sheer desperation, which isn’t any better.’

On and on it went, *Radio Doom and Gloom*, broadcasting at full volume. And the more Soula tuned in to it, the more she lost track of the party going on all around her. She hardly tasted the food, hardly heard the conversation; she became increasingly disconnected from the warmth, joy and love that surrounded her.

Of course, it is true that Soula was single and getting older and that most of her friends were in long-term relationships. But remember the key question: is this story helpful? In this case it clearly wasn’t. And this was by no means an isolated episode. For most of a year now the ‘single and lonely’ story had been a major source of misery for Soula, making her increasingly depressed. When her friends talked about their relationships she was consumed with envy. And when she spent time with couples she felt like a complete ‘reject’. Developing connection skills played a vital part in Soula’s recovery. It enabled her to enjoy the good things she had in her life, instead of always focusing on what she lacked. (However I wouldn’t want you to think this was some ‘quick fix’ that changed her life overnight. It was only the start of Soula’s journey. We’ll revisit her later in the book to see how else she transformed her life.)

Sadly, scenarios like Soula’s are all too common. The more we focus on unpleasant thoughts and feelings, the more we disconnect from the present moment. This particularly tends to happen with depression and anxiety disorders. With anxiety you tend to get hooked by stories about the future: about things that might go wrong and how badly you’re sure to handle them. With depression you tend to get hooked by stories from the past: about all the things that actually have gone wrong and how badly they’ve affected you. The thinking self then uses that history to convince you that the future is going to be just more of the same. These stories are very compelling and we’re all too ready to give them our full attention.

It’s no surprise, then, that a common symptom of depression is anhedonia, which is the inability to take pleasure in previously enjoyable activities—after all, it’s hard to enjoy what you’re doing if you’re not connected with it. But the reverse is also true: the more connected you are with a pleasurable activity, the more fulfilling it will be. Thus, connection is an important skill for getting the most out of life.

### Connection With Pleasant Experiences

To appreciate connection, practise it with at least one pleasant activity each day. Make sure it’s a values-driven activity, not an avoidance-driven activity—that is, it’s something you’re doing because it’s important or meaningful, or a genuinely valued part of your life, and not just an attempt

to avoid ‘bad feelings’. The activity doesn’t have to be anything mind-blowing. It can be something as simple as eating lunch, stroking the cat, walking the dog, listening to the birds, cuddling your kids, drinking a can of Coke, sitting in the sunshine, listening to a favourite piece of music or chatting with a friend.

Now, as you do this activity, imagine that this is the first time you’ve ever done it. Really pay attention to what you can see, hear, smell, touch and taste. Savour every moment. And the moment you realise you’ve disconnected, thank your mind and refocus on what you’re doing.

Then at the end of the day, reflect on what it was like to be fully present .

If it’s hard to connect fully with *pleasant* events, then it’s natural that we should so easily disconnect from the unpleasant ones. Whenever we encounter an unpleasant event, we naturally try our best to get rid of it or avoid it. But what if getting rid of it isn’t our best option? What if this unpleasant situation is necessary for us to improve our quality of life?

For example, in order to maintain good health, you may at some stage need to have an operation, undergo some dental treatment, or practise some uncomfortable muscle-stretching routine. And to keep our finances healthy, most of us have to do a certain amount of bookkeeping and keep up with our tax returns. If we want to live in a clean house, we may need to do a variety of unpleasant chores, and if we want a better job, we may need to attend some highly stressful interviews.

So why is connection helpful in these situations? First, it helps us turn off that struggle switch. The more we struggle against unpleasant situations, the more unpleasant thoughts and feelings we generate. Naturally, this only makes the situation worse. And second, when we really pay attention and we put aside the stories of the thinking self, we discover that these events just aren’t as bad as we expected. You’ve probably already experienced this with expansion: when you observe unpleasant feelings with interest and openness, they’re nowhere near as bad as they first seemed. Do I detect a note of scepticism? Then let me tell you about...

## **Washing My Dirty Dog**

Recently I took my dog for a walk in the park and he rolled around in the carcass of a dead bird. He loves to do disgusting things like that. Afterward he stank like ... well, like a rotting carcass, so I had no choice but to bathe him. I had some very important matters to deal with that night and I was frustrated that I had to waste my time on this unpleasant task. My mind was making all sorts of judgements: ‘Stupid dog! Why did you have to pick tonight to do something like this? Yuck! That smells disgusting!’ And I was growing increasingly tense and irritable. But as I filled the tub with warm water, I realised what I was doing and I made the conscious choice to respond differently.

The fact was, no one else was going to wash the dog and I didn’t want to leave him smelling like that. (Not that he would have minded.) I knew it would take about half an hour to wash him and dry him, so I figured I had a choice. I could spend that time stressed and irritable, disconnected from my experience, pressuring myself to finish as quickly as possible, while thinking about all the things I had to do afterward. Or I could connect with my experience and make the most of it. Either way, it would still take half an hour.

How do you make the most of washing a dirty dog? By being present and engaging in what is happening without judging it. So as I inhaled that foul odour I made room for my feelings of disgust and irritation. I allowed my unhelpful thoughts to come and go and I focused on connecting through my five senses. I noticed the warm water on my hands and the reactions of my dog as I spoke to him gently. I focused with interest and openness on the feel of his wet hair, the smell of the shampoo, the changing colour of the water, the sound of splashing, the movement of my arms, the movement of the dog, the movement of the water...

And I’d be lying if I said I enjoyed it. But the experience was much richer than on previous

occasions, when I rushed through it completely disconnected. And as a bonus, it was much less stressful for the two of us. However, as always, you should trust your own experience rather than what I say. Practise connecting with unpleasant, boring or disagreeable tasks and notice what happens. And make sure that they're tasks you truly value; activities that serve to enhance your life in the long term. Following are some exercises to help you connect with the mundane activities in life.

### **Connection With A Useful Chore**

Pick a chore that you don't like but that you know is helpful in the long run. It could be ironing clothes, washing dishes, vacuuming, cleaning out the car, cooking a healthy meal, putting the garbage out, bathing the kids, polishing your shoes, tidying the garage—any task that you'd just as soon avoid doing. Then each time you do it, practise connection. Have no expectations; just notice what happens. For example, if you're ironing clothes, notice the colour and shape of the clothing. Notice the patterns made by the creases and shadows. Notice how the patterns change as the creases disappear. Notice the hiss of the steam, the creak of the ironing board, the faint whispery sound of the iron moving over the material. Notice the grip of your hand on the iron and the movement of your arm and your shoulder.

If boredom or frustration arises, make room for it and refocus on what you're doing. When thoughts arise, let them be and go back to focusing on what you're doing. The moment you realise that your attention has wandered (and it will, repeatedly), gently thank your mind, briefly note what distracted you and bring your attention back to what you're doing.

### **Connection With A Task You've Been Avoiding**

Pick a task you've been putting off for a while. Set aside twenty minutes to make a start on it. During that time, focus completely on the experience. Connect with it fully, through the five senses, while making room for your feelings and defusing your thoughts. After twenty minutes, feel free either to stop or to continue. Do this for twenty minutes every day, until your task is completed.

### **Build Your Muscles, Build Your Life**

Practising connection is like building your muscles. The more you practise, the more strength you have to change your life. Many people fail to make important changes—changes that could significantly enhance their lives—because they're unwilling to accept the discomfort that accompanies change. For example, you may avoid changing to a more meaningful career because you don't want the discomfort of starting from scratch. Or you may avoid asking someone on a date because you don't want to risk rejection. The more you learn to connect, defuse and expand, the less power you will give such discomfort to act as an obstacle. So aim once a day to connect with both a pleasant, valued action and an uncomfortable one. In the long run, the rewards will be well worth it.

## **Chapter 19**

### **A CONFUSING WORD**

It's time for us to take a little detour. In this chapter, we're going to look at the similarities and differences between ACT and other approaches to human suffering. But first we need to introduce and define a new word: 'mindfulness'. It's a slightly confusing word because it has nothing to do with having 'a full mind'. Different books will give you different definitions of 'mindfulness', depending on their content. A spiritual or religious book will define it very differently to a book on sports psychology or effective leadership. So here's my definition: 'mindfulness' means consciously bringing awareness to your here-and-now experience, with openness, receptiveness and interest.

This definition tells us several things. Firstly, mindfulness is a conscious process; something we do deliberately. Secondly, it's *not* a thinking process; it's about *awareness*. Thirdly, it's about bringing our awareness to the present moment; in other words, paying attention to what's happening here and now. Fourthly, it's about doing this with a particular attitude: one of openness, interest and receptiveness to our experience, rather than one of struggle, judgement and avoidance.

When we practise mindfulness, we connect with the world directly through our five senses, rather than being caught up in our thoughts. We let our judgements, complaints, and criticisms come and go, and instead we fully engage in the present moment. When we are mindful of our own thoughts, we can see them for what they are, and let them go. When we are mindful of our feelings, we can make room for them and let them be. And when we are mindful of our here-and-now experience, we are deeply connected with it. Thus defusion, expansion and connection are all mindfulness skills.

So ACT is clearly a mindfulness-based therapy, and the purpose of this chapter is to point out the significant differences between ACT and other mindfulness-based approaches.

### **ACT Is About Taking Action**

ACT is based firmly in the tradition of behavioural psychology: a branch of science that seeks to understand, predict and influence human behaviour. A major concept in ACT is the idea of 'workability'. (It's a concept I've been referring to throughout this book, but I haven't given it a name until now.) The workability of any given behaviour means how well it works in the long run toward creating a rich and meaningful life. In ACT, we learn mindfulness skills to assist us in taking action to improve our life. We do not practise mindfulness in order to enter some mystical state, or to get in touch with a higher truth. In any given circumstance, if defusion, expansion and connection can help you act effectively, then it makes sense to practise them. Conversely, if they don't help you, then don't use them! The bottom line is always the same: does this help me create the life I want?

### **ACT Is Not A Religion Or A Spiritual Belief System**

Many of the concepts in ACT closely resemble those from many religions, particularly the idea of living life according to your values. But whereas most religions prescribe a ready-made set of values for you, ACT asks you to clarify and connect with your own values. Moreover, ACT does not encourage you to adopt any particular belief system. (Thus, my frequent advice throughout this book: 'Don't believe something just because I say so—trust your own experience.') ACT takes the view that if your beliefs work to enrich your life, then that's all that matters.

People often see similarities between ACT and Buddhism: both emphasise the practice of mindfulness; both encourage living by your values; both share the assumption that psychological suffering is a universal human phenomenon, created by the natural processes of the normal human mind; and both assume that our commonsense attempts to find happiness and avoid pain frequently lead only to more pain. As Steven Hayes puts it: ‘The large overlap between ACT and Buddhism is remarkable, considering that the former is based on principles of behaviour therapy and the second is embedded in a spiritual and religious tradition that spans thousands of years.’

Given these parallels, it’s important to emphasise that ACT is not in any sense a religious or spiritual tradition, nor was it consciously influenced by Buddhism. Unlike Buddhism, it prescribes no formal meditation or prayer practices, has no rituals, chants, prayers or symbols, has no prescribed set of approved values, and no supernatural or religious beliefs of any sort. ACT is firmly based on the latest cutting-edge research into human behaviour, particularly on recent discoveries about the functioning of the human mind. Steven Hayes and his team were behind much of this ground breaking research. Over twenty years ago Hayes proposed a revolutionary new theory of human language and cognition, known as Relational Frame Theory. Since then, a vast amount of research has gone into investigating this theory, and the data coming through increasingly support it. (This in itself makes ACT unique. No other western psychotherapy has ever been developed along with its own basic research program into human language and cognition. If you’d like to know more about Relational Frame Theory, visit the website [www.contextualpsychology.org/rft](http://www.contextualpsychology.org/rft).)

## ACT Is Not Meditation

Many of the exercises in ACT have a meditative feel to them and some bear strong similarities to formal mindfulness meditation practices (especially the ones that involve focusing on the breath). But as psychologist Kelly Wilson says, ‘If you want to learn to meditate, go see a guru.’

ACT is not about meditation. There’s no special way to sit, no secret mantra, no prayer beads, incense sticks or candles. ACT is about the practical application of mindfulness skills for the express purpose of making important life changes. And that’s it. (Having said that, a daily mindfulness meditation practice can be very helpful in developing the skills in this book. If you’re interested, read Jon Kabat-Zinn’s excellent book, *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*.)

## ACT Is Not A Pathway To Enlightenment

There are many spiritual or ‘new age’ books about reaching enlightenment, all of which place a major emphasis on living in the present moment. ACT stays out of this territory altogether. (ACT is about creating a life, not becoming ‘enlightened’.)

Interestingly, many of these books directly feed into the happiness trap by promising the reader such things as a ‘pain-free existence, through living fully in the present’. While many such books do a fine job of teaching mindfulness concepts, any search for a ‘pain-free existence’ is doomed to failure. The more we try to avoid the basic reality that all human life involves pain, the more we are likely to struggle with that pain when it arises, thereby creating even more suffering. In contrast to such books, ACT aims to help you create a rich, full and meaningful life while *accepting* the pain that inevitably comes with living.

One particularly unhelpful idea that commonly occurs in books proposing various paths to enlightenment is the utter falsehood that ‘negativity is unnatural’. Evolutionary biology tells us otherwise. The mind has evolved in such a manner that negativity is not only natural but inevitable. To see it as unnatural just sets you up for a struggle with your own human nature.

## **ACT Is Not Based On Just One Person's Life Experience**

Many forms of self-help are based on the life experience of one person, who then goes on to write books and give talks about it. The logic goes: ‘This is how I did it, so it should work for you.’ The problem is that this gives rise to a lot of untried and untested ideas. Just because the author used certain methods to recover from cancer, get over a mental illness or otherwise transform her life, doesn’t mean those methods are going to work for the next person. In contrast, ACT is based on an international program of scientific research that has repeatedly shown the efficacy of its methods.

So, ACT is not a religious, mystical or spiritual path, although it may have some parallels. ACT is about creating a meaningful life through accepting our internal experience, staying present and taking action while being guided by our values. And workability is always the deciding factor. So if there’s anything in this book (or any other self-help book) that works toward creating the life you want, then please, make use of it. But don’t believe anything in this or any other book simply because you read it—your own experience trumps someone else’s advice.

And that completes this little detour. We’re back on the road and it’s time to continue our journey. In the next chapter we’ll take a closer look at connection and the many surprising ways it can help you overcome life’s obstacles.

## Chapter 20

### IF YOU'RE BREATHING, YOU'RE ALIVE

'It's like I'm in a bad dream or losing my mind. Nothing seems real. And I feel like something terrible is going to happen. First I go all dizzy and light-headed and I can't think straight. Then my face gets hot and I get these "pins and needles" in my hands and feet. Then my chest goes all tight and my heart starts beating like crazy and I'm sure I'm going to faint or have a heart attack. So I go outside to get some air. But I can't seem to breathe properly. It's like I'm suffocating.'

This is Rachel, the secretary you met in Chapter 11, describing one of her panic attacks. During a panic attack, many people experience symptoms such as a racing heart, facial flushing, tightness in the chest, light-headedness, tingling hands and feet, a sense of unreality, fears of fainting or dying or going crazy, and a frightening sensation of being unable to breathe.

As we discussed in Chapter 11, a major part of the problem here is the struggle switch, which creates anxiety about anxiety. But a not her, really major part of the problem is rapid, shallow breathing, technically known as 'hyperventilation'. Whenever we feel stressed, upset, angry or anxious, our breath rate increases. This is part of the fight-or-flight response, which we covered in Chapter 10—the increased breath rate gives us increased oxygen in our blood, which helps us prepare either to fight or to run away. But this alters the levels of the gases in our bloodstream, creating a chemical imbalance in the body. And this imbalance triggers a whole series of physical changes in the body, including increased heart rate, increased blood pressure and increased muscle tension.

And this is why I ask you to practise *slow, deep breathing* with every breathing exercise in this book. By breathing slowly when you're stressed, you will reduce the level of tension in your body. This won't get rid of or control your unpleasant emotions, but it will help you to handle them more effectively. Moreover, as we will explore in this chapter, your breathing can be a powerful aid in connection—an anchor that steadies you in the midst of emotional storms. So slow, deep breathing is useful for all of us whenever we're stressed in any way. But it's especially important at times when you feel as if you can't breathe properly.

If you're so stressed that you feel unable to breathe properly—as though you're not getting enough oxygen, or you need some fresh air, or you somehow just can't open up your lungs—then the problem is probably this: *you're breathing so fast that you're not giving your lungs a chance to empty!* If you don't empty your lungs, then you can't breathe in properly, because you're trying to suck air into a space that's already mostly full. So the first thing you need to do is *breathe out*—fully and completely exhale, emptying your lungs as much as is physically possible. Once they're empty, you can take a full breath in. And the slower you can take these breaths, the better, because you're helping to rebalance the gases in your bloodstream.

The one thing to be wary of is trying to use your breathing as a control strategy; that is, as a way to get rid of unpleasant emotions or create feelings of relaxation. As with all the other acceptance techniques in this book, relaxation will often arise as a byproduct—but don't expect it or strive for it, or you'll fall right back into the whole vicious cycle of control.

### The Present Moment

Breathing is wonderful. Not only does it keep you alive, it *reminds* you that you're alive. How do you feel on a crisp, clear morning when you stop and take a breath of fresh air? How do you feel when you breathe a deep sigh of relief after some stressful event? Your breathing never stops until the day you die and that makes it a perfect aid to help you stay connected.

In a moment I'm going to ask you to take six slow, deep breaths and empty your lungs as much as possible. Once you've emptied your lungs, don't force the in-breath, otherwise you will over-inflate them. (You'll know if this happens, because your chest will feel uncomfortably full.) After a full out-breath, just breathe in gently and your lungs will fill comfortably by themselves. As you breathe in you should notice your tummy pushing outward. (This tells you that you're using your diaphragm. The diaphragm helps the lungs to inflate by 'pushing down' your stomach, to make more room in the chest.) As you breathe, connect with the movements of your chest and stomach. Notice what you can feel as they rise and fall. Okay, now put the book down and take six slow, deep breaths.

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What did you notice? Probably one of the following:

1. a sense of easing tension
2. a sense of connecting with your body
3. a sense of slowing down
4. a sense of 'letting go'
5. a sense of your mind quieting
6. a sense of dizziness, discomfort or difficulty because it felt strange or hard to breathe in this manner.

Hopefully, you experienced one or more of the first five reactions. But if you experienced the last one, don't be concerned. The more you're in the habit of shallow, rapid breathing, the stranger or more difficult this exercise will seem. And if you're an especially rapid breather, it may at first give you a feeling of dizziness or discomfort. If this is true for you, then it's all the more important for you to practise. If you practise taking ten to twenty deep breaths in this manner, every hour or two throughout the day, then within about a week it'll feel much more natural and comfortable.

Tuning in to your breathing like this can help you 'step out of the rat race' for a few moments; to slow down, let go and collect yourself. More importantly, it can help you connect with what's happening *here and now*. To demonstrate this, I'm going to ask you to do the exercise again, but with a twist. First read the instructions.

Take six slow, deep breaths. For the first three breaths, focus on your chest and abdomen; connect with your breathing. For the next three breaths, expand your focus, so that as well as being aware of your breathing, you're also connecting fully with your environment; that is, while noticing your breathing, also notice what you can see, hear, touch, taste and smell. Ready? Put the book down and give it a go.

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What did you notice? Most people report that they feel far more 'present'—more connected with where they are and what they're doing. Now, here's another variation on the exercise. Again, read the instructions first before trying it.

This time take nine slow, deep breaths. For the first three breaths, focus on your breathing. For the next three breaths, focus on your breathing and also *notice* what thoughts are running through your

mind. (Whatever they are, just let them be.) For the final three breaths, focus on your breathing and also scan your body and notice what you can feel. (Whatever you feel, just make room for it.) Okay. Put the book down and give it a go.

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This variation on the exercise gives you a rapid way to increase self-awareness, accept what you're feeling and thinking, and gather your wits so you're not on autopilot.

Now, here's one more variation, which requires twelve breaths. This is the most important of all these breathing exercises, so don't skip it.

Take twelve slow, deep breaths. For the first three breaths, focus on your breathing. For the next three breaths, notice your breathing and also *notice* what thoughts are running through your mind. (Whatever they are, just let them be.) For the next three breaths, notice your breathing and also *scan* your body and *notice* what you feel. (Whatever you feel, just make room for it.) For the final three breaths, as well as connecting with your breathing, *connect* with your environment. Notice what you can see, hear, taste, touch and smell, as well as staying aware of your breathing. Ready? Put the book down now and give it a go.

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The idea of Breathing to Connect is to increase self-awareness, accept what you're thinking and feeling, and connect with where you are and what you're doing. Once you've done this, you're in the best psychological space to take effective—that is, life-enhancing—action, if that should seem like the thing to do right then.

Breathing to Connect doesn't have to be exactly twelve breaths; you can shorten or lengthen the exercise as you like. So from now on, instead of the Ten Deep Breaths technique (from Chapter 7), start Breathing to Connect throughout the day. Practise it at traffic lights, while waiting in line, before you get out of bed in the morning, during your lunchbreak, while your computer is booting up, while you're waiting for your husband to get ready to go out.

Try longer and shorter versions of the exercise. At traffic lights you might have time for only three or four slow, deep breaths. In a slow-moving grocery line, you may have time for 30 or more. You don't have to keep an exact count or follow the order precisely as described above.

In particular, start Breathing to Connect whenever you're stressed or whenever you realise you're all caught up in thoughts and feelings. In the midst of a tense situation, even one deep breath can give you precious seconds to collect your wits.

## The Power Of One Deep Breath

If I am with a client who tells me that he intends to go and kill himself, I naturally feel a surge of anxiety. Now, it won't help my client if I get carried away by my thoughts and feelings. So I immediately take one slow, deep breath and during those few seconds I make room for my anxiety, allow my thoughts to fade into the background and focus my attention firmly on my client. And until the crisis is resolved, I keep breathing slowly and deeply, allowing my thoughts and feelings to come and go as I remain fully connected with what I'm doing. In this way my breathing acts as an anchor. It doesn't get rid of my anxiety, but it stops me from getting carried away. It's like a constant, soothing presence in the background, while my attention is focused on taking effective action.

Remember Donna, whose husband and child died in a car crash? For many months afterward, feelings of sadness would suddenly surge within her, out of the blue. Donna found that even one deep breath could give her a foothold to stop that wave of sadness from sweeping her away. She could then breathe into the sadness, make room for it and reconnect with her experience here and

now. Often this sadness triggered a strong urge to drink alcohol. And here again, even one deep breath made a difference. It gave her a few precious seconds to realise what was happening. Then she could make a conscious choice as to whether or not she would act on that urge.

Remember Michelle, whose life revolved around trying to push away deep feelings of unworthiness? Her boss frequently asked her to do extra work and she had always stayed late to do it, trying to prove that she was worthy. As therapy progressed, Michelle wanted to break this habit, because she realised it was taking valuable time away from her family. (And also there was no extra pay for all that extra work!) Saying yes to her boss was a hard habit to break. She'd been doing it her entire working life and the thought of saying no brought up all sorts of fears. ('What if he gets angry?' 'What if he thinks I'm lazy?') But Michelle was willing to feel that fear in order to take her life in the direction she wanted.

Well, the next time her boss made an urgent request only ten minutes before the close of the day, Michelle felt an immediate urge to say yes. But this time she didn't. Instead she took a long, deep breath. Those few seconds were enough for her to collect her wits and say, 'I'm sorry, I can't do that now. I have to go home. I'll deal with it first thing tomorrow morning.'

Her boss looked astounded. Michelle's anxiety skyrocketed and her mind started telling her all sorts of horror stories. But she connected with her breathing, made room for her thoughts and feelings, and remained focused on the situation at hand. There was an awkward pause that seemed to last several hours and then, to Michelle's astonishment, her boss just smiled and said, 'That'll be fine.'

## Fancy A Challenge?

If you really want to get super-duper, whiz-bang brilliant at connection, put aside ten minutes every day to practise Breathing to Connect, as outlined below.

Sit or lie comfortably with your eyes closed. For the first six minutes connect with your breathing. Notice the gentle rise and fall of your rib cage and follow the air as it flows in and out of your lungs. Let any thoughts and feelings come and go, and each time you notice that your attention has wandered, gently refocus. (You'll need to do this again and again ... and again.) For the next three minutes expand your awareness, so that you're aware of your body and your feelings as well as your breathing. For the final minute open your eyes and connect with the room around you, as well as with your body, your feelings and your breathing.

For the first week do this exercise ten minutes a day, then gradually increase the duration by two or three minutes per week, until you can do it for twenty minutes at a time. This is a very powerful mindfulness technique and regular practice will bring noticeable physical and psychological benefits. (This is another exercise which I have recorded on CD. For details, go to the resources section at the end of this book.)

## What Should You Do When You're In A Crisis?

No matter how bad the situation you're in, no matter how much pain you may be suffering, start by taking a few deep breaths. If you're breathing, you know you're alive. And as long as you're alive, there's hope. Taking a few breaths in the midst of a crisis gives you valuable time to get present, to notice what's happening and how you're responding and to think about what effective action you can take. Sometimes there is no immediate action to take. In this case, being present and accepting what you are feeling *is* the most effective action.

## Control Your Breathing, Not Your Feelings

If you use Breathing to Connect at every opportunity, it will start to become second nature. That's

important, because otherwise you'll forget to do it at the times you need it most. Especially aim to practise it whenever you get caught up in your thoughts and feelings. And as with all the other acceptance techniques, don't try to use this as a control strategy in order to try to feel good. Breathing to Connect will often give rise to nice feelings such as calmness or a sense of relief. But those are just pleasant byproducts and you certainly won't always get them, so don't come to expect them or try to force them.

When Breathing to Connect, allow yourself to feel whatever you're feeling. Make room for those feelings. You don't have to like them; just let them be.

## **What's The Role Of The Thinking Self In All This?**

So far, in learning about connection we've focused on the observing self; on paying attention with openness, receptiveness and interest. And we've tended to view the thinking self as a hindrance; as something that disrupts our connection by distracting us with stories. But the thinking self can also be of tremendous help to us—*if* we use it wisely. And that's what the next chapter is all about.

## Chapter 21

### TELL IT LIKE IT IS

Do any of the following thoughts sound familiar? ‘You’re not doing it right. You’re screwing it up!’, ‘It’s useless. You may as well just give up now’, ‘This is so boring!’, ‘This is a complete waste of time!’, ‘You blithering idiot! Why aren’t you practising what you read in that book?’, ‘You dumb so-and-so! You completely forgot to try out those new techniques!'

As you work through this book, your thinking self will undoubtedly give you plenty of tongue-lashings like these. But remember, it’s not deliberately trying to upset you—it’s just doing the job that it evolved to do.

The observing self, as you know, doesn’t make judgements. It’s like a camera filming a wildlife documentary. When the lion kills the antelope, the camera doesn’t judge it as good or bad; it simply records what happens.

The thinking self, on the other hand, *loves* to judge—that’s what it does all day long, day in and day out. Go back a hundred thousand years and this makes good sense. Our ancestors needed to make judgements to stay alive: ‘Is that dark shape a boulder or a bear?’ ‘Is this fruit safe to eat or poisonous?’ ‘Is that person in the distance friend or foe?’ If our ancestors made the wrong judgement, they could end up paying with their lives. So over the course of a hundred thousand years our mind became very good at judging and, as a result, today it never stops. ‘This shouldn’t be happening’, ‘She can’t do that’, ‘This is bad’, ‘That sucks’, ‘It’s just not fair!'

Obviously, the ability to judge is vital to our wellbeing. But as we have already seen, many of the mind’s judgements are extremely unhelpful. All too often they set us up for a struggle—with ourselves, our feelings or reality itself. As with any unhelpful thought, the aim in ACT is to let such judgements come and go; rather than buying into them, we can simply acknowledge, ‘It’s a judgement.’

In using the thinking self to assist in connection, we need to consciously put aside judgemental ways of talking, and instead use factual descriptions.

### Factual Descriptions

What do I mean by ‘factual descriptions’? Well, here’s an example: ‘Julia Roberts is a film actress.’ Compare this with a few judgemental descriptions:

- Julia Roberts is beautiful.
- Julia Roberts is a wonderfully talented actress.
- Julia Roberts gets paid too much for what she does.

In the very first statement all you have are non-judgemental facts: she acts in films and she’s female. In the following three statements you have only judgements: she’s beautiful, she’s talented and she gets paid too much. None of these are *facts*; they’re only opinions.

When we make negative judgements about our experience, we can easily get into a struggle. But when we describe our experience in terms of facts, it helps us connect with what is actually happening.

Now, you've already been doing this to some degree, for example, when you use terms like: 'I'm having the thought that...', 'I'm getting the image of...', 'I'm having the feeling of...', 'I'm having the urge to...', 'I'm making the judgement that...'

These are all factual descriptions of your current experience. In each case you are simply stating what is currently happening: that in this moment you're having a thought, image, feeling, urge or judgement. This allows you to stay connected with what is happening, to be present, open and self-aware. We can build on this skill by giving a running commentary.

By 'running commentary' I mean an ongoing *factual* description, not a judgemental one, of what is taking place from moment to moment. Doing this can help us stay present, even in the midst of powerful feelings.

Here's how Donna used it with her terrible grief: When a wave of sadness hit her, she would silently say to herself, 'I'm having that feeling of sadness again. I can feel it in my chest, like a heavy weight. I don't like it, but I know I can make room for it. Taking a few deep breaths, now ... breathing into it ... That's it ... making room ... letting it be. And now I'm having the urge to drink some wine. I can feel it in my mouth: all dry and parched. And I can feel my hands shaking and my legs getting restless. And now I'm having the image of a bottle of red. And my mind's telling me to go ahead and have just one glass. And that urge is growing stronger. It's a 7 out of 10 now. And I'm feeling like I want to cry. And I don't like it, but I can accept it. Breathing into it ... breathing again ... making room ... And now that urge to drink is an 8 out of 10. Breathing into it...'

Sometimes Donna would do this on and off for anywhere from a couple of minutes to the better part of an hour, depending on how powerful her feelings of grief were and how quickly they shifted. This helped her stay present so she could then choose to focus on a valued activity, instead of drinking. Sometimes she even added that choice into the commentary: 'Now, what do I value doing at this moment? Well, I was just about to cook something healthy for dinner. Is this something I value? Yes, it is. So let's focus on chopping up these potatoes.'

Once Donna had chosen a valued activity, she would then connect with it fully, through all of her five senses. For example, she carefully observed the appearance and texture of the potatoes, the sounds of peeling and slicing, the feeling of the knife cutting and chopping, and the movements in her arms, hands and neck.

Over time, as her grieving process continued, these feelings and urges troubled her less and less. And as she got better at expansion, defusion and connection, she needed the thinking self less and less to assist her.

Some people find running commentary extremely helpful; others don't. So why not give it a go and see how it works? As always, if it's helpful, make use of it. And if it isn't, don't!

We'll return to connection later in the book, when we use it in taking action. But now it's time for something completely different.

## Chapter 22

### THE BIG STORY

What do you most dislike about yourself? I've asked this question of hundreds and hundreds of people, either individually or in groups, and here are some of their most common responses:

- I'm too shy/fearful/anxious/needy/fragile/passive/guilty.
- I'm stupid/silly/disorganised/a time waster.
- I'm fat/ugly/unfit/lazy/uncoordinated.
- I'm selfish/critical/arrogant/vain/egotistical/materialistic.
- I'm judgemental/angry/greedy/aggressive/obnoxious/jealous.
- I'm an underachiever/failure/loser.
- I'm a workaholic/chocoholic/alcoholic.
- I'm too obsessive/controlling/fastidious/perfectionist.
- I'm boring/dull/predictable/serious/unmotivated/ignorant/uneducated.
- I have no passion/commitment/direction/purpose/inspiration.

And those are just a few of the responses. The range is almost infinite. Everyone has their own personal dislikes, but all the answers point to the same basic theme: 'I'm not good enough as I am. There is something wrong or lacking in me.' It's a message our minds send us again and again.

No matter how hard we try or how much we achieve, our thinking self can always find something to dislike: some way in which we are lacking, deficient, not good enough. And this is hardly surprising when we remember the evolution of the human mind. The 'Don't get killed!' device of our ancestors helped them survive by constantly comparing them to other members of our society, to ensure that they didn't get rejected by the clan; constantly drawing attention to their weaknesses, so they could improve on them and thereby contribute more to the clan (which also made rejection less likely).

The question is, what effect does this have on you over the years, living with a mind that continually points out your deficiencies? Does it make you feel good about yourself? Does it cultivate a deep sense of self-worth or self-acceptance?

Obviously not. The thinking self's tendency to point out the ways in which we are *not good enough* eventually leads us to feel as if we are unsuccessful, inadequate, unworthy, unlikable, unlovable, incompetent, inferior, unintelligent, unattractive or whatever your own version of *not good enough*

happens to be. We have a common term for this: ‘low self-esteem’.

## Low Self-esteem

Susie, a physiotherapist, age 23, says: ‘I feel so lonely. I think if I could just feel better about myself, I’d socialise more. But I’m always so down on myself. I need more self-esteem.’

Antonio, a gardener, age 35, says: ‘I always undercharge for my services and it makes me really angry with myself. But I find it so hard to ask for more. I just have no self-esteem.’

Low self-esteem is an epidemic. As the two examples above illustrate, it gets blamed for almost everything from lack of a social life to the inability to ask for adequate payment. Clients frequently tell me they want to get rid of it or, alternatively, to boost it, so that it’s ‘high’. And I always ask them this question: ‘What does “self-esteem” actually mean?’ Over the years I’ve had an astonishing variety of answers, many of them exceedingly complex. But actually the answer is very simple: self-esteem is an opinion that you hold about what sort of person you are. High self-esteem is a positive opinion; low self-esteem is a negative one.

So there you have it. Self-esteem is a bunch of thoughts about what sort of person you are. And here’s the key thing: self-esteem is not a *fact*; it’s just an *opinion*. That’s right, it’s not the truth; it’s just an opinion—nothing more than a highly subjective judgement, made by your thinking self. ‘Fair enough,’ you might say, ‘but isn’t it important to have a good opinion of yourself?’

Well, not necessarily. First let’s consider what an opinion is: it’s a story, nothing more than words. Second, it’s a judgement, not a factual description. (Remember, Julia Roberts is a film actress=factual description; Julia Roberts is a very talented actress=opinion/judgement.) So self-esteem is basically a judgement that our thinking self makes about us as a person. Now, suppose we decide that we want ‘high’ self-esteem. How do we go about getting it? What we tend to do is a whole lot of reasoning, justifying and negotiating until—maybe—we eventually convince our thinking self to declare that we’re a ‘good person’. For example, we may put forward the argument: ‘I’m doing well at my job; I’m exercising regularly; I’m eating healthily; I spend lots of quality time with my family; my friends like me; I help people out when they’re in trouble; so basically, that means I’m a good person.’

And if we can really *believe* that last bit, about being a ‘good person’, then we have ‘high’ self-esteem. The problem is, with this approach you constantly have to *prove* that you’re a good person. You constantly have to *justify* this good opinion. You constantly have to challenge those ‘not good enough’ stories. And all that takes a lot of time and effort. In fact, it’s rather like playing a never-ending game of chess.

Imagine a game of chess in which the pieces are your own thoughts and feelings. On one side of the board we have the black pieces: all your ‘bad’ thoughts and feelings; and on the other side we have the white pieces: all your ‘good’ thoughts and feelings. And there’s an ongoing battle between them: the white pieces attacking the black pieces and vice versa. We spend a huge chunk of our life caught up in this game. But it’s a war that will never end because there are an infinite number of pieces on both sides. No matter how many pieces get knocked off, they are always replaced by others.

Now, in trying to raise your self-esteem, you gather as many white pieces together as you can with thoughts like, ‘My boss just gave me a pay rise’, ‘I’m going to the gym three times a week’, ‘I’m helping my best friend through a major crisis’, and so on.

As you advance these white pieces across the board, your self-esteem starts to rise. But here’s the problem: there’s a whole army of black pieces waiting to counterattack! And the moment you slip up—the moment you stop doing any of those things you’re using to justify ‘I’m a good person’—those black pieces attack and your self-esteem dissolves like a sugar cube in the rain.

You stop exercising for a few days and you get, ‘See? You knew it couldn’t last! You’re so pathetic!’ You lose your temper with a friend and you get, ‘What sort of lousy friend are you?’ You make a mistake at work and you get, ‘Jeez, what a loser—you can’t even do your job right!’

So then you need to rally some more white pieces. Some people try to do this with positive affirmations, repeating over and over things like, ‘I love, cherish and approve of myself’, ‘I am a wonderful human being, full of love, strength and courage.’ The problem with such affirmations is that most people don’t really believe what they are saying. It’s a bit like saying, ‘I am Superman’, or ‘I am Wonder Woman.’ No matter how often you said that to yourself, you wouldn’t really believe it, would you?

Another problem is that any positive affirmation you use, regardless of whether it’s ‘true’, naturally tends to attract a negative response. (The white pieces always attract the black pieces.) To illustrate this, try the following exercise.

### **Attraction Of Opposites**

In this exercise, read each sentence slowly and try your very hardest to believe it. As you do so, notice what your thinking self does in reaction; that is, notice what thoughts automatically pop into your head.

- I am a human being.
- I am a worthwhile human being.
- I am a worthwhile, lovable human being.
- I am a worthwhile, lovable, valuable human being.
- I am a worthwhile, lovable, valuable, wonderful human being.
- I am complete, whole and perfect.

What happened as you tried to believe those thoughts? For most people, the more positive the thought, the harder it is to believe and the more resistance there is from negative thoughts such as, ‘Yeah, right!’, ‘Who are you kidding?’, ‘Stop talking rubbish!’, ‘You wish!’, ‘What a joke! ’

A few people do actually manage to fuse with the above affirmations and therefore feel wonderful—for a moment. But that feeling won’t last very long. Pretty soon the black pieces will attack again.

Now, I’d like you to do the same exercise with one more sentence: ‘I am a useless, worthless, unlovable piece of human garbage.’

What happened this time? Most people produce a positive thought in their own defence, something like, ‘Hang on a minute, I’m not that bad!’ or ‘No way, I don’t believe that.’

And again, a tiny number of people totally fuse with the thought and, as a result, feel lousy.

The reality is, we can find an infinite number of good and bad stories to tell about ourselves and as long as we’re invested in self-esteem, we’re going to waste a lot of time in this chess game fighting an endless battle against our own limitless supply of negative thoughts.

Let’s suppose a black piece appears saying, ‘How could you be such a bloody idiot?’ and you rally

the white pieces for help: ‘Of course you’re not an idiot. You just made a mistake, that’s all. You’re human.’ But another black piece appears saying, ‘Who are you kidding? Just look at how you stuffed it up last time!’ And you counterattack with another white piece: ‘Yeah, but this time it’s different; I’ve learned my lesson.’ Another black piece says: ‘Oh, you think so? You’re such a moron, you’ll never get it right!’

The battle’s heating up with more and more pieces getting involved. And guess what? While all your attention is on this chess game, it’s pretty hard to connect with anything else. You disconnect from life and the world around you, totally lost in the struggle with your own opinions.

Is this really how you want to spend your days? Fighting your own thoughts? Trying to prove to yourself that you’re a good person? Continually having to justify or earn your worthiness? Wouldn’t you prefer just to step out of the battle?

## Letting Go Of Self-esteem

If your self-esteem is low, you feel miserable; but if it’s high, you’re constantly straining to maintain it. (And there’s always the background worry that it might fall again.) So what would life be like if you were to let go of self-esteem altogether; if you completely let go of judging yourself as a person?

Of course, your thinking self would still keep making all the usual judgements, but you would see them for what they are—words and pictures—and let them come and go without a struggle. (And if you wanted to use some defusion techniques to help, you could try thanking your mind or acknowledging, ‘I’m having the thought that ... I’m not good enough.’ Or you could simply name the ‘not good enough’ story.)

How does this seem to you as a concept? Weird? Wonderful? Wacky? Undoubtedly it raises a few questions, such as:

**Q:** Don’t I need high self-esteem in order to create a rich and meaningful life?

**A:** No, you don’t. All you need to do is connect with your values and act accordingly.

**Q:** Doesn’t high self-esteem make that easier to do?

**A:** Sometimes it does, but all too often it doesn’t.

**Q:** Why not?

**A:** Because continually trying to maintain that high self-esteem can actually pull you away from what you value. Remember Michelle, working late at the office to improve her sense of worthiness, but missing out on spending time with her family? High self-esteem may give you some pleasant feelings in the short term, but in the long run, trying to maintain it will probably exhaust you. Because of the way the human mind has evolved, the ‘not good enough’ story will always return in one form or another. Do you want to spend the rest of your life battling it? Why bother when you can have a fulfilling life without exerting all that effort?

**Q:** But aren’t people with high self-esteem happier?

**A:** Not necessarily. Having high self-esteem can create all sorts of problems for people. It can easily lead to arrogance, righteousness, selfishness, egotism, narcissism or a false sense of superiority. The sort of happiness we’re talking about in this book—leading a rich, full and meaningful life—doesn’t depend on self-esteem in the slightest.

**Q:** So what are you suggesting as an alternative?

**A:** Don’t try to prove yourself. Don’t try to think of yourself as a ‘good person’.

Don’t try to justify your self-worth. Whatever judgements your thinking self makes of you, just see

them for what they are and let them go.

And at the same time take action in line with your values. Enhance your life by acting on what is meaningful. And when you slip up and stray off course from those values—which I guarantee you will do over and over again—then don’t buy into all those harsh self-judgements. Let those negative judgements come and go. Instead, accept that it has happened and that there’s no going back. Then connect with where you are and what you’re doing; choose a valued direction and take action.

If you step out of the battle to win self-esteem, then what you are left with is...

## Self-acceptance

Self-acceptance means being okay with who you are, recognising that you are neither the black pieces nor the white pieces in a chess game. Rather, you are the board. The board is in intimate contact with the pieces but is not caught up in the fray.

‘Whoa!’ you might say. ‘That all sounds a bit “out there”. What do you mean, I’m the board, not the pieces?’

What I mean is, those pieces on the board are just cognitions—nothing more than thoughts, images and memories. Are you a thought? For example, are you the words ‘I’m not good enough’? Are you an image, nothing more than a picture in your own head? Are you a memory, merely a record of something that happened in the past?

If these questions are making your head spin, don’t worry; you’re not the only one. So let’s put them aside for a moment and consider the following scenario.

## A Documentary On Africa

Have you ever watched a documentary on Africa? What did you see? Lots of crocodiles, lions, antelopes, gorillas and giraffes? Tribal dances? Military conflict? Political upheaval? Colourful marketplaces? Amazing mountains? Beautiful, placid villages in the country side? Poverty-stricken shantytowns? Starving children? You can learn a lot from watching a documentary, but one thing is for sure: a documentary about Africa is not Africa itself.

A documentary can give you *impressions* of Africa. It can certainly show you some dramatic sights and sounds, but it wouldn’t even come close to the actual experience of travelling there in the flesh. No matter how brilliantly filmed, no matter how ‘authentic’ it is, a documentary about Africa is not the same thing as Africa itself.

Similarly, a documentary about you would not be the same thing as you yourself. Even if that documentary lasted for a thousand hours and included all sorts of relevant scenes from your life, all sorts of interviews with people who know you, and all sorts of fascinating details about your innermost secrets, even then the documentary would not be you.

To really clarify this, think of the person you love most on this planet. Now, which would you prefer to spend time with: the actual living person or a documentary about that person?

So, there’s this huge difference between who we are and any documentary that anyone could ever make about us—no matter how ‘truthful’ that documentary may be. And I’ve put ‘truthful’ in quotation marks because all documentaries are hopelessly biased in that they only show you a tiny part of the big picture. Since the advent of cheap video, the typical hour-long television documentary is the ‘best’ of literally dozens, if not hundreds of hours of footage. So inevitably it’s going to be quite biased.

And the bias of a human film director is nothing compared to the bias of our thinking self. Out of an

entire lifetime of experience—literally hundreds of thousands of hours of archival ‘film footage’—our thinking self selects a few dramatic memories, edits them together with some related judgements and opinions and turns it into a powerful documentary entitled *This Is Who I Am!* And the problem is, when we watch that documentary we forget that it’s just a heavily edited video. Instead, we believe that we are that video! But in the same way that a documentary of Africa is not Africa, a documentary of you is not you.

Your self-image, your self-esteem, your ideas about the sort of person you are: all these things are nothing more than thoughts and memories. They are not you.

Right about now you may ask, ‘But if I’m not my thoughts and memories, then who am I?’

Good question ...

## Chapter 23

### YOU'RE NOT WHO YOU THINK YOU ARE

'I think, therefore I am.'

These immortal words by the French philosopher René Descartes have had a major influence on western civilisation. In the western world, we believe that the thinking self is the pinnacle of human development. 'Develop your mind,' we are told. 'Learn to think for yourself.' Lateral thinking, rational thinking, logical thinking, positive thinking, analytical thinking and optimistic thinking are all widely encouraged. And let's face it: thinking skills are really important in solving many problems in life. Indeed, Part 3 of this book places a major emphasis on effective thinking. But there's more to human consciousness than just the thinking self—we also have the observing self.

'I think, therefore I am,' said Descartes. In other words, the mere fact that I have thoughts proves that I exist. But this begs the question: Who is there to observe those thoughts? 'I am,' you may say. But then, who, precisely, is this 'I'?

Feeling a little confused? Good—that's the perfect state to start from. We're embarking on another major paradigm shift and strong reactions are expected. The following exercise is derived from similar ones devised by Hank Robb, Steven Hayes and Roberto Assagioli. It consists of a series of short paragraphs, each ending in a question. As you read each question, I want you to observe your *immediate* reaction: the thoughts and feelings that instantly spring to mind.

#### Who Is the 'I'?

As you read, observe what you are doing. Notice that you are involved in the act of reading. Be aware of your eyes moving across the page. Observe your eyes moving from word to word in this sentence. Now ask yourself, who is doing the observing?

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What was your reaction to that last question? It was probably a thought like, 'Me!' or 'I am!' Alternatively, rather than a coherent thought, you may have observed a feeling of confusion or irritation, or a sense of 'going blank'. Whatever it was that you observed—whether a thought, feeling, confusion or blankness—ask yourself: Who was doing the observing?

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Now, whatever reaction you are having at this time, just observe it. If it's the same thought, 'Me' or 'I am', just observe that thought. If it's a feeling of irritation or confusion, just observe that feeling. If it's a thought like, 'Where is he going with this?' or 'I don't understand', just observe it. And as you observe, ask yourself, who is doing the observing?

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Now, observe the position that you're sitting in right now. Observe what sensations you can feel in your legs and in your feet. Wiggle your toes and observe what it feels like. Now ask yourself, who is doing the observing?

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Your answer to each of the above questions was probably either 'Me' or 'I am.'

So now let me ask you: that 'me' or 'I' who's doing all this observing—is it a thought or image or sensation? Or is it a place from which you observe thoughts, images and sensations?

## The Observing Self

Hopefully, in the above exercise you experienced that no matter what thoughts, images or sensations came up, there was a part of you that was separate from them; a part that was able to ‘step back’ and observe them. That part of you is what I’ve been calling the observing self. It’s the place from which you observe thoughts, feelings, sensations, memories, images, urges, sights, sounds, smells and tastes.

Whatever you are thinking, whatever you are feeling, whatever you’re sensing, whatever you’re doing, this part of you is always there, observing it. You know what you’re thinking only because this part of you is able to observe your thoughts. You know what you are feeling or sensing only because this part of you is able to observe your feelings and sensations. You know what you’re doing only because this part of you can observe your actions. Without this observing self, you have no capacity for self-awareness.

Consider this: Which part of you does not change from the day you are born till the day you die? Your thoughts and images change continuously. (How many thoughts have passed through your head in the past five minutes?) Sometimes they’re pleasant, sometimes painful, sometimes helpful, sometimes a hindrance. But one thing’s for sure: they keep changing. Now, in a moment I’m going to ask you to close your eyes and take twenty seconds to observe your thoughts. When you do this, notice where your thoughts seem to be located in space—above you, in front of you, inside you—and notice, too, the form that those thoughts take: are they more like pictures, words or sounds? And as you observe those thoughts, be aware that you’re observing them. Notice, there are your thoughts—and there’s you observing them. (Do this now, for twenty seconds, then open your eyes and read on.)

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Your feelings and sensations, like your thoughts and images, change continuously. Sometimes you feel sad, sometimes you feel happy. Sometimes calm, sometimes angry. Sometimes healthy, sometimes sick. Sometime energised, sometimes tired. (How many different sensations and emotions have you experienced in the past 24 hours?) Now, in a moment, I’m going to ask you to close your eyes and take twenty seconds to observe your feelings and sensations. And as you observe those feelings, be aware that you’re observing them. Notice, there are your sensations—and there’s you observing them. (Do this now, for twenty seconds, then open your eyes and read on.)

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Your body changes continuously. The body you have now is not the one you had as a baby, as a child or as a teenager. You may have had bits cut out of it or bits put into it. You have scars, wrinkles and moles that certainly weren’t there ten years ago. You generate a whole new skin every six weeks. And your liver replaces every single cell over a period of three months. In fact, over the past seven years, every single cell in your body has been replaced by new ones. Now, in a moment I’m going to ask you to close your eyes and take twenty seconds to observe your body. When you do this, notice how you can instantly observe any part of your body you wish—your toes, ears, elbows or knees. And as you observe your body, be aware that you’re observing it. Notice, there are all the different parts of your body—and there’s you observing them. (Do this now, for twenty seconds, then open your eyes and read on.)

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So the roles you play and your thoughts, images, feelings, sensations and physical body all change continuously throughout your life. However, the ‘I’ that observes thoughts and images doesn’t change. The ‘I’ that observes feelings and sensations doesn’t change. The ‘I’ that observes your body doesn’t change.

Now ask yourself this: That ‘I’—the place from which you observe all these things—is it good or

bad, right or wrong, or is it ‘just there’?

## Qualities Of The Observing Self

Hopefully, you answered ‘just there’ to the last question. The observing self can’t be judged as good or bad, right or wrong, because all it does is observe. If you do ‘the wrong thing’ or a ‘bad thing’, the observing self is not in any way responsible; it merely notices what you’ve done and helps make you aware of it (thereby enabling you to learn from it). Moreover, the observing self will never judge you, because judgements are thoughts and the observing self cannot think.

The observing self sees things as they are, without judging, criticising or doing any of the other thinking processes that set us up for a struggle with reality. Therefore, it gives acceptance in its truest, purest form.

The observing self can’t be improved on in any way. It is always there, working perfectly and seamlessly. All you need do is connect with it.

The observing self can’t be harmed, either. If your body is physically damaged through illness, aging or injury, the observing self notices that damage. And if pain arises, the observing self notices that pain. And if bad thoughts or memories happen as a result, the observing self notices those, too. But neither the physical damage, nor the painful feelings, nor any of the bad thoughts or memories can harm that part of you that observes them.

In summary:

- The observing self is there from birth to death and is unchanging.
- It observes everything you do, but never judges you.
- It cannot be hurt or damaged in any way.
- It is always there, even if we forget about it or know nothing of it.
- It is the source of true acceptance.
- It is not a ‘thing’. It is not made of physical matter.
- It cannot be improved on in any way; therefore, it is perfect.

When you take a look at that summary, you can see why people draw parallels between ACT and religion. But ACT places no religious or spiritual beliefs or expectations on this observing self. You are free to conceptualise it as you wish and call it what you will.

Personally, I think of the observing self as being like the sky, while thoughts, sensations and images are like the weather. The weather constantly changes throughout the day. And whatever it is, the sky always has room for it. No matter how bad the weather, no matter how violent the thunderstorm, no matter how severe the sun, the sky cannot be damaged in any way. Even hurricanes and tsunamis, which may wreak death and destruction on the land, are unable to hurt the sky. And, of course, as time passes, the weather will change again and again, while the sky remains as pure and clear as ever. (This metaphor—comparing human consciousness to the expansiveness of the sky—is actually thousands of years old and can be found in many ancient spiritual/religious

traditions!)

## The Observing Self In Everyday Life

In normal, everyday life, all we get are ‘glimpses’ of the observing self because most of the time it’s obscured by a constant flow of thoughts. Again, this is like the sky, which may at times be completely obscured by clouds. But even when we can’t see the sky, we know it’s there; and if we rise up high enough above those clouds, we will always find it.

Similarly, when we rise above our thoughts, we ‘find’ the observing self: a perspective from which we can observe our negative self-judgements or self-limiting beliefs without being hurt by them. From the perspective of the observing self, you can look at that ‘documentary’ about who you are and see it for what it is: a collection of words and pictures compiled by the thinking self. The thinking self tells you that the documentary is you. But all you need to do is step back and observe it and notice who is doing the observing, and in that moment, there is the ‘real you’!

Tuning in to your observing self is very simple to do. Choose anything you are aware of: a sight, sound, smell, taste, sensation, thought, feeling, movement, body part, material object—literally anything. Focus on that thing and observe it as if you were a curious scientist. As you’re observing it, notice who’s doing the observing.

That’s all there is to it. In that moment, when you observe the observing, you are the observing self. In that moment, you are awareness of awareness; consciousness of consciousness. Of course, this will only last for a moment or two. Almost instantly your thinking self will start analysing or commenting on what’s happening, or conjuring up a variety of images or memories. And as you get caught up in those cognitions, the observing self is once more obscured.

Still, it’s comforting to know that it’s always there and instantly accessible whenever you want it. The reality is, for the rest of your life, you will get caught up in stories about who you are. Because of the nature of the mind, this will happen again and again, until the day you die. However, hopefully you now have the *direct experience* that you are not those stories. So the moment you realise what is happening—that you’re fusing with stories or believing that you are the documentary—you can instantly step back and observe. Then all you need to do is notice that you’re observing and in that moment, there is the real you.

## The End?

This brings us to the end of Part 2 of this book. Part 3 is about taking action to create the life you want. Inevitably, as you take that action, you will face many fears and encounter many unpleasant thoughts and feelings. But more and more, via defusion, expansion and connection, you can learn to overcome such obstacles. And it helps to know that no matter how daunting they may seem, there’s always a safe place, deep within you, where the essence of who you are cannot be harmed.

## PART 3

# Creating A Life Worth Living

## Chapter 24

### FOLLOW YOUR HEART

Fyodor Dostoyevsky once said: ‘The secret of man’s being is not only to live, but to have something to live for.’ Have you ever considered this or other questions such as: What’s life all about? What are you here for? What makes your life worth living?

It’s amazing how many of us have never deeply considered these questions. We go through life following the same routine, day after day. But in order to create a rich, full and meaningful life, we need to stop to reflect on what we’re doing and why we’re doing it. So it’s time now to ask yourself:

- Deep down inside, what is important to you?
- What do you want your life to be about?
- What sort of person do you want to be?
- What sort of relationships do you want to build?
- If you weren’t struggling with your feelings or avoiding your fears, what would you channel your time and energy into doing?

Don’t worry if you don’t have all these answers on the tip of your tongue. Over the next few chapters we’ll explore them in depth, and your answers will connect you with your values.

### Your Values

We’ve already touched on values several times in this book. Values are:

- Our heart’s deepest desires: how we want to be, what we want to stand for and how we want to relate to the world around us.
- Leading principles that can guide us and motivate us as we move through life.

When you go through life guided by your values, not only do you gain a sense of vitality and joyfulness, but you also experience that life can be rich, full and meaningful, even when bad things happen. Take the case of my good friend Fred.

Fred had a business venture that went horribly wrong. As a result, he and his wife lost almost

everything they owned, including their house. In dire financial straits, they decided to move from the city out to the country, so they could live somewhere decent with affordable rent. There Fred found a job at a local boarding school that catered to foreign school students, mainly teenagers from China and Korea.

This job was totally unrelated to Fred's business experience. His duties involved maintaining order and security in the boarding house, ensuring that the kids did their homework and making sure they went to bed at the right time. He would also sleep in the boarding house overnight and prepare the children for school the next morning.

Many people in Fred's shoes would have been deeply depressed. After all, he'd lost his business, his house and a huge amount of money, and now he was stuck in a low-paying job that kept him away from his wife five nights a week!

But Fred realised he had two choices: he could dwell on his losses, beat himself up and make himself miserable, or he could make the most of it.

Fortunately, he chose the latter.

Fred had always valued coaching, mentoring and supporting others and now he decided to bring these values into the workplace. So he began to teach the children useful skills, such as how to iron their clothes and cook simple meals. He also organised the school's first-ever talent contest and helped the kids film a humorous documentary about student life. On top of this, he became the students' unofficial counsellor. Many of them came to him for help and advice in dealing with their various troubles: relationship difficulties, family issues, problems with studies and so on. None of these things were part of Fred's job description and he didn't get any extra pay for doing them; he did them purely and simply because he valued giving and caring. And as a result, what could have been a mundane job became work that was meaningful and satisfying.

At the same time, Fred didn't give up on his career. While he needed this job in the short term to pay the bills, he continued to look for work that he genuinely desired. He'd always been an excellent organiser and administrator, with a particular interest in theatrical and musical events, and this was the area he most wanted to work in. Eventually, after many months of applying for all sorts of work, Fred found a job as the organiser of a local arts festival. It was a job that fulfilled him, paid him well and allowed him to spend a lot more time with his wife.

Fred's story serves as a great example of how we can live by our values even when life treats us harshly. It's also a good example of how we can find fulfilment in any job—even if it's one we don't want—by bringing those values into the workplace. That way, even while we search or train for a better job, we can find satisfaction within the one we have.

## Values Versus Goals

It's important to recognise that values are not the same as goals. A value is a direction we desire to keep moving in; an ongoing process that never reaches an end. For example, the desire to be a loving and caring partner is a value. It's ongoing for the rest of your life. The moment you stop being loving and caring, you are no longer living by that value.

A goal is a desired outcome that can be achieved or completed. For example, the desire to get married is a goal. Once achieved, it's 'done' and can be crossed off the list. Once you're married you're married, no matter how loving and kind, or how hard-hearted and uncaring you are to your partner.

A value is like heading west. No matter how far you travel, there's always farther west you can go.

A goal is like a mountain or river you wish to cross on your westward journey. Once you've gone over it, it's a 'done deal'.

If you want a better job, that's a goal. Once you've got it: goal achieved. But if you want to apply yourself fully at work, to be attentive to detail, supportive to your colleagues and engaged in what you're doing, those are values.

## Why Are Values So Important?

Auschwitz was the most notorious of the Nazi death camps. We can scarcely begin to imagine what took place there: the horrific abuse and torture, the extremes of human degradation, the countless deaths through disease, violence, starvation and the infamous mass gas chambers. Viktor Frankl was a Jewish psychiatrist who survived years of unspeakable horror in Auschwitz and other camps, which he described in gruesome detail in his awe-inspiring book *Man's Search for Meaning*.

One of the most fascinating revelations in this book is that, contrary to what you would expect, the people who survived longest in the death camps were often not the physically fittest and strongest, but rather, those who were most connected with a purpose in life. If prisoners could connect with something they valued, such as a loving relationship with their children or an important book they wished to write, that connection gave them something to live for; something that made it worthwhile to endure all that suffering. Those who could not connect with a deeper value soon lost the will to live—and thus, their lives.

Frankl's own sense of purpose came from several sources. For example, he deeply valued his loving relationship with his wife and was determined to survive so he could one day see her again. Many a time during strenuous work shifts in the snow, with his feet in agony from frostbite and his body racked with pain from brutal beatings, he would conjure up a mental image of his wife and think about how much he loved her. That sense of connection was enough to keep him going.

Another of Frankl's values lay in helping others and so, throughout his time in the camps, he consistently helped other prisoners to cope with their suffering. He listened compassionately to their woes, gave them words of kindness and inspiration and tended to the sick and the dying. Most importantly, he helped people to connect with their own deepest values so they could find a sense of meaning, of purpose. This would then quite literally give them the strength to survive. As the great philosopher Friedrich Nietzsche once said, 'He who has a why to live for can bear almost any how.'

## Values Make Life Worth Living

Life involves hard work. All meaningful projects require effort, whether you're raising kids, renovating your house, learning kung fu or starting your own business. These things are challenging. Unfortunately, all too often, when faced with a challenge we think, 'It's too hard' and we give up or avoid it. That's where our values come in.

Connecting with our values gives us a sense that our hard work is worth the effort. For instance, if we value connecting with nature, this makes it worth the effort to organise a trip to the countryside. If we value being a loving parent, it's worth taking the time to play with our kids. If we value our health, we're willing to exercise on a regular basis despite the inconvenience and exertion. In this way, values act as motivators. We may not feel like exercising, but valuing our health can give us the will to 'just do it!'.

The same principle applies to life in general. Many of my clients ask questions like, 'What's the point of life?', 'Is this all there is?', 'Why don't I feel excited about anything?' Others say things like, 'Maybe the world would be better off without me', 'I have nothing to offer', 'Sometimes I wish I could go to bed and never wake up again.'

Such thoughts are commonplace not just among the 10 per cent of adults who suffer from depression at any given time, but also among the rest of the population. Values provide a powerful antidote: a way to give your life purpose, meaning and passion.

## Imagine You're 80 Years Old

Here's a simple exercise to get you started on clarifying your values. Please take a few minutes to write out or think about your answers. (You'll get more out of it if you write!) Imagine that you're 80 years old and you're looking back on your life as it is today. Then finish the following sentences:

- I spent too much time worrying about...
- I spent too little time doing things such as...
- If I could go back in time, I would...

How did it go? For many people this simple exercise is quite an eye-opener. It often points to a big difference between what we *value* doing and what we are *actually* doing. In the next chapter we'll explore your values in more detail. In the meantime, I'll leave you with this oft-quoted extract from *Man's Search for Meaning*:

*We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of human freedoms—to choose one's attitude in any given set of circumstances; to choose one's own way.*

## Chapter 25

### THE BIG QUESTION

Deep down inside, what do you *really* want? Usually when I ask people this question, people reply with superficial answers like:

- ‘I just want to be happy.’
- ‘I want to be rich.’
- ‘I want to be successful at something.’
- ‘I want someone to love me.’
- ‘I want a great job.’
- ‘I just want to get married and have kids.’

Now, these may all be truthful answers, but they’re not particularly ‘deep’, reflective or carefully considered. So in this chapter we will go deeper, to connect with your heart and soul. The pages that follow are a questionnaire—a series of questions inspired by Kelly Wilson’s ‘Valued Living Questionnaire’—to help you find out what you *really* want!

Although many of us have similar values, no two people are exactly the same and this is not some test to see if you have the ‘right’ ones. There is no right or wrong, no good or bad, when it comes to values. What you value is what you value, full stop! There’s no need to justify or defend your values any more than there is a need to justify or defend your favourite flavour of ice cream. My favourite ice cream is maple walnut. Why? I don’t know. My taste buds just prefer it. Do I have to justify it? If someone else prefers vanilla, does that mean their tastebuds are ‘right’ and mine are ‘wrong’? Obviously not! And it’s exactly the same with values. Someone else may have different values from yours, but that doesn’t mean that theirs are better or worse—it just means they value different things.

In the last chapter we spoke about the difference between values and goals. The aim of this chapter is to consider what you want in life in terms of general directions, *not* in terms of specific goals. We’ll look at setting goals later, once you know what your values are.

There may be some sections in this chapter that seem unimportant to you. If so, that’s fine—not everyone values the same things, so just move on to the next section. Also, there may be considerable overlap. For example, if you value being helpful, supportive and caring, that may show up in several different domains, such as friendship, family and parenting.

As you keep reading, it’s important not to get side-tracked by your mind—by stories about what is realistic or what you (or others) believe you deserve. In answering these questions, you’re daring to dream; looking at possibilities, not absolute certainties. So answer as if there were no obstacles in your way; nothing to stop you from making the changes you want.

Finally, it’s preferable that you actually write down your answers. Writing concentrates your thinking and helps you to consciously remember what you answer. (If, however, you’re not willing

to write, then at least think long and hard about your answers.)

As you work through this questionnaire, it's important to keep in mind that feelings are not values. If you say, 'I want to feel confident', or 'I want to feel happy', those are goals, not values. Why? Because a feeling of confidence or a feeling of happiness can be achieved, done and completed. A feeling is not an ongoing process; it's a transient event, like a television program. Once you've watched the program: goal accomplished. Likewise, once you've had a feeling of happiness: goal accomplished. So if in your answers to these questions, you keep writing about how you want to feel, then you need to ask yourself: 'If I did feel this way, what would I do differently? How would I act differently? How would I behave differently in my relationships with others?' Your answers then reveal your underlying values. Okay, enough talk. Now it's time for the questionnaire.

## THE LIFE VALUES QUESTIONNAIRE

### Values Domain No.1: Family

1. What sort of brother/sister, son/daughter, father/mother (or other relative) do you want to be?
2. What personal qualities would you like to bring to these relationships?
3. How would you treat others if you were the 'ideal you' in these relationships?
4. What sort of ongoing activities do you want to do with your relatives?
5. What sort of relationships do you want to build?

Notice that these questions are all about you: how you would like to be and what you would like to contribute to these relationships. Why? Because the only aspect of a relationship you have control over is the way *you behave*. You have no control over what the other person thinks, feels or behaves. Sure, you can influence them, but you can't control them. And what's the best way to influence them? With your actions, of course! And those actions will be most effective when they're aligned with your values.

For example, if a relative is treating you poorly, you have every right to request that they change their behaviour. But they are far more likely to go along with your request if you are being the 'ideal you': loving, supportive, accepting, caring and helpful. If you're all caught up in anger, bitterness or resentment, don't expect much of a positive response from the other person.

On the same note, if you're being true to your values and yet your relative continues to treat you poorly, then it makes sense to spend less time with them. After all, you have values about looking after your own health and wellbeing—and those need to be considered too. It may even be the case that you need to stop seeing this relative altogether if they're continually hostile or abusive. Remember: being helpful, loving and supportive doesn't mean subjecting yourself to abuse. At the same time, the last of the questions above is important to consider, because even if your relationships have been bad in the past, you can start building better ones right now.

### Values Domain No.2: Marriage and Other Intimate Relationships

1. What sort of partner would you like to be in an intimate relationship?
2. What personal qualities would you like to develop within this relationship?
3. How would you treat your partner if you were the 'ideal you' in this relationship?
4. What sort of relationship do you want to build?
5. What sort of ongoing activities do you want to do with your partner?

You'll notice that these are virtually identical to the first set of questions. Again, they're all about how you want to be, not about how you want your partner to be. Why? Because in any relationship, you only have control over one person and that's you. How your partner behaves is up to your

partner. Of course, it is in your control to request changes from your partner and to set boundaries on what you will and won't accept. And as I said, this will be far more effective if you're behaving as the 'ideal you'. These same principles apply to all the relationships you have with friends, family, colleagues, employees and anyone you'll ever meet! Remember the golden rule: treat others as you'd like them to treat you.

Sometimes, as a response to the above questions, my clients jot down a long list of the qualities they're looking for in a partner. But in describing the sort of partner you want, you're describing a goal. To get to your values in this domain, you need to ask, 'If I did find the partner I want, how would I like to be in that relationship? What personal qualities would I like to bring to it?' (Of course, it can be very useful to think about the sort of partner you'd like—but that's not what this exercise is about.)

### **Values Domain No.3: Friendships**

1. What does it mean to you to be a good friend?
2. If you could be the 'ideal you', how would you behave toward your friends?
3. What personal qualities would you like to bring to these friendships?
4. What sort of friendships do you want to build?
5. What sort of ongoing activities do you want to do with your friends?

Once again, these questions focus on what's in your control: how you behave as a friend. If you've written about the sort of friends you'd like, that's useful. You can set yourself a goal to go out and meet people like that. But to clarify your values on friendship, you need to ask yourself, 'What sort of friend would I like to be?'

### **Values Domain No.4: Employment**

1. What sort of worker or employer would you like to be?
2. What personal qualities would you like to bring to the workplace?
3. How would you treat your co-workers/colleagues/employees if you were the 'ideal you' in your workplace?
4. What sort of relationships do you want to build with your workers/colleagues/employees?
5. What sort of ongoing activities do you want to do with your workers/colleagues/employees?
6. What would make your work more meaningful (regardless of whether you like it)?

Sometimes my clients write a long description of the ideal job they want. But in describing your ideal job, you're describing a goal. To get to your values around work, you need to ask, 'If I did have the job I want, how would I behave differently when I'm at work? What personal qualities would I like to bring to it?' Naturally, if you don't like your current job, it makes sense to start retraining or looking around for more meaningful or satisfying work. So if you've written about the sort of work you'd ideally like, great—you can set yourself a goal to go out and find it. In the meantime, you can make the most of *whatever* job you're in by bringing your values into the workplace. (Remember Fred, in the last chapter.)

### **Values Domain No.5: Education and Personal Development**

1. What do you value about learning, education or training?
2. What new skills or knowledge would you like to gain?
3. What further education or training appeals to you?
4. What sort of student/trainee would you like to be?
5. What personal qualities would you like to bring to your studies or training?

6. What sort of relationships would you like to build with other students/trainees?

#### **Values Domain No.6: Recreation, Fun and Leisure**

1. What sorts of hobbies, sports or leisure activities do you want to participate in?
2. On an ongoing basis, how do you wish to relax and unwind?
3. On an ongoing basis, how do you wish to have fun?
4. How do you wish to be creative?
5. What sorts of new activities would you like to try?
6. What old activities would you like to take up again or do more of?

#### **Values Domain No.7: Spirituality**

1. What is important to you in this area of life?
2. What spiritual activities would you like to do on an ongoing basis?

The word ‘spirituality’ has different meanings for different people. It may mean getting out into nature, dancing, meditating, practising yoga or participating in an organised religion. Whatever it means to you is fine.

#### **Values Domain No.8: Community Life**

1. How would you like to contribute to your community (for instance, through volunteering, recycling or helping an elderly neighbour)?
2. What interest groups, charities or political parties would you like to support or become actively involved in?

#### **Values Domain No.9: Environment and Nature**

1. What aspects of nature would you like to connect with?
2. What environments would you like to spend more time in?
3. How would you like to care for, change or contribute to the variety of environments around you—in nature, at work and at home?
4. What activities would you like to do that get you out into nature?
5. What activities would you like to do that alter your environment at home or at work in creative, helpful or pleasing ways?

#### **Values Domain No.10: Health and Body**

1. How would you like to care for your body?
2. What sort of physical health do you want to build?
3. What sort of ongoing activities do you want to do in terms of connecting with and taking care of your body?
4. How do you want to look after your health with regard to sleep, diet, exercise, smoking, alcohol?

Did you have trouble with these exercises? Did uncomfortable thoughts and feelings show up? Often when we connect with our values, we realise that we've been neglecting them for a long time and this can be very painful. But remember, this is not an excuse to beat yourself up! ('What a hypocrite I am! I say I value doing all these different things, yet I'm not doing any of them! I'm pathetic!') All of us lose touch with our values from time to time. Dwelling on those times is pointless because there's nothing we can do to change the past. What's important is to connect with our values here and now and to use them to guide and motivate our current actions. So if your mind does start beating up on you, simply thank it.

You may have found that you skipped parts of this chapter or avoided the exercises because you fused with unhelpful thoughts like, ‘I don’t know if these are my real values’ or ‘I’m setting myself up for disappointment.’ If this is the case, read through the next chapter. Once you’ve done that, come back and work through this chapter again. If, on the other hand, you’ve completed this chapter to your satisfaction, then you can skip the next one and go straight to Chapter 27.

## Time To Reflect

Now it’s time to look back over your answers and reflect on them.

Ask yourself:

- Which of the above values are the most important to me?
- Which of them am I actively living by, right now?
- Which of them am I most neglecting?
- Which are the most important to start working on right away?

Write your answers down and hold on to them. You’ll need them for the next few chapters.

## Values And Relationships

Usually when we talk about relationships, we are referring to relationships between people. However, the questions in this chapter refer to many different sorts of relationships, such as:

- your relationship with your own body
- your relationship with your work
- your relationship with nature.

Our lives revolve around relationships—with ourselves, others and everything we encounter in the world around us. The more you act in line with your values, the better will be the quality of those relationships and therefore the more enjoyable and rewarding your life will be.

In the next few chapters we’re going to look at how you can use your values to set purposeful goals, create meaning and find fulfilment. In the meantime, reflect further on this chapter. Discuss your values with friends or loved ones. Write about those values in more detail. And look for opportunities to act on them in daily life.

## **Chapter 26**

### **TROUBLESHOOTING VALUES**

The demons are getting restless. They know what you're up to: you're plotting a new course, planning to steer that boat toward land. Naturally, they want to stop you. As you worked through those exercises in the last chapter, a number of different demons may have challenged you. Here are a few of the more common ones.

#### **THE ‘I DON’T KNOW IF THESE ARE MY REAL VALUES’ DEMON**

This is a very sneaky demon. It seeks to undermine your confidence by having you doubt your answers. The way to deal with it is to answer these questions:

1. If a miracle could happen so that you automatically had the full approval of everyone who matters to you (and therefore you weren't trying to please or impress anyone), then what sort of things would you do with your life and what sort of person would you try to be?
2. If you weren't guided by other people's judgements and opinions, what would you do differently in your life?

The questions above are to help you clarify what you really want, so that you are living by your own values and not someone else's. The next three questions ask you to think about your death, as a way of clarifying what's important in life:

1. If you could somehow listen in on your own funeral and the people you most care about were there, what sort of things would you love to hear them say about you? What would you like them to think about the role you played in their lives?
2. If you knew you had only one year left to live, how would you like to be as a person and what would you like to do during that time?
3. If you were trapped in a collapsed building and knew you had only a few minutes to live, who would you call on your mobile and what would you say to them? What does your answer reveal about what's important to you?

#### **THE ‘I DON’T KNOW WHAT I WANT’ DEMON**

If you're not sure what you want, ask yourself this: If I could have any values I wanted, which ones would I choose?

Whatever values you would choose, those already are your values! Why? Because the fact that you would choose them shows you already value them!

#### **THE ‘I DON’T WANT TO THINK ABOUT IT’ DEMON**

If you've experienced a lot of failure, frustration or disappointment in your life, then you may be

afraid to acknowledge what you really want, for fear it will only lead to more of the same. If so, remind yourself that the past is the past—it's over and can't be changed. But no matter what has happened in the past, you can make changes right now that will allow you to create a new future. So do the exercises, and if uncomfortable feelings arise, breathe into them, make room for them and keep focused on the questions.

## **THE ‘I’M JUST SETTING MYSELF UP FOR DISAPPOINTMENT’ DEMON**

This sneaky critter is usually accompanied by several of its buddies, such as: ‘I’ll only fail if I try’, or ‘I don’t deserve anything better in life’, or ‘I can’t change.’ Remember, these are nothing more than ‘pop-up’ thoughts. So thank your mind, let them come and go and refocus on answering the questions.

## **THE ‘I CAN’T BE BOTHERED RIGHT NOW; I’LL DO IT LATER’ DEMON**

You know this creature far too well to believe what it says. You know that ‘later’ never gets here. So thank your mind and answer the questions now.

## **THE ‘THIS IS SO CORNY’ DEMON**

So your mind’s making the judgement that your values are corny or clichéd. Fine. Let your mind make whatever judgements it wants. Clarifying what you want in your heart is one of the most important and profound things you will ever do in your life. So thank your mind for its comments and carry on.

## **THE ‘WHAT IF MY VALUES CONFLICT?’ DEMON**

This demon is making a valid point: sometimes your values will pull you in different directions. But don’t let that stop you from acting on them. All it means is that sometimes you’ll need to compromise—to focus more on one value than another. For example, a few years ago my older brother was working in a high-powered job that required him to spend a lot of time travelling away from home.

There was a major conflict of values here. On the one hand he valued being a loving father, and he wanted to spend as much time with his young son as possible. On the other hand, he valued his work and, of course, the financial benefits it gave to his family.

These conflicting values are common for many parents and there’s rarely a perfect solution. The important thing is to find the best balance that you can. For instance, when my brother was away on overseas trips, he rang home every night without fail, to read his son a bedtime story over the phone. Sure, it wasn’t the same as being there in person, but it was nonetheless a very loving act that fostered a deep sense of caring and connection.

The reality is, there will be times that you have to prioritise your values; to focus more on some domains of life than others. This calls for soul-searching; for asking yourself, ‘What’s most important at this moment in my life, given all my conflicting concerns?’ Then choose to act on that value, rather than wasting your time uselessly worrying about what you might be giving up or missing out on.

There are many other demons that will try to deter you—but you already know that they’re only a bunch of words. So let them be and focus your attention where it’s most useful: on plotting the course, steering the ship onwards and thoroughly appreciating the voyage. Therefore, if you didn’t complete the exercises in the last chapter, then go back and do them now. And if you have

completed them, it's time to move on.

## **Chapter 27**

### **THE THOUSAND-MILE JOURNEY**

So you've identified your values and now you know what really matters to you, deep inside. Now what?

Well, now it's time to take action. A rich, full and meaningful life doesn't spontaneously happen just because you've identified your values. It happens through taking action, guided by those values. So take a few moments to reflect once more on what's important to you. As you read down the list below, mentally remind yourself of your values in each domain:

1. Family
2. Marriage and other intimate relationships
3. Friendships
4. Employment
5. Education and personal development
6. Recreation, fun and leisure
7. Spirituality
8. Community life
9. Environment and nature
10. Health and body.

Now ask yourself: 'In which of these domains am I most out of touch with my values?' If several (or all) domains come to mind, consider, 'Which domain is the most important to start working on right now?'

It's important to start with only one domain at a time, because if you try to make too many changes at once, you'll probably just feel overwhelmed and quit. (Naturally, over time, the idea is to work on all the important areas of your life. However, frequently as you start making changes in one domain, it spills over into others: a sort of domino effect.) So once you've identified which domain to begin with, it's time to start setting meaningful goals.

### **Setting Meaningful Goals**

Sorry to be a nag, but once again, I have to stress the importance of writing down your answers to

these exercises. Research shows that you're far likelier to take action if you write your goals down than if you just think about them. So please, for the sake of a better, more fulfilling, values-driven life, put down this book and go get a pen and paper!

There are five steps in setting meaningful goals.

### **Step 1: Summarise Your Values**

Write a brief description of the domain and the values you're going to work on. For example, 'In the domain of family, I value being open, honest, loving and supportive.'

### **Step 2: Set An Immediate Goal**

Ask yourself: 'What's the smallest, easiest thing I can do today that is consistent with this value?' It's always good to boost your confidence by starting with a small, easy goal—one that can be accomplished straightaway. For example, if your value is to be a loving partner, your goal may be, 'During my lunchbreak, I'll ring up my wife and tell her I love her.'

When setting goals it's important to be specific about what you will do. For instance, 'I'll go swimming for 30 minutes, twice a week', as opposed to making vague statements like 'I'll do more exercise.' Also, specify when and where you'll do it, for example, 'I'll go for a run in the park right after work on Wednesday.'

Starting with small, easy goals will help you defeat the 'It's all too hard' demon, which is guaranteed to raise its ugly head right about now. And it's always useful to remind yourself of this ancient Chinese proverb by the great philosopher Lao-Tse: 'A journey of a thousand miles begins with one step.'

### **Step 3: Set Some Short-term Goals**

Ask yourself: 'What small things can I do over the next few days and weeks that are consistent with this value?' Remember: be specific. What actions will you take? When and where will you do them? For example, in the domain of work, if you value helping others but your current job gives you little opportunity to do so, then one of your short-term goals might read, 'Each night this week, between nine and ten, I will do some research on the Internet into finding a more meaningful job', or 'Tomorrow morning I will make an appointment with a careers counsellor.'

### **Step 4: Set Some Medium-range Goals**

Ask yourself: 'What larger challenges can I set for the next few weeks and months that will take me in my valued direction?' Again, be specific. For example, if your value is about getting fitter, a medium-range goal might be, 'I will quit smoking by the end of this month', 'Five nights a week I will cook dinner using recipes from the Weight Watchers cookbook', 'I will go for a 30-minute walk every morning', or 'I will lose 10 kilograms within the next three months.'

### **Step 5: Set Some Long-term Goals**

Ask yourself: 'What major challenges can I set for the next few years, which will take me in my valued direction?' This is where you dare to think big. What would you like to achieve in the next few years? Where would you like to be five years from now? Long-term goals may include anything from changing careers and having kids to sailing around the world. Allow yourself to dream.

## **Don't Set A Dead Person's Goal**

Never set as your goal something that a dead person can do better than you. For example, to stop eating chocolate—that's something a dead person can do better than you because, no matter what, they'll definitely never, ever eat chocolate again. Or to stop feeling depressed—that's something a dead person can do better than you, because they'll never feel depressed ever again. Any goal that is about *not* doing something or *stopping* doing something is a dead person's goal. To convert it to a live person's goal (i.e. something that a live person can do better than a dead one) you need to ask yourself: 'If I was no longer doing this activity (or feeling this way or thinking like this), what would I be doing with my time? How would I be acting differently?' For example, suppose you answered, 'If I was no longer smoking, I'd be going for a walk after lunch, breathing in the fresh air, instead of puffing on a cigarette.' Okay, so make that your goal: after lunch, instead of having a cigarette, get up and go for a walk and breathe in the fresh air. That is definitely something you can do better than a dead person. Or suppose you answered, 'If I stopped feeling so anxious, I'd spend more time socialising with friends.' Great! Now you can set a live person's goal: to socialise more with your friends. A dead person always feels less anxiety than a live one—but a dead person can't socialise!

## **Imagine Yourself Taking Effective Action**

In much of this book we've looked at the dark side of cognitive fusion: the problems that happen when we fuse with unhelpful thoughts or images. But we can also use cognitive fusion for good. In the world of elite sports, top athletes use a technique called 'visualisation' as a way of enhancing their performance. They vividly imagine themselves performing at their peak—alert, focused, using their skills to the very best of their ability—and this process of mental rehearsal actually improves their performance in reality.

Now it's time for you to do the same thing. Once you've set a goal, close your eyes and spend a few moments vividly imagining yourself taking effective action. Imagine this in any way that comes naturally. Some people can easily conjure up vivid mental pictures, but others imagine more with words, sounds or feelings. However you imagine this scenario is the right way for you. See yourself, feel yourself and hear yourself taking effective action to achieve your goal. Notice what you're saying and what you're doing. Keep rehearsing, until it's clear to you what your actions are. (And if your mind starts trying to disrupt this process with stories like 'I can't do it', 'It's too hard' or 'Who am I trying to kid?' then simply say, 'Thanks, Mind!' and come back to the exercise.)

Most books on visualisation or mental rehearsal will encourage you to imagine yourself feeling relaxed and confident as you take action. I strongly advise against this because those are feelings over which you have very little control—and if your goal is particularly challenging, it's very unlikely that you will feel relaxed and confident. You're far more likely to have feelings of anxiety and self-doubt. So I suggest that in your mental rehearsals, you focus on what is directly in your control: your actions. Imagine yourself taking action to the very best of your ability, saying and doing the things that are most likely to be effective. And also imagine yourself making room for whatever thoughts and feelings show up in the moment and continuing to take effective action, no matter how you feel!

It's helpful to practise this exercise again and again, whenever you set yourself challenging new goals. Of course, it won't guarantee that you'll achieve your goals, but it'll make it more likely. So put the book down now, close your eyes and spend a few minutes imagining yourself taking effective action.

Remember Soula? She had just turned 33 and was feeling sad and lonely because she was still single while all her friends were in long-term relationships. In the domain of intimate relationships, Soula valued being loving, caring, open, sensual and fun-loving. But because she didn't currently

have a partner, her major long-term goal was to find one. Therefore, her short-term goals included research into dating agencies and social clubs, and asking her friends to fix her up with blind dates. More challenging, medium-term goals included *actually joining* a dating agency and *actually going out* on some blind dates.

Once Donna had come to terms with the death of her husband and child and had given up drinking alcohol, she was faced with rebuilding her life, piece by piece. She had lost a lot of weight and her body was in terrible condition, so she began by focusing on the domain of physical health. Small, easy short-term goals included buying a healthy sandwich at lunchtime, going to bed at a reasonable hour and taking a hot bath at night to unwind. More challenging medium-range goals included signing up for a yoga class and hiking in the countryside on weekends.

Once Michelle had identified that she wished to spend more quality time with her family, she started saying no to extra work and made sure she left the office at a reasonable hour. Her values were to be a loving, caring mother, to be present and connected with her children, and to spend more quality time with them, engaging in shared activities rather than simply waiting on them hand and foot. Small goals included listening intently to her kids when they talked to her (instead of being caught up in her own thoughts) and putting aside an hour two nights a week to play a family game, such as Scrabble or Monopoly. Larger, mid-range goals included organising a family picnic or outing most weekends. A long-term goal was to take the children on a camping trip to Spain.

## Action Plans

Once you've identified your goals, you need to break them down into an action plan. Ask yourself:

- What smaller steps are required in order to complete this goal?
- What resources (if any) do I need in order to take these steps?
- When, specifically, will I carry out these actions?

For example, if you value exercising and your goal is to go to the gym three times a week, your action plan may include (a) joining the gym, (b) getting your gym wear together, (c) planning the times you will go, and (d) rearranging your schedule to accommodate this activity. The resources you may need are (a) money to join the gym, (b) your gym gear (sneakers, shorts, T-shirt, towel and a bag to carry it in). Next, specify when you will actually do this. For example, 'I'll pack my bag tonight. Then I'll join the gym tomorrow after work and I'll start my first session then and there.'

If you find you're lacking the necessary resources to achieve your goal, you have two options:

1. Change your goal. For example, if you don't have the money for gym membership, go for a run and do a program of crunches and push-ups instead.
2. Make a plan of action to obtain the necessary resources. For example, borrow the money or charge it to your credit card (after determining exactly how and when you can pay it back).

Sometimes the resource you need is actually a skill. For example, if your goal is to do with improving relationships, you may need to learn some communication or assertiveness skills. If your goal is around improving your finances, you may need to learn some investment skills. If this is the case, make a plan as to how you will learn this skill; that is, what books can you read or courses can you take?

Now, take a pen and paper (or a laptop) and do these exercises. Even if you don't have time to complete it right now, at least get your feet wet, even for five or ten minutes. It's amazing, once you get started, how much can happen in a short time. Write down:

- your values
- your goals (immediate, short-term, mid-range and long-term)
- your action plan for those goals.

This may seem like a lot of hard work right now, but the more you practise thinking this way—moving from values to goals to specific actions—the more it will start to come naturally, without the need for all this planning.

## Does This Sound A Bit Contrived?

Values? Goals? Action plans? Does this all sound just a little too contrived—too orderly, too detailed, too structured? What happened to good old spontaneity; to taking life as it comes?

Well, unfortunately, these things are the nuts and bolts that give our lives structure and function. There's plenty of room for spontaneity once your boat is sailing in the right direction, but first you've got to choose where you're heading, then use a map and compass to plot your course. And, of course, you mustn't forget to appreciate the voyage.

Change happens in an instant. The moment you steer that ship toward shore, you are successfully creating a meaningful life. Your mind will try to tell you that the most important thing is to reach the shore, but that's not really the case. The most important thing is *sailing toward shore*. When you're drifting aimlessly at sea, you feel half-dead. But when you're heading for shore, you feel alive. As renowned author and educator Helen Keller put it: 'Life is either a daring adventure or nothing.'

Of course, that shore you're heading for may be a long way off and it may take weeks or months or even years to get there. And sometimes when you get there, you may not even like it. So it's sensible to make the most out of the voyage. Look around, take it in and notice what you can see, hear, smell, touch and taste. When we move in a valued direction, every moment of our journey becomes meaningful. So engage fully in everything you do along the way. Practise your mindfulness skills: be open to and interested in your experience. That way, you'll find it stimulating, satisfying and invigorating, even during those times when the going gets tough.

## Chapter 28

### FINDING FULFILMENT

In western society we tend to lead a goal-focused life. Life is all about achievement, and success is usually defined in terms of status, wealth and power. Typically, we aren't that closely connected with our values and, because of that, we can easily get caught up in goals that are not truly meaningful to us. For instance, we can get so caught up in earning money or furthering our careers that we neglect to spend time with our family—the classic workaholic syndrome.

A more destructive version of the goal-focused life is when our goals centre on avoiding painful thoughts and feelings. As we've already seen, this leads to major suffering in the form of addictions, self-defeating behaviours and increasing remoteness from what we really want.

That's why, in ACT, we advocate a values-focused life. Yes, we set goals, because goals are essential to a fulfilling, rewarding life—but we set them guided by our values. This means the goals we pursue are a lot more personally meaningful. And life itself becomes much more rewarding. We live more in the present and we appreciate what we have. So even as we move toward our goals, we find a deep satisfaction in life as it is right now.

To make this distinction clearer, consider the following story. A mother decides to take her two kids to a fantastic zoo, which happens to be a good two hours' drive away. One kid has only one aim: to get to the zoo as fast as possible. All the way there he's sitting on the edge of his seat, in a state of constant frustration, every few minutes whining, 'Are we there, yet?', 'I'm bored', 'How much longer?' The second kid, however, has two aims: to get to the zoo as fast as possible *and* to appreciate the journey. So this second kid is looking out the window, noticing all the fields full of cows and sheep, watching in fascination at the giant trucks zooming past, waving out of the window at friendly pedestrians. He's not frustrated, not whining and not miserable. He's living in the moment, appreciating where he is, rather than focusing on where he's not.

Now if the car breaks down halfway and the kids never reach the zoo, then which child has had the most rewarding journey? And if the car does make it to the zoo, obviously both kids will have a great reward—but still, only one of them has enjoyed the journey.

The values-focused life will always be more fulfilling than the goal-focused life because you get to appreciate the journey even as you're working towards your goals. What's more, in a values-focused life, you're likelier to achieve your goals. Why? Because if you make sure that your goals are in line with your values, then you'll be more motivated to pursue them.

### Abundance

Connecting with your values and acting on them gives you a sense of contentment, fulfilment and abundance because living by your values gives you satisfaction *right now*. For instance, suppose you really want to buy a house. Buying a house is a goal (that is, something that can be achieved and 'crossed off the list'). But suppose that because of your current finances it will be a long time before you can actually buy that house. If you believe you can't be happy until you've achieved that goal, life will be pretty miserable.

Ask yourself: 'What's this goal in the service of? What will it enable me to do that's truly meaningful?' If the answer is, 'To provide security for my family', then you've identified a core value: taking good care of your family. And taking care of your family is something you can do right now, in a hundred and one different ways. For example, you can cook a healthy dinner, read a story to your kids, or give your partner a hug and some words of support.

This doesn't mean you give up on your goals. If you want to buy a house, start saving! But you don't have to wait until you buy that house to have the satisfaction of caring for your family.

Let's take another example. Suppose you have the long-term goal of being a doctor. The training will take some time and I'd hate for you to spend ten years of your life doggedly focused on that goal, thinking you can't be happy until you've achieved it. Now, ask yourself: 'What is this goal in the service of? What will it enable me to do that's truly meaningful?'

Let's say you answered, 'I'd be able to help people.' Now you've identified a core value: helping others. And helping others is something you can do right now, in a myriad of ways: you can visit an elderly relative, contribute money to a worthy cause, help a fellow student with their homework or even do some volunteer work.

This doesn't mean you give up your goal of becoming a doctor. What it means is, for the next ten years, while you're working toward that goal, you have the ongoing satisfaction of living by your values—in this case, helping people.

'But suppose my motivation isn't helping people', you may be saying. 'Suppose I just want to get rich.' Well, for starters, being rich is a goal, not a value. It's a goal because it can be achieved and crossed off the list. But to answer this question more fully, here's a transcript of a session I had with Jeff. Jeff was a businessman in his mid-thirties, making a reasonable living but obsessed with earning more. He was making himself miserable by constantly focusing on all the people he knew who were richer than he was. I asked Jeff, 'What do you really want?'

**Jeff:** To be absolutely honest, I want to be stinking rich.

**Russ:** Fair enough. If you were stinking rich, what would that enable you to do?

**Jeff:** Lots of things.

**Russ:** Such as?

**Jeff:** Travel around the world.

**Russ:** What would you do on your travels?

**Jeff:** I'd laze around on beaches ... explore exotic countries ... visit the wonders of the world.

**Russ:** Okay. What do you value about lazing around on beaches?

**Jeff:** It's relaxing. It's a great way to chill out.

**Russ:** And what do you value about visiting exotic countries?

**Jeff:** Meeting new people, tasting new cuisines, discovering exotic arts and crafts.

**Russ:** Okay. Now, I want to be clear on this. I'm not for a moment suggesting that you give up on your goal. If you want to be rich, by all means, go for it. But I'd hate to see you spend the next ten years feeling miserable because you think you have to be rich before you can find fulfilment. See, you identified 'relaxing' and 'chilling out' as activities you value. Well, there's a zillion different ways you can relax and chill out right now, and you don't have to be rich. You could have a hot bath, listen to some music, do yoga...

**Jeff:** Yeah, but I really do like lazing on beaches.

**Russ:** Absolutely. And so it makes sense to save up your money and plan a beach holiday. But you don't have to wait until you're rich to have the satisfaction of relaxing—that's something you can do every day. And it's the same for those other values. For example, if you value tasting exotic cuisine, how could you do that right now?

**Jeff:** I guess I could try some ethnic restaurants.

**Russ:** Yeah, or some ethnic cookbooks.

**Jeff:** Yes, but that's not the same as eating the local food in a foreign country.

**Russ:** I'm not suggesting that it is. I'm just pointing out that if you truly value eating exotic food, you don't have to wait until you're rich enough to travel the world. And the same goes for discovering little-known arts and crafts. If you wanted to do that right now, what could you do?

**Jeff:** Go to art galleries?

**Russ:** Exactly. Or visit museums or local arts-and-crafts fairs. Or you could read about it or research it on the Internet.

**Jeff:** Yeah, but that's not the same as—

**Russ:** I know. And again, if you want to travel overseas, then it makes sense to save money and plan for it. All I'm saying is, if you value relaxing, eating different foods and learning about unusual arts and crafts, you can do all these things right now. You don't have to go through life desperately wanting. Now, let's come back to your goal of being rich. Why else is that important?

**Jeff:** Because people look up to you when you're rich.

**Russ:** Well, I don't know if that's always the case, but let's assume you're right. What's so important about having people look up to you?

**Jeff:** They treat you better. They respect you.

**Russ:** So let's suppose that people treated you well and respected you and looked up to you. What would that enable you to do?

**Jeff:** I guess I'd be more at ease. I wouldn't have to try and impress anyone. I could just be myself.

**Russ:** So what you really value is being yourself? Being genuine?

**Jeff:** Yeah. I just want to be me.

**Russ:** Okay. So can you be genuine right now? Do you have to wait until you're rich?

**Jeff:** It's easier if you're rich.

**Russ:** Maybe so. But are you going to wait until you're rich before you give yourself the satisfaction of being genuine?

**Jeff:** What if I'm genuine and people don't like me?

**Russ:** Do you want to spend your life building friendships with people who only like you because you're rich?

**Jeff:** No.

**Russ:** What sort of friendships do you want to build?

**Jeff:** Ones where I can be myself; where I can be accepted for who I am.

**Russ:** Okay. So if you value being genuine, why not start right now in the relationships you already have? Ask yourself: 'What's one small thing I could say or do that would be truer to the real me?'

As you can see, Jeff was quite convinced that he needed to be rich before he could find satisfaction in life. But over time, as Jeff chose increasingly to live by his values, he found a deep sense of fulfilment—even as he pursued his financial and business goals.

## **Riches, Fame And Success**

Jeff's case is hardly unique. Many people want to be rich, famous and successful. Yet these things are goals, not values. To get to the values underlying a goal, you need to ask yourself: 'What's this goal in the service of? What will it enable me to do that's truly meaningful?'

As in Jeff's case, you may need to ask this question several times over to get to the underlying value. There may be many motivating factors underlying the desire for fame, wealth and success. One particularly common motivation is to have others look up to you, admire you, respect you. And why is this important? Because, as Jeff put it, then you wouldn't have to try to impress anyone. You'd have much less fear of rejection. And that would then allow you to 'be yourself'.

Most of us go through life too scared to let others see who we really are. We're ruled by the thought: 'They won't like me if they know what I'm really like.' The cost of this is enormous: we end up disconnected from the people around us and our relationships lack intimacy, depth and openness. We end up going through life wearing a mask, trying to hide who we are—putting on a show in order to win approval, love or friendship. Why does this happen? Simple: because we've fused with the 'I'm not good enough' story. Our minds tell us we have to be rich or famous or successful to compensate for our shortcomings; that only then will we be accepted, liked and loved. And, foolishly, we believe them!

So if being genuine and open is what you value, why wait until you're rich, famous or successful? Why not start being more yourself *today*? Let people start to know you. Be real. Be authentic. Be open. Ask yourself: 'What's one small thing I could say or do that would be more consistent with the real me?'

As with acting on any value, always start with small, short-term goals. For example, in a conversation or group discussion, you might express your genuine opinion rather than an insincere one designed to win approval. Or you might share a bit more about what's really happening in your life, instead of pretending that everything's perfectly all right. (Of course, you'll have to defuse the 'They Won't Like Me/Respect Me/Approve of Me' stories.)

## Other Motivations

Needless to say, there are plenty of other motivations for becoming rich, famous or successful. But if you work through them as I did with Jeff, you'll eventually get down to core values—which you can live by right now. For example, you might say, 'If I were rich, I could buy a helicopter and learn to fly it.' The values underlying this may be about learning new skills, personal development, having fun or facing your fears. All these are values you can live by, right here and now, without being rich or owning a helicopter.

Let's return to Soula, whose major goal was to find a loving partner. You'll recall that she set herself some smaller goals, including joining a dating agency and going on some blind dates. These were important steps, to be sure. But as long as Soula believed that life could not be fulfilling without a partner, she was setting herself up for a lot of unnecessary suffering. So I asked her to connect with the values underlying that goal. As a partner, Soula valued being loving, caring, open, sensual and fun. I pointed out to her that although she didn't have a partner right now, she could still act on those values in other domains of her life.

'But that's not the same as having a partner,' she said.

'Absolutely right,' I replied. 'But which helps you to lead a fuller life: living by your values here and now, or making yourself miserable by constantly focusing on a goal you haven't achieved yet?'

Soula got the point. She started to be more loving and caring toward her family, and more open and fun-loving with her friends and co-workers. She also chose to be more sensual with herself—having regular massages, taking soothing hot baths and enjoying erotic literature. And the result? Life became far more satisfying, even though she hadn't yet achieved her major goal.

## **What If You Do Achieve That Goal?**

The truth is, no matter how many goals you achieve, there will always be something else you want. You know what it's like. You get that fabulous new job and it's all very exciting, but how long before the novelty wears off? How long before you're yearning for something new? Or you get that pay rise and you love having all that extra money, but how long before you take it for granted and want more? Or perhaps you meet the partner of your dreams and fall madly in love, but how long before you start noticing that your dream lover snores or wears the same socks three days in a row?

If you're living a goal-focused life, then no matter what you have, it's never enough. Not so with the values-focused life, because your values are always available to you, no matter what your circumstance. (Remember Viktor Frankl, who lived by his values while stuck in a Nazi concentration camp.)

So if you're feeling miserable because you haven't yet achieved a particular goal, here's what to do. First find the values underlying your goal and then ask yourself, 'What's a small action I can take right now that's consistent with those values?' Next go ahead and take action (and do it mindfully).

Your values are always with you; always available. And acting faithfully to them is usually deeply rewarding. So the more you embrace your values, the greater your sense of fulfilment and in the next chapter we'll learn how to take this attitude even deeper.

## Chapter 29

### A LIFE OF PLENTY

Have you ever gazed in wonder at a brilliant sunset or an impossibly large full moon or the ocean waves crashing against a rocky shore? Ever looked adoringly into the eyes of your child or your partner? Revelled in the aroma of baking pies or the fragrant scent of jasmine or roses? Listened in delight to a singing bird or a purring cat or the laughter of a small child?

So far in this book, we've spent a lot of time on handling unpleasant thoughts and feelings, but precious little on enhancing the positive ones. This is deliberate. Our whole society, and the self-help movement in particular, is so focused on creating positive feelings that this focus itself has become a major component of the happiness trap. The more your life is focused on having pleasant feelings, the more you'll struggle against the uncomfortable ones, creating and intensifying the whole vicious cycle of struggle and suffering.

But as a beneficial byproduct of creating a meaningful life, all sorts of positive experiences and emotions will happen. So it only makes sense to appreciate these things to the fullest while avoiding the trap of making them your main goal in life. Every day is a wealth of opportunities to appreciate the world we live in. Practising your mindfulness skills will help you make the most of your life right now, even as you take action to change it for the better. We have always had expressions like, 'Count your blessings' and 'Stop and smell the roses.' These sayings point to the abundance in our lives. We are surrounded by wonderful things, but sadly, we usually take them for granted. So here are a few suggestions for waking up and experiencing the richness of the world around you:

- When you eat something, take the opportunity to savour it, to fully taste it. Let your thoughts come and go and focus on the sensations in your mouth. Most of the time when we eat and drink, we're scarcely aware of what we're doing. Given that eating is a pleasurable activity, why not take the time to appreciate it fully? Instead of wolfing your food down, eat it slowly—actually chew it. (After all, you wouldn't watch a video on fast-forward, so why eat your food that way?)
- Next time it's raining, pay attention to the sound of it: the rhythm, the pitch, the ebb and flow of the volume. And take a look at the raindrops trickling down the windows. Notice the patterns they make and the way they catch the light. And when the rain stops, go for a walk and notice the freshness of the air, the way the wet leaves sparkle and the way the sidewalks glisten as if they'd been polished. Better yet, put on rain gear or grab an umbrella and go for a walk during the rain and notice what it's like to be warm and dry and secure in the midst of that cold, wet downpour.
- Next time it's sunny, take a few moments to appreciate the warmth and the light. Notice how everything brightens: houses, flowers, trees, the sky, people. Go for a walk, listen to the birds and notice how the sun feels against your skin.
- When you hug or kiss someone—or even shake hands—fully engage in it. Notice what you can feel. Let your warmth and openness flow through that contact.
- Next time you're feeling happy or calm or joyful or content or some other pleasant emotion, take the opportunity to fully notice what that feels like. Notice what you feel in your body. Notice how you're breathing, talking or gesturing. Notice any urges, thoughts, memories, sensations and images. Take a few moments to really drink in this emotion; to marvel that you are capable of having such experiences.

- Look with new eyes at the people you care about, as if you'd never seen them before. Do this with your spouse or partner, friends, family, children, co-workers, colleagues. Notice how they walk, talk, eat and drink, and gesture with their faces, bodies and hands. Notice their facial expressions. Notice the lines of their faces and the colour of their eyes. Notice the way they smile: how their mouth moves, how their eyes twinkle. Notice the way they laugh: the sounds they make, the facial changes, the shoulder movements.
- Next time you see an animal, whether it's a family pet, a cat on a wall or a bird in a tree, take a moment to stop and fully observe it. Look at it as if you were a young child who still doesn't even know the name or nature of this animal. Notice its structure and its movements, its colours and contours, its face and its body.
- Once a day examine some familiar object that you normally take for granted, such as a penknife, a glass of water, a pen, a book, a shirt or a shoe, a vacuum cleaner, a wedding ring, a window frame—literally *anything*. Study it as if it were an alien artefact that had just dropped out of a passing UFO. Notice what you can see and touch (and smell and hear and taste, if appropriate). Take a moment to appreciate the role this object plays in your life.
- Before you get out of bed in the morning, take ten deep breaths and focus on the movement of your lungs. Cultivate a sense of wonder that you are alive, that your lungs have provided you with oxygen all night long, even while you were fast asleep.

As you connect with your values and act in accordance with them, you're likely to notice changes in the people around you. The more you act like the person you want to be with your partner, children, friends, family and co-workers, the more you'll notice their positive responses toward you. Enjoy those responses; be mindful of them and notice what is happening and appreciate it.

When you act with openness, kindness and acceptance, the chances are, you'll receive the same in return. (And if you don't, you may have to make some choices about what sort of people you spend your time with.) So as your relationships improve, make the most of them. Savour those positive interactions. Make sure you're present. Catch yourself drifting off into the land of thoughts and bring your attention back to whomever you're with.

A great job, a loving partner, a home of your own: all these are goals. As you work toward them, connect with the values underlying them. Notice that you're living by those values and appreciate the satisfaction this brings.

If your values include sharing and connecting, then as well as *noticing* the abundance in your life, talk about it with others. Most of us tend to talk far more about the negative aspects of our lives than the positives. Let people know what you appreciate—about them, about life, about yourself. (This doesn't mean go around with a fake smile, pretending to be happy all the time. It means be genuine, open and balanced. Share the difficult things in your life and the rewarding parts!) And make sure to let people know what they mean to you—what you appreciate about them and what you're grateful for.

When you achieve goals that are in line with your values, there's often a pleasant emotion of some sort. Notice how it feels and enjoy it. Even tiny, easy goals can give great satisfaction when achieved. For example, I feel enormous satisfaction when I tidy my desktop, cook a healthy dinner or send a brief email to an overseas relative. So appreciate and savour those feelings. It's all too easy to miss them when the thinking self tries to distract you with 'not good enough' stories.

## It's All About Connection

The more you open your eyes and notice the things you've taken for granted, and the more you live by what you value while appreciating what you have, the richer, fuller and more meaningful your life becomes. Mindfulness skills help you cultivate an attitude of openness, interest and receptiveness toward the world around you. This attitude in itself will make life more rewarding. You'll notice more opportunities, you'll be more stimulated and interested, you'll find more contentment and your relationships will improve. I like to put it like this: Life gives most to those who make the most out of what life gives.

And now, after all that focus on positive emotion, it's time for another reminder: don't get too attached to pleasant feelings. Don't centre your life on chasing them. Pleasant feelings will come and they will go, just like every other feeling you've ever had in your life. So allow them to happen spontaneously, while you focus on living by your values. Enjoy them and appreciate them when they come along, but don't cling to them! As with all emotions, just make room for them and let them come and go as they please.

At times mindfulness is easy and at times it's incredibly hard. In fact, one of the hardest things about mindfulness is *remembering* to practise it. Steven Hayes likens it to riding a bicycle. When you're on a bike, you're always about to fall over; you're always catching yourself, continually adjusting your balance. So it is with mindfulness. No matter how deeply connected we are with our here-and-now experience, our thoughts will continually pull us out of it. We have to keep catching ourselves—realising our mind has pulled us off-balance yet again. (And remember how hard it was to balance, when you first started learning to ride that bike? And how it got easier over time?)

Life is like climbing a mountain: there are easy stretches and tough ones. But if you're open and interested in your experience, then the obstacles you encounter will help you to learn, grow and develop, so that as time goes on, your climbing skills improve. Naturally, it's far easier to be mindful when the going is easy, than when it gets tough. Yet the more you face your difficulties with mindfulness, the more you'll find you grow stronger, calmer and wiser. This is easier said than done, but you can do it. Especially once you've read the next chapter.

## Chapter 30

### FACING FEAR

How's it all going? Are you taking action? Making some meaningful changes in your life? If not, you've probably come up against at least one of the four major obstacles to change. These obstacles are so universal, they even form their own acronym—FEAR:

Fusion with unhelpful thoughts.

Expectations that are unrealistic.

Avoidance of uncomfortable feelings.

Remoteness from your values.

Let's take a look at these obstacles one by one.

#### F: Fusion With Unhelpful Thoughts

By now you're well familiar with cognitive fusion. As soon as you start setting goals, *Radio Doom and Gloom* will start to broadcast, 'I can't do it', 'It's too hard', 'I'm wasting my time', 'There's no point in trying' and a whole play list of other golden oldies.

The solution is to use your defusion skills: see these thoughts for what they are (just words), let them come and go, and return your focus to taking effective action.

#### E: Expectations That Are Unrealistic

Unrealistic expectations can create a major roadblock. If your goals are too ambitious or there are too many of them, you'll feel overwhelmed and will probably give up (or at least put it off for another day).

If this has happened to you, the solution is to break your goals down into smaller bites. Ask yourself: 'What's the smallest, easiest step I could take that would bring me a little closer to achieving this goal?' Then do it.

Once you've taken that step, ask the same question: 'What's the next small, easy step that would bring me a little bit closer to my goal?' (It's like that old joke: How do you eat an elephant? One mouthful at a time!)

Here are two other common unrealistic expectations:

- too-short time frames for results
- the need to be perfect, to make no mistakes.

The solution for any unrealistic expectation is simple: make it more realistic. If your time frame is unrealistic, extend it, and meanwhile break down your large goal into smaller bites. And as for making mistakes, that's a fundamental part of being human. Almost every activity you take for granted today—reading, talking, walking, riding a bicycle—was once hard to do. (Think how many times a baby falls on its bottom while learning to walk.) But the point is, you learned by making mistakes. You learned what not to do and you learned how to do it differently, so you became more effective. Making mistakes is an essential part of learning, so embrace it. Let go of aiming for perfection—it's much more satisfying and fulfilling to be human.

## A: Avoidance Of Uncomfortable Feelings

The more you try to avoid unpleasant feelings, the harder it will be to make important changes. Change involves risk. It requires facing your fears, stepping out of your comfort zone—all of which points to one thing: change will usually give rise to uncomfortable feelings.

By now you're well aware of the whole vicious cycle that results when we try to avoid discomfort. The only effective solution is true acceptance (not tolerance or 'putting up with it'). Therefore, practise your expansion skills, make room for your discomfort and focus on taking effective action.

Of course, setting and working toward goals will not only create discomfort. It will often generate pleasant feelings, too, such as excitement and curiosity and the pleasure and satisfaction you'll feel when you finally achieve those goals. But you can't have the pleasant feelings if you're not first willing to face the discomfort.

## R: Remoteness From Your Values

It's not enough to clarify your values—you need to connect with them. You need to know what's important in your heart and remind yourself on a regular basis. And you need to make sure your goals are in line with those values. Doing this will provide you with motivation, inspiration and meaning.

But if you're remote from your values, it's all too easy to lose heart, give up or get side-tracked. The more remote you are from your deepest values, the more your goals seem pointless, meaningless or insignificant. Obviously, this doesn't do much for motivation.

The solution? Connect with your values. If you haven't already done so, write them down. Read them through and change them as required. Share them with someone you trust. Re-read them on a regular basis. First thing in the morning, mentally go over them. At the end of each week, take a few minutes to check in with yourself and ask: 'How true have I been to my values?'

## Back To Fusion

So that's FEAR: fusion, expectations, avoidance and remoteness. And of these four obstacles, fusion is probably the most common. When we fuse with unhelpful thoughts, the demons on our boat grow bigger and nastier. And the scariest of all these demons is called, 'You will fail!', which usually hangs around with several of his pals, 'There's no point in trying', 'You're wasting your time' and 'Look at all the times you failed in the past.'

If we take these demons seriously and give them our full attention, our boat is doomed to drifting out at sea. So when they appear, it's helpful to remember this quote by Henry James: 'Until you try, you don't know what you can't do.' In setting goals for ourselves, we're talking about what is possible, not what is certain. There's very little certainty in this world. You can't even be certain that you'll still be alive tomorrow. So none of us can ever be certain that we'll achieve our goals. But what we can be certain of is this: if we don't even attempt to achieve them, there's no possibility of success.

Kelly Wilson uses the table below (inspired by the philosopher Blaise Pascal) to help people face the 'I will fail' demon. (Table 30.1)

	Success IS possible	Success is NOT possible
Assume 'Yes, I can achieve this goal!' and move in a	1	2

valued direction towards it.		
Assume ‘No, I can’t achieve this goal!’ and don’t even start moving in that direction.	3	4

Table 30.1

On the top row of this table are two headings: ‘Success IS possible’ and ‘Success is NOT possible’. ‘Success IS possible’ means that the universe is structured in such a way that if you apply yourself fully to achieving your valued goal, you will be successful. ‘Success is NOT possible’ means that the universe is structured in such a way that no matter how hard you apply yourself to achieving your valued goal, you will not be successful.

As we move in a valued direction toward our goals, we can never know which of these two conditions applies because we have no way of accurately predicting the future. (Your mind likes to think it knows, but it doesn’t. Let’s face it: if your mind could predict the future with absolute certainty, you’d be a very wealthy and powerful person by now.)

Down the side of the table are two statements: Assume ‘Yes, I can achieve this goal!’ and move in a valued direction towards it (in other words, assume success is possible and give it your best shot); Assume ‘No, I can’t achieve this goal!’ and don’t even start moving in that direction (in other words, assume the worst, and give up before you even start).

There are four possible outcomes, as shown below: (Table 30.2)

	Success IS possible	Success is NOT possible
Assume ‘Yes, I can achieve this goal!’ and move in a valued direction towards it.	1 An exciting journey as you move in a valued direction. Along the way you develop new skills and experience personal growth. Then you achieve your goal and feel absolutely fantastic!	2 A rewarding journey as you move in a valued direction. Along the way you develop new skills and experience personal growth. You feel disappointed that you did not achieve your goal, but you have the satisfaction of knowing you gave it your best shot.
Assume ‘No, I can’t achieve this goal!’ and don’t even start moving in that direction.	3 No exciting journey! No new skills! No personal growth! No goals achieved! And if you later discover that you would have been successful if you’d tried, you feel absolutely terrible!	4 No exciting journey! No new skills! No personal growth! No goals achieved! All you get is the booby prize: you saved yourself from the disappointment of failure.

Table 30.2

The outcomes depicted result from the choices you make. In quadrant 1, you go on an adventurous journey, learn new skills as you face your challenges, experience powerful personal growth in the process and on top of all that, you attempt your goal and you’re successful. Life is wonderful!

In quadrant 2, you attempt your goal and you’re ultimately unsuccessful. Naturally you feel disappointed, but at least there is the satisfaction of knowing you tried. Years later you won’t be tormenting yourself thinking, ‘If only I’d given it a go...’ Instead, you can look back with pride and say, ‘Hey, I gave it my best shot!’ Moreover, you can appreciate the journey, even if you don’t reach your destination. You can appreciate the process of connecting with and acting on your values and the personal growth that comes from facing your fears. And you can appreciate that you spent your time on an adventure: heading toward shore instead of just aimlessly drifting out at sea.

In quadrant 3, you don’t even try to reach your goal. So no adventurous journey, no new skills, no personal growth from facing your fears. And then suppose you find out later that if you *had* really applied yourself, you would have succeeded. At that point, imagine how terrible you’d feel: a

painful sense of loss and of missing out. *If only I'd tried!*

In quadrant 4, you give up on your goal without even trying and then you later find out that even if you had really applied yourself, you still would have failed. Once again, you have had no exciting journey, no personal growth. And you have not achieved your valued goal. Your only satisfaction is that you saved yourself from the disappointment of failure. This is the booby prize: you don't get what you want, but at least you didn't fail. (Or the other booby prize: you proved yourself right, that you really couldn't do it!) You then try to console yourself with, 'At least I didn't waste my time trying.' But it's empty consolation. Why? Because you spent all that time miserably drifting out at sea when you could have been heading toward shore on an exciting adventure.

Based on these four possible outcomes, which seems the best bet: to attempt your goal or to give up on it without even trying?

If you give it a go, in the best-case scenario you will feel fantastic. In the worst-case scenario you'll feel disappointed, but with the satisfaction that you gave it a go, you took on a meaningful journey, and you experienced personal growth.

If you don't even try, at best you will still feel disappointed, and at worst you will feel absolutely terrible—and there's no personal growth.

Of course, your mind will not be swayed by this logic for long. The 'give up' story will appear again and again. Therefore, again and again, you will need to detect and defuse it.

Your mind will also tell you lots of 'what if?' stories. 'What if I try and I fail?' 'What if I invest all that time and energy and money and it all amounts to nothing?' 'What if I make a fool of myself?' If you let yourself get hooked in by these stories, you can easily waste endless hours debating with yourself instead of taking action. So acknowledge the stories, thank your mind and let them come and go, then choose actions that are aligned with your values. Make your choices based on what you *truly care about* instead of on keeping the demons below deck. And especially be alert for a type of unhelpful thinking known as reason-giving.

## Reason-giving

The mind is very good at coming up with reasons for not doing the things we really want to do. Take physical exercise. In most western countries, over 40 per cent of the adult population is overweight or obese, and in the United States alone it's over 50 per cent. Yet almost all of us, deep down inside, value our health. Sure, many of us neglect our health (some of us much of the time), but that doesn't mean we don't value it. It just means we're not taking action. To clarify this, ask yourself: 'Which would I prefer: a healthy body or an unhealthy one?'

The fact is, most of us would prefer to eat healthier and exercise more. So why don't we? Well, part of the explanation is that our mind is a genius at giving us reasons not to: 'I don't have enough time today/this week/this month', 'I'm too tired', 'I can't be bothered', 'I hate exercise', 'It's too cold outside.'

The first thing to realise is that reasons are just thoughts. The second thing is that thoughts do not *control* your behaviour. Does that sound surprising to you? Well, check your own experience. How often have you had the thought 'I can't do this!' and then gone ahead and done it? How often have you thought 'Yes, I am going to do this!' and then not followed through on it? How often have you *thought about* taking hurtful, harmful, hostile or self-defeating actions but not actually done so? (It's just as well that thoughts don't control our behaviour otherwise most of us would be in prison, laid up in the hospital or dead.)

To demonstrate conclusively that thoughts do not control your behaviour, do these two exercises:

1. Think to yourself, 'I can't scratch my head! I can't scratch my head!' and as you do, lift your

arm and scratch your head.

2. Think to yourself, ‘I have to close this book! I have to close this book!’ and as you do, keep the book open.

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How’d you go? No doubt you found that you could take those actions even though your thoughts said you couldn’t. Of course, thoughts can *influence* your behaviour, even though they can’t *control* it. And the greater the degree of fusion with a thought, the greater the influence it will have on your behaviour.

This means that reasons are not a problem unless we fuse with them; that is, take them as the literal truth, or treat them as commands we must obey. Therefore, it’s important to realise that reasons are not facts.

Here’s an example of a reason: ‘I can’t go for a run because I’m too tired.’ But does being tired make you physically unable to run? Of course not. You can feel tired and still go for a run. (In fact, ask any athlete—they’ll tell you that sometimes they can feel tired or sluggish and end up having one of their best workouts.)

Here’s an example of a fact: ‘I can’t go for a run because a spinal injury has completely paralysed my legs.’ Does spinal paralysis of the legs make it physically impossible to run? Yes. So the above statement is a fact.

Reasons are basically just excuses; things we say to justify what we do (or don’t do). Can you feel as though you don’t have enough time and still exercise? Can you feel tired and still exercise? Can you feel as though you can’t be bothered and still exercise? Can you hate exercise and still exercise? Can you notice that it’s cold outside and still exercise?

Obviously, the answer to all these questions is yes. The reasons given are all just excuses for not doing exercise.

As soon as you have to face any sort of challenge, your mind will come up with a whole list of reasons not to do it: ‘I’m too tired’, ‘It’s too hard’, ‘I’ll only fail’, ‘It’s too expensive’, ‘It’ll take too long’, ‘I’m too depressed’ etc. And that’s okay, as long as we see these reasons for what they are: excuses.

## How Do You Tell An Excuse From A Fact?

Often we know full well when we’re making excuses—we just need to be honest with ourselves. But if you’ve set a valued goal and your mind gives you a reason not to attempt it, sometimes it’s not so clear that this is just an excuse. So if you’re genuinely unsure whether the thought is merely an excuse for inaction or a statement of fact about something that truly is impossible, just ask yourself this question: ‘If the person you care about more than anyone else in the world were kidnapped, and the kidnappers told you they will never release that person until you take a particular action toward your goals, would you then take action?’ If the answer is yes, then you know that any reason (for not taking that action) is merely an excuse.

‘Ah, yes,’ you may be saying, ‘but that’s just a silly hypothetical question. In the real world, the person I love has not been kidnapped.’

Right you are. But what’s at stake in the real world is something equally important: your life! Do you want to live a life in which you do the things that are really meaningful to you? Or do you want to live a life of drifting aimlessly, letting your demons run the ship?

‘Okay’, I hear you say. ‘I agree that I could attempt this goal, but it’s not that important to me.’

The question here is, are you being honest with yourself? Or are you just buying into another thought? If the goal you’re avoiding is *truly* unimportant to you, fine, don’t attempt it. But make sure you check in with your values. And if this goal really *is* something you value, then you are faced with a choice: either act in accordance with what you value or let yourself be pushed around by your own thoughts.

In particular, you need to watch out for this sneaky thought: ‘If this were really so important to me, I’d be doing it already!’ This thought is just another ‘reason’ in disguise. The reasoning goes something like this: ‘I haven’t taken action up to now, which means it can’t really be that important, which means it’s not a true value of mine, which means there’s no point in putting any effort into it.’

This reasoning is based on the false assumption that humans will *naturally* act in line with their values. But if this were true, there’d be no need for a book such as this or a therapy such as ACT. The fact is, many of us *don’t* act on our values for long periods of time: months, years or even decades. But those values are always there deep inside us, no matter how remote from them we are. A value is like your body: even if you’ve totally neglected it for years, it’s still there, it’s still an essential part of your life, and it’s never too late to connect with it.

You may say, ‘But it’s not that easy. These reasons seem so convincing.’

That’s right. They do seem convincing if you fuse with them. So you need to remember, they’re just thoughts. You can then defuse them in a number of different ways:

- You can simply notice them and label them. Each time a reason pops into your head, acknowledge it by silently saying, ‘Reason-giving’.
- You can say to yourself, ‘Thanks mind!'
- You can acknowledge, ‘I’m having the thought “I can’t do this because...”’
- You can ask yourself the kidnap question: ‘If the life of a loved one depended on it, could I attempt this goal, even with all these “reasons” not to?’
- You can name the stories underlying the reasons: ‘Aha! The “too tired” story or the “not enough time” story.’
- You can simply let these thoughts come and go, like passing cars, while you focus your attention on taking action.

## Where To From Here?

This is a key juncture in the book. You know your values, you’ve set some goals; now it’s time to take action. FEAR is usually the only thing that prevents you and now you know how to deal with it. Yet even so, you may still be resisting taking action. So in the next chapter we’re going to look at willingness, a powerful ally in overcoming resistance.

## Chapter 31

### WILLINGNESS

Suppose you're climbing a mountain that has spectacular views from the top. You're halfway up when you come to a really steep slope where the path is narrow and rocky. Right about now it starts pouring with rain. Now you're cold and wet, you're struggling up this steep, slippery track and your legs are getting tired and you're gasping for air. And you start thinking, 'Why didn't anyone tell me it would be this tough?'

At this point you have a choice: you can turn back or keep going. If you keep going, it's not because you want to get colder and wetter and more exhausted—it's because you want the satisfaction of reaching the summit and experiencing those magnificent vistas. You're willing to endure the discomfort not because you *want* it or *enjoy* it, but because it gets between you and where you're going.

### My Lack Of Willingness

I first got permission from Steven Hayes to write this book back in July 2004. But I didn't start writing it until four months later. Why not? Because every time I thought about making a start, I would feel this huge surge of anxiety: a fist-size knot in my stomach, tightness in my chest and an urge to stay as far away as possible from my computer. Thoughts would flow through my head: 'You're wasting your time—you'll never get published', 'You don't even know how to write', 'It'll just be a load of rubbish', 'It's too tough; it'll take too much time', 'You're kidding, right?' (One particularly troublesome thought was indeed a fact: I had already written five books, each of which had taken a huge amount of time and effort and none of which had ever seen print.) Unfortunately, I fused with all those thoughts and avoided all those feelings—and, as a result, I didn't write a word.

Naturally, the more I put off writing, the more dissatisfied I felt. I distracted myself in all kinds of ways: reading, going to movies, eating chocolate. I also tried telling myself, 'There's no hurry. I've got the whole rest of my life to write it.' But my dissatisfaction continued to grow. I was all too aware that my demons were in charge of the boat and I felt like a total hypocrite.

Finally, after four months of growing frustration, I thought to myself, 'You've got all these terrific tools and techniques. You use them with your clients every day and get great results. How about putting into practice what you preach?' So I sat down and wrote, 'What is my goal?' And I answered, 'To write a self-help book based on ACT.' Next, I wrote, 'What are the values underlying my goal?' And I answered, 'The underlying values are: challenging myself; personal growth through facing my fears; helping people (after all, this book could help a lot more people than I ever could through one-on-one therapy); supporting my family (because if this book makes money, my family prospers); modelling for others the principles that I advocate (i.e. practising what I preach); developing my career; and the creativity of the writing process itself.'

Writing all this down made a huge difference. It clarified for me that not only would this book benefit others, it would also benefit me. And even if it never got published, I would learn and grow simply through the act of writing it.

Next I wrote, 'What thoughts, feelings, sensations and urges am I willing to have in order to complete this goal?' This is a very important question, which we need to ask ourselves repeatedly when facing life's challenges. And although we've already discussed it earlier in the book, it's important to really clarify the word 'willingness'. Willingness doesn't mean you like, want, enjoy, desire or approve of something. Willingness means you'll allow it, make room for it or let it be, *in order to do something that you value*.

If I said, ‘How’d you like a course of injections that will make you feel weak and tired for several months, make all your hair fall out and make you vomit repeatedly?’ I’m sure you’d say, ‘No way!’ But if you had cancer and I offered you a course of chemotherapy that could totally cure it, you’d take it willingly and side effects be damned. Why would you put yourself through all that? Not because you like it, want it or approve of it, but in order to keep on doing something that you value: *living*.

Willingness means we make room for the negative side effects, such as unpleasant thoughts and feelings, in order to create a meaningful life. (And this, in turn, gives us plenty of positive side effects.)

But willingness doesn’t mean merely tolerating, gritting our teeth or being able to stand it. It means actively embracing our experience, even though we don’t like it.

Suppose you’re in a loving, committed relationship and your partner wants to invite his or her father over for dinner. And suppose you *intensely dislike* your partner’s father. You dislike his dress sense; you dislike his aftershave; you dislike his opinions and his boastfulness and his arrogance. Yet inviting this man for dinner would mean the world to your partner. If it’s really important for you to support your partner, then you could invite this man over for dinner, greet him warmly at the door, welcome him into your house and make him feel completely at home, even though you intensely dislike him.

That’s willingness.

## **Willingness In Everyday Life**

Willingness is something we practise in small ways every day of our lives. For example, when you go to the movies you’re willing to pay for the ticket. It’s not that you actively want to pay for it. If someone said, ‘Here’s a free ticket’, you wouldn’t say, ‘No, thanks. I really prefer to pay my hard-earned money for that ticket.’ So it’s not that you *like* paying for that ticket. It’s more that you consent to pay for it in the interest of seeing the movie.

Similarly, if you’re going on vacation, you probably don’t *enjoy* packing your suitcases. You don’t *desire* it, but you go ahead and do it in the interest of having a good trip.

And if you’ve ever taken a driving test, you probably didn’t want all that stress, but you consented to it in the interest of getting your licence.

Willingness is essential because it’s the only effective way to deal with life’s obstacles.

Whenever an obstacle presents itself, you can either say yes or no. If you say no, your life gets smaller. If you say yes, your life gets bigger.

If you keep saying yes, there’s no guarantee life will get easier because the next obstacle may be just as difficult or even tougher! But saying yes becomes more of a habit, and the experience you gain from saying yes gives you a reservoir of strength.

Even if you don’t *want* to say yes, you can still *choose* to. And each time you make that choice, you grow as a person.

At the same time, the more you practise expansion, defusion and connection, the less discomfort you actually have to deal with. If you see the thought, ‘You’ll fail’ as only words, it’s a lot easier to accept it. And when you turn OFF that struggle switch, your feelings are a lot easier to live with, because they don’t get amplified.

When the struggle switch is ON, you do whatever you can to avoid, fight with, suppress, change or get rid of uncomfortable feelings. And when it’s OFF, you simply allow them to be. So we could also refer to this switch—with its poles reversed—as ‘the willingness switch’. When the willingness switch is ON, you give your feelings permission to be as they are; and when the switch is OFF, you

fight or avoid them.

## **Willingness Has No Shades of Grey**

Willingness is an all-or-nothing experience, like being pregnant or being alive. Either you're willing or you're not. The switch is either ON or OFF—there's no in-between. (Those 'in-between' positions are variously called tolerance, resignation or giving up.) This all-or-nothing property of willingness is expressed in the ancient eastern saying: 'You can't leap a chasm in two jumps.'

To pursue her goal of finding a partner, Soula joined a commercial dating agency. She was willing to make room for feelings of vulnerability, insecurity, anxiety, and for thoughts like 'I'm wasting my money', 'I'll meet only weirdos and losers' and 'If I do meet anyone nice, they won't like me.' Her willingness enabled her to go on some dates and meet some nice guys.

To spend more quality time with her children, Michelle was willing to have the anxiety of repeatedly saying no to her boss's extra-work demands.

To reclaim her life and put her alcoholism behind her, Donna was willing to grieve for her husband and child—to let her sadness be there—without trying to drink it away.

Kirk was a commercial lawyer who realised, once he had connected with his values, that his work was not meaningful. He had become a lawyer primarily for status and money, and also to win the approval of his parents (who were both lawyers). What he really wanted to do, though, was to help and care for people; especially to help them grow, learn, and develop. Ultimately, he decided to retrain as a psychologist. In order to do this, he was willing to make room for a lot of discomfort: loss in income, many years of extra study, parental disapproval, anxiety over whether he was doing the right thing, thoughts of all the years he had wasted, and so on. The last time I saw Kirk, he'd graduated as a psychologist, and loved the profession. But he'd never have gotten there without willingness to have all that discomfort.

## **My Willingness**

So now let's return to how I wrote this book. As mentioned above, my next step in overcoming my inertia was to write down all the thoughts, feelings, sensations and urges that I would be willing to have, in order to achieve my goal. My thoughts included, 'It's too hard', 'I can't write', 'I'm wasting my time', and 'I'll never get published.' My feelings included anxiety, boredom, and frustration. My sensations included a tightness in my jaw, churning in the stomach, sweaty palms and a racing heart. And last but not least, I had strong urges to run away, play with the dog, go to sleep, get something to eat or drink, read a book, look up words in the dictionary, surf the Internet, watch television, or do anything else except write!

Writing this down was enormously useful because it helped me take a realistic look at the situation: to prepare for the demons I'd be facing on my voyage. That way, no surprises.

Next I wrote, 'Is there any one of these thoughts and feelings (and sensations and urges) that I can't handle, provided I practise expansion, defusion and connection?' And the answer I wrote was: 'No. Provided I defuse these thoughts, make room for these feelings and connect with the action I am taking, then I can handle every one of them.'

The next question was, 'What would be useful to remind myself?' In answer to this, I pulled out a blank card and wrote down four inspiring quotes:

'A journey of a thousand miles begins with one step.'—*Lao-Tse*

'The first draft of anything is shit!'—*Ernest Hemingway*

‘Don’t be afraid to go out on a limb. That’s where the fruit is.’— *H. Jackson Browne*

‘Twenty years from now you will be more disappointed by the things that you didn’t do than by the ones you did do. So throw off the bowlines. Sail away from the safe harbour. Catch the trade winds in your sails. Explore. Dream. Discover.’— *Mark Twain*

Obviously, these quotes apply to any meaningful enterprise, not just writing. I find them both reassuring and inspiring. And ever since that day, I’ve kept that card beside my computer and I frequently re-read it.

Following that, I wrote, ‘How can I break this goal down into smaller steps?’ My answer was: ‘I only need to write one chapter at a time. Actually, I only need to write one paragraph at a time. Come to think of it, I only need to write one sentence at a time.’ Once I realised that I only needed to write one sentence at a time, my anxiety lessened considerably. To write a book, that’s overwhelming. But to write a sentence, that’s a lot easier.

Next I wrote, ‘What’s the smallest, easiest step I can begin with?’ And I answered: ‘Write one sentence.’ Finally I asked, ‘When will I take that first step?’ And I answered: ‘Right now!'

So there and then, I forced myself to start writing. The knot in my stomach was huge. So I studied it as if I were a scientist. It felt like a lump that started just above my waist and reached up underneath my rib cage. There was movement within that lump: a sort of squelching. And also a slight sense of nausea. I observed it for a minute, breathed into it and made room for it. I reminded myself, ‘This is nothing more than an unpleasant sensation, coupled with an urge to run away.’ And I asked myself, ‘Am I willing to have this in order to pursue my goal?’ The answer came back loud and clear: ‘Yes!’

Then I turned my attention to the thoughts swirling around in my head: *Radio Doom and Gloom* playing at full volume. I pictured those thoughts as words on a television screen; I looked at them and saw them for what they were: words and pictures. Then I let them come and go while I focused on my writing.

That was November 2004. Now, as I am writing this sentence, it is eighteen months later and the book is nearly finished. It has taken me many hundreds of hours to write and I’ve had many unpleasant thoughts and feelings during that time. I’ve also had enormous satisfaction from acting in accordance with my values. And I’ve also had plenty of extremely pleasant thoughts and feelings: every time I’ve completed a paragraph, every time I’ve completed a chapter, every time I’ve sat down and written even though I didn’t feel like it.

Of course, I still have no idea whether this book will ever be successful, but no matter what happens, I’ve gained enormously in writing it. I’ve developed my writing skills, learned how to simplify concepts in order to teach them more effectively, developed new ideas to enhance my work, proved to myself that ACT really works (when I apply it, anyway) and had the satisfaction of living by my values. It’s been vastly more fulfilling than the four months I spent avoiding writing.

Now imagine how different it would have been if my only purpose in writing this book was to become rich and famous: there would be no satisfaction or fulfilment until that goal was achieved. And because that particular outcome is so unlikely, if that were my only motivation I probably would have given up long ago.

## The Power Of Black And White

Again and again throughout this book I’ve emphasised the importance of writing: to clarify your thoughts; to aid conscious memory; to enhance motivation. When you set your values and goals down in black and white you’re far likelier to follow through on them. So I recommend that you

write out an action plan, using the format below, to help you achieve any goal that you're currently procrastinating on.

### **The Willingness-and-Action Plan**

My goal is to

[space left intentionally blank in the original book]

The values underlying my goal are

[space left intentionally blank in the original book]

The thoughts, feelings, sensations and urges

[space left intentionally blank in the original book]

I'm willing to have in order to achieve this goal are

[space left intentionally blank in the original book]

It would be useful to remind myself that I can break this goal down into smaller steps, such as

[space left intentionally blank in the original book]

The smallest, easiest step

[space left intentionally blank in the original book]

I can begin with is

[space left intentionally blank in the original book]

The time, day and date that I will take that first step, is

[space left intentionally blank in the original book]

### **Is Willingness Enough?**

As you can see, willingness is tremendously important. But by itself it's not enough for a meaningful life. There's one final piece to this puzzle, a piece that completes the whole picture. So read on...

## **Chapter 32**

### **ONWARD AND UPWARD**

No matter how well you learn to walk, sooner or later you will stumble. Sometimes you'll catch yourself in time and sometimes you'll fall over. Sometimes you may even hurt yourself. The fact is, from the day you took your very first step, you have fallen down many hundreds of times—and yet at no point did you ever give up walking! You always picked yourself up, learned from the experience and carried on. It is this sort of attitude that we are referring to when we use the word 'commitment' in Acceptance and Commitment Therapy. You can accept your internal experience, be psychologically present and connect with your values all you like, but without the commitment to take effective action, you won't create a rich and meaningful life. This, then, is the final piece of the puzzle—the piece that completes the whole picture.

'Commitment', like 'acceptance', is a frequently misunderstood term. Commitment isn't about being perfect, always following through or never going astray. 'Commitment' means that when you do (inevitably) stumble or get off track, you pick yourself up, find your bearings and carry on in the direction you want to go.

This is well exemplified in the legend of the great Scottish hero Robert the Bruce. It's a true story that happened 700 years ago, in a period of history when the king of England ruled over Scotland. The English king was violent and cruel and he brutally oppressed the Scots for many years. But in the year 1306, Robert the Bruce was crowned king of Scotland, and he made it his number one priority to liberate his country. Soon after he took the throne, he raised an army and led it into war against the English, on the blood-soaked battlefield of Strath-Fillan. Unfortunately, the English army had greater numbers and superior weapons, and the Scots were brutally defeated.

Robert the Bruce escaped and went into hiding in a cave. Cold, wet, exhausted and bleeding from his wounds, he felt utterly hopeless. So great was his shame, so crushing his despair, he thought about leaving the country and never returning.

But as he lay there, he looked up and noticed a spider, which was trying to spin a web across a gap in the wall of the cave. This was no easy task. The spider would spin a strand and string it from one side of the gap to the other. Then it would spin another and another, weaving back and forth to build the web. Yet every few minutes a strong gust of wind would blow through the gap, breaking the web and sending the spider tumbling.

But the spider didn't give up. The moment the wind died down, it would crawl back up to the edge of the gap and start spinning again from scratch.

Again and again the wind blew the web apart, and again and again the spider started rebuilding. Eventually, the wind died down long enough for the spider to spin a truly firm foundation, so that the next time the wind kicked up, the web was strong enough to withstand it, and the spider was finally able to finish the job.

Robert the Bruce was amazed by this spider's persistence. He thought, 'If that tiny creature can persist despite all those setbacks, then so can I!' The spider became his personal symbol of inspiration and he coined the famous motto: 'If at first you don't succeed, try, try again.' After his wounds had healed he raised another army and continued to battle against the English for the next eight years, finally defeating them in 1314 at the Battle of Bannockburn—a battle in which his own men were outnumbered ten to one!

Of course, Robert the Bruce didn't know he would succeed at his goal. He only knew that freedom was everything to him. And as long as he pursued that freedom, he was living a life he valued. (And he was therefore *willing* to endure all the hardship that went with it.) Such is the nature of

commitment: you can never know in advance whether you will achieve your goals; all you can do is keep moving forward in a valued direction. The future is not in your control. What is in your control is your ability to continue your journey, step by step, learning and growing as you progress—and getting back on track whenever you wander. In the words of the great leader, Sir Winston Churchill: ‘Success is not final. Failure is not fatal. It is the courage to continue that counts.’

## Making Mistakes

As we have seen, one of the sneakiest demons on that boat of yours is the one known as ‘You must not make mistakes’. This demon has a variety of other guises such as: ‘If you’re going to do this, you’d better do it brilliantly’, and ‘If you can’t do it well, there’s no point in doing it at all.’ When you fuse with such thoughts, they will hold you back from learning new skills or facing meaningful challenges. If, however, you *defuse* them—recognise that they’re only words (or pictures)—then they no longer can get in your way. They’re just mind stuff.

When we make a commitment, it doesn’t mean we won’t ever screw up. Obviously, we try to do our best, but even then we will sometimes get it wrong. (Besides that, is there really a person on this planet who *always* does their best in *everything*?) Making mistakes is part of being human and an *essential* part of any learning process. The only way to avoid it is to do nothing, which is probably the biggest mistake of all. Commitment means we take effective action, allow ourselves the freedom to make mistakes, accept ourselves compassionately when we screw up, and carry on moving in a valued direction.

## Embracing Uncertainty

Not long ago I watched a documentary about Mel Gibson and the making of his film *The Passion of the Christ*. This controversial movie was a graphically violent portrayal of the last twelve hours of the life of Jesus Christ. When Mel tried to interest the major Hollywood studios in the project, they all turned him down. The studios believed the film was doomed to failure, not least because of Mel’s idea that the actors would speak their lines in the ancient languages of Aramaic and Latin. But despite Hollywood’s lack of enthusiasm, Mel was committed to his project—enough so that he financed the entire film out of his own pocket.

Not surprisingly, once he started filming, his anxiety knew no bounds. It was only the third film he had ever directed and all of Hollywood had predicted it would lose money. Every day he would wake up thinking he was making a terrible mistake, that he was crazy, that he didn’t know what he was doing.

But that didn’t stop him. Even though he was racked with doubt, day after day he would make his way to the film set and start directing. Throughout the day he would think he had no idea what he was doing, that the film was a disaster in the making, that he’d lose all his money, that he’d be a laughing-stock.

But he kept on making that film. Day after day he showed up on location and did his job to the best of his ability. He didn’t know what the final outcome would be—that wasn’t in his control. He couldn’t get rid of his doubts, fears and insecurities—they weren’t in his control either. So he focused on what was in his control: his ability to direct the film as well as he could. History tells the rest. Mel finished his film and despite widespread predictions of box-office failure, it was a huge success, earning over \$200 million during its initial release.

The point here is *not* that your dreams will always come true if you persist—although many motivational books claim you can achieve anything you want if you just hang in there. The truth is, sometimes you will and sometimes you won’t. While there’s no doubt that persistence makes achieving your goals *likelier*, this is never guaranteed. For every film that makes a heap of money,

there's another that takes a major loss. The point is that you can feel anxious, uncertain and riddled with self-doubt—and yet, even with those feelings, you can still take action! You may not be able to control your thoughts and feelings, but you can control what you do with your hands and feet! So this is what we mean by commitment: that you keep taking action, under the guidance of your values, no matter what thoughts and feelings may arise on the way.

## Redefining Success

There's a potential danger in telling inspirational stories: Robert the Bruce freeing Scotland from the English; Mel Gibson making a hit film against all odds. The danger is in the way we define success. Whether we're talking of artists, doctors, athletes, businesspeople, rock stars, politicians or police officers, 'successful people' are typically defined in terms of the goals they've achieved. If we buy into this woefully limited definition, then we're condemned to a goal-focused life: chronic frustration and wanting punctuated by fleeting moments of gratification. So I invite you now to consider a new definition: *success in life means living by your values*.

Adopting this definition means you can be successful right now, whether or not you've achieved your major goals. Fulfilment is here, in this moment—anytime you act in line with your values. And you are free from the need for other people's approval. You don't need someone to tell you that you've 'made it'. You don't need someone to confirm that you're 'doing the right thing'. You know when you're acting on your values, and that's enough.

Soula, Donna and the other people we've met in this book weren't heroes of the sort we find in movies. They didn't accomplish awe-inspiring feats or triumph against overwhelming odds. But they were all successful in connecting with their hearts and making meaningful changes in their lives. (Of course, as I've said before, living by your values doesn't mean giving up on your goals; it merely means shifting the emphasis, so life becomes about appreciating what you have now rather than always focusing on what you don't have.)

It's also worth mentioning that every one of the clients I've written about did, on many occasions, go 'off track'. They all lost touch with their values at times, got caught up in unhelpful thoughts, struggled with painful feelings and acted out in self-defeating ways. But because they were committed, sooner or later they always got back on track again.

Take Donna, for example. It took her the best part of a year to recover completely from her alcoholism. There were plenty of times where she stayed off the drink for a few weeks, but then something would trigger another binge: the anniversary of the car crash; the anniversary of the funeral; the first Christmas Day since her husband and daughter had died. Occasions such as these brought up many painful feelings and memories for Donna, and with them came strong urges to drink. At times she 'forgot' all the skills she'd learned in therapy and turned to alcohol to try to escape her pain.

But as time went on, Donna got better and better at catching herself. Her first relapse came on the day of her daughter's birthday. This triggered an entire week of heavy drinking. Her second relapse involved only three days of drinking and her third lasted for just one day.

Donna learned quickly that there's no point in beating yourself up when you screw up or fail to follow through. Guilt trips and self-criticism don't motivate you to make meaningful changes; they just keep you stuck, dwelling on the past, which is something you have no power over. So after each relapse, Donna came back to the basic ACT formula:

Accept your internal experience and be present.

Choose a valued direction.

Take action.

So what does this mean in practice? Well, the first step, once you've gone off track, is to recognise it consciously: to be fully present with what's happening. At the same time, you need to accept that once this has happened, you can't change it; there is no way you can possibly alter the past. And while it may be valuable to reflect on the past and think about what you might do differently next time around, there's no point in dwelling on it and crucifying yourself for being imperfect. So accept that you went off track, accept that it's in the past and is now unchangeable, and accept that you're human and therefore imperfect.

The second step is to ask yourself: 'What do I want to do now? Rather than dwelling on the past, what can I do in the present that's important or meaningful?'

Then the third step is, of course, to take committed action in line with that value.

## Try, Try Again?

'If at first you don't succeed, try, try again' is a powerful motto. But it's still only half the story. The other half of the story is that we must pay careful attention to what we're doing in order to assess whether it's effective. A better motto might be: 'If at first you don't succeed, try, try again; and if it still isn't working, try something different.'

But there's a fine line to tread here, too. Whenever you face a significant challenge, the 'It's too hard!' demons will be on your back. 'You can't do it! Give up!' your mind will tell you. And the temptation then is to quit and try something else. Yet, often persistence is precisely what is required. In the words of Thomas Edison: 'Many of life's failures are people who did not realise how close they were to success when they gave up.' This is where your connection skills come in handy. By paying full attention to what you are doing and noticing the impact it is having, you're in the best position to answer this question: 'In order to most effectively live by my values, do I need to persist with my behaviour or change it?' Then, depending on your answer, commit to either changing that behaviour, or persisting with it.

## An Attitude Of Optimism

As we saw in the last chapter, Soula joined a dating agency and started going out with a variety of different men. At first this was an awkward, embarrassing and nerve-racking process for her. Her mind repeatedly told her she was a 'loser' and that she would only ever meet other losers. But despite these unhelpful stories, Soula persisted and over time she gradually became more comfortable with the process.

Some of her dates were disastrous: the men were boring, arrogant, sexist, egotistical or just generally obnoxious. On the other hand, some of her dates were a lot of fun: the men were witty, charming, intelligent, open-minded and attractive. It was always hit-and-miss. At one point she dated a guy for seven weeks, fell madly in love with him, and then found out he'd been cheating on her. Naturally, she was devastated and, being human, she went off track for a while. For over a month she fell back into her old habits: staying home alone, cutting herself off from friends, dwelling obsessively on her loneliness and eating ice cream by the bucket to 'cheer herself up'. Still, eventually Soula realised what she was doing and she applied the basic ACT formula.

As a first step, she made room for her sadness and her loneliness. She defused from her story that 'life is worthless without a partner' and she chose to connect with the present (instead of stewing pointlessly over the past).

Second, she connected with her values: her desire to cultivate loving, meaningful relationships.

Third, she took effective action: she resumed spending time with friends and family, and she also continued the dating process.

A little while later Soula fell in love with another man, whom she dated for over seven months. Unfortunately, it didn't work out; they split up because Soula wanted to get engaged but he wasn't ready to settle down.

So far, there's no fairytale ending to Soula's story. The last time I saw her, she was still dating. But she was also investing in meaningful, loving relationships with her friends and family and herself—and although this didn't get rid of her desire for a partner, it certainly gave her a lot of satisfaction and fulfilment. What's more, she had developed a sense of humour about the dating game. She had learned to see it as an opportunity to meet new people, discover new social venues and learn more about men! She also used dates as an opportunity to try new activities, from playing miniature golf to riding horses. In other words, the process of dating became a valued activity: a means for personal growth rather than a painful ordeal driven by loneliness.

As we go through life, we encounter all sorts of obstacles, difficulties and challenges, and each time this happens we have a choice: we can embrace the situation as an opportunity to grow, learn and develop; or we can fight, struggle and try whatever we can to avoid it. A stressful job, a physical illness, a failed relationship: all these are opportunities to grow as a person, to develop new and better skills for dealing with life's problems. As Winston Churchill put it: 'A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty.'

ACT is an inherently optimistic approach. ACT assumes that no matter what problems you encounter, you can learn and grow from them; no matter how dire your circumstances, you can always gain fulfilment from living by your values; and no matter how many times you wander off the path, you can always get back on track and start again, right where you are.

## Opportunity

Thomas Edison was perhaps the greatest inventor of all time. He patented over a thousand different inventions, including the first phonograph, the first commercial power station and, most famously, the electric light bulb. From a young age he thirsted for scientific knowledge and this passion kept him actively inventing for his entire lifetime, even after he was famous and incredibly wealthy. One of his most famous quotes is: 'Opportunity is missed by most people because it is dressed in overalls and looks like work.'

We could just as accurately say: 'Opportunity is missed by most people because it is dressed in a monster suit and looks dangerous.' Whatever valued direction you pursue, there will be challenges. These challenges will give rise to anxiety, insecurity, vulnerability or other uncomfortable feelings. It is the willingness to feel that discomfort and to keep moving forward that allows you to make the most of life's opportunities.

It took Thomas Edison and his assistants several years of hard work to make a commercially viable light bulb, and in the process they failed thousands of times. They tried constructing light bulb filaments from many hundreds of different substances, but time after time they burned up, melted down or simply failed to conduct an electric current. One day, after many more failed attempts, one of Edison's assistants complained, 'It's hopeless; we'll never make a light bulb.'

Edison replied, 'Nonsense! We now know more about how not to make a light bulb than anyone else in the world—which brings us closer and closer to making one that works!'

Many hundreds of failed attempts later, Edison finally succeeded—and changed the face of the world as we know it today. Now that's commitment!

Again, the point of this story is not that if you try hard enough you will be rich and famous. The point is, you can appreciate the journey of life, no matter how far you are from your destination. Edison valued the process of scientific discovery and was therefore able to appreciate that each individual experiment furthered his scientific knowledge, *regardless of the results*. Naturally, it was

thrilling when the experiments gave him good results, but he could appreciate the voyage of discovery, even when land was nowhere in sight.

Notice that I said ‘appreciate’ rather than ‘enjoy’. You can *appreciate* an operation that saves your life, but you probably won’t *enjoy* it. Similarly, you can appreciate your life’s journey even when it’s uncomfortable, but it’s unrealistic to expect that you will always enjoy it. As Steven Hayes often points out, there’s as much life in one moment of pain as in one moment of joy. We only truly know this when we practise connection: when we bring our full awareness to our experience right now, with an attitude of openness and interest.

## Choose To Grow

A core theme in this book is that life involves pain. Sooner or later we all experience it—physically, emotionally and psychologically. But in every painful life circumstance there is an opportunity for us to grow. Earlier in the book we encountered Roxy, a 32-year-old lawyer who had been diagnosed with MS (multiple sclerosis). Before her illness, Roxy’s life had been totally focused on work.

Success in her career meant everything and she had indeed done very well for herself, getting promoted to junior partner and earning a huge salary. But she was working an average of 80 to 90 hours a week and was neglecting other important parts of her life: she lived on take-out food, rarely exercised and was always ‘too tired’ to spend time with friends and family. Her relationships with men were typically short-lived and superficial because she never had the time or energy to invest in them. And she rarely found time just to chill out and have fun.

After her diagnosis, Roxy realised that her life was out of balance. Facing the possibility of severe disability or premature death awoke her to the fact that there’s more to life than work and money. She realised that, for every one of us, our time on this planet is limited and she started to think about what was really important, deep in her heart. She realised with a shock that her career was actually not that important to her. So she cut back on her work hours, started spending more time with the people she cared about and began to take care of her health through swimming, yoga and sensible eating.

She also changed the way she related to people at work. She had always been so driven to excel, she’d paid little attention to social niceties in the workplace and, as a result, appeared to her colleagues as closed-off and cold. Facing the possibility that illness might force her to leave the workplace, she realised that this was not how she would like to be remembered. So she started treating her colleagues differently: showing an interest in their lives outside work and opening up, letting them know more about her own life. As she warmed to her colleagues, they in turn warmed to her and she started to make some genuine workplace friendships. Indeed, over time she came to appreciate the social interaction far more than doing the actual work itself.

By embracing the opportunity in her difficulty, Roxy made her life far richer and more meaningful. Of course, she would rather not have had the illness in the first place, but since that was something not in her control, she chose to go down the path of personal growth.

Stories like this are commonplace. I have seen many people face a serious diagnosis—cancer, heart disease, a stroke—and completely re-evaluate their lives as a result. But we don’t have to wait until death is looking us in the eyes; we can commit to making meaningful changes whenever we choose to. And in keeping that commitment, we create a meaningful life.

## Chapter 33

### A MEANINGFUL LIFE

So here we are at last: the final chapter. Hopefully, by this stage you're already well on your way to creating a rich, full and meaningful life. If that's you, carry on; do more of what's working. But if it's not happening, you need to look at why not and what you can do about it. But before we go any further, let's recap the six core principles of ACT:

**Defusion:** Recognising thoughts, images and memories for what they are—just words and pictures—and allowing them to come and go as they please, without fighting them, running from them or giving them more attention than they deserve.

**Expansion:** Making room for feelings, sensations and urges and allowing them to come and go as they please, without fighting them, running from them or giving them undue attention.

**Connection:** Bringing full awareness to your here-and-now experience with openness, interest and receptiveness; focusing on and engaging fully in whatever you're doing.

**The Observing Self:** Recognising that you are not your thoughts, feelings, memories, urges, sensations, images, roles or physical body. These are constantly changing, peripheral aspects of you, but they are not the essence of who you are. Take time to regularly connect with the one part of you which is unchanging, ever-present and impervious to harm: the observing self.

**Values:** Clarifying what is most important in your heart: what sort of person you want to be; what is significant and meaningful to you; what you want to stand for in this life.

**Committed Action:** Taking effective action in line with your values (again and again, no matter how many times you go off track).

These six basic principles are neatly summarised in the basic ACT formula:

Accept your internal experience, and be present.

Choose a valued direction.

Take action.

The more you live by these six core principles, the more fulfilling and rewarding your life will be. But don't believe this just because I say so. Try it out and trust your own experience. If these principles work for you, if they give you a rich, full life, then it makes sense to embrace them as fully as possible.

At the same time, see this as a personal choice. You don't have to live by these principles. There's no obligation, no right or wrong, good or bad. If you embrace these principles, it won't make you a 'good person' or superior to others in any way. And if you ignore them, it won't make you 'bad' or 'inferior'. If you go around thinking you have to live by these principles, it creates a sense of coercion, as if you were being forced to do something you don't really want to do—and that's neither pleasant nor constructive. Such an attitude only gives rise to pressure, stress and anxiety and ultimately leads to failure.

The way you live your life is a personal choice. And while most people find that these six basic

principles will transform their lives in many positive ways, it's important to remember they aren't the Ten Commandments! Apply them if and when you choose to, and always in the interest of making life richer, fuller and more meaningful. But don't make them into rules that must be obeyed absolutely and at all times!

I'm quite sure there will be plenty of times when you 'forget' what you've learned in this book. You'll get caught up in unhelpful thoughts, struggle uselessly with your feelings and act in self-defeating ways. But the instant you recognise what you're doing, you can choose to do something about it—if you want to, that is. Again, this is a personal choice. You don't have to do anything. In fact, I'm sure there will be times that you deliberately choose not to use the principles in this book. And that's okay with me and I hope it is with you, too. Just aim to be more aware of the choices you make and pay attention to the effects they have on your life. The more self-awareness you develop, the likelier you are to make choices that enhance your life, rather than ones that constrict or stagnate it.

## **Feeling Stuck?**

It may be that you've reached this point in the book and still haven't made many (or any) significant changes. If that's what's happening, you've probably come up against one or more components of FEAR:

Fusion with unhelpful thoughts.

Expectations that are unrealistic.

Avoidance of discomfort.

Remoteness from values.

So if you're feeling stuck or you're putting off taking action, take a few moments to identify what's getting in your way and think about how to resolve it.

If you're fusing with unhelpful thoughts like 'It's too hard', 'I can't do it', 'It won't work', 'I can't be bothered', 'I'll do it later', then practise defusion skills.

If your expectations are unrealistic, break your goals down into smaller steps, give yourself more time and allow yourself to make mistakes.

If you're avoiding uncomfortable feelings such as fear or anxiety, practise your expansion skills and develop willingness.

If you're remote from your values, then keep asking yourself: 'What do I really care about?' 'What really matters deep in my heart?' 'What sort of person do I want to be?' 'Deep down inside, what do I really want?'

And if you're not quite sure how to implement these solutions, then go back to the relevant chapters in the book. This book was never intended to be read just once and integrated fully into your life. It's intended to be used as a reference book. As often as you need to, go back to the relevant chapters and read them again. (And if you've read through the book without doing any of the exercises, now's the time to go back and actually do them.)

## **Applying ACT In Different Domains of Life**

In whichever domain of life you feel dissatisfied—whether it's health, work, friends, family, relationships or something else—applying the basic ACT principles will help you transform it.

Whatever you're doing, engage yourself fully in it. Whoever you're with, be present. When unhelpful thoughts arise, defuse them. When unpleasant feelings arise, make room for them. And whatever your values are, be faithful to them.

Using the six core principles of ACT can help you rise to the Serenity Challenge:

*Develop the courage to solve those problems that can be solved, the serenity to accept those problems that can't be solved and the wisdom to know the difference.*

If your problems *can* be solved, then take effective action, guided by your values, to solve them. If your problems *can't* be solved, use defusion, expansion and connection to help you accept this. And the more you practise connection—that is, the more awareness you bring to your experience right now—the more you'll be able to tell which problems are which.

No matter what sort of problematic situation you encounter, there are only ever two sensible courses of action:

1. accept it
2. take effective action to improve it.

If no effective action is possible right now, then the only option is to accept it until you *can* take action.

## **Focus On What's In Your Control**

Whatever you attempt to do, you'll get the best results when you focus on what is in your control (and the worst results when you focus on what's not in your control).

So what *is* in your control? Well, mainly two things: your actions and your attention. You *can* control the actions you take, no matter what your thoughts and feelings may be telling you (as long as you are aware of your internal experience and you focus on what you're doing). And you *can* control how you direct your attention; that is, what you focus on and whether you do so with openness, interest and receptiveness.

Apart from your actions and your attention, you don't have much control over anything else. For example:

- You have little control over your feelings, thoughts, memories, urges and sensations—and the more intense they are, the less control you have.
- You have no control over other people. (You can influence other people, of course, but only through your actions. Therefore, those people are not directly in your control; only your actions are. Even if you were to point a gun at someone's head, you couldn't control them, because they could still choose to die rather than obey you.)
- You have no control over the world around you. (You can interact with and transform the world around you, but only through your actions—your actions are in your control; the world isn't.)

Therefore, it makes sense to put your life's energy mainly into action and attention. Do what you value. Engage yourself fully in what you're doing. And pay attention to the effect your actions are having.

Remember, each time you act in line with your values, no matter how tiny that action is, you're contributing to a rich and meaningful life.

## How Far Have You Come?

The whole purpose of this book is to help you escape from the vicious cycle of the happiness trap—to live a full and meaningful life instead of basing your existence on chasing ‘good’ feelings and avoiding ‘bad’ ones. Of course, in a full human life you will experience the full range of human feelings. You will experience every emotion, from joy and love to fear and anger, and willingly make room for them all.

So how far have you come since you started this book? How often are you still getting caught in the happiness trap—running away from ‘negative’ emotions and desperately striving for ‘positive’ ones? If you really want to know, try this. Turn back to the very end of Chapter 1 and do the Control of Thoughts and Feelings Questionnaire again. Compare your score now with your score when you started the book. If it’s lower, then you’re on the right track. If it’s not, then you’ve still learned something valuable: that although you may have gained some useful ideas from this book, you haven’t yet applied them effectively in your life. (And if that’s the case, there’s no need to worry—it simply means you need to do more practice.)

There’s an ancient eastern saying: ‘If you don’t decide where you’re going, you’ll end up wherever you’re heading.’ To live a meaningful life, you need direction, and your values are there, deep in your heart, to provide it. So connect with those values; use them for guidance. Cultivate a sense of purpose. Keep setting meaningful goals and pursue them vigorously. At the same time, appreciate what you have in your life *right* now. This is important, because now is the only time you ever have. The past doesn’t exist; it’s nothing more than memories in the present. And the future doesn’t exist; it’s nothing more than thoughts and images in the present. The only time you ever have is this moment. So make the most of it. Notice what is happening. Appreciate it in its fullness.

And remember, life gives most to those who make the most out of what life gives.

## **Further Reading**

Frankl, Viktor, 2000, *Man's Search for Meaning*, Beacon Press, Boston.

Hayes, Steven, & Smith, Spencer, 2005, *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy Guide*, New Harbinger Publications, Oakland CA.

Kabat-Zinn, Jon, 1994, *Wherever You Go, There You Are: Mindfulness Meditation In Everyday Life*, Hyperion, New York.

# Resources

Russ Harris has recorded a number of CDs that can be used in conjunction with this book to help you develop mindfulness skills. You can purchase these from: [www.mindfulnessresources.com](http://www.mindfulnessresources.com)

Russ also runs a variety of workshops based on ACT, for health professionals, life coaches, the general public, and the corporate world. If you are a health professional, therapist, or life coach wishing to train in ACT, please visit: [www.actmindfully.com.au](http://www.actmindfully.com.au)

If you are member of the general public, wanting to attend a workshop for personal growth and self-development, please visit: [www.mindfulnessresources.com](http://www.mindfulnessresources.com)

ACT has been proven to be very effective in the workplace for stress reduction and improving emotional intelligence. If your company or business is interested in coaching or training based on this approach, please visit: [www.mindfulnessatwork.net](http://www.mindfulnessatwork.net)

To learn more about ACT, visit the main website:

[www.contextualpsychology.org/act](http://www.contextualpsychology.org/act). Here you'll find a wealth of information about ACT, including details of therapists who have trained in it.

# Acknowledgments

Words cannot adequately express the enormous gratitude I feel towards Steven Hayes, the originator of Acceptance and Commitment Therapy (ACT). He has given a great gift to me, my family, my clients, and to the world at large. I am also indebted to the wider ACT community, for all the useful advice, experience and information that is so freely shared among them at workshops, conferences, and via the Internet. I am especially grateful to Kelly Wilson and Hank Robb, whose insights and interventions I have frequently drawn upon throughout these pages, and likewise to all those colleagues in the ACT community who have given me feedback and advice during various stages of writing: Jim Marchman, Joe Ciarrochi, Joe Parsons, Sonja Batten, Julian McNally, and Graham Taylor.

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Heartfelt thanks to the three editors who worked with me at various stages: Xavier Waterkeyn, who helped enormously with the early chapters, and also came up with the book's title; Michael Carr, who did the major 'grunt work', and taught me a lot in the process; and Monica Berton who helped wonderfully in trimming the fat and pulling the book into its final shape. And of course I am especially grateful to all the good folks at Exisle Publishing, who have worked so hard to bring this book together: Gareth St John Thomas, Benny St John Thomas, Anouska Jones, Penny Capp, and Sandra Noakes. And on that note, many thanks to my agent, Sammie Justesen, for bringing myself and the Exisle team together.

Last, but not least, a big thank you to columnist and author, Martha Beck. Her article on ACT in *O Magazine* acted as a major source of inspiration, because it showed me how the complex concepts of ACT could be put into plain, simple English.

Russ Harris

Melbourne, Australia

# **Front Cover Flap**

Do you ever feel stressed, worried, miserable or unfulfilled-yet you put on a happy face and pretend everything's fine? If so, you are not alone. Stress, anxiety, depression, and low self-esteem are everywhere. In one way or another, it seems that almost everyone is struggling. But why should this be, when our standard of living is the highest it's ever been?

New scientific research suggests that we are all caught in a hidden psychological trap: a vicious cycle, whereby the more we strive for happiness, the more we suffer in the long term. Fortunately we can all escape from the 'Happiness Trap' via a groundbreaking new approach based on mindfulness skills.

Mindfulness is a mental state of awareness, openness, and focus. Mindfulness skills are easy to learn and will rapidly and effectively help you to reduce stress, enhance performance, manage emotions, improve health, increase vitality, and generally change your life for the better. The concept of mindfulness has been around in the East for thousands of years-but until recently, we in the West could only develop these skills if we embarked on long, slow, arduous Eastern practices, such as meditation, yoga, Tai-Chi, Zen, or the martial arts. However, thanks to cutting-edge developments in western psychology, you can now learn these powerful life-changing techniques in a matter of minutes. So if you'd like to make life rich and full and meaningful, then this is a book you definitely have to read!

## **Back Cover Flap**

Dr Russ Harris is a medical practitioner with a passion for life, health and healing. A leading authority on stress management, Russ regularly travels all over Australia, and internationally, training coaches, psychologists, doctors, and other health professionals in the use of ‘mindfulness’. (Mindfulness is a key theme in this book: a mental state of awareness, openness, and focus which helps you to reduce stress, transcend fear, enhance performance, and increase life satisfaction.)

Russ was born in Liverpool, England, and qualified as a doctor in 1989, at the University of Newcastle-Upon-Tyne, UK. He migrated to Australia in 1991, and set up practice as a GP. He became increasingly interested in the psychological aspects of medical illness, and when he started teaching mindfulness skills to his patients, he was astonished at the dramatic results-especially in stress-related conditions. Russ's interest eventually led to a career change, and he now works as a speaker, trainer, therapist, and executive coach.

Russ wrote this book because there is a huge need for it: depression, anxiety, worry and stress are epidemic-and most popular approaches are ineffective. In his own life, Russ has used mindfulness to effectively transcend his own deep-seated insecurity, low self-confidence, and chronic anxiety. Over the years, he has also used this approach with many hundreds of clients, from lawyers and shopkeepers to policemen and housewives-obtaining equally outstanding results. Russ lives in Melbourne with his wife, a dog, a cat, and one child (so far).

# Back Cover Material

**A guide to ACT: the revolutionary mindfulness-based program for reducing stress, overcoming fear, and finding fulfilment.**

Popular ideas about happiness are misleading, inaccurate, and are directly contributing to our current epidemic of stress, anxiety and depression. And unfortunately, popular psychological approaches are making it even worse!

In this controversial but **empowering** self-help book, Dr Russ Harris, M.D., reveals how millions of people are unwittingly caught in '**The Happiness Trap**'! He then provides an **effective means to escape**, through a **revolutionary new approach** which is shaking the very foundations of western psychology.

**This book is for everyone**, from CEOs to sales staff, and astronauts to housewives. Whether you're lacking confidence, facing illness, coping with loss, working in a high-stress job, suffering from anxiety or depression, or preparing for the performance of your life-within these pages you will learn scientifically proven techniques to:

- **reduce** stress and worry
- **rise above** fear, doubt and insecurity
- **handle** painful thoughts and feelings far more effectively
- **break** self-defeating habits
- **improve** performance and find fulfilment in your work
- **build** more satisfying relationships and, above all,
- **create** a rich, full and meaningful life

**'Dr Harris shines a powerful beacon forward into the night. Enjoy the journey. You are in excellent hands.'** Steven Hayes-best-selling author of *Get Out Of Your Mind And Into Your Life*

"A TRANSFORMATIVE READ." —BRENÉ BROWN

THE PROVEN  
POWER OF BEING KIND  
TO YOURSELF

# Self- Compassion



KRISTIN NEFF, PH.D.

# Self- Compassion

The Proven Power of  
Being Kind to Yourself

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WILLIAM MORROW

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## **DEDICATION**

*To Rupert and Rowan  
For the joy, wonder, love, and inspiration they give me*

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Dedication

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## ACKNOWLEDGMENTS

First and foremost, I have to thank my husband, Rupert, for encouraging me to write this book, for helping me to craft the proposal and book itself, and for being my main editor. He taught me how to drop the academic-speak and write in plain English, and I couldn't ask for a more brilliant or eloquent mentor. Thanks also to my friend and agent, Elizabeth Sheinkman, who believed in me and somehow managed to make my dream a reality. Thanks to all the kind and supportive people at HarperCollins, who have taken a chance on me and made this book happen.

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Finally, I'd like to thank my mother and father, who each in their own way opened my mind and heart to spirituality when I was a young child, so that my personality formed around the desire to awaken.

*Part One*

## WHY SELF-COMPASSION?

## *Chapter One*

# DISCOVERING SELF-COMPASSION

*This kind of compulsive concern with “I, me, and mine” isn’t the same as loving ourselves . . . Loving ourselves points us to capacities of resilience, compassion, and understanding within that are simply part of being alive.*

—SHARON SALZBERG, *The Force of Kindness*

**I**N THIS INCREDIBLY COMPETITIVE SOCIETY OF OURS, HOW MANY OF us truly feel good about ourselves? It seems such a fleeting thing—feeling good—especially as we need to feel *special and above average* to feel worthy. Anything less seems like a failure. I remember once as a freshman in college, after spending hours getting ready for a big party, I complained to my boyfriend that my hair, makeup, and outfit were woefully inadequate. He tried to reassure me by saying, “Don’t worry, you look fine.”

“Fine? Oh great, I always wanted to look *fine . . .*”

The desire to feel special is understandable. The problem is that by definition, it’s impossible for *everyone* to be above average at the same time. Although there are some ways in which we excel, there is always someone smarter, prettier, more successful. How do we cope with this? Not very well. To see ourselves positively, we tend to inflate our own egos and put others down so that we can feel good in comparison. But this strategy comes at a price—it holds us back from reaching our full potential in life.

## Distorting Mirrors

If I have to feel better than you to feel good about myself, then how clearly am I really going to see you, or myself for that matter? Let's say I had a stressful day at work and am grumpy and irritable with my husband when he gets home later that evening (purely hypothetical, of course). If I'm highly invested in having a positive self-image and don't want to risk viewing myself in a negative light, I'm going to slant my interpretation of what transpires to make sure that any friction between us is seen as my husband's fault, not my own.

"GOOD, YOU'RE HOME. DID YOU PICK UP THE GROCERIES LIKE I ASKED?"

"I JUST WALKED THOUGH THE DOOR, HOW ABOUT 'NICE TO SEE YOU, DEAR, HOW WAS YOUR DAY?'"

"WELL, IF *you* WEREN'T SO FORGETFUL, MAYBE I WOULDN'T HAVE TO ALWAYS HOUND YOU."

"AS A MATTER OF FACT, I DID PICK UP THE GROCERIES."

"OH . . . WELL, UM . . . IT'S THE EXCEPTION THAT PROVES THE RULE. I WISH YOU WEREN'T SO UNRELIABLE."

Not exactly a recipe for happiness.

Why is it so hard to admit when we step out of line, are rude, or act impatient? Because our ego feels so much better when we project our flaws and shortcomings on to someone else. *It's your fault, not mine.* Just think about all the arguments and fights that grow out of this simple dynamic. Each person blames the other for saying or doing something wrong, justifying their own actions as if their life depended on it, while both know, in their heart of hearts, that it takes two to tango. How much time do we waste like this? Wouldn't it be so much better if we could just fess up and play fair?

But change is easier said than done. It's almost impossible to notice those aspects of ourselves that cause problems relating to others, or that keep us from reaching our full potential, if we can't see ourselves clearly. How can we grow if we can't acknowledge our own weaknesses? We might *temporarily* feel better about ourselves by ignoring our flaws, or by believing our issues and difficulties are somebody else's fault, but in the long run we only harm ourselves by getting stuck in endless cycles of stagnation and conflict.

## The Costs of Self-Judgment

Continually feeding our need for positive self-evaluation is a bit like stuffing ourselves with candy. We get a brief sugar high, then a crash. And right after the crash comes a pendulum swing to despair as we realize that—however much we'd like to—we can't always blame our problems on someone else. We can't always feel special and above average. The result is often devastating. We look in the mirror and don't like what we see (both literally and figuratively), and the shame starts to set in. Most of us are incredibly hard on ourselves when we finally admit some flaw or shortcoming. "I'm not good enough. I'm worthless." It's not surprising that we hide the truth from ourselves when honesty is met with such harsh condemnation.

In areas where it is hard to fool ourselves—when comparing our weight to those of magazine models, for instance, or our bank accounts to those of the rich and successful—we cause ourselves incredible amounts of emotional pain. We lose faith in ourselves, start doubting our potential, and become hopeless. Of course, this sorry state just yields more self-condemnation for being such a do-nothing loser, and down, down we go.

Even if we do manage to get our act together, the goalposts for what counts as "good enough" seem always to remain frustratingly out of reach. We must be smart *and* fit *and* fashionable *and* interesting *and* successful *and* sexy. Oh, and spiritual, too. And no matter how well we do, someone else always seems to be doing it better. The result of this line of thinking is sobering: millions of people need to take pharmaceuticals every day just to cope with daily life. Insecurity, anxiety, and depression are incredibly common in our society, and much of this is due to self-judgment, to beating ourselves up when we feel we aren't winning in the game of life.

## Another Way

So what's the answer? *To stop judging and evaluating ourselves altogether.* To stop trying to label ourselves as "good" or "bad" and simply accept ourselves with an open heart. To treat ourselves with the same kindness, caring, and compassion we would show to a good friend, or even a stranger for that matter. Sadly, however, there's almost no one whom we treat as

badly as ourselves.

When I first came across the idea of self-compassion, it changed my life almost immediately. It was during my last year in the Human Development doctoral program at the University of California at Berkeley, as I was putting the finishing touches on my dissertation. I was going through a really difficult time following the breakup of my first marriage, and I was full of shame and self-loathing. I thought signing up for meditation classes at a local Buddhist center might help. I had been interested in Eastern spirituality from the time I was a small child, having been raised by an open-minded mother just outside of Los Angeles. But I had never taken meditation seriously. I had also never examined Buddhist philosophy, as my exposure to Eastern thought had been more along California New Age lines. As part of my exploration, I read Sharon Salzberg's classic book *Lovingkindness* and was never the same again.

I had known that Buddhists talk a lot about the importance of compassion, but I had never considered that having compassion for *yourself* might be as important as having compassion for others. From the Buddhist point of view, you have to care about yourself before you can really care about other people. If you are continually judging and criticizing yourself while trying to be kind to others, you are drawing artificial boundaries and distinctions that only lead to feelings of separation and isolation. This is the opposite of oneness, interconnection, and universal love—the ultimate goal of most spiritual paths, no matter which tradition.

I remember talking to my new fiancé, Rupert, who joined me for the weekly Buddhist group meetings, and shaking my head in amazement. “You mean you’re actually allowed to be *nice* to yourself, to have compassion for yourself when you mess up or are going through a really hard time? I don’t know . . . If I’m too self-compassionate, won’t I just be lazy and selfish?” It took me a while to get my head around it. But I slowly came to realize that self-criticism—despite being socially sanctioned—was not at all helpful, and in fact only made things worse. I wasn’t making myself a better person by beating myself up all the time. Instead, I was causing myself to feel inadequate and insecure, then taking out my frustration on the people closest to me. More than that, I wasn’t owning up to many things because I was so afraid of the self-hate that would follow if I admitted the truth.

What Rupert and I both came to learn was that instead of relying on our

relationship to meet all our needs for love, acceptance, and security, we could actually provide some of these feelings for *ourselves*. And this would mean that we had even more in our hearts to give to each other. We were both so moved by the concept of self-compassion that in our marriage ceremony later that year, each of us ended our vows by saying “Most of all, I promise to help you have compassion for yourself, so that you can thrive and be happy.”

After getting my Ph.D., I did two years of postdoctoral training with a leading self-esteem researcher. I wanted to know more about how people determine their sense of self-worth. I quickly learned that the field of psychology was falling out of love with self-esteem as the ultimate marker of positive mental health. Although thousands of articles had been written on the importance of self-esteem, researchers were now starting to point out all the traps that people can fall into when they try to get and keep a sense of high self-esteem: narcissism, self-absorption, self-righteous anger, prejudice, discrimination, and so on. I realized that self-compassion was the perfect alternative to the relentless pursuit of self-esteem. Why? Because it offers the same protection against harsh self-criticism as self-esteem, but without the need to see ourselves as perfect or as better than others. *In other words, self-compassion provides the same benefits as high self-esteem without its drawbacks.*

When I got a job as an assistant professor at the University of Texas at Austin, I decided that as soon as I got settled I would conduct research on self-compassion. Although no one had yet defined self-compassion from an academic perspective—let alone done any research on it—I knew that this would be my life’s work.

So what is self-compassion? What does it mean exactly? I usually find that the best way to describe self-compassion is to start with a more familiar experience—compassion for others. After all, compassion is the same whether we direct it to ourselves or to other people.

## Compassion for Others

Imagine you’re stuck in traffic on the way to work, and a homeless man tries to get you to pay him a buck for washing your car windows. *He’s so pushy!* you think to yourself. *He’ll make me miss the light and be late. He probably*

*just wants the money for booze or drugs anyway. Maybe if I ignore him, he'll just leave me alone.* But he doesn't ignore you, and you sit there hating him while he washes your window, feeling guilty if you don't toss him some money, resentful if you do.

Then one day, you're struck as if by lightning. There you are in the same commuter traffic, at the same light, at the same time, and there's the homeless man, with his bucket and squeegee as usual. Yet for some unknown reason, today you see him differently. You see him as a *person* rather than just a mere annoyance. You notice his suffering. *How does he survive? Most people just shoo him away. He's out here in the traffic and fumes all day and certainly isn't earning much. At least he's trying to offer something in return for the cash. It must be really tough to have people be so irritated with you all the time. I wonder what his story is? How he ended up on the streets?* The moment you see the man as an actual human being who is suffering, your heart connects with him. Instead of ignoring him, you find—to your amazement—that you're taking a moment to think about how difficult his life is. You are moved by his pain and feel the urge to help him in some way. Importantly, if what you feel is true compassion rather than mere pity, you say to yourself, *There but for the grace of God go I. If I'd been born in different circumstances, or maybe had just been unlucky, I might also be struggling to survive like that. We're all vulnerable.*

Of course, that might be the moment when you harden your heart completely—your own fear of ending up on the street causing you to dehumanize this horrid heap of rags and beard. Many people do. But it doesn't make them happy; it doesn't help them deal with the stresses of their work, their spouse, or their child when they get home. It doesn't help them face their own fears. If anything, this hardening of the heart, which involves feeling *better* than the homeless man, just makes the whole thing that little bit worse.

But let's say you don't close up. Let's say you really do experience compassion for the homeless man's misfortune. How does it feel? Actually, it feels pretty good. It's wonderful when your heart opens—you immediately feel more connected, alive, present.

Now, let's say the man wasn't trying to wash windows in return for some cash. Maybe he *was* just begging for money to buy alcohol or drugs—should you still feel compassion for him? Yes. You don't have to invite him home.

You don't even have to give him a buck. You may decide to give him a kind smile or a sandwich rather than money if you feel that's the more responsible thing to do. But yes, he is still worthy of compassion—all of us are. Compassion is not only relevant to those who are blameless victims, but also to those whose suffering stems from failures, personal weakness, or bad decisions. You know, the kind you and I make every day.

Compassion, then, involves the recognition and clear seeing of suffering. It also involves feelings of kindness for people who are suffering, so that the desire to help—to *ameliorate suffering*—emerges. Finally, compassion involves recognizing our shared human condition, flawed and fragile as it is.

## Compassion for Ourselves

Self-compassion, by definition, involves the same qualities. First, it requires that we stop to recognize our own suffering. We can't be moved by our own pain if we don't even acknowledge that it exists in the first place. Of course, sometimes the fact that we're in pain is blindingly obvious and we can think of nothing else. More often than you might think, however, we *don't* recognize when we are suffering. Much of Western culture has a strong “stiff-upper-lip” tradition. We are taught that we shouldn't complain, that we should just *carry on* (to be read in a clipped British accent while giving a smart salute). If we're in a difficult or stressful situation, we rarely take the time to step back and recognize how hard it is for us in the moment.

And when our pain comes from self-judgment—if you're angry at yourself for mistreating someone, or for making some stupid remark at a party—it's even harder to see these as moments of suffering. Like the time I asked a friend I hadn't seen in a while, eyeing the bump of her belly, “Are we expecting?” “Er, no,” she answered, “I've just put on some weight lately.” “Oh . . .” I said as my face turned beet red. We typically don't recognize such moments as a type of pain that is worthy of a compassionate response. After all, I messed up, doesn't that mean I should be punished? Well, do you punish your friends or your family when they mess up? Okay, maybe sometimes a little, but do you feel good about it?

Everybody makes mistakes at one time or another, it's a fact of life. And if you think about it, why should you expect anything different? Where is that

written contract you signed before birth promising that you'd be perfect, that you'd never fail, and that your life would go absolutely the way you want it to? *Uh, excuse me. There must be some error. I signed up for the “everything will go swimmingly until the day I die” plan. Can I speak to the management, please?* It's absurd, and yet most of us act as if something has gone terribly awry when we fall down or life takes an unwanted or unexpected turn.

One of the downsides of living in a culture that stresses the ethic of independence and individual achievement is that if we don't continually reach our ideal goals, we feel that we only have ourselves to blame. And if we're at fault, that means we don't deserve compassion, right? The truth is, *everyone* is worthy of compassion. The very fact that we are conscious human beings experiencing life on the planet means that we are intrinsically valuable and deserving of care. According to the Dalai Lama, “Human beings by nature want happiness and do not want suffering. With that feeling everyone tries to achieve happiness and tries to get rid of suffering, and everyone has the basic right to do this. . . . Basically, from the viewpoint of real human value we are all the same.” This is the same sentiment, of course, that inspired the Declaration of Independence: “We hold these Truths to be self-evident, that all Men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.” We don't have to earn the right to compassion; it is our birthright. We are human, and our ability to think and feel, combined with our desire to be happy rather than to suffer, warrants compassion for its own sake.

Many people are resistant to the idea of self-compassion, however. Isn't it really just a form of self-pity? Or a dressed-up word for self-indulgence? I will show throughout this book that these assumptions are false and run directly counter to the actual meaning of self-compassion. As you'll come to see, self-compassion involves wanting health and well-being for oneself and leads to proactive behavior to better one's situation, rather than passivity. And self-compassion doesn't mean that I think my problems are more important than yours, it just means I think that my problems are *also* important and worthy of being attended to.

Rather than condemning yourself for your mistakes and failures, therefore, you can use the experience of suffering to soften your heart. You can let go of those unrealistic expectations of perfection that make you so

dissatisfied, and open the door to real and lasting satisfaction. All by giving yourself the compassion you need in the moment.

The research that my colleagues and I have conducted over the past decade shows that self-compassion is a powerful way to achieve emotional well-being and contentment in our lives. By giving ourselves unconditional kindness and comfort while embracing the human experience, difficult as it is, we avoid destructive patterns of fear, negativity, and isolation. At the same time, self-compassion fosters positive mind-states such as happiness and optimism. The nurturing quality of self-compassion allows us to flourish, to appreciate the beauty and richness of life, even in hard times. When we soothe our agitated minds with self-compassion, we're better able to notice what's right as well as what's wrong, so that we can orient ourselves toward that which gives us joy.

Self-compassion provides an island of calm, a refuge from the stormy seas of endless positive and negative self-judgment, so that we can finally stop asking, "Am I as good as they are? Am I good enough?" Right here at our fingertips we have the means to provide ourselves with the warm, supportive care we deeply yearn for. By tapping into our inner wellsprings of kindness, acknowledging the shared nature of our imperfect human condition, we can start to feel more secure, accepted, and alive.

In many ways self-compassion is like magic, because it has the power to transform suffering into joy. In her book *Emotional Alchemy: How the Mind Can Heal the Heart*, Tara Bennett-Goleman uses the metaphor of alchemy to symbolize the spiritual and emotional transformation that's possible when we embrace our pain with caring concern. When we give ourselves compassion, the tight knot of negative self-judgment starts to dissolve, replaced by a feeling of peaceful, connected acceptance—a sparkling diamond that emerges from the coal.

## Exercise One

### *How Do You React to Yourself and Your Life?*

#### **How Do You TYPICALLY REACT TO YOURSELF?**

- What types of things do you typically judge and criticize

yourself for—appearance, career, relationships, parenting, and so on?

- What type of language do you use with yourself when you notice some flaw or make a mistake—do you insult yourself, or do you take a more kind and understanding tone?
- If you are highly self-critical, how does this make you feel inside?
- What are the consequences of being so hard on yourself? Does it make you more motivated, or does it tend to make you discouraged and depressed?
- How do you think you would feel if you could truly accept yourself exactly as you are? Does this possibility scare you, give you hope, or both?

#### How Do You TYPICALLY REACT TO LIFE DIFFICULTIES?

- How do you treat yourself when you run into challenges in your life? Do you tend to ignore the fact that you’re suffering and focus exclusively on fixing the problem, or do you stop to give yourself care and comfort?
- Do you tend to get carried away by the drama of difficult situations, so that you make a bigger deal out of them than you need to, or do you tend to keep things in balanced perspective?
- Do you tend to feel cut off from others when things go wrong, with the irrational feeling that everyone else is having a better time of it than you are, or do you try to remember that all people experience hardship in their lives?

If you feel that you lack sufficient self-compassion, check in with yourself—are you criticizing yourself for this, too? If so, stop right there. Try to feel compassion for how difficult it is to be an imperfect human being in this extremely competitive society of ours. Our culture does not emphasize self-compassion, quite the opposite. We’re told that no matter how hard we try, our best just isn’t good enough. It’s time for something different. We can all benefit by learning to be more self-compassionate, and now is the perfect time to start.

So how is all this relevant to you, the reader? This and every chapter contain exercises that will help you understand how your continual self-judgment is harming you. There are also exercises to help you develop greater self-compassion so that it becomes a habit in daily life, allowing you to establish a healthier way of relating to yourself. You can determine your precise level of self-compassion using the self-compassion scale I developed for my research. Go to my website—[www.self-compassion.org](http://www.self-compassion.org)—and click on the “How Self-Compassionate Are You?” link. After filling out a series of questions, your level of self-compassion will be calculated for you. You may want to record your score and take the test again after reading the book, to determine if you’ve increased your level of self-compassion with practice.

You can’t always have high self-esteem and your life will continue to be flawed and imperfect—but self-compassion will always be there, waiting for you, a safe haven. In good times and bad, whether you’re on top of the world or at the bottom of the heap, self-compassion will keep you going, helping you move to a better place. It does take work to break the self-criticizing habits of a lifetime, but at the end of the day, you are only being asked to relax, allow life to be as it is, and open your heart to yourself. It’s easier than you might think, and it could change your life.

## Exercise Two

### *Exploring Self-Compassion Through Letter Writing*

#### PART ONE

Everybody has something about themselves that they don’t like; something that causes them to feel shame, to feel insecure or not “good enough.” It is the human condition to be imperfect, and feelings of failure and inadequacy are part of the experience of living. Try thinking about an issue that tends to make you feel inadequate or bad about yourself (physical appearance, work or relationship issues, etc.). How does this aspect of yourself make you feel inside—scared, sad, depressed, insecure, angry? What emotions come up for you when you think about this aspect of yourself? Please try to be as emotionally honest as possible and to

avoid repressing any feelings, while at the same time not being melodramatic. Try to just feel your emotions exactly as they are—no more, no less.

## PART TWO

Now think about an imaginary friend who is unconditionally loving, accepting, kind, and compassionate. Imagine that this friend can see all your strengths and all your weaknesses, including the aspect of yourself you have just been thinking about. Reflect upon what this friend feels toward you, and how you are loved and accepted exactly as you are, with all your very human imperfections. This friend recognizes the limits of human nature and is kind and forgiving toward you. In his/her great wisdom this friend understands your life history and the millions of things that have happened in your life to create you as you are in this moment. Your particular inadequacy is connected to so many things you didn't necessarily choose: your genes, your family history, life circumstances—things that were outside of your control.

Write a letter to yourself from the perspective of this imaginary friend—focusing on the perceived inadequacy you tend to judge yourself for. What would this friend say to you about your “flaw” from the perspective of unlimited compassion? How would this friend convey the deep compassion he/she feels for you, especially for the discomfort you feel when you judge yourself so harshly? What would this friend write in order to remind you that you are only human, that all people have both strengths and weaknesses? And if you think this friend would suggest possible changes you should make, how would these suggestions embody feelings of unconditional understanding and compassion? As you write to yourself from the perspective of this imaginary friend, try to infuse your letter with a strong sense of the person's acceptance, kindness, caring, and desire for your health and happiness.

After writing the letter, put it down for a little while. Then come back and read it again, really letting the words sink in. Feel the compassion as it pours into you, soothing and comforting you like a cool breeze on a hot day. Love, connection, and acceptance are

your birthright. To claim them you need only look within yourself.

## *Chapter Two*

# ENDING THE MADNESS

*What is this self inside us, this silent observer,  
Severe and speechless critic, who can terrorize us  
And urge us on to futile activity  
And in the end, judge us still more severely  
For the errors into which his own reproaches drove us?*

—T. S. ELIOT, *The Elder Statesman*

**B**EFORE EXAMINING SELF-COMPASSION IN MORE DETAIL, IT'S WORTH considering what our more habitual, unhealthy states of mind look like. As we begin to see the workings of our psyches more clearly, we start to recognize how much we skew our perceptions of the world in order to feel better about ourselves. It's as if we're continually airbrushing our self-image to try to make it more to our liking, even if it radically distorts reality. At the same time, we mercilessly criticize ourselves when we fall short of our ideals, reacting so harshly that reality is equally distorted in the opposite direction. The result can look like a Salvador Dalí picture (extra warped). As we first start to learn about self-compassion as a viable alternative to this madness, it's easy for us to end up judging our ego dysfunctions themselves. "I'm so full of myself, I should be more humble!" Or else, "I get so down on myself, I should be more kind and self-accepting!" It's very important to stop condemning yourself for these patterns, fruitless as they may be. The only way to truly have compassion for yourself is to realize that these neurotic ego cycles are not of your own choosing, they are natural and universal. Put simply, we come by our dysfunctions honestly—they are part of our human

inheritance.

So why do we vacillate between self-serving distortions and ruthless self-criticism? Because we want to be safe. Our development, both as a species and as individuals, is predicated on basic survival instincts. Because human beings tend to live in hierarchical social groups, those who are dominant within their group are less likely to be rejected and have more access to valued resources. In the same way, those who accept their subordinate status also have a secure place in the social order. We can't take the risk of being outcast by the people who keep us out of harm's way. Not if we want to stay alive. Surely this behavior need not be judged—how could the desire to be safe and secure be anything other than normal and natural for any living organism?

## The Need to Feel Better Than Others

Garrison Keillor famously describes the fictional town of Lake Wobegon as a place where “all the women are strong, all the men are good-looking, and all the children are above average.” For this reason, psychologists sometimes use the phrase “Lake Wobegon effect” to describe the common tendency to think of oneself as superior to others on a long list of desirable personality traits. Research has shown that fully 85 percent of students think that they’re above average in terms of getting along with others, for instance. Ninety-four percent of college faculty members think they’re better teachers than their colleagues, and 90 percent of drivers think they’re more skilled than their road mates. Even people who’ve recently caused a car accident think they’re superior drivers! Research shows that people tend to think they’re funnier, more logical, more popular, better looking, nicer, more trustworthy, wiser, and more intelligent than others. Ironically, most people also think they’re above average in the ability to view themselves objectively. Logically speaking, of course, if our self-perceptions were accurate, only half of all people would say they’re above average on any particular trait, the other half admitting they were below average. But this almost never happens. It’s unacceptable to be average in our society, so pretty much everyone wears a pair of rose-colored glasses, at least when they’re looking in the mirror. How else can we explain all those *American Idol* contestants with marginal talent

who seem so genuinely shocked when they're booted off the show?

One might assume that the tendency to see oneself as better than and superior to other people is primarily found in individualistic cultures such as the United States, where self-promotion is a way of life. Where else could Muhammad Ali have gotten away with the line, "I'm not the greatest; I'm the *double* greatest"? In more collectivistic Asian cultures, where conceit is frowned upon, aren't people more modest? The answer is yes, most Asians think they're more modest than others. Research suggests that all people self-enhance, but only on those traits valued by their culture. Whereas Americans tend to think they're more independent, self-reliant, original, and leader-like than the average American, Asians tend to think they're more cooperative, self-sacrificing, respectful, and humble than their peers. *I'm more modest than you are!* It's the same almost everywhere.

And we don't just see ourselves as "better," we also see others as "worse." Psychologists use the term "downward social comparison" to describe our tendency to see others in a negative light so that we can feel superior by contrast. If I'm trying to gild my own ego, you can be damn sure I'll try to tarnish yours. "Sure you're rich, but look at that bald spot!" This tendency was brilliantly illustrated in the film *Mean Girls*. The movie was actually based on the nonfiction book *Queen Bees and Wannabes* by Rosalind Wiseman, which describes how female cliques in high school maintain their social status. *Mean Girls* tells the story of three beautiful, rich, and well-dressed girls who seem to have it all. Certainly they think so. As one says, "I'm sorry that people are so jealous of me . . . I can't help it that I'm so popular." The girls, however, are hated despite their popularity. The clique keeps something called the "Burn Book"—a top secret notebook filled with rumors, secrets, and gossip about the other girls in school. "See," says one, "we cut out girls' pictures from the yearbook, and then we wrote comments. 'Trang Pak is a grotsky little byotch.' Still true. 'Dawn Schweitzer is a fat virgin.' Still half true." When the existence of the book is revealed to the school body at large, it ends up causing a riot. The film was a blockbuster hit in the United States and struck a huge chord with audiences. While exaggerated for comedic effect, the mean girl (or boy) phenomenon is something we're all too familiar with.

Although most of us don't go to the lengths of keeping a "Burn Book," it's very common to look for flaws and shortcomings in others as a way to

feel better about ourselves. Why else do we love pictures of stars spilling out of their swimsuits, making fashion flubs, or having a bad hair day? This approach, while ego gratifying for a few moments, has some serious drawbacks. When we are always seeing the worst in others, our perception becomes obscured by a dark cloud of negativity. Our thoughts become malevolent, and this is the mental world we then inhabit. Downward social comparisons actually harm rather than help us. By putting others down to puff ourselves up, we are cutting off our nose to spite our face, creating and maintaining the state of disconnection and isolation we actually want to avoid.

## Exercise One

### *Seeing Yourself as You Are*

Many people think they're above average on personal traits that society values—like being friendlier, smarter, more attractive than average. This tendency helps us to feel good about ourselves, but it also can lead us to feel more separate and cut off from others. This exercise is designed to help us see ourselves clearly and accept ourselves exactly as we are. All people have culturally valued traits that might be considered “better” than average, some traits that are just average, and some that are “below” average. Can we accept this reality with kindness and equanimity?

- A. List five culturally valued traits for which you're *above average*:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- B. List five culturally valued traits for which you're *just average*:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

C. List five culturally valued traits for which you're *below average*:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

D. Consider the full range of traits listed above. Can you accept all these facets of yourself? Being human does not mean being better than others. Being human means you encompass the full range of human experience, the positive, the negative, and the neutral. Being human means you *are* average in many ways. Can you celebrate the experience of being alive on this planet in all your complexity and wonder?

## Why Is It So Hard to Stop Beating Ourselves Up?

Perhaps more perplexing than the desire to think well of ourselves is our equally strong tendency toward self-criticism. As British novelist Anthony Powell noted, “Self-love seems so often unrequited.” When we don’t succeed in reinterpreting reality so that we feel better than others, when we’re forced to finally face up to the fact that our self-image is more blemished than we would like it to be, what happens? All too often, Cruella De Vil or Mr. Hyde emerges from the shadows, attacking our imperfect selves with a surprising viciousness. And the language of self-criticism cuts like a knife.

Most of our self-critical thoughts take the form of an inner dialogue, a

constant commentary and evaluation of what we are experiencing. Because there is no social censure when our inner dialogue is harsh or callous, we often talk to ourselves in an especially brutal way. “You’re so fat and disgusting!” “That was a totally stupid thing to say.” “You’re such a loser. No wonder nobody wants you.” Ouch! Yet such self-abuse is incredibly common. *Floccinaucinihilipilification*, defined as the habit of estimating something as worthless, is one of the longest words in the English language. The mystery of why we do it is as baffling as how to pronounce it.

Perhaps our behavior becomes more understandable, however, when we remember that just like self-aggrandizement, self-criticism is a type of safety behavior designed to ensure acceptance within the larger social group. Even though the alpha dog gets to eat first, the dog that shows his belly when snarled at still gets his share. He’s given a safe place in the pack even if it’s at the bottom of the pecking order. Self-criticism serves as a submissive behavior because it allows us to abase ourselves before imaginary others who pronounce judgment over us—then reward our submission with a few crumbs from the table. When we are forced to admit our failings, we can appease our mental judges by acquiescing to their negative opinions of us.

Consider, for example, how people often criticize themselves in front of others: “I look like a cow in this dress,” “I’m hopelessly inept with computers,” “I have the worst sense of direction of anyone I know!” (I’m prone to spouting this last line, especially when I’m driving friends somewhere and have gotten lost for the umpteenth time.) It’s as if we’re saying, “I’m going to beat you to the punch and criticize myself before you can. I recognize how flawed and imperfect I am so you don’t have to cut me down and tell me what I already know. Hopefully you will then have sympathy for me instead of judging me and assure me that I’m not as bad as I think I am.” This defensive posture stems from the natural desire not to be rejected and abandoned and makes sense in terms of our most basic survival instincts.

## The Role of Parents

The social group that is most important for survival, of course, is the immediate family. Children rely on their parents to provide food, comfort,

warmth, and shelter. They instinctively trust parents to interpret the meaning of things, to help deal with scary new challenges, to keep them safe from harm's way. Children have no choice but to rely on parents in order to get by in the world. Sadly, however, many parents don't provide comfort and support, but rather try to control their children through constant criticism. Many of you have grown up this way.

When mothers or fathers use harsh criticism as a means to keep their kids out of trouble ("don't be so stupid or you'll get run over by a car"), or to improve their behavior ("you'll never get into college if you keep getting such pathetic grades"), children assume that criticism is a useful and necessary motivational tool. As comedian Phyllis Diller notes, "We spend the first twelve months of our children's lives teaching them to walk and talk and the next twelve telling them to sit down and shut up." Unsurprisingly, research shows that individuals who grow up with highly critical parents in childhood are much more likely to be critical toward themselves as adults.

People deeply internalize their parents' criticisms, meaning that the disparaging running commentary they hear inside their own head is often a reflection of parental voices—sometimes passed down and replicated throughout generations. As one man told me, "I just can't shut the voice up. My mom used to pick on me no matter what I did—for eating my dinner like a pig, wearing the wrong clothes to church, watching too much TV, whatever. 'You're never going to amount to anything,' she'd say over and over again. I hated her and promised myself I'd never raise my children that way. The irony is that even though I'm a loving, supportive dad to my kids, I'm a complete bastard to myself. I tear myself to shreds all the time, even worse than my mother did." People with critical parents learn the message early on that they are so bad and flawed that they have no right to be accepted for who they are.

Critical parents tend to play the role of both good and bad cop with their kids in the hope that they will be able to mold their children into who they want them to be. Bad cop punishes undesirable behavior, and good cop rewards desirable behavior. This leads to fear and distrust among children, who soon come to believe that only by being perfect will they be worthy of love. Given that perfection is impossible, children come to expect that rejection is inevitable.

While most research into the origins of self-criticism focuses on parents,

the truth is that constant criticism by *any* significant figure in a child's life—a grandparent, a sibling, a teacher, a coach—can lead that child to experience inner demons later on in life. I have an English friend named Kenneth who is extremely hard on himself. No matter how much success he achieves, he is continually plagued by feelings of inadequacy and insecurity—which makes sense once he talks about his childhood: “Almost everyone in my life told me how crap I was. My sister was the worst. She’d scream ‘you’re disgusting!’ just because she thought I was breathing too loudly, and hide under her bed until I left the room. My mother didn’t defend me, but instead often made me apologize to my sister as a way to calm her and keep the peace.”

The natural response of children who are being verbally pummeled is to protect themselves, and sometimes the surest means of defense is to have nothing to attack. In other words, children start to believe that self-criticism will prevent them from making future mistakes, thereby circumventing others’ criticism. At the very least, they can blunt the force of others’ criticism by making it redundant. A verbal assault doesn’t have quite the same power when it merely repeats what you’ve already said to yourself.

## The Role of Culture

The tendency to criticize ourselves and feel worthless as a result can be traced in part to larger cultural messages. In fact, there is a well-known story about a group of Western scholars who were meeting with the Dalai Lama, who asked him how to help people suffering from low self-esteem. His Holiness was confused, and the concept of self-esteem had to be explained to him. He looked around this room of educated, successful people and asked, “Who here feels low self-esteem?” Everyone looked at one another and replied, “We all do.” One of the downsides of living in a culture that stresses the ethic of independence and individual achievement is that if we don’t reach our ideal goals, we feel that we only have ourselves to blame.

It is not only Westerners who are harshly judgmental toward themselves, of course. We recently conducted a study in the United States, Thailand, and Taiwan and found that in Taiwan—where there is a strong Confucian ethic—there is also strong belief in self-criticism as a motivating force. The Confucian ideal is that you should criticize yourself in order to keep yourself

in line—focusing on meeting the needs of others instead of yourself. In countries where Buddhism plays a stronger role in daily life, such as Thailand, people are much more self-compassionate. In fact, in our cross-cultural study we found that people had the highest levels of self-compassion in Thailand and the lowest in Taiwan, with the United States falling in between. In all three countries, however, we found that self-criticism was strongly related to depression and dissatisfaction with life. It appears that the negative impact of self-criticism may be universal, even though different cultures encourage it to a greater or lesser degree.

## A Means to an End

If we look more deeply, we see that harsh self-criticism is often used as a cover for something else: the desire for control. Given that the parents of self-critics are usually overly controlling, the message is received early on that self-control is possible. When parents blame their children for making mistakes, children learn that they are personally responsible for all their failures. The implication is that failure is an option box that need not be checked. That falling short of perfection is something that can and *should* be avoided. Surely if I just try hard enough I should always be able to succeed, shouldn't I?

Wouldn't that be nice! If only we could wriggle our nose like Samantha from the TV show *Bewitched* and never fall off our diet, drop the ball on an important work assignment, say something in anger that we would later regret. But life doesn't work that way. Things are too complicated for us to be able to fully control either our external circumstances or our internal responses to them. To expect otherwise is like expecting the sky to be green instead of blue.

Ironically, there is also a way in which our desire to be superior is *fed* by the process of self-criticism. Our self-concept is multifaceted, and we can identify with different parts of ourselves at any one time. When we judge and attack ourselves, we are taking the role of both the criticizer and the criticized. By taking the perspective of the one holding the whip as well as the one quivering on the ground, we are able to indulge in feelings of righteous indignation toward our own inadequacies. And righteous

indignation feels pretty good. “At least I’m smart enough to see how stupid that comment I just made was.” “Yes, I did treat that person in an unforgivably bad way, but I’m so just and fair that I will now punish myself without mercy.” Anger often gives us a feeling of strength and power, and so when we angrily cut ourselves down for our failings, we have a chance to feel superior to those aspects of ourselves that we judge and thus buttress our sense of authority (in the words of Thomas Hobbes, “The privilege of absurdity, to which no living creature is subject but man only”).

Similarly, by setting unrealistically high standards for ourselves and getting so upset when we fail to meet them, we can subtly reinforce feelings of supremacy associated with having such high standards in the first place. When complaining miserably about “ballooning” up to those size 6 jeans, for instance, or receiving that one minor negative comment from our boss on an otherwise glowing yearly review, we are sending the message that normally we are very much above average in our success, and that “good” just isn’t good enough for someone so used to excellence.

When served up with a slice of humor, of course, cutting ourselves down can be a way of endearing ourselves to others. “Better to have them laugh *with* you than laugh *at* you,” as the saying goes. A great example of this can be found in the opening scene of Al Gore’s *An Inconvenient Truth*. The former presidential candidate takes the stage in front of an enormous audience, with an even more enormous screen behind him, and the first words out of his mouth are, “Hello, my name is Al Gore, and I used to be the next president of the United States.” By highlighting his failure in a lighthearted way, Gore had the audience eating out of his hand. There is a difference, however, between healthy self-deprecating humor and unhealthy self-disparagement. The first indicates that someone is self-confident enough to poke fun at him- or herself. The second reveals deep-seated insecurities about personal worth and value.

## A Self-Fulfilling Prophecy

Because self-critics often come from unsupportive family backgrounds, they tend not to trust others and assume that those they care about will eventually try to hurt them. This creates a steady state of fear that causes problems in

interpersonal interactions. For instance, research shows that highly self-critical people tend to be dissatisfied in their romantic relationships because they assume their partners are judging them as harshly as they judge themselves. The misperception of even fairly neutral statements as disparaging often leads to oversensitive reactions and unnecessary conflicts. This means that self-critics often undermine the closeness and supportiveness in relationships that they so desperately seek.

My friend Emily was like this. She was awkward, gangly, and painfully shy as a child. Her mother was embarrassed by Emily and told her so constantly. “Why do you always cower in the corner? Stand up straight. Learn your manners. Why can’t you be more like your big sister?” Emily grew up to become a professional dancer, in part to appease her mother’s criticisms. A beautiful, graceful woman, you’d think it would have been easy for her to find a good relationship, to find the love and acceptance she craved. Not so. Emily certainly had no problems attracting men and starting relationships, but she did have a hard time getting them to last. She was so certain she was being judged as inadequate that she would overreact to the tiniest perceived slight by her partner. Innocent behaviors like forgetting to call the first night he was away on a business trip would be seen as proof that he didn’t really care about her. Not complimenting her new dress would be interpreted to mean that he thought she looked ugly. These overreactions would eventually cause her partners to get fed up and leave. In this way, Emily’s fear of rejection was transformed into reality over and over again.

To make things even worse, people who harshly judge themselves are often their own worst enemy when it comes to choosing relationship partners in the first place. Social psychologist Bill Swann argues that people want to be known by others according to their firmly held beliefs and feelings about themselves—a model known as “self-verification theory.” That is, they want their self-views to be validated because it helps to provide a sense of stability in their lives. His research shows that even people who make strong negative evaluations of themselves follow this pattern. They seek to interact with others who dislike them, so that their experiences will be more familiar and coherent.

So now you know why you—or your wonderful, successful friend—keep picking the wrong guy or gal. Self-critics are often attracted to judgmental romantic partners who confirm their feelings of worthlessness. The certainty

of rejection feels safer than not knowing what to expect next. It's the devil they know. Unfortunately, I'm all too familiar with this unhealthy pattern.

## My Story: Abandoned and Unlovable

I was never an exceptionally ferocious self-critic; at least, I wasn't out of the ordinary. Luckily my mother was a loving rather than critical presence while growing up. But I was still pretty bad. Self-criticism is incredibly common in our society, especially among women. And I was hamstrung by the same troubles that afflict many women: daddy issues.

My mother and father met at a college in Southern California. She was a homecoming queen, a beauty whose belt, shoes, and purse always matched. He was a "big man on campus." Smart, athletic, ambitious, handsome. After he graduated they got married, rented a house in the suburbs, and had two lovely children—a boy and a girl. Soon my father was a rising young executive in a large corporation while my mother dropped her studies and stayed home to watch the kids. The American dream. Except that the fifties were over and it was now the sixties—an era of unprecedented social revolution.

My father tuned in to the changes happening around him and recognized the coffin of conventionality that his life had become. But he didn't handle it in a mature way. He left my mother, brother, and me when I was only three, dropped out to become a hippie, and moved into a commune on Maui, Hawaii. Given how far away he lived from our home in Los Angeles, I saw him only every two or three years while growing up, mainly during summer vacations. Although he was affectionate and loving during our visits, he was trapped in Hippieville to the point that he couldn't see very clearly, couldn't even admit to himself that he had abandoned us. "It's all just our karma" he was fond of saying.

One day when I was about eight, after using the word *Dad* in the course of asking him some question, he turned to me and my brother in all seriousness and asked that we please not call him Dad anymore. He wanted us to use his new name, "Brother Dionysus," because "we are all just brothers and sisters at the end of the day—children of God." I had been clinging to the flimsy, occasional father-daughter relationship that we had, but now his

rejection of the father role seemed complete. My dad had truly left me, emotionally as well as physically. The bottom dropped out of my stomach, but I couldn't cry. I couldn't express any reaction whatsoever. I didn't want to risk harming any small thread of connection that might still be there. So for more than twenty years I found myself in the awkward situation of not knowing how—on those rare occasions when he was around—to address him. I couldn't bring myself to use his ridiculous hippie name, so ended up using no name at all. "Um, hey, uh, excuse me, could you pass the salt, please?" Needless to say, this rejection caused some deep scars in my psyche.

You should have seen the boys I chose as boyfriends in high school. Although I was a straight A student in all honors classes, attractive and friendly, I basically only liked guys who didn't like me. I was drawn to the boys who had a lot less going for them than I did, but who still acted equivocally toward me. I had no idea of my own worth and value, and at some level I was trying to recapture my relationship with my father—unconsciously hoping that I could magically transform the experience of rejection into one of acceptance. Almost every single one of my boyfriends ended up dumping me eventually, which surprised me at the time but makes sense given what I know now. I was simply re-creating situations that validated my sense of self as an unlovable girl who would always be abandoned.

## How Bad Can It Get?

Even though my feelings of insecurity caused me to make some bad decisions, not to mention making me unhappy, it was not *that* extreme. Sadly, the damage caused by self-judgment can get much, much worse. Feelings of inadequacy and inferiority are associated with acts of self-harm—like drug and alcohol abuse, reckless driving on purpose, and cutting—which are really attempts to externalize and release emotional pain. In extreme cases, when self-criticism goes unchecked for years, when ruthless self-pummeling becomes a way of life, some choose to escape the pain by escaping life itself. A number of large-scale studies have found that extreme self-critics are much more likely to attempt suicide than others. Feelings of shame and insignificance can lead to a devaluing of oneself to the extent that it even

overpowers our most basic and fundamental instinct—the will to stay alive. The thought patterns linking self-criticism to suicide are apparent in this blog posting taken from a depression website:

*All my life I've been depressed. I've always felt like there was something wrong with me and that I was stupid and ugly and gross. I want to have more friends but I can't figure out how to do it. I've been able to have one or two friends at a time, but they really never last. Some of them betray me and hurt me and I can never figure out what I did that made them hate me so much. I don't say things out in public much because I might say something stupid and someone will laugh at me and humiliate me. So even if someone is nice and wants to be with me, I end up driving them away. I'm so lonely sometimes that it seems like I'd be better off dead. I think about dying because I'm just so worthless and no one loves me. I don't love me. Being all the way dead has to be better than feeling dead inside.*

This tragic train of thought is much more common than might be assumed. Worldwide, there are an estimated ten to twenty million attempted suicides each year. Sadly, this shocking act of violence is often just an outward manifestation of the inner violence more familiar to us: harsh self-criticism.

## The Way Out

Although it's important for us to see our psychological patterns clearly, it's equally important that we do not judge ourselves for them. If you are a habitual self-critic, remember that your behavior actually represents a convoluted form of self-care, an attempt to keep yourself safe and on track. *You don't want to beat yourself up for beating yourself up in the vain hope that it will somehow make you stop beating yourself up.* Just as hate can't conquer hate—but only strengthens and reinforces it—self-judgment can't stop self-judgment.

The best way to counteract self-criticism, therefore, is to understand it,

have compassion for it, and then replace it with a kinder response. By letting ourselves be moved by the suffering we have experienced at the hands of our own self-criticism, we strengthen our desire to heal. Eventually, after banging our heads against the wall long enough, we'll decide that enough is enough and demand an end to our self-inflicted pain.

Fortunately, we can actually provide ourselves with the security and nurturance we want. We can recognize that weakness and imperfection are part of the shared human experience. We can feel more connected to our fellow life travelers who are just as flawed and vulnerable as we are. At the same time, we can let go of the need to feel better than others. We can see through the self-serving distortions that inflate our own egos at others' expense.

And who wants to be stuck in a box labeled "good" anyway? Isn't it more interesting to revel in the full range of human experience? Instead of trying to control ourselves and our lives to obtain a perfectionistic ideal, why not embrace life as it is—both the light and the shadow? What adventures might follow if we free ourselves in this way? Happiness is found when we go with the flow of life, not when we rail against it, and self-compassion can help us navigate these turbulent rapids with a wise, accepting heart.

## Exercise Two

### *The Criticizer, the Criticized, and the Compassionate Observer*

This exercise is modeled on the two-chair dialogue studied by Gestalt therapist Leslie Greenberg. In this exercise, clients sit in different chairs to help get in touch with different, often conflicting parts of their selves, experiencing how each aspect feels in the present moment.

To begin, put out three empty chairs, preferably in a triangular arrangement. Next, think about an issue that often troubles you, and that often elicits harsh self-criticism. Designate one chair as the voice of your inner self-critic, one chair as the voice of the part of you that feels judged and criticized, and one chair as the voice of a wise, compassionate observer. You are going to be role-playing all

three parts of yourself—you, you, and you. It may feel a bit silly at first, but you may be surprised at what comes out once you really start letting your feelings flow.

1. Think about your “issue,” and then sit in the chair of the self-critic. As you take your seat, express out loud what the self-critical part of you is thinking and feeling. For example, “I hate the fact that you’re such a wimp and aren’t self-assertive enough.” Notice the words and tone of voice the self-critical part of you uses, and also how it is feeling. Worried, angry, self-righteous, exasperated? Note what your body posture is like. Strong, rigid, upright?

2. Now take the chair of the criticized aspect of yourself. Try to get in touch with how you feel being criticized in this manner. Talk about how you feel, responding directly to your inner critic. For example, “I feel so hurt by you” or “I feel so unsupported.” Just speak whatever comes into your mind. Again, notice the tone of your voice. Is it sad, discouraged, childlike, scared, helpless? What is your body posture like? Are you slumped, downward facing, frowning?

3. Conduct a dialogue between these two parts of yourself for a while, switching back and forth between the chair of the criticizer and the criticized. Really try to experience each aspect of yourself so each knows how the other feels. Allow each to fully express its views and be heard.

4. Now occupy the chair of the compassionate observer. Call upon your deepest wisdom, the wells of your caring concern, and address both the critic and the criticized. What does your compassionate self say to the critic, what insight does it have? For example, “You sound very much like your mother” or, “I see that you’re really scared, and you’re trying to help me so I don’t screw up.” What does your compassionate self say to the criticized part of yourself? For example, “It must be incredibly difficult to hear such harsh judgment day after day. I see you’re really hurting” or “All you want is to be accepted for who you are.” Try to relax, letting your heart soften and open. What words of compassion naturally spring forth? How is your tone of voice? Tender, gentle, warm? What is your body posture like—balanced, centered, relaxed?

5. After the dialogue finishes—stop whenever it feels right—reflect upon what just happened. Do you have any new insights about where your patterns come from, new ways of thinking about your situation that are more productive? As you contemplate what you have learned, set your intention to relate to yourself in a kinder, healthier way in the future. A truce can be called in your inner war. Peace is possible. Your old habits of self-criticism don't need to rule you forever. What you need to do is listen to the voice that's already there, even if a bit hidden—your wise, compassionate self.

*Part Two*

## THE CORE COMPONENTS OF SELF-COMPASSION

## *Chapter Three*

### BEING KIND TO OURSELVES

*When you begin to touch your heart or let your heart be touched, you begin to discover that it's bottomless, that it doesn't have any resolution, that this heart is huge, vast, and limitless. You begin to discover how much warmth and gentleness is there, as well as how much space.*

—PEMA CHÖDRÖN, *Start Where You Are*

AS I'VE DEFINED IT, SELF-COMPASSION ENTAILS THREE CORE COMPONENTS. First, it requires *self-kindness*, that we be gentle and understanding with ourselves rather than harshly critical and judgmental. Second, it requires recognition of our *common humanity*, feeling connected with others in the experience of life rather than feeling isolated and alienated by our suffering. Third, it requires *mindfulness*—that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it. We must achieve and combine these three essential elements in order to be truly self-compassionate. This chapter and the next two focus on each component separately, as they are all equally important. We'll start with what is perhaps the most obvious ingredient of self-compassion: self-kindness.

#### The Path of Self-Kindness

Western culture places great emphasis on being kind to our friends, family, and neighbors who are struggling. Not so when it comes to ourselves. When we make a mistake or fail in some way, we're more likely to hit ourselves

over the head with a club than put a supportive arm around our own shoulder. Most likely, even the thought of comforting ourselves in this way seems absurd. And even when our problems stem from forces beyond our control, self-kindness is not a culturally valued response. Somewhere along the line we get the message that strong individuals should be stoic and silent toward their own suffering—like John Wayne in a western. Unfortunately, these attitudes rob us of one of our most powerful coping mechanisms when dealing with the difficulties of life.

Self-kindness, by definition, means that we stop the constant self-judgment and disparaging internal commentary that most of us have come to see as normal. It requires us to *understand* our foibles and failures instead of condemning them. It entails clearly seeing the extent to which we harm ourselves through relentless self-criticism, and ending our internal war.

But self-kindness involves more than merely stopping self-judgment. It involves *actively* comforting ourselves, responding just as we would to a dear friend in need. It means we allow ourselves to be emotionally moved by our own pain, stopping to say, “This is really difficult right now. How can I care for and comfort myself in this moment?” With self-kindness, we soothe and calm our troubled minds. We make a peace offering of warmth, gentleness, and sympathy *from ourselves to ourselves*, so that true healing can occur.

And if our pain is caused by a misstep we have made—this is *precisely* the time to give ourselves compassion. I remember once during high school I went on a first date with a boy I had a huge crush on. I had a slight cold but didn’t think much about it. At one point while I was talking and laughing, trying to impress him with how clever and funny I was, he looked at me sideways and raised his eyebrows. I paused, wondering what was the matter. “Nice snot bubble,” he said.

The shame and humiliation floored me for weeks. I felt totally lame and told myself so over and over again. I wish I knew then what I know now.

Rather than relentlessly cutting ourselves down when we fall, even if our fall is a spectacular one, we do have another option. We can recognize that everyone has times when they blow it, and treat ourselves kindly. Maybe we weren’t able to put our best foot forward, but we tried, and falling flat on one’s face is an inevitable part of life. An honorable part, in fact.

Sadly, however, many people believe that they *shouldn’t* be kind to themselves, especially if they received that message in childhood. And even

among those who *want* to be kinder to themselves, who would happily do away with their inner tyrant if they could, there is often the belief that change is not possible. Because they've developed such a strong habit of self-criticism, they don't think they are actually *capable* of self-kindness. Luckily, however, being kind to yourself is easier than you think.

## The Attachment and Caregiving System

Our brains and bodies have the innate capacity to both give and receive care. It's part of our genetic inheritance. Not only does survival depend on the fight-or-flight instinct, it also depends on the "tend and befriend" instinct. In times of threat or stress, animals that are protective of their offspring are more likely to pass their genes successfully on to the next generation, meaning that caregiving behavior has a strong adaptive function.

For this reason, all mammals are born with an "attachment system"—a set of behaviors that allow for strong emotional bonds between caregivers and their young. Unlike reptiles, who could care less about their offspring once they've slithered out of their eggs—often eating them, in fact—mammals spend considerable time and energy nurturing their young, making sure they are adequately fed, warm, and safe. Mammals are born in an immature state. They can't take care of themselves as newborns, and they rely on parents to be their lifeline until they are ready to leave home. Evolution ensured that mammals could both give and receive nurturance, so that parents wouldn't abandon their children after birth and children wouldn't wander off alone into the dangerous wild. The emotion of care comes naturally to us, because without it our species would not be able to survive. This means that the capacity to feel affection and interconnection is part of our biological nature. *Our brains are actually designed to care.*

The well-known psychologist Harry Harlow was one of the first to examine the development of the mammalian attachment system back in the 1950s. In a series of clever (if ethically questionable) experiments, Harlow studied the behavior of newborn rhesus monkeys who were separated from their mothers and reared alone in a cage. The question was whether the baby monkeys would spend more time with a soft, terry-cloth pretend mother—who at least offered some degree of warmth and comfort—or a stark, wire-mesh

figure that held a milk-dispensing bottle but provided little comfort. The answer was clear. The baby monkeys clung to their cloth mommies as if their life depended on it, only moving to the stark wire-mesh figures long enough to take a quick drink. What's striking about this finding is that the emotional comfort offered by a snuggly cloth appeared to create a stronger drive in the monkeys than food itself. Care was as powerful a survival need as nutrition. As the Bible says, "Man cannot live by bread alone." Harlow interpreted his experiments as providing evidence for the biological underpinnings of the attachment system.

John Bowlby, another influential psychologist working in the same period, took the study of attachment a step further—to humans. He proposed that infants develop a secure attachment bond to parents when their needs are consistently met. If children are consoled and supported by parents when they're upset or frightened, they learn to trust them. Every time a mom picks up and rocks her crying baby, the baby starts to feel that the world is a safe place, that he or she can turn to mommy for support when needed. This then allows children to use their parents as a "secure base," meaning they can safely explore the world around them because they know help is always at hand. If parents provide inconsistent support, however, or are cold and rejecting, children develop what's called an insecure attachment bond. This insecurity means that children can't trust their parents to soothe their distress—to kiss the boo-boo and make it go away. They learn that the world is really *not* safe, that their parents can't be relied upon. This tends to impair children's confidence in exploring the world—an impairment that often extends to adulthood.

Bowlby argued that early attachment bonds with parents affect the formation of our "internal working model" of self in relation to others. This is an unconscious, deep-seated mental portrait of who we are and what we can expect from other people. If children are securely attached to parents, they feel they are worthy of love. They typically grow up to be healthy and happy adults, secure in the belief they can count on others to provide comfort and support. But if children are insecurely attached, they tend to feel they are unworthy and unlovable, and that other people cannot be trusted. This creates a pervasive feeling of insecurity that can cause long-term emotional distress and affect the ability to form close, stable relationships later on in life.

It probably comes as no surprise then that our research shows people who

are insecurely attached have less self-compassion than those who are securely attached. In other words, our internal working models of self have a significant impact on how we treat ourselves—with compassion or contempt. And if our internal working models tell us that we can't rely on others to be there for us in times of need, we will not allow ourselves to depend on them. Just like Emily, the professional dancer whose story was told in the last chapter, we may find it easier to assume the worst and act accordingly rather than make ourselves vulnerable by allowing others into our heart. But in doing so we cut ourselves off from human happiness.

The good news is that our internal working models are not etched in stone—they can be changed. Because the ability to give and receive care is inborn, our attachment buttons can be reset. A person who is insecurely attached as a child but somehow manages to find a loving, supportive romantic partner as an adult can eventually learn to become securely attached. Healthy romantic relationships allow us to realize that actually, we *are* valuable and worthy of care, that others *can* be trusted to meet our needs. Skilled therapists can also help change insecure attachment bonds by providing unconditional support to their clients. The safe space and deep listening provided by a therapist allows access to the deep-rooted patterns formed in our childhood, bringing them to the surface so they can be *re*-formed.

Of course, there are problems with depending solely on other people to change how we feel about ourselves. Romantic relationships may end, therapists may move away or become unaffordable. And those we rely upon often have their own dragons to slay—sickness, depression, job stress—that prevent them from being there for us when we need them. Fortunately, we don't have to solely rely on others to change our self views. When we consistently give *ourselves* nurturance and understanding, we also come to feel worthy of care and acceptance. When we give ourselves empathy and support, we learn to trust that help is always at hand. When we wrap ourselves in the warm embrace of self-kindness, we feel safe and secure.

Luckily, Emily was finally able to learn this. She came to realize that unless she had compassion for the feelings of insecurity woven deep within the fabric of her personality, she would keep driving men away with her defensive reactions. So Emily started to practice being kinder and more accepting of herself. Every time a wave of insecurity came over her she would silently say, “I love and accept myself exactly as I am.” Every time she

started to criticize herself, or to interpret someone else's actions as a deliberate rejection, she would repeat, "I love and accept myself exactly as I am." Eventually, deep wells of grief arose as she let herself experience the full extent of the pain caused by her mother's rejection and disapproval. But as long as she repeated her phrase, she found she could feel her emotions without being overwhelmed by them.

Finally, as her pain started to subside, she began to trust others once more. She started to realize how much she had to offer others, and that her past no longer had anything to do with her present. The last time I heard from her, Emily was engaged to a wonderful man who deeply loved and appreciated her, and whose love and appreciation she could finally allow herself to receive.

## The Chemicals of Care

The power of self-kindness is not just an idea—some feel-good but insubstantial notion that doesn't really change anything. It's very real. When we soothe our own pain, we are tapping into the mammalian caregiving system. And one important way the caregiving system works is by triggering the release of oxytocin. Researchers have dubbed oxytocin the "hormone of love and bonding" because of the important role it plays in social relationships. For instance, one study found that levels of oxytocin measured in pregnant mothers during their first trimester predicted the strength of mother-child bonding after birth. Research has also shown that increased levels of oxytocin strongly increase feelings of trust, calm, safety, generosity, and connectedness and also facilitate the ability to feel warmth and compassion for ourselves. Oxytocin reduces fear and anxiety and can counteract the increased blood pressure and cortisol associated with stress. Interestingly, the party drug MDMA (otherwise known as Ecstasy) mimics the actions of oxytocin, which is why people report feeling more relaxed, loving, and accepting toward themselves and others when taking the drug.

Oxytocin is released in a variety of social situations, including when a mother breast-feeds her child, when parents interact with their young children, or when someone gives or receives a soft, tender caress. Because thoughts and emotions have the same effect on our bodies whether they're

directed to ourselves or to others, this research suggests that self-compassion may be a powerful trigger for the release of oxytocin.

Self-criticism appears to have a very different effect on our body. The amygdala is the oldest part of the brain and is designed to quickly detect threats in the environment. When we experience a threatening situation, the fight-or-flight response is triggered: the amygdala sends signals that increase blood pressure, adrenaline, and the hormone cortisol, mobilizing the strength and energy needed to confront or avoid a threat. Although this system was designed by evolution to deal with physical attacks, it is activated just as readily by emotional attacks—from ourselves or others. Over time increased cortisol levels lead to depression by depleting various neurotransmitters involved in the ability to experience pleasure.

There is also neurological evidence showing that self-kindness and self-criticism operate quite differently in terms of brain function. A recent study examined reactions to personal failure using fMRI (functional magnetic resonance imaging) technology. While in a brain scanner, participants were presented with hypothetical situations such as “A third job rejection letter in a row arrives in the post.” They were then told to imagine reacting to the situation in either a kind or a self-critical way. Self-criticism was associated with activity in the lateral prefrontal cortex and dorsal anterior cingulate—areas of the brain associated with error processing and problem solving. Being kind and reassuring toward oneself was associated with left temporal pole and insula activation—areas of the brain associated with positive emotions and compassion. Instead of seeing ourselves as a problem to be fixed, therefore, self-kindness allows us to see ourselves as valuable human beings who are worthy of care.

When we experience warm and tender feelings toward ourselves, we are altering our bodies as well as our minds. Rather than feeling worried and anxious, we feel calm, content, trusting, and secure. Self-kindness allows us to feel safe as we respond to painful experiences, so that we are no longer operating from a place of fear—and once we let go of insecurity we can pursue our dreams with the confidence needed to actually achieve them.

## Exercise One

### *Hugging Practice*

One easy way to soothe and comfort yourself when you're feeling badly is to give yourself a gentle hug. It seems a bit silly at first, but your body doesn't know that. It just responds to the physical gesture of warmth and care, just as a baby responds to being held in its mother's arms. Our skin is an incredibly sensitive organ. Research indicates that physical touch releases oxytocin, provides a sense of security, soothes distressing emotions, and calms cardiovascular stress. So why not try it?

If you notice that you're feeling tense, upset, sad, or self-critical, try giving yourself a warm hug, tenderly stroking your arm or face, or gently rocking your body. What's important is that you make a clear gesture that conveys feelings of love, care, and tenderness. If other people are around, you can often fold your arms in a nonobvious way, gently squeezing yourself in a comforting manner. You can also simply *imagine* hugging yourself if you can't make the actual physical gesture.

Notice how your body feels after receiving the hug. Does it feel warmer, softer, calmer? It's amazing how easy it is to tap into the oxytocin system and change your biochemical experience.

Try giving yourself a hug in times of suffering several times a day for a period of at least a week. Hopefully you'll start to develop the habit of physically comforting yourself when needed, taking full advantage of this surprisingly simple and straightforward way to be kind to ourselves.

### **The Power of a Gentle Caress**

The warm embrace of self-kindness makes our suffering bearable, providing a soothing balm that softens the hard edges of our pain. When we treat ourselves as a kind friend would, we are no longer totally absorbed by playing the role of the one who is suffering. *Yes, I hurt. But I also feel care and concern. I am both the comforter and the one in need of comfort. There is more to me than the pain I am feeling right now, I am also the heartfelt*

*response to that pain.* When we are moved by how difficult life is in the moment, somehow that moment isn't as difficult as it was just a second ago. We add a new ingredient to our experience, providing relief like a cool spring bubbling up in a hot, dry desert.

I remember once I was feeling really down after hearing something mean someone had said about me—someone who didn't know me at all, but who nonetheless was making negative assumptions about my honesty and integrity. I felt like I had been hit by a car. This is so unfair! The nerve! Who does she think she is? I created all sorts of “payback” scenarios in my mind—of showing this person up, publicly proving her wrong, making her feel so horrible about herself that she would cringe in shame. These mental movies were only making me feel worse, however, causing me to relive the pain over and over again. Then I remembered. *What I need to do is give myself compassion for how difficult the situation is.* I gently stroked my arms and spoke to myself in kind, sympathetic tones. *Poor darling. This is really hard right now.* I comforted myself for the pain of being treated so unfairly.

This is what I *actually* needed in the moment. Rather than merely venting my anger, I needed to feel loved and understood, to be seen for who I really was. This was the only remedy that could heal my pain. The moment I changed my approach, I felt my mood start to lift. I stopped obsessing about payback scenarios and instead realized that this person's negativity had nothing to do with me; it was her own issue. Relatively quickly I was able to let go and move on, my equilibrium restored and the impact of her words greatly lessened.

Choosing to relate to ourselves with kindness rather than contempt is highly pragmatic. We don't have a lot of control over our personal characteristics—our inborn personality, our body type, our health, the good or bad fortune of our circumstances. But what we *can* do is start being kind to ourselves when confronting our limitations, and we can suffer less because of them.

One of the most important ways we can be kind to ourselves involves changing our critical self-talk. Marshall Rosenberg, author of the bestselling book *Nonviolent Communication*, stresses the importance of using sympathetic rather than judgmental language when we talk to ourselves. He argues that to be at peace with ourselves, we should reframe our inner dialogues so that they express empathy for our basic human needs.

Rosenberg's suggested method for doing so involves asking four simple questions:

- What am I observing?
- What am I feeling?
- What am I needing right now?
- Do I have a request of myself or someone else?

These four questions allow us to listen deeply to what we need most in the moment.

For example, let's say you're working from home and take a break to make yourself some tea. When you come into the kitchen, you see that there are dirty dishes piled up a mile high. The first step involves noticing if your self-talk is critical or judgmental. Are you saying things like "I'm such a hopeless slob"? The next step involves tuning into the feelings underlying your harsh words. Are you feeling frustrated, overwhelmed, irritated with yourself or the situation? The third step entails examining the unmet needs driving your reaction. Perhaps you're frustrated because you know you need a sense of order to deal with the pressing demands of your work, and that the chaos in the kitchen is hindering you. Finally, you consider whether there is anything you want to request of yourself or someone else that may help to meet your needs. Perhaps you can ask your best friend to lend a hand until your work deadline passes. Or maybe you can ask yourself to put off working on your project for a half hour while you clean up, so that you can have the sense of harmony you need to concentrate. The main point is that you validate and listen to what you really need in the moment, and you express empathy toward yourself rather than condemnation.

## Exercise Two

### *Changing Your Critical Self-Talk*

This exercise should be done over several weeks and will eventually form the blueprint for changing how you relate to yourself long term. Some people find it useful to work on their inner critic by writing in a journal. Others are more comfortable

doing it via internal dialogues. If you are someone who likes to write things down and revisit them later, journaling can be an excellent tool for transformation. If you are someone (like me) who never manages to be consistent with a journal, then do whatever works for you. You can speak aloud to yourself, or think silently.

1. The first step toward changing the way you treat yourself is to notice when you are being self-critical. It may be that—like many of us—your self-critical voice comes up so frequently that you don't even notice when it is present. Whenever you're feeling bad about something, think about what you've just said to yourself. Try to be as accurate as possible, noting your inner speech verbatim. What words do you actually use when you're self-critical? Are there key phrases that come up over and over again? What is the tone of your voice—harsh, cold, angry? Does the voice remind you of anyone in your past who was critical of you? You want to be able to get to know the inner self-critic very well, and to become aware of when your inner judge is active. For instance, if you've just eaten half a box of Oreos, does your inner voice say something like “you're so disgusting,” “you make me sick,” and so on? Really try to get a clear sense of how you talk to yourself.

2. Make an active effort to soften the self-critical voice, but do so with compassion rather than self-judgment (i.e., don't say “you're such a bitch” to your inner critic!). Say something like “I know you're trying to keep me safe, and to point out ways that I need to improve, but your harsh criticism and judgment is not helping at all. Please stop being so critical, you are causing me unnecessary pain.”

3. Reframe the observations made by your inner critic in a kind, friendly, positive way. If you're having trouble thinking of what words to use, you might want to imagine what a very compassionate friend would say to you in this situation. It might help to use a term of endearment that strengthens expressed feelings of warmth and care, but only if it feels natural rather than schmaltzy. For instance, you can say something like “Darling, I know you ate that bag of cookies because you're feeling really sad right now and you thought it would cheer you up. But you feel even

worse and are not feeling good in your body. I want you to be happy, so why don't you take a long walk so you feel better?" While engaging in this supportive self-talk, try gently stroking your arm, or holding your face tenderly in your hands (as long as no one's looking). Even if you're having trouble calling up emotions of kindness at first, physical gestures of warmth can tap into the caregiving system, releasing oxytocin that will help change your biochemistry. The important thing is that you start acting kindly, and feelings of true warmth and caring will eventually follow.

The healing power of self-kindness was demonstrated in a recent study of chronic acne sufferers. People who have chronic acne are often depressed and experience intense shame and self-judgment. For this reason, researchers held a two-week intervention in which participants were taught how to soothe the negative emotions and self-criticism associated with their acne. For instance, they were told, "There is an inner critic inside of each of us that can say mean and negative things about ourselves in a hostile way . . . We also have an 'inner soother' (a compassionate part within us) that has the ability to soothe ourselves by saying accepting things in a warm and compassionate way." Participants were then given a series of exercises designed to help them self-soothe. They were instructed to write five compassionate phrases on cue cards, such as "I feel upset about my acne and it is okay to feel this way" or "I would be accepting of a friend in my position. I want to be this way to myself too." They were also taught how to challenge and confront their inner critic. They were asked to write five additional phrases on cue cards, such as "It's not true that people will reject me just because I have acne" and "I have the inner strength to fight my distress and my role in creating it."

Participants were then instructed to read the cue cards three times a day over the course of the next two weeks, as well as doing other exercises like writing a compassionate letter to themselves (see exercise one, chapter 1). It was found that the intervention significantly lessened people's feelings of depression and shame due to their acne. Interestingly, it also lessened the degree to which their acne bothered them physically, reducing sensations of burning and stinging.

When faced with our human imperfection, we can either respond with kindness and care, or with judgment and criticism. An important question to

ask is, what qualities of heart and mind do we want to encourage in ourselves? We can't stop our judgmental thoughts, but we don't have to encourage or believe in them either. If we hold our self-judgments with gentleness and understanding, the force of self-contempt will eventually fade and wither, deprived of the sustenance needed to survive. We have the power to live with joy and contentment by responding to our suffering with kindness. Although this habit is not taught by the larger culture, change is possible. I know this from personal experience.

## My Story: To Err Is Human

As mentioned at the start of this book, I first learned about self-compassion in the Buddhist meditation group I joined during my last year of graduate school. The main reason I joined was because I was drowning in feelings of shame, guilt, and unworthiness; and I was desperately looking to find some inner peace. It was just months before Rupert and I were set to marry, and I was still reeling from the mess I had made of my personal life some years previous.

You see, I had been married before, to a man called John (not his real name) whom I had met while a junior in college. After the string of losers I had dated as a teenager, I thought I had finally met a keeper. John was handsome, intelligent, and cultured. He was also extremely judgmental. When he tried to break up with me due to my perceived shortcomings, a standard theme in my relationships up to that point, I resisted. *This one is too good to lose*, I thought. And of course, his rejection just hooked me even more. I pulled out every resource of charm I had, and we ended up staying together. A few years later we got married.

John was basically a good man, but his judgmental nature meant that he was extremely skeptical about any sort of spirituality. He certainly did not approve of the spiritual beliefs I had been raised with—he thought they were complete hogwash and did not shy away from telling me so. Because I wanted so desperately to be loved and accepted, I began to change myself into the person he thought I should be. I started becoming a skeptic myself, giving up the one thing that had probably been most important in my life up to that point—my relationship with God, or Universal Consciousness as I

often thought of it. To be fair, however, some part of me was already starting to question the concepts of reincarnation, karma, and enlightenment I had put so much faith in during my New Age childhood. Who could say whether these ideas were real or merely wishful thinking—a type of feel-good science fiction? John's skeptical nature was the perfect springboard for my crisis of faith, and I dove right in.

Shortly after starting our relationship, I dropped all spiritual pursuits and enrolled in graduate school at Berkeley to become a research psychologist. Rationality became my new God. This period lasted about seven years. What I didn't realize, of course, was how firmly my heart shut down when I closed off the door to spirituality. My rational mind alone was not enough to make me happy, but I didn't know it. I wasn't happy in my marriage, either, but because it was stable and there were no obvious problems, my dissatisfaction remained largely unconscious. I had never experienced what it felt like to be really seen, cherished, and loved by a man for who I was. So I assumed that having someone who didn't leave me was as good as it got.

Until I met someone who did actually understand and appreciate the real me, that is—an older man (let's call him Peter) who was wiser and more experienced than I. After a friendship that grew increasingly close over about a year, Peter and I started having an affair. I could tell things to Peter that I had never felt safe telling to anyone before, and it made him love me even more. In one way I was happier with Peter than I ever had been in my life. My heart broke wide open and I felt a joy, an aliveness, a self-acceptance more intense than I had ever thought possible. My spiritual side was reawakened. I felt whole and complete for the first time in a long while. The fact that Peter was so much older than me also played into it, no doubt. His desire for me was probably some sort of substitute for feeling unwanted by my father.

Because I felt so terrible about being unfaithful to John, however, I couldn't really acknowledge what was happening, even to myself. My self-judgment made it impossible to own up to what I was doing—such a damning self-portrait was just too painful. It was as if I had developed a split personality, with each side of my life completely disconnected and out of touch with the other. There was an awful period of lying and self-deception that lasted about three months, and I was actually relieved when we were finally found out.

To make a long story short, I left John for Peter, believing that surely we must be soul mates destined to be together forever. How else could I justify the horrible pain I had caused my husband if it wasn't for something pure and noble? Peter, however, did not leave his wife for me.

I sank to one of the lowest points in my life. I hated myself for hurting John so deeply, but I also hated Peter for not making an honest—or at least partially honest—woman out of me. Thank goodness I had already arranged to spend a year studying in India to conduct my dissertation research. (It was on reasoning about rights and responsibilities within Indian marriages, and no, the irony was not lost on me.) The time abroad afforded me the opportunity to get away for a while and lick my wounds. It was in India that I met Rupert, a British travel writer working on a guidebook to the region. Even though I told him I was an emotional mess and that he shouldn't touch me with a ten-foot pole—which for him was like waving a red flag at a bull—it somehow worked out between us.

But when I eventually returned to Berkeley to finish my dissertation, I still had to face up to the chaos I had left behind. Apologizing to John didn't help. He was still furious and not about to forgive me. He still hasn't to this day. But blaming things on Peter didn't help either. And I couldn't remain angry once I learned that he had developed cancer shortly after our breakup and only had a few months left to live.

It was precisely at this point that I started learning about self-compassion in my weekly Buddhist forays, and you can imagine what a lifesaver it was for me. I started to judge myself a little less, to have compassion for my early childhood wounds, and to accept the limitations that led to my unfaithfulness. I wish I had been mature enough to realize that my marriage wasn't working and been able to choose a more honorable way of making a change. I wish I had been wise enough to see that the source of the aliveness and passion I had discovered wasn't in my lover, but in myself. But I wasn't able to do so at the time. I failed to live up to my ideals, and that was a very human thing to do.

It was hard for me to let go of my self-criticism though. Looking back, I see that I was trying to salvage my self-esteem in a convoluted way. At least the part of me that was constantly judging and criticizing myself was good, even if the rest of me was bad.

Another stumbling block was the belief that if I forgave myself it would just amount to letting myself off the hook. But to my surprise I found that

when I started to accept myself with more kindness and compassion, I could actually be more honest about the ways in which I had harmed others. Not only John, but also Peter and his wife. Peter, being more worldly and experienced than I was, had realized that my first flush of passion for a much older man was unlikely to last. I have to admit he was probably right. In some ways I was just using Peter as an escape route from an unhappy marriage. Though I didn't realize it at the time, I probably would have left him once that goal was accomplished. It was the right choice for him to stay with his wife, who was rock solid and his main source of strength during his months of chemotherapy.

What amazed me about my newfound practice of self-compassion was the incredible ability it gave me to see myself clearly, and to learn from the mistakes I had made. Once I stopped cringing and found the bravery to look closely, I could see more precisely where I had gone wrong. With the blessing of my fiancé—Rupert—I took several long, peaceful mountain walks with Peter and we came to a place of mutual understanding, the urgency of our discussions being intensified by Peter's impending death. I could understand why I had made the choices I did, and why Peter had made the choices he did. It wasn't pretty, but it was how life had unfolded.

After Peter passed away, I could finally let go of my shame and self-judgment. I saw that relentlessly attacking myself for my weakness and immaturity was a complete waste of time and wasn't helping myself or anybody else. I realized that by giving myself kindness and understanding, I could start to heal. This new place of inner warmth, peace, and emotional stability not only brought me great happiness, it also allowed me to give more in my relationship with Rupert.

## A Precious Gift

Self-compassion is a gift available to anyone willing to open up to themselves. When we develop the habit of self-kindness, suffering becomes an opportunity to experience love and tenderness from within. No matter how difficult things get, we can always wrap our torn and tattered selves in our own soft embrace. We can soothe and comfort our own pain, just as a child is soothed and comforted by her mother's arms. We don't have to wait until we

are perfect, until life goes exactly as we want it to. We don't need others to respond with care and compassion in order to feel worthy of love. We don't need to look outside ourselves for the acceptance and security we crave. This is not to say that we don't need other people. Of course we do. But who is in the best position to know how you really feel underneath that cheerful façade? Who is most likely to know the full extent of the pain and fear you face, to know what you need most? Who is the only person in your life who is available 24/7 to provide you with care and kindness? You.

## *Chapter Four*

### **WE'RE ALL IN THIS TOGETHER**

*A human being is part of the whole, called by us “Universe,” a part limited in time and space. He experiences himself, his thoughts and feelings, as something separate from the rest—a kind of optical delusion of consciousness. This delusion is a kind of prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole of nature in its beauty.*

—EINSTEIN, *The Einstein Papers*

THE SECOND FUNDAMENTAL ELEMENT OF SELF-COMPASSION IS RECOGNITION of the common human experience. Acknowledgment of the interconnected nature of our lives—indeed of life itself—helps to distinguish self-compassion from mere self-acceptance or self-love. Although self-acceptance and self-love are important, they are incomplete by themselves. They leave out an essential factor—other people. Compassion is, by definition, relational. Compassion literally means “to suffer with,” which implies a basic mutuality in the experience of suffering. The emotion of compassion springs from the recognition that the human experience is imperfect. Why else would we say “it’s only human” to comfort someone who has made a mistake? Self-compassion honors the fact that all human beings are fallible, that wrong choices and feelings of regret are inevitable, no matter how high and mighty one is. (As the saying goes, a clear conscience is usually the sign of a bad memory.)

When we're in touch with our common humanity, we remember that feelings of inadequacy and disappointment are shared by all. This is what distinguishes self-compassion from self-pity. Whereas self-pity says "poor me," self-compassion remembers that everyone suffers, and it offers comfort because everyone is human. The pain I feel in difficult times is the same pain that you feel in difficult times. The triggers are different, the circumstances are different, the degree of pain is different, but the process is the same. *You can't always get what you want.* This is true for everyone, even the Rolling Stones.

We often become scared and angry when we focus on undesired aspects of ourselves or our lives. We feel helpless and frustrated by our inability to control things—to get what we want, to be who we want to be. We rail against things as they are, and we cling to our narrow vision of how things *should* be. Every single human is in the same boat. The beauty of recognizing this basic fact of life—the silver lining so to speak—is that it provides deep insight into the shared human condition.

## Isolated and Alone

Sadly, however, most people don't focus on what they have in common with others, especially when they feel ashamed or inadequate. Rather than framing their imperfection in light of the shared human experience, they're more likely to feel isolated and disconnected from the world around them when they fail.

When we focus on our shortcomings without taking the bigger human picture into account, our perspective tends to narrow. We become absorbed by our own feelings of insufficiency and insecurity. When we're in the confined space of self-loathing, it's as if the rest of humanity doesn't even exist. This isn't a logical thought process, but a type of emotional tunnel vision. Somehow it feels like *I am* the only one who is being dumped, proven wrong, or made a fool of. As Tara Brach (author of *Radical Acceptance*) writes: "Feeling unworthy goes hand in hand with feeling separate from others, separate from life. If we are defective, how can we possibly belong? It seems like a vicious cycle: the more deficient we feel, the more separate and vulnerable we feel."

And even when we're having a painful experience that is not our fault—perhaps we've been laid off our job because of an economic downturn, for instance—we often irrationally feel that the rest of the world is happily employed while it's only me sitting at home watching reruns all day. Or when we become ill, it feels like sickness is an unusual, abnormal state (like the dying eighty-four-year-old man whose final words were “why me?”). Once we fall into the trap of believing that things are “supposed” to go well, we tend to think something has gone terribly amiss when they suddenly don't. Again, this isn't a conscious thought process but a hidden assumption that colors our emotional reactions. If we were to take a completely logical approach to the issue, we'd consider the fact that thousands of things can go wrong in life at any one time, so it's highly likely—in fact inevitable—that we'll experience hardships on a regular basis. But we don't tend to be rational about these matters. Instead, we suffer, and we feel all alone in our suffering.

## The Need to Belong

Abraham Maslow was a well-known American psychologist working in the mid-twentieth century who led the humanistic psychology movement. He argued that needs for individual growth and happiness can't be met without first satisfying the more basic need for human connection. Without bonds of love and affection with others, he argued, we cannot go on to achieve our full potential as human beings. Similarly, psychoanalyst Heinz Kohut, who developed a model called “self psychology” in the early 1970s, proposed that belongingness was one of the core needs of the self. He defined belongingness as the feeling of being “human among humans,” a feeling that allows us to feel connected to other people. One of the major causes of mental health problems, he felt, was a lack of belongingness, the perception that we are cut off from our fellows.

Loneliness stems from the feeling that we don't belong, whether or not we're in the presence of others. If you attend a large party where you don't quite fit in, you're still likely to feel alone. Loneliness comes from feeling disconnected from others, even if they're only inches away. Public speaking anxiety, the number one phobia experienced in our culture, is also caused by

fear of rejection and isolation. Why does the instruction to imagine your audience in their underwear work? Because it reminds you that the audience is vulnerable and imperfect too, and the image boosts your sense of shared humanity.

Even the fear of death itself stems largely from apprehension about losing companionship, closeness, and relationships to others. And feelings of isolation can actually help make that fear a reality. Research indicates that social isolation increases the risk of coronary heart disease by two or three times. In contrast, involvement in a support group lessens the anxiety and depression experienced by cancer victims, while increasing their long-term chances of survival. One of the key reasons support groups are so effective is because members feel less isolated throughout their ordeal. The need to belong, therefore, is fundamental to both physical and emotional health.

Feelings of connectedness, like feelings of kindness, activate the brain's attachment system. The "befriend" part of the "tend and befriend" instinct has to do with the human tendency to affiliate, to come together in groups in order to feel secure. For this reason, people who feel connected to others are not as frightened by difficult life circumstances and are more readily able to roll with the punches.

Of course, it's wonderful when we can get our need to belong met by loved ones such as friends or family. But if you're someone who has trouble sustaining good relationships, this type of social support may be missing in your life. And even in the best of circumstances, other people aren't always able to make us feel that we belong and are accepted. In the cavernous halls of our own minds, we may feel isolated in any moment, even if this isn't the way things actually are. Our fears and self-judgments are like blinders that often prevent us from seeing the hands that are being held out to help us. We may also be ashamed to admit our feelings of inadequacy to those we love, for fear that they wouldn't love us anymore if they knew the way we really were. Hiding our true selves from others then makes us feel even more alone.

That's why it's so important to transform our relationship with ourselves by recognizing our *inherent* interconnectedness. If we can compassionately remind ourselves in moments of falling down that failure is part of the shared human experience, then that moment becomes one of togetherness rather than isolation. When our troubled, painful experiences are framed by the recognition that countless others have undergone similar hardships, the blow

is softened. The pain still hurts, but it doesn't become compounded by feelings of separation. Sadly, however, our culture tells us to notice how we are *unique* from others, not how we are the same.

## The Comparison Game

Because our culture demands that we perceive ourselves as “special and above average,” we routinely engage in an egoistic process of social comparison with others. When we’re deeply invested in seeing ourselves positively, we tend to feel threatened if others do better than we do.

Liz, for instance, felt great after getting her first annual review at her new job. The report praised her hard work and effort and also promised a 5 percent raise starting the next fiscal year. Elated, she rang her boyfriend with the news. “Fantastic!” he said. “I’ll have the champagne ready when you get home.” Later in the parking lot, however, Liz overheard a colleague talking excitedly on her cell phone. “The report said I was the most promising new employee of the year! And get this, they’re giving me a 10 percent raise! That’s twice the 5 percent everyone else gets. Isn’t that amazing?” In half a second Liz went from feeling fabulous to feeling like a complete failure. Instead of celebrating her good fortune with her boyfriend when she got home, she ended up crying on his shoulder.

One of the saddest consequences of social comparison is how we distance ourselves from people whose success makes us feel bad about ourselves. Interestingly, one study found this to be true both literally and figuratively. Researchers told study participants they were assessing student interest in and knowledge of various topics for an upcoming College Bowl competition. Students thought they were being tested in pairs, but the other student was really part of the research team. A mock competition was held, and students fielded a series of questions about topics such as rock music or football. The experimenters told students either that they had outperformed their partner, or else that their partner had outperformed them. Next, experimenters assessed how close participants felt to their study partner by asking how much they thought they had in common and how much they wanted to work with their partner in the future. They even looked at how physically close they sat to their partner when both were moved to another room. Students felt more

distant from partners, and also sat farther away from them, when they were told that they had been outperformed.

The sad irony is that the very reason we want to succeed in the first place is because we want to feel accepted and worthy, to be close to others, to feel that we belong. It's a classic catch-22. The very act of competing with others for success sets up an unwinnable situation in which the feelings of connectedness we crave are forever out of reach.

## Us Against Them

And we don't just compare ourselves to other individuals. We also compare the groups we belong to—Americans, Russians, Republicans, Democrats, Christians, Muslims, and so on—to other groups. That's why we tend to wear the mantle of our group affiliations on our sleeves (or our car bumpers). Our sense of self is imbued with social labels that define us and make us feel safe and accepted within clearly defined group boundaries. Although a sense of belongingness can be found within these group identities, it is still limited. As long as we're identifying with subsets of people rather than the entire human race, we're creating divisions that separate us from our fellows.

Sadly, these divisions often lead to prejudice and hatred. Just as we like to feel we are superior and above average in terms of personal traits, we also like to feel that our groups are superior to others. According to Henri Tajfel's social identity theory, when we incorporate a group into our identity, we derive our sense of self-worth from being a member of that group. We therefore become heavily invested in seeing "us" positively and "them" negatively. It's our investment in social identities that underlies group discrimination and racism. The reason I want to see your gender-ethnic-racial-political-national group as inferior is because it validates the preeminence of my own group, thereby giving me a sense of pride and righteous superiority. When the Ku Klux Klan member dons his white hood and robe, or the would-be terrorist attends a hate rally, his sense of self-worth gets a hit more powerful—and more dangerous—than any drug.

Tajfel's research showed that the process of group prejudice occurs even when the groups we belong to are based on arbitrary criteria. For instance, putting people into different groups based on their preference for the abstract

artists Klee or Kandinsky, or even based on the flip of a coin, leads people to like their own group members better, to provide them with more resources, and to distrust members of the other group.

Group identity lies at the root of most violent conflicts—whether it's a scuffle between two local high school football teams or a full-scale international war. Tajfel understood the ramifications of this type of group bias firsthand. A Polish Jew who studied at the Sorbonne in Paris during the outbreak of World War II, he was drafted into the French army and captured by the Nazis. He was put in a prisoner of war camp but survived only because no one discovered he was Jewish. Most of his friends and family back in Poland were killed, however. The Holocaust was one of the worst—but sadly not the last—examples of the degree to which people can mistreat each other by classifying the self and others into distinct groups.

Fortunately, psychologists have discovered that when our sense of belonging extends to the whole human community rather than stopping at the boundaries of our own social groups, conflict is dramatically lessened. As long as we recognize that we are interconnected rather than distinct entities, understanding and forgiveness can be extended to oneself and others with fewer barriers in between. One study illustrates this point quite well. Jewish college students were asked about their willingness to forgive modern-day Germans for what happened in the Holocaust. The study had two conditions —either the Holocaust was described as an event in which Germans behaved aggressively toward Jews, or as an event in which humans behaved aggressively toward other humans. The Jewish participants were more willing to forgive modern-day Germans when the event was described as occurring between humans rather than distinct social groups, and they also saw Germans as more similar to themselves in this condition. By simply shifting our frame of reference from distinctiveness to similarity with others, we can dramatically alter our perceptions and emotional reactions.

There's a wonderful program called Challenge Day that provides a powerful experience of common humanity for adolescents. The program puts a group of high school students through a daylong series of activities designed to promote feelings of connectedness with their peers. In an exercise called "Lines that divide us," for example, teens are asked to line up on one side of the school gym. Then, a team leader calls out a series of painful experiences and asks people to cross over to the other side of the gym

if they've ever had that experience. Each event is called out slowly, providing ample time for everyone to see who among them has suffered as they have. "Please cross the line if you've ever felt hurt or judged because of the color of your skin. . . . Been humiliated in a classroom by a teacher or a student. . . . Been bullied or teased or hurt for wearing glasses, braces, a hearing aid . . . for the way that you talked, for the clothes that you wore, or for the shape, size, or appearance of your body." At some point, almost every single person in the room crosses the line, making it vividly clear that all teens suffer from judgmental cruelty at one point or another. Typically, even the toughest kids will tear up after participating in the exercise, as compassion flows for themselves and others. The experience shatters the imaginary walls that make teens feel all alone, allowing them to realize that their sense of isolation has been an illusion, and lessening the chance of conflicts between them.

This is why the recognition of common humanity embedded in self-compassion is such a powerful healing force. When our sense of self-worth and belonging is grounded in simply being human, we can't be rejected or cast out by others. Our humanity can never be taken away from us, no matter how far we fall. The very fact that we are imperfect affirms that we are card-carrying members of the human race and are therefore always, automatically, connected to the whole.

## The Illusion of Perfection

All too often, however, our minds fool us into thinking that we can, and in fact *should*, be other than we are. Nobody likes to feel they're flawed. But for some, imperfection is especially hard to bear. Perfectionism is defined as the compulsive need to achieve and accomplish one's goals, with no allowance for falling short of one's ideals. Perfectionists experience enormous stress and anxiety about getting things exactly right, and they feel devastated when they don't. The unrealistically high expectations of perfectionists mean that they will inevitably be disappointed. By seeing things in black-and-white terms—either I'm perfect or I'm worthless—perfectionists are continually dissatisfied with themselves.

Tom, for example, was a writer who made a decent living writing historical fiction novels, but he had never had a major success. While able to

pay his living expenses from his royalties (no mean feat for a writer), Tom felt he wouldn't be satisfied until he had written a national best seller. Then, finally, he got his big break. His latest novel got a glowing review from the *New York Times*, and shortly thereafter he was invited for interviews on various TV and radio stations. Sales of his book started to take off. It didn't take long before he started to envision the words "Number one best-selling novel" written on the cover of the paperback edition. Although he did see a peak in sales, and the book did in fact make the best-seller list (number 23), Tom still wasn't happy. He could only focus on the fact that his sales weren't higher. He wasn't number one, he wasn't even in the top ten. Ironically, Tom felt more depressed *after* his sales went up than before, the possibility of being "the best" now having been firmly entrenched in his mind. Good just wasn't good enough, so he ended up feeling like a failure even though in fact he was a bona fide success. Tom's story highlights the insidious nature of perfectionism, and the suffering it so often causes.

So does perfectionism have an upside? The positive aspect of perfectionism has to do with the determination to do your best. Striving to achieve and setting high standards for yourself can be a productive and healthy trait. But when your *entire* sense of self-worth is based on being productive and successful, when failure is simply not allowed, then the striving to achieve becomes tyrannical. And counterproductive. Research indicates that perfectionists are at much greater risk for eating disorders, anxiety, depression, and a whole host of other psychological problems.

If we were perfect, we wouldn't be human; we'd be Barbie and Ken—plastic figurines that look good but are also dead as doorknobs. Warm, breathing, human life is a constantly unfolding wonder, not a static state of flawless sameness. Being alive involves struggle and despair as well as joy and glory. To demand perfection is to turn our backs on real life, the full range of human experience. And perfection is boring! The popular YouTube character Kelly (an adolescent girl played by comedian Liam Kyle Sullivan) captures this sentiment perfectly when she says in a typically bored teen-girl voice: "I've already been to heaven. After five minutes I was like, let's go!" Isn't it so true? Would you really want to inhabit a world where everything and everyone was absolutely perfect? It's precisely *because* of the unwanted and unexpected that our lives have such intrigue and interest.

Imperfection also makes growth and learning possible. Like it or not, the

main way we learn is by falling flat on our face, just as we did when we first learned to walk. Our parents may tell us a million times not to touch that hot stove, but it's only after we actually burn ourselves that we really understand why it's not such a great idea. The learning opportunities provided by failure can actually help us to achieve our dreams. In the words of restaurateur Wolfgang Puck, "I learned more from the one restaurant that didn't work than from all the ones that were successes." Yes, failure is frustrating. But it's also temporary and eventually yields wisdom. We can think of failure as part of life's apprenticeship. If we were perfect and had all the answers, we'd never get to ask questions, and we wouldn't be able to discover anything new.

## Interconnectedness

When we judge ourselves for our inadequacies, we typically assume that there is in fact a separate, clearly bounded entity called "me" that can be blamed for failing. But is this really true? Who we are, how we think, and what we do is inextricably interwoven with other people and events, which makes the assignment of blame quite ambiguous. Let's say you have an anger issue that you habitually criticize yourself for. What are the causes and conditions that led you to be so angry? Perhaps inborn genetics plays a role. But did you choose your genes before entering this world? Of course not, your genetic makeup stems from factors completely beyond your control. Or maybe you grew up in a conflict-filled household in which shouting and anger were the only ways to get heard. But did you choose for your family to be this way?

If we closely examine our "personal" failings, it soon becomes clear that they are not there by choice. Typically, outside circumstances conspired to form our particular patterns without our input. If you had control over your maladaptive thoughts, emotions, and behaviors, you wouldn't still have them. You would have already jettisoned your dark, anxious, neurotic persona and become a calm, confident ray of sunshine. Clearly you don't have complete control over your actions, or else you'd only act in ways that you approved of. So why are you judging yourself so harshly for the way you are?

We are the expression of millions of prior circumstances that have all

come together to shape us in the present moment. Our economic and social background, our past associations and conversations, our culture, our family history, our genetics—they've all had a profound role in creating the person we are today. Zen master Thich Nhat Hahn calls this “interbeing.”

*If you are a poet, you will see clearly that there is a cloud floating in this sheet of paper. Without a cloud there will be no water; without water, the trees cannot grow; and without trees, you cannot make paper. So the cloud is in here. The existence of this page is dependent upon the existence of a cloud. Paper and cloud are so close.*

Many people are scared to acknowledge their essential interconnectedness, because it means they must admit they don't have complete control over how they think and act. This makes them feel powerless. However, the illusion of being in control is just that—an illusion. And a harmful one at that, because it encourages self-judgment and self-blame. In reality, it doesn't make any more sense to harshly blame ourselves than it does to blame a hurricane. Despite the fact that we give hurricanes names like Katrina and Rita, a hurricane isn't a self-contained unit. A hurricane is an impermanent, ever-changing phenomenon arising out of a particular set of interacting conditions—air pressure, ground temperature, humidity, wind, and so on. The same applies to us: we aren't self-contained units either. Like weather patterns, we are also an impermanent, ever-changing phenomenon arising out of a particular set of interacting conditions. Without food, water, air, and shelter, we'd be dead. Without our genes, family, friends, social history, and culture, we wouldn't act or feel as we do.

When we recognize that we are the product of countless factors that we don't normally identify with, we don't need to take our “personal failings” so personally. When we acknowledge the intricate web of causes and conditions in which we are all imbedded, we can be less judgmental of ourselves and others. A deep understanding of interbeing allows us to have compassion for the fact that we're doing the best we can given the hand life has dealt us.

“But” is often the interjection at this point. What's wrong with judgment? Don't we need judgment to figure out right from wrong? To take personal responsibility for our mistakes?

It's useful here to draw a distinction between judgment and discriminating wisdom. Discriminating wisdom recognizes when things are harmful or unjust, but also recognizes the causes and conditions that lead to situations of harm or injustice in the first place. When wrongdoers are treated with compassion rather than harsh condemnation, cycles of conflict and suffering can be broken.

Imagine hearing a story about a young man who robs a bank and shoots a teller in the arm as she tries to call for help. At first you might make a ruthless judgment of the man—he's a monster and should be locked in jail for eternity. End of story. But then, you learn more about the criminal's background and history. His parents were drug addicts. By eleven he was out on the streets in a neighborhood where he had to fight and steal to survive. He tried to get a job and go straight but kept getting fired because he didn't know how to read or write properly, and eventually he turned to crime again. Your hard-line attitude toward the offender might begin to soften. You might even come to have compassion for him. This compassion wouldn't mean that you absolve the man of responsibility for his crimes, or think that what he did was okay. You might still decide that he needs to be put away in prison to ensure the safety of society. But you would have a deeper understanding of the conditions that led him to act as he did, and you would retain respect for his humanity in the process. And who knows, it's even possible that with the right help and encouragement—in other words, a new set of conditions—he could change.

This is discriminating wisdom rather than judgment. Judgment defines people as bad versus good and tries to capture their essential nature with simplistic labels. Discriminating wisdom recognizes complexity and ambiguity. It acknowledges that life has unfolded in such a way as to cause something to happen, but also allows for the possibility that with a new set of circumstances things might well go differently.

Jesus famously said, "Let him who is without sin cast the first stone." And later, as he hung dying on the cross, he said, "Father, forgive them, for they know not what they do." The message was clear: we need to have understanding and compassion for even the worst wrongdoers, ourselves included.

## Exercise One

### *Letting Go of Our Self-Definitions by Identifying Our Interconnectedness*

Think about a trait that you often judge yourself for, and that is an important part of your self-definition. For example, you may think of yourself as a shy person, lazy, angry, and so on. Then ask yourself the following questions:

1. How often do you display this trait—most of the time, sometimes, only occasionally? Who are you when you don't display the trait? Are you still you?
2. Are there particular circumstances that seem to draw out the trait, and others in which the trait is not apparent? Does this trait really define you if particular circumstances must be present in order for the trait to emerge?
3. What are the various causes and conditions that led to having the trait in the first place (early family experiences, genetics, life pressures, etc.)? If these “outside” forces were partly responsible for you having this trait, is it accurate to think of the trait as reflecting the inner you?
4. Did you choose to have this trait, and do you have much choice about whether or not you display this trait? If not, why are you judging yourself for this trait?
5. What happens when you reframe your self-description so that you are not defining yourself in terms of the trait? For example, instead of saying “I am an angry person,” what happens when you say “Sometimes, in certain circumstances, I get angry.” By not identifying so strongly with this trait, does anything change? Can you sense any more space, freedom, peace of mind?

We are all subject to human limitations. Every single one of us is in the same predicament. The British novelist Jerome K. Jerome once wrote, “It is in our faults and failings, not in our virtues, that we touch each other, and find sympathy. It is in our follies that we are one.” In recognizing the shared nature of our imperfection, self-compassion provides the sense of

connectedness needed to truly thrive and reach our full potential. Instead of looking outside ourselves for a sense of acceptance and belonging, we can directly satisfy these needs by looking within.

## My Story: What's Normal, Anyway?

The practice of self-compassion, and especially of remembering our shared humanity, helped me deal with the greatest challenge in my life so far. A couple of years after getting a job at the University of Texas at Austin, I gave birth to a beautiful little boy named Rowan. At eighteen months, we knew there was something wrong with him. He wasn't pointing, something most babies do by their first birthday. He didn't turn his head when we called his name, didn't call me Mama, didn't call me anything at all. He only had about five words—all starting with the letter B—and a few names, mostly of Thomas the Tank engine trains. He would spend hours obsessively lining up his toy animals. He would tantrum violently at the drop of a hat. I'd known parenthood would be hard, but not this hard. Why couldn't I stop his disruptive behaviors? Was it because I was a bad mother? Was I not being firm enough?

I did wonder whether Rowan might have some sort of developmental disorder. Could it be hearing problems, speech delay, central auditory processing disorder? I took him to all sorts of specialists. Ordered any book I thought might help. Did anything and everything *except* seriously investigate if Rowan was showing signs of autism. Looking back, I must have unconsciously suspected he was autistic, but my conscious mind wouldn't allow me to admit it. Whatever's wrong with Rowan, I thought, there's no way that this adorable, charming, funny child could be autistic. After all, he was so loving and affectionate, and he made direct eye contact. Autistic children aren't supposed to do that, are they? I remember once after Rowan gave me one of his beautiful, heartwarming smiles, I even half-jokingly said to my husband, Rupert—"At least we know he's not autistic!"

Then one day, as I was packing for a silent meditation retreat that was to start later that afternoon, I couldn't ignore the nagging worry any longer. I took a few deep breaths, turned toward the computer, and typed in the words "Autism, early signs of." The web page said that if your child showed at least

three out of a list of ten signs, he or she had a good chance of being autistic and should be taken in for professional evaluation as soon as possible. Rowan had nine out of ten. Lack of eye contact was the only sign he *didn't* have.

At that moment, I knew Rowan was autistic. I called Rupert and told him. He was as stunned as I was. “I’ll cancel my retreat,” I said. “No, you should go,” he said. “You need it. And I’ll need you to be strong and centered so you can help *me* when you get back.” I cried during the entire two-hour drive to the retreat center, and for the next four days I quite literally sat with the pain of knowing my son was autistic. “How can this be happening?” “Is Rowan slipping away from us?” “How are we going to cope?” I allowed myself to fully feel my fear and grief. I gave myself as much loving-kindness and compassion as I could. If a guilty thought would creep in—“How can I be grieving for Rowan, when I love him so much?”—I wouldn’t allow myself to run away with self-judgment. My feelings of grief were only natural, something all parents in such situations go through.

When I got back from the retreat, Rupert and I had to deal with the fact that this was now our life. All our dreams of having the perfect son—we assumed that he would go on to get a Ph.D. like me, of course, or maybe become a successful writer like his father—flew out the window. We had an autistic child.

I freely admit that at times, the experience pushed me into self-pity. When at the park with Rowan, for instance, watching other moms with their “normal” kids, I would start to feel very sorry for myself. Why can’t I have a normal child? Why can’t Rowan even respond when another child asks him his name? Why are the other kids making faces at how weird he’s being? I would start to feel isolated, alone, cut off from the world of “normal” families. I found myself internally screaming, “*HAVING CHILDREN IS NOT SUPPOSED TO BE THIS WAY! THIS IS NOT THE PLAN I SIGNED UP FOR! WHY ME?*” But luckily self-compassion saved me from going too far down this path. While watching the other kids playing on the swings or swooshing down the slide, I would remind myself that most families had difficulties raising their kids. Maybe the challenge wasn’t autism, but it could be any number of other issues—depression, eating disorders, drug addiction, being bullied at school, serious illness. I would look at the other families at the park and remember that they surely had their woes and sorrows too, if not now then sometime in the future. Instead of feeling “poor me,” I would try to

open my heart to all parents everywhere who were trying to do their best in challenging circumstances. What about the millions of parents in developing countries whose children didn't even have enough to eat? I certainly wasn't the only one having a hard time.

Two things would happen as a result of this line of thinking. First, I would begin to feel deeply in touch with the unpredictability of being human. My heart would swell up with tenderness for all the challenges and sorrows involved in being a parent, but also for all the joy, love, and wonder that children bring us. Second, my situation was put into much clearer perspective. Rather than falling into the trap of believing that other parents were having an easier time than I was, I remembered that it could be worse—much worse. In the overall scheme of things, autism wasn't so bad, and there were things we could do to help Rowan tremendously. The real gift of self-compassion, in fact, was that it gave me the equanimity needed to take actions that *did* ultimately help him.

Perhaps more important, focusing on common humanity helped me to love Rowan for who he was. Once I remembered that having problems and challenges *was* normal, I could more easily get over the disappointment of not having a “normal” child.

And what is “normal” anyway? Maybe Rowan had difficulty expressing himself with language, or engaging in appropriate social interactions, but he was a loving, happy kid. Being human is not about being any one particular way; it is about being as life creates you—with your own particular strengths and weaknesses, gifts and challenges, quirks and oddities. By accepting and embracing the human condition, I could better accept and embrace Rowan and also my role as the mother of an autistic child.

## *Chapter Five*

### BEING MINDFUL OF WHAT IS

*You can't stop the waves, but you can learn to surf.*

—JON KABAT-ZINN, *Wherever You Go, There You Are*

THE THIRD KEY INGREDIENT OF SELF-COMPASSION IS MINDFULNESS. Mindfulness refers to the clear seeing and nonjudgmental acceptance of what's occurring in the present moment. Facing up to reality, in other words. The idea is that we need to see things as they are, no more, no less, in order to respond to our current situation in the most compassionate—and therefore effective—manner.

#### Stopping to Notice Moments of Suffering

To give ourselves compassion, we first have to recognize that we are suffering. We can't heal what we can't feel. As mentioned earlier, we often fail to recognize feelings of guilt, defectiveness, sadness, loneliness, and so on, as moments of suffering that can be responded to with compassion. When you look in the mirror and decide you're too short, or that your nose is too big, do you immediately tell yourself that these feelings of inadequacy are painful and deserving of a kind, caring response? When your boss calls you into his office and tells you that your job performance is below par, is your first instinct to comfort yourself for going through such a difficult experience? Probably not.

We certainly feel the sting of falling short of our ideals, but our mind tends to focus on the failure itself, rather than the pain caused by failure. This

is a crucial difference. The moment we see something about ourselves we don't like, our attention tends to become completely absorbed by our perceived flaws. In that moment, we don't have the perspective needed to recognize the suffering caused by our feelings of imperfection, let alone to respond to them with compassion.

And it's not just the pain of personal inadequacy that we tend to ignore. We are surprisingly brusque toward ourselves when the more general circumstances of our life go wrong through no fault of our own. Let's say your mother becomes seriously ill, or you get rear-ended on the freeway. Most people, even if they don't blame themselves for their current circumstances, tend to immediately go into problem-solving mode in such situations. We are likely to spend enormous amounts of time and energy dealing with the crisis, making doctors appointments, calling insurance companies, and so on. Although all this is certainly necessary, it's also very important to recognize that these experiences take a lot out of us emotionally. We need to stop for a breath or two and acknowledge that we're having a hard time, and that our pain is deserving of a kind, caring response. Otherwise, our suffering will go unattended, and feelings of stress and worry will only mount. We risk getting burned out, exhausted, and overwhelmed, because we're spending all our energy trying to fix external problems without remembering to refresh ourselves internally.

It's not surprising that we often ignore our own pain, given that we're physiologically programmed to avoid it. Pain signals that something is wrong, triggering our fight-or-flight response. It screams PROBLEM, GET AWAY, DANGER!!! Imagine if pain couldn't signal something as basic as "finger caught in car door, open door and remove finger immediately!" Because of our innate tendency to move away from pain, it can be extremely difficult to turn toward our pain, to hold it, to be with it as it is. This is why so many people shut themselves off from their emotions. It's a very natural thing to do.

Jacob was one of these people. He avoided conflict and was quick to appease anyone who showed any signs of getting upset. He just didn't want to deal with any sort of emotional intensity. Jacob was a good man, but he was unwilling to face up to the pain of his past. His mother had been a well-known television actress who was seriously devoted to her acting career. She often left Jacob in the hands of nannies while she worked on various

production sets. On an unconscious level, Jacob deeply resented all the time his mother spent away from him, feeling that she prioritized her career over him. If he were to allow his feelings of anger in, however, he was afraid he'd start hating his mother, destroying the feelings of love and connection he felt with her. So basically, he just suppressed his rage.

Several years ago, Jacob became depressed and entered therapy. The therapist helped him to realize that his depression stemmed in part from the deep wells of anger he was harboring toward his mother, and the effort it was taking to repress his rage. What he needed was to get in touch with his true feelings. When Jacob did finally turn toward his anger, however, rather than simply holding it in mindful awareness, it took him over, and he ended up wielding his anger like an assault rifle. He dove into his rage with full force, getting more and more riled up as he thought about the "horrible" way his mother had treated him. He started seeing her as a narcissistic monster—Norma Desmond in *Sunset Boulevard*. In short, he became hysterical rather than mindful. Unfortunately, this type of extreme pendulum swing is common when people first start working with difficult emotions.

## Running Away with Painful Feelings

Like Jacob, suppressing and then exploding with our emotions is something most of us have experienced. I like to term this process "overidentification." Our sense of self becomes so wrapped up in our emotional reactions that our entire reality is consumed by them. There's no mental space left over to say, "Gosh, I'm getting a bit worked up here. Maybe there's another way to look at this." Rather than stepping back and objectively observing what's occurring, we're lost in the thick of it. What we think and feel seems like a direct perception of reality, and we forget that we are putting a personal spin on things.

I remember once my mother and mother-in-law were both visiting from out of town and they borrowed my car for an outing with my son, Rowan. I have a silver Toyota hybrid with keyless technology, meaning that you just have to hold the key near the car door and it will open. There is no button to push or key to insert. This novel technology made them a bit nervous—they just didn't trust it. After going on the outing and coming back to the parking

lot, they tried holding the magical key thingy next to the car door and, of course, it didn't work. My mother tried the key over and over again, and nothing happened. "See! You can't rely on these newfangled gimmicks!" They both got very upset—here they were, almost an hour from home, stranded with a confused child, all because of some goddamned modern technology. What were they to do?

They called the local Toyota dealership, who told them to call a locksmith. Once the locksmith had been arranged and was on his way, they saw a parking lot security person. Maybe he could help in the meantime. "Sir, we're locked out of our Toyota hybrid that has this weird key thing; have you ever used one of these before?" The man looked at the key, then looked at the car. "Uh, ladies, you said it was a Toyota hybrid? This car isn't a hybrid. It isn't even a Toyota." My car was actually three spaces down. They had become so lost in their reactions that neither of them thought to take a very sensible next step: checking to see whether they were trying to get into the right car! In the immortal words of Charlie Chaplin, "Life is a tragedy when seen in a close-up, but a comedy when seen in a long-shot."

There's another reason I call this process overidentification. Extreme reactions—or perhaps more accurately, overreactions—are especially common when the sense of self is involved. If I am afraid of other people judging me—let's say I have to give a public speech and am nervous about it—then the feelings that come up when thinking about the speech will tend to wildly distort reality. Rather than simply noticing that I am nervous, I might create elaborate scenarios in my mind of rejection, people laughing at me, throwing rotten vegetables, and so on.

What often drives this type of emotional overreaction is the attempt to avoid seeing ourselves as flawed or "bad." When our self-concept is threatened, things ramp up very quickly. I can think of a recent example (very recent, I must admit), of my own "overidentified" reaction. I thought I'd lost an important tax certificate sent to me by the IRS, which I had applied for months earlier and had just received in the mail. The deadline for filing the certificate was fast approaching. I was about to send it to my accountant but couldn't find it anywhere. I looked and looked but to no avail. Panic ensued. I was racked with anxiety. What a catastrophe! I'm in deep jeopardy! I became angry, distraught—losing it, in other words. Underlying my reaction was the fear that I was just a screwup, that my lack of organization skills (mail tends

to pile up on my kitchen table like leaves in autumn) had finally come back to haunt me. Luckily, I eventually recognized what was happening and was able to be mindful of my reactions. Yes, I was feeling anxious about losing the certificate, but was it really all that bad? I could always ask the IRS for another copy, which, though a hassle, wouldn't be the end of the world. I even managed to remember to have compassion for the anxiety I felt, and to recognize that my life was very busy and I was actually pretty organized considering everything. I stopped to comfort myself in this painful situation, remembering that these things happen.

A few hours later, my husband, Rupert, came home with a sheepish look on his face. He told me that he had accidentally used the back of the IRS envelope for a shopping list, so it wasn't really lost after all. Rather than lambasting him, which I probably would have done if I was still wrestling with the self-judgment that I was incompetent, I was able to laugh at the whole situation. How often do we make mountains out of molehills? How often do we create the illusion that things are worse than they really are? If we can be mindful of our fears and anxieties rather than overidentifying with them, we can save ourselves from a lot of unwarranted pain. As the seventeenth-century French philosopher Montaigne once said, "My life has been filled with terrible misfortune, most of which never happened."

Mindfulness brings us back to the present moment and provides the type of balanced awareness that forms the foundation of self-compassion. Like a clear, still pool without ripples, mindfulness perfectly mirrors what's occurring without distortion. Rather than becoming lost in our own personal soap opera, mindfulness allows us to view our situation with greater perspective and helps to ensure that we don't suffer unnecessarily.

## Awareness of Awareness

When we notice our pain without exaggerating it, this is a moment of mindfulness. Mindfulness entails observing what is going on in our field of awareness just as it is—right here, right now. I remember quite clearly the first time I experienced mindfulness. I was about twelve years old, home alone after school. My mother had a copy of Ram Dass's book *Be Here Now* lying on the coffee table. Although the book had been there for several

months, one day, for whatever reason, I actually thought about what the words meant. BE HERE NOW. Hmm. I *am* here, and it *is* now. I walked across the living room. Still here, still now. Then I walked into the kitchen. Still here, still now. Where else could I be but here? When else could it be but now? Then it dawned on me—there is *only* here and *only* now. No matter where we go or what we do, we are here, now. I felt a giddy excitement and ran around the house laughing with amazement. HERE! NOW! HERE! NOW! HERE! NOW! I had gained insight into one of the most fundamental truths of life—that conscious awareness *only exists in the here and now*.

Why is this important? Because this insight allows us to see that thoughts about the past and the future are just that: thoughts. The past doesn't exist except in our memories, and the future doesn't exist except in our imagination. Rather than being lost in our train of thought, therefore, we can take a step back and say—ahh, this is what I'm thinking, feeling, and experiencing *right now*. We can awaken to the reality of the present moment.

Mindfulness is sometimes seen as a form of “meta-awareness,” which means awareness of awareness. Instead of simply feeling anger, I am aware that I am now feeling anger. Rather than just feeling the blister on my heel, I am aware that I now feel the blister on my heel. Not only am I thinking about what I'm going to say at the meeting tomorrow, I am aware that I'm now thinking about what I'm going to say tomorrow. This may seem like a vague, insubstantial distinction, but it makes all the difference in the world in terms of our ability to respond effectively to difficult situations. When we can see our situation with clarity and objectivity, we open the door to wisdom. When our awareness narrows and gets lost in our thoughts and emotions, we can't reflect on our reactions and question whether they are out of line. This limits our ability to act wisely.

A commonly used analogy among those who write about mindfulness is that of a movie theater. When you're lost in the story line of a movie—perhaps a thriller—sometimes you suddenly remember that you're watching a movie. A moment earlier, when you thought the heroine might be pushed out of the window by the villain, you were gripping your armrests in fear. Then the man next to you sneezes and you realize that there isn't really any danger—it's just a movie. Rather than being totally consumed by the plot, your awareness broadens and you recognize what is actually happening in the present moment. You are simply watching pixels of light dancing across a

scene. So you loosen your grip on the armrest, your heartbeat returns to normal, and you allow yourself to become lost in the story once again.

Mindfulness operates in a very similar manner. When you focus on the fact that you are having certain thoughts and feelings, you are no longer lost in their story line. You can wake up and look around you, taking an outsider's perspective on your experience. You can turn your awareness in on itself, as if you were gazing in a reflective pool and see an image of yourself gazing in a reflective pool. Try it right now. You've been reading the words on this page without realizing that you were reading, but now you can read this sentence with the *awareness* that you are reading. If you're sitting, you probably haven't noticed the sensations in your feet as they touch the floor. Now focus on the fact that your feet feel a certain way. Not only do your feet tingle (or are warm, cold, cramped, etc.), you are now *aware* that your feet feel this way. This is mindfulness.

Fortunately, Jacob finally learned how to become mindful of the anger spurred by his mother's acting career instead of just "letting it all hang out." His therapist taught him how to fully feel and experience the hurt and resentment he had been harboring toward his mother all those years, without necessarily believing that the story line he was telling himself was *real and true*. The anger was true, but the gentle, nonjudgmental awareness that held his anger helped him realize that his mother's deep love for him was also true. Yes, she loved her career and was devoted to it—perhaps to a fault—but this was partly because it gave her the financial resources needed to provide the advantages in life she so wanted for him. Before confronting his mother with angry accusations, therefore, Jacob was able to calm and center himself with mindfulness. He then had a frank but kind conversation with his mother about the difficulties of his childhood that actually ended up bringing them closer together. If he had not chosen the path of mindfulness, he might have caused a destructive rift in their relationship that would have taken years to heal.

## Shining the Light of Consciousness

One key to understanding mindfulness lies in distinguishing awareness itself from the contents of awareness. All sorts of different things arise within the

frame of our awareness—physical sensations, visual perceptions, sounds, smells, tastes, emotions, thoughts. These are all contents—things that come and go. And the contents of awareness are always changing. Even when staying perfectly still, our breath rises and falls, our heart beats, our eyes blink, sounds arise and pass away. If the contents of awareness didn't change, we'd be dead. Life, by definition, entails transformation and change.

What about the awareness that holds all these phenomena, however? The light of consciousness that illuminates the sights, sounds, sensations, and thoughts? Awareness does not change. It is the only thing in our waking experience that remains still and constant, the calm foundation on which our ever-changing experience rests. Experiences continually vary, but the conscious awareness that illuminates those experiences does not.

Imagine a red cardinal bird flying across a clear blue sky. The bird represents a particular thought or emotion we're experiencing, and the sky represents mindfulness, which holds the thought or emotion. The bird might start doing crazy loops, take a nose dive, land on a tree branch, whatever, but the sky is still there, unperturbed. When we identify with the sky rather than with the bird, or in other words, when our attention rests in awareness itself, rather than the particular thought or emotion arising within that awareness, we can stay calm and centered.

This is important, because when we are mindful, we find our resting place—our seat, as it's sometimes called. Rather than having our sense of self caught up in and carried away by the contents of awareness, our sense of self remains centered in awareness itself. We can notice what is happening—an angry thought, a fear, a throbbing sensation in our temple—without falling into the trap of thinking that we are *defined* by this anger, fear, or pain. We can't be defined by *what* we are thinking and feeling when our consciousness is *aware* that we are thinking and feeling: otherwise, who is it that is being aware of our thoughts and feelings?

## Exercise One

### *Noting Practice*

(Also available as a guided meditation in MP3 format at [www.self-](http://www.self-help.com)

[compassion.org](http://compassion.org))

An important tool used to develop mindfulness is the practice of noting. The idea is to make a soft mental note whenever a particular thought, emotion, or sensation arises. This helps us to become more consciously aware of what we're experiencing. If I note that I feel angry, for instance, I become consciously aware that I'm angry. If I note that my back is uncomfortable as I'm sitting at my desk, I become consciously aware of my discomfort. This then provides me with the opportunity to respond wisely to my current circumstances. Perhaps I should take a few deep breaths to calm down or stretch to relieve my back pain. The noting practice can be used in any situation and helps engender mindfulness in daily life.

For this exercise, find a relaxed position and sit down for about ten to twenty minutes. Get comfortable, close your eyes, and simply note whatever thoughts, emotions, smells, sounds, or other physical sensations arise in your awareness. For example: "breathing in," "sound of children playing," "itch in left foot," "wondering what to wear for the party," "insecurity," "excitement," "plane flying overhead," and so on. Every time you become aware of a new experience, acknowledge the experience with a quiet mental note. Then allow your attention to settle on the next experience it is drawn to.

Sometimes you'll find yourself lost in thought and realize that for the last five minutes you've been thinking about your lunch and have forgotten entirely about your noting practice. Not to worry. As soon as you notice that you've been lost in thought, simply note "lost in thought" and turn your attention back to your noting practice.

We can train our brains to pay better attention and become more aware of what's happening to us moment to moment. This skill offers a big payoff in terms of allowing us to be more fully engaged in the present, and it also provides us with the mental perspective needed to deal with challenging situations effectively.

## Responding Rather Than Reacting

Mindfulness provides incredible freedom, because it means we don't have to believe every passing thought or emotion as *real and true*. Rather, we can see that different thoughts and emotions arise and pass away, and we can decide which are worth paying attention to and which are not. We can question the accuracy of our perceptions and ask if our thoughts and emotions need to be taken quite so seriously. The real treasure offered by mindfulness—its most amazing gift—is that mindfulness provides us with the opportunity to *respond* rather than simply *react*.

When I am lost in the story of a powerful emotion—let's say I feel insulted by something my friend just said and I'm feeling hurt and indignant—I am likely to react in a way I'll later regret. For instance, I was once talking with a friend on the phone and we got into an argument. I was trying to convince her that a choice I was making was in fact a good one. At first it was just a discussion—I was presenting my reasons for making this choice and my friend was presenting her concerns about whether or not it was actually right for me. At some point, however, my friend voiced her fear that I was being “naive.” It's funny how quickly the tenor of the discussion changed. I felt insulted, then angry. I started raising my voice and was soon shouting. I was defending my point of view as if my life depended on it, exaggerating my claims to know what was right for me and portraying my friend as the one who was ignorant and confused. Before I knew it, I had hung up on her.

Luckily we're old friends and I called her back a few minutes later to apologize. Once we started talking calmly, I realized she didn't mean to be insulting by voicing her fear that I was being naive about this particular issue. She was really concerned I was making a decision without having the experience or knowledge needed to make a good one. Sure, it wasn't the most politic choice of words on her part, but her intentions were good and I certainly overreacted. The fact that I had had a stressful day at work that day probably hadn't helped things either.

If I had been able to be mindful during our conversation, I would have been able to say to myself: *I am aware that I am feeling hurt, insulted, and angry right now. I'm going to take a deep breath and pause before I start*

*shouting accusations. What are her motives—is she really trying to hurt me?* In other words, when we’re able to recognize what we’re feeling in the moment, we don’t have to let those feelings immediately propel us into action. We can stop to question whether we really want to say what’s on the tip of our tongue and choose to say something more productive instead.

To have any choice in how we respond, however, we need the mental space to consider our options. We need to be able to ask ourselves—what is really happening right here, right now? Is the danger real, or am I only having *thoughts* of danger, like pixels of light dancing on a screen? What is the *actual* situation that needs to be responded to? This is how we gain the freedom needed to make wise choices.

And even when we aren’t able to be mindful in the moment—which is admittedly very difficult to do when our emotions are running high—mindfulness allows us to recover from our overreactions more quickly. No, I wasn’t able to stop myself before hanging up on my friend. But I didn’t have to spend the next few hours, days, or weeks justifying my behavior either. I was quickly able to recognize what had just happened, to be mindful of the reality that I regretted my behavior, to make amends, and move on.

There is remarkable power in mindfulness—it gives us the breathing room needed to respond in a way that helps rather than harms us. And of course, one of the ways we harm ourselves most is through the reactive habit of self-criticism. Whether due to our parents, our culture, or our personality type, many of us have built up lifelong patterns of beating ourselves up when we fail or make some mistake. Our automatic reaction when we see something about ourselves we don’t like is to put ourselves down. Or when faced with adversity, our first reaction might be to immediately go into problem-solving mode without first stopping to tend to our emotional needs. But if we can be mindful, even for just a moment, of the pain associated with failure or the stress and hardship entailed by difficult circumstances, we can take a step back and respond to our pain with kindness. We can soothe and comfort ourselves with compassionate understanding. We can reframe our situation in light of our shared humanity, so that we don’t feel so isolated by adversity. Not only am I suffering, *I am aware that I am suffering*, and therefore I can try to do something about it.

After some practice you can actually make a habit of this, so that as soon as you notice you’re suffering you automatically embrace yourself with

compassion. Think of it as pushing the reset button on your computer when it gets locked up. Rather than staying stuck in painful feelings of self-judgment or merciless stoicism, you can reboot your heart and mind so that they start flowing freely again. Then, whatever actions are needed to help your situation can be carried out with more calm, stability, and grace—not to mention effectiveness.

## Suffering = Pain x Resistance

Suffering stems from a single source—comparing our reality to our ideals. When reality matches our wants and desires, we’re happy and satisfied. When reality doesn’t match our wants and desires, we suffer. Of course, we have about a snowball’s chance in hell of our reality completely matching our ideals 100 percent of the time. That’s why suffering is so ubiquitous.

I once went on a meditation retreat with a wonderful teacher named Shinzen Young, who gave me words of wisdom that I’ll never forget. He said that the key to happiness was understanding that suffering is caused by *resisting* pain. We can’t avoid pain in life, he said, but we don’t necessarily have to suffer because of that pain. Because Shinzen was a bit of a Buddhist “nerd” (he even wore horn-rimmed glasses), he chose to express these words of wisdom with an equation: “Suffering = Pain x Resistance.” He then added, “Actually, it’s an exponential rather than a multiplicative relationship.” His point was that we can distinguish between the normal pain of life—difficult emotions, physical discomfort, and so on—and actual *suffering*, which is the mental anguish caused by fighting against the fact that life is sometimes painful.

Let’s say you get caught in a nasty traffic jam. This situation may be mildly stressful and annoying. You’ll probably be a few minutes late for work and somewhat bored while sitting there. No big deal. If, however, you resist the fact that you are caught in a traffic jam, mentally screaming “THIS SHOULD NOT BE HAPPENING!!!!” you are likely to suffer a great deal. You’ll become much more upset, agitated, and angry than you would be otherwise. Road rage incidents are due to precisely this type of overreaction. There are about three hundred serious injuries or deaths caused by road rage in the United States alone each year.

Our emotional suffering is caused by our desire for things to be other than they are. The more we resist the fact of what is happening right now, the more we suffer. Pain is like a gaseous substance. If you allow it to just *be* there, freely, it will eventually dissipate on its own. If you fight and resist the pain, however, walling it into a confined space, the pressure will grow and grow until there is an explosion.

Resisting pain truly is banging your head against the wall of reality. When you fight against the fact that pain is arising in your conscious experience, you are piling on feelings of anger, frustration, and stress on top of the pain. This only exacerbates your suffering. Once something has occurred in reality, there is nothing you can do to change that reality in the present moment. *This is how things are.* You can choose to accept this fact or not, but reality will remain the same either way.

Mindfulness allows us to stop resisting reality because it holds all experience in nonjudgmental awareness. It allows us to accept the fact that something unpleasant is occurring, even if we don't like it. By mindfully relating to our difficult emotions, they have the chance to take their natural course, arising and eventually passing away. If we can wait out the storm with relative equanimity, we won't make things any worse than they already are. Pain is unavoidable; suffering is optional.

## Exercise Two

### *Mindfully Working with Pain*

Conduct this small experiment to observe how mindfulness and self-compassion can help us suffer less when we're in pain.

1. Hold an ice cube in your hand for several seconds (this will be mildly uncomfortable). Just react as you normally would, and put the ice cube down when the discomfort becomes overwhelming. Notice how intense your discomfort was, and how long you could hold the ice cube before needing to put it down.

2. Hold an ice cube in your other hand for several seconds. This time, as you feel the discomfort, try not to resist it. Relax around the sensation and allow it just to be. Mindfully note the qualities of

the sensation—cold, burning, tingling, and so on. As you do so, give yourself compassion for any discomfort you feel. (For example, you might say “Ouch, this really hurts. It’s difficult to feel this sensation. But it’s okay, I’ll get through it.”) Put the ice cube down when the discomfort becomes overwhelming. Once again, notice how intense your discomfort was, and how long you could hold the ice cube.

After you’re done, compare the two experiences. Did anything change when you didn’t resist the pain? Were you able to hold the ice cube for a longer time? Was your discomfort less intense? Were you able to provide empirical support for the proposition that “Suffering = Pain x Resistance”? The less you resist, the less you suffer.

## Relating to That Which Is Beyond Our Control

Sometimes—not always, but sometimes—there is the possibility of making changes to your current situation so that your future circumstances will improve. If you relate to the present moment mindfully, you’ll be in a better place to wisely consider what you want to do in the next moment. If you judge and resist the present moment, however, not only will you cause yourself extra frustration and anger, you will also cloud your ability to choose your next steps wisely. Mindfulness, then, allows us to consider what proactive steps might be taken to improve our situation, but also to recognize when things cannot be changed and must be accepted.

The serenity prayer—made famous by Alcoholics Anonymous and other twelve-step programs—captures this idea beautifully:

*God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.*

Mindfulness allows us to distinguish between those aspects of our experience we can change and those we can’t. If a heavy object falls on my foot, I can take the object off—that’s something I can change. But the

throbbing I feel in my foot can't be changed, at least in the moment. If I accept that the event has happened—maybe even throwing in a dash of humor—I will still feel the pain but remain relatively peaceful as it fades away. I won't add to my predicament by getting frustrated and agitated, or kicking the offending object in anger (you laugh but you know we've all done it!). My calm state will also help me to make a wise decision, like wrapping my foot in an ice pack before it swells up.

Although it may be counterintuitive, one thing that we have little power to change is what goes on inside our own heads. What arises within our field of conscious awareness is a mystery. Thoughts and emotions arise unbidden and often overstay their welcome. We may wish we had an internal filter for our thoughts and emotions—similar to the lint filter on a dryer—that would prevent any negative thoughts and emotions from entering our awareness. Then all we'd have to do is peel off the accumulated bundle of painful, critical, and self-sabotaging thoughts and throw them in the trash. That's not how our minds work, however.

Thoughts and feelings arise based on our history, our past experiences and associations, our hardwiring, our hormonal cycle, our physical comfort level, our cultural conditioning, our previous thoughts and feelings, and numerous other factors. As discussed in the last chapter, there are untold prior causes and conditions that have come together to produce our current mental and emotional experience—conditions beyond our conscious choosing. We can't control which thoughts and emotions pass through the gates of awareness and which do not. If our particular thoughts and feelings aren't healthy, we can't make these mental experiences go away. However, *we can change the way we relate to them.*

When we judge ourselves for our mental experience, we are only making things worse. "What a horrible person I am for having that thought!" "A nicer person would feel sympathy rather than annoyance in this situation!" Did you choose to have that particular thought or emotion, however? If not, should you be judging yourself so? We can release ourselves from the tangled knot of self-judgment by accepting the fact of our experience in the here and now. "These are the thoughts and emotions that are arising in my conscious awareness in the present moment." A simple statement of fact, with no blame attached. We don't need to lambast ourselves for thinking those nasty thoughts or feeling those destructive emotions. We can simply let them go.

As long as we don't get lost in a story line that justifies and reinforces them, they will tend to dissipate on their own. A weed that is not given water will eventually wither and fade away. At the same time, when a wholesome thought or feeling arises, we can hold it in loving awareness and allow it to fully blossom.

A Native American wisdom story tells of an old Cherokee who is teaching his grandson about life. "A fight is going on inside me," he said to the boy. "It is a terrible fight and it is between two wolves. One is evil—he is anger, envy, sorrow, regret, greed, arrogance, self-pity, guilt, resentment, inferiority, lies, false pride, superiority, and ego. The other is good—he is joy, peace, love, hope, serenity, humility, kindness, benevolence, empathy, generosity, truth, compassion, and faith. The same fight is going on inside you—and inside every other person, too." The grandson thought about it for a minute and then asked his grandfather, "Which wolf will win?" The old Cherokee simply replied, "The one you feed."

The gift of mindfulness, then, is that by accepting the present moment you are better able to shape your future moments with wisdom and clarity. Not only do you reduce your own suffering, you are also able to make good choices about how to act next. It makes perfect sense, if you think about it, but it's not a habit that many of us were taught as children. In the West we are raised to be knowledgeable, to work hard, and to be productive members of society, but no one teaches us how to deal productively with our own emotions, especially the difficult ones.

## Learning to Be Mindful

Fortunately, this is starting to change. Western scientists are starting to document the health benefits of mindfulness, bringing attention to an idea that originated in Eastern meditation traditions thousands of years ago. Many hundreds of studies have now shown that people who are able to pay attention to their present moment experience in a mindful way have greater emotional balance. For instance, brain scans using fMRI technology have shown that people who are more mindful are less reactive to scary or threatening images, as measured by amygdala activation (the reptilian part of our brain responsible for the fight-or-flight response). In short, they are less

easily “freaked out” and therefore less at the mercy of circumstance. For this reason, mindfulness skills are commonly taught by therapists and other health professionals to help people deal with stress, addiction, physical pain, and other forms of suffering.

Jon Kabat-Zinn’s Mindfulness-Based Stress Reduction (MBSR) program is one of the most ubiquitous and successful stress-reduction programs in the country. MBSR courses are offered by hundreds of hospitals, clinics, and medical centers around the United States and elsewhere in the world. The eight-week intensive program guides people through a series of exercises to help them learn to be more mindful. Research has shown that learning to be more mindful by taking an MBSR course helps people cope with life challenges with less stress and greater ease. MBSR also helps people cope with chronic pain. One of Kabat-Zinn’s early studies, for instance, found that people experiencing debilitating back pain reported substantial decreases in pain (around 50% less) after taking an MBSR course.

One of the key practices taught in MBSR courses is mindfulness meditation. This type of meditation typically involves reducing sensory input by sitting quietly and closing one’s eyes, so that it is easier to pay attention to what’s arising in one’s present moment experience without getting overwhelmed by too many outside sensations. People often start their meditation by focusing on their breath for a period to quiet their minds and sharpen their attention. Then, once the mind is fairly quiet, the attention moves freely to any thought, sound, or sensation that arises in one’s field of awareness. The idea is to observe whatever arises without judgment, without trying to push any particular experience away or else hold on to it. One simply allows thoughts and feelings to come and go, like a bird flying across a wide-open sky. Tracking the arising and passing away of mental phenomena builds skills that increase one’s ability to be mindful during the course of everyday life.

It’s important to note, however, that although meditation is a powerful way to strengthen one’s mindfulness muscle, there are other ways to quiet the mind and break the reverie of thought—like silent prayer, or even taking a solitary walk in the woods. Another tried and true method is to take a few slow, deep breaths, carefully paying attention to all the sensations generated during the in-breath and the out-breath. Mindfulness is not some special esoteric practice we have to pull out of a magician’s hat: we’re all innately

gifted with the ability to be aware of our own field of awareness. This means that it is fully within our power to be mindful. Mostly, the key is *intentionally choosing* to focus on the thoughts, emotions, and sensations that are arising in the present moment in a friendly, nonjudgmental way.

## Exercise Three

### *Mindfulness in Daily Life*

Pick one activity a day in which you'll be mindful. It may be while you brush your teeth, while you walk from the parking garage to work, when you eat your breakfast, or whenever your cell phone rings. You might want to choose an activity that occurs early in the day, to help you remember to be mindful before you get overwhelmed with the daily tasks of life. As you're engaging in your mindful activity—let's say you choose the walk from the parking lot to your office—bring your focused awareness to your actual experience in the present moment.

Try not to immediately start thinking of what you need to do once you get to your office. Simply notice how it feels to be walking. How do your feet feel as they touch the ground? Can you notice the change in sensations as each foot rises and falls? How do your legs feel as they move, as the weight shifts from the right to left? What is the air temperature like as you walk? Warm? Cold? Try to bring your awareness to as many aspects of the experience of walking as possible. It's helpful to focus on one distinct sensation at a time, so that you don't become overwhelmed. If you become lost in thoughts or emotions, simply note this and bring your awareness back to the experience of walking.

What you're doing is sharpening your skills of attention, building your mindfulness muscle. This will eventually help you when challenging situations arise, so that you can be aware of difficult emotions without running away with them. We are all capable of being mindful, but in the midst of our hectic lives, we must choose to slow down and notice—if even just for a moment—

what's happening to us right here, right now.

Because mindfulness is one of the core components of self-compassion, when we improve our mindfulness skills, we automatically increase our ability to be self-compassionate. Several studies have demonstrated that participation in an eight-week MBSR course increases self-compassion levels. Similarly, studies have demonstrated that experienced mindfulness meditators have more self-compassion than those who are less experienced.

While increasing our mindfulness skills is an important way to foster self-compassion, the two other components of self-compassion—self-kindness and common humanity—also enhance our ability to be mindful, creating a positive and self-reinforcing cycle. One of the enemies of mindfulness is the process of overidentification—becoming so carried away by our personal drama that we can't clearly see what is occurring in the present moment. If you're upset because you're lost in self-judgment or are feeling isolated from others, it will be much harder for you to be mindful of your painful emotions. If you are able to calm and soothe your feelings by giving yourself kindness or by putting things into the larger human perspective, however, you can give yourself the space needed to break out of your melodrama, and therefore your suffering. Realizing that you're overreacting isn't so difficult when you feel cared for and connected.

## Three Doorways In

The beauty of using self-compassion as a tool for dealing with difficult emotions is that it has three distinct doorways in. Whenever you notice you are in pain, you have three potential courses of action.

- You can give yourself kindness and care.
- You can remind yourself that encountering pain is part of the shared human experience.
- You can hold your thoughts and emotions in mindful awareness.

Engaging any one of the three components of self-compassion when confronting difficult feelings will then make it easier to engage the others. Sometimes you'll find it easier to enter in through one doorway than another

depending on your mood and the current situation, but once you're in, you're in. You'll have tapped into the power of self-compassion, allowing you to transform your relationship with the pain of life in a revolutionary, creative way. From the stable platform of self-compassion, you'll be able to wisely guide your next steps in a manner that leads to greater health, happiness, and well-being. Instead of letting your difficult emotions carry you away, you can carry your difficult emotions to a better place. You can hold them, accept them, and be compassionate toward yourself when you feel them. And the amazing thing is that you don't have to rely on anyone or anything else to give yourself this gift. Nor do you have to wait until circumstances are exactly right. It's precisely *when* you've fallen on hard times and things are looking their worst that self-compassion is most available.

## Exercise Four

### *Self-Compassion Journal*

Try keeping a daily self-compassion journal for one week (or as long as you like). Journaling is an effective way to express emotions and has been found to enhance both mental and physical well-being. At some point during the evening when you have a few quiet moments, review the day's events. In your journal, write down anything that you felt bad about, anything you judged yourself for, or any difficult experience that caused you pain. (For instance, maybe you got angry at a waitress at lunch because she took forever to bring the check. You made a rude comment and stormed off without leaving a tip. Afterward, you felt ashamed and embarrassed.) For each event, use mindfulness, a sense of common humanity, and kindness to process the event in a self-compassionate way.

### MINDFULNESS

This will mainly involve bringing awareness to the painful emotions that arose due to your self-judgment or difficult circumstances. Write about how you felt: sad, ashamed, frightened,

stressed, and so on. As you write, try to be accepting and nonjudgmental of your experience, not belittling it nor making it overly dramatic. (For example, “I was frustrated because she was being so slow. I got angry, overreacted, and felt foolish afterward.”)

#### COMMON HUMANITY

Write down the ways in which your experience was connected to the larger human experience. This might include acknowledging that being human means being imperfect, and that all people have these sorts of painful experiences. (“Everyone overreacts sometimes; it’s only human.”) You might also want to think about the various causes and conditions underlying the painful event. (“My frustration was exacerbated by the fact that I was late for my doctor’s appointment across town and there was a lot of traffic that day. If the circumstances had been different, my reaction probably would have been different.”)

#### SELF-KINDNESS

Write yourself some kind, understanding words of comfort. Let yourself know that you care about yourself, adopting a gentle, reassuring tone. (*It’s okay. You messed up but it isn’t the end of the world. I understand how frustrated you were and you just lost it. I know how much you value being kind to other people and how badly you feel right now. Maybe you can try being extra patient and generous to any waitstaff this week . . .*)

Practicing the three components of self-compassion with this writing exercise will help organize your thoughts and emotions, while helping to encode them in your memory. If you’re the type who likes to keep a journal regularly, your self-compassion practice will become even stronger and translate more easily into daily life.

### My Story: Getting Through the Dark Times

I can tell you from firsthand experience what a lifesaver self-compassion can

be. It pulled me back from the precipice of despair over and over again as I struggled to deal with Rowan's autism. When my mind would start to walk down the dark alley of fear—*What's going to happen to him? Will he ever live independently? Will he ever have a job, a family?*—I would try to stay in the present moment. *I am right here, right now. Rowan is safe and happy. I have no idea what's going to happen to him, or what his future holds. It's a mystery, but running away with my fear is not going to help. Let me focus on calming and comforting myself. Poor darling, I know how incredibly difficult it is for you right now . . .* When I soothed my troubled mind with this kind of caring concern, I was able to stay centered without being overwhelmed, realizing that whatever Rowan's future held, I loved him exactly as he was.

At times when I thought I couldn't cope a moment longer, self-compassion got me through. When Rowan would launch into an earsplitting tantrum because he momentarily mislaid his toy zebra, or because of some other seemingly insignificant trigger, I would try to mindfully watch my breath, sending myself compassion for the pain rather than fighting and resisting it. Autistic children's tantrums are neurological in origin and are often due to an overloaded sensory system. They literally can't stop their reaction or be consoled. The only thing parents can do is try to keep their children from hurting themselves, and wait till the storm passes.

When people gave me disapproving looks in the grocery store because they assumed Rowan was a spoiled brat and that I was a bad mother for not being able to control his behavior (one autism mother told me a stranger actually slapped her child because she thought he needed some "real discipline"), I would send myself compassion. I would hold my feelings of pain in mindful, spacious awareness so that they didn't overwhelm me.

Rowan's autism forced me to surrender any pretense of control, and mindfulness taught me that maybe this wasn't such a bad thing. No matter how much I wanted to be off that airplane, trapped twenty thousand feet in the air as Rowan screamed away, every other passenger looking at us like they wished we were dead, having to run to the bathroom (which was occupied, of course) to change Rowan's poop-filled underpants, I had no other choice but to deal with it. NO OTHER CHOICE. All I could do was try to get through the situation with as much grace as I could muster. Once I surrendered, a sense of deep calm descended. I felt a quiet joy, knowing that my peace of mind didn't depend on external circumstances. If I could get

through this moment, I could get through anything.

Self-compassion helped me steer clear of anger and self-pity, allowing me to remain patient and loving toward Rowan despite the feelings of despair and frustration that would inevitably arise. I'm not saying that I didn't have times when I lost it. I had many. But in those times I still had my practice of self-compassion to fall back on. I could forgive myself for reacting badly, for making mistakes, for being human. If I hadn't been aware of the power of self-compassion at that time, I don't know how I would have gotten through those especially difficult early years. And for that reason, I'll always be eternally grateful, knowing that the angel of self-compassion sits on my shoulder, available whenever I need it.

## *Part Three*

### THE BENEFITS OF SELF-COMPASSION

## *Chapter Six*

# EMOTIONAL RESILIENCE

*You know quite well, deep within you, that there is only a single magic, a single power, a single salvation . . . and that is called loving. Well, then, love your suffering. Do not resist it, do not flee from it. It is your aversion that hurts, nothing else.*

—HERMAN HESSE, *Wer lieben kann ist glücklich.  
Über die Liebe.*

SELF-COMPASSION IS AN INCREDIBLY POWERFUL TOOL FOR DEALING with difficult emotions. It can free us from the destructive cycle of emotional reactivity that so often rules our lives. This chapter looks more closely at the ways that self-compassion provides emotional resilience and enhances well-being. By changing the way we relate to ourselves and our lives, we can find the emotional stability needed to be truly happy.

## Self-Compassion and Negative Emotions

One of the most robust and consistent findings in the research literature is that people who are more self-compassionate tend to be less anxious and depressed. The relationship is a strong one, with self-compassion explaining one-third to one-half of the variation found in how anxious or depressed people are. This means that self-compassion is a major protective factor for anxiety and depression. As discussed earlier, self-criticism and feelings of inadequacy are implicated in the experience of depression and anxiety. When we feel fatally flawed, incapable of handling the challenges life throws our

way, we tend to shut down emotionally in response to fear and shame. All we see is doom and gloom, and things go down from there, as our negative mind-set colors all our experiences. I like to call this mental state “black goo” mind.

Though sticky and unpleasant, this process is actually quite natural. Research has demonstrated that our brains have a negativity bias, meaning we’re more sensitive to negative than to positive information. When evaluating others or ourselves, for instance, negative facts are given more weight than positive ones. Think about it. If you glance in a mirror before heading out for a party and see that you have a pimple on your chin, you’re not going to notice the fact that your hair looks great or that your outfit is fabulous. All you’ll see is that pimple, flashing at you like the red emergency light on top of an ambulance. Your sense of how you look for your big evening out will be skewed accordingly. There’s a reason for this.

In the natural environment, negative information usually signals a threat. If we don’t notice that crocodile lurking in the banks of the river immediately, we’ll soon become his lunch. Our brains evolved to be highly sensitive to negative information so that the fight-or-flight response could be triggered quickly and easily in the brain’s amygdala, meaning that our chances of taking action to ensure our survival would be maximized. Positive information isn’t as crucial to immediate survival as it is to long-term survival. Noticing that the river has fresh, clean water is important, especially if you’re thirsty or deciding on a place to camp, but there’s not the same urgency to act on these data. Thus, our brains give less time and attention to positive than to negative information. As Rick Hanson, author of *The Buddha’s Brain*, says, “our brain is like Velcro for negative experiences but Teflon for positive ones.” We tend to take the positive for granted while focusing on the negative as if our life depended on it.

Once our minds latch on to negative thoughts, they tend to repeat over and over again like a broken record player. This process is called “rumination” (the same word that’s used for a cow chewing the cud) and involves a recurrent, intrusive, and uncontrollable style of thinking that can cause both depression and anxiety. Rumination about negative events in the past leads to depression, while rumination about potentially negative events in the future leads to anxiety. This is why depression and anxiety so often go hand in hand; they both stem from the underlying tendency to ruminate.

Research indicates that women are much more likely to ruminate than men, which helps explain why women suffer from depression and anxiety about twice as often as men. Although some of these gender differences may be physiological in origin, culture also plays a role. Because women have historically had less power in society than men, they've had less control over what happens to them and have therefore had to be more vigilant for danger.

If you are someone who tends to ruminate, or who suffers from anxiety and depression, it's important that you *don't judge yourself* for this way of being. Remember that rumination on negative thoughts and emotions stems from the underlying desire to be safe. Even though these brain patterns may be counterproductive, we can still honor them for trying so diligently to keep us out of the jaws of that crocodile. Also remember that although some people tend to ruminate more than others, all people have a negativity bias to some extent. It's hardwired in our brains.

## Breaking Free of the Ties That Bind

So how do we release ourselves from this deep-rooted tendency to wallow in black goo? By giving ourselves compassion. Research shows that self-compassionate people tend to experience fewer negative emotions—such as fear, irritability, hostility, or distress—than those who lack self-compassion. These emotions still come up, but they aren't as frequent, long lasting, or persistent. This is partly because self-compassionate people have been found to ruminate much less than those who lack self-compassion. Rumination is often fueled by feelings of fear, shame, and inadequacy. Because self-compassion directly counters these insecurities, it can help unravel the knot of negative rumination as surely as detangling spray.

When we hold negative thoughts and feelings in nonjudgmental awareness, we are able to pay attention to them without getting stuck like Velcro. Mindfulness allows us to see that our negative thoughts and emotions are just that—thoughts and emotions—not necessarily reality. They are therefore given less weight—they are *observed*, but not necessarily *believed*. In this way, negatively biased thoughts and emotions are allowed to arise and pass away without resistance. This allows us to deal with whatever life brings our way with greater equanimity.

A useful method of mindfully relating to our negative emotions is to become aware of them as a physical sensation. This may seem like an unfamiliar concept, but all emotions can be felt in the body. Anger is often experienced as a tight clenching in the jaw or gut, sadness as heaviness around the eyes, fear as a gripping sensation in one's throat. The physical manifestation of emotions will be experienced differently by different people and will shift and change over time, but still they can be tracked in the body if we pay close attention. When we experience our emotions on the physical level, rather than *thinking* about what's making us so unhappy, it's easier to stay present. It's the difference between noticing "tightness in my chest" and thinking *I can't believe she said that to me; who does she think she is?* And so on and so on . . . By staying anchored in our body, we can soothe and comfort ourselves for the pain we're feeling without getting lost in negativity.

For some reason I often wake up at about four A.M. in a negative, anxious mind-state. While I lie there in bed my mind swirls with fear and dissatisfaction, focusing in on everything that's wrong in my life. Because it happens so regularly, I've learned to envision this mood quite literally as a storm passing in the night. Rather than getting caught up in my thoughts, I try to imagine dark clouds passing overhead, complete with violent lightning and thunder. The lightning represents the agitation in my brain, which is somehow triggered by my sleep cycle. Instead of taking the mood too seriously, I try to ground my awareness in my body: the weight of my body on the bed, the feel of the blanket on top of me, the sensations in my hands and feet. I try to remember to be in the here and now, and just watch the storm pass over. And sure enough, I eventually fall back asleep and wake up in a much better mood. This is the power of mindfulness. It allows you to fully experience what's arising in the present moment without being caught by it.

Often, however, mindfulness alone is not enough to avoid getting trapped in depressed and anxious mind-states. Try as we may, sometimes our minds just keep getting stuck in negativity. In this case, we need to actively try to soothe ourselves. By being kind to ourselves when we experience black goo mind, remembering our inherent interconnectedness, we start to feel cared for, accepted, and secure. We balance the dark energy of negative emotions with the bright energy of love and social connection. These feelings of warmth and safety then deactivate the body's threat system and activate the

attachment system, calming down the amygdala and ramping up the production of oxytocin. Fortunately, research shows that oxytocin helps dampen our natural negativity bias.

In one study, researchers asked participants to identify the emotions displayed on people's faces in a series of photos. Half were given a nasal spray that contained oxytocin; the other half received a placebo spray (the control group). Volunteers who had received the oxytocin spray were slower to identify fearful facial expression in the photos, and were less likely to mistake positive facial emotions for negative ones, as compared with the control group. This means that oxytocin lessens the tendency of our mind to immediately latch on to negative information.

Relating to our negative thoughts and emotions with compassion, then, is a good way to lessen our negativity bias. Compassion stops rumination in its tracks, engendering a hopeful outlook that asks "How can I calm and comfort myself right now?"

## Exercise One

### *Dealing with Difficult Emotions in the Body: Soften, Soothe, Allow*

(Also available as a guided meditation in MP3 format at [www.self-compassion.org](http://www.self-compassion.org))

The next time you experience a difficult emotion and want to work with it directly, try processing the emotion in your body (this exercise will take fifteen to twenty minutes).

To begin, sit in a comfortable position or lie down with your back on the floor. Try to locate the difficult feeling in your body. Where is it centered? In your head, your throat, your heart, your stomach? Describe the emotion using mental noting—tingling, burning, pressure, tightness, sharp stabbing (sorry, but typically sensations like pleasant bubbling don't come up when dealing with emotional pain). Is the sensation hard and solid, or fluid and shifting? Sometimes all you will feel is numbness—you can bring your attention to this sensation as well.

If the feeling is particularly distressing and difficult to experience, go gently. You want to try to soften any resistance you feel toward the sensation, so that you can feel it fully, but you don't want to push yourself beyond your limits. Sometimes it helps to first focus on the outer edge of the sensation, moving inward only if it starts feeling safer and more bearable.

Once you feel in touch with the painful emotion in your body, send it compassion. Tell yourself how difficult it is to feel this right now, and let yourself know you're concerned about your well-being. Try using terms of endearment if it feels comfortable for you, like "I know this is really difficult, darling," or "I'm sorry you're in such pain, dear." Imagine mentally caressing the spot where the painful emotion is lodged, as if you were stroking the head of a child who was crying. Reassure yourself that it's okay, that all will be well, and that you will give yourself the emotional support needed to get through this difficult experience.

When you find yourself carried away by thinking about the situation driving your painful feelings (which you're likely to do), simply bring your awareness back to the physical sensation in your body, and start again.

When doing this exercise, it often helps to silently repeat the phrase "Softening, soothe, allow." This reminds you to accept the feeling as it is, softening any resistance to it, while actively soothing and consoling yourself for any discomfort you feel.

As you give yourself compassion, notice if the physical sensations you experience change. Is there any lessening or relief from the painful sensations? Do they become easier to bear over time? Does that solid mass of tension feel like it's starting to break up, to move and shift? Whether or not things seem to get better, worse, or stay the same, keep giving yourself compassion for what you're experiencing.

Then, when you feel it's the right time, get up, do a few stretches, and carry on with your day. With some practice you'll find that you can help yourself cope with difficult situations without having to delve deeply into thinking or problem-solving mode, the power of self-compassion working its magic on your

body itself.

## Feeling It All

Self-compassion helps lessen the hold of negative emotions, but it's important to remember that self-compassion does not push negative emotions away in an aversive manner either. This point is often confusing, because conventional wisdom (and the famous Johnny Mercer tune) tells us that we should accentuate the positive and eliminate the negative. The problem, however, is that if you try to eliminate the negative, it's going to backfire. Mental or emotional resistance to pain merely exacerbates suffering (remember, Suffering = Pain x Resistance). Our subconscious registers any attempt at avoidance or suppression, so that what we're trying to avoid ends up being amplified.

Psychologists have conducted a great deal of research on our ability to consciously suppress unwanted thoughts and emotions. Their findings are clear: *we have no such ability*. Paradoxically, any attempt to consciously suppress unwanted thoughts and emotions appears to only make them stronger. In one classic study, participants were asked to report the thoughts that were going through their heads for a period of five minutes. Before doing so, however, they were instructed *not* to think of a white bear. If they *did* end up thinking of a white bear, they were asked to ring a small bell. Bells pealed forth like it was Christmastime. In the next study, participants were asked to go ahead and think about a white bear for five minutes, actively visualizing it, before they were asked *not* to think about a white bear. Once again, they were instructed to report on their thoughts for a five-minute interval and ring a bell whenever they thought of a white bear. Bells rang out much less often. The attempt to suppress unwanted thoughts causes them to emerge into conscious awareness more strongly and more frequently than if they were given attention in the first place. (Interestingly, a white bear was chosen for the preceding experiment because it is said that Fyodor Dostoyevsky, while attempting to illustrate the persuasive power of the mind, challenged his brother to stand in the corner of a room and not return until he had stopped thinking of a white bear. Needless to say, his brother missed supper that night.)

Research shows that people with higher levels of self-compassion are significantly less likely to suppress unwanted thoughts and emotions than those who lack self-compassion. They're more willing to experience their difficult feelings and to acknowledge that their emotions are valid and important. This is because of the safety provided by self-compassion. It's not as scary to confront emotional pain when you know that you will be supported throughout the process. Just as it feels easier to open up to a close friend whom you can rely on to be caring and understanding, it's easier to open up to yourself when you can trust that your pain will be held in compassionate awareness.

The beauty of self-compassion is that instead of *replacing* negative feelings with positive ones, new positive emotions are generated by *embracing* the negative ones. The positive emotions of care and connectedness are felt alongside our painful feelings. When we have compassion for ourselves, sunshine and shadow are both experienced simultaneously. This is important—ensuring that the fuel of resistance isn't added to the fire of negativity. It also allows us to celebrate the entire range of human experience, so that we can become whole. As Marcel Proust said, "We are healed from suffering only by experiencing it to the full."

## A Journey to Wholeness

The road to becoming whole takes some time to travel and doesn't happen overnight. Rachel was a good friend of mine back in graduate school, and though she was witty and intelligent, she could also be a bit of a black hole. The T-shirt she was wearing when I first met her pretty much sums it up: LIFE'S A BITCH, 'CAUSE IF IT WAS A SLUT IT'D BE EASY. Rachel was a classic negative thinker, always seeing the glass as half empty rather than half full. Even when everything was going relatively well, with only a few challenges to deal with, Rachel would focus almost exclusively on what was wrong in any given situation. She took everything that was right about her life for granted, because it wasn't a problem and therefore didn't need fixing. This meant she was often anxious, frustrated, and depressed.

I remember one time Rachel made a homemade chocolate cake for my birthday. The cake was delicious, despite the fact that the grocery store had

been out of her favorite brand of chocolate and she was forced to use an alternate brand that wasn't as good. No matter how much I told her I loved the cake, she could only focus on its ever-so-slightly-less-sumptuous-than-usual quality. (I think her comment was "tastes like imitation Ding Dongs.") She fell into such a foul mood while obsessing about the cake that she actually ended up leaving my birthday party early.

I could handle Rachel's negativity because she often made me laugh. Like the time I asked her how her blind date went. "A total bore. I asked him how he was and he actually told me." The boyfriend she had during graduate school didn't find her so funny, however, and eventually dumped her for being such a bummer all of the time. She then started to get down on herself for being so negative, which of course just made things worse.

Once she finished her studies, Rachel swore she was going to change her ways. After reading some books on positive thinking, Rachel started saying daily positive affirmations, like "I am a radiant person of positive energy" and "Every day in every way I am getting better and better." She tried to think positively no matter what the circumstances, even if she felt miserable inside. She kept it up for a few months, but it didn't last long. It seemed phony to her and took way too much effort.

Rachel and I kept in touch over the years. When she asked what I was up to, I told her about my research on self-compassion. At first she wasn't impressed. "Isn't that just sugar coating for the fact that life sucks?" But because we were old friends and she valued my opinion, she managed to get through her initial resistance and listened as I explained the concept to her. She didn't say anything for a while, and I assumed she was going to roll her eyes and dismiss everything I had said. Instead, she told me that she wanted to try to be more compassionate with herself and asked for my help. What should she do? So I told her what I did.

I had developed this practice years earlier to help myself remember to be self-compassionate, and I still use it constantly. It's a sort of self-compassion mantra and is highly effective for dealing with negative emotions. Whenever I notice something about myself I don't like, or whenever something goes wrong in my life, I silently repeat the following phrases:

*This is a moment of suffering.  
Suffering is part of life.*

*May I be kind to myself in this moment.  
May I give myself the compassion I need.*

I find these phrases particularly useful, not only because they're short and easily memorized, but because they invoke all three aspects of self-compassion simultaneously. The first phrase, "This is a moment of suffering," is important because it brings mindfulness to the fact that you're in pain. If you're upset because you notice you've gained a few pounds, or if you get pulled over for a traffic violation, it's often hard to remember that these are moments of suffering worthy of compassion.

The second phrase, "Suffering is part of life," reminds you that imperfection is part of the shared human condition. You don't need to fight against the fact that things aren't exactly as you want them to be, because this is a normal, natural state of affairs. More than that, it's one that every other person on the planet also experiences, and you're certainly not alone in your predicament.

The third phrase, "May I be kind to myself in this moment," helps bring a sense of caring concern to your present experience. Your heart starts to soften when you soothe and comfort yourself for the pain you're going through.

The final phrase, "May I give myself the compassion I need," firmly sets your intention to be self-compassionate and reminds you that you are worthy of receiving compassionate care.

After a few weeks of practicing this self-compassion mantra, Rachel started to get a small taste of freedom from her constantly negative mind-set. She began to be more aware of her dark, depressive thoughts, so that she didn't become so hopelessly lost in gloominess. She found herself being less self-critical, and she didn't complain as much about what was wrong with her life. Instead, when she experienced negative thoughts and emotions, she said her phrases and tried to focus on the fact that she was hurting and in need of care.

The thing she liked most about self-compassion, she told me, was that "I don't have to fool myself to make it work." Unlike the practice of positive affirmations, in which she tried to convince herself that everything was fine and dandy even when it wasn't, self-compassion enabled Rachel to accept and acknowledge the fact that sometimes, life *does* suck. But we don't have to make things worse than they already are. The key to self-compassion is not

to deny suffering, but to recognize that it's perfectly normal. There isn't anything wrong with the imperfection of life as long as we don't expect it to be other than it is.

"It's weird," she said, "but sometimes my negativity vanishes as soon as I say the phrases. Even though I'm not trying to make them go away, they just go—poof—like a cheesy David Copperfield show."

Rachel didn't become some kind of Pollyanna, however. She is still someone who tends to notice what's wrong about a situation before she sees what's right. But her negativity doesn't cause her to descend into depression anymore. She can laugh at the darkness of her own thoughts, because they no longer fully control her. Once she remembers to be self-compassionate, she can appreciate the half of the glass that's full as well as noticing the half that's empty.

## Exercise Two

### *Developing Your Own Self-Compassion Mantra*

A self-compassion mantra is a set of memorized phrases that are repeated silently whenever you want to give yourself compassion. They are most useful in the heat of the moment, whenever strong feelings of distress arise.

You might find that the phrases I created work for you, but it's worth playing with them to see if you can find phrases that fit you better. What's important is that all three aspects of self-compassion are evoked, not the particular words used.

Other possible wordings for the first phrase, "This is a moment of suffering," are "I'm having a really hard time right now," "It's painful for me to feel this now," and so on.

Other possible wordings for the second phrase, "Suffering is part of life," are "Everyone feels this way sometimes," "This is part of being human," and so on.

Other possible wordings for the third phrase, "May I be kind to myself in this moment," are "May I hold my pain with tenderness," "May I be gentle and understanding with myself," and so on.

Other possible wordings for the final phrase, “May I give myself the compassion I need,” are “I am worthy of receiving self-compassion,” “I will try to be as compassionate as possible,” and so on.

Find the four phrases that seem most comfortable for you and repeat them until you have them memorized. Then, the next time you judge yourself or have a difficult experience, you can use your mantra to help remind yourself to be more self-compassionate. It’s a handy tool to help soothe and calm troubled states of mind.

## Self-Compassion and Emotional Intelligence

Self-compassion is a powerful form of emotional intelligence. As defined in Daniel Goleman’s influential book of the same name, emotional intelligence involves the ability to monitor your own emotions and to skillfully use this information to guide your thinking and action—in other words, being *aware* of your feelings without being hijacked by them, so that you can make wise choices. If you realize that you’re mad at someone who made an insensitive comment, for instance, you might take a walk around the block to cool down before discussing it, rather than spouting the first disparaging remark that springs to mind. Perhaps better *not* to say, “Calling you an idiot would be an insult to all the stupid people,” satisfying though it may be at the time.

Research shows that people who are more self-compassionate have more emotional intelligence, meaning they are better able to maintain emotional balance when flustered. For example, one study looked at people’s reactions to an awkward and embarrassing task—being videotaped while looking into a camera and making up a children’s story that began “Once upon a time there was a little bear . . .” Participants were later asked to watch their taped performances and report on the emotions they experienced while doing so. Those with higher levels of self-compassion were more likely to say they felt happy, relaxed, and peaceful while watching themselves make up the silly story. Those who lacked self-compassion were more likely to feel sad, embarrassed, or nervous.

Another study looked at the way self-compassionate people tend to deal with negative events in their daily lives. Participants were asked to report on

problems experienced over a twenty-day period, such as having a fight with a romantic partner or tension at work. Results indicated that people with higher levels of self-compassion had more perspective on their problems and were less likely to feel isolated by them. For example, they felt their struggles were no worse than what lots of other people were going through. Self-compassionate people also experienced less anxiety and self-consciousness when thinking about their problems.

There is also physiological data supporting the claim that self-compassionate people have better emotional coping skills. Researchers measured cortisol levels and heart rate variability among a group of people trained to have more self-compassion. Cortisol is a stress hormone, while heart rate variability is an indicator of the ability to adapt effectively to stress. The more self-compassionate versus self-critical that people were, the lower their cortisol levels and the higher their heart rate variability. This suggests that self-compassionate people are able to deal with the challenges life throws their way with greater emotional equanimity.

Of course, people who experience extreme life challenges—such as almost dying in a car accident or being sexually assaulted—may have an especially hard time coping. In such cases, people may develop posttraumatic stress disorder (PTSD). PTSD is a severe and ongoing emotional reaction to an extreme psychological trauma. It often involves reexperiencing the traumatic event through flashbacks or nightmares, having disturbed sleep patterns, and persistent fear or anger. One of the key symptoms of PTSD is experiential avoidance, which means that trauma victims tend to push away uncomfortable emotions associated with what happened. Unfortunately, such avoidance only makes PTSD symptoms worse, given that suppressed emotions tend to grow stronger as they vie to break through to conscious awareness. The effort needed to keep suppressed emotions at bay can also sap the energy needed to deal with frustration, meaning that PTSD sufferers are often irritable.

There is some evidence that self-compassion helps people get through PTSD. For example, in one study of college students who showed PTSD symptoms after experiencing a traumatic event such as an accident, a fire, or a life-threatening illness, those with more self-compassion showed less severe symptoms than those who lacked self-compassion. In particular, they were less likely to display signs of emotional avoidance and were more

comfortable facing the thoughts, feelings, and sensations triggered by what happened. When you're willing to feel painful emotions and hold them with compassion, they're less likely to interfere with everyday life.

Self-compassion gives us the calm courage needed to face our unwanted emotions head-on. Because escape from painful feelings is not actually possible, our best option is to clearly but compassionately experience our difficult emotions just as they are in the present moment. Given that all experiences eventually come to an end, if we can allow ourselves to remain present with our pain, it can go through its natural bell-curve cycle—arising, peaking, and fading away. As it says in the Bible, “This too shall pass.” Or as the Buddha said, all emotions are “liable to destruction, to evanescence, to fading away, to cessation.” Painful feelings are, by their very nature, temporary. They will weaken over time as long as we don’t prolong or amplify them through resistance or avoidance. The only way to eventually free ourselves from debilitating pain, therefore, is to *be* with it as it is. *The only way out is through.* We need to bravely turn toward our suffering, comforting ourselves in the process, so that time can work its healing magic.

## The Healing Power of Self-Compassion

Penny—a forty-six-year-old divorced sales rep—suffered from near constant anxiety. When her twenty-one-year-old daughter, Erin (who was away at college), didn’t call her for a few days, she immediately assumed that something was wrong. She would leave Erin desperate phone messages asking her if she was okay, assuming that no news was bad news. Or when Erin was home, if she overheard her say something like “Oh no!” while talking on her cell, she would interrupt the conversation, frantically asking “What’s wrong, what’s wrong?” Although Erin loved her mother, she dreaded coming home for visits because her mother was always so tense and nervous. Penny was aware of her daughter’s reluctance and harshly judged herself for being such an uptight and uneasy person. It wasn’t how she wanted to be.

Erin was pretty convinced her mother’s anxiety was caused by unresolved emotional trauma. Penny’s father had been declared missing in action in the Vietnam War, when Penny was only six. Penny’s mother had a nervous

breakdown upon receiving the news, so Penny was raised by her maternal grandmother for two years before her mother was able to take care of her again. Penny's father was never found, and she never really got to properly grieve for him. The result was that Penny irrationally feared losing her daughter, Erin, in the same way she lost her father—anxiety permeating every corner of her life.

Erin had heard a guest lecture on self-compassion at her university and tried to convince her mother that she should have more compassion for herself. "I want you to be happy, Mom," she said, "and I think it would help you. I also think it would help our relationship."

Mainly out of love for her daughter, Penny reluctantly decided to enter therapy, choosing a counselor who explicitly incorporated self-compassion into his therapeutic approach. She wanted to finally get to grips with her anxiety and also to deal with the grief she felt over the loss of her father. Her therapist advised her to go slowly, only feeling as much as was comfortable at any one time.

Penny first tried to focus on having compassion for the anxiety she felt as an adult. She began to realize how much she suffered from having a fist of fear ready to clamp tight over her heart at any time. Her therapist gently reminded her that anxiety was an incredibly common experience, something that millions and millions of other people struggle with on a daily basis. Over time Penny learned to judge herself a little less severely for being anxious, and she instead started trying to comfort herself for having such constant and uncontrollable fear. Once she felt ready, she was then able to turn her attention to the source of her fear: the experience of losing her mother and father at the same time when she was only a small child.

At first Penny mainly focused on the compassion she felt for her mother, which somehow felt more manageable. Her heart started to crack open as she thought about the horror her mother must have experienced when her husband was declared missing, not even knowing for sure if he was dead or alive. Then she tried feeling compassion for herself, for how scared and alone she felt when her father disappeared and her mother had her breakdown. At first she was just numb, unable to feel anything.

The therapist asked her to bring a picture of herself as a young girl to their next session, to see if that would help. The photo was of a six-year-old girl wearing a maroon velvet dress, opening Christmas presents. When Penny

looked at the photo, she saw the face of Erin looking back at her. She imagined how Erin would have felt at age six if the same thing had happened to her. This broke through her defenses, and she had a powerful moment of getting in touch with her six-year-old self—the incredible fear, confusion, and sadness she had felt.

For several weeks all Penny could do was sob whenever she thought about her childhood. There was nothing she could do to fix things, to change what had happened. There was nothing she could do to ensure that her daughter would never have any harm befall her. There was only pain, sadness, grief, worry, and fear. But there was also compassion. Whenever she felt that she would be engulfed by her negative emotions, she would think of that picture of herself as a child. She would imagine stroking the child's hair, using a gentle tone of voice and telling her that she was going to be okay. Although the anxiety didn't go away, its edges started to soften. It became more bearable, less overwhelming.

One day Penny came to her therapy appointment extremely excited. “Erin was home yesterday and I heard her say ‘That’s terrible! Oh my God!’ on her cell phone. My instinctive reaction was to immediately demand what was wrong. Instead, I just let myself feel the fear. I managed not to pounce on Erin as soon as she hung up the phone. Instead, I figured that if there was a dire emergency she would tell me. It was hard to wait, but I felt strong enough to handle it. And sure enough, it turns out that her favorite TV character had been killed off in the latest episode. That was all. What a victory!”

Such stories are actually quite common. Especially when helped along by a supportive person such as a therapist, self-compassion has the power to radically transform lives. For this reason, many clinical psychologists are starting to explicitly incorporate self-compassion into their therapeutic approaches.

## Compassionate Mind Training

Paul Gilbert, a clinician at the University of Derby and author of *The Compassionate Mind*, is one of the leading thinkers and researchers on self-compassion as a therapeutic tool. He has developed a group-based therapy

model called “Compassionate Mind Training” (CMT), which is designed to help people who suffer from severe shame and self-judgment. His approach focuses on helping clients understand the harm they do themselves through constant self-criticism, while also having compassion for these same tendencies. Gilbert argues that self-criticism is an evolutionarily based survival mechanism designed to help keep oneself safe (see chapter 2) and therefore should not be judged. CMT helps people to understand this mechanism and teaches them how to relate to themselves with compassion rather than self-condemnation. This process can be tricky for some.

Many of Gilbert’s patients have a history of being abused by their parents, either physically or emotionally. For this reason, they are often frightened of self-compassion at first, and they feel vulnerable when they are kind to themselves. This is because as children, the same people who gave them care and nurturance—their parents—also betrayed their trust by harming them. Feelings of warmth thus became jumbled together with feelings of fear, making the foray into self-compassion rather complicated. Gilbert cautions that people with a history of parental abuse should proceed slowly down the path of self-compassion, so that they don’t become too frightened or overwhelmed. Even among those without histories of physical or mental abuse, Gilbert’s research indicates that people are often afraid of being compassionate to themselves. They worry that they will become weak, or that they will be rejected, if they don’t use self-criticism as a way of addressing personal shortcomings. This fear of compassion then acts as a roadblock to treating oneself kindly and exacerbates self-judgment and feelings of inadequacy.

CMT relies heavily on the practice of self-compassionate imagery to generate feelings of warmth and safety for clients. Practitioners first instruct patients to generate an image of a safe place to help counter any fears that may arise. They are then instructed to create an ideal image of a caring and compassionate figure. Especially for people who have a hard time having feelings of compassion for themselves, their compassionate image can be used as a proxy source of soothing. Eventually, self-compassion becomes less frightening and can be drawn upon to help deal with feelings of defectiveness and inadequacy.

In a study of the effectiveness of CMT for patients in a treatment program at a mental health hospital—people who were being treated for intense shame

and self-criticism—patients were led through weekly two-hour CMT sessions for twelve weeks. The training resulted in significant reductions in depression, self-attacking, feelings of inferiority, and shame. Moreover, almost all of the patients felt ready to be discharged from the hospital at the end of the intervention.

## Exercise Three

### *Using Compassionate Imagery*

This exercise is adapted from Paul Gilbert, *The Compassionate Mind* (London: Constable, 2009).

1. Sit comfortably in a quiet spot. The first task is to create an image of a safe place. This can be imaginary or real—any place that makes you feel peaceful, calm, and relaxed: a white sandy beach, a forest glade with deer grazing nearby, Grandmother's kitchen, or near a crackling fire. Try to really envisage this place in your mind's eye. What are the colors? How bright is it? What sounds or smells are there? If you ever feel anxious or insecure during your voyage into self-compassion, you can call up this image of your safe place to help calm and soothe yourself.

2. The next task is to create an image of an ideally caring and compassionate figure, someone who embodies wisdom, strength, warmth, and nonjudgmental acceptance. For some this will be a known religious figure like Christ or the Buddha. For others it will be someone they have known in the past who was very compassionate, like a favorite aunt or teacher. For still others it might be a beloved pet, a completely imaginary being, or even an abstract image like a white light. Try to see this image as vividly as possible, incorporating as many of the senses as possible.

3. If you are suffering in some way right now, think about the type of wise, caring things that this idealized source of compassion would say to comfort you right now. How would his or her voice sound? What feelings would be conveyed in his or her tone? If

you're feeling a bit numb or shut down, just let yourself bask in the compassionate presence of your ideal image, simply allowing yourself to be there.

4. Now release your compassionate image, take a few breaths, and sit quietly in your own body, savoring the comfort and ease that you generated in your own mind and body. Know that whenever you want to generate compassion for yourself, you can use this image as a springboard, allowing yourself to receive the gift of kindness.

## Mindful Self-Compassion

Christopher Germer, a clinical psychologist affiliated with Harvard who specializes in the integration of mindfulness and psychotherapy, teaches self-compassion to most of his therapy clients. Chris is also a friend and colleague with whom I teach self-compassion workshops. He wrote the wonderful book *The Mindful Path to Self-Compassion*, which summarizes the knowledge he's gained over the years while helping his clients to relate to themselves more compassionately.

Germer observes that his clients typically go through several distinct stages of self-compassion practice during their therapy. A common experience at the beginning, especially for those who suffer from intense feelings of worthlessness, is "backdraft." When a fire is deprived of oxygen and fresh air is suddenly let in, an explosion often occurs (the process known by firefighters as backdraft). Similarly, people who are used to constant self-criticism often erupt with anger and intense negativity when they first try to take a kinder, more gentle approach with themselves. It's as if their sense of self has been so invested in feeling inadequate that this "worthless self" fights for survival when it's threatened. The way to deal with backdraft, of course, is to mindfully accept the experience and have compassion for how hard it is to experience such intense negativity.

Once the initial resistance softens, clients often feel great enthusiasm for self-compassion practice as they begin to realize what a powerful tool it is. Germer calls this the "infatuation" stage. After battling themselves for so long, people often fall in love with the feeling of peace and freedom they find

by relating to themselves in a tender way. Like receiving a kiss from a new lover, they tingle from head to toe. During this stage, people tend to get attached to the good feelings provided by self-compassion, and they want to experience those good feelings constantly.

As time goes on, however, the infatuation typically fades as people realize that self-compassion doesn't magically make all their negative thoughts and feelings go away. Remember that self-compassion doesn't eradicate pain or negative experiences, it just embraces them with kindness and gives them space to transform on their own. When people practice self-compassion as a subtle way of resisting their negative emotions, not only will the bad feelings remain, they will often get worse. Germer says that he sees this phase of the therapy process as a good sign, because it means clients can begin to question their motivations. Are they being compassionate primarily because they want to be emotionally healthy, or because they mainly want to eliminate their pain?

If people can stick with the practice during this tricky middle bit, they eventually discover the wisdom of "true acceptance." During this stage, the motivation for self-compassion shifts from "cure" to "care." The fact that life is painful, and that we are all imperfect, is then fully accepted as an integral part of being alive. It becomes understood that happiness is not dependent on circumstances being exactly as we want them to be, or on ourselves being exactly as we'd like to be. Rather, happiness stems from loving ourselves and our lives exactly as they are, knowing that joy and pain, strength and weakness, glory and failure are all essential to the full human experience.

Chris Germer and I are now working on an exciting new project together; developing an eight-week training program in Mindful Self-Compassion (MSC). The program is similar to Kabat-Zinn's MBSR program, and we hope it will be a useful complement to it. In the first day of the program, we mainly focus on explaining the concept of self-compassion and how it differs from self-esteem (see chapter 7). In the following weeks we focus on how to use self-compassion to deal with difficult emotions using various meditations, homework assignments, and experiential exercises (including those found in this chapter and others). The program appears to be quite powerful in terms of changing people's lives for the better, and hopefully we'll soon have research data that examines the effectiveness of MSC as a therapeutic intervention. We are both convinced that participating in the MSC

program will help people maximize their emotional resilience and well-being. (For more information on the program, go to [www.self-compassion.org](http://www.self-compassion.org) or [www.mindfulselfcompassion.org](http://www.mindfulselfcompassion.org).)

## Exercise Four

### *Compassionate Body Scan*

(Also available as a guided meditation in MP3 format at [www.self-compassion.org](http://www.self-compassion.org))

One technique commonly taught in mindfulness courses such as MBSR is “the body scan.” The idea is to systematically sweep your attention from the crown of your head to the soles of your feet, bringing mindful awareness to all of the physical sensations in your body. Chris Germer and I also use this technique in our MSC workshops, but with a twist. We add in self-compassion. The idea is that whenever you come into contact with an uncomfortable sensation while scanning your body, you should try to actively soothe the tension, giving yourself compassion for your suffering. By mentally caressing your body in this way, you can help ease your aches and pains to a remarkable extent.

To begin, it’s best to lie down on a bed or the floor. Lie flat on your back, and gently rest your arms about six inches away from your sides and hold your legs about shoulder width apart. This is called “the corpse pose” in yoga, and allows you to completely relax all your muscles. Start with the crown of your head. Notice what your scalp feels like. Is it itching, tingling, hot, cold? Then notice if there’s any discomfort there. If so, try to relax and soften any tension in this area and extend kind, caring concern to this part of your body. Internal words said in a soothing, comforting voice like “poor darling, there’s a lot of tightness there, it’s okay, just relax” often help tremendously. Once you’ve given this body part compassion, or if there was no discomfort in the first place, move on to the next body part.

There are many pathways through the body you can take, but typically I move from the top of my head to my face, to the back of my head, to my neck, my shoulders, my right arm (moving from upper arm to lower arm to hand), my left arm, my chest, my abdomen, my back, my pelvic region, my gluts, my right leg (moving from thigh to knee to calf to foot), then my left leg. Other people start with their feet and move up through their body to the crown of their head. There is no one right way to do it, just what feels right for you.

As you scan each new body part with your awareness, check in to see if there is any tension there, and offer yourself compassion for your pain, consciously trying to soften, relax, and comfort this area. I often try to express gratitude to the body part that aches, appreciating how hard it works for me (like my neck, which has to hold up my big head!). It's an opportunity to be kind to yourself in a very concrete way, and the more slowly and mindfully you do the exercise, the more you'll get out of it.

Once you finish sweeping your awareness from head to toe—this can take anywhere from five minutes to thirty minutes depending on how quickly you do it—bring your attention to your entire body with all its buzzing, pulsating sensations, and send yourself love and compassion. Most people report feeling wonderfully relaxed yet vibrant after this exercise—and it's cheaper than a massage.

## *Chapter Seven*

### OPTING OUT OF THE SELF-ESTEEM GAME

*Don't take the ego too seriously. When you detect egoic behavior in yourself, smile. At times you may even laugh. How could humanity have been taken in by this for so long?*

—ECKHART TOLLE, *A New Earth: Awakening to Your Life's Purpose*

THE IDEA THAT WE NEED TO HAVE HIGH SELF-ESTEEM TO BE PSYCHOLOGICALLY healthy is so widespread in Western culture that people are terrified of doing anything that might endanger it. We're told we must think positively of ourselves at all costs. Teachers are encouraged to give all their students gold stars so that each can feel proud and special. High self-esteem is portrayed as the pot of gold at the end of the rainbow, a precious commodity that must be acquired and protected.

It's true that people with high self-esteem tend to be cheerful, report having lots of friends, and are motivated in life, while people with low self-esteem are lonely, anxious, and depressed. Those with high self-esteem are optimistic, seeing the world as their oyster. Those with low self-esteem often can't even tie their shoes in the morning. The assumption is that self-esteem *causes* these outcomes. The almost religious faith placed in the power of high self-esteem to create mental health has led to a deluge of self-esteem programs in schools, community centers, and mental health facilities. In 1986, the State of California launched a Task Force on Self-Esteem and Personal and Social Responsibility that had an annual budget of a quarter-million dollars a year. The reasoning was that if the self-esteem of California's children were raised, problems such as bullying, crime, teen

pregnancy, drug abuse, and academic underachievement would be eased. It was even argued that investing in the self-esteem of children would pay off in tax revenues in the long run, because people with high self-esteem tend to earn more than those with low self-esteem. Dozens of women's magazines have touted the benefits of high self-esteem, and thousands of books have been written on how to get it, raise it, or keep it.

## The Emperor Has No Clothes

This fascination with high self-esteem has largely been fueled by psychologists, who have published more than fifteen thousand journal articles on the topic. More recently, however, psychologists have started questioning whether high self-esteem is truly the panacea it's been made out to be. Reports on the efficacy of California's self-esteem initiative, for instance, suggest that it was a total failure. Hardly any of the program's hoped-for outcomes were achieved. Of course, this didn't stop the Task Force from concluding that "diminished self-esteem stands as a powerful *independent variable* (condition, cause, factor) in the genesis of major social problems. We all know this to be true, and it is really not necessary to create a special California task force on the subject to convince us." In other words, we *know* self-esteem works even though our own data says it doesn't, so we shouldn't have bothered trying to prove what was self-evident in the first place. As humorist Will Rogers once commented, "I don't make jokes. I just watch the government and report the facts."

In one influential review of the self-esteem literature, it was concluded that high self-esteem actually did *not* improve academic achievement or job performance or leadership skills or prevent children from smoking, drinking, taking drugs, and engaging in early sex. If anything, high self-esteem appears to be the *consequence* rather than the cause of healthy behaviors. The report also challenged the assumption that bullies act as they do because they have low self-esteem. In fact, bullies are just as likely to have high self-esteem as others. Picking on other people is one of the key ways they can feel strong and superior. People with high self-esteem tend to be cliquish—they generally like members of the in-groups they belong to better than "outsiders." Accordingly, research shows that people with high self-esteem

are just as prejudiced, if not more so, than those who dislike themselves. People with high self-esteem also engage in socially undesirable behavior such as cheating on tests just as often as people with low self-esteem do.

And when people with high self-esteem feel insulted, they frequently lash out at others. In one study, for instance, college students were told they did worse than average on an intelligence test. Those with high self-esteem tended to compensate for the bad news by insulting the other study participants and putting them down. Those with low self-esteem, on the other hand, tended to react by being nicer and complimenting other participants as a way to seem more likable. Who would *you* rather hang out with when yearly performance reviews are being passed out at work?

## What Is Self-Esteem Anyway?

Before going further, it's worth taking a closer look at what actually constitutes self-esteem. At its core, self-esteem is an evaluation of our worthiness, a judgment that we are good, valuable people. William James, one of the founding fathers of Western psychology, argued that self-esteem was a product of "perceived competence in domains of importance." This means that self-esteem is derived from thinking we're good at things that have personal significance to us. I may excel at checkers and be an atrocious chess player, but this will only affect my self-esteem if I value being good at checkers or chess. The dynamic that James identified suggests that we can raise our self-esteem in two main ways.

One approach is to value the things we're good at and devalue the things we're bad at. A teen boy who's good at basketball and bad at math may decide that basketball is really important while math is for the birds. The potential problem with this approach, of course, is that we may undercut the importance of learning valuable skills just because it makes us feel better about ourselves. When a kid focuses all his energy on becoming a pro basketball player and ignores learning math, he's limiting his future employment opportunities—a scenario that happens all too often. In other words, our desire to achieve high self-esteem in the short term may harm our development in the long run.

The other way to raise our self-esteem involves increasing our

competence in those areas that are important to us. For instance, a woman who values looking like a model may keep trying to lose that last fifteen pounds in order to reach her desired weight. The problem here is that sometimes striving to improve is counterproductive. The woman who tries to fit into size 2 jeans even though she doesn't have a naturally thin body type will just end up feeling hungry, frustrated, and dejected and would have been better off downplaying the importance of looking model-skinny in the first place. (After all, most men say they prefer curves.)

Charles Horton Cooley, a well-known sociologist writing at the turn of the twentieth century, identified another common source of self-esteem. He proposed that feelings of self-worth stem from the "looking glass self." That is, our perceptions of how we appear in the eyes of others. If we believe that others judge us positively, we'll feel good about ourselves. If we believe that others judge us negatively, we'll feel bad about ourselves. Self-esteem, in other words, stems not only from our own self-judgments, but also the perceived judgments of others. Highlight the word *perceived*.

Research shows that self-esteem is more strongly influenced by the perceived judgments of strangers than close friends and family. Think about it. When your mother tells you how smart or attractive you are, how seriously are you going to take the comment? "*Of course* my mother would say that, she's my mother!" We tend to give more weight to what nameless, faceless "other people" think of us—coworkers, neighbors, other kids at school, and so on, who are supposedly more objective. The big hole in this line of reasoning, of course, is that the thread on which we're hanging our self-esteem is incredibly thin. First, given that people who don't know us very well aren't able to make well-informed judgments of us, why should we be so swayed by their opinions? Second, how well do we know their opinions in the first place?

When I was in college, I used to spend hours getting my Goth hair and makeup just right before going to a popular death-rock nightclub. I wanted to appear cool to the other Goths. I always felt like a "poser," however, and assumed people rolled their eyes at me behind my back. I generally had poor self-esteem when it came to my rocker looks, despite all my white-face-and-big-hair efforts. Years later, some friends told me that other people actually *did* think I looked cool at the time and had even tried to emulate me. In other words, my perceptions of others' perceptions were way off base. And after

reviewing the photographic evidence, their perceptions also seem to have been off base. I can definitely say that Goth was *not* a good look for me.

We tend to think it's only young people who fall prey to peer pressure and insecurity of this sort, but how often do we adults feel good or bad about ourselves simply because of some vague and unsubstantiated notion about how "other people" are viewing us? Not only are our perceptions of reality often seriously clouded, our obsession with the impression we're making on others may lead to some serious self-delusion.

## Mirror, Mirror on the Wall

People with high self-esteem describe themselves as being more likable and attractive, and as having better relationships with others, than people with low self-esteem do. Objective observers, however, do not necessarily agree. In one study, researchers examined how college undergraduates rated their interpersonal skills—their ability to start new friendships, talk and open up to others, deal with conflicts, and provide emotional support. Not surprisingly, people with high self-esteem reported that they had these good qualities in spades. According to their roommates, however, their interpersonal skills were merely (God forbid!) average. Similar studies have found that high-self-esteem people are more confident about their popularity, whereas low-self-esteem people assume that others don't like them much. Typically, however, people with high and low self-esteem are equally liked by others. It's just that those with low self-esteem greatly underestimate how much others actually approve of them, while those with high self-esteem greatly overestimate others' approval. In other words, high self-esteem isn't associated with *being* a better person, just with *thinking* you are.

My husband's grandfather Robbie was a wealthy white farmer in Zimbabwe who ran his plantations with an iron fist. Robbie had an extremely high opinion of himself and assumed everyone else did too. On one visit to Zimbabwe, as we were being served tea by Robbie's black manservant (who actually called him "master"), I remember him telling a story about his farmworkers and his relationship with them. At the end of his tale Robbie got a wistful look on his face and said, "You know, I think they rather like me . ." He had absolutely no idea—or at least he suppressed the idea—that his

workers just kissed his butt because they were terrified of losing their jobs. Though friendless (he had alienated most of his family through his tyrannical behaviors), he clung to his delusions of being loved and admired until the day he died. In an interesting postscript, Robbie's death occurred suddenly, just days after Robert Mugabe declared he was taking over all the white farms in Zimbabwe. Perhaps Robbie didn't want to live without his most salient source of self-esteem.

It is true that high self-esteem has at least one tangible, and by no means unimportant, benefit: happiness. When you like yourself, you tend to be cheerful; when you dislike yourself, you tend to be depressed. These mood states then color our feelings about our lives more generally. When we believe *we're* great, life is great; when we don't, life stinks. Happiness is an important feature of living a good life and is definitely worth cultivating. But the price paid for the momentary happiness of high self-esteem can be steep.

## The Pool of Narcissus

Narcissists have extremely high self-esteem and are quite happy most of the time. Of course, they also have inflated, unrealistic conceptions of their own attractiveness, competence, and intelligence and feel entitled to special treatment.

Narcissus, from whose myth *narcissism* was named, was the son of the river god Cephissus and the nymph Liriope. He fell in love with his own image reflected in a pool, being so transfixed that he couldn't pull himself away, eventually wasting away to death. In modern psychology, narcissism is typically measured by examining people's scores on the Narcissistic Personality Inventory, which includes items such as "I think I am a special person," "I like to look at myself in a mirror," and "If I ruled the world it would be a better place." Research generally finds that people who score high on this scale also report being very satisfied with their lives. Who wouldn't love the show in which they have the starring role?

But narcissists are actually caught in a social trap. Although they hope their personal greatness will be admired by others, winning them friends and devotees, the truth is that over time, narcissists almost always drive people away. People may be impressed by the self-confidence and swagger of

narcissists at first but are eventually turned off by these same tendencies. Most report disliking those high in the trait of narcissism, and the relationships of narcissists typically fall apart after a while. It's hard to feel understood or get your needs met when your partner is so self-absorbed.

Many people believe that deep down, narcissists hate themselves, and their inflated self-image is just a cover for insecurity. This idea has penetrated the American popular media. When discussing the troubles of young stars such as Lindsay Lohan or Paris Hilton, for instance, one TV commentator said, "They have everything you'd ever want in life—they've finally achieved their faces on television. Meanwhile that little voice inside is saying, 'You're not good enough. Not good enough.'" The cure for narcissism, it is therefore assumed, must be higher self-esteem. Research has shown this assumption to be false. Scientists have found a way to assess unconscious self-attitudes using something called the Implicit Association Test (IAT). This computer-based test measures how fast people associate the labels "me" and "not me" with positive words like *wonderful* versus negative words like *awful*. People who quickly associate "me" with positive words but are slow to associate "me" with negative words are said to have high implicit self-esteem, while the reverse pattern indicates low implicit self-esteem. It turns out that narcissists think they're wonderful both implicitly and explicitly. When Paris Hilton claimed "There's nobody in the world like me. I think every decade has an iconic blonde—like Marilyn Monroe or Princess Diana—and right now, I'm that icon," she probably didn't do so because deep down she feels insecure. Trying to help a narcissist by telling her to love herself more is about as effective as throwing oil on a fire.

The metaphor of a fire is an appropriate one. As long as they're receiving the attention and admiration they believe they deserve, narcissists are on top of the world. The problem comes when their position of superiority starts to slip. When confronted with bad reviews, the narcissist typically responds with feelings of rage and defiance.

In one classic study, researchers examined the behavior of narcissists when their ego was threatened. The study required people to write an essay on an important issue, which was supposedly read and evaluated by a research partner in the next room (who the participant never met and who didn't actually exist). The essays were randomly given one of two written comments by the fictitious partner: "This is one of the worst essays I have

read!” or “No suggestions, great essay!” In the next part of the study, which was described as a learning task, participants were told that they and their partner would have to press a button as fast as possible after solving a simple problem. They were then told that whoever was slower would receive a blast of noise in order to help them learn. The task was rigged, of course. Participants were told that they had been the fastest and were asked to set the noise level and duration of the blast for their “slow” partner (the same person who they believed had just evaluated their essay). Narcissists who had received derogatory feedback were the most violent, giving long, loud blasts of noise as payback for their partner’s earlier insult.

When narcissists receive put-downs from others, their retaliation can be fast and furious, even violent. Narcissistic anger serves an important function for the narcissist: it deflects negative attention away from the self toward others, who can then be blamed for all the dark emotions being experienced. This pattern helps explain why clinician Otto Kernberg refers to the violence of school shooters as “malignant narcissism.” Eric Harris and Dylan Klebold, for instance, the Columbine High School gunmen, committed their atrocious deeds in reaction to relatively minor insults doled out by some school jocks. But in their ego-inflated minds, the jocks were getting their just deserts. Just days before pulling the trigger on their classmates, Eric and Dylan laughingly told each other, “Isn’t it fun to get the respect we’re going to deserve?”

If you’ve ever known a narcissist, this pattern will be all too familiar. The narcissist’s need and demand for respect is constant. Because narcissists are always trying to hang on to that elusive feeling of high self-esteem, the wrath that descends when their precious ego is jeopardized can be truly something to behold.

My friend Irene once told me a story about a woman who had all the hallmarks of a classic narcissist. She said that at first glance you’d never guess Susan was a narcissist—she was overweight and overworked, and didn’t have much of a social life. But she did have one passion in life: helping needy children. She went on volunteer missions to third world countries at least twice a year, and she was a very effective aid worker.

Unfortunately, Irene realized the hard way that Susan was mainly using her charity work as a way to feel superior. Susan was “one of the world’s leading experts” on the problem of malnutrition among third world children (at least according to Susan), and she clearly identified with being in the

position of helper—a knight in shining armor who rescued those in need. Susan’s lifelong dream, as she was fond of telling people, was to open a food bank where she could feed malnourished children year-round. When Irene received an unexpected financial windfall, she was now in a position to make Susan’s dream a reality. She decided to found a nonprofit that would build a food bank in rural Bangladesh, employing Susan as the center’s manager.

Instead of being grateful for her assistance, however, Susan immediately started to turn on Irene. She started bad-mouthing her behind her back, complaining to anyone who would listen about having to work with such a stupid woman. She was willing to be the manager of the food bank “for the sake of the children” she said, but it would be a penance to do so under the supervision of someone so obviously incompetent. Then she started to spread nasty and false rumors that attacked Irene’s personal character and integrity. Luckily, an acquaintance told her what was happening about a week before the food bank was set to open, and Irene managed to pull out of her contract with Susan just in the nick of time.

Irene felt like she’d received a slap in the face. But after a while she began to realize that Susan’s behavior had little to do with her. Susan had painted a glowing portrait of herself as world savior, and finding herself in the position of receiving rather than giving assistance was just too much for her ego to bear. Susan had to cast Irene as the devil to maintain her own self-image as an angel. Sadly, narcissism is more common than you might think among people doing good works in the world. But when the force driving philanthropy is the pursuit of high self-esteem, even beautiful acts of charity can be sullied by the needy, greedy ego.

## Indiscriminate Praise

Although problems are associated with the *pursuit* of high self-esteem, high self-esteem is not bad in and of itself. It’s clearly much better to feel worthy and valuable than worthless and insignificant. It’s just that there are both healthy and unhealthy pathways to high self-esteem. Having a supportive family or working hard to achieve valued goals are healthy sources of high self-esteem. Puffing up your ego and putting other people down is not so great. The majority of research that examines self-esteem, however, does not

distinguish healthy self-esteem from its other, less productive forms.

The most commonly used measure of self-esteem, the Rosenberg Self-Esteem Scale, asks questions that are quite general. For instance, “I feel that I have a number of good qualities,” or “I take a positive attitude toward myself.” The narcissist who thinks he’s the best thing since sliced bread will score quite high on this scale, as will the humble person who likes himself simply because he is a human being intrinsically worthy of respect. Put simply, it’s impossible to tell if high self-esteem is healthy or unhealthy until you determine its source.

The problem with many of the school-based programs to increase self-esteem is that they don’t distinguish between healthy and unhealthy self-esteem either. They tend to use indiscriminate praise to boost children’s self-image, focusing only on the child’s level of self-esteem, not on how or why it gets there. As a result, many children come to believe they deserve compliments and admiration no matter what they do.

Jean Twenge writes about this trend in her fascinating book *Generation Me*. She notes that self-esteem programs for schoolkids tend to be ego flattering to the point of nausea. Children are given books to read such as *The Lovables in the Kingdom of Self-Esteem*, where children learn that the gates to self-esteem will open if they repeat “I’m lovable!” three times with pride. Weighty tomes like *Be a Winner: A Self-Esteem Coloring and Activity Book* help children realize how special and important they are. Games such as “The Magic Circle” designate one child a day to wear a badge that says “I’m great” while classmates write up a list of praise for the anointed one. Elementary schools in particular assume that their mission is to raise the self-esteem of their pupils, to prepare children for success and happiness later on in life. For this reason, they discourage teachers from making critical remarks to little ones because of the damage it might do to their self-esteem.

Some schools have even eliminated “F” as a grade category because “F” stands for “fail.” Instead, they simply assign the letter “E” for unacceptable work, presumably because it is a nonjudgmental letter that merely follows “D” (and still connotes positive things like “excellent,” perhaps?). The desire to raise children’s self-esteem has led to some serious grade inflation. One study found that 48 percent of high school students received an A average in 2004, as compared to 18 percent in 1968. Not surprisingly, American students think they’re the best and brightest in the world, even though they’re

beaten by students from other countries on almost every measure of academic success. We might as well change our name to the United States of Lake Wobegon.

Although the emphasis on raising children's self-esteem comes from good motives, and breaks away from the harsh educational practices of the past that often lowered children's self-esteem, indiscriminate praise can hinder children's capacity to see themselves clearly, limiting their ability to reach their full potential.

This emphasis on high self-esteem at all costs has also led to a worrying trend toward increasing narcissism. Twenge and colleagues examined the scores of more than fifteen thousand college students who took the Narcissistic Personality Inventory between 1987 and 2006. During the twenty-year period, scores went through the roof, with 65 percent of modern-day students scoring higher in narcissism than previous generations. Not coincidentally, students' average self-esteem levels rose by an even greater margin over the same period.

Twenge recently coauthored a book called *The Narcissism Epidemic: Living in the Age of Entitlement* with leading narcissism researcher Keith Campbell. The authors examine how the emphasis on raising self-esteem in America has led to a real cultural sickness, writing:

*Understanding the narcissism epidemic is important because its long-term consequences are destructive to society. American culture's focus on self-admiration has caused a flight from reality to the land of grandiose fantasy. We have phony rich people (with interest-only mortgages and piles of debt), phony beauty (with plastic surgery and cosmetic procedures), phony athletes (with performance-enhancing drugs), phony celebrities (via reality TV and YouTube), phony genius students (with grade inflation), a phony national economy (with \$11 trillion of government debt), phony feelings of being special among children (with parenting and education focused on self-esteem), and phony friends (with the social networking explosion). All this fantasy might feel good, but unfortunately, reality always wins. The mortgage meltdown and the resulting financial crisis are just one demonstration of how inflated desires eventually crash to earth.*

Because the praise given by teachers and parents to boost children's self-esteem is so unconditional, some argue that praise should be contingent on hard work and effort, so that kids feel good about themselves *only* if they deserve it. Why bother putting in the effort to do well, the thinking goes, if mediocrity receives the same praise as first-rate work? Subtly embedded in this position is the idea that praise and criticism are effective motivating forces when they're tied to success and failure, and that feeling good about oneself should come in one scenario, not the other. Sadly, however, there is ample evidence that using self-esteem in a conditional way, so that we only feel good about ourselves when we succeed and feel bad about ourselves when we fail, is as problematic as basing our self-esteem on nothing at all.

## Contingent Self-Worth

"Contingent self-worth" is a term psychologists use to refer to a sense of self-esteem that depends on success or failure, on approval or disapproval. Several common areas of contingent self-worth have been identified, such as personal attractiveness, peer approval, competition with others, work/school success, family support, feeling virtuous, and even God's love. People vary in terms of the degree to which their self-esteem is contingent on positive evaluations in these different areas. Some people put all their eggs into one basket, like personal attractiveness, whereas others strive to be good at everything. Research shows that the more your overall sense of self-worth is dependent on success in particular life areas, the more generally miserable you feel when you fail in those areas.

Having contingent self-esteem can feel like Mr. Toad's wild ride—your mood swinging from elation one moment to devastation the next. Let's say you derive your sense of self-worth from doing well at your marketing job. You'll feel like a king when you're named salesperson of the month but a pauper when your monthly sales figures are merely average. Or maybe you tend to base your self-esteem on being liked by others. You'll get an incredible high when you receive a nice compliment but crash in the dust when someone ignores you or—worse—criticizes you.

Once, I actually had the experience of feeling hugely complimented and devastatingly criticized at the exact same moment. I was visiting an

equestrian center with Rupert, a lifelong horseman, and the elderly Spanish riding instructor who ran the stable apparently liked my dark Mediterranean looks. In his desire to be gallant he paid me what he clearly thought was the highest compliment: “You are veeerry beautiful. Don’t *ever* shave your muuustache.”

I didn’t know whether to laugh, hit him, hang my head in shame, or say thank you. (I chose the first and last options, but seriously considered the other two!) Rupert was too busy laughing to say anything.

Ironically, people who excel in areas important to their self-esteem are the most vulnerable to letdowns. The straight A student feels crushed if she receives anything less than an A on an exam, whereas the D student might feel on top of the world for merely getting a C. The higher you climb, the farther you have to fall.

And contingent self-esteem has an addictive quality that’s hard to shake. Because the initial rush of self-esteem feels so good, we want to keep getting those compliments or winning those competitions. We keep chasing after that initial high, but as with drugs or alcohol, we build up a tolerance so that it progressively takes more and more to get our fix. Psychologists refer to this process as the “hedonic treadmill” (hedonic means pleasure seeking), comparing the pursuit of happiness to a person on a treadmill who has to continually work harder just to stay in the same place.

Trying to continually prove your mettle in areas where your self-esteem is invested can also backfire. If the main reason you want to win that marathon is to feel good about yourself, what happens to your love of running in and of itself? Instead of doing it because you enjoy it, you start doing it to get the reward of high self-esteem. Which means you’re more likely to give up if you stop winning races. It’s like being a dolphin who jumps through a flaming hoop only because it wants a fish treat. But if the treat isn’t given, if you stop getting the self-esteem boost you’re so invested in, the dolphin doesn’t jump.

Jeanie loved classical piano and learned to play when she was only four. The piano was the biggest source of joy in her life, reliably transporting her to a place of serenity and beauty. As a teen, however, her mother started entering her into piano competitions. Suddenly it wasn’t about the music anymore. Because her developing identity was so wrapped up in being a “good” pianist, it mattered hugely (both to Jeanie and her mother) whether

she came in first, second, or third in a competition. And if she didn't place at all, she felt utterly worthless. The harder Jeanie tried to play well, the worse she performed, because she would focus more on the competition than the music itself. By the time she entered college, Jeanie dropped piano altogether. It had stopped being fun. Artists and athletes often tell such stories. Once we start basing our self-esteem purely on our performance, our greatest joys in life can start to seem like so much hard work, our pleasure morphing into pain.

## Confusing the Map for the Territory

As human beings with the capacity for self-reflection, with the ability to construct a self-concept, our thoughts and evaluations of ourselves can easily become confused with who we actually are. It's as if we conflate that Cezanne still life of a bowl of fruit with the fruit itself, mistaking the paint and canvas for the actual apples, pears, and oranges that the still life represents, and getting frustrated when we find we can't eat them. Our self-concept is not our *actual* self, of course. It is simply a representation, a sometimes accurate but more often wildly inaccurate portrayal of our habitual thoughts, emotions, and behaviors. And the sad thing is that the broad brush strokes that outline our self-concept don't even begin to do justice to the complexity, subtlety, and wonder of our actual self.

Still, we identify so strongly with our mental self-portrait that painting a positive rather than a negative picture of ourselves can feel like a matter of life and death. If the image I construct of myself is perfect and desirable, the unconscious thought process goes, then *I* am perfect and desirable, and therefore others will accept rather than reject me. If the image I construct is flawed or undesirable, however, then I am worthless and will be cast out and abandoned. Our thinking on these matters tends to be incredibly black and white—either we're all good (phew, breathe a sigh of relief) or we're all bad (might as well throw in the towel now). Any threat to our mental representation of who we are, therefore, feels like an actual, visceral threat, and we respond as powerfully as a soldier defending his very life.

We grasp onto self-esteem as if it were an inflatable raft that will save us—or at least save and prop up the positive sense of self that we so crave—

only to find that the raft has a gaping hole and is rapidly running out of air. The truth is this: sometimes we display good qualities and sometimes bad. Sometimes we act in helpful, productive ways and sometimes in harmful, maladaptive ways. But we are not *defined* by these qualities or behaviors. We are a verb not a noun, a process rather than a fixed “thing.” Our actions change—mercurial beings that we are—according to time, circumstance, mood, setting. We often forget this, however, and continue to flog ourselves into the relentless pursuit of high self-esteem—the elusive holy grail—trying to find a permanent box labeled good in which to stuff ourselves.

By sacrificing ourselves to the insatiable god of self-esteem, we are trading the ever-unfolding wonder and mystery of our lives for a sterile Polaroid snapshot. Instead of reveling in the richness and complexity of our experience—the joy and the pain, the love and anger, the passion, the triumphs and the tragedies—we try to capture and sum up our lived experience with extremely simplistic evaluations of self-worth. But these judgments, in a very real sense, are just thoughts. And more often than not they aren’t even accurate thoughts. The need to see ourselves as superior also makes us emphasize our separation from others rather than our interconnectedness, which in turns leads to feelings of isolation, disconnection, and insecurity. So, one might ask, is it worth it?

## Self-Compassion Versus Self-Esteem

Rather than trying to define our self-worth with judgments and evaluations, what if our positive feelings toward ourselves came from a totally different source? What if they came from our hearts, rather than our minds?

Self-compassion does not try to capture and define the worth or essence of who we are. It is not a thought or a label, a judgment or an evaluation. Instead, self-compassion is a way of *relating* to the mystery of who we are. Rather than managing our self-image so that it is always palatable, self-compassion honors the fact that all human beings have both strengths and weaknesses. Rather than getting lost in thoughts of being good or bad, we become mindful of our present moment experience, realizing that it is ever changing and impermanent. Our successes and failures come and go—they neither define us nor do they determine our worthiness. They are merely part

of the process of being alive. Our minds may try to convince us otherwise, but our *hearts* know that our true value lies in the core experience of being a conscious being who feels and perceives.

This means that unlike self-esteem, the good feelings of self-compassion do not depend on being special and above average, or on meeting ideal goals. Instead, they come from caring about ourselves—fragile and imperfect yet magnificent as we are. Rather than pitting ourselves against other people in an endless comparison game, we embrace what we share with others and feel more connected and whole in the process. And the good feelings of self-compassion don't go away when we mess up or things go wrong. In fact, self-compassion steps in *precisely* where self-esteem lets us down—whenever we fail or feel inadequate. When the fickle fancy of self-esteem deserts us, the all-encompassing embrace of self-compassion is there, patiently waiting.

Sure, you skeptics may be saying to yourself, but what does the research show? The bottom line is that according to the science, self-compassion appears to offer the same advantages as high self-esteem, with no discernible downsides. The first thing to know is that self-compassion and self-esteem *do* tend to go together. If you're self-compassionate, you'll tend to have higher self-esteem than if you're endlessly self-critical. And like high self-esteem—self-compassion is associated with significantly less anxiety and depression, as well as more happiness, optimism, and positive emotions. However, self-compassion offers clear advantages over self-esteem when things go wrong, or when our egos are threatened.

In one study my colleagues and I conducted, for instance, undergraduate students were asked to fill out measures of self-compassion and self-esteem. Next came the hard part. They were asked to participate in a mock job interview to “test their interviewing skills.” A lot of undergrads are nervous about the interviewing process, especially given that they will soon be applying for jobs in real life. As part of the experiment, students were asked to write an answer to that dreaded but inevitable interview question, “Please describe your greatest weakness.” Afterward they were asked to report how anxious they were feeling.

Participants’ self-compassion levels, but not their self-esteem levels, predicted how much anxiety they felt. In other words, self-compassionate students reported feeling less self-conscious and nervous than those who

lacked self-compassion, presumably because they felt okay admitting and talking about their weak points. Students with high self-esteem, by contrast, were no less anxious than those with low self-esteem, having been thrown off balance by the challenge of discussing their failings. And interestingly, self-compassionate people used fewer first-person singular pronouns such as “I” when writing about their weaknesses, instead using more third-person plural pronouns such as “we.” They also made references to friends, family, and other humans more often. This suggests that the sense of interconnectedness inherent to self-compassion plays an important role in its ability to buffer against anxiety.

Another study required people to imagine being in potentially embarrassing situations: being on a sports team and blowing a big game, for instance, or performing in a play and forgetting one’s lines. How would participants feel if something like this happened to them? Self-compassionate participants were less likely to feel humiliated or incompetent, or to take it too personally. Instead, they said they would take things in their stride, thinking thoughts like “Everybody goofs up now and then” and “In the long run, this doesn’t really matter.” Having high self-esteem, however, made little difference. Those with both high *and* low self-esteem were equally likely to have thoughts like “I’m such a loser” or “I wish I could die.” Once again, high self-esteem tends to come up empty-handed when the chips are down.

In a different study, participants were asked to make a videotape that would introduce and describe themselves. They were then told that someone would watch their tape and give them feedback in terms of how warm, friendly, intelligent, likable, and mature they appeared (the feedback was bogus, of course). Half the participants received positive feedback, the other neutral feedback. Self-compassionate people were relatively unflustered regardless of whether the feedback was positive or neutral, and they were willing to say the feedback was based on their own personality either way. People with high levels of self-esteem, however, tended to get upset when they received neutral feedback (what, I’m just *average*?). They were also more likely to deny that the neutral feedback was due to their own personality (surely it’s because the person who watched my tape was an idiot!). This suggests that self-compassionate people are better able to accept who they are regardless of the degree of praise they receive from others. Self-esteem, on the other hand, only thrives when the reviews are good and may lead to

evasive and counterproductive tactics when there's a possibility of facing any unpleasant truths about oneself.

Recently, my colleague Roos Vonk and I investigated the benefits of self-compassion versus self-esteem with more than three thousand people from various walks of life, the largest study to examine this issue so far. First, we examined the stability of positive feelings experienced toward the self over time. Did these feelings tend to go up and down like a yo-yo or were they relatively constant? We hypothesized that self-esteem would be associated with relatively *unstable* feelings of self-worth, since self-esteem tends to be diminished whenever things don't turn out as well as desired. On the other hand, because compassion can be extended to oneself in both good times and bad, we expected the feelings of self-worth associated with self-compassion to remain steadier over time.

To test this idea, we had participants report on how they were feeling toward themselves at the time—for instance, “I feel inferior to others at this moment” or “I feel good about myself”—doing so twelve different times over a period of eight months.

Next, we calculated the degree to which overall levels of self-compassion or self-esteem predicted stability in self-worth over this period. As expected, self-compassion was clearly associated with steadier and more constant feelings of self-worth than self-esteem. We also found that self-compassion was less likely than self-esteem to be contingent on particular outcomes like social approval, competing successfully, or feeling attractive. When our sense of self-worth stems from being a human being intrinsically worthy of respect—rather than being contingent on obtaining certain ideals—our sense of self-worth is much less easily shaken.

We also found that in comparison to self-esteem, self-compassion was associated with less social comparison and less need to retaliate for perceived personal slights. It was also linked to less “need for cognitive closure,” which is psych-speak for the need to be right without question. People who invest their self-worth in feeling superior and infallible tend to get angry and defensive when their status is threatened. People who compassionately accept their imperfection, however, no longer need to engage in such unhealthy behaviors to protect their egos. In fact, a striking finding of the study was that people with high self-esteem were much more narcissistic than those with low self-esteem. In contrast, self-compassion was completely unassociated

with narcissism. (The reason there wasn't a negative association is because people who lack self-compassion don't tend to be narcissistic, either.)

## Exercise One

### *Identifying the Trickster*

- A. List up to ten aspects of yourself that play a significant role in your self-esteem—things that either make you feel good or bad about yourself (job performance, role as parent, weight, etc.).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

- B. Ask yourself the following questions as they relate to each item, and consider whether your answers change how you think about things. Are there ways in which the trickster of self-esteem is leading you astray?

1. Q1. Do I want to feel better than others, or to feel connected?
2. Q2. Does my worth come from being special, or from being human?
3. Q3. Do I want to be perfect, or to be healthy?

## Freedom from the Ego

One might say that with self-compassion, although the ego doesn't

completely go away, it moves from the foreground into the background. Instead of evaluating yourself as an isolated individual with boundaries that are clearly defined in contrast to others, you see yourself as part of a greater, interconnected whole. The idea that there is some “separate self” that can be judged independently from the many interacting conditions that created that “self” is an illusion. It is only when we fall into the trap of believing that we are “distinct entities” that the issue of self-esteem even comes into play. Of course we want to experience the happiness that stems from feeling good about ourselves; everyone does. Moreover, this happiness is our birthright. But happiness—real, lasting happiness—can be best experienced when we are engaged in the flow of life—connected to rather than separate from everything else.

When we’re mainly filtering our experience through the ego, constantly trying to improve or maintain our high self-esteem, we’re denying ourselves the thing we actually want most. To be accepted as we are, an integral part of something much greater than our small selves. Unbounded. Immeasurable. Free.

## *Chapter Eight*

# MOTIVATION AND PERSONAL GROWTH

*The curious paradox is that when I accept myself just as I am, then I can change.*

—CARL ROGERS, *On Becoming a Person*

**T**WO OUTLAWS WERE SITTING IN THE SALOON WHEN ONE SAYS TO the other, “Have you seen Billy the Kid lately?”

“Yep. I had lunch with him the other day.”

“Oh?”

“Yep, I was riding my horse over the bridge into town, and there was Billy, with a gun, pointed at me. ‘Get down off yer horse,’ he says.

“What can I do? He has the gun, so I get down off the horse.

“Billy points at a pile of horse poop. ‘See the horse poop? Eat the horse poop.’

“What can I do? He has the gun. I eat the poop.

“Then Billy laughs; he laughs so hard he drops the gun. I grab it.

“‘Hey Billy,’ I say. ‘Now I have the gun. See the horse poop? Eat the horse poop.’

“What can he do? I have the gun. He eats the poop.

“So like I said, we had lunch together the other day.”

THIS (ADMITTEDLY SOMEWHAT GRATUITOUS) JOKE HIGHLIGHTS THE widespread belief that we need to put a gun to someone’s head to make them do something unpalatable—especially when the someone is us.

The number one reason people give for why they aren’t more

compassionate to themselves is fear of laziness and self-indulgence. “Spare the rod, spoil the child,” the saying goes, revealing the belief that only harsh punishment can keep indolence at bay. Corporal punishment might be less common in families and schools today, but we still cling to this approach with ourselves, believing that self-flagellation (even if only mental) is both useful and effective. It’s the old carrot-and-stick approach—self-judgment is the stick and self-esteem is the carrot. If you do what you’re supposed to do even though you don’t want to, you can avoid being bashed with self-criticism and feel better about yourself.

I had an undergraduate student named Holly who really bought into this. She was convinced that she needed to be tough on herself to keep herself in line, so that she would be the person she wanted to be. Born to a conservative Texas family with incredibly high expectations, she felt it wasn’t enough to merely graduate college; she had to earn an MBA. Her parents had never gotten beyond high school: all their hopes and dreams were pinned on their daughter’s success. The way she kept up this intense pressure on herself was through constant self-criticism. If she got a worse-than-expected grade on an exam, she would pummel herself with harsh self-talk: “You’re so stupid and lame. You’ll never get into grad school if you keep messing up like this,” and so on. The reward she dangled in front of her nose for working so hard was pride. Holly wanted her parents to be proud of her, and she wanted to be proud of herself. She believed that the only way she would ever be able to reach her goals was to spur herself on with merciless self-criticism.

This type of thinking is incredibly common, *but is it true?*

## The Demoralizing Whip

First, consider the mind-state that self-criticism engenders. What type of mood do the words “You’re such a lazy good-for-nothing, I hate you” put you in? Energized, inspired, ready to take on the world? Go get ’em, champ.

It’s even easier to see when we think about motivating other people, such as children. Let’s say your ten-year-old daughter comes home with a failing exam grade. What’s the best way to encourage her to adopt better study habits so that she can do better next time? Should you fiercely criticize her? Tell her she’s useless and send her to bed without any supper? Of course not.

Such harsh criticism would emotionally flatten her to the point where she'd have little energy left over to reapply herself to her studies. Sadly, some parents do take this approach, but it's far from ideal. More effective would be to reassure her that these things happen, that she is still loved, and to firmly but compassionately encourage a new study routine, assuring her that she can and will do better.

We all know that positive, reassuring messages create the mind-state most conducive to working hard and reaching one's highest potential. We need to feel calm, secure, and confident in order to do our best. That's why when we try to motivate those we love, we usually bend over backward to let them know we believe in them, that they have our undying loyalty, affection, and support. But for some strange reason, we often take the exact opposite approach with ourselves.

Researchers who study motivation have consistently found that our level of self-confidence has a dramatic impact on our ability to reach our goals. Dozens of studies have confirmed that our beliefs in our own abilities—which research psychologist Albert Bandura terms “self-efficacy” beliefs—are directly related to our ability to achieve our dreams.

For example, one study followed more than two hundred high school wrestlers through the course of one wrestling season. It was found that, independent of their prior success at wrestling, those students who had stronger self-efficacy beliefs won more matches than those who doubted themselves. This was especially apparent in high-pressure overtime situations where the match was tied. Wrestling matches decided in overtime are “sudden death”—where the first wrestler to score wins. They are difficult because both wrestlers are exhausted, and a tie indicates an even match of physical skills. In such cases, the only factor that predicts a win is the wrestler’s mental belief in his own ability.

Because self-criticism tends to undermine self-efficacy beliefs, self-criticism may harm rather than help our ability to do our best. By constantly putting ourselves down we eventually begin to lose faith in ourselves, meaning we aren’t able to go as far as we’re capable of going. Self-criticism is also strongly associated with depression, and a depressive mind-set is not exactly conducive to a “get-up-and-go” attitude.

Of course, self-criticism must be *somewhat* effective as a motivator, otherwise so many people wouldn’t do it. If self-criticism works at all,

however, it is only for one reason: *fear*. Because it is so unpleasant to be harshly criticized by ourselves when we fail, we become motivated by the desire to escape our own self-judgment. It's like we're putting our own heads on the chopping block, constantly threatening the worst, knowing that the terror of our own harsh self-criticism will prevent us from being complacent.

This approach works to a certain degree, but it has some serious drawbacks. One of the biggest problems with using fear as a motivator is that anxiety itself can undermine performance. Whether it's public speaking anxiety, test anxiety, writer's block, or stage fright, we know that fear of being negatively judged can be pretty debilitating. Anxiety distracts people from the task at hand, interfering with their ability to focus and give their best.

Not only does self-criticism create anxiety, it can also lead to psychological tricks designed to prevent self-blame in the case of failure, which in turn makes failure more likely. The tendency to undermine your performance in ways that create a plausible excuse for failing is known as "self-handicapping." One common form of self-handicapping is simply not trying very hard. If I don't practice ahead of time for my neighborhood tennis match, I can blame losing the match on my lack of practice rather than on being a bad tennis player. Another common strategy is procrastination. If I mess up on a work assignment that I didn't start preparing for until the last minute, I can blame my failure on lack of preparation rather than incompetence.

Research indicates that self-critics are less likely to achieve their goals because of these sorts of self-handicapping strategies. In one study, for instance, college students were asked to describe their various academic, social, and health-related goals, and then to report on how much progress they had made toward these goals. Self-critics made significantly less progress toward their goals than others and also reported that they procrastinated more often. So, instead of being a useful motivational tool, self-criticism may actually cause us to shoot ourselves in the foot.

Jim was one of the worst procrastinators I'd ever met. Everything he did was done at the last minute. Whenever he felt insecure about his ability to pull off an important task, he'd procrastinate so that if he messed up he would have a ready excuse—"I ran out of time." When he took his GRE exam to try to get into grad school, for instance, he didn't start studying until a few days

before. When he got his score back, which was okay but not fantastic, he told me, “Well, it’s actually not that bad considering I hardly studied.” When it came time to get an internship as part of his master’s program in social work, he waited until the last minute to send out his applications. Not surprisingly, the only internship he ended up being offered was the one no one else wanted. His response? “Well, most of the positions were already filled by the time I sent in my application. At least I got something.”

The worst, however, was his wedding day. Jim’s fiancée, Naomi, made all the arrangements for the big event herself, hoping that the ceremony—held in the beautiful nineteenth-century church her family had attended when she was a child—would be perfect. Naomi picked out matching dresses for her bridesmaids and tuxedos for Jim and his groomsmen. The one thing she asked Jim to do was buy a pair of black dress shoes for his tux. The wedding was Sunday at noon, so Jim thought he was doing great by hitting the shopping mall at 9:00 A.M. He’d have plenty of time to buy the shoes and show up at the church vestibule at 11:00 A.M. as instructed.

What he forgot, of course, was that the mall didn’t open until noon on Sunday. There were *no* shoe stores in the local area that opened before noon. Jim didn’t own a pair of dress shoes; all he had were two pairs of colored high-top sneakers and a grungy pair of leather sandals. He was screwed. Luckily, he remembered that the local dollar store opened at 10:00 A.M. and that they had a small shoe collection. He could pick up something there. The only shoes they had in black, however, were some cheap Croc rip-offs. They would have to do. Naomi didn’t see Jim’s shoes until he was walking down the aisle, and although her face registered a brief look of shock and horror, she quite rightly decided to ignore the issue for the time being and focus on what was most important—their wedding vows. Afterward at the reception, however, I saw them having a pretty tense exchange. While trying not to eavesdrop (okay, maybe I was eavesdropping a little), I heard Jim say: “Well, considering I didn’t go shopping until this morning, they aren’t so bad. And they’re pretty comfortable . . .”

Although it’s true that Jim somehow managed to squeak by with his last-minute efforts, and saved himself from harsh self-criticism by always having a ready excuse at hand when he messed up, Jim never reached his full potential. He could have gotten into a better grad school, one where his intelligence could really shine, if he had started studying for his GREs earlier.

He could have gotten a better internship, one that gave him experience in the area of social work that most appealed to him, if he had sent out his applications in a timely manner. He could have prevented the fight he had with his new bride on his wedding day if he'd just gone to the mall a day earlier. If Jim was more comfortable with the fact that he *might* fail even when he did his best, he wouldn't have to self-sabotage in order to save his ego when he *did* fail. And failure of some sort is inevitable when we only make a halfhearted effort.

## Because You Care

So why is self-compassion a more effective motivator than self-criticism? *Because its driving force is love not fear.* Love allows us to feel confident and secure (in part by pumping up our oxytocin), while fear makes us feel insecure and jittery (sending our amygdala into overdrive and flooding our systems with cortisol). When we trust ourselves to be understanding and compassionate when we fail, we won't cause ourselves unnecessary stress and anxiety. We can relax knowing that we'll be accepted regardless of how well or how poorly we do. But if that's true, why should we try working hard at all? Why not just kick up our feet eating pizza and watching TV reruns all day?

Many people assume that self-compassion is just a feel-good warm fuzzy—a way to coddle ourselves and nothing more. But healing and growth are not served by such superficial treatment. Unlike self-criticism, which asks if you're good enough, self-compassion asks *what's good for you?* Self-compassion taps into your inner desire to be healthy and happy. If you care about yourself, you'll do what you need to do to in order to learn and grow. You'll *want* to change unhelpful patterns of behavior, even if that means giving up certain things you like for a while. Caring parents don't constantly feed their children candy just because their kids love candy. Indulging your child's every whim is not a sign of good parenting. Being nurturing toward those we care about means sometimes saying no.

In the same way, self-compassion involves valuing yourself in a deep way, making choices that lead to well-being in the long term. Self-compassion wants to heal dysfunctions, not perpetuate them. There's nothing

wrong with occasionally indulging yourself, of course. Sometimes eating that piece of lemon cheesecake is actually a form of self-care. But overindulgence (i.e., eating the whole cheesecake) doesn't feel good. It's counterproductive because it prevents us from getting what we really want: to reach our highest potential.

The Buddha referred to the motivational quality of self-compassion as "right effort." From this point of view, wrong effort comes from concern with the ego, with proving oneself, with the desire for control. This type of effort actually increases suffering, because it makes you feel separate and disconnected from the rest of the world and sets up the expectation that things should always be as we want them to be. Right effort, on the other hand, comes from the natural desire to heal suffering. As the Buddha said, "It is like perceiving one's hair being on fire." The actions that are spurred when we see our hair go up in smoke, like grabbing a wet towel or jumping in the shower, stem from wanting to solve the problem, to escape from the danger of being burned. They don't come from the desire to prove ourselves (see what an excellent fire-putter-outer I am?). In the same way, the effort that comes from self-compassion is not the result of egoistic striving, but the natural desire to ameliorate suffering.

If we want to prosper, we need to face up to ways we might be harming ourselves and figure out how to make things better. We don't have to be cruel to ourselves in this process, however. We can be kind and supportive while engaging in the difficult work of change. We can recognize that life is hard, that challenges are part of the human experience. Luckily, kindness and encouragement feel pretty good, and they sure help the medicine go down.

## Exercise One

### *Identifying What We Really Want*

1. Think about the ways that you use self-criticism as a motivator. Is there any personal trait that you criticize yourself for (such as being moody, lazy, overweight, etc.) because you think being hard on yourself will help you change? If so, first try to get in touch with the emotional pain that your self-criticism causes, giving yourself

compassion for the experience of feeling so judged.

2. Next, see if you can think of a kinder, more caring way to motivate yourself to make a change if needed. What language would a wise and nurturing friend, parent, teacher, or mentor use to gently point out how your behavior is unproductive, while simultaneously encouraging you to do something different? What is the most supportive message you can think of that's in line with your underlying wish to be healthy and happy?

3. Every time you catch yourself being judgmental about your unwanted trait in the future, first notice the pain of your self-judgment and give yourself compassion. Then try to reframe your inner dialogue so that it is more encouraging and supportive. Remember that if you really want to motivate yourself, love is more powerful than fear.

## Self-Compassion, Learning, and Personal Growth

Many people are afraid they won't be ambitious enough if they're compassionate with themselves. Research suggests otherwise. In one study, for example, we examined how people reacted when they failed to meet their standards, and also how high their standards were in the first place. We found that self-compassionate people were just as likely to have high standards for themselves as those who lacked self-compassion, but they were much *less* likely to be hard on themselves on the occasions when they didn't meet those standards. We've also found that self-compassionate people are more oriented toward personal growth than those who continually criticize themselves. They're more likely to formulate specific plans for reaching their goals, and for making their lives more balanced. Self-compassion in no way lowers where you set your sites in life. It does, however, soften how you react when you don't do as well as you hoped, which actually helps you achieve your goals in the long run.

The ability to realize our potential depends partly on where our motivation comes from. Is it intrinsic or extrinsic? Intrinsic motivation occurs when we're driven to do something because we want to learn, grow, or because the activity is just plain interesting. Extrinsic motivation occurs when

we're driven to do something in order to gain a reward or escape a punishment. Even when rewards and punishments come from within, like the reward of self-esteem or the punishment of self-criticism, our motivation is still extrinsic because we're engaging in an activity for ulterior motives.

Research psychologist Carol Dweck, author of *Mindset*, distinguishes two main reasons why people want to achieve their goals. People with *learning* goals are intrinsically motivated by curiosity and the desire to develop new skills. They want to achieve because they want to gain knowledge, and most important, they view making mistakes as a part of the learning process. Those with *performance* goals, on the other hand, are extrinsically motivated to defend or enhance their self-esteem. They want to do well so that others will approve of them and tend to avoid failure at all costs. This means that instead of challenging themselves they take the safe road. You know the type. People who just want the easy A and don't really care how much they learn in the process. Research shows that in the long run, learning goals are more effective than performance goals. Learning goals propel people to try harder for longer, because they enjoy what they do. They also enable people to ask for the help and guidance they need, because they're less worried about looking incompetent for not already knowing the right answer.

Take Kate and Danielle, for example. Twin sisters who both loved animals as young girls, they had dozens of pictures of lions, zebras, rhinos, giraffes, and other exotic animals plastered all over their bedroom walls while growing up. They used to dream about being zookeepers one day. They ended up going to the same local university and enrolled in an upper-level zoology course their junior year. The course was extremely difficult, and both actually failed their first exam. Danielle had always thought of herself as a good student and couldn't stand the thought that she might get a failing grade in the course. So she dropped out. Kate didn't care. She was learning about animals, and that was what was most important. She went to the teaching assistant's office hours almost every week and ended up getting a B in the course. After graduation, Danielle got an entry-level management position at a large corporation. The job was well paid, and she was able to impress all her friends by buying a new car after only a few months of employment. The job was relatively easy and secure, but also pretty boring. Kate, on the other hand, saved up enough money working as a waitress to go to Botswana for a month, where she had the best time of her life. She decided that she wanted to

open her own safari business one day, and after various low-paid and demanding internships learning the ropes, eventually did. Kate and Danielle were both intelligent, hardworking young women, but it was Kate who challenged herself and ended up fulfilling a lifelong dream.

As you might suspect, our research finds that self-compassionate people are more likely to have learning rather than performance goals. Because their motivation stems from the desire to learn and grow, rather than from the desire to escape self-criticism, they are more willing to take learning risks. This is largely because they're not so afraid of failure. Among a group of undergraduates who had recently failed a midterm exam, for example, we found that self-compassionate students were more likely to reinterpret their failure as a growth opportunity rather than as a condemnation of self-worth. When you can trust that failure will be greeted with understanding rather than judgment, it no longer becomes the boogeyman lurking in the closet. Instead, failure can be recognized as the master teacher that it is.

Research also indicates that failure is less likely to damage the overall self-efficacy beliefs of self-compassionate people. Because they aren't so hard on themselves when they fall down, they retain enough confidence in their abilities to pick themselves up and try again. In fact, a recent study found that when self-compassionate people are forced to give up on a goal that's important to them—an inevitability at some point in life—they tend to refocus their energy on a new and different goal. Self-critics, on the other hand, are more likely to throw in the towel. Self-compassionate people have also been found to procrastinate less than those lacking self-compassion. This is partly because they report being less worried about how others view their performances, and thus don't require a plausible excuse for failing.

So it's definitely *not* the case that self-compassion leads to complacency and inertia. Quite the opposite. By losing our fear of failure, we become free to challenge ourselves to a far greater degree than would otherwise be possible. At the same time, by acknowledging the limitations of being human, we are better able to recognize which goals are working for us and which are not, and when it's time to take a new approach. Far from being a form of self-indulgence, self-compassion and real achievement go hand in hand. Self-compassion inspires us to pursue our dreams and creates the brave, confident, curious, and resilient mind-set that allows us to actually achieve them.

## Exercise Two

### *Self-Compassion and Procrastination*

We procrastinate for different reasons. Sometimes we just don't want to do an unpleasant task. Sometimes we procrastinate because we're afraid of failing. Luckily, self-compassion can help deal with procrastination so that it becomes less of a hindrance.

#### UNPLEASANTNESS

It's very common to keep putting off unpleasant tasks, like doing our taxes or writing up those incredibly boring notes for work. Or even if the chore isn't particularly unpleasant, like folding and putting away laundry, sometimes we just don't feel like getting off our butts. This isn't surprising, given that it's natural to want to relax and avoid unpleasantness. And putting off these types of tasks is not necessarily a problem unless it ends up causing you more stress in your life because you aren't getting the needful done. If you find that you habitually procrastinate when faced with doing things you don't want to do, it can help to go to the emotion underlying your resistance itself. We often avoid thinking about unwanted tasks because it makes us feel uncomfortable. Another approach, however, is to give yourself compassion for the very human reactions of displeasure and avoidance. Allow yourself to fully dive into the sensation of dread or lethargy or whatever is coming up for you when you think about the task. Can you feel the emotions in your body, holding them in nonjudgmental, mindful awareness? Recognize that these are moments of suffering, even if on a small scale. All our emotions are worthy of being felt and validated. Once you give yourself the sense of comfort you want, you'll probably find yourself less resistant to getting started.

#### FEAR OF FAILURE

Sometimes the emotions underlying our habitual procrastination run deeper. If the task is an important one, like starting a big work

project, we are often daunted by the possibility of failure. The feelings of fear that come up when thinking about taking on the project, and the feelings of unworthiness that come up when we think about possibly blowing it, can be overwhelming. Again, when we don't want to experience unpleasant emotions, procrastination is a very common way to tune out. And sometimes our unconscious tries to sabotage us so that if we do fail, we can avoid feeling unworthy by blaming our failure on not having enough time to do the job well. If this pattern is habitual, it could seriously limit the extent to which you reach your full potential.

If you suspect your procrastination is due to fear of failure, it's a good time to revisit much of what has been discussed in this book. Remember that all people fail sometimes; it's part of the human condition. And every failure is an incredibly powerful learning opportunity. Promise yourself that if you do fail, you'll be kind, gentle, and understanding with yourself rather than harshly self-critical. Comfort the scared little child inside of you who doesn't want to venture into the dark unknown, assuring him or her that you'll be there to provide support along the way. And then see if you can take the plunge. As we all know from experience, the worst part of dealing with a difficult task is often drawing up the courage to start.

## Searching for True Happiness

The types of dreams inspired by self-compassion are more likely to yield true happiness than those motivated by self-criticism. Our research indicates that self-compassionate people tend to be more authentic and autonomous in their lives, whereas those who lack self-compassion tend to be more conformist because they don't want to risk social judgment or rejection. Authenticity and autonomy are crucial for happiness, of course, because without them life can feel like meaningless drudgery.

Holly, the undergraduate student I talked about earlier in the chapter, learned this lesson eventually. After studying the concept of self-compassion in one of my classes, she began to see that being so critical of herself was

only causing her harm. She was getting migraine headaches, which the doctor told her was from stress. Self-induced stress. The headaches got so bad she was having trouble studying. She had to do something. So she decided to give self-compassion a proper try. She set the timer on her cell phone to go off at various intervals throughout the day, and whenever it beeped she asked herself the question—what would be the most healthy and most self-compassionate thing for me to do right now? (As you can see, Holly did everything in a very methodical and determined manner!)

After about a month we met to talk about how her experiment was going. To her surprise, she said that she didn't find herself studying any less frequently or working any less hard by being kinder to herself. In fact, whenever she stopped to ask what would be the healthiest thing to do in the moment, the answer was often focused on her school work. However, she did start taking naps if she had stayed up late studying the night before, so as a result she was more alert when she worked. She also tried to use gentler, more supportive language with herself whenever she had difficulties or got stuck. This seemed to help her get unstuck more quickly. In fact, when she was having a particularly hard time with one paper, she actually stopped by the professor's office to ask for assistance. She never would have done that before, she said, out of fear of seeming stupid. But she eventually realized that it was only human to need help, and she ended up doing a much better job on the paper than she would have done otherwise.

About a year later, Holly stopped by my office again to say hello and to see whether I would write her a letter of recommendation for graduate school. Holly had been a business major and had always planned on getting her MBA. This was certainly what her parents wanted and expected. But instead, she was applying to a school of special education. She had been volunteering for a local nonprofit that worked with disabled kids (to make her résumé look good, she admitted) and said she unexpectedly found her calling. Her time as a volunteer was the happiest she had ever been, and she wanted her professional life to make a difference in the world. Despite her parents' protestations, Holly realized she wanted to be happy in her life, to do what personally fulfilled her. So Holly got a master's degree in special education, and at last report was thriving as a special needs teacher in a local elementary school. Self-compassion might lead us to make unconventional choices for ourselves, but these will be the right choices made for the right reasons—the

desire to follow our hearts.

## Self-Compassion and Our Bodies

Much of my discussion of self-compassion and motivation has focused on the realm of learning, probably because I'm a university professor and I deal with these issues every day. But self-compassion is a powerful motivator in many different domains. One area in which self-compassion plays a particularly strong role is in the epic struggle to accept our bodies. We often tear ourselves to shreds with self-criticism when we don't look the way we think we're supposed to. We stare at the superthin, aerobicized models on the covers of magazines and, understandably, don't feel we measure up. Even the cover girls don't feel they measure up, since most images are digitally enhanced.

Given the value placed on beauty in our society, it's not surprising that perceived attractiveness is one of the most important areas in which people invest their sense of self-worth. This holds true for both genders, but especially for females. If you want to know why teen girls often have self-esteem issues, you need only consider their perceived attractiveness. Research shows that boys' perceptions of their attractiveness tends to remain relatively stable during the child and adolescent years: third grade—looking good; seventh grade—looking good; eleventh grade—still looking good. Girls, on the other hand, feel more insecure about their looks as they grow older: third grade—looking good; seventh grade—not so sure anymore; eleventh grade—I'm so ugly! What's wrong with this picture? Are guys really more attractive than girls are? I think not.

The problem is that standards for female beauty are so much higher than those for males, especially when it comes to weight. Women are supposed to be rail thin but also super curvy, a nearly impossible ideal to achieve without plastic surgery and constant dieting. We may think it's mainly the rich and famous who cling to such unrealistic ideals, as jokes like this one attest: "A beggar walked up to a well-dressed woman shopping on Rodeo Drive and said to her, 'I haven't eaten anything in four days.' She looked at him and said, 'God, I wish I had your willpower.'" In fact, research indicates that four out of five American women are dissatisfied with the way they look, and over

half are on a diet at any one time. Almost 50 percent of all girls between first and third grade say they want to be thinner, and by age eighteen fully 80 percent of girls report that they have dieted at some point in their life.

For some, the obsession with thinness leads to eating disorders such as anorexia or bulimia. Anorexia involves undereating to the point of near starvation. Bulimia entails eating unusually large amounts of food in one sitting (binging), then getting rid of the calories afterward (purging) either by vomiting, abusing laxatives, or overexercising. Despite the strong cultural emphasis on thinness and dieting, however, the most prevalent eating disorder is actually binge eating—which occurs when people overeat past the point of fullness but *don't purge* afterward.

Psychologists agree that when people binge eat they are often trying to satiate an internal emotional hunger. Stuffing yourself numbs painful feelings. It's a way of medicating yourself with food. Indulging in the pleasures of food is also an easy way to make yourself happy, at least in the short term. The long-term impact of overeating, however, is not pleasant. Fully one-third of all Americans are classified as obese, and it's estimated that about half of all people who are obese suffer from binge-eating disorder. This causes major health problems in society and costs the medical system billions of dollars each year. Not to mention the emotional pain and self-loathing experienced by people who are obese. People with binge eating disorder are caught in an unfortunate downward spiral—depression fuels overeating, which leads to obesity, which leads to further depression.

So why is being overweight so common at the same time that most people are trying to diet? Because as almost everyone knows from personal experience, diets don't work. People start diets because they hate the way they look, but when they break their diet—as everyone eventually does—they're likely to gain back more than they lost in the first place. After overeating at an office party, for instance, the inner dialogue may go like this: *I can't believe I ate so much. I'm so disgusted with myself. I guess I might as well finish off that bowl of chips since I'm clearly a lost cause.* And, of course, criticizing yourself in this way will probably make you eat even more as a means of self-comfort—eating to feel better because you feel bad about eating. It's a vicious cycle that's hard to stop and is one of the reasons why the pattern of yo-yo dieting is so common.

A self-compassionate response to breaking one's diet looks radically

different. First, self-compassion involves forgiving yourself for your lapses. If your ultimate goal is to be healthy, then it doesn't really matter if you fall off your diet from time to time. We are not machines whose dial can simply be turned to "reduce calorie input." Most people fluctuate in their ability to stay focused on their eating goals. Two steps forward, one step back seems to be the natural way of things. By having compassion for yourself when you fall off your diet, you'll be less driven to overeat as a way to make you feel better afterward.

A recent study supports this claim. Female undergraduate students were asked to eat a doughnut as part of a research study—they were given the cover story that they were taking part in a study of eating habits while watching television. After eating the doughnut, half the participants were given instructions to help them feel more compassionate about indulging in the sweet treat: "Several people have told me that they feel bad about eating doughnuts in this study, so I hope you won't be hard on yourself. Everyone eats unhealthily sometimes, and everyone in this study eats this stuff, so I don't think there's any reason to feel really bad about it." The other half in the control group weren't told anything. Researchers found that among women who were on a diet, those in the control group reported feeling more guilty and ashamed after eating the doughnut. And later on, when they were given the opportunity to eat as much candy as they wanted as part of a supposed "taste-testing" session, they actually ate *more* candy than those who weren't on a diet. In contrast, dieting women who were encouraged to be self-compassionate about the doughnut were much less distraught. They also didn't overeat in the taste-testing session afterward, meaning that they were better able to stick to their weight-loss goals despite momentarily falling off the wagon.

Exercise is also an important part of being healthy, and research suggests that self-compassionate people tend to exercise for the right reasons. For instance, self-compassionate women tend to have intrinsic rather than extrinsic motivation to exercise. This means they play sports or work out because they find it fulfilling and worthwhile and not because they think they're supposed to. Research also shows that self-compassionate people are more comfortable with their bodies and aren't as obsessed with physical appearance as those who are more self-critical. They're also less likely to worry about how they look to other people.

Oprah, whose weight-loss efforts have been the focus of intense media attention, is a good role model for how to deal with body issues compassionately. In a memorable 1988 episode of her show, she wheeled out a wagon loaded with fat to represent the sixty-seven pounds she had shed. Shortly afterward she gained the weight back. She dropped the weight again in 2005 through a well-chronicled diet and exercise program. She eventually gained much of it back. Despite the ups and downs, Oprah remains focused on what's most important: "My goal isn't to be thin. My goal is for my body to be the weight it can hold—to be strong and healthy and fit, to be itself. My goal is to learn to embrace this body and to be grateful every day for what it has given me."

When you don't need to be perfect in order to feel good about yourself, you can drop the obsessive fixation with being thin enough or pretty enough and accept yourself as you are, even revel in who you are. Being comfortable in your own skin allows you to focus on what's really important, being healthy—and that always looks good.

### Exercise Three

#### *Self-Compassion and Our Bodies*

Having compassion for the imperfection of our bodies can be especially challenging in a culture that is obsessed with physical attractiveness. We need to learn to love and accept our bodies as they are, not in comparison to unrealistic media images of beauty. At the same time, many people don't take good care of their bodies. The stress of life often leads us to eat and drink more than we should, and our bodies can suffer due to a lack of exercise and time outdoors. The middle way involves accepting our imperfection, recognizing that beauty comes in all different shapes and sizes, at the same time that we nurture our physical health and well-being.

1. Start by taking a pen and paper and making a kind but honest assessment of your body. First list all the features of your body that you like. Maybe you have great hair or a lovely smile. Don't overlook things that may not normally factor into your self-image:

the fact that you have strong hands, or the fact that your stomach digests food well (not something to be taken for granted!). Let yourself fully appreciate the aspects of your body that you're happy with.

2. Now list all the features of your body that you don't like so well. Maybe you have blemished skin, or think your hips are too wide, or you're out of shape and get tired easily. Give yourself compassion for the difficulty of being an imperfect human. Everyone has aspects of their body they're unhappy with. Almost no one reaches their physical ideal. At the same time, make sure you're making a balanced assessment of your deficits. Is the fact that your hair is turning gray really such a problem? Are those extra ten pounds really an issue in terms of feeling good and healthy in your body? Don't try to minimize your flaws, but don't blow them out of proportion either.

3. Now give yourself compassion for your imperfections, remembering how difficult it is to feel such strong societal pressure to look a certain way. Try to be kind, supportive, and understanding toward yourself as you confront the suffering you face—the suffering that most people face—because you're dissatisfied with your body.

4. Finally, try to think if there are any steps you want to take that will help you feel better in your body. Forgetting about what other people think, is there anything you would like to change because you care about yourself? Would you feel better if you lost some weight or exercised more, or if you got highlights in your hair to hide the gray? If so, go for it! As you chart out the changes you want to make, make sure that you motivate yourself with kindness rather than self-criticism. Remember that what's most important is your desire to be healthy and happy.

## Self-Clarity and Self-Improvement

Not only does self-compassion provide a powerful motivational engine for change, it also provides the clarity needed to know what needs changing in

the first place. Research indicates that people who suffer from shame and self-judgment are more likely to blame others for their moral failures. Who wants to admit their inadequacies when it means facing the attack dogs of self-criticism? It's easier to sweep things under the rug or point your finger at someone else.

Men are especially vulnerable to this pattern, given that the ideal man in our culture is supposed to be strong and infallible. When faced with his inadequacies, men often use anger as a way to deflect responsibility. Anger allows a man to feel temporarily tough and powerful, covering up any feelings of weakness stemming from personal failure. By blaming others he can also feel like a victim (of his wife's erratic moods or sharp tongue, for example), which in turn justifies his feelings of righteous anger. It's a vicious cycle that can lead to truly vicious behavior.

Steven Stosny, the well-known author of *Love Without Hurt*, has created a program for emotionally and physically abusive men that centers on the development of self-compassion. In three-day workshops he calls "boot camps," men with severe anger issues are taught to clearly see and understand the feelings of vulnerability underlying their rage, so that the cycle of blame and anger can end. When men start to relate to their deficiencies with compassion rather than shame, they no longer need to deny personal responsibility in order to defend their egos. This allows them to focus on their true desire: fostering loving, mutually supportive relationships with others. Stosny's anger-management boot camps are some of the most successful in the country and attest to the power of self-compassion to foster self-clarity and change.

A recent research study also supports the notion that self-compassion makes it easier to admit to needed areas of improvement. Participants were asked to recall a previous failure, rejection, or loss that made them feel bad about themselves. They were then told to write about the event, what led up to the event, who was present, precisely what happened, and how they felt and behaved at the time. Afterward, researchers gave one group of participants exercises designed to help them have compassion for the event. For instance, they were asked to list ways that others have had similar experiences, and to write a paragraph expressing feelings of kindness, concern, and understanding for what had happened. Another group was simply asked to write about the event with no particular instructions. The

group who were encouraged to have self-compassion had fewer negative emotions such as anger, anxiety, or sadness when writing about what happened than those in the other group. At the same time, they also took more personal responsibility for the event.

Self-compassion doesn't just amount to letting ourselves off the hook. Rather, by softening the blow of self-judgment and recognizing our imperfect humanity, we can see ourselves with much greater honesty and clarity. Maybe we do tend to overreact, to be irresponsible, to be passive, to be controlling, and so on. In order to work on these patterns and help ourselves (and others) suffer less because of them, we need to acknowledge our shortcomings. We need to recognize how we have harmed others in order to heal the wounds we have caused. By self-compassionately accepting the fact that all people make mistakes and act in ways they regret, we can more easily admit our wrongdoings and try to make things right again. If we're consumed with feelings of shame and inadequacy because of what we've done, we are actually being self-absorbed. We aren't focusing our attention and concern where it's most needed—on the person we've hurt. Self-compassion provides the emotional safety needed to take responsibility for our actions, consider their impact on others, and sincerely apologize for our behavior.

## My Story: Still Trying After All These Years

After studying self-compassion for almost fifteen years now, guess what: I don't always practice what I preach. I have a tendency to be irritable when I'm stressed—and as I alluded at the start of this book—I often take this out on my husband, Rupert. Let's say I'm in a bad mood and notice that Rupert hasn't done the dishes when it's his turn. I might have a very negative reaction that's out of all proportion to the event. I'll then tend to exaggerate the seriousness of his offense to justify my overly negative emotions. "You never run the dishwasher and always just leave the dirty dishes to rot" (even though it actually doesn't happen all that often, and sometimes I do the exact same thing). "You're so irresponsible" (completely ignoring the fact that he's under an intense work deadline that's taking up all his attention). Before I started my practice of self-compassion, I would use all my mental ingenuity to convince Rupert that my reactions were his fault, not my own. If he

accused me of being unfair, I could find ten reasons why actually my response was perfectly appropriate given his actions. It's painful to admit that sometimes one just gets in a foul mood and—for whatever reason—feels compelled to take it out on other people, usually those we love.

One fruit of my self-compassion practice, however, is that I'm now much more able to see myself clearly and admit my mistakes. If I'm irritable and make some cutting comment, I usually apologize before even hearing the words "That's unfair!" come out of Rupert's mouth. It's funny, but I don't take my negative moods so personally anymore. For whatever reason—my wiring, hormonal cycle, the weather?—sometimes I'm just plain tetchy. Not always, not usually, just sometimes. It happens to be an Achilles heel, but in no way does it define me.

By being self-compassionate when this mood arises, I can more easily admit when I'm out of line and focus on how to remedy the situation. This usually involves explaining to Rupert that I'm in a negative mood that has nothing to do with him, which then allows him to be understanding, even sympathetic, rather than defensive. Then I try to find ways to change my mood. Asking for a hug is a great remedy, and one that's only possible after an apology. And after the apology and hug, guess what? He usually apologizes right back—spats are often a two-way street. Although my irritable moods still come up, I don't take them out on Rupert nearly as often as I used to.

So when you make mistakes or fall short of your expectations, you can throw away that rawhide whip and instead throw a cozy blanket of compassion around your shoulders. You will be more motivated to learn, grow, and make the much-needed changes in your life, while also having more clarity to see where you are now and where you'd like to go next. You'll have the security needed to go after what you really want as well as the support and encouragement necessary to fulfill your dreams.

*Part Four*

## SELF-COMPASSION IN RELATION TO OTHERS

## *Chapter Nine*

# COMPASSION FOR OTHERS

*If one is cruel to himself, how can we expect him to be compassionate with others?*

—HASDAI IBN SHAPRUT (10TH C. JEWISH SCHOLAR)

THE WOMAN WAS IN HER MID-FORTIES, WITH BLOND HAIR, GRAY eyes, and a kind face. We were at a dinner party, taking turns at the carrots and hummus dip, when she asked me what I did for a living. “I study self-compassion,” I said. She cocked her head slightly to one side. “*Self*-compassion? But I thought compassion, by definition, was something you had for *other* people. How can you have compassion for yourself?” I explained that compassion was simply a way of relating to suffering, either your own or someone else’s. I could see her digesting the idea. “Hmm. I guess that makes sense. So,” she asked, “does having more self-compassion mean that you also have more compassion for other people?” “Well,” I ventured, “yes and no . . .”

People ask me this question all the time. The answer is actually a bit complicated. In the first study I ever conducted on self-compassion, I asked people the following question: “Do you tend to be kinder to yourself or to others?” I found that people who were low in self-compassion tended to say that they were kinder to others than themselves, whereas those high in self-compassion said they were equally kind to others and themselves. In other words, everyone said they were kind to others, but only self-compassionate people were *also* kind to themselves.

In other research, my colleagues and I have found that self-compassionate people score no higher on general measures of compassionate love, empathy,

or altruism—which all tap into concern for others’ well-being—than those who lack self-compassion. This is because individuals who lack self-compassion, who constantly judge themselves, are still often very caring toward other people.

Take the woman I met at that party, for instance. An experienced geriatric nurse, Sharon was a model of compassion. She often made home visits to her elderly patients, bringing little treats like cookies or flowers from her garden to make them feel special and cared for. She was constantly cracking jokes to keep their spirits up: “You know you’re old when getting lucky means finding your car in the parking lot.” When she had to help her patients with an embarrassing task, such as changing an adult diaper, she bent over backward to make sure they didn’t feel embarrassed or ashamed. “Happens to everyone at some point, nothing to fret about.”

Though Sharon found it easy to be kind and understanding toward the elderly in her care, she was extremely hard on herself. If she was late for an appointment, or forgot to do something on her daily checklist, she would eviscerate herself with self-criticism. “What a moron! These people depend on you! When are you going to grow up?” I asked Sharon if she would ever talk to the patients she cared for in the same way she talked to herself. “Of course not!” Why, then, did she treat herself so? “I don’t know,” she said with a puzzled look on her face. “I guess I feel like I should?”

People like Sharon are everywhere, especially in the West, where religious and cultural traditions tend to extol self-sacrifice. Particularly for women. Our research shows that women tend to have slightly lower levels of self-compassion than men do, largely because they tend to judge and criticize themselves more often. At the same time, there is ample research evidence showing that women tend to be more caring, empathetic, and giving toward others than men. Women are socialized to be caregivers, to selflessly open their hearts to their husbands, children, friends, and elderly parents, but they aren’t taught to care for themselves. As forever seared into the public imagination by the 1970s film *The Stepford Wives*, the ideal woman is supposed to fulfill her role as cook, maid, lover, and nanny without complaint. She is not supposed to have needs and concerns of her own.

Although the feminist revolution has helped expand the roles available to women, and we now see more female leaders in business and politics than ever before, the idea that women should be selfless caregivers hasn’t really

gone away. It's just that women are now supposed to be successful at their careers *in addition* to being the loving wife and ultimate nurturer at home. Dana Crowley Jack's book *Silencing the Self* opens with a quote that captures the experience of many:

*Even though I can objectively say, okay, I am above average in looks, I have been very successful with my art, I have been very successful at singing, I'm gregarious, I make friends easily. I can say all that, and still there is this, 'You are no good, what's the use.' I always feel the failure of my marriage was my fault, because I wanted a career, and didn't know how to manage being a professional with being a wife.*

Rather than being compassionate toward herself, realizing that she is only human and can only do so much, women such as this one tend to judge themselves relentlessly in the belief that they *should* be doing more. As a result, many women have a deep-seated feeling that they're not entitled to be the recipients of self-care. To understand why compassion for oneself and others do not necessarily go together, therefore, we need only to look to the self-sacrificing women who have cared for us all our lives.

## Putting Things into Perspective

Having said all this, there's also evidence that having compassion for yourself *is* related to having compassion for others in certain contexts. For instance, a recent study found that self-compassionate individuals have different goals in their friendships than those who lack self-compassion. They are more likely to focus on helping and encouraging their friends, as well as being compassionate toward their friends' mistakes and weaknesses. They are also more willing to admit their own mistakes and weaknesses to their friends. In sum, the study found that self-compassionate people are better able to create close, authentic, and mutually supportive friendships than those who are self-critical. (As the next chapter will discuss, research also shows that self-compassionate people tend to be more supportive, accepting, and caring with romantic partners.) Because we are so emotionally vulnerable in

close relationships, because our inner selves are laid so bare, we often feel insecure about whether others are judging us. When we stop judging and evaluating ourselves, however, we don't need to worry so much about others' approval and can instead focus on meeting the emotional needs of others.

Although compassion involves feelings of care and concern for others, it also involves taking the perspective of those who are suffering—walking a mile in their shoes, so to speak. (Though perhaps not in the way meant by Scottish comedian Billy Connolly, who once said: “Before you judge a man, walk a mile in his shoes. After that who cares? . . . He's a mile away and you've got his shoes!”) Rather than making quick and easy judgments of those who make mistakes, compassion considers what it must feel like to be the person making the mistake. It looks at things from the inside rather than the outside. To feel compassion for the public figure who has just made a blooper (like Dan Quayle when he exclaimed “Republicans understand the importance of bondage between a mother and child”), you must take on his perspective. Rather than merely seeing things from your own point of view (how amusing) you also see things from his point of view (how embarrassing).

We also have to engage in perspective taking when we give *ourselves* compassion. Rather than merely focusing on our own point of view in painful situations—I feel humiliated, afraid, inadequate, and so on—we take the perspective of an “other” toward ourselves. We respond with kindness and concern to our own human limitations, just as a kind friend or loving parent would. By seeing our flawed self from an outsider’s perspective, self-compassion allows us to stop judging ourselves so harshly. Our research shows that people with higher levels of self-compassion are also more likely to engage in perspective taking when contemplating the failures and weaknesses of other people. They are more likely to say things like: “Before criticizing somebody, I try to imagine how *I* would feel if *I* were in their place.” By its very nature, compassion is relational, stepping back and forth between various perspectives to see the mutuality of the human condition.

Though important for social harmony, taking the perspective of others does have one downside. It can be overwhelming, especially when others are really hurting. When we see images of hurricane survivors on TV, for instance, we may fear that by letting just a drop of their pain into our hearts we will ourselves be deluged. So to protect ourselves we shut down, or

switch the channel. Instead of tuning out, however, we have another option. Our research shows that self-compassion allows us to feel others' pain without becoming overwhelmed by it. In other words, when we recognize how difficult it is sometimes to be there for people who are struggling, and comfort *ourselves* in the process, we are able to be stronger, more stable, and resilient when supporting others in their suffering. This is an especially important skill for those who deal with others' problems for a living.

## Compassion Fatigue

Focusing a lot of our energy on helping others can lead to "compassion fatigue," a syndrome that frequently occurs with therapists, nurses, and other caregivers. Compassion fatigue is a type of exhaustion and burnout experienced as a result of continually dealing with traumatized patients. When listening to tales of abuse or horror, or when tending to bodies that have been ravaged by sickness or violence, caregivers often relive their patients' trauma. For this reason, compassion fatigue is also known by the name "secondary traumatic stress." The symptoms of secondary traumatic stress can resemble those of posttraumatic stress disorder, such as nightmares, emotional numbing, and an exaggerated startle response. Secondary stress may also lead to decreased feelings of safety, increased cynicism, and disconnection from loved ones.

Caregivers who are the most empathic and sensitive tend to be the most at risk, given that they feel the pain of their patients most deeply. It's been estimated that about one-quarter of professionals who work with traumatized patients experience some kind of compassion fatigue. Among those working with survivors of extreme situations such as the Oklahoma City bombing, the figure is almost three times that. Although we do not know how many skilled caregivers quit as a result, the numbers are surely high.

Research suggests that caregivers who have been trained in self-compassion are less likely to experience compassion fatigue—because they have the skills needed to avoid getting overly stressed or burned out when interacting with their patients. It also suggests that self-compassion leads to more "compassion satisfaction"—feeling energized, happy, and grateful that one is able to make a difference in the world. When you're not so

overwhelmed by your caregiving duties, you can focus more easily on the fruits of your efforts.

When caregivers have self-compassion, they are also more likely to engage in concrete acts of self-care such as taking time off, sleeping more, and eating well. They'll stop to care for their own emotional needs, recognizing how difficult it is to deal with such a high level of suffering on a daily basis. The hardships of being a caregiver are just as valid and worthy of compassion as the hardships of being a trauma victim. Certainly there are differences in how debilitating and intense the pain is, but all pain deserves to be held in the warm embrace of compassion, so that healing can occur.

Self-compassion is a way of emotionally recharging our batteries. Rather than becoming drained by helping others, self-compassion allows us to fill up our internal reserves, so that we have more to give to those who need us. It's like those little videos they always show on planes before takeoff, which tell adults to put on their own oxygen mask before helping children to put on theirs. We need to have a steady supply of compassion available to ourselves in order to have adequate resources to share with others. If we're knocked flat on our backs because our own resources are depleted, what use are we to those who rely on us? In many ways, then, self-compassion is an altruistic act, because it puts us into the optimal mental and emotional mind-set to help others in a sustainable, long-lasting way.

## Exercise One

### *Taking Care of the Caregiver*

If you work in a caregiving profession (and that includes being a family member), you'll need to recharge your batteries so you have enough energy available to give to others. Give yourself permission to meet your own needs, recognizing that this will not only enhance your quality of life, it will also enhance your ability to be there for those who rely on you. Here are some ideas:

- Get a massage, a pedicure, or other form of pampering.
- Take a nap in the middle of the day.

- Go to a comedy club; laughter provides a great release of tension.
- Listen to a soothing song. (I like the Beatles’ “Let It Be.” Paul McCartney allegedly wrote the song when he was going through a particularly hard time and dreamed about his deceased mother, Mary, who tried to comfort him with the words “let it be.”)
- Stretch or do yoga for a half hour.
- Take a walk in nature.
- Lie on the floor, stomach-side down, while someone gently rocks your lower back from side to side. It’s incredibly relaxing without requiring too much effort from your partner.
- Go dancing. If you don’t want to go to a club or take formal dance lessons, do an Internet search on “five rhythms,” “free-form,” or “expressive” dance in your area.
- Do the compassionate body scan (see page 133).
- If you decide to have that oh-so-compassionate glass of red wine to help you relax at the end of the day, drink a large glass of water as well so you don’t become dehydrated. Or, if you want to cut down on alcohol, have some dark red juice (cranberry, pomegranate, or cherry) mixed with sparkling water in a wineglass. Often just the sight of dark red liquid in a wineglass will trigger a relaxation response.

## Self-Compassion and Forgiveness

Having compassion for others doesn’t just involve being responsive to their suffering—it also involves forgiving those who have hurt us. Forgiveness happens when we stop holding a grudge and let go of our right to resentment for being mistreated. It means turning the other cheek—doing unto others as we *would have* others do unto us, not as they *did* do unto us. Forgiveness doesn’t mean we stop protecting ourselves, of course, but it does mean we let go of tit-for-tat retaliation. This includes the emotional retaliation of anger and bitterness, which only hurts *ourselves* in the long run. Self-compassion makes it easier to forgive, partly because it gives us the ability to heal the emotional wounds caused by others. My colleagues and I conducted one

study that directly examined the link between self-compassion and forgiveness. The propensity to forgive was assessed by agreement with statements such as “When someone disappoints me, I can eventually move past it” and disagreement with statements like “I continue to punish a person who has done something that I think is wrong.” We found that self-compassionate people were significantly more likely to forgive others for their transgressions than those who lacked self-compassion.

One of the main ways that self-compassion translates into forgiveness is through the recognition of our common humanity. As discussed in chapter 4, when we see people as separate individuals who are in complete control of their thoughts and deeds, it’s natural to blame those who hurt us, just as we blame ourselves when we screw up. But when we gain insight into interconnectedness, we see that innumerable factors continually influence who we are and what we do. We begin to see how impossible it is to completely blame any one individual for anything—ourselves included. Each conscious being rests at the nexus of a vast number of interwoven causes and conditions that influence their behavior. This insight is often the key that allows us to forgive ourselves and others, letting go of anger and resentment and engendering compassion for all.

## My Story: To Forgive Is Divine

I know that for me, forgiving myself for betraying and leaving my first husband and forgiving my father for leaving and neglecting me were closely interwoven. Before my first marriage fell apart, I had a tremendous amount of judgment and anger toward my father. I would roll my eyes whenever talking about him to close friends, making sarcastic comments about the casual way he abandoned me and my brother. “Free love, baby, no strings attached. That’s the hippie way.” But I had never directly let my father know how angry I was. Our relationship hung on such a tenuous thread that I felt it couldn’t withstand the merest tug. On our very occasional visits, I typically put on my “sweet daughter” face to preserve what little sliver of a father-daughter relationship we had. I would then just criticize him behind his back as soon as he walked out the door. It wasn’t a healthy dynamic, but it was all I could do to cope with my complicated feelings of hurt, anger, and rejection

at the time.

And then I ended up leaving John for Peter. Not out of malice, not out of a lack of caring, but because part of me was desperately unhappy and wanted—needed—to break free. I ended up doing what I thought *I* would never do, hurting and abandoning someone I loved. After learning about self-compassion at my local meditation center, however, I started to gain insight into my behavior and the pain that drove it. I started to forgive myself for leaving John, just as I started to forgive Peter for *not* leaving his wife for me. My understanding of the heart, of the complications and limitations of being human, began to grow and mature. This had a paradoxical effect on my relationship with my father. I started to get even more angry at him.

A few months before I was to marry Rupert, I remember talking on the phone with my dad. Somehow I found the courage to bring up the truth of how hurt I was that he had left me as a child. The equanimity I had started to gain due to my meditation practice had given me courage. My father didn't take this newfound honesty well, however. He immediately started to get agitated and defensive. "It's just our karma, everything happens for a reason." "Screw karma!" I shouted as I hung up the phone on him, collapsing into tears.

Rupert tried to comfort me, but to no avail. I needed to fully experience my rage, anger, and hurt. Devastating feelings of abandonment and rejection welled up, threatening to destroy me (or so it felt at the time). I entered a very dark place, knowing that the time had come to fully acknowledge my feelings of pain and grief.

At the same time, I was also processing the grief and pain I had caused John. This came to a head after bumping into him at a party thrown by mutual friends. His look of withering reproach stopped me dead in my tracks. I quickly left the party, shame permeating my every pore. My first reaction was to meekly accept John's reaction as just deserts for my abominable behavior, and to become even more depressed. Luckily Rupert, who had been learning about self-compassion with me each week, was able to pull my head above water long enough for me to take a few deep breaths. He reminded me that one of the reasons I had married the wrong man was because of the insecurity created by my father's abandonment. I had just continued a cycle of bad decisions based on an intricate web of pain. He encouraged me to have compassion for my mistakes and to stop judging myself. I had done the best I

could at the time.

This led me to think about what had driven my father's actions, and to be less judgmental and more forgiving toward *him* as well. My father was raised by incredibly cold and disconnected parents who were also rigid authoritarians. He never really felt loved, but instead always felt like a burden, a mouth to feed and not much more. His parents didn't even bother to attend his wedding to my mother, for instance, although they lived locally, because they felt too uncomfortable in social situations. His parents also had no idea how to handle conflict. After my grandmother got in a fight with her other son over some laundry, for example, they didn't speak again for thirty years. In terms of my grandparents' relationship with me, there was none. They never once visited me as a child after my father left, even though they lived less than an hour away. They just felt too awkward. To put it mildly, my father's parents were completely shut down.

But then I had to think about my grandfather's story. He came to the United States as an economic refugee from Greece at the turn of the twentieth century, traveling through Ellis Island with his parents. (My last name, Neff, is actually a shortened version of the Greek name Nefferados.) He was the eldest of eight brothers and sisters and excelled in the American academic system. He won prestigious prizes in both scholastics and sports, and when he graduated from high school, he had scholarship offers from a number of colleges. The American dream was about to come true. On the day of his high school graduation, however, his father left to go back home to Greece, telling my grandfather that since he was an adult now, he must take on the responsibility of caring for his mother and seven brothers and sisters. He was forced to abandon his dreams of college, of achieving a better life, and instead got a job at a gas station to support his family. He worked in a gas station his whole life, even though he eventually owned the station himself. My grandfather never got over this disappointment, and it destroyed him emotionally.

And so it goes. Pain and dysfunction get passed down from generation to generation. A mixture of genetic inheritance and environmental circumstance ensures that our lives unfold according to a complex web of conditions that is infinitely larger than ourselves. The only way to stop the vicious cycle of reacting to pain by causing more pain is to step out of the system. We need to let our hearts fill with compassion, and forgive ourselves and others.

This was, in fact, what I was finally able to do with my father. After he got over the shock of my anger, and was able to regroup, we actually started to have an honest relationship with each other for the first time ever. A year or two after that angry phone call, during one of our rare visits, my father gave me a heartfelt apology. His love for me had never wavered, he assured me, but he just wasn't capable of giving me what I needed. When he realized that my mother wasn't the right woman for him, and that he had got himself stuck in a life that was making him deeply unhappy, he couldn't deal with it maturely. He had never had a good example of how to talk through a problem, let alone how to make compromises that balanced his own needs with those of others. He saw himself getting trapped into a life he didn't want, just as his father had gotten trapped into a life he didn't want, and he bolted. He didn't present this as an excuse for his behavior, just as an explanation. I could clearly see how grieved he was about the deep pain he had caused me. Luckily by that point I had already done a lot of forgiving of myself and my father (and his father and *his* father), as I had delved more deeply into the practice of compassion. What was important was that the chain had been broken, and that we were now ready to start relating to each other in a new way.

It's important to remember that forgiveness doesn't mean condoning bad behavior, or that we need to interact with people who have hurt us. Discriminating wisdom clearly sees when an action is harmful or maladaptive, and when we need to protect ourselves from those with bad intentions. However, it also understands that all people are imperfect, that we all make mistakes. It understands that people often act out of ignorance, immaturity, fear, or irrational impulse, and that we shouldn't judge people for their actions as if they had full conscious control over them. And even in those cases where people are cognizant of the harm they are causing, the question still needs to be asked—what happened to make them lose touch with their hearts? What wound occurred to lead to such cold and callous behavior? What's *their* story?

Being human involves doing wrong at times. This means that to judge one person is to judge all the world. But to forgive one person is to forgive all the world—ourselves included.

## Exercise Two

### *Forgiving Someone Who Has Hurt Us*

Think of someone you've harbored anger and resentment toward for a long while, and whom you now want to forgive. If you don't feel ready to forgive yet, don't. Forgiveness comes in its own time and shouldn't be rushed. But when you are ready, one of the best ways to forgive someone is to recognize the causes and conditions leading the person to act as they did. Our thoughts, emotions, and behaviors are the product of innumerable interconnected factors, many of which are outside of our control. Understanding interconnectedness can therefore help facilitate the process of forgiveness.

1. When considering the person's harmful actions, see if you can identify any precipitating factors or events. Was the person feeling fear, confusion, lust, anger, or other powerful emotions? Was the person having a stressful life experience, like financial insecurity or some other setback? What demons might this person have been dealing with?

2. Now consider why the person didn't stop themselves anyway. Clearly, the factors necessary to enable self-control (emotional maturity, empathy, ability to delay gratification, etc.) weren't present. Why not? Did the person have poor role models growing up, so that he or she never developed these skills?

3. If it comes down to the fact that this person was just plain mean or selfish—think about what could have created this personality type. Insecure attachment, social isolation, life history, genetically inherited traits?

4. Once you have a better understanding of the causes and conditions leading this person to act as he or she did, see if it's a bit easier to let go of your anger and resentment. This was a limited, fallible human being, and humans sometimes act in ways they shouldn't. Can you forgive this person? Doing so doesn't necessarily mean you should interact with this person again. It may not be wise. But by freeing yourself from the corrosive effects of

anger and blame, you'll help create more peace and contentment in your own mind.

## Cultivating Loving-Kindness

One of the wonderful things about self-compassion is that it allows you to open your heart—and once it's open, it's open. Compassion engages our capacity for love, wisdom, and generosity. It's a beautiful mental and emotional state that is boundless, directionless. By being more understanding and accepting toward ourselves, we can also be more understanding and accepting toward others. By honoring the limitations of our own human imperfection, we can be more forgiving of others' mistakes. By soothing and comforting ourselves when feelings of insecurity arise, we provide ourselves with the sense of safety needed to explore the emotionally complex world inhabited by other people.

One of the traditional Buddhist practices designed to develop goodwill toward ourselves and others is called “loving-kindness meditation.” In this practice, phrases that invoke benevolent feelings are repeated silently and are aimed at various targets. Traditionally, the phrases are first directed toward oneself, and the goal is to *personally experience* the loving-kindness being generated. Different versions of the phrases are used, but one set is as follows: *May I be safe, May I be peaceful, May I be healthy, May I live with ease*. The phrases are then directed to a mentor/benefactor, to a dear friend, to a neutral person, to a mildly difficult person, and finally to all conscious beings: *May you be safe, May you be peaceful, May you be healthy, May you live with ease*.

When loving-kindness practice was first brought to the West, teachers often found that people had a hard time generating feelings of loving-kindness for themselves given our culture's emphasis on self-criticism. For this reason, many now switch the order of targets so that one first directs the loving-kindness phrases toward a mentor or benefactor. The idea is to choose someone with whom we have an unconditionally positive relationship, so that feelings of loving-kindness are easy to access. (This someone might even be a beloved pet.) Only then are the phrases directed toward oneself, after the loving-kindness juices have started flowing.

Note that traditional loving-kindness phrases are designed to cultivate feelings of goodwill, not necessarily compassion. Feelings of goodwill are relevant in all situations, happy or otherwise, whereas compassion only arises in response to suffering. To target the feeling of compassion more directly, Chris Germer and I give people a variant of the traditional loving-kindness phrases in our Mindful Self-Compassion workshops. They're designed to help people generate greater self-compassion when they are experiencing feelings of personal inadequacy: *May I be safe, May I be peaceful, May I be kind to myself, May I accept myself as I am*. Or if the suffering stems from external circumstances, the last phrase can be changed to *May I accept my life as it is*. We find that the self-compassion variant of the traditional loving-kindness phrases tends to be more powerful when people are struggling and in need of compassionate care.

There is no one “right” way to do loving-kindness practice. Many people change the wording of the phrases to feel more natural. For instance, some people don’t like saying “May I” at the beginning of each phrase. It feels too much like prayer, or like asking permission from an authority figure (“May I go to the bathroom please, Mrs. Smith?”). Alternatives are “I’d like,” “I hope,” or “I want.” Sometimes, people want the phrases to sound more realistic by adding “as possible” to the end. For example, *May I be as safe as possible*.

Finally, it’s important to realize that loving-kindness practice works on the level of intention. We nourish the desire for health and happiness—for ourselves and others—as a way to open our hearts. This is not an exercise in wishful thinking, nor are we ignoring the reality that suffering exists. Rather, the idea is that by cultivating the intention for ourselves and others to experience well-being, corresponding feelings of love, concern, and compassion will eventually arise. This in turn translates into more concrete acts of kindness and care.

### Exercise Three

#### *Directing Loving-Kindness Toward Our Suffering*

(Also available as a guided meditation in MP3 format at [www.self-compassion.org](http://www.self-compassion.org))

compassion.org)

If you're grappling with self-judgment, or if you find yourself in the midst of difficult or stressful times, see if you can take fifteen to twenty minutes out of your day to cultivate feelings of loving-kindness and compassion for yourself. To start the practice, sit in a quiet, comfortable place where you won't be disturbed, or else take a solitary walk in a quiet spot. Take a few deep breaths to settle into your body and the present moment. You are right here, right now.

- First, gently get in touch with the source of your suffering. Are you feeling scared, lonely, angry, worthless, frustrated? See if you can just be with the emotions as they are, without doing too much thinking about the story line driving the emotions (what you did, what he didn't do, etc.). Whatever you are feeling is okay. All visitors are welcome. No need to cling to anything or to push it away.
- Now see if you can sense the emotions in your body. Let's say you feel sad. What does sadness feel like? Is there dullness, a pulling sensation at the corner of your eyes, tenseness between your eyebrows, and so on? By locating your emotions in your body, it's easier to feel them without getting lost in thought, and instead be with your present moment experience as it is.
- Now place your hand on your heart, and set your intention to offer yourself kindness, understanding, and compassion for the suffering you're experiencing right now. Remember that what you're feeling is an integral part of the human experience. You are not alone in your suffering.
- Now repeat the following phrases to yourself, softly and gently:

*May I be safe.*

*May I be peaceful.*

*May I be kind to myself.*

*May I accept myself as I am.*

Or if it feels more appropriate, change the last phrase to:

*May I accept my life as it is.*

- Keep repeating the phrases, refreshing their emotional content by either getting in touch with the painful emotions in your body, or else feeling the gentle and comforting pressure of your hand on your heart.
- When you notice that your mind has wandered, return to the phrases, or to the experience of your emotions in your body, or to the feeling of your hand on your heart. And start again.
- If you are ever overwhelmed with emotion, you can always return to your breathing as a way of soothing and calming yourself. Then, when you're comfortable, return to the phrases.
- Finally, take a few breaths and just be still for a few moments. If the feeling of compassion is arising for you, allow yourself to savor this sweet feeling. If few or no feelings of compassion are arising, this is the equally beautiful truth of the present moment. Allow yourself to savor your goodwill and intention to care for yourself. This is what matters most.
- When you're ready, slowly resume your normal activities, knowing that you can return to the phrases anytime you wish.

A recent study by Richie Davidson and colleagues confirms the power of loving-kindness. Researchers trained a group of people to do loving-kindness meditation for thirty minutes a day for two weeks. As a point of comparison, they trained another group of people to think more constructively about difficult situations in their lives. In other words, they taught one group to change their hearts, the other to change their heads. Only the loving-kindness group showed significant increases in self-compassion. They also did brain scans of study participants while showing them images of suffering, such as a child with an eye tumor. Those trained in loving-kindness meditation felt significantly more empathy (as evidenced by increased activity in the insula) than those trained merely to change their thinking patterns. Moreover, the larger the increases in self-compassion, the higher the level of insula activation, supporting the idea that self-compassion increases one's capacity

for perspective taking. At the end of the experiment, researchers asked participants if they wanted to donate some of their \$165 honorarium to a charitable cause or keep the money for themselves. Those in the loving-kindness group donated more money. Even a brief training period in loving-kindness meditation, therefore, can lead to increases in compassion for self and others, as well as demonstrable acts of care and generosity.

The wonderful thing about loving-kindness practice is that it does not necessarily have to be done on the meditation cushion. We can generate feelings of kindness and compassion toward ourselves and others while driving to work, shopping at the grocery store, or waiting in the dentist's office. What's happening is that we are *training our brains* to react to suffering in a caring manner. By focusing on our deepest desire—for all beings to be happy, peaceful, and healthy—we can actually improve our lives and those of others. The Bible teaches that what you sow, so shall you reap. By planting seeds of loving-kindness into our hearts and minds, we can transform our own mental and emotional landscape into something beautiful beyond measure.

There is a famous story of a Tibetan monk held in jail for years by Chinese prison guards, who later made it to India and had an audience with the Dalai Lama. When asked about his time in the prison, the monk said he faced danger a few times. “What danger?” the Dalai Lama asked. “Of losing compassion toward the Chinese,” the monk replied. From a Buddhist perspective, having compassion toward those who have hurt us allows us to have peace of mind even in the most hostile surroundings, which in turn prevents that hurt from destroying us. Compassion toward others is really a gift for ourselves, because it nourishes us with benevolent feelings and allows us to feel more secure by recognizing our inherent interconnectedness. With the equanimity of an open heart, the slings and arrows of our difficult and frustrating lives find less purchase, and suffering becomes a doorway into love.

## *Chapter Ten*

# SELF-COMPASSIONATE PARENTING

*For only as we ourselves, as adults, actually move and have our being in the state of love, can we be appropriate models and guides for our children. What we are teaches the child far more than what we say, so we must be what we want our children to become.*

—JOSEPH CHILTON PEARCE, INTRODUCTION TO *Teaching Children to Love* BY  
DOC LEW CHILDRE

**S**ELF-COMPASSION IS ESSENTIAL FOR GOOD PARENTING. BY TEACHING our children to have self-compassion, we can help them deal with the inevitable pain and imperfection of life. By being compassionate to ourselves, we can better handle the frustrations and difficulties of parenting, so that the world's toughest profession—and let's face it, parenting *is* a profession, just an unpaid one—isn't quite so tough.

### Compassion for Our Imperfect Parenting

Carol was running late. The babysitter was arriving soon to watch her two kids while she went out to a concert with some friends. She put some spaghetti in the pot to boil while she styled her hair and put on makeup. When she returned to the kitchen, she realized the timer had been going off for almost ten minutes. “Mom, I’m starving!” her young son complained. “When will dinner be ready?” The overcooked spaghetti, once drained, was the consistency of mushy mashed potatoes. She poured on extra sauce hoping her kids wouldn’t notice, but that was like hoping they wouldn’t notice if she

served oatmeal rather than Cap'n Crunch for breakfast. "Disgusting!" her eldest complained, frowning and turning up her nose. "You expect us to eat this? Why can't you make nice food like Jan does?" This was an especially spiteful comment. Jan was her ex-husband's new wife, who—among her many other talents—was a gourmet chef.

Carol's first instinct was to accept the blow. To feel horrible for never getting anything right, for being an inadequate mother, for losing her husband to a superior woman. But luckily she caught herself in time. Carol had been trying to be kinder to herself lately and realized that this was a perfect opportunity to be more self-compassionate. She reminded herself that motherhood involved juggling multiple balls in the air, and it was inevitable that one would occasionally drop. And overcooking spaghetti was not exactly a sign of a fatally flawed character. "I'm sorry I ruined dinner, but it's not the end of the world. How about I order in some pizza?" Needless to say her kids were in favor of this idea. She even overheard her daughter whisper to her son, "Cool—Jan never lets us have pizza!" As writer Peter de Vries once commented, "There are times when parenthood seems nothing more than feeding the hand that bites you."

Of course, we don't always handle difficult situations with our children in an ideal way. Our lovable little darlings can drive us absolutely batty, and there's no parent on the planet who hasn't lost it occasionally. We snap at our kids when they annoy us, ignore them when they try to get our attention, or yell at them when we're angry. Everyone gets it wrong at one time or another. When we have compassion for this fact, however, we can more easily admit our imperfections as parents and apologize for our behavior. This not only helps our children feel loved and cared for, it also lets them know that even Mommy and Daddy are fallible human beings who sometimes make mistakes—and that mistakes aren't the end of the world.

Although it's important to apologize to our children when we're out of line, it's equally important not to be overly critical of ourselves either. *Especially* in front of our children. "I forgot to get gas even though the car's almost on empty! How stupid of me! I'm so irresponsible!" This communicates the idea that self-criticism is a valued and appropriate response when we fall short of our ideals. But do you really want your children to suffer at the hands of self-judgment the way you have? This is something parents often overlook. Perhaps you're very careful to be nurturing and

supportive toward your children when they've taken a misstep. But if you tear yourself to shreds whenever you mess up, you'll send them the wrong message. If, however, you clearly but compassionately acknowledge your limitations in front of your children, you'll provide a much better example. "How annoying! I forgot to fill up the car, and I'm almost on empty. I've been pretty busy at work lately, so I guess it's not surprising that it slipped my mind. I probably have enough gas to get to the station regardless." Modeling self-compassion in front of your children is one of the most powerful ways to help them develop this skill for themselves.

## Exercise One

### *Having Compassion for Our Mistakes as Parents*

At the end of each day, think about any mistakes you made as a parent. Anything you wish you had (or hadn't) done. Try to be as honest as possible, knowing that it's okay to be human and imperfect. Try to be as kind and understanding toward yourself as you would be to a good friend in a similar situation.

Then, think about whether there is anything you can do to help repair the situation. Offer your kids an apology? Promise you'll make it up to them (and really do so)? By modeling the process of making then repairing mistakes, you'll teach your children an invaluable lesson.

Next, try to determine if any difficult emotions underlie your behavior, such as stress, frustration, exhaustion. If so, give yourself compassion for your emotional pain. It's hard to be a parent! Do you think you need to make any changes to help ease your stress, like taking more time for yourself?

Decide on a couple of the self-care activities suggested in the first exercise of chapter 9 (or else make up some of your own), then *really do them!* It's easy as a parent to say "Yeah, I should take the time to do that for myself" while never actually getting around to it. Yes, you're pressed for time, but you'll actually be a more effective and supportive parent by taking your own needs more seriously.

It's a win-win situation all around.

## Correcting Your Child While Encouraging Self-Compassion

Many parents wonder how to go about disciplining their children when they step out of line, while at the same time helping them to be more self-compassionate. First and foremost, it's crucial that you don't harshly criticize children or make them feel ashamed for not living up to your expectations. (Besides, it might backfire. As actor Jack Nicholson once commented, "My mother never saw the irony in calling me a son of a bitch.") Our research shows that continual parental criticism can cause some serious problems: children of critical parents are more likely to lack self-compassion and suffer from anxiety and depression in adulthood. As discussed in chapter 2, children often internalize a parent's critical voice, and then carry it with them throughout their lives. Although no parent wants his or her child to suffer, many believe that discipline must be hard-hitting in order to work.

Although it's true that laissez-faire parenting in which children are never reprimanded can hinder a child's growth and development, you *can* set clear boundaries and correct problem behaviors in a kind, compassionate way. This will let children understand why it's important for them to change their ways without making them feel bad about themselves because they messed up.

One key to compassionately responding to our children's misdeeds is to focus on their actual behavior, rather than on their general character. You want to emphasize that we are not defined by our failures and shortcomings but are instead all of us works in progress, in a continual state of learning. It's also important to validate the emotions underlying your child's misbehavior before trying to correct it. Let's say your son Neil tells his younger sister Mary to "shut up" while he's playing his favorite video game. Instead of snapping "You are so rude, Neil! Why can't you be nicer to Mary?," you can try saying "I realize you were irritated by having your game interrupted but you hurt Mary's feelings when you told her to shut up." Or let's say your daughter leaves a honey jar open on the kitchen counter after she takes a call from a friend. Instead of exclaiming "You're such a slob!," you can say something like "I know you were distracted by your phone call, but we can't have bugs crawling everywhere." A little humor might work even better here

—“Do you really want our kitchen to look like a scene from *Attack of the Killer Ants?*” If children feel understood rather than attacked, they’ll be much more likely to listen to you.

The main thing is to convey to your children that it’s okay to make mistakes, and that imperfection is part of life. Statements like “it’s only human,” “it’s only natural to get frustrated,” and so on, are good ways to provide this validation.

It’s not just what you say that matters, however. Equally important is your tone of voice. Even as preverbal infants, we unconsciously register the emotional meaning conveyed by parents’ tone of voice—loving, fearful, angry, and so on. If your tone conveys negative judgment even though your words are neutral, your child is still likely to feel inadequate and ashamed. This may then trigger an angry or defensive reaction. Who wants to feel bad about themselves when it’s so much easier to blame someone else? If you make it safe for your child to take personal responsibility for his actions by using compassionate language combined with a kind and caring tone, however, he will find it much easier to acknowledge his problem behavior and work on changing it.

One thing that’s also worth considering before correcting your child is whether or not your own reactions are at all ego defensive. Are you identifying with your child, so that you feel his or her subpar behavior reflects poorly on you? When your daughter is fidgeting and can’t sit still in a restaurant, is the problem really the fidgeting, or other people’s judgments that you must be a bad parent because your child isn’t well behaved? Unless you can admit this to yourself, and give yourself compassion for this very human reaction, you’re likely to handle the situation poorly. When you are compassionate toward yourself, however, you’ll be in a better position to respond compassionately to your child.

## Parenting Young Children

Raising infants and toddlers, with their constant need for supervision, picky food habits, tantrums, not to mention dirty diapers, has to be one of the most challenging jobs around. As humorist Erma Bombeck commented, “When my kids become wild and unruly, I use a nice, safe playpen. When they’re

finished, I climb out.” Parents of young children need all the help they can get. Luckily, when you give yourself compassion, help is always at hand.

Dr. Rebecca Coleman, a clinical psychologist in Australia, has developed a program that teaches mindfulness and self-compassion skills to parents of children under five. The program is called MAP, which stands for Mindful Awareness Parenting. The goal of the program is to help parents improve their ability to make wise decisions in difficult parenting situations. In other words, how to keep sane when little Johnny has just poured a whole bottle of dishwashing soap into the bath you’re running, and little Suzy is tugging on your leg and whining for you to braid her hair while you’re trying to clean up the mess.

MAP promotes parental sensitivity by teaching parents to have empathy for their kids, increasing their ability to be aware of and nurture their children’s relationship needs. Sometimes when children act in difficult or tiresome ways, they are actually sending the message that they need their parents’ emotional support. It may not be attention that children are seeking but connection. As discussed in chapter 3, children are physiologically designed to form close attachment bonds with their parents, using them as a secure base from which to explore their world. When children feel frightened or are unsure of themselves, they naturally turn to parents as their primary source of reassurance and comfort. Once they feel safe, they can then engage in the important process of play, discovery, and learning.

Coleman points out that one of the key ways that parents help their children feel safe is through the process of “affective attunement,” which involves matching or mirroring the emotion of the child. When a child is upset, parents mirror their child’s emotions by making sad noises and expressions, but then they alter their child’s emotions by adopting a more soothing face and tone. For instance, a mother may rock her infant and smile gently when he cries, softly repeating “It’s okay darling, it’s okay.” Eventually the child is reassured and calms down. Parents tend to do this instinctively and are not consciously aware that they’re regulating their child’s emotions.

If a mother with a crying infant feels overwhelmed by her own emotions, however—“why can’t the damn kid shut up, he’s driving me crazy!”—she won’t be able to help her son calm down. Instead, she’ll just make him more upset, as the child mirrors his parent’s agitation. When parents respond to

their own frustration with self-compassion, however, they're able to quiet their own turbulent emotions and are therefore in a better position to then help their child become calm and peaceful as well.

Consider a situation that one of my graduate students, Pittman, encountered several months ago. He and his wife, Merilee, recently had a baby girl, and as a result their three-year-old son, Finn, started displaying some "challenging behaviors." One day when returning home from an errand, Pittman found his supposedly toilet-trained son peeing on the living-room wall. When confronted about this, Finn just turned toward his dad, flashed an evil grin, and said, "I hate you."

Thank God for Pittman's self-compassion practice! Though anyone would have understood if he had lost it, he managed to stay centered, take a few deep breaths, and give himself compassion for how difficult and challenging the moment was. This helped him to refocus and remember that —outward signs to the contrary—Finn was not simply being naughty. He was actually suffering from the very human emotion of jealousy, and at three was ill equipped to deal with it effectively. Instead of getting angry at Finn, therefore, he sat down and put his arm around his shoulder. First, he acknowledged Finn's feelings of frustration at the change in the household routine. "I know this is hard for you right now because your baby sister is taking up so much of our attention. But your mom and I love you more than ever . . ." Finn's unhappy mood started to lift almost instantly, as did Pittman's. He even started to see the humor of the situation, knowing he'd have a good story to dine out on for years. The more Finn feels reassured of his parents' love and support as he adjusts to the new member of his family —especially when he acts out—the more he'll realize that his parents' love is unshakable (even though their walls may be a little stained).

## Exercise Two

### *Taking a "Time-In" with Your Child*

This exercise is adapted from Dr. Rebecca Coleman's MAP protocol (for more information, go to [www.maplinc.com.au](http://www.maplinc.com.au)).

Young children often express “big feelings” (i.e., crying, tantrums) when they feel misunderstood, ignored, or limited by a parent saying no. When your child is expressing big feelings or is out of control, you can take a “time-in” to help her get back on track. While your child’s behavior may look like something that is being done on purpose, it is often really an issue of needing to reconnect and handle overwhelming emotions in a safe way. Your child may need your help to do this.

Before beginning a time-in, make sure that you are calm enough to be sensitive to your child’s needs and to help her feel secure. If you need to soothe your own emotions first, try sending yourself compassion for your difficult emotions, or practice some mindful breathing. You may need to tell your child that you need ten seconds of private time while you calm yourself down—just make sure you’re back when you said you’d be.

- Choose a specific time-in spot. It’s best if this is a neutral place, for example, a chair or a cushion that can be moved so as to not disturb other family members.
- The time-in place is where you and your child can sit together and watch feelings begin to change.
- Invite your child to the time-in place. (If he is emotionally out of control and presents a danger to others, he may need help getting there.)
- Maintain a firm, reassuring, and kind tone of voice.
- Watch your child closely. Observe her behavior. Try to guess the meaning and feelings behind her behavior. What’s really happening?
- Time-in allows your child’s feelings to “be felt” and accepted. It shows your child that you are willing to help him and that your love means you will be welcoming and accepting of his emotions—even difficult ones.
- Stay in charge in a sympathetic and connected way. Stay present and sensitive. This has a calming effect on young children.
- It may take a while for your child to calm down if she is

overwhelmed by her emotions.

- When your child is calm enough, help her to describe her feelings. You might say: “You look like you are struggling with this . . .” or “This looks hard for you; are you angry/afraid/sad?”
- Wait for the answer. Listen well. Acknowledge and accept the answer (or lack of answer).
- Then talk about *your* feelings. Use sentences like: “When you did \_\_\_\_\_, I felt \_\_\_\_\_ (name the emotion) \_\_\_\_\_ arising in me.” Don’t expect an apology, just communicate your feelings with a matter-of-fact, nonblaming tone.
- When your child is connected and calm enough, help him find another activity to change the mood, or simply go ahead with your plans for the day as normal (bedtime, preschool, eating a meal, etc.).

## Parenting Adolescents

Although all children benefit from having self-compassion, it’s an especially important skill to teach in the teen years. One of the cognitive advances of adolescence is increased perspective-taking ability, meaning teens are better able to see themselves from the viewpoint of others. This ability means that adolescence is often a time of intense self-evaluation and social comparison. Adolescents ask themselves “What do other people think of me?” or “Am I as good as everyone else?” This process occurs as teens attempt to establish their identity and place in the social hierarchy. The intense pressures faced by most adolescents—stress over academic performance, the need to “fit in” with the right peer crowd, concerns with sexual attractiveness—means that the self-evaluations of teens are often unfavorable.

To make things worse, the introspection of the teen years often leads to what is called “the personal fable,” a cognitive fallacy leading adolescents to believe that their experiences are unique and that others cannot possibly understand what they are going through. Remember the first time you fell in love? I bet you couldn’t possibly imagine that your parents had ever felt anything remotely similar. Adolescents have a hard time understanding the

shared human experience, because they haven't yet had enough close relationships to realize that their own thoughts and feelings aren't in fact unique. They also tend to overestimate how much they know and how little others know because, well, *what* they know is *all* they know. As Mark Twain said, "When I was fourteen, my father was so stupid that I could hardly stand to be around the old man. When I turned twenty-one, I was simply amazed at what this elderly gentleman had learned in only seven short years." Our research shows that teens who are under the sway of the personal fable tend to be less self-compassionate, because they don't recognize that their difficulties and failings are merely a normal part of what it means to be human.

For all these reasons, teaching teens about self-compassion can be immensely valuable. Of course, teens are sometimes resistant to the idea of self-compassion at first given that it sounds a bit hearts and flowers-y. Not cool when your favorite band is Napalm Ghost Slayer. However, when you explain that self-compassion is not the same as complaining, self-pity, or self-indulgence, most teens become much more open to the concept. (After all, the lead singer of Napalm Ghost Slayer had to learn self-compassion when he went into rehab, right?) It can also be useful to talk about the difference between self-esteem and self-compassion. Given teens' daily experience with the horrors of school lunchroom dynamics, they can readily grasp the problem with striving to feel special and above average all the time. By explaining that self-compassion is a way to feel good about yourself that doesn't require feeling superior to others, you can help teens more easily understand why self-compassion is a healthier way to relate to themselves.

## My Story: Parenting Rowan

While Rupert and I certainly suffered in the early years of Rowan's autism, our commitment to self-compassion made a huge difference. First, we helped each other to be self-compassionate toward all the mistakes we made as parents, and there were many. When I would snap in anger at Rowan after a particularly frustrating day, for instance, and feel horribly guilty as a result, Rupert would help me remember that I couldn't be expected to deal with things perfectly all the time. I could then more easily get over my frustration,

apologize and comfort Rowan if he was still upset, and start over.

Perhaps most important, Rupert and I made sure that we didn't get so lost in our roles as caregivers that we stopped meeting our own needs. We realized that we both required regular time off from being a parent of a child with autism. Unfortunately, both our parents lived out of town, and we couldn't find a babysitter who could handle Rowan's tantrums and incontinence, so we made a policy of babysitting for each other. One night a week I was free to do whatever I wanted, go to a meditation or dance class, have a drink with friends, or see a music show; and one night a week, Rupert did the same. We made sure we were giving attention to our own needs, which helped us stay refreshed and relaxed when dealing with the challenges of parenting Rowan and supporting each other.

Now that Rowan is getting older (he's eight at the time of writing), I'm starting to model the process of self-compassion for him, and he's slowly taking it on board. One feature of autism is "echolalia," which refers to the tendency to directly repeat phrases that others say. I've treated Rowan's echolalia as an opportunity to shape his internal dialogue, so the words he uses when he becomes upset are soothing, self-compassionate ones. Autistic children have an extremely hard time dealing with frustration. If Rowan spills a glass of water on his clothes, for instance, it can cause a level of suffering and anxiety that's way out of proportion to the actual incident. And once that distress train gets rolling, it's hard to stop.

In such situations, I try to model how to respond in an accepting, compassionate way. "Poor darling, you spilled the water and got all wet. It's okay to be upset and frustrated. This is really hard for you right now, isn't it?" This helps him learn to accept and validate his emotions in the present moment. Then I try to model steps to help him move on emotionally in the next moment, rather than continuing to obsess about what went wrong. "I know you're feeling bad, but we've changed your clothes and everything is okay now. There's really no need for you to cry about it anymore, and I'm worried that you're making yourself unhappy. Do you want to be sad or do you want to be happy?"

Sometimes when I ask this, Rowan says he wants to be sad, in which case I hold and comfort him while he feels his sadness. "These things happen, it's okay to be upset." Sometimes, however, he says, "I want to be happy." In this case, I try to help him find things to be happy about. "Can you tell me

something that's good right now? Like the fact that we're together, or that you have two cool leopard geckos called Gary I and Gary II?"

Although he still has trouble getting beyond his distressed moods, a compassionate approach does seem to help them pass more quickly. I also know that he's begun to take this way of talking to himself on board. The other day he got upset because his DVD was stuck, for instance, and I overheard him say, "It's okay. Things break sometimes."

The time I really knew that he had "gotten it," however, was when we went to the zoo together. I had had several frustrating experiences that morning (traffic, trouble parking, etc.) and was in a foul mood. After a few minutes of huffing and stamping at the African wildlife exhibit (me, not the wildebeests), Rowan turned and said, "It's okay, Mommy. Do you want to be sad or happy?" And I thought *I* was supposed to be the wise, mature grown-up! Though taken aback at first, I realized he was right! It was a beautiful day, and here I was being comforted and helped by my beloved son. The message of self-compassion had come full circle.

## *Chapter Eleven*

# LOVE AND SEX

*Love is fed by the imagination, by which we become wiser than we know, better than we feel, nobler than we are: by which we can see Life as a whole: by which, and by which alone, we can understand others in their real as in their ideal relations.*

—OSCAR WILDE, *De Profundis*

**S**ELF-COMPASSION NOT ONLY HELPS US BE BETTER PARENTS AND caregivers, it also enhances our love and sex lives. When we let go of egoistic striving—ending our obsession with evaluating ourselves positively—our love and desire for others only intensifies. By embracing life as it is, allowing the life force to flow through us freely, our passion can reach new, more wonderful heights.

## Love and Romance

One of the challenges of finding a romantic relationship that meets our deepest needs is just that—our reliance on a relationship to meet our deepest needs. The reason it's so blissful to fall in love is partly because it allows us to feel truly valued, accepted, and understood by another. Our partner loves us warts and all, which means that maybe our warts aren't so bad. And of course there is much truth to this. It's a wonderful gift to see one's own beauty reflected in the eyes of another. But if we exclusively rely on our partner's good opinion of us to feel okay about ourselves, some time or another we're going to get a rude awakening. Eventually the stardust starts to

thin in even the best of romances, and not only are our partners going to see things about us they don't like—they're going to let us know it. On our wedding day, Rupert's father told us "Don't worry, the first forty years of marriage are tricky, but after that it's plain sailing." Okay, he was exaggerating for comedic effect, but there's no denying that relationships are difficult.

We can't always rely on our partners to make us feel good about ourselves because at the end of the day, for acceptance to truly penetrate our hearts, it has to come from within. Although feeling loved and accepted by our partner certainly helps, it's too easy to dismiss the approval of others as misplaced "niceness." Yes, my partner loves me, you might say to yourself, but he doesn't see the *real* me. He doesn't hear the nasty, petty thoughts that constantly go on inside my head. If he saw the real me, he wouldn't think I was so great anymore.

I had a colleague named Diane who suffered greatly from this pattern. Her live-in boyfriend, Eric, thought the world of her, and in many ways Eric's love and support was what kept her going. But Diane thought Eric's good opinion of her was mainly because he didn't *really* know her. She constantly judged and criticized herself and assumed that if she revealed her true self to Eric, he would judge her too. The thing Diane disliked about herself the most was that she had a strong tendency to be controlling and just couldn't seem to loosen up.

Diane adored Eric, and she tried to appear as relaxed as possible around him because she didn't want him to realize she was actually an "anal-retentive tyrant," as she put it. Eric was a laid-back guy, which is one of the things Diane loved about him. The irony, of course, was that Eric's relaxed nature was constantly pushing Diane's desire-for-control buttons. He was always forgetting to do small things like stopping by the grocery store to pick up the quart of milk she asked for, or closing the toilet seat lid after going to the bathroom, or mowing the lawn before it started to resemble a tropical jungle. Eric was a dreamer whose behavior tended toward the scattered and distracted, and this drove her absolutely crazy.

After about two years of living together, Diane and Eric were arguing more and more often. Instead of just being annoyed at Eric's forgetfulness, she was becoming increasingly angry and mean toward him. She started to call him names like irresponsible, lazy, and immature. If Eric hadn't been so

in love, he probably would have gotten fed up with the constant criticism and left. Instead, he wanted to understand what was going on.

After many long conversations, it soon became clear that Diane's desire to control really stemmed from fear. Shortly after she got her driver's license at age sixteen, Diane was driving some friends to the beach, overcorrected on a curve, and flipped the car three times. One of her best friends almost died. She was so freaked out that she wanted to make sure nothing bad would ever happen again. By attempting to control everything in her life, Diane felt safer, as if she could counter the unpredictability of existence. Instead of having compassion for her controlling tendencies, however, her first instinct was either to criticize herself for being so rigid, or else criticize Eric for being so careless—often both.

Once Eric understood what was causing her behavior, he was able to help her deal with her emotions more productively. Eric had dabbled in Buddhism and other Eastern traditions and understood the value of self-compassion. He realized that this was what Diane needed most. Whenever he saw Diane getting stressed or angry, therefore, even when she was attacking him with a barrage of criticism, he would remind her to get in touch with the feelings underlying her reaction. “Are you upset because you feel afraid and out of control? Why don’t you take a moment to give yourself some compassion, *then we can talk about what happened.*”

While this did feel odd at first, Diane started to practice being self-compassionate more and more, using her angry feelings as a reminder that she needed to be kind, gentle, and understanding with herself. Whenever she felt the desire to control rise up, she would comfort herself with caring, soothing words. “I know you feel this way because you were so frightened when your best friend almost died. This situation is triggering your fear, which is understandable. This is really hard for you right now.” As soon as she changed her attitude toward herself, she found that her feelings of agitation would start to quiet. She would become more trusting and relaxed.

After a few months of this new pattern, Diane and Eric were arguing much less often. Diane finally allowed herself to realize that Eric *did* love the real her, and that she was worthy of his love. Eric, for his part, started to be a little more responsible—he didn’t want to cause Diane any unnecessary pain. While they’re still a work in progress, their relationship is better than it’s ever been. They’ve even broached the subject of getting married at some point

(though if they do, they'll definitely leave the wedding arrangements up to Diane!).

## Exercise One

### *Identifying Your Relationship Patterns*

Think about your current or most recent romantic relationship. What are your strongest emotional buttons? Do you get hurt easily, immediately jumping to the conclusion your partner doesn't care? Do you get anxious, assuming your partner will leave? Almost all people have core issues that cause them to overreact in relationships. It's as if a whole boatload of extra "stuff" gets added on to what our partner says or does, causing things to quickly spiral out of control. Our patterns are scars, vestiges from previous relationships gone wrong. Although a loving, supportive partner can help us heal these patterns, the most direct source of healing comes from within.

The next time a button gets pushed in your relationship, try to get clarity about what is actually happening. Rather than immediately blaming your partner for how you feel, try to assess the extent to which it's just your old pattern reasserting itself, and take the opportunity to give yourself compassion. If you feel hurt, for example, try to become mindful of this feeling, fully accepting your overreaction. Actively focus on soothing and calming your pain with self-kindness, recognizing that all humans have emotional wounds of one sort or another. (Your self-compassion mantra might come in handy here.)

Rather than relying on your partner to give you exactly what you need, try meeting your own needs first. Identify what you're craving (validation, care, support, etc.) and see if self-compassion can help give it to you. This will help take the pressure off your partner to be a mind reader and react in the exact manner you want. As you learn to rely more on self-compassion to deal with your patterns when they arise, you'll eventually find that they have less

hold over you. Wounds do heal, as long as they are given the care and attention they need.

## Relationship Dynamics

Research psychologist John Gottman is one of the world's leading experts on understanding what makes a romantic relationship work. He claims he can tell whether or not a couple is going to split up with 91 percent accuracy based on a brief observation of how they interact in conflict situations. The key is not *whether* a couple has conflicts (show me the couple who doesn't), but *how* they have conflicts. There are four main problem behaviors in conflicts that typically indicate a doomed relationship—what Gottman calls the “four horsemen of the apocalypse.” They are, in order of importance: criticism, contempt, defensiveness, and stonewalling. If people harshly criticize their partners while fighting, show disgust or contempt (eye rolling, sarcasm, etc.), are overly defensive and blame problems on their partners, or engage in stonewalling (ignoring partners and shutting down communication), the prognosis is bleak. Luckily, Gottman has also identified factors that predict happy, stable relationships. If a couple shows any sort of positive emotion during a conflict—a kind look, a small gesture of affection, an apology, laughter—these relationships are likely to last.

Self-compassion tends to inspire positive rather than destructive emotions during relationship conflicts. When we're upset over a relationship issue, self-compassion allows us to soothe and calm the intensity of our feelings, meaning that we're better able to rein in the four horsemen. We're less likely to be harshly critical, show contempt, or be ego defensive during an argument if we experience the emotional safety needed to acknowledge our own role in the dispute. Self-compassion also provides the equanimity needed for talking through difficult relationship issues, meaning that it can reduce stonewalling. Self-compassion tends to soften our hearts, making it easier to get in touch with the affection we feel for our partners, and facilitating the expression of positive emotions during conflicts. And because self-compassion lets us take our egos less seriously, we can sometimes even find humor in our overreactions.

I remember once when I was having a fight with Rupert, the line “give

me a break!” came out of my mouth in the exact same sarcastic voice of my mother, who often spouts this line when she’s angry. We both looked at each other and burst out laughing, silently acknowledging that we come by our bad habits honestly. Needless to say, the conflict was much easier to resolve afterward.

There’s another way that self-compassion can help in conflict situations. Often fights between partners stem from each person wanting their own point of view to be validated at the same time. If I talk about the way I see a relationship problem, and Rupert doesn’t acknowledge how I feel but merely states his differing view, I won’t feel heard. Let’s say I’m upset because Rupert has spent three weekends in a row riding horses with friends (horses are his passion), and I ask him not to ride next weekend because I want to spend more time with him. Instead of acknowledging the fact that I’m upset, he tells me how he sees things. “But you know how much I love riding and you’re not being very generous, especially since the weather is so good for riding right now.” Because I don’t feel that Rupert has taken my feelings seriously, my reaction will start becoming more extreme as if to say, “See? I’m justified in feeling this way!” For instance, I might say, “But we never spend time together as a family anymore!” (Even though we actually just spent a weeklong family vacation together last month.) This just causes him to ramp things up from his end. “You always exaggerate. And you never consider what I want or need!” The tone of anger and blame in both our voices will then make it even less likely for us to come to a point of mutual understanding.

The wise advice of relationship counselors is for each partner to validate the emotions of the other partner before presenting his or her own point of view. “I know that you love riding and want to do it as much as possible before the hot and humid weather begins, but I get lonely when you’re away and would like to spend more of next weekend with you.” Or “I can understand that you feel left out when I spend the weekend riding with my friends, but this is really important to me and I won’t be gone nearly as often once the heat sets in.” Sometimes, however, in the thick of things, it’s hard for people to break out of their own reactions to really listen to their partners and validate their emotions. If I wait for my partner to give me what I need while he’s waiting for me to give him what he needs, we might both be waiting a long time. This is where self-compassion can come in handy.

If you can compassionately validate *your own* feelings, gently reminding yourself that it's only natural for you to feel the way you do, you won't have to speak louder and louder in order to feel heard. You can tell yourself what you really want to hear in the moment, "I'm so sorry you're feeling hurt and frustrated right now, what can I do to help?" Then, once you begin to feel accepted and cared for, you'll be in a better place to listen to what your partner is saying and see things from his or her point of view. Less fuel will be added to the fire, and the conflict will hopefully start to cool down.

## The Relationship Benefits of Self-Compassion

Research demonstrates that self-compassion really does improve the quality of romantic relationships. We recently conducted a study with more than a hundred couples, measuring each partner's self-compassion level and asking them to tell us how happy and satisfied they were in their relationship. We also asked each participant to describe their partner's relationship behavior. Were they caring and sensitive or controlling and demanding? Did they get angry at the drop of a hat or could they talk things out? This enabled us to see if highly self-compassionate people would report having better romantic relationships, and if they would be described as being more loving, supportive, and considerate by their partners.

We also assessed participants' self-esteem levels, but we didn't think that people with high self-esteem would necessarily have better relationships than those who lacked self-esteem. People often become angry, jealous, and defensive when their self-esteem is threatened by partners, a pattern that's at the root of many relationship problems. When self-esteem comes in the form of narcissism, moreover, it often leads to selfishness and game playing in romantic relationships—not exactly keys to lasting happiness.

The results of our study indicated that self-compassionate people *did* in fact have happier and more satisfying romantic relationships than those who lacked self-compassion. This is largely because self-compassionate participants were described by their partners as being more accepting and nonjudgmental than those who lacked self-compassion. Rather than trying to change their partners, self-compassionate people tended to respect their partners' opinions and consider their point of view. They were also described

as being more caring, connected, affectionate, intimate, and willing to talk over relationship problems than those who lacked self-compassion. At the same time, self-compassionate men and women were described as giving their partners more freedom and autonomy in their relationships. They tended to encourage partners to make their own decisions and to follow their own interests. In contrast, people who lacked self-compassion were described as being less affectionate and more critical toward their partners. They were more controlling, trying to order their partners around and dominate them. They were also described as being more self-centered, inflexibly wanting everything their own way.

High self-esteem, it should be noted, did not appear to do a whole hell of a lot for couples. Self-esteem was *not* associated with happier, healthier relationships, and people with high self-esteem weren't described by their partners as being any more accepting, caring, or supportive in their relationships than those who lacked self-esteem. In other words, the results of our study suggest that self-compassion plays an important role in fostering good relationships, but that having high self-esteem doesn't necessarily help. Self-compassion fosters feelings of mutuality in relationships so that the needs of self and other are balanced and integrated. Self-esteem, on the other hand, is more ego-focused, magnifying a sense of separation and competition between the needs of each partner.

To have the type of close, connected relationships you really want with others, you first need to feel close and connected to *yourself*. By being caring and supportive when you confront the limitations of living a human life, you'll have the emotional resources needed to act in a caring and supportive way with your significant other. By meeting your own needs for love and acceptance, you'll be less needy and clingy. And by accepting the fact neither you nor your relationship is going to be perfect, you'll be able to enjoy your relationship more for what it is rather than comparing it to some notion of how a romance is *supposed* to be—a Cinderella meets Prince Charming fairy tale that doesn't exist in real life (and which would be too one-dimensional to hold anyone's interest for long anyway). Self-compassion embraces imperfection with love, providing the fertile soil needed for romance to truly flourish.

## My Story: And I Promise to Help You Have Compassion for Yourself

As I mentioned earlier, when Rupert and I got married we included in our vows the promise to help each other be more self-compassionate. This was not an empty promise, but a commitment to a way of being with ourselves and each other that radically transformed our relationship. Moreover, we took some concrete steps to help us become more self-compassionate when relating to each other. One practice we found to be particularly effective was to take “self-compassion breaks” during arguments. Such breaks provide a space in which we can not only cool down, but also give ourselves compassion for the difficult situation in which we have landed ourselves. This practice is helpful for a variety of reasons. For one thing, it helps us to both soothe our bruised egos, a useful tool given that many of the fights couples have stem from the need to protect one’s self-esteem.

As a typical example, I remember once when Rupert got irritated with me because I kept interjecting into a discussion he was having with a friend. It was when the British government was proposing to ban foxhunting (which they subsequently did in 2004). Rupert, an avid equestrian, grew up with the sport, while I’m a vegetarian. Needless to say we had vastly different opinions on the ethical nature of galloping across the countryside following hounds chasing down a fox. The problem wasn’t that I was expressing my opinion; it was that I kept cutting Rupert off mid-sentence so he couldn’t properly express his own point of view. After the friend went home, Rupert mildly rebuked me for continually butting in on his conversation. Instead of gracefully apologizing, I merely upped the ante by suggesting that Rupert’s opinion on foxhunting was thickheaded and needed to be corrected. In hindsight, I could see that I was too ashamed to admit that I was indeed out of line by continually interrupting him, even if I *did* believe foxhunting was cruel. So to salvage my self-esteem I tried to change the subject to a more self-flattering topic: the fact that I was right and Rupert was wrong. This just exacerbated things, of course, as Rupert now had the double whammy of feeling humiliated in front of his friend while also being insulted by his wife. Things started to heat up from there.

Fortunately, before things spun too far out of control, I somehow

managed to squeak out “self-compassion break!” between the rounds of machine-gun fire. We both took a few minutes to close our eyes and send ourselves compassion. I realized that it was only human of me to want to express my opinion on a topic that I felt passionately about. I wasn’t trying to shut Rupert up, I was just carried away by my enthusiasm. Once my defensive posture softened and I forgave myself for stepping out of line, I was able to properly apologize to Rupert. “You know, you’re right. It was really rude of me to keep cutting you off and it must have been terribly frustrating for you. I apologize. Even though I still don’t agree with your opinion, to be fair, you were making some very valid points that I wasn’t open to considering.”

Rupert, for his part, had been giving himself compassion for how frustrated he felt, so when I validated his feelings and his point of view he was ready to accept my apology. He didn’t feel he had to defend himself any longer and was in a more receptive frame of mind after being soothed and comforted by his own compassion. In fact, he admitted that many of my points were also valid, and we ended up having a really productive discussion about the evils *and* merits of foxhunting, enabling us to come to more agreement and consensus about the issue than I had thought possible. Rupert did give up foxhunting later that year, in fact, but not in order to placate me. Rather, his own compassionate sense allowed him to feel more for the fox than for the culture he grew up with. (He still jumps horses over fences across country, but without the moral quandary of having to hunt an animal in order to do so.)

Sometimes when Rupert and I are having a conflict, of course, the issues go deeper than mere bruised egos, or an abstract moral concept such as whether or not it’s okay to foxhunt. Most people develop patterns of reacting in relationships that are unhelpful, patterns that are typically formed in response to early childhood traumas. My pattern, for instance, I call “hurt little girl.” Because I felt abandoned by my father at an early age, feelings of hurt and abandonment come up quite easily in my relationships with men. This pattern was especially strong in the early years of my relationship with Rupert. As mentioned earlier, I met Rupert while conducting my dissertation research in India. Rupert, for his part, was a travel guidebook writer who was gathering information for a guide to South India. After we got married, Rupert continued to largely earn his living by writing articles for travel

magazines. Even though I knew that Rupert's job required him, by definition, to be away from home a lot, I would still sometimes act as if he were abandoning me when he went off on a new assignment. I would pout when Rupert left and sulk when he returned, the feeling of being hurt and abandoned coloring my every expression.

Rupert's childhood pattern, in contrast, he calls "unfairly treated little boy." A lot of his early childhood pain stemmed from being harshly treated by the British teachers at the private school he attended, who were supposed to have his best interests at heart. When he got a poor grade in his math class, for instance, they responded by publicly humiliating him and making him drop his favorite course in history—even though he really excelled in this subject—as punishment. And with the teacher persecution came bullying from other kids, who got the message that it was okay to pick on him. The stress of such unfair treatment was so bad that he actually suffered a nervous breakdown at age eleven and spent three months in bed. When I acted hurt every time Rupert had to take a business trip—work that was necessary to help support us as a couple—it quickly pressed his "that's unfair!" button. Rather than being able to alleviate my insecurities, therefore, Rupert would tend to become angry and upset when I acted hurt. From his point of view, my reactions were a direct criticism of him—a criticism that was grossly unjust given that he had done nothing wrong. His feelings, like mine, were experienced in an exaggerated manner, our overreactions stemming from a well of pain that ran much deeper than the pain of the particular circumstances at hand.

Luckily, because Rupert and I had made a commitment to self-compassion, we were eventually able to break free of the grip of our childhood conditioning. This was challenging because our complementary patterns meant that we both tended to be simultaneously under their irrational sway. Still, as long as one of us remembered to start the self-compassion process during a conflict, the engine driving our negative reactions would start to run out of steam. My hurt little girl would get her needs met by feeling cared for and accepted, so that I could recognize that I wasn't really being abandoned. Similarly, Rupert's unfairly treated little boy would start to feel assuaged, so he could let go of his anger and realize that my reactions were not actually a personal criticism. Once we were able to treat our childhood patterns with compassion, we could focus on what was actually

happening here and now, and our conflict would unravel more easily. The vow we made to help each other be more self-compassionate was one of the best things we ever did.

## Exercise Two

### *Take a Self-Compassion Break*

The next time you're in a heated argument with your partner, try taking a self-compassion break. It's best if you have both agreed to do this, but even if your partner isn't on board, taking a brief "time-out" to give yourself compassion during a conflict can be incredibly useful. The hardest thing is mustering up enough awareness to remember to take a break. Often we're so involved in the story line of what's driving the conflict that nothing else enters our awareness. With practice, however, you can use the pain involved in a conflict to remind yourself that what you need in the moment is self-compassion.

During the break, you should go to a place where you can be alone for a few minutes (even the bathroom if need be). The first thing to do is to put the "story" of what the fight is about on hold. Your task now is just to soothe your upset state by validating your emotions. Tell yourself "this is really hard right now" (once again, your self-compassion mantra will probably be useful here). One of the key causes of suffering when in conflict is that each person is trying so hard to make their point that the other person doesn't feel heard or validated. Also, each feels unloved and rejected by the other's angry tone. So hear and validate yourself first. Accept and care for yourself first. This will help de-escalate your emotional reactivity and put you in a more peaceful frame of mind.

Once the break is over, you'll be able to engage with your partner more constructively. If you can, try to express at least one positive emotion to your partner—a laugh, a smile, a kind word, or a statement that you understand what your partner is saying. This can help shift the dynamics of the conflict considerably and help to

transform it into a productive discussion.

Self-compassion gives incredible strength to romantic relationships. When we stop depending on our partners to meet all our emotional needs—giving *ourselves* the love and acceptance we want—we become less clingy, needy, and dependent. When we remember that we’re only human, we can admit our mistakes and talk things through with greater calm and clarity. And by being gentle and warm with ourselves, we’ll be in a better emotional space to be there for the person we love.

## Self-Compassion in the Bedroom

Not only can self-compassion lead to satisfying and mutually validating romantic relationships—it can also improve our sex lives. Bonus. Sex is an amazing way to feel alive, passionate, and connected. It’s also one of the most pleasurable activities we can engage in as adults. So why is our society so conflicted when it comes to sex? Even though sexual images are everywhere, people have a hard time dealing with sex in an open, honest way. There can be incredible shame associated with sexuality, especially for women. Even for those raised after the sexual revolution of the 1960s, society sends the message that a woman’s value and self-worth lies in her ability to keep herself sexually pure. A woman who outright enjoys sex and—God forbid—wants a lot of it is called . . . well, we know what she’s called.

It’s not nearly as bad as it used to be, of course. Women are no longer required to be virgins when they marry, but there’s still a huge double standard. Men who have multiple sexual partners are praised for being studs, while women are condemned for the exact same thing. There are few role models of women who are proud and unapologetic about their sexuality. The character Samantha from *Sex in the City* is a good example. Her views on when to have sex with a man she’s just started dating? “Don’t play ‘hard to get’ with a man who’s hard to get.” The reason Samantha is so funny, of course, is because she is brave enough to celebrate something that is usually so frowned upon.

On the other hand, a woman who has sex with a man on their first date mainly because she wants him to like her, not because it reflects her authentic

sexuality, is in fact devaluing herself. If a woman derives her sense of self-worth primarily based on how many catcalls she gets while walking in her stilettos (Jimmy Choos or not), she's selling herself short because her self-worth is dependent on how the outside world views her rather than coming from within. Using sex as a means to get self-esteem may lead to poor decisions about who to have sex with and can also make you emotionally vulnerable. "Why didn't he call me back? Wasn't I good enough?"

Teen girls face an especially daunting challenge when it comes to sexuality and self-worth. On the one hand, adolescence is becoming more and more sexualized in our society. Take a stroll in any suburban shopping mall and you'll see girls with thongs peeking out of their low-cut jeans, their lacy push-up bras clearly visible underneath paper-thin T-shirts. And not just teens. According to Diane Levin and Jean Kilbourne, the authors of the book *So Sexy, So Soon*, even prepubescent girls are wearing miniskirts, thongs, and padded bras. The message? Your value lies in what you got, and if you got it, flaunt it. The music young people listen to reinforces the notion that girls are primarily sex objects. Approximately two-thirds of the popular songs that focus on sex have lyrics that are degrading toward women. Like this song from the Ying Yang Twins: "They say a closed mouth don't get fed. So I don't mind asking for head. You heard what I said, we need to make our way to the bed." The average teen listens to about two and a half hours of music per day.

For some young women, sex itself is becoming less meaningful. In her book *Unhooked*, Laura Sessions Stepp documents how "hookups" are the norm in many high schools and college campuses, and that it is no longer considered cool to want sex in the context of a long-term, emotionally intimate relationship. In reaction to rampant misogyny, some girls are responding in kind. As one put it, "Sometimes you just want to screw them before they screw you." Stepp recounts the story of a girl named Nicole who had sex with a guy in his room after he sent her a text asking to meet up. "Several hours later, as she prepared to leave, he asked her, 'What do we do about this?' . . . 'We do nothing,' she said. 'I got what I wanted.'"

At the same time that sexual norms appear to be getting looser, the opposite trend is also occurring. If you look closely, you'll see that many of the young girls in the mall wearing thigh-high boots and cutoff tops are also sporting purity rings. Almost one-quarter of teen girls (and about one-sixth of

teen boys) have taken a pledge to remain sexually abstinent until marriage. Some have made successful careers out of being virgins, like Britney Spears, Jessica Simpson, or Brooke Shields. These young stars largely became popular for showing as much skin as possible, posing provocatively for the camera, and waxing lyrical about the importance of chastity. Such conflicting messages about sex are not without their consequences. Several large-scale studies have found that young people who make virginity pledges are just as likely to have premarital sex as those who don't take the pledge, but are *less* likely to use condoms and *more* likely to have anal and oral sex. (Like, technically it doesn't count.)

It's no wonder that girls and women in our society have such a hard time relating to their sexuality in a healthy way. We are either made to feel ashamed for being too sexual, or else for not being sexual enough.

Self-compassion can help us develop a healthier, more authentic way of relating to sex. First and foremost, by being supportive and nurturing toward our sexuality—whatever shape or form it comes in—we can stop being victims of sexual shame. We don't need to judge ourselves according to society's mixed-up sexual norms. Some people are straight, some homosexual, some bisexual, others trysexual (as in "I'll try anything"). Some people want sex all the time, others only occasionally. Some people choose to remain virgins until they're married, others don't. Some people want lifelong celibacy, others monogamy, others serial monogamy, others polyamory. Some married couples are basically platonic and don't have sex at all. There is no right or wrong when it comes to sex, only what's healthy or unhealthy for each individual or couple. When we deny our human nature—and sexual desire certainly lies at the very core of human nature—we will not have healthy sexual relationships. And therefore we will not have healthy romantic relationships either. Well-being cannot be nurtured in a lie.

When we give ourselves compassion, however, when we care for and look after ourselves, we can start to let go of society's narrow definitions of how men and women are supposed to be sexually. We can start to love and accept ourselves exactly as we are and can express our sexuality in the way that most fulfills us. In his book *The Soul Beneath the Skin: The Unseen Hearts and Habits of Gay Men*, author David Nimmons argues that gay men are probably the most liberated on this front. Because they've had to buck societal convention anyway, they are more likely to find support in their

communities for sexual authenticity in whatever form it takes.

What's most important is to honor the passionate aliveness that results when two human souls join together. What is right for one person may not be right for another, so it's unreasonable to expect that all people should follow one "acceptable" pattern of sexuality and one pattern only. Our sexual decisions should stem from our inner desire for happiness, not from the pressure to mold ourselves into a particular form to get societal approval, or even approval from our partner.

### Exercise Three

#### *Releasing Sexual Shame*

Take a good, honest look at your sexual self. Are you fully accepting of your sexual feelings, whatever they may be? Is there anything you feel ashamed about, or judge yourself for? First, give yourself compassion for the self-judgment you are experiencing. Realize that almost all people have sexual thoughts and feelings they are ashamed of, and have compassion for this shared aspect of the human experience. Try to let go of your self-blame, and instead give yourself compassion for the difficulty of being a sexual being in our sexually conflicted, confused society.

Then, it's important to ask yourself whether the negative feelings you have about your sexuality come from the fact that you're harming yourself in some way, or if they stem primarily from societal conventions. Do you feel ashamed mainly because the larger culture tells you you're not supposed to be the way you are? Or do you feel there is in fact an unhealthy aspect to your sexuality, that you're harming yourself or someone else by acting out sexual urges in a way you truly regret? As you think about your sexual self, try to determine what's authentic for you. Remember that all human beings are different sexually, but there is one thing we share—most of us suffer at some point in our lives because our sexuality comes into conflict with societal dictates. If you want to make changes in your sex life, make sure your decisions are driven

by your desire to be healthy and happy. Authentic sexuality means you accept and validate all your sexual feelings, and fulfill your desires in a way that helps you to grow and flourish.

When we accept ourselves, our bodies, and our sexuality—embracing ourselves with kindness—we may also be directly enhancing our sexual responsiveness. Although this is a new area of research, some evidence suggests that self-compassionate women are more in touch with their bodies. One study assigned a group of female undergraduates to a fifteen-week mindfulness training course, or else to a control group. Researchers found that the mindfulness group increased their levels of self-compassion compared to controls—a finding consistent with other research. However, results also showed that increased self-compassion was associated with faster recognition of sexual feelings. When presented with erotic images, self-compassionate women were quicker to notice when they had become aroused. This suggests that self-compassion can help women become more attuned to their bodies and more comfortable with their sexuality.

Self-compassion can also improve our sex lives in another way. It can help heal the childhood wounds that spill over into the bedroom. Again, this issue can be especially salient for women. Given that half of all marriages end in divorce, and that most children from divorced homes are raised by single mothers, a huge number of girls are deprived of their fathers' love and attention while growing up. The "hurt little girl" pattern caused by this deprivation is incredibly common, and I know I'm not at all unusual in suffering from it. I also know, however, that the pattern can interfere with sexual intimacy. Because sex opens us up psychologically and spiritually, it also tends to open up old wounds having to do with not feeling loved enough. This creates a neediness and craving for validation that is about as sexy as a cold, wet blanket.

## My Story: Sexual Healing

I remember early on in my relationship with Rupert, I'd sometimes find myself inexplicably switching from sex goddess to wounded little girl in the blink of an eye, sighs of passion suddenly devolving into sobs of sadness

without warning. This was disconcerting for Rupert, to say the least. It was as if by receiving the love and intimacy I had always wanted, old patterns of feeling unloved and rejected felt safe enough to break through to conscious awareness. Because of our commitment to self-compassion, we'd try to use these occasions as opportunities for healing. Instead of being ashamed of my decidedly *unsexy* behavior, with Rupert's encouragement I was able to focus on the suffering I was experiencing in the moment, and the desire to ameliorate that suffering. Both of us would concentrate all our attention on soothing the emotions of my wounded self, having compassion for the deep scars still imbedded in my psyche. There was a several-month period where this was happening frequently, and Rupert, bless him, was completely supportive.

What happened may sound strange, and can be interpreted on a metaphoric level, but while we were focusing on healing "hurt little girl" as we made love, it felt as if we were also healing the wounds of countless women who had gone before me. I got clear mental images of women passing through my body and being released, and I felt deeply in touch with the pain caused to women throughout history. Repressed, suppressed, used, abused, devalued, disempowered, and abandoned: so many souls in need of healing. As we focused our intention on releasing these wounded souls, Rupert and I fell into a sort of trance, transforming suffering through the power of compassion—my own and that of innumerable others. After a few months of consciously dedicating our lovemaking in this way, I stopped seeing these mental images of hurt women. The cycle seemed to be over, the healing complete. And amazingly, hurt little girl never asserted herself in the bedroom again, assured that she *was and is* loved. (Luckily, sex goddess still likes to make an appearance now and then.)

*Part Five*

THE JOY OF SELF-COMPASSION

## *Chapter Twelve*

# THE BUTTERFLY EMERGES

*The deeper that sorrow carves into your being the more joy you can contain.*

*Is not the cup that holds your wine the very cup that was burned in the potter's oven?*

—KAHLIL GIBRAN, *The Prophet*

**S**ELF-COMPASSION HAS THE POWER TO RADICALLY TRANSFORM OUR mental and emotional reality. Just like the alchemists of old, who sought to use the philosopher's stone to transmute lead into gold, we can use self-compassion to transmute suffering into joy. By changing the way we relate to our own imperfection and pain, we can actually change our experience of living. Try as we may, we can't control life so that it goes exactly as we want it to. The unexpected and undesired do happen, every day. Yet when we wrap our suffering in the cocoon of compassion, something new emerges. Something wonderful, exquisite, beautiful.

## Openheartedness

When we give ourselves compassion, we are opening our hearts in a way that transforms our lives. What does it mean to be openhearted? It's a phrase we use all the time, but what does it actually mean? Openheartedness is a state of emotional receptivity in which even unpleasant or negative experiences are held with caring concern. When we kiss the boo-boo on a child's hurt finger or listen empathetically to a dear friend telling us their woes—when we feel

compassion, in other words—we experience an inner warmth spreading out from the center of our chest. This feeling is what lets us know that our hearts are open. And how does it feel to have an open heart? Pretty damn good! When compassion is flowing through our veins, we feel at our vibrant best—connected, alive, “plugged in.” When we unlock our hearts, new experiences are free to emerge—experiences of love, courage, and unlimited possibility.

When our hearts are closed, however, we remain unmoved by life’s sorrows. As we shut out the pain, we also shut ourselves down. Our fear of being overwhelmed by negative emotions leads us to tune out, so that we feel only constriction in the center of our chest. The price paid for protecting our hearts is to cut off our very lifeblood. We feel cold, empty, unhappy, and deeply unsatisfied. And the time when our hearts are most likely to close is when our pain is caused by negative self-judgment, when we feel we aren’t good enough in some way. We’re often incredibly callous when relating to our own inadequacies and imperfections, meaning that much of the time we’re slamming the door of our heart right in our own face.

Fortunately, when we decide to hold our flawed humanity with compassion, everything changes. By responding to our own pain with a sense of kindness and connection, by soothing and comforting ourselves when faced with the imperfection of ourselves or our lives, we are creating new positive emotions that weren’t there a moment earlier. Instead of just feeling inadequate, we now feel both inadequate *and connected in remembering this shared aspect of the human experience*. Instead of just feeling sadness, we now feel both sadness *and the sweet tenderness of concern for a wound that needs healing*. Instead of just feeling frightened, we now feel both frightened *and comforted by our own kindness and caring*. By relating to ourselves with compassion, we are holding our negative emotions in the warm embrace of good feeling.

This means that hidden within every moment of anguish lies the potential for contentment. Pain can become the doorway to happiness, because feeling loved, cared for, and connected is what makes us truly happy.

I remember the first time the penny dropped for me that self-compassion had the power to transform difficult, painful experiences into pleasurable ones. It was in my last year of graduate school at Berkeley, a couple months after learning about self-compassion in my weekly meditation group. I was in a particularly bad mood. My soon-to-be-ex-husband John had just called me

up on the phone to tell me what a horrible, disgusting person I was, so that I had to hang up on him mid-harangue. Rupert was out of town on a work assignment, and we had argued the morning he departed so things had been left on a sour note between us. The deadline for submitting the final draft of my dissertation was fast approaching. I was behind in my work and seriously wondering if I really had what it took to make it as an academic. Would I ever get a “real” job, would I ever have a happy, uncomplicated life? I was rolled up into a tight black ball of insecurity, fear, and self-loathing.

And then I remembered self-compassion. *What did the teacher say again?* I thought to myself. *Oh yeah, that's right, first just be mindful of what you're experiencing. Observe each thought and emotion as it arises and describe it gently, without trying to resist it or push it away. Okay I think I can do that. Let's see. Shame, tightness in my throat, pressure, pain in my stomach. Heaviness, sinking, sinking. Fear, pressure in the back of my head, heart beating fast, hard to breathe . . . All right, now try giving yourself compassion for how hard it is to feel this way right now. Hmm. Can't feel anything. I'll try giving myself a little hug . . . Warmth. Warm tingles rising up my arms. Softness.* And then the tears came. Deep wells of grief as I allowed myself to really feel how hard it was at the moment. *It's okay, it's okay. Life is hard sometimes, it's okay. Everyone has these moments. I'm here for you, I care about you. It's not so bad, it will pass. Softening in my chest and throat. Little waves of contentment spreading from the center of my face. Quieting. Quieting. Quiet.*

Each time a new painful feeling arose, I would hold it in my awareness like this, describe it mentally, and send myself compassion for feeling it. And then I would hold the feeling of compassion in my awareness, describing it and feeling it in my body, savoring how good it felt to be cared for. After things quieted down, another painful feeling would soon rise up, and round I'd go through the whole cycle again. It went on like this for about an hour.

Yet after a while, I realized that my predominant experience was no longer an unpleasant one. Change was afoot. Instead of being stuck in the pain, my awareness was increasingly resting in the feelings of love, kindness, and connectedness that held the pain. As it did, the pain itself started to soften, the worry to lift, and I began to feel a lightness in my body. It was perhaps the first time I had really opened my heart to myself, and I started to feel almost giddy, like I had drunk a glass of champagne for the first time. Or

perhaps it was more like drinking a glass of vintage red wine—the flavors were rich, deep, spicy, and complex. I felt centered, stable, at peace. I realized that these beautiful sensations I was experiencing weren't contingent on things going the way I wanted them to. They didn't depend on receiving praise, or being successful, or having a perfect relationship. I realized that my own heart was a deep well I could drink from at any time, and that ironically I would be *most* likely to remember to drink from that well when things were at their most difficult. I had found something that would change my life forever, and I was grateful beyond words.

## Exercise One

### *Transforming Negativity*

The next time you find yourself in the grip of negative emotions, try generating some positive emotions to go alongside them. You can use the following phrases when you're stuck in negativity, designed to validate your feelings while also focusing on your desire to be happy:

*It's hard to feel (fill in the blank) right now.  
Feeling (blank) is part of the human experience.  
What can I do to make myself happier in this moment?*

The first phrase compassionately acknowledges the difficulty of having negative emotions. The second phrase is a reminder that negative emotions are a normal, natural part of being human, and therefore should not be judged. The third phrase helps you get in touch with your desire to be happy. This may enable you to broaden your focus, finding creative ways to reset your buttons. You might take a hot bath, or consider what's good about your present situation (there's almost always *something* good in any given moment). These steps are not taken to resist being in a negative frame of mind, but because you want health and well-being for yourself.

Once you say these phrases, your negative mood may start to

lift, replaced by a feeling of calm contentment. You might even be able to have a sense of humor about it all, and nothing lifts a bad mood like a good chuckle. Woody Allen made a career out of laughing at negativity, of course: “What if everything is an illusion and nothing exists? In that case, I definitely overpaid for my carpet.”

## Open-Mindedness

Not only does self-compassion open our hearts, it also opens our minds, releasing our perceptions from the tight clamp of negativity. When we’re lost in negative judgment, our awareness automatically narrows in on what’s wrong with ourselves and our lives. We only see the blemish of imperfection, taking for granted the beauty and wonder of the bigger picture.

The evolutionary purpose of negative emotions is to spur actions that will help us survive, eliciting powerful urges known as *specific action tendencies*. Anger, for instance, creates the urge to attack, fear the urge to escape, shame the urge to hide, and so on. When caught in the grip of negative emotions, it feels like we have one option and one option only. When the bear is charging us, we don’t have time to deliberate between choices. We act or we die. This tendency may come in handy when threatened by hairy carnivores, but it’s not so useful when our problems are less directly life threatening, like when our new car gets dinged by a stray shopping cart in the grocery store parking lot. Negative emotions narrow our worldview to the point that we can’t see other possibilities right under our noses. As Helen Keller said, “When one door of happiness closes, another opens, but often we look so long at the closed door that we do not see the one that has been opened for us.”

When we give ourselves compassion, holding our disappointment in kind, connected, mindful awareness, the door opens up again. When we soothe and comfort ourselves, we provide ourselves with a sense of safety, giving us the courage to finally peek out from the rock we’ve been hiding under and see what’s outside. More often than not, things aren’t as bad as we feared, and we start noticing things about ourselves and our lives that are actually pretty good.

The calm, hopeful mind-set provided by self-compassion can lead to an

upward spiral of positive emotions that helps us break free of fear and greatly improves the quality of our lives. Leading social psychologist Barbara Frederickson, author of the book *Positivity*, has proposed something called broaden-and-build theory to explain how it all works. Frederickson argues that positive emotions allow you to take *advantage* of opportunities rather than merely *avoid* dangers. Positive emotions, rather than narrowing our attention, do just the opposite. Because they help us to feel calm and safe, good feelings increase openness to new experiences, as well as increasing a sense of connectedness and trust in others. As Frederickson says, “Positivity opens us. The first core truth about positive emotions is that they open our hearts and minds, making us more receptive and more creative.”

First, let’s consider how negative emotions tend to interfere with seeing things clearly and prevent us from making wise decisions. Let’s say you’re running late for work and still have to walk your dog before leaving for the day. You’re stressed and mad at yourself for not getting up earlier. You grab the leash and try to attach it to Fido’s collar, leash in one hand, cup of coffee in the other. But in your harried state you keep missing the ring on his collar and it takes you three times longer than it should to hook the leash on. What’s more, you take so long that Fido thinks you’re bending down for a cuddle. He excitedly tries to lick your face and ends up spilling your coffee all over the kitchen floor. You curse, wipe up the spill, and roughly pull Fido out the door. You’re impatient and grumpy as you take the dog for a walk around the block. *When is he going to do his morning business? I’m fifteen minutes late already.* When he finally does his morning duty, he does so smack-dab in the middle of the sidewalk. You reach into your purse for your disposable dog poop bags, only to find that you forgot to bring the bags in your rush to get out the door. Five minutes, ten leaves, and fifteen grimaces later you manage to clear the mess from the sidewalk. When you finally get home, you wash your hands and go to grab your car key from the front pocket of your purse, where it normally resides. But the key isn’t there. You look once, twice, three times, each time getting more and more frustrated. You finally dump all the contents of your purse out only to find that your car key is, in fact, in your back pocket. You had put it there so you could get out the door more quickly after returning home from walking the dog. When you finally get to work, you’re a half hour late and have missed the beginning of your work-group’s daily meeting. You walk in sheepishly, all eyes staring as you try to find a

chair, wishing you were invisible. Your negative mind-set has caused you to be clumsy and inefficient, not to mention landing you in trouble with your boss. And your day is likely to just keep getting worse from there.

Now consider how this scenario might have played out if you had focused on the positive rather than the negative. You're running late for work and have to walk your dog before leaving for the day. Although you slept in a bit too long, you're grateful that you got those few extra minutes of sleep. You pour yourself a cup of coffee, noticing how good it smells. You take a moment to enjoy the first few sips and realize that you should probably put your coffee in a travel mug before you take Fido for his walk. You grab the leash for Fido's collar, leash in one hand, cup of coffee in the other. As you do so, Fido tries to give you a kiss. You put down your coffee (which fortunately was in a spill-proof travel mug), give Fido a scratch behind the ears, and quickly and easily attach his leash. *What a sweet dog, he's such a good companion*, you think to yourself. You calmly walk outside, remembering to pick up the dog poop bags on your way out. You notice what a bright, beautiful morning it is and thoroughly enjoy your brief walk. As soon as Fido finishes his morning business, you clean up and soon arrive back home. You wash your hands and search your purse for your car keys. *Where are they? I always keep them in the front pocket of my purse. Oh yeah. That's right. I put them in my back pocket so I could get out the door more quickly. Guess I'm cleverer than I thought!* You arrive to work only ten minutes late, with five minutes to spare before your work-group's morning meeting starts. Your spirits are high as the meeting begins, especially when your boss approves of the creative solution you offer for a problem he brings up. Your positive mind-set has helped you to be deft, careful, and efficient in your actions and will likely lead to a day that just keeps getting better.

We've all had many times that have unfolded like the first scenario, and thankfully also many times that have unfolded like the second. It seems that when we're in a negative mind-state, everything that can go wrong *does* go wrong. When we're in a positive frame of mind, however, things seem to go more smoothly. Frederickson's research shows that this process isn't magic. Rather, negative emotions tend to narrow our attention so much that we miss the obvious and make mistakes, meaning that we cause ourselves extra stress and problems. Positive emotions, on the other hand, tend to broaden our attention so that we notice useful details and have creative ideas, meaning

that we maximize our thinking, decision-making abilities, and coping skills.

## Exercise Two

### *Take a Pleasure Walk*

Take a fifteen- to thirty-minute pleasure walk outside. It's best if you can take the walk in nature but any outdoor walk will do (e.g., walking from your office to the bus stop). The goal of the walk is to notice as many pleasant things as possible, so that you are generating an upbeat frame of mind. How many happy, beautiful, or inspiring things can you notice while you're walking? Is it a nice day? Or if it's raining, can you focus on the life-giving qualities of the rain? Are there beautiful plants or flowers? Bird song? A squirrel? Are there any pleasant scents? What's good about the experience of walking itself? Can you get in touch with the wonder of being able to walk, of feeling the earth underneath your feet? And how about any people you pass? Are there two lovers holding hands, friends laughing, a mother with her small child? If you're smiling at this point (and you probably will be after generating such positive emotions), are you getting any smiles back? Perhaps even a hello? So much of our mental state depends on our intention to notice the good, an intention that will water the seeds of happiness.

Fredrickson and her colleagues have recently become interested in how feelings of compassion help to cultivate positive emotions. They conducted a study in which participants were taught how to do the loving-kindness meditation described in chapter 9. Five days a week, for eight weeks, participants generated feelings of loving-kindness for themselves, close others, acquaintances, strangers, and finally to all living beings.

Compared with a control group (who had signed up for the meditation course but hadn't yet taken it), participants who practiced loving-kindness meditation reported feeling more positive emotions such as love, joy, gratitude, contentment, hope, pride, interest, amusement, and awe on a daily basis. They also reported feeling greater self-acceptance, as well as more

positive relationships with other people in their lives. Interestingly, participants also experienced better physical health, reporting fewer symptoms of illness such as headaches, congestion, or weakness.

Similarly, an fMRI study by Richie Davidson examined the brain functioning of experienced Buddhist monks and novice student volunteers who meditated on unconditional compassion for all beings, the self included. Results indicated that while meditating, both groups had higher levels of brain activation in the left prefrontal cortex, the brain region associated with joy and optimism. The monks, in fact, had the highest levels of activation ever recorded by Western scientists. (Those were some happy monks!)

## Self-Compassion and Positive Psychology

Over the past decade, eminent psychologists such as Martin Seligman and Mihaly Csikzentmihalyi have become increasingly interested in the way that positive emotions like love, joy, curiosity, and hope can help to maximize health and well-being. Generally known as the “positive psychology” movement, its focus is on understanding the factors that lead to mental health rather than mental illness—on cultivating strengths rather than eliminating weaknesses. Our research shows that self-compassionate people experience more positive emotions in their lives—such as enthusiasm, interest, inspiration, and excitement—than those who are self-critical. They also report being much happier. Ironically, even though self-compassion arises during experiences of suffering, it tends to create joyous mind-states. Again, self-compassion doesn’t erase negative feelings, it *embraces* them with care and kindness. This sets off the “broaden-and-build cycle” mentioned earlier. Because self-compassion makes us feel safe, centered, and connected, we can delight in what’s wonderful about our lives rather than dwelling solely on problems and limitations. We can start to pursue our dreams rather than merely ward off dangers.

Accordingly, our research shows that self-compassionate people are much more optimistic than those who lack self-compassion. Optimism refers to the belief that things are going to be okay, that the future holds good things. Unlike pessimists, who often don’t bother trying because they assume that everything is going to hell in a handbasket (as the saying goes, you should

always borrow money from a pessimist—they don’t expect it back), optimists usually work diligently toward their goals, secure in the assumption that their efforts will bear fruit. Self-compassionate people are more optimistic because they know that if problems occur, they can deal with them. They have the emotional strength needed to cope with whatever arises. If you’re able to comfort yourself every time something painful happens, staying centered and not running away with reactivity, you can start to *trust* yourself. You can more easily find inner courage when hard times hit, knowing that you can get through almost anything with the help of your own compassionate support.

Similarly, we’ve also found that self-compassionate people tend to be more curious about life than others. Curiosity is the engine of growth, spurring us on to explore, discover, and take risks, even when we feel anxious or uncomfortable. Self-compassion provides us with the sense of safety and equanimity needed to remain open as we take leaps into the unknown. It allows us to take refuge in interest and discovery when we have no idea what’s going to unfold from one moment to the next.

People with self-compassion also tend to be more satisfied with their lives than those who lack self-compassion, a finding we’ve demonstrated among people living in both Eastern and Western cultures. Life satisfaction refers to an overall sense of contentment with how one’s life has developed, the feeling that one’s life has meaning and value. When you apply the soothing balm of self-compassion to your broken bits—your failures and disappointments—you can integrate your sorrow into a deep, rich, and satisfying acceptance of what it means to live a human life.

## Celebrating the Human Experience

We know that self-compassion generates positive feelings that maximize health and well-being. What is truly wondrous, however, is the fact that these positive emotions do not require you to *pretend* that reality is anything other than what it is. Instead, self-compassion allows you to widen your outlook so that you can fully appreciate and acknowledge all aspects of life, the bad as well as the good.

A truly satisfying, enjoyable life is varied and diverse—polyphone, not monotone. Imagine if the only songs you ever heard were your top ten

favorites, and that was it. Forever and ever. You'd soon want to jump out of a window due to the relentless boredom. To keep things interesting we need contrast and variety in our lives. The Doris Day ideal of a constantly sunny disposition is just that—a Hollywood ideal. A cardboard cutout of a real person that ultimately leaves one wanting more. Hollywood lore has it that Doris Day turned down the role of Mrs. Robinson in the film *The Graduate* because it clashed with her usual goodie-two-shoes film persona. Can you imagine how much more interesting her film biography would have been—and how much longer her career would have lasted—if she had accepted the part and run with it?

While we ultimately want happiness in our lives, achieving this state requires feeling all of our emotions—the highs and the lows, the leaps forward as well as the setbacks. Emotions such as sadness, shame, anger, and fear are as necessary and integral to life's drama as joy, pride, love, and courage. As Carl Jung once wrote, "Even a happy life cannot be without a measure of darkness, and the word happy would lose its meaning if it were not balanced by sadness." The key word here is *balance*. We don't want negative feelings to color all of our perceptions, but we don't want to totally exclude them either. As if excluding them was even possible.

When we're compassionate toward our suffering, the pleasures of kindness, connectedness, and mindfulness quickly become blended with our painful feelings. The resulting flavor can be surprisingly satisfying—a little like dark chocolate. Without any pain, the pleasure of life would be too sugary, without any depth or complexity. On the other hand, pain without pleasure would be too bitter, like unsweetened cocoa. But when pain and pleasure are combined, when both are embraced with an open heart, you start to feel whole, full, complete. So next time you're having a hard time, try remembering the words *dark chocolate*. It might just provide the inspiration you need to wrap your bitter pain in the sweet, loving folds of compassion.

## My Story: The Horse Boy

I certainly have firsthand knowledge of the joy that self-compassion can provide. The commitment that Rupert and I made to having open hearts and open minds allowed us to do something crazy—to pursue an impossible

dream and have that dream come true.

No one knows what causes autism, it's a mystery. We also don't understand why autism has been increasing at such alarming rates. For parents in the front line, however, the big question isn't what causes autism, but what to do about it? Much of the information on therapies and treatments for autism is conflicting. All of it is expensive. When our son, Rowan, was diagnosed with the disorder, we had no choice but to accept the unknowns and deal with each moment as best we could. Because there were so few answers, we decided we'd try anything to help Rowan that wasn't going to harm him. Little did I know the adventure that decision would take us on.

Autism is exhausting. As I mentioned earlier, Rowan was subject to endless screaming fits caused by his overstimulated nervous system. But out in nature he would calm a little. When the tantrums came, Rupert would often take Rowan out into the woods behind our house. One day, when Rowan was three, he suddenly ran out of the woods and into our neighbor's horse pasture, getting through the fence and in among the horses' hooves before Rupert could stop him.

There he was, flat on his back, five horses milling and stamping around him.

That's when something extraordinary happened. The boss mare—a notoriously grumpy old horse called Betsy—gently nosed the others aside and bent her head to our son in submission. Something amazingly gentle and unfathomable passed between them. Rupert—a lifelong horseman—had assumed that Rowan wasn't safe around horses, but after seeing Betsy's reaction, he immediately got the idea to take Rowan riding on her. I was nervous and begged him to be cautious. But the moment Rupert put him into the saddle and climbed up behind, Rowan began, amazingly, to talk. He began to use meaningful speech for the first time. We were blown away.

That same year, another extraordinary thing happened. Rupert—who works in human rights as well as being a writer—brought a group of San (or Bushmen) tribesmen from Southern Africa to speak at the UN to protest being evicted from their ancestral hunting grounds. The Bushmen have a strong tradition of healing through the use of trance. We joined them for a few days at a gathering of traditional healers outside of Los Angeles, and they offered to "work" on Rowan. Almost immediately Rowan began to point, show his toys to people, engage with others far more than he usually

did. For a few days it was almost, tantalizingly, like having a “normal” child. We were ecstatic. Sadly, he fell back into the depths of his negative symptoms as soon as the Bushmen went home. But this sudden, inexplicable leap forward, combined with Rowan’s radical, positive reaction to Betsy, had planted an idea in Rupert’s mind.

One evening he came in from riding with Rowan and said, as if it was the most natural thing in the world, that he thought it might be a good idea for us to take Rowan to the one place on Earth where horses and healing went together—Mongolia. This is the country where the horse was first domesticated, and where the word *shaman* (meaning “he who knows”) comes from. A no-brainer, he said. I disagreed. Strongly.

“Let me get this straight,” I said. “You want us to take our autistic son across Mongolia on horseback? That’s absurd! It’s the *last* thing we need to do. It’s hard enough to get through each day, let alone do something crazy like this. I can’t believe you’d even seriously suggest it. And I hate horses!”

Maybe hate is too strong a word, but I was never one of those I-want-a-pony girls. Rupert is the horsy one in our family. Growing up in the suburbs of L.A., I had been more about Goth rock and trying to be cool. Rupert had taught me to ride—kind of. But I never had the desire to really impose my will over a horse. And horses know that: I’ve been run away with and bucked off more times than I can count.

But Rupert had a strong and persistent gut feeling that we needed to take Rowan to Mongolia in order to help him. The feeling in *my* gut when I thought of going to Mongolia wasn’t intuition—more like terror. Rupert and I fought about it, and fought hard. Then uncharacteristically—for we’re both pretty stubborn—we both backed off, half hoping the other would cave in. Two years passed. Rowan and Rupert rode together almost every day, and the effects of this homegrown equine therapy were clear in terms of Rowan’s rapidly developing language. But by age five, Rowan still wasn’t toilet trained. We had taken him out of diapers, thinking he’d be so uncomfortable pooping in his underpants that he’d become motivated to use the toilet. But it wasn’t working. Nothing worked. And Rowan still suffered from unfathomable, inconsolable tantrums. He was also cut off from his peers, unable to make friends.

Rupert had been in e-mail contact with a Mongolian travel operator and was tentatively planning the trip despite my reservations. A young filmmaker

friend, Michel, wanted to go along to document the journey. He would go without being paid, he said, seeing it as a great filmmaking opportunity. I continued to resist.

Still, I had learned through the years that when Rupert gets a strong gut feeling, it's often right. He had a gut feeling about me, after all, and actually asked me to marry him the first day we met. So I thought about the whole Mongolia thing for a while, and my reaction surprised me. I realized that I didn't want to miss the adventure. That life was providing me with the chance to turn things around, to channel our grief over Rowan's autism into a quest for healing. That I was being offered a choice between love and fear. So I took a deep breath and said yes. I did joke, however, that for me it was a win-win. If the trip was a failure, I'd get to say "I told you so" to Rupert forever, and if it was a success, well, even better.

Rupert, being a writer, had put in a proposal to write a book about the trip called *The Horse Boy*, hoping that he might get a book advance to offset at least some of our costs and lost income while we were away. The proposal had been with Rupert's agent for several months, however, and we hadn't heard anything back. As an act of faith, we decided to go ahead and buy the plane tickets, maxing out our credit cards.

Amazingly, about two weeks later, a bidding war broke out and Rupert got a book advance that exceeded our wildest dreams. Suddenly there was more than enough money to cover all our expenses, to make a proper documentary (also called *The Horse Boy*), and most important, to put money away for Rowan's future. It was as if life was affirming our decision to take the adventure and giving us as much security as possible to do so. We were overwhelmed with gratitude.

So it was in this thankful frame of mind that we found ourselves in August 2007 at the foot of a sacred mountain in Mongolia, where nine shamans had gathered outside the capital city of Ulaanbaatar to conduct a ritual for us. According to our guide Tulga, most had come hundreds of miles just to help Rowan. It was perhaps the most intense afternoon of my life. Rowan hated it at first, screamed and resisted, clearly disoriented and not understanding all the noise and drumming going on around us. (Although I must say, he was not really more distressed than he would have been on a typical visit to the grocery store.)

Then it got really bizarre—the shamans said that a black energy had

entered my womb during my pregnancy, and they made me go down to the river to wash my private parts with vodka. Yes, vodka. They also said that a female ancestor on my mother's side, someone with mental illness, was somehow clinging to Rowan. In fact, my maternal grandmother had lost her eight-year-old son in a car crash when my mother was only two. Then—years later—only a few weeks after my mom moved out and got married, my mom's father died of a heart attack. My grandmother went mad with grief and had to be committed. Was this the female ancestor they meant? Bizarre. There was little time to reflect because next thing we knew Rupert and I were being made to kneel, facing the mountain wall while a shaman whipped us (not Rowan, thank God) with rawhide thongs, raising agonizing red welts on our backs, arms, and thighs while Tulga, laughing nervously, told us: "Is important not to cry out."

Childbirth apart, I don't think I've ever experienced anything so painful. As I knelt in the grass, breathing deeply and feeling the rawhide thongs pierce my skin, I sent myself compassion. Compassion for the pain of the whip, compassion for the pain of having an autistic child, compassion for everyone in the world suffering in so many different ways. I knew that the pain the shaman was causing was born from the intention to heal, and that made it bearable.

"Do you forgive your crazy husband?" asked Rupert, once the ritual was done. We hugged, laughing. What else could we do?

And then something beautiful happened. Rowan started laughing, giggling, playing with the shamans. Shortly afterward, to our amazement, Rowan turned to this little boy who'd been standing at the edge of the circle, hugged him, and said, "Mongolian brother."

He'd never done anything like that before.

The little boy was called Tomoo—our guide Tulga's son. Seeing the boys' amazing interaction, Tulga decided to bring Tomoo along on the trip with us. Rowan had made his first friend.

So off into the great interior we went. It started with near disaster. Rowan suffered a sudden loss of confidence during our first day on horseback, completely rejecting the horses so that we had to abandon them and continue on in a 4x4. This was heartbreak for Rupert: horses were the place where he and Rowan connected most. But watching as Rowan's friendship with Tomoo began to flourish during the endless days of travel and the long,

impossibly beautiful evenings camped out on the open steppe was pure joy. Something in our son was changing.

We washed ourselves and prayed in the sacred waters of Sharga Lake, a strange, dreamlike place of wild swans and wilder horses, before traveling north into Siberia, land of the mysterious reindeer people. Their healers were, by reputation, the most powerful in the region. Rupert had heard that these nomadic peoples (purportedly the ancestors of the first Native Americans who crossed the Bering Strait tens of thousands of years earlier) could be very difficult to locate, however. Finding them and asking for a healing for Rowan was the final goal of our journey. But there were no roads to their remote settlement. To get there, Rowan would have to accept being on horseback again.

By now I was getting pretty exhausted by the trip. Imagine washing a five-year-old's soiled underwear three times a day with bottles of water filled up at streams (no washers or dryers out on the steppe). I was also sick of the terrible food—especially the rancid alcoholic mare's milk called *airag*, which tastes like vomit. Still, something was drawing us onward.

Rowan did finally get back on a horse again and started enjoying riding once more. So up we went, following our guides up the twelve-thousand-foot pass that had to be crossed to reach the high summer pastures of the reindeer people. Three days' hard riding later, we finally came upon their teepees. Rowan was entranced. The people here—as everywhere in Mongolia—could not have been more welcoming, bringing out tame reindeer for him and Tomoo to ride, letting them cuddle with the impossibly cute baby reindeer before the healings began.

For three days the shaman, an old, intensely charismatic man called Ghoste, worked on Rowan, dancing and drumming in the firelit glow of his teepee while Rowan crawled about, pretending to be a baby elephant.

On the last night I had a strange dream—and I almost never remember my dreams. My late grandmother was with her son who had been killed. Only now he was a grown man, and they were walking away together, hand in hand, happy.

Next morning, Ghoste said it was time for us to go. He also said that the stuff that really drove us crazy—Rowan's incontinence, his tantruming—these would stop now . . . today.

I was guarding my heart—so was Rupert. But the next day, while camped

down by the river, Rowan did his first intentional bowel movement and cleaned himself. Two days later, he had his first success in a real toilet—something not even his grannies or paid professionals had been able to achieve. From that point on, we had only a few tantrums of any note. Within weeks of returning home, they had ceased completely. Meanwhile Rowan’s circle of friends started to grow. He even began riding Betsy by himself—for Rupert, the fulfillment of a dream.

Was it the shamans, was it some sort of placebo effect, or was it simply the effect of taking him to a radically new environment, pushing him to his limits? I honestly don’t know. What I do know, though, is that as a family we took a risk and somehow, through whatever crazy leap of faith, we found healing.

Healing, not cure. Rowan did not get cured of his autism. Rowan is still autistic. But he did get healed of the dysfunctions that went along with his autism. These days Rowan is now so functional that some people have trouble telling that he’s “on the spectrum” anymore. But his autism will always be at the core of who he is and how he sees the world, and we wouldn’t want it any other way.

The healing that *Rupert and I* received in Mongolia was that we came to truly accept Rowan’s autism and stopped fighting against it. By opening up to the mystery of autism, by learning to see it as an adventure rather than a curse, we realized that Rowan’s autism was actually the best thing that ever happened to us. We wouldn’t be leading such an incredibly interesting life if it weren’t for Rowan’s autism. Ghoste had told us we needed to take Rowan to a good traditional healer each year until he was nine. It didn’t matter from which tradition. So in 2008 we took him to Namibia to see the Bushman healer Rupert is closest to—a powerful shaman named Besa (a measure of their closeness is that Rowan’s full name is Rowan Besa Isaacson). In 2009 we took him to see an amazing Aboriginal healer in Australia. In 2010 we traveled to New Mexico and Arizona to see a Navajo medicine man. Each time we’ve taken one of these journeys, Rowan has been transformed, and we’ve been transformed—coming together closer as a family.

We’ve also been able to share the types of experiences we’ve had with Rowan with other families. We’ve started running four-day “Horse Boy” camps for families with autistic children, allowing for a more intense immersion in horses and nature. Several children have had major

breakthroughs at the camps, including nonverbal kids who have uttered their first words on horseback, to the astonishment of their parents. I've been talking a lot about self-compassion to the parents at the camps, how crucial it is when trying to cope with the stress of raising an autistic child. The joy, satisfaction, and plain old fun we have doing all this is truly awe inspiring.

Autism is a gift, if you allow it to be. All of Rowan's charm, humor, talent, and intense interest in the natural world is because of his autism, not in spite of it. Why would we ever want to change that? As Rupert likes to remind me: "The old saying is that when life gives you lemons, make lemonade. I say f\*\*\* that. When life gives you lemons, make margaritas."

### Exercise Three

#### *Find the Silver Lining*

Think of one or two of the biggest challenges you've faced in your life so far, problems that were so difficult you thought you'd never get through them at the time. In hindsight, can you see if anything good came out of the experience? Did you grow as a person, learn something important, find more meaning in your life? If you could, would you go back in time and change what happened, if it meant that you wouldn't be the person you are now because of it?

Next, think about a challenge you're facing right now. Is there any way to see your problem in a different light? Is there anything positive that might come out of your present circumstances? Any learning opportunities, career possibilities, new relationships, a reorganization of your priorities?

If you're finding it difficult to see *anything* positive about your current situation, it's probably a signal you need more self-compassion. Try using the three doorways of kindness, common humanity, and mindfulness to approach your feelings of fear or distress. Silently offer kind, nurturing words of support, as if from a close friend. Maybe even give yourself a little hug if no one's looking. Think about the ways your situation connects you with other people having similar problems—you are not alone. Try

taking a few deep breaths, and accepting that the situation *is* happening, even though you don't like it much.

Now look again. What is life trying to teach you right now? Is this an opportunity to open your heart, to open your mind? Is there any way that this seeming curse might actually be a blessing? Margaritas anyone?

## *Chapter Thirteen*

### **SELF-APPRECIATION**

*Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, Who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small doesn't serve the world. There is nothing enlightened about shrinking so that other people won't feel insecure around you. We are all meant to shine, as children do. We were born to make manifest the glory of God that is within us. It's not just in some of us; it's in everyone. And as we let our own light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others.*

—MARIANNE WILLIAMSON, *A Return to Love*

**T**HIS BOOK HAS LARGELY FOCUSED ON HOW TO RELATE TO OUR FAILURES and inadequacies with self-compassion. But the three basic components of self-compassion—kindness, a sense of common humanity, and mindfulness—are not just relevant to what we don't like about ourselves. They are equally relevant to what we *do* like.

#### **Appreciating Our Good Side**

Sometimes it's more difficult to see what's right about ourselves than what's wrong. For those of us who don't want to seem vain, even *thinking* about our

positive traits can make us uncomfortable. For this reason, a lot of people have a hard time accepting compliments. You know the type. “Mary, you look great! I like your blouse.” “Oh. Thanks, but it would look better on someone who wasn’t so flat-chested.” Praise can make us squirm, and we often don’t know how to respond without self-consciousness.

Flattery feels a lot better than insults, of course, but how many of us really take the praise in? Own it. Delight in it. For a whole host of reasons, it’s often trickier than you might think to feel positive about ourselves; most of these stem from fear.

One fear involves setting up overly high expectations. Underplaying our good points means that we’re more likely to pleasantly surprise others rather than disappoint them. If you score the winning goal in your weekly soccer match after repeatedly bemoaning what a crap player you are, you’re likely to receive astonished praise from your teammates. “I didn’t know you had it in you! Well done!” At the same time, if you miss that crucial shot at the close of the game, sympathy will still be forthcoming. “Oh well, at least you tried.” Appearing proud and confident about your skills, on the other hand, opens you up for attack when things go wrong. “Hey, I thought you said you were one of the best players on your college team. What college was that, the University of Uncoordinated Lame Asses?”

We also fear letting go of the devil we know. If we’re in the habit of cutting ourselves down, recognition of our positive qualities will feel alien to us. Our sense of self may be so infused with feelings of inadequacy that it becomes frightening to see ourselves as worthy and valuable. Ironically, this can feel like a sort of death to us, and our negative sense of self will therefore fight hard to survive.

Fear of outshining others is another stumbling block. There’s no doubt we live in a competitive culture where we need to feel special and above average to feel okay about ourselves. At the same time, it’s lonely at the top. Some part of our psyche recognizes that the climb toward superiority is also a descent into isolation. Although we want high self-esteem, we also intuitively know its potential downsides—feeling separate and disconnected from others. If I acknowledge my greatness, does that mean I’m better than you, and does that in turn mean you and I can no longer relate as equals? The bipolar way in which we both crave and fear high self-esteem makes it hard to be comfortable in our own skin.

Thomas, an accountant at a technology company, felt extremely awkward and uncomfortable when anybody praised him. If he received a compliment on his work performance, for instance, he'd quickly say "thanks" for the sake of politeness but just as quickly change the subject. He felt like a fish out of water and almost nauseated whenever a positive spotlight was turned on him. He had no role model for how to accept a compliment, or how to linger in the warmth of another's praise. Instead, he was frightened to death of turning into his boss, a cigar-smoking slick guy with a swollen head who thought he was the cat's pajamas. He hated his boss's vain imperiousness and was terrified of being anything like him.

There's a reason we always root for the modest, self-effacing hero of the movie rather than his cocky, brash antagonist. Nobody likes a narcissist—except the narcissist. If we acknowledge our positive features and delight in them, doesn't that mean we're egotists? And egotists are unlovable, aren't they? It's a bit of a catch-22. If we admit good things about ourselves, it must mean we're bad, so we focus on what's bad about ourselves in order to feel good. Absurd, isn't it? Yet we all do it.

So how do we celebrate our admirable qualities without falling into the egotism trap? I believe the answer is still self-compassion, though in a different guise. I like to call it "self-appreciation." When we can enjoy what's good about ourselves, acknowledging that all people have strengths as well as weaknesses, we allow ourselves to revel in our goodness without evoking feelings of arrogance, superiority, or overconfidence. William James once wrote that "the deepest principle in human nature is the craving to be appreciated." Luckily, we can meet our deep need to be appreciated without depending on other people to approve of us. We can acknowledge our own beauty. Not because we're better than others, but because we are human beings expressing the beautiful side of human nature.

## Sympathetic Joy

In Buddhism, one of the foundations of well-being is *mudita*, which translates as "sympathetic joy." This state occurs when we are delighted by the good qualities and circumstances of others. An understanding of sympathetic joy can help us better grasp the meaning of self-appreciation, since the two are

closely related. The basic sentiment underlying sympathetic joy is kindness and goodwill. If I am concerned for your well-being and want the best for you, I will want you to succeed. I'll be glad that you have gifts and talents that help you be contented in life.

Typically, however, others' good qualities tend to make us feel inadequate. *That woman is gorgeous so I must be ugly. He's intelligent so I must be stupid.* The green-eyed monster causes us to suffer when others shine, which means we suffer a lot. But what if we radically altered our perceptions? What if we took pleasure in others' accomplishments, felt genuinely happy for them? This would increase our odds of feeling happy by the number of people we have the opportunity to feel happy for. Given the latest estimates of the world population, that's about 6.8 billion percent!

An essential ingredient of sympathetic joy is the recognition of our inherent connectedness. When we're part of a larger whole, we can feel glad whenever one of "us" has something to celebrate. I work at the University of Texas at Austin, and we Austinites have serious college football fever. Whenever the Longhorns win a big game, the entire city is elated. Of course, as team supporters we don't personally throw that winning touchdown. It's our sense of oneness with our team that allows us to delight in their success. When we feel connected with others, we can fully revel in their glory. But what would happen if we widened that sense of belonging to include all of humanity, not just our local sports team? Then our side would always win.

We need to be aware of others' positive qualities to fully appreciate them, of course. If I take my husband's intelligence, good looks, creativity, or sense of humor for granted, that means I will stop being consciously aware of his good characteristics. They will morph into the background of the assumed and the expected. I must take note of his strengths and talents to fully appreciate and acknowledge the amazing person he is. For this reason, sympathetic joy also requires mindfulness.

## The Roots of Self-Appreciation

When qualities of kindness, common humanity, and mindfulness are applied toward the suffering of others, they manifest as compassion. When they're applied to our own suffering, they manifest as self-compassion. When they're

directed toward others' positive qualities, they manifest as mudita: sympathetic joy. And when they're directed toward our own positive qualities, they manifest as self-appreciation.

Let's first consider the quality of kindness as it applies to self-appreciation. Many of us focus much more on our weaknesses rather than on our strengths. As discussed, we often belittle our positive features because it feels too scary and uncomfortable to acknowledge them. If we are kind to ourselves, however, we can rejoice in our good qualities. Isn't it wonderful that I'm a good father, a hard worker, a faithful friend, a committed environmental activist? Aren't my traits of honesty, patience, diligence, creativity, sensuality, spirituality, and empathy something to be celebrated? It's a great gift of self-kindness to have appreciation for ourselves, and to demonstrate our approval with sincere praise. We don't have to speak this praise aloud, making ourselves and others uncomfortable in the process. But we can quietly give ourselves the inner acknowledgment we deserve—and need.

The sense of common humanity inherent in self-appreciation means that we appreciate ourselves not because we're better than others, but because all people have goodness in them. To appreciate others' goodness while ignoring or deprecating our own creates a false division between us and them. But as a distinctive expression of the universal life force that animates all our experience, we honor everything when we honor ourselves. As the Zen master Thich Nhat Hahn writes, "You are a wonderful manifestation. The whole universe has come together to make your existence possible." If you take the notion of *interbeing* seriously, then celebrating your achievements is no more self-centered than having compassion for your failings. We can't really claim personal responsibility for our gifts and talents. They were born from our ancestral gene pool, the love and nurturing of our parents, the generosity of friends, the guidance of teachers, and the wisdom of our collective culture. A unique nexus of causes and conditions went into creating the ever-evolving person we are. Appreciation for our good qualities, then, is really an expression of gratitude for all that has shaped us both as individuals and as a species. Self-appreciation humbly honors all of creation.

Self-appreciation also requires mindfulness. Just as we need to notice others' good qualities in order to appreciate them, we need to consciously acknowledge our own positive features. Given the discomfort that often

arises when we appreciate ourselves, however, we sometimes screen such thoughts from our conscious awareness. We suppress our suspicions that maybe we aren't so bad after all, because we don't know what to do with these novel good feelings. Mindfulness allows us to approach things in a new way, letting go of our habitual tendencies. One of the most powerful habits of the mind, of course, is to focus on the negative rather than the positive, and this tendency is no more apparent than when we think about ourselves. Our instinct tells us to identify problems and fix them so that we can survive. This means we often take our good qualities for granted while obsessing about our weaknesses. *If I could only lose fifteen pounds*, she told herself over and over again, blithely ignoring her youth, good health, intelligence, successful career, and loving boyfriend. By adopting the intention to notice what's good about ourselves, though, we are able to counter this slide toward negativity.

Some may be concerned that if we focus too much on what's right about ourselves we'll ignore much needed areas of growth. This is true only if our focus is, in fact, "too much." If we take a lopsided view of ourselves—"I am perfect and have no flaws whatsoever"—that would certainly be a problem. I don't know why we so often fall into the trap of this kind of either/or thinking, but it doesn't serve us. Every human being has both positive and negative traits. Rather than running away with an exaggerated story line about either, good or bad, we instead need to honor and accept ourselves as we authentically are. No better and no worse. The key is having balance and perspective so that we can see ourselves without distortion. When the sun rises we can appreciate our light, and when the sun sets we can have compassion for our darkness.

## Exercise One

### *Appreciating Yourself*

List ten things about yourself that you really like or appreciate. (These don't have to be qualities you display all of the time, just some of the time.) As you write down each quality, see if you can notice any uncomfortable feelings—embarrassment, fear of vanity, unfamiliarity? If discomfort comes up, remind yourself that you are

not claiming you're better than anyone else, or that you're perfect. You're simply noting the good qualities that you sometimes display. Everyone has good features. See if you can acknowledge and enjoy these positive aspects of yourself, lingering over them and really taking them in.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

## Self-Appreciation Versus Self-Esteem

On the surface, self-appreciation and self-esteem may appear to be quite similar. After all, they both involve an apparent focus on our good qualities, don't they? But though there are certainly many points of overlap between self-appreciation and self-esteem, there are also some important ways in which they differ. One key distinction centers on their acknowledgment of the common human experience. Self-esteem tends to be predicated on separation and comparison, on being *better* than others, and therefore special. Self-appreciation, in contrast, is based on connectedness, on seeing our similarities with others, recognizing that everyone has their strong points.

Another important distinction has to do with the tendency to *define* ourselves as either good or bad. Remember that self-esteem is a judgment of worthiness that operates at the level of representational self-concept. It involves labeling ourselves in an attempt to capture our unique essence (I am thin and wealthy, successful and beautiful, and so on). Self-esteem stems from *thoughts* about who we are, rather than simply *being* who we are. This is why it's so important to paint a positive self-portrait in order to have high

self-esteem. Our self-concept becomes confused with our *actual* self. Self-appreciation, on the other hand, is not a judgment or label, nor does it define us. It is a way of *relating* to what is good in us. It recognizes that we are an ever-changing process that can never fully be defined—whether positively or negatively. It does, however, acknowledge our moments of splendor.

There are always wonderful things to appreciate about ourselves, even if they don't make us unique. The fact that I can breathe, walk, eat, make love, hug a friend—these are all magnificent abilities that are definitely to be celebrated, despite the fact that just about everyone shares these abilities—despite the fact that they are beautifully *average*. It's usually only after people lose one of these gifts that they realize how wondrous they actually are. And when we can appreciate those aspects of ourselves that *are* unique, it can be done in the context of recognizing our complex, interconnected nature, not as a way of scoring points over our fellows.

With self-appreciation, we don't need to put others down to feel good about ourselves. I can appreciate my own achievements *at the same time* that I recognize yours. I can rejoice in your talents *while also* celebrating my own. Appreciation involves acknowledging the light in everyone, ourselves included.

## Appreciation for What's Good in Our Lives

Although I've mainly been discussing the importance of appreciating our personal qualities, appreciation can also be extended to our life circumstances in general. Self-appreciation embraces all that is good and wholesome, both internally and externally.

Because the same fears of vanity and egotism aren't generated when we acknowledge our favorable life conditions, we have fewer blocks to this form of self-appreciation. It's not nearly as challenging to appreciate what's good in our lives—our loving family, our supportive friends, our stable job—as it is to appreciate *ourselves*. Having said that, because of the habitual tendency of our minds to focus on the negative, we often take our good fortune for granted. We get so caught up in problem solving and coping with the pain of life that we give insufficient attention to that which gives us pleasure—and so suffer more than we need to. As research is beginning to demonstrate,

however, appreciation can radically transform our experience.

In her book *The How of Happiness*, researcher Sonia Lyubomirsky notes that positive life circumstances account for a surprisingly small slice of happiness—explaining only about 10 percent. Even after a grand event like winning the lottery, people tend to settle back to their previous levels of (un)happiness after only a couple of years. For this reason, many psychologists argue that we have a happiness “set point” that is largely genetic. This is only part of the story, however. Research also shows that people can boost their happiness levels significantly simply by changing the way they relate to their lives. In other words, it’s not so much *what* happens to you but your *attitude* toward what happens that matters. Lyubomirsky finds that several key factors make a difference in terms of maximizing happiness. Some of the most important are being grateful for what you have, looking at the bright side of difficult situations, not comparing yourself to others, practicing acts of kindness, being mindful, and savoring joy. All of these factors fall nicely within the larger concept of self-appreciation, but we’ll focus on two in particular: gratitude and savoring.

## Gratitude and Savoring

### GRATITUDE

Religion has long emphasized the value of gratitude in daily life, typically in the form of giving thanks in prayer. Consider this passage from the Bible’s book of Psalms. “Give thanks to Him who spread the earth above the water, who made the heavenly lights, who made the sun to rule by day and the moon and stars to rule by night. For His loving-kindness is ever-lasting” (Psalms 136: 5–9, American Standard Version). Prayers such as these focus attention on celebrating the beauty and wonder of creation. Gratitude pulses at the core of most religions and is considered an important gateway to spiritual fulfillment.

Robert Emmons, one of the foremost researchers on gratitude, has found strong support for the notion that gratitude leads directly to happiness. He defines gratitude as recognizing and acknowledging the gifts we are given, either by other people, God, or by life itself. Studies show that grateful individuals tend to feel more happy, hopeful, vital, and satisfied with their

lives, while being less materialistic and envious of others' success. Luckily, research also suggests that gratitude is something that can be learned.

In one study, for instance, researchers asked a group of undergraduate students to give weekly reports on their current life experience over a period of ten weeks. Students were randomly assigned to three different groups. Individuals in Group A had to write about things they felt grateful for (e.g., "the generosity of friends," "wonderful parents," "the Rolling Stones"). Group B students were asked to write about things they found annoying or irritating (e.g., "finding parking," "messy kitchen no one will clean," "stupid people driving"). Group C was a control group; students in this group were simply asked to write about anything that affected them that week, without specifying whether the impact was positive or negative (e.g., "cleaned out my shoe closet"). The researchers found that people in the gratitude group were not only happier than the others, they also reported fewer symptoms of illness and exercised more often than those in the other two conditions. It appears that gratitude changes both our emotional and physical experience for the better.

## Exercise Two

### *Keeping a Gratitude Journal*

Research suggests that keeping a daily gratitude journal is one of the best and most reliable ways to increase happiness. You may want to choose a special notebook for your journal, one that provides a sense of beauty and reverence. It doesn't really matter, however; there's no right way to do it. What's important is that you set aside a specified time to write about the gifts, kindnesses, pleasant surprises, and good moments of each day, as well as the things that give you joy in life more generally.

Make sure you continually try to find new things to be grateful for. Your friends, family, and loved ones will probably be regulars, but don't let the exercise become stale or repetitive. What gifts have you enjoyed that you perhaps took for granted the day before? Sunshine, the rule of law, indoor plumbing? The amazing things

that allow us to lead our incredibly leisure-filled lives are endless.

It also helps to be as specific as possible about what we're grateful for, to make it more real and concrete. For instance, instead of saying "I'm grateful for my cat" try "I'm grateful for the way my cat purrs and rubs up against my leg, making me feel loved."

After a relatively short time, keeping a gratitude journal can make a substantial contribution to your level of happiness. Yet another thing to be grateful for!

## SAVORING

The practice of savoring is closely related to gratitude. Savoring refers to the *conscious enjoyment* of that which gives us pleasure; that is, lingering over delightful experiences, swishing them around in our awareness like a glass of good wine. We often think of savoring in terms of a sensual experience: noticing the subtle taste and aroma of our food rather than merely wolfing it down. Smelling, tasting, and caressing our lover's skin rather than merely "doing the deed." But savoring can be applied to all enjoyable experiences—reveling in the lovely sound of a friend's laughter, the beauty of a fallen leaf, the satisfying depth and complexity of a well-written novel.

When we savor an experience, we hold it in mindful awareness, paying conscious attention to the pleasant thoughts, sensations, and emotions arising in the present moment. We can also savor delightful memories, so that we relive joyous experiences and appreciate them all over again—like the day we met our life partner, or first held our newborn child, or took that romantic trip to Prague. Savoring is an intentional act designed to prolong and deepen pleasure, luxuriating in its beauty.

## Exercise Three

### *Savor the Moment*

Pick a food or drink that you find particularly tasty. It could be a piece of dark chocolate, a slice of hot pizza, lobster with butter, a cup of Earl Grey tea, a glass of fine champagne—whatever food or drink reliably gives you pleasure.

As you eat or drink the item, try to savor it as much as possible. Notice all your senses. How does it taste? What subtle flavors are there? Sweet, bitter, salty? How does it smell? What aromas can you detect? How does it feel as you hold it, chew it, swallow it? What textures does it have? How does it look? Does it have interesting colors, or does it catch the light in a particular way? How does it sound? (Okay, this one might be easier if you chose the champagne, but you might notice a satisfying crunch or sizzle . . .) Slow down and fully dive into all the pleasurable sensations of your delicious treat, savoring each sensation fully.

Next, notice how it feels to experience pleasure itself. Do you feel little bubbles of happiness in your throat, a warm feeling in your chest, tingling in your nose? Enjoy the sensation of pleasure as long as possible, and when it fades, let it go. Then take a moment to give thanks and appreciation to one of the great gifts of life—food and drink!

Psychologists have begun to examine the effect of savoring on well-being. Studies indicate that people who are able to savor the pleasant aspects of their lives are happier and less depressed than those who don't. In one study, for instance, people were asked to take a twenty-minute walk once a day for a week. Participants were randomly assigned to one of three conditions. One condition involved a “positive focus” group in which people were instructed to consciously acknowledge as many pleasant things as possible—flowers, sunshine, and so on—and think about what made these things enjoyable. (The pleasure-walk exercise in chapter 12 was inspired by this study.) Another condition involved a “negative focus” group that was instructed to notice as many unpleasant things as possible—trash, traffic noise, and so on—and think about what made these things so disagreeable. The third condition was a control group that was simply told to “go for a walk” with no specific instructions. The people who were asked to savor their positive experiences were significantly happier after the walk compared with the other groups. In follow-up interviews, they also said that they felt a greater sense of appreciation for the world around them.

By simply taking the time to notice and savor the everyday things that give us pleasure, we can dramatically intensify our experience of joy.

## The Gift That Keeps on Giving

Self-appreciation allows us to revel in what's positive about ourselves and our lives. And the amazing thing is that nothing special or out of the ordinary has to happen in order to tap into this wellspring of good feeling. Good feeling can be refreshingly, wonderfully average. You don't need to have something new occur in order to stop and smell the roses. You just need to pay attention to what's in front of your nose. Rather than wandering around in problem-solving mode all day, thinking mainly of what you want to fix about yourself or your life, you can pause for a few moments throughout the day to marvel at *what's not broken*.

You can feel how amazing it is to have a body pulsing with life right now as you read these words. You can consider the wondrous fact that by looking at a few squiggles on a page, you are able to receive and retain the transmission of ideas. Even though you and I have never met, our minds can communicate, all through the sheer power of the written word. Remarkable! You can feel the soft coolness of your breath as it enters and exits your nostrils, fully appreciating the usually-taken-for-granted process that makes your life possible. The wonder of normal day-to-day existence far surpasses our ability to take it all in, but by appreciating it even just a little, we're capable of increasing our happiness to a truly extraordinary degree. As noted by the French writer de la Rochefoucauld, "Happiness does not consist in things themselves but in the relish we have of them."

Self-appreciation is a gift that's there for the taking. All people have aspects of themselves and their lives that are worthy of being appreciated. The good and beautiful is all around us. And within us. Splendor is a human quality and belongs to us all.

## Conclusion

Self-appreciation and self-compassion are really two sides of the same coin. One is focused on what brings us pleasure, the other on what brings us suffering. One celebrates our strengths as humans, the other accepts our weaknesses. What really matters is that our hearts and minds are open. Rather than continually evaluating, comparing, resisting, obsessing, and distorting—

we simply open. Open to seeing ourselves and our lives exactly as they are, in all their glory and ignominy. Open to the love of all creation, ourselves included, without exception.

As we walk through the triumphs and tragedies of our lives, we relate to everything with kindness. We feel our interconnectedness with everyone and everything. We become aware of the present moment without judgment. We experience the full spectrum of life without needing to change it.

We don't need to be perfect to feel good about ourselves, and our lives don't need to be any certain way for us to be content. Every one of us has the capacity for resilience, growth, and happiness, simply by relating to our ever-arising experience with both compassion and appreciation. And if you feel you can't change, that it's too hard, that the countervailing forces of our culture are too strong, then have compassion for that feeling and start from there. Each new moment presents an opportunity for a radically different way of being. We can embrace both the joy and the sorrow of being human, and by doing so we can transform our lives.

## NOTES

The pagination of this electronic edition does not match the edition from which it was made. To locate a specific passage, please use the search feature on your e-book reader.

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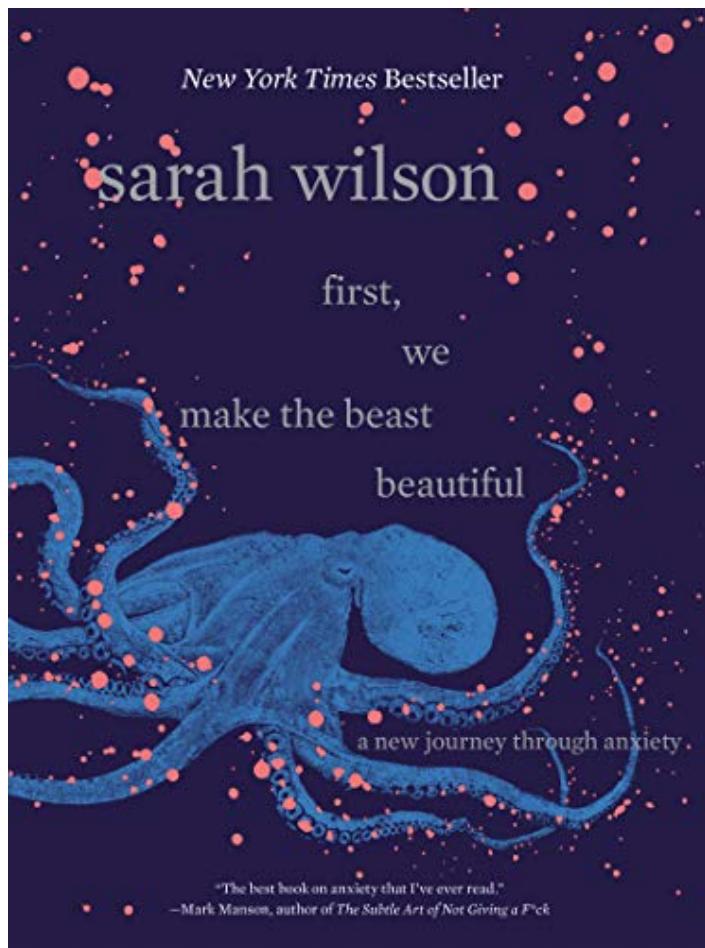
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# feeling good

the new  
mood therapy

THE CLINICALLY PROVEN DRUG-FREE  
TREATMENT FOR DEPRESSION

feeling  
good  
the new  
mood therapy

DAVID D. BURNS, M.D.

Preface by Aaron T. Beck, M.D.

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## **Dedication**

*This book is dedicated to Aaron T. Beck, M.D., in admiration of his knowledge and courage and in appreciation of his patience, dedication and empathy.*

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## Preface

I am pleased that David Burns is making available to the general public an approach to mood modification which has stimulated much interest and excitement among mental health professionals. Dr. Burns has condensed years of research conducted at the University of Pennsylvania on the causes and treatments of depression, and lucidly presents the essential self-help component of the specialized treatment that has derived from that research. The book is an important contribution to those who wish to give themselves a “top flight” education in understanding and mastering their moods.

A few words about the evolution of cognitive therapy may interest readers of *Feeling Good: The New Mood Therapy*. Soon after I began my professional career as an enthusiastic student and practitioner of traditional psychoanalytic psychiatry, I began to investigate the empirical support for the Freudian theory and therapy of depression. While such support proved elusive, the data I obtained in my quest suggested a new, testable theory about the causes of emotional disturbances. The research seemed to reveal that the depressed individual sees himself as a “loser,” as an inadequate person doomed to frustration, deprivation, humiliation, and failure. Further experiments showed a marked difference between the depressed person’s self-evaluation, expectations, the aspirations on the one hand and his actual achievements—often very striking—on the other. My conclusion was that depression must involve a disturbance in thinking: the depressed person thinks in idiosyncratic and negative ways about himself, his environment, and his future. The pessimistic mental set affects his mood, his motivation, and his relationships with others, and leads to the full spectrum of psychological and physical symptoms typical of depression.

We now have a large body of research data and clinical experience which suggests that people can learn to control painful mood swings and self-defeating behavior through the application of a few relatively simple principles and techniques. The promising results of this investigation have triggered interest in cognitive theory among psychiatrists, psychologists,

and other mental health professionals. Many writers have viewed our findings as a major development in the scientific study of psychotherapy and personal change. The developing theory of the emotional disorders that underlies this research has become the subject of intensive investigations at academic centers around the world.

Dr. Burns clearly describes this advance in our understanding of depression. He presents, in simple language, innovative and effective methods for altering painful depressed moods and reducing debilitating anxiety. I expect that readers of this book will be able to apply to their own problems the principles and techniques evolved in our work with patients. While those individuals with more severe emotional disturbances will need the help of a mental health professional, individuals with more manageable problems can benefit by using the newly developed "common sense" coping skills which Dr. Burns delineates. Thus *Feeling Good* should prove to be an immensely useful step-by-step guide for people who wish to help themselves.

Finally, this book reflects the unique personal flair of its author, whose enthusiasm and creative energy have been his particular gifts to his patients and to his colleagues.

Aaron T. Beck, M.D.  
*Professor of Psychiatry,*  
*University of Pennsylvania*  
*School of Medicine*

## **Introduction (Revised Edition, 1999)**

I have been amazed by the interest in cognitive behavioral therapy that has developed since *Feeling Good* was first published in 1980. At that time, very few people had heard of cognitive therapy. Since that time, cognitive therapy has caught on in a big way among mental health professionals and the general public as well. In fact, cognitive therapy has become one of the most widely practiced and most intensely researched forms of psychotherapy in the world.

Why such interest in this particular brand of psychotherapy? There are at least three reasons. First, the basic ideas are very down-to-earth and intuitively appealing. Second, many research studies have confirmed that cognitive therapy can be very helpful for individuals suffering depression and anxiety and a number of other common problems as well. In fact, cognitive therapy appears to be at least as helpful as the best antidepressant medications (such as Prozac). And third, many successful self-help books, including my own *Feeling Good*, have created a strong popular demand for cognitive therapy in the United States and throughout the world as well.

Before I explain some of the exciting new developments, let me briefly explain what cognitive therapy is. A cognition is a thought or perception. In other words, your cognitions are the way you are thinking about things at any moment, including this very moment. These thoughts scroll across your mind automatically and often have a huge impact on how you feel.

For example, right now you are probably having some thoughts and feelings about this book. If you picked this book up because you have been feeling depressed and discouraged, you may be thinking about things in a negative, self-critical way: "I'm such a loser. What's wrong with me? I'll never get better. A stupid self-help book like this couldn't possibly help me. I don't have any problem with my *thoughts*. My problems are *real*." If you are feeling angry or annoyed you may be thinking: "This guy Burns is just a con artist and he's just trying to get rich. He probably doesn't even know what he's talking about." And if you are feeling optimistic and interested

you may be thinking: “Hey, this is interesting. I may learn something really exciting and helpful.” In each case, your thoughts create your feelings.

This example illustrates the powerful principle at the heart of cognitive therapy—your feelings result from the messages you give yourself. In fact, your thoughts often have much more to do with how you feel than what is actually happening in your life.

This isn’t a new idea. Nearly two thousand years ago the Greek philosopher, Epictetus, stated that people are disturbed “not by things, but by the views we take of them.” In the Book of Proverbs (23: 7) in the Old Testament you can find this passage: “For as he thinks within himself, so he is.” And even Shakespeare expressed a similar idea when he said: “for there is nothing either good or bad, but thinking makes it so” (*Hamlet*, Act 2, Scene 2).

Although the idea has been around for ages, most depressed people do not really comprehend it. If you feel depressed, you may think it is because of bad things that have happened to you. You may think you are inferior and destined to be unhappy because you failed in your work or were rejected by someone you loved. You may think your feelings of inadequacy result from some personal defect—you may feel convinced you are not smart enough, successful enough, attractive enough, or talented enough to feel happy and fulfilled. You may think your negative feelings are the result of an unloving or traumatic childhood, or bad genes you inherited, or a chemical or hormonal imbalance of some type. Or you may blame others when you get upset: “It’s these lousy stupid drivers that tick me off when I drive to work! If it weren’t for these jerks, I’d be having a perfect day!” And nearly all depressed people are convinced that they are facing some special, awful truth about themselves and the world and that their terrible feelings are absolutely realistic and inevitable.

Certainly all these ideas contain an important germ of truth—bad things do happen, and life beats up on most of us at times. Many people do experience catastrophic losses and confront devastating personal problems. Our genes, hormones, and childhood experiences probably do have an impact on how we think and feel. And other people can be annoying, cruel, or thoughtless. But all these theories about the causes of our bad moods have the tendency to make us victims—because we think the causes result from something beyond our control. After all, there is little we can do to

change the way people drive at rush hour, or the way we were treated when we were young, or our genes or body chemistry (save taking a pill). In contrast, you can learn to change the way you think about things, and you can also change your basic values and beliefs. And when you do, you will often experience profound and lasting changes in your mood, outlook, and productivity. That, in a nutshell, is what cognitive therapy is all about.

The theory is straightforward and may even seem overly simple—but don't write it off as pop psychology. I think you will discover that cognitive therapy can be surprisingly helpful—even if you feel pretty skeptical (as I did) when you first learn about it. I have personally conducted more than thirty thousand cognitive therapy sessions with hundreds of depressed and anxious individuals, and I am always surprised about how helpful and powerful this method can be.

The effectiveness of cognitive therapy has been confirmed by many outcome studies by researchers throughout the world during the past two decades. In a recent landmark article entitled “Psychotherapy vs. Medication for Depression: Challenging the Conventional Wisdom with Data,” Drs. David O. Antonuccio and William G. Danton from the University of Nevada and Dr. Gurland Y. DeNelsky from the Cleveland Clinic reviewed many of the most carefully conducted studies on depression that have been published in scientific journals throughout the world.<sup>1</sup> The studies reviewed compared the antidepressant medications with psychotherapy in the treatment of depression and anxiety. Short-term studies as well as long-term follow-up studies were included in this review. The authors came to a number of startling conclusions that are at odds with the conventional wisdom:

- Although depression is conventionally viewed as a medical illness, research studies indicate that genetic influences appear to account for only about 16 percent of depression. For many individuals, life influences appear to be the most important causes.
- Drugs are the most common treatment for depression in the United States, and there is a widespread belief, popularized by the media, that drugs are the most effective treatment. However, this opinion is not consistent with the results of many carefully conducted outcome studies during the past twenty years. These studies show that the newer

forms of psychotherapy, especially cognitive therapy, can be at least as effective as drugs, and for many patients appear to be more effective. This is good news for individuals who prefer to be treated without medications—due to personal preferences or health concerns. It is also good news for the millions of individuals who have not responded adequately to antidepressants after years and years of treatment and who still struggle with depression and anxiety.

- Following recovery from depression, patients treated with psychotherapy are more likely to remain undepressed and are significantly less likely to relapse than patients treated with antidepressants alone. This is especially important because of the growing awareness that many people relapse following recovery from depression, especially if they are treated with antidepressant medications alone without any talking therapy.

Based on these findings, Dr. Antonuccio and his coauthors concluded that psychotherapy should not be considered a second-rate treatment but should usually be the initial treatment for depression. In addition, they emphasized that cognitive therapy appears to be one of the most effective psychotherapies for depression, if not the most effective.

Of course, medications can be helpful for some individuals—even life-saving. Medications can be combined with psychotherapy for maximum effect as well, especially when the depression is severe. It is extremely important to know that we have powerful new weapons to fight depression, and that drug-free treatments such as cognitive therapy can be highly effective.

Recent studies indicate that psychotherapy can be helpful not only for mild depressions, but also for severe depressions as well. These findings are at odds with the popular belief that “talking therapy” can only help people with mild problems, and that if you have a serious depression you need to be treated with drugs.

Although we are taught that depression may result from an imbalance in brain chemistry, recent studies indicate that cognitive behavioral therapy may actually change brain chemistry. In these studies, Drs. Lewis R. Baxter, Jr., Jeffrey M. Schwartz, Kenneth S. Bergman, and their colleagues at UCLA School of Medicine,” used positron emission tomography (PET

scanning) to evaluate changes in brain metabolism in two groups of patients before and after treatment.<sup>2</sup> One group received cognitive behavioral therapy and no drugs, and the other group received an antidepressant medication and no psychotherapy.

As one might expect, there were changes in brain chemistry in the patients in the drug therapy group who improved. These changes indicated that their brain metabolism had slowed down—in other words, the nerves in a certain region of the brain appeared to become more “relaxed.” What came as quite a surprise was there were similar changes in the brains of the patients successfully treated with cognitive behavioral therapy. However, these patients received no medications. Further, there were *no significant differences* in the brain changes in the drug therapy and psychotherapy groups, or in the effectiveness of the two treatments. Because of these and other similar studies, investigators are starting for the first time to entertain the possibility that cognitive behavior therapy—the methods described in this book—may actually help people by changing the chemistry and architecture of the human brain!

Although no one treatment will ever be a panacea, research studies indicate that cognitive therapy can be helpful for a variety of disorders in addition to depression. For example, in several studies patients with panic attacks have responded so well to cognitive therapy without any medications that many experts now consider cognitive therapy alone to be the best treatment for this disorder. Cognitive therapy can also be helpful in many other forms of anxiety (such as chronic worrying, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder), and is also being used with some success in the personality disorders, such as borderline personality disorder.

Cognitive therapy is gaining popularity in the treatment of many other disorders as well. At the 1998 Stanford Psychopharmacology Conference, I was intrigued by the presentation by a colleague from Stanford, Dr. Stuart Agras. Dr. Agras is a renowned expert in eating disorders such as binge eating, anorexia nervosa, and bulimia. He presented the results of numerous recent studies on the treatment of eating disorders with antidepressant medications versus psychotherapy. These studies indicated that cognitive

behavior therapy is the most effective treatment for eating disorders—better than any known drug or any other form of psychotherapy.\*

We are also beginning to learn more about *how* cognitive therapy works. One important discovery is that self-help seems to be a key to recovery whether or not you receive treatment. In a series of five remarkable studies published in the prestigious *Journal of Consulting and Clinical Psychology* and in *The Gerontologist*, Dr. Forest Scogin and his colleagues at the University of Alabama studied the effects of simply reading a good self-help book like *Feeling Good*—without any other therapy. The name of this new type of treatment is “bibliotherapy” (reading therapy). They discovered that *Feeling Good* bibliotherapy may be as effective as a full course of psychotherapy or treatment with the best antidepressant drugs.<sup>3-7</sup> Given the tremendous pressures to cut health care costs, this is of considerable interest, since a paperback copy of the *Feeling Good* book costs less than two Prozac pills—and is presumably free of any troublesome side effects!

In a recent study, Dr. Scogin and his colleague, Dr. Christine Jamison, randomly assigned eighty individuals seeking treatment for a major depressive episode to one of two groups. The researchers gave the patients in the first group a copy of my *Feeling Good* and encouraged them to read it within four weeks. This group was called the Immediate Bibliotherapy Group. These patients also received a booklet containing blank copies of the self-help forms in the book in case they decided to do some of the suggested exercises in the book.

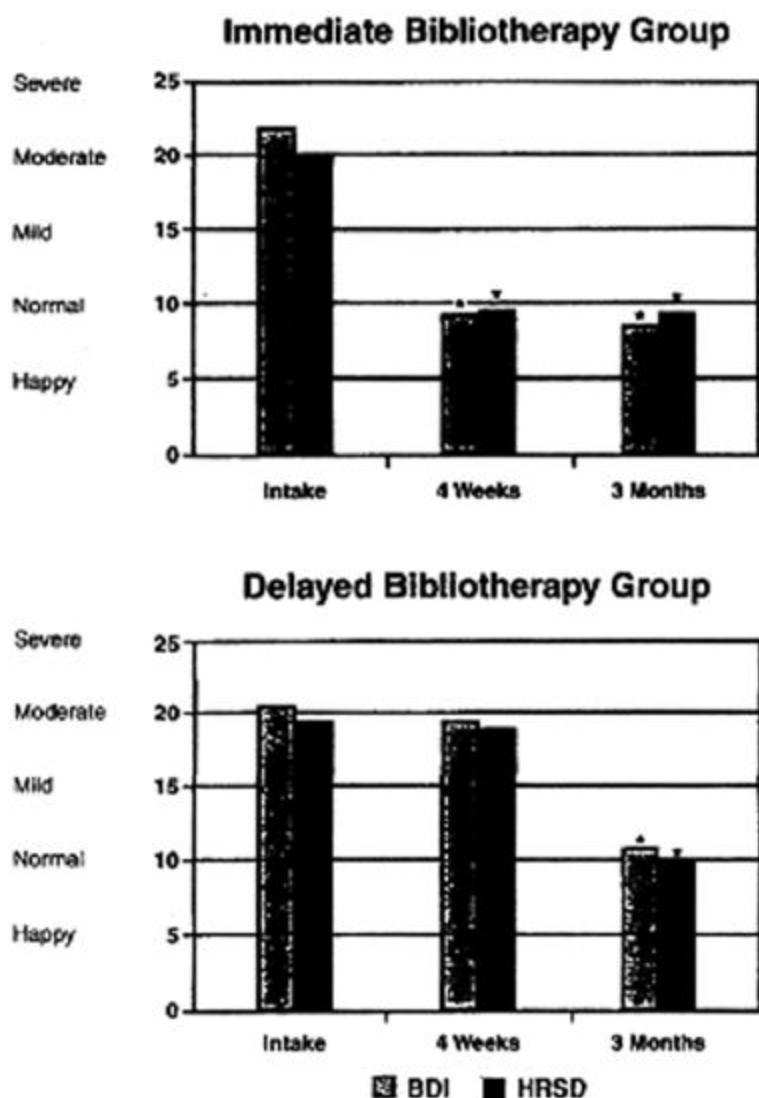
Patients in the second group were told they would be placed on a four-week waiting list before beginning treatment. This group was called the Delayed Bibliotherapy Group because these patients were not given a copy of *Feeling Good* until the second four weeks of the study. The patients in the Delayed Bibliotherapy Group served as a control group to make sure that any improvement in the Immediate Bibliotherapy was not just due to the passage of time.

At the initial evaluation, the researchers administered two depression tests to all the patients. One was the Beck Depression Inventory (BDI), a time-honored self-assessment test that patients fill out on their own, and the second was the Hamilton Rating Scale for Depression (HRSD), which is administered by trained depression researchers. As you can see in Figure 1,

there was no difference in the depression levels in the two groups at the initial evaluation. You can also see that the average scores for the patients in the Immediate Bibliotherapy Group and the Delayed Bibliotherapy group at the initial evaluation were both around 20 or above on the BDI and on the HRSD. These scores indicate that the depression levels in both groups were similar to the depression levels in most published studies of antidepressants or psychotherapy. In fact, the BDI score was nearly identical to the average BDI scores of approximately five hundred patients seeking treatment at my clinic in Philadelphia during the late 1980s.

Every week a research assistant called the patients in both groups and administered the BDI by telephone. The assistant also answered any questions patients had about the study and encouraged the patients in the Immediate Bibliotherapy Group to try to complete the book within four weeks. These calls were limited to ten minutes and no counseling was offered.

At the end of the four weeks, the two groups were compared. You can see in Figure 1 that the patients in the Immediate Bibliotherapy Group improved considerably. In fact, the average scores on both the BDI and HRSD were around 10 or below, scores in the range considered normal.



**Figure 1.** The patients in the Immediate Bibliotherapy Group (top Chart) received *Feeling Good* at the intake evaluation. The patients in the Delayed Bibliotherapy Group (bottom chart) received *Feeling Good* at the four-week evaluation. BDI=Beck Depression Inventory. HRSD=Hamilton Rating Scale for Depression.

These changes in depression were very significant. You can also see that the patients maintained their gains at the three-month evaluation and did not relapse. In fact, there was a tendency for continued improvement following the completion of the bibliotherapy treatment; the scores on both depression tests were actually lower at the three-month evaluation.

In contrast, you can see in Figure 1 that the patients in the Delayed Bibliotherapy Group barely changed and were still around 20 at the four-week evaluation. This showed that the improvement from *Feeling Good* was not just due to the passage of time. Then Drs. Jamison and Scogin gave the patients in the Delayed Bibliotherapy Group a copy of *Feeling Good* and asked them to read it during the second four weeks of the study. Their improvement in the next four weeks was similar to the improvement in the Immediate Bibliotherapy Group during the first four weeks of the study. You can also see in Figure 1 that the patients in both groups did not relapse but maintained their gains at the three-month evaluation.

The results of this study indicated that *Feeling Good* appeared to have substantial antidepressant effects. At the end of the first four-week Bibliotherapy period, 70 percent of the patients in the Immediate Bibliotherapy Group no longer met the criteria for a major depressive episode, according to the diagnostic criteria for a major depressive episode that are outlined in the American Psychiatric Association's official *Diagnostic and Statistical Manual (DSM)*. In fact, the improvement was so great most of these patients did not need any further treatment at the medical center. To the best of my knowledge, these are the first published scientific studies showing that a self-help book can actually have significant antidepressant effects in patients suffering from episodes of major depression.

In contrast, only 3 percent of the patients in the Delayed Bibliotherapy Group recovered during the first four weeks. In other words, the patients who did not read *Feeling Good* failed to improve. However, at the three-month evaluation, when both groups had read *Feeling Good*, 75 percent of the patients in the Immediate Bibliotherapy Group and 73 percent of the patients in the Delayed Bibliotherapy Group no longer qualified for a diagnosis of major depressive episode according to DSM criteria.

The researchers compared the magnitude of the improvement in these groups with the amount of improvement in published outcome studies using antidepressant medications or psychotherapy or both. In the large National Institute of Mental Health Collaborative Depression study, there was an average reduction of 11.6 points on the HRSD in patients who received cognitive therapy from highly trained therapists for twelve weeks. This was very similar to the 10.6-point change in the HRSD observed in the patients

who read *Feeling Good* after just four weeks. However, the bibliotherapy treatment seemed to work significantly faster. My own clinical experience confirms this. In my private practice, very few patients have recovered during the first four weeks of treatment.

The percentage of patients who dropped out of the bibliotherapy therapy was also very small, around 10 percent. This is less than most published outcome studies using drugs or psychotherapy, which typically have dropout rates from 15 percent to over 50 percent. Finally, the patients developed significantly more positive attitudes and thinking patterns after reading *Feeling Good*. This was consistent with the premise of the book; namely, that you can defeat depression by changing the negative thinking patterns that cause it.

The researchers concluded that the bibliotherapy was effective for patients suffering from depression and might also have a significant role in public education and in depression prevention programs. They speculated that *Feeling Good* bibliotherapy might help prevent serious episodes of depression among individuals with a tendency toward negative thinking.

Finally, the researchers addressed another important concern: would the antidepressant effects of *Feeling Good* last? Skillful motivational speakers can get a crowd of people excited and optimistic for brief periods of time—but these brief mood-elevating effects often don't last. The same problem holds for the treatment of depression. Following successful treatment with drugs or psychotherapy, many patients feel tremendously improved—only to relapse back into depression after a period of time. These relapses can be devastating because patients feel so demoralized.

In 1997, the investigators reported the results of a three-year follow-up of the patients in the study I've just described.<sup>7</sup> The authors were Drs. Nancy Smith, Mark Floyd, and Forest Scogin from the University of Alabama and Dr. Christine Jamison from the Tuskegee Veterans Affairs Medical Center. The researchers contacted the patients three years after reading *Feeling Good* and administered the depression tests once again. They also asked the patients several questions about how they had been doing since the completion of the study. The researchers learned that the patients did not relapse but maintained their gains during this three-year period. In fact, the scores on the two depression tests at the three-year evaluation were actually

slightly better than the scores at the completion of the bibliotherapy treatment. More than half of the patients said that their moods continued to improve following the completion of the initial study.

The diagnostic findings at the three-year evaluation confirmed this—72 percent of the patients still did not meet the criteria for a major depressive episode, and 70 percent did not seek or receive any further treatment with medications or psychotherapy during the follow-up period. Although they experienced the normal ups and downs we all feel from time to time, approximately half indicated that when they were upset, they opened up *Feeling Good* and reread the most helpful sections. The researchers speculated that these self-administered “booster sessions” may have been important in maintaining a positive outlook following recovery. Forty percent of the patients said that the best part of the book was that it helped them change their negative thinking patterns, such as learning to be less perfectionistic and to give up all-or-nothing thinking.

Of course, this study had limitations, like all studies. For one thing, not every patient was “cured” by reading *Feeling Good*. No treatment is a panacea. While it is encouraging that many patients seem to respond to reading *Feeling Good*, it is also clear that some patients with more severe or chronic depressions will need the help of a therapist and possibly an antidepressant medication as well. This is nothing to be ashamed of. Different individuals respond better to different approaches. It is good that we now have three types of effective treatment for depression: antidepressant medications, individual and group psychotherapy, and bibliotherapy.

Remember that you can use the cognitive bibliotherapy between therapy sessions to speed your recovery even if you are in treatment. In fact, when I first wrote *Feeling Good*, this is how I imagined the book would be used. I intended it to be a tool my patients could use between therapy sessions to speed up the treatment and never dreamed that it might someday be used alone as a treatment for depression.

It appears that more and more therapists are beginning to assign bibliotherapy to their patients as psychotherapy “homework” between therapy sessions. In 1994, the results of a nationwide survey about the use of bibliotherapy by mental health professionals were published in the *Authoritative Guide to Self-Help Books* (published by Guilford Press, New

York). Drs. John W. Santrock and Ann M. Minnet from the University of Texas in Dallas and Barbara D. Campbell, a research associate at the university, conducted this study. These three researchers surveyed five hundred American mental health professionals from all fifty states and asked whether they “prescribed” books for patients to read between sessions to speed recovery. Seventy percent of the therapists polled indicated that they had recommended at least three self-help books to their patients during the previous year, and 86 percent reported that these books provided a positive benefit to their patients. The therapists were also asked which self-help books, from a list of one thousand, they most frequently recommended for their patients. *Feeling Good* was the number-one-rated book for depressed patients, and my *Feeling Good Handbook* (published as a Plume paperback in 1989) was rated number two.

I was not aware this survey was being conducted, and was thrilled to learn about the results of it. One of my goals when I wrote *Feeling Good* was to provide reading for my own patients to speed their learning and recovery between therapy sessions, but I never dreamed this idea would catch on in such a big way!

Should you expect to improve or recover after reading *Feeling Good*? That would be unreasonable. The research clearly indicates that while many people who read *Feeling Good* improved, others needed the additional help of a mental health professional. I have received many letters (probably more than ten thousand) from people who read *Feeling Good*. Many of them kindly described in glowing terms how *Feeling Good* had helped them, often after years and years of unsuccessful treatment with medications and even electroconvulsive therapy. Others indicated that they found the ideas in *Feeling Good* appealing but needed a referral to a good local therapist to make these ideas work for them. This is understandable—we are all different, and it would be unrealistic to think that any one book or form of therapy would be the answer for everyone.

Depression is one of the worst forms of suffering, because of the immense feelings of shame, worthlessness, hopelessness, and demoralization. Depression can seem worse than terminal cancer, because most cancer patients feel loved and they have hope and self-esteem. Many depressed patients have told me, in fact, that they yearned for death and

prayed every night that they would get cancer, so they could die in dignity without having to commit suicide.

But no matter how terrible your depression and anxiety may feel, the prognosis for recovery is excellent. You may be convinced that your own case is so bad, so over-whelming and hopeless, that you are the one person who will never get well, no matter what. But sooner or later, the clouds have a way of blowing away and the sky suddenly clears and the sun begins to shine again. When this happens, the feelings of relief and joy can be overwhelming. And if you are now struggling with depression and low self-esteem, I believe this transformation can happen for you as well, no matter how discouraged or depressed you may feel.

Well, it's time to get on to Chapter 1 so we can start to work together. I want to wish you the very best as you read it, and hope you find these ideas and methods helpful!

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Part I

**Theory and Research**

## Chapter 1

### A Breakthrough in the Treatment of Mood Disorders

Depression has been called the world's number one public health problem. In fact, depression is so widespread it is considered the common cold of psychiatric disturbances. But there is a grim difference between depression and a cold. Depression can kill you. The suicide rate, studies indicate, has been on a shocking increase in recent years, even among children and adolescents. This escalating death rate has occurred in spite of the billions of antidepressant drugs and tranquilizers that have been dispensed during the past several decades.

This might sound fairly gloomy. Before you get even *more* depressed, let me tell you the good news. Depression is an illness and not a necessary part of healthy living. What's more important—you *can* overcome it by learning some simple methods for mood elevation. A group of psychiatrists and psychologists at the University of Pennsylvania School of Medicine has reported a significant breakthrough in the treatment and prevention of mood disorders. Dissatisfied with traditional methods for treating depression because they found them to be slow and ineffective, these doctors developed and systematically tested an entirely new and remarkably successful approach to depression and other emotional disorders. A series of recent studies confirms that these techniques reduce the symptoms of depression much more rapidly than conventional psychotherapy or drug therapy. The name of this revolutionary treatment is “cognitive therapy.”

I have been centrally involved in the development of cognitive therapy, and this book is the first to describe these methods to the general public. The systematic application and scientific evaluation of this approach in treating clinical depression traces its origins to the innovative work of Drs. Albert Ellis and Aaron T. Beck, who began to refine their unique approach to mood transformation in the mid-1950's and early 1960's.\* Their

pioneering efforts began to emerge into prominence in the past decade because of the research that many mental-health professionals have undertaken to refine and evaluate cognitive therapy methods at academic institutions in the United States and abroad.

Cognitive therapy is a fast-acting technology of mood modification that you can learn to apply on your own. It can help you eliminate the symptoms and experience personal growth so you can minimize future upsets and cope with depression more effectively in the future.

The simple, effective mood-control techniques of cognitive therapy provide:

1. *Rapid Symptomatic Improvement.* In milder depressions, relief from your symptoms can often be observed in as short a time as twelve weeks.
2. *Understanding:* A clear explanation of why you get moody and what you can do to change your moods. You will learn what causes your powerful feelings; how to distinguish “normal” from “abnormal” emotions; and how to diagnose and assess the severity of your upsets.
3. *Self-control:* You will learn how to apply safe and effective coping strategies that will make you feel better whenever you are upset. I will guide you as you develop a practical, realistic, step-by-step self-help plan. As you apply it, your moods can come under greater voluntary control.
4. *Prevention and Personal Growth:* Genuine and long-lasting prophylaxis (prevention) of future mood swings can effectively be based on a reassessment of some basic values and attitudes which lie at the core of your tendency toward painful depressions. I will show you how to challenge and reevaluate certain assumptions about the basis for human worth.

The problem-solving and coping techniques you learn will encompass every crisis in modern life, from minor irritations to major emotional collapse. These will include realistic problems, such as divorce, death, or failure, as well as those vague, chronic problems that seem to have no obvious external cause, such as low self-confidence, frustration, guilt, or apathy.

The question may now occur to you, “Is this just another self-help pop psychology?” Actually, cognitive therapy is one of the first forms of psychotherapy which has been shown to be effective through rigorous scientific research under the critical scrutiny of the academic community. This therapy is unique in having professional evaluation and validation at the highest academic levels. It is *not* just another self-help fad but a major development that has become an important part of the mainstream of modern psychiatric research and practice. Cognitive therapy’s academic foundation has enhanced its impact and should give it staying power for years to come. But don’t be turned off by the professional status that cognitive therapy has acquired. Unlike much traditional psychotherapy, it is not occult and anti-intuitive. It is practical and based on common sense, and you can make it work for you.

The first principle of cognitive therapy is that *all* your moods are created by your “cognitions,” or thoughts. A cognition refers to the way you look at things—your perceptions, mental attitudes, and beliefs. It includes the way you interpret things—what you say about something or someone to yourself. You *feel* the way you do right now because of the *thoughts you are thinking at this moment*.

Let me illustrate this. How have you been feeling as you read this? You might have been thinking, “Cognitive therapy sounds too good to be true. It would never work for me.” If your thoughts run along these lines, you are feeling skeptical or even discouraged. What causes you to feel that way? Your *thoughts*. You create those feelings by the dialogue you are having with yourself about this book!

Conversely, you may have felt a sudden uplift in mood because you thought, “Hey, this sounds like something which might finally help me.” Your emotional reaction is generated *not* by the sentences you are reading but by the way you are *thinking*. The moment you have a certain thought and believe it, you will experience an immediate emotional response. Your thought actually *creates* the emotion.

The second principle is that when you are feeling depressed, your thoughts are dominated by a pervasive negativity. You perceive not only yourself but the entire world in dark, gloomy terms. What is even worse—you’ll come to believe things *really are* as bad as you imagine them to be.

If you are substantially depressed, you will even begin to believe that things always have been and always will be negative. As you look into your past, you remember all the bad things that have happened to you. As you try to imagine the future, you see only emptiness or unending problems and anguish. This bleak vision creates a sense of hopelessness. This feeling is absolutely illogical, but it seems so real that you have convinced yourself that your inadequacy will go on forever.

The third principle is of substantial philosophical and therapeutic importance. Our research has documented that the negative thoughts which cause your emotional turmoil nearly *always* contain gross distortions. Although these thoughts appear valid, you will learn that they are irrational or just plain wrong, and that twisted thinking is a major *cause* of your suffering.

The implications are important. Your depression is probably not based on accurate perceptions of reality but is often the product of mental slippage.

Suppose you believe that what I've said has validity. What good will it do you? Now we come to the most important result of our clinical research. You can learn to deal with your moods more effectively if you master methods that will help you pinpoint and eliminate the mental distortions which cause you to feel upset. As you begin to think more objectively, you will begin to feel better.

How effective is cognitive therapy compared with other established and accepted methods for treating depression? Can the new therapy enable severely depressed individuals to get better without drugs? How rapidly does cognitive therapy work? Do the results last?

Several years ago a group of investigators at the Center for Cognitive Therapy at the University of Pennsylvania School of Medicine including Drs. John Rush, Aaron Beck, Maria Kovacs and Steve Hollon began a pilot study comparing cognitive therapy with one of the most widely used and effective antidepressant drugs on the market, Tofranil (imipramine hydrochloride). Over forty severely depressed patients were randomly assigned to two groups. One group was to receive individual cognitive therapy sessions and no drugs, while the other group would be treated with Tofranil and no therapy. This either-or research design was chosen because it provided the maximum opportunity to see how the treatments compared. Up to that time, no form of psychotherapy had been shown to be as

effective for depression as treatment with an antidepressant drug. This is why antidepressants have experienced such a wave of interest from the media, and have come to be regarded by the professional community in the past two decades as the best treatment for most serious forms of depression.

Both groups of patients were treated for a twelve-week period. All patients were systematically evaluated with extensive psychological testing prior to therapy, as well as at several monthly intervals for one year after completion of treatment. The doctors who performed the psychological tests were not the therapists who administered the treatment. This ensured an objective assessment of the merits of each form of treatment.

The patients were suffering from moderate to severe depressive episodes. The majority had failed to improve in spite of previous treatment with two or more therapists at other clinics. Three quarters were suicidal at the time of their referral. The average patient had been troubled by chronic or intermittent depression for eight years. Many were absolutely convinced their problems were insoluble, and felt their lives were hopeless. Your own mood problems may not seem as overwhelming as theirs. A tough patient population was chosen so that the treatment could be tested under the most difficult, challenging conditions.

The outcome of the study was quite unexpected and encouraging. The cognitive therapy was at least as effective as, if not more effective than, the antidepressant drug therapy. As you can see (Table 1–1, page 15), fifteen of the nineteen patients treated with cognitive therapy had shown a substantial reduction of symptoms after twelve weeks of active treatment.\* An additional two individuals had improved, but were still experiencing borderline to mild depression. Only one patient had dropped out of treatment, and one had not yet begun to improve at the end of this period. In contrast, only five of the twenty-five patients assigned to antidepressant drug therapy had shown complete recovery by the end of the twelve-week period. Eight of these patients dropped out of therapy as a result of the adverse side effects of the medication, and twelve others showed no improvement or only partial improvement.

**Table 1–1.** Status of 44 Severely Depressed Patients, 12 Weeks After Beginning Treatment

<i>Number who Entered Treatment</i>	<i>Patients Treated with Cognitive Therapy Only</i>	<i>Patients Treated with Antidepressant Drug Therapy Only</i>
	19	25
Number who had recovered completely*	15	5
Number who were considerably improved but still experienced borderline to mild depression	2	7
Number who were not substantially improved	1	5
Number who dropped out of treatment	1	8

\*The superior improvement of the patients treated with cognitive therapy was statistically significant

Of particular importance was the discovery that many patients treated with cognitive therapy improved more rapidly than those successfully treated with drugs. Within the first week or two, there was a pronounced reduction in suicidal thoughts among the cognitive therapy group. The effectiveness of cognitive therapy should be encouraging for individuals who prefer not to rely on drugs to raise their spirits, but prefer to develop an understanding of what is troubling them and do something to cope with it.

How about those patients who had not recovered by the end of twelve weeks? Like any form of treatment, this one is not a panacea. Clinical experience has shown that all individuals do not respond as rapidly, but most can nevertheless improve if they persist for a longer period of time. Sometimes this is hard work! One particularly encouraging development for individuals with refractory severe depressions is a recent study by Drs. Ivy Blackburn and her associates at the Medical Research Council at the University of Edinburgh in Scotland.\* These investigators have shown that the combination of antidepressant drugs with cognitive therapy can be more effective than either modality above. In my experience the most crucial

predictor of recovery is a persistent willingness to exert some effort to help yourself. Given this attitude, you will succeed.

Just how much improvement can you hope for? The average cognitively treated patient experienced a substantial elimination of symptoms by the end of treatment. Many reported they felt the happiest they had ever felt in their lives. They emphasized that the mood-training brought about a sense of self-esteem and confidence. No matter how miserable, depressed, and pessimistic you now feel, I am convinced that you can experience beneficial effects if you are willing to apply the methods described in this book with persistence and consistency.

How long do the effects last? The findings from follow-up studies during the year after completion of treatment are quite interesting. While many individuals from both groups had occasional mood swings at various times during the year, both groups continued on the whole to maintain the gains they had demonstrated by the end of twelve weeks of active treatment.

Which group actually fared better during the follow-up period? The psychological tests, as well as the patients' own reports, confirmed that the cognitive therapy group continued to feel substantially better, and these differences were statistically significant. The relapse rate over the course of the year in the cognitive therapy group was less than half that observed in me drug patients. These were sizable differences that favored the patients treated with the new approach.

Does this mean that I can guarantee you will never again have the blues after using cognitive methods to eliminate your current depression? Obviously not. That would be like saying that once you have achieved good physical condition through daily jogging, you will never again be short of breath. Part of being human means getting upset from time to time, so I can guarantee you *will not* achieve a state of never-ending bliss! This means you will have to reapply the techniques that help you if you want to continue to master your moods. There's a difference between *feeling* better—which can occur spontaneously—and *getting* better—which results from systematically applying and reapplying the methods that will lift your mood whenever the need arises.

How has this work been received by the academic community? The impact of these findings on psychiatrists, psychologists, and other mental-health professionals has been substantial. It has now been twenty years

since this chapter was first written. During that time, numerous well-controlled studies of the effectiveness of cognitive therapy have been published in scientific journals. These studies have compared the effectiveness of cognitive therapy with the effectiveness of antidepressant medications as well as other forms of psychotherapy in the treatment of depression, anxiety, and other disorders. The results of these studies have been quite encouraging. Researchers have confirmed our early impressions that cognitive therapy was at least as effective as medications, and often more effective, both in the short term and in the long term.

What does this all add up to? We are experiencing a crucial development in modern psychiatry and psychology—a promising new approach to understanding human emotions based on a cogent testable therapy. Large numbers of mental-health professionals are now showing a great interest in this approach, and the ground swell seems to be just beginning.

Since the first edition of *Feeling Good* in 1980, many thousands of depressed individuals have been successfully treated with cognitive therapy. Some had considered themselves hopelessly unbeatable and came to us as a last-ditch effort before committing suicide. Many others were simply troubled by the nagging tensions of daily living and wanted a greater share of personal happiness. This book is a carefully thought-out practical application of our work, and it is designed for you. Good luck!

## Chapter 2

### How to Diagnose Your Moods: The First Step in the Cure

Perhaps you are wondering if you have in fact been suffering from depression. Let's go ahead and see where you stand. The Burns Depression Checklist (BDC) (see Table 2–1, page 20) is a reliable mood-measuring device that detects the presence of depression and accurately rates its severity.\* This simple questionnaire will take only a few minutes to complete. After you have completed the BDC, I will show you how to make a simple interpretation of the results, based on your total score. Then you will know immediately whether or not you are suffering from a true depression and, if so, how severe it is. I will also lay out some important guidelines to help you determine whether you can safely and effectively treat your own blue mood using this book as your guide, or whether you have a more serious emotional disorder and might benefit from professional intervention in addition to your own efforts to help yourself.

As you fill out the questionnaire, read each item carefully and put a check (✓) in the box that indicates how you have been feeling during the past few days. Make sure you check one answer for each of the twenty-five items.

If in doubt, make your best guess. Do not leave any questions unanswered. Regardless of the outcome, this can be your first step toward emotional improvement.

**Table 2–1. Burns Depression Checklist\***

**Instructions:** Put a check (✓) to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.

0—Not At All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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<b>Thoughts and Feelings</b>				
1. Feeling sad or down in the dumps				
2. Feeling unhappy or blue				
3. Crying spells or tearfulness				
4. Feeling discouraged				
5. Feeling hopeless				
6. Low self-esteem				
7. Feeling worthless or inadequate				
8. Guilt or shame				
9. Criticizing yourself or blaming yourself				
10. Difficulty making decisions				
<b>Activities and Personal Relationships</b>				
11. Loss of interest in family, friends or colleagues				
12. Loneliness				
13. Spending less time with family or friends				
14. Loss of motivation				
15. Loss of interest in work or other activities				
16. Avoiding work or other activities				
17. Loss of pleasure or satisfaction in life				
<b>Physical Symptoms</b>				
18. Feeling tired				
19. Difficulty sleeping or sleeping too much				
20. Decreased or increased appetite				
21. Loss of interest in sex				
22. Worrying about your health				

**Burns Depression  
Checklist  
continued**

0—Not At All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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<b>Suicidal Urges**</b>				
23. Do you have any suicidal thoughts?				
24. Would you like to end your life?				
25. Do you have a plan for harming yourself?				

Please Total Your Score on Items 1 to 25 Here →

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**\*\*Anyone with suicidal urges should seek help from a mental health professional.**

*Interpreting the Burns Depression Checklist.* Now that you have completed the test, add up the score for each of the twenty-five items and obtain the total. Since the highest score you can get on each of the twenty-five symptoms is 4, the highest score for the whole test would be 100. (This would indicate the most severe depression possible.) Since the lowest score for each item is 0, the lowest score for the test would be zero. (This would indicate no symptoms of depression at all.)

You can now evaluate your depression according to Table 2–2. As you can see, the higher the total score, the more severe your depression. In contrast, the lower the score, the better you are feeling.

Although the BDC is not difficult or time-consuming to fill out and score, don't be deceived by its simplicity. You have just learned to use a highly sophisticated tool for detecting depression and measuring its severity. Research studies have demonstrated that the BDC is highly accurate and reliable. Studies in a variety of settings, such as psychiatric emergency rooms, have indicated that instruments of this type actually pick up the presence of depressive symptoms far more frequently than formal interviews by experienced clinicians.

**Table 2–2.** Interpreting the Burns Depression Checklist

<i>Total Score</i>	<i>Level of Depression*</i>
0–5	no depression
6–10	normal but unhappy
11–25	mild depression
26–50	moderate depression
51–75	severe depression
76–100	extreme depression

\*Anyone with a persistent score above 10 may benefit from professional

treatment. Anyone with suicidal feelings should seek an immediate consultation with a mental health professional.

You can use the BDC with confidence to monitor your progress as well. In my clinical work, I have insisted that every patient must fill out the test on his or her own between all sessions and report the score to me at the beginning of the next session. Changes in the score show me whether the patient is getting better, worse, or staying the same.

As you apply the various self-help techniques described in this book, take the BDC test at regular intervals to assess your progress objectively. I suggest a minimum of once a week. Compare it to weighing yourself regularly when you're on a diet. You will notice that various chapters in this book focus on different symptoms of depression. As you learn to overcome these symptoms, you will find that your total score will begin to fall. This will show that you are improving. When your score is under ten, you will be in the range considered normal. When it is under five, you will be feeling especially good. Ideally, I'd like to see your score under five the majority of the time. This is one aim of your treatment.

Is it safe for depressed individuals to try to help themselves using the principles and methods outlined in this book? The answer is—*definitely yes!* This is because the crucial decision *to try to help yourself* is the key that will allow you to feel better as soon as possible, regardless of how severe your mood disturbance might seem to be.

Under what conditions should you seek professional help? If your score is between 0 and 5, you are probably feeling good already. This is in the range of normal, and most people with scores this low feel pretty happily contented.

If your score was between 6 and 10, it is still in the range of normal, but you are probably feeling a bit on the “lumpy” side. There’s room for improvement, a little mental “tune-up,” if you will. The cognitive therapy techniques in this book can often be remarkably helpful in these instances. Problems in daily living bug all of us, and a change of perspective can often make a big difference in how you feel.

If your score was between 11 and 25, your depression, at least at this time, is mild and should not be a cause for alarm. You will definitely want

to correct this problem, and you may be able to make substantial progress on your own. Systematic self-help efforts along the lines proposed in this book, combined with frank communication on a number of occasions with a trusted friend, may help a great deal. But if your score remains in this range for more than a few weeks, you should consider professional treatment. The help of a therapist or an antidepressant medication may considerably speed your recovery.

Some of the thorniest depressions I have treated were actually individuals whose scores were in the mild range. Often these individuals had been mildly depressed for years, sometimes for most of their entire life. A mild chronic depression that goes on and on is now called “dysthymic disorder.” Although that is a big, fancy-sounding term, it has a simple meaning. All it means is, “this person is awfully gloomy and negative most of the time.” You probably know someone who is like that, and you may have fallen into spells of pessimism yourself. Fortunately, the same methods in this book that have proven so helpful for severe depressions can also be very helpful for these mild, chronic depressions.

If you scored between 26 and 50 on the BDC, it means you are moderately depressed. But don’t be fooled by the term, “moderate.” A score in this range can indicate pretty intense suffering. Most of us can feel quite upset for brief periods, but we usually snap out of it. If your score remains in this range for more than two weeks, you should definitely seek professional treatment.

If your score was above 50, it indicates your depression is severe or even extreme. This degree of suffering can be almost unbearable, especially when the score is increased above 75. Your moods are apt to be intensely uncomfortable and possibly dangerous because the feelings of despair and hopelessness may even trigger suicidal impulses.

Fortunately, the prognosis for successful treatment is excellent. In fact, sometimes the most severe depressions respond the most rapidly. But it is not wise to try to treat a severe depression on your own. A professional consultation is a must. Seek out a trusted and competent counselor.

Even if you receive psychotherapy or antidepressant medications, I am convinced you can still benefit greatly by applying what I teach you. My research studies have indicated that the spirit of self-help greatly speeds up recovery, even when patients receive professional treatment.

In addition to evaluating your total score on the BDC, be sure you pay special attention to items 23, 24, and 25. These items ask about suicidal feelings, urges, and plans. If you had elevated scores on any of these items, I would strongly recommend that you obtain professional help right away.

Many depressed individuals have elevated scores on item 23, but zeros on items 24 and 25. This usually means they have suicidal thoughts, such as “I’d probably be better off dead,” but no actual suicidal intentions or urges and no plans to commit suicide. This pattern is quite common. If your scores on item 24 or 25 are elevated, however, this is a cause for alarm. Seek treatment *immediately!*

I have provided some effective methods for assessing and reversing suicidal impulses in a later chapter, but you must consult a professional when suicide begins to appear to be a desirable or necessary option. Your conviction that you are hopeless is the reason to seek treatment, not suicide. The majority of seriously depressed individuals believe they are hopeless beyond any shadow of a doubt. This destructive delusion is merely a symptom of the illness, not a fact. Your feeling that you are hopeless is powerful evidence that you are actually not!

It is also important for you to look at item 22, which asks if you have been more worried about your health recently. Have you experienced any unexplained aches, pains, fever, weight loss, or other possible symptoms of medical illness? If so, it would be worthwhile to have a medical consultation, which would include a history, a complete physical examination, and laboratory tests. Your doctor will probably give you a clean bill of health. This will suggest that your uncomfortable physical symptoms are related to your emotional state. Depression can mimic a great number of medical disorders because your mood swings often create a wide variety of puzzling physical symptoms. These include, to name just a few, constipation, diarrhea, pain, insomnia or the tendency to sleep too much, fatigue, loss of sexual interest, light-headedness, trembling, and numbness. As your depression improves, these symptoms will in all likelihood vanish. However, keep in mind that many treatable illnesses may initially masquerade as depression, and a medical examination could reveal an early (and life-saving) diagnosis of a reversible organic disorder.

There are a number of symptoms that indicate—but do not prove—the existence of a serious mental disturbance, and these require a consultation

with and possible treatment by a mental-health professional, *in addition to* the self-administered personal-growth program in this book. Some of the major symptoms include: the belief that people are plotting and conspiring against you in order to hurt you or take your life; a bizarre experience which the ordinary person cannot understand; the conviction that external forces are controlling your mind or body; the feeling that other people can hear your thoughts or read your mind; hearing voices from outside your head; seeing things that aren't there; and receiving personal messages broadcast from radio or television programs.

These symptoms are not a part of depressive illness, but represent major mental disorders. Psychiatric treatment is a must. Quite often, people with these symptoms are convinced that nothing is wrong with them, and may meet the suggestion to seek psychiatric therapy with suspicious resentment and resistance. In contrast, if you are harboring the deep fear that you are going insane and are experiencing episodes of panic in which you sense you are losing control or going over the deep end, it is a near certainty that you are not. These are typical symptoms of ordinary anxiety, a much less serious disorder.

Mania is a special type of mood disorder with which you should be familiar. Mania is the opposite of depression and requires prompt intervention by a psychiatrist who can prescribe lithium. Lithium stabilizes extreme mood swings and allows the patient to lead a normal life. However, until therapy is initiated, the disease can be emotionally destructive. The symptoms include an abnormally elated or irritable mood that persists for at least two days and is not caused by drugs or alcohol. The manic patient's behavior is characterized by impulsive actions which reflect poor judgment (such as irresponsible, excessive spending) along with a grandiose sense of self-confidence. Mania is accompanied by increased sexual or aggressive activity; hyperactive, continuous body movements; racing thoughts; nonstop, excited talking; and a decreased need to sleep. Manic individuals have the delusion that they are extraordinarily powerful and brilliant, and often insist they are on the verge of some philosophical or scientific breakthrough or lucrative money-making scheme. Many famous creative individuals suffer from this illness and manage to control it with lithium. Because the disease *feels* so good, individuals who are having their first attack often cannot be convinced to seek treatment. The first symptoms are

so intoxicating that the victim resists accepting the idea that his or her sudden acquisition of self-confidence and inner ecstasy is actually just a manifestation of a destructive illness.

After a while, the euphoric state may escalate into uncontrollable delirium requiring involuntary hospitalization, or it may just as suddenly switch into an incapacitating depression with pronounced immobility and apathy. I want you to be familiar with the symptoms of mania because a significant percentage of individuals who experience a true major depressive episode will at some later time develop these symptoms. When this occurs, the personality of the afflicted individual undergoes a profound transformation over a period of days or weeks. While psychotherapy and a self-help program can be extremely helpful, concomitant treatment with lithium under medical supervision is a must for an optimal response. With such treatment the prognosis for manic illness is excellent.

Let's assume that you do *not* have a strong suicidal urge, hallucinations, or symptoms of mania. Instead of moping and feeling miserable, you can now proceed to get better, using me methods outlined in this book. You can start enjoying life and work, and use the energy spent in being depressed for vital and creative living.

## Chapter 3

### **Understanding Your Moods: You Feel the Way You Think**

As you read the previous chapter, you became aware of how extensive the effects of depression are—your mood slumps, your self-image crumbles, your body doesn’t function properly, your willpower becomes paralyzed, and your actions defeat you. That’s why you feel so *totally* down in the dumps. What’s the key to it all?

Because depression has been viewed as an emotional disorder throughout the history of psychiatry, therapists from most schools of thought place a strong emphasis on “getting in touch” with your feelings. Our research reveals the unexpected: Depression is not an emotional disorder at all! The sudden change in the way you *feel* is of no more causal relevance than a runny nose is when you have a cold. Every bad feeling you have is the result of your distorted negative thinking. Illogical pessimistic attitudes play the central role in the development and continuation of all your symptoms.

Intense negative thinking *always* accompanies a depressive episode, or any painful emotion for that matter. Your moody thoughts are likely to be entirely different from those you have when you are not upset. A young woman, about to receive her Ph.D., expressed it this way:

Every time I become depressed, I feel as if I have been hit with a sudden cosmic jolt, and I begin to *see* things differently. The change can come within less than an hour. My thoughts become negative and pessimistic. As I look into the past, I become convinced that everything that I’ve ever done is worthless. Any happy period seems like an illusion. My accomplishments appear as genuine as the false facade for the set of a Western movie. I become convinced that the real me is worthless and inadequate. I can’t move forward with my work

because I become frozen with doubt. But I can't stand still because the misery is unbearable.

You will learn, as she did, that the negative thoughts that flood your mind are the actual *cause* of your self-defeating emotions. These thoughts are what keep you lethargic and make you feel inadequate. Your negative thoughts, or cognitions, are the most frequently overlooked symptoms of your depression. These cognitions contain the key to relief and are therefore your most important symptoms.

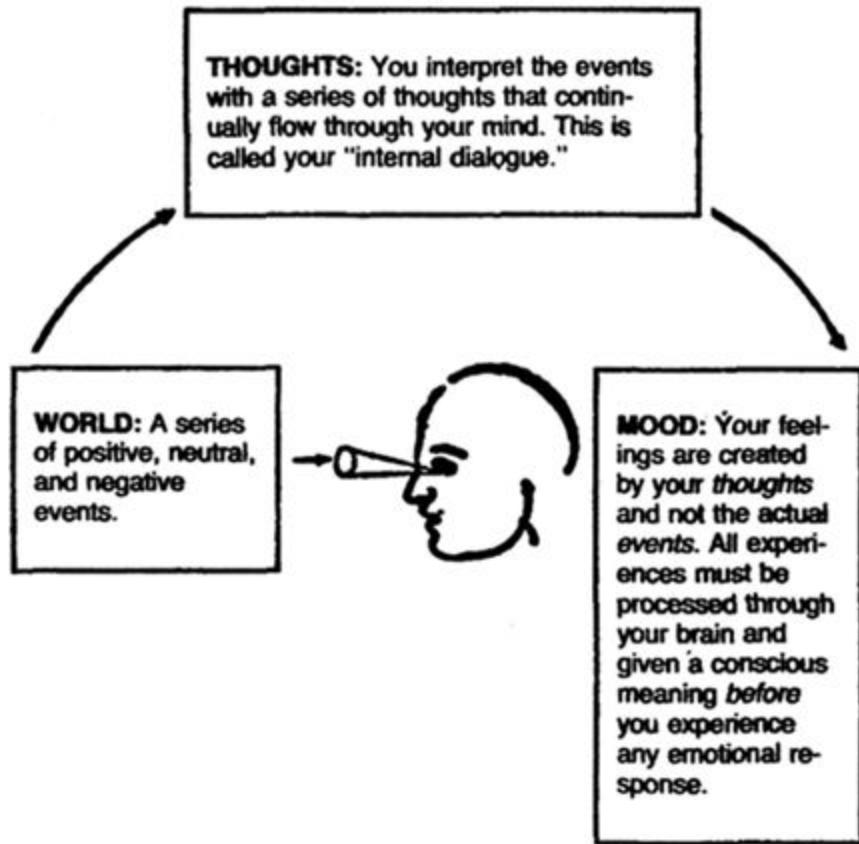
Every time you feel depressed about something, try to identify a corresponding negative thought you had just prior to and during the depression. Because these thoughts have actually created your bad mood, by learning to restructure them, you can change your mood.

You are probably skeptical of all this because your negative thinking has become such a part of your life that it has become automatic. For this reason I call negative thoughts “automatic thoughts.” They run through your mind automatically without the slightest effort on your part to put them there. They are as obvious and natural to you as the way you hold a fork.

The relationship between the way you *think* and the way you *feel* is diagrammed in Figure 3–1. This illustrates the first major key to understanding your moods: Your emotions result entirely from the way you *look* at things. It is an obvious neurological fact that before you can experience any event, you must process it with your mind and give it meaning. You must *understand* what is happening to you before you can *feel* it.

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**Figure 3–1.** The relationship between the world and the way you feel. It is not the actual events but your perceptions that result in changes in mood. When you are *sad*, your thoughts will represent a realistic interpretation of negative events. When you are depressed or anxious, your thoughts will always be illogical, distorted, unrealistic, or just plain wrong.

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If your understanding of what is happening is accurate, your emotions will be normal. If your perception is twisted and distorted in some way, your emotional response will be abnormal. Depression falls into this category. It is always the result of mental “static”—distortions. Your blue moods can be compared to the scratchy music coming from a radio that is not properly tuned to the station. The problem is *not* that the tubes or transistors are blown out or defective, or that the signal from the radio station is distorted as a result of bad weather. You just simply have to adjust

the dials. When you learn to bring about this mental tuning, the music will come through clearly again and your depression will lift.

Some readers—maybe you—will experience a pang of despair when they read that paragraph. Yet there is *nothing upsetting* about it. If anything, the paragraph should bring hope. Then what caused your mood to plunge as you were reading? It was your thought, “For other people a little tuning may suffice. But I’m the radio that is broken beyond repair. My tubes are blown out. I don’t care if ten thousand other depressed patients all get well—I’m convinced beyond any shadow of doubt that my problems are hopeless.” I hear this statement fifty times a week! Nearly every depressed person seems convinced beyond all rhyme or reason that he or she is the special one who *really is* beyond hope. This delusion reflects the kind of mental processing that is at the very core of your illness!

I have always been fascinated by the ability certain people have to create illusions. As a child, I used to spend hours at the local library, reading books on magic. Saturdays I would hang out in magic stores for hours, watching the man behind the counter produce remarkable effects with cards and silks and chromium spheres that floated through the air, defying all the laws of common sense. One of my happiest childhood memories is when I was eight years old and saw “Blackstone—World’s Greatest Magician” perform in Denver, Colorado. I was invited with several other children from the audience to come up on stage. Blackstone instructed us to place our hands on a two-feet by two-feet birdcage filled with live white doves until the top, bottom, and all four sides were enclosed entirely by our hands. He stood nearby and said, “Stare at the cage!” I did. My eyes were bulging and I refused to blink. He exclaimed, “Now I’ll clap my hands.” He did. In that instant the cage of birds vanished. My hands were suspended in empty air. It was impossible! Yet it happened! I was stunned.

Now I know that his ability as an illusionist was no greater than that of the average depressed patient. This includes you. When you are depressed, you possess the remarkable ability to *believe*, and to get the people around you to believe, things which have no basis in reality. As a therapist, it is my job to *penetrate* your illusion, to teach you how to *look behind* the mirrors so you can see how you have been fooling yourself. You might even say that I’m planning to dis illusion you! But I don’t think you’re going to mind at all.

Read over the following list of ten cognitive distortions that form the basis of all your depressions. Get a feel for them. I have prepared this list with great care; it represents the distilled essence of many years of research and clinical experience. Refer to it over and over when you read the how-to-do-it section of the book. When you’re feeling upset, the list will be invaluable in making you aware of how you are fooling yourself.

## **Definitions of Cognitive Distortions**

1. *All-or-Nothing Thinking.* This refers to your tendency to evaluate your personal qualities in extreme, black-or-white categories. For example, a prominent politician told me, “Because I lost the race for governor, I’m a zero.” A straight-A student who received a B on an exam concluded, “Now I’m a total failure.” All-or-nothing thinking forms the basis for perfectionism. It causes you to fear any mistake or imperfection because you will then see yourself as a complete loser, and you will feel inadequate and worthless.

This way of evaluating things is unrealistic because life is rarely completely either one way or the other. For example, no one is absolutely brilliant or totally stupid. Similarly, no one is either completely attractive or totally ugly. Look at the floor of the room you are sitting in now. Is it perfectly clean? Is every inch piled high with dust and dirt? Or is it partially clean? Absolutes do not exist in this universe. If you try to force your experiences into absolute categories, you will be constantly depressed because your perceptions will not conform to reality. You will set yourself up for discrediting yourself endlessly because whatever you do will *never* measure up to your exaggerated expectations. The technical name for this type of perceptual error is “dichotomous thinking.” You see everything as black or white—shades of gray do not exist.

2. *Overgeneralization.* When I was eleven years old, I bought a deck of trick cards at the Arizona State Fair called the Svengali Deck. You may have seen this simple but impressive illusion yourself: I show the deck to you—every card is different. You choose a card at random. Let’s assume you pick the Jack of Spades. Without telling me what card it is, you replace

it in the deck. Now I exclaim, “Svengali!” As I turn the deck over, every card has turned into the Jack of Spades.

When you overgeneralize, this is performing the mental equivalent of Svengali. You arbitrarily conclude that one thing that happened to you once will occur over and over again, will multiply like the Jack of Spades. Since what happened is invariably unpleasant, you feel upset.

A depressed salesman noticed bird dung on his car window and thought, “That’s just my luck. The birds are always crapping on *my* window!” This is a perfect example of overgeneralization. When I asked him about this experience, he admitted that in twenty years of traveling, he could not remember another time when he found bird dung on his car window.

The pain of rejection is generated almost entirely from overgeneralization. In its absence, a personal affront is temporarily disappointing but *cannot* be seriously disturbing. A shy young man mustered up his courage to ask a girl for a date. When she politely declined because of a previous engagement, he said to himself, “I’m never going to get a date. No girl would ever want a date with me. I’ll be lonely and miserable all my life.” In his distorted cognitions, he concluded that because she turned him down once, she would *always* do so, and that since all women have 100 percent identical tastes, he would be endlessly and repeatedly rejected by any eligible woman on the face of the earth. Svengali!

3. *Mental Filter*. You pick out a negative detail in any situation and dwell on it exclusively, thus perceiving that the whole situation is negative. For example, a depressed college student heard some other students making fun of her best friend. She became furious because she was thinking, “That’s what the human race is basically like—cruel and insensitive!” She was overlooking the fact that in the previous months few people, if any, had been cruel or insensitive to her! On another occasion when she completed her first midterm exam, she felt certain she had missed approximately seventeen questions out of a hundred. She thought exclusively about those seventeen questions and concluded she would flunk out of college. When she got the paper back there was a note attached that read, “You got 83 out of 100 correct. This was by far the highest grade of any student this year. A +”

When you are depressed, you wear a pair of eyeglasses with special lenses that filter out anything positive. All that you allow to enter your conscious mind is negative. Because you are not aware of this “filtering process,” you conclude that *everything* is negative. The technical name for this process is “selective abstraction.” It is a bad habit that can cause you to suffer much needless anguish.

*4. Disqualifying the Positive.* An even more spectacular mental illusion is the persistent tendency of some depressed individuals to transform neutral or even positive experiences into negative ones. You don’t just *ignore* positive experiences, you cleverly and swiftly turn them into their nightmarish opposite. I call this “reverse alchemy.” The medieval alchemists dreamed of finding some method for transmuting the baser metals into gold. If you have been depressed, you may have developed the talent for doing the exact opposite—you can instantly transform golden joy into emotional lead. Not intentionally, however—you’re probably not even aware of what you’re doing to yourself.

An everyday example of this would be the way most of us have been conditioned to respond to compliments. When someone praises your appearance or your work, you might automatically tell yourself, “They’re just being nice.” With one swift blow you mentally disqualify their compliment. You do the same thing to them when you tell them, “Oh, it was nothing, really.” If you constantly throw cold water on the good things that happen, no wonder life seems damp and chilly to you!

Disqualifying the positive is one of the most destructive forms of cognitive distortion. You’re like a scientist intent on finding evidence to support some pet hypothesis. The hypothesis that dominates your depressive thinking is usually some version of “I’m second-rate.” Whenever you have a negative experience, you dwell on it and conclude, “That proves what I’ve known all along.” In contrast, when you have a positive experience, you tell yourself, “That was a fluke. It doesn’t count.” The price you pay for this tendency is intense misery and an inability to appreciate the good things that happen.

While this type of cognitive distortion is commonplace, it can also form the basis for some of the most extreme and intractable forms of depression. For example, a young woman hospitalized during a severe depressive

episode told me, “No one could possibly care about me because I’m such an awful person. I’m a complete loner. Not one person on earth gives a damn about me.” When she was discharged from the hospital, many patients and staff members expressed great fondness for her. Can you guess how she negated all this? “They don’t count because they don’t see me in the real world. A *real* person outside a hospital could never care about me.” I then asked her how she reconciled this with the fact that she had numerous friends and family outside the hospital who *did* care about her. She replied, “They don’t count because they don’t know the real me. You see Dr. Burns, inside I’m absolutely rotten. I’m the worst person in the world. It would be impossible for anyone to really like me for even one moment!” By disqualifying positive experiences in this manner, she can maintain a negative belief which is clearly unrealistic and inconsistent with her everyday experiences.

While your negative thinking is probably not as extreme as hers, there may be many times every day when you do inadvertently ignore genuinely positive things that have happened to you. This removes much of life’s richness and makes things appear needlessly bleak.

*5. Jumping to Conclusions.* You arbitrarily jump to a negative conclusion that is not justified by the facts of the situation. Two examples of this are “mind reading” and “the fortune teller error.”

MIND READING: You make the assumption that other people are looking down on you, and you’re so convinced about this that you don’t even bother to check it out. Suppose you are giving an excellent lecture, and you notice that a man in the front row is nodding off. He was up most of the night on a wild fling, but you of course don’t know this. You might have the thought, ‘This audience thinks I’m a bore.’ Suppose a friend passes you on the street and fails to say hello because he is so absorbed in his thoughts he doesn’t notice you. You might erroneously conclude, “He is ignoring me so he must not like me anymore.” Perhaps your spouse is unresponsive one evening because he or she was criticized at work and is too upset to want to talk about it. Your heart sinks because of the way you interpret the silence: “He (or she) is mad at me. What did I do wrong?”

You may then respond to these imagined negative reactions by withdrawal or counterattack. This self-defeating behavior pattern may act as

a self-fulfilling prophecy and set up a negative interaction in a relationship when none exists in the first place.

**THE FORTUNE TELLER ERROR:** It's as if you had a crystal ball that foretold only misery for you. You imagine that something bad is about to happen, and you take this prediction as *a fact* even though it is unrealistic. A high-school librarian repeatedly told herself during anxiety attacks, "I'm going to pass out or go crazy." These predictions were unrealistic because she had never once passed out (or gone crazy!) in her entire life. Nor did she have any serious symptoms to suggest impending insanity. During a therapy session an acutely depressed physician explained to me why he was giving up his practice: "I realize I'll be depressed forever. My misery will go on and on, and I'm absolutely convinced that this or any treatment will be doomed to failure." This negative prediction about his prognosis caused him to feel hopeless. His symptomatic improvement soon after initiating therapy indicated just how off-base his fortune telling had been.

Do you ever find yourself jumping to conclusions like these? Suppose you telephone a friend who fails to return your call after a reasonable time. You then feel depressed when you tell yourself that your friend probably got the message but wasn't interested enough to call you back. Your distortion?—mind reading. You then feel bitter, and decide not to call back and check this out because you say to yourself, "He'll think I'm being obnoxious if I call him back again. I'll only make a fool of myself." Because of these negative predictions (the fortune teller error), you avoid your friend and feel put down. Three weeks later you learn that your friend never got your message. All that stewing, it turns out, was just a lot of self-imposed hokum. Another painful product of your mental magic!

*6. Magnification and Minimization.* Another thinking trap you might fall into is called "magnification" and "minimization," but I like to think of it as the "binocular trick" because you are either blowing things up out of proportion or shrinking them. Magnification commonly occurs when you look at your own errors, fears, or imperfections and exaggerate their importance: "My God—I made a mistake. How terrible! How awful! The word will spread like wildfire! My reputation is ruined!" You're looking at your faults through the end of the binoculars that makes them appear

gigantic and grotesque. This has also been called “catastrophizing” because you turn commonplace negative events into nightmarish monsters.

When you think about your strengths, you may do the opposite—look through the wrong end of the binoculars so that things look small and unimportant. If you magnify your imperfections and minimize your good points, you’re guaranteed to feel inferior. But the problem isn’t *you*—it’s the crazy lenses you’re wearing!

7. *Emotional Reasoning.* You take your emotions as evidence for the truth. Your logic: “I feel like a dud, therefore I *am* a dud.” This kind of reasoning is misleading because your feelings reflect your thoughts and beliefs. If they are distorted—as is quite often the case—your emotions will have no validity. Examples of emotional reasoning include “I feel guilty. Therefore, I must have done something bad”; “I feel overwhelmed and hopeless. Therefore, my problems must be impossible to solve”; “I feel inadequate. Therefore, I must be a worthless person”; “I’m not in the mood to do anything. Therefore, I might as well just lie in bed”; or “I’m mad at you. This proves that you’ve been acting rotten and trying to take advantage of me.”

Emotional reasoning plays a role in nearly all your depressions. Because things *feel* so negative to you, you assume they truly are. It doesn’t occur to you to challenge the validity of the perceptions that create your feelings.

One usual side effect of emotional reasoning is procrastination. You avoid cleaning up your desk because you tell yourself, “I feel so lousy when I think about that messy desk, cleaning it will be impossible.” Six months later you finally give yourself a little push and do it. It turns out to be quite gratifying and not so tough at all. You were fooling yourself all along because you are in the habit of letting your negative feelings guide the way you act.

8. *Should Statements.* You try to motivate yourself by saying, “I *should* do this” or “I *must* do that.” These statements cause you to feel pressured and resentful. Paradoxically, you end up feeling apathetic and unmotivated. Albert Ellis calls this “*musturbation*.” I call it the “shouldy” approach to life.

When you direct should statements toward others, you will usually feel frustrated. When an emergency caused me to be five minutes late for the first therapy session, the new patient thought, “He *shouldn’t* be so self-centered and thoughtless. He *ought to be* prompt.” This thought caused her to feel sour and resentful.

Should statements generate a lot of unnecessary emotional turmoil in your daily life. When the reality of your own behavior falls short of your standards, your shoulds and shouldn’ts create self-loathing, shame, and guilt. When the all-too-human performance of other people falls short of your expectations, as will inevitably happen from time to time, you’ll feel bitter and self-righteous. You’ll either have to change your expectations to approximate reality or always feel let down by human behavior. If you recognize this bad *should* habit in yourself, I have outlined many effective “should and shouldn’t” removal methods in later chapters on guilt and anger.

9. *Labeling and Mislabeled*. Personal labeling means creating a completely negative self-image based on your errors. It is an extreme form of overgeneralization. The philosophy behind it is “The measure of a man is the mistakes he makes.” There is a good chance you are involved in a personal labeling whenever you describe your mistakes with sentences beginning with “*I’m a ...*” For example, when you miss your putt on the eighteenth hole, you might say, “*I’m a born loser*” instead of “I goofed up on my putt.” Similarly, when the stock you invested in goes down instead of up, you might think, “*I’m a failure*” instead of “I made a mistake.”

Labeling yourself is not only self-defeating, it is irrational. Your *self* cannot be equated with any *one* thing you do. Your life is a complex and ever-changing flow of thoughts, emotions, and actions. To put it another way, you are more like a river than a statue. Stop trying to define yourself with negative labels—they are overly simplistic and wrong. Would you think of yourself exclusively as an “eater” just because you eat, or a “breather” just because you breathe? This is nonsense, but such nonsense becomes painful when you label yourself out of a sense of your own inadequacies.

When you label other people, you will invariably generate hostility. A common example is the boss who sees his occasionally irritable secretary as

“an uncooperative bitch.” Because of this label, he resents her and jumps at every chance to criticize her. She, in turn, labels him an “insensitive chauvinist” and complains about him at every opportunity. So, around and around they go at each other’s throats, focusing on every weakness or imperfection as proof of the other’s worthlessness.

Mislabeling involves describing an event with words that are inaccurate and emotionally heavily loaded. For example, a woman on a diet ate a dish of ice cream and thought, “How disgusting and repulsive of me. I’m a *pig*.” These thoughts made her so upset she ate the whole quart of ice cream!

*10. Personalization.* This distortion is the mother of guilt! You assume responsibility for a negative even when there is no basis for doing so. You arbitrarily conclude that what happened was your fault or reflects your inadequacy, even when you were not responsible for it. For example, when a patient didn’t do a self-help assignment I had suggested, I felt guilty because of my thought, “I must be a lousy therapist. It’s my fault that she isn’t working harder to help herself. It’s my responsibility to make sure she gets well.” When a mother saw her child’s report card, there was a note from the teacher indicating the child was not working well. She immediately decided, “I must be a bad mother. This shows how I’ve failed.”

Personalization causes you to feel crippling guilt. You suffer from a paralyzing and burdensome sense of responsibility that forces you to carry the whole world on your shoulders. You have confused *influence* with *control* over others. In your role as a teacher, counselor, parent, physician, salesman, executive, you will certainly influence the people you interact with, but no one could reasonably expect you to control them. What the other person does is ultimately his or her responsibility, not yours. Methods to help you overcome your tendency to personalize and trim your sense of responsibility down to manageable, realistic proportions will be discussed later on in this book.

The ten forms of cognitive distortions cause many, if not all, of your depressed states. They are summarized in Table 3–1 on page 42. Study this table and master these concepts; try to become as familiar with them as with your phone number. Refer to Table 3–1 over and over again as you learn about the various methods for mood modification. When you become

familiar with these ten forms of distortion, you will benefit from this knowledge all your life.

I have prepared a simple self-assessment quiz to help you test and strengthen your understanding of the ten distortions. As you read each of the following brief vignettes, imagine you are the person who is being described. Circle one or more answers which indicate the distortions contained in the negative thoughts. I will explain the answer to the first question. The answer key to subsequent questions is given at the end of this chapter. But don't look ahead! I'm *certain* you will be able to identify at least *one* distortion in the first question—and that will be a start!

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**Table 3–1.** Definitions of Cognitive Distortions

1. **ALL-OR-NOTHING THINKING:** You see things in black-and-white categories. If your performance falls short of perfect, you see yourself as a total failure.
2. **OVERGENERALIZATION:** You see a single negative event as a never-ending pattern of defeat.
3. **MENTAL FILTER:** You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that colors the entire beaker of water.
4. **DISQUALIFYING THE POSITIVE:** You reject positive experiences by insisting they "don't count" for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experiences.
5. **JUMPING TO CONCLUSIONS:** You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.
  - a. *Mind reading.* You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out.
  - b. *The Fortune Teller Error.* You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact.
6. **MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION:** You exaggerate the importance of things (such as your goof-up or someone

else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick."

7. EMOTIONAL REASONING: You assume that your negative emotions necessarily reflect the way things really are: "I feel it, therefore it must be true."
  8. SHOULD STATEMENTS: You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment.
  9. LABELING AND MISLABELING: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: "I'm a *loser*." When someone else's behavior rubs you the wrong way, you attach a negative label to him: "He's a goddam louse." Mislabeling involves describing an event with language that is highly colored and emotionally loaded.
  10. PERSONALIZATION: You see yourself as the cause of some negative external event which in fact you were not primarily responsible for.
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1. You are a housewife, and your heart sinks when your husband has just complained disgruntledly that the roast beef was overdone. The following thought crosses your mind: "I'm a total failure. I can't stand it! I *never* do *anything* right. I work like a slave and this is all the thanks I get! The jerk!" These thoughts cause you to feel sad and angry. Your distortions include one or more of the following:

- a. all-or-nothing thinking;
- b. overgeneralization;
- c. magnification;
- d. labeling;
- e. all the above.

Now I will discuss the correct answers to this question so you can get some immediate feedback. Any answer(s) you might have circled was (were) correct. So if you circled *anything*, you were right! Here's why. When you tell yourself, "I'm a *total* failure," you engage in *all-or-nothing*

thinking. Cut it out! The meat was a little dry, but that doesn't make your entire life a total failure. When you think, "I never do anything right," you are *over generalizing*. Never? Come on now! Not *anything*? When you tell yourself, "I can't stand it," you are *magnifying* the pain you are feeling. You're blowing it way out of proportion because you *are* standing it, and if you *are*, you *can*. Your husband's grumbling is not exactly what you like to hear, but it's not a reflection of your worth. Finally, when you proclaim, "I work like a slave and this is all the thanks I get! The jerk!" you are *labeling* both of you. He's not *a jerk*, he's just being irritable and insensitive. Jerky behavior exists, but jerks do not. Similarly, it's silly to label yourself a *slave*. You're just letting his moodiness sour your evening.

Okay, now let's continue with the quiz.

2. You have just read the sentence in which I informed you that you would have to take this self-assessment quiz. Your heart suddenly sinks and you think, "Oh no, not other test! I always do lousy on tests. I'll have to skip this section of the book. It makes me nervous, so it wouldn't help anyway." Your distortions include:

- a. jumping to conclusions (fortune teller error);
- b. overgeneralization;
- c. all-or-nothing thinking;
- d. personalization;
- e. emotional reasoning.

3. You are a psychiatrist at the University of Pennsylvania. You are attempting to revise your manuscript on depression after meeting with your editor in New York. Although your editor seemed extremely enthusiastic, you notice you are feeling nervous and inadequate due to your thoughts, "They made a terrible mistake when they chose my book! I won't be able to do a good job. I'll never be able to make the book fresh, lively, and punchy. My writing is too drab, and my ideas aren't good enough." Your cognitive distortions include:

- a. all-or-nothing thinking;
- b. jumping to conclusions (negative prediction);

- c. mental filter;
- d. disqualifying the positive;
- e. magnification.

4. You are lonely and you decide to attend a social affair for singles. Soon after you get there, you have the urge to leave because you feel anxious and defensive. The following thoughts run through your mind: “They probably aren’t very interesting people. Why torture myself? They’re just a bunch of losers. I can tell because I feel so bored. This party will be a drag.” Your errors involve:

- a. labeling;
- b. magnification;
- c. jumping to conclusions (fortune teller error and mind reading);
- d. emotional reasoning;
- e. personalization.

5. You receive a layoff notice from your employer. You feel mad and frustrated. You think, “This proves the world is no damn good. I never get a break.” Your distortions include:

- a. all-or-nothing thinking;
- b. disqualifying the positive;
- c. mental filter;
- d. personalization;
- e. should statement.

6. You are about to give a lecture and you notice that your heart is pounding. You feel tense and nervous because you think, “My God, I’ll probably forget what I’m supposed to say. My speech isn’t any good anyway. My mind will blank out. I’ll make a fool of myself.” Your thinking errors involve:

- a. all-or-nothing thinking;
- b. disqualifying the positive;
- c. jumping to conclusions (fortune teller error);
- d. minimization;

e. labeling.

7. Your date calls you at the last minute to cancel out because of illness. You feel angry and disappointed because you think, “I’m getting jilted. What did I do to foul things up?” Your thinking errors include:

- a. all-or-nothing thinking;
- b. should statements;
- c. jumping to conclusions (mind reading);
- d. personalization;
- e. overgeneralization.

8. You have put off writing a report for work. Every night when you try to get down to it, the whole project seems so difficult that you watch TV instead. You begin to feel overwhelmed and guilty. You are thinking the following: “I’m so lazy I’ll never get this done. I just can’t do the darn thing. It would take forever. It won’t turn out right anyway.” Your thinking errors include:

- a. jumping to conclusions (fortune teller error);
- b. overgeneralization;
- c. labeling;
- d. magnification;
- e. emotional reasoning.

9. You’ve read this entire book and after applying the methods for several weeks, you begin to feel better. Your BDC score went down from twenty-six (moderately depressed) to eleven (borderline depression). Then you suddenly begin to feel worse, and in three days your score has gone back up to twenty-eight. You feel disillusioned, hopeless, bitter, and desperate due to thinking, “I’m not getting anywhere. These methods won’t help me after all. I should be well by now. That ‘improvement’ was a fluke. I was fooling myself when I thought I was feeling better. I’ll never get well.” Your cognitive distortions include:

- a. disqualifying the positive;
- b. should statement;
- c. emotional reasoning;

- d. all-or-nothing thinking;
- e. jumping to conclusions (negative prediction).

10. You've been trying to diet. This weekend you've been nervous, and, since you didn't have anything to do, you've been nibbling, nibbling. After your fourth piece of candy, you tell yourself, "I just can't control myself. My dieting and jogging all week have gone down the drain. I must look like a balloon. I shouldn't have eaten that. I can't stand this. I'm going to pig out all weekend!" You begin to feel so guilty you push another handful of candy into your mouth in an abortive effort to feel better. Your distortions include:

- a. all-or-nothing thinking;
  - b. mislabeling;
  - c. negative prediction;
  - d. should statement;
  - e. disqualifying the positive.
- 

#### ANSWER KEY

1. A B C D E
  2. A B C E
  3. A B D E
  4. A B C D
  5. A C
  6. A C D E
  7. C D
  8. A B C D E
  9. A B C D E
  10. A B C D E
- 

### Feelings Aren't Facts

At this point you may be asking yourself, "Okay. I understand that my depression results from my negative thoughts because my outlook on life changes enormously when my moods go up or down. But if my negative thoughts are so distorted, how do I continually get fooled? I can think as

clearly and realistically as the next person, so if what I am telling myself is irrational, why does it seem so right?"

Even though your depressing thoughts may be distorted, they nevertheless create a powerful illusion of truth. Let me expose the basis for the deception in blunt terms—your feelings are not facts! In fact, your feelings, *per se*, don't even count—except as a mirror of the way you are thinking. If your perceptions make no sense, the feelings they create will be as absurd as the images reflected in the trick mirrors at an amusement park. But these abnormal emotions *feel* just as valid and realistic as the genuine feelings created by undistorted thoughts, so you automatically attribute truth to them. This is why depression is such a powerful form of mental black magic.

Once you invite depression through an "automatic" series of cognitive distortions, your feelings and actions will reinforce each other in a self-perpetuating vicious cycle. Because you *believe* whatever your depressed brain tells you, you find yourself feeling negative about almost everything. This reaction occurs in milliseconds, too quickly for you even to be aware of it. The negative emotion *feels* realistic and in turn lends an aura of credibility to the distorted thought which created it. The cycle goes on and on, and you are eventually trapped. The mental prison is an illusion, a hoax you have inadvertently created, but it *seems* real because it *feels* real.

What is the key to releasing yourself from your emotional prison? Simply this: Your thoughts create your emotions; therefore, your emotions cannot prove that your thoughts are accurate. Unpleasant feelings merely indicate that you are thinking something negative and believing it. Your emotions *follow* your thoughts just as surely as baby ducks follow their mother. But the fact that the baby ducks follow faithfully along doesn't prove that the mother knows where she is going!

Let's examine your equation, "I feel, therefore I am." This attitude that emotions reflect a kind of self-evident, ultimate truth is not unique to depressed people. Most psychotherapists today share the conviction that becoming more *aware* of your feelings and expressing them more openly represent emotional maturity. The implication is that your feelings represent a higher reality, a personal integrity, a truth beyond question.

My position is quite different. Your feelings, *per se*, are not necessarily special at all. In fact, to the extent that your negative emotions are based on

mental distortions—as is all too often the case—they can hardly be viewed as desirable.

Do I mean you should get rid of *all* emotions? Do I want you to turn into a robot? No. I want to teach you to avoid painful feelings based on mental distortions, because they are neither valid nor desirable. I believe that once you have learned how to perceive life more realistically you will experience an enhanced emotional life with a greater appreciation for genuine sadness—which lacks distortion—as well as joy.

As you go on to the next sections of this book, you can learn to correct the distortions that fool you when you are upset. At the same time, you will have the opportunity to reevaluate some of the basic values and assumptions that create your vulnerability to destructive mood swings. I have outlined the necessary steps in detail. The modifications in illogical thinking patterns will have a profound effect on your moods and increase your capacity for productive living. Now, let's go ahead and see how we can turn your problems around.

**Part II**

**Practical Applications**

## Chapter 4

### Start by Building Self-Esteem

When you are depressed, you invariably believe that you are worthless. The worse the depression, the more you feel this way. You are not alone. A survey by Dr. Aaron Beck revealed that over 80 percent of depressed patients expressed self-dislike.\* Furthermore, Dr. Beck found that depressed patients see themselves as deficient in the very qualities they value most highly: intelligence, achievement, popularity, attractiveness, health, and strength. He said a depressed self-image can be characterized by the four D's: You feel Defeated, Defective, Deserted, and Deprived.

Almost all negative emotional reactions inflict their damage *only* as a result of low self-esteem. A poor self-image is the magnifying glass that can transform a trivial mistake or an imperfection into an overwhelming symbol of personal defeat. For example, Eric, a first-year law student, feels a sense of panic in class. "When the professor calls on me, I'll probably goof up." Although Eric's fear of "goofing up" was foremost on his mind, my dialogue with him revealed that a sense of personal inadequacy was the real cause of the problem:

DAVID: Suppose you did goof up in class. Why would that be particularly upsetting to you? Why is that so tragic?

ERIC: Then I would make a fool of myself.

DAVID: Suppose you did make a fool of yourself. Why would that be upsetting?

ERIC: Because then everyone would look down on me.

DAVID: Suppose people did look down on you? What then?

ERIC: Then I would feel miserable.

DAVID: Why? Why is it that you would have to feel miserable if people were looking down on you?

ERIC: Well, that would mean I wouldn't be a worthwhile person. Furthermore, it might ruin my career. I'd get bad grades, and maybe I could never be an attorney.

DAVID: Suppose you didn't become an attorney. Let's assume for the purposes of discussion that you did flunk out. Why would that be particularly upsetting to you?

ERIC: That would mean that I had failed at something I've wanted all my life.

DAVID: And what would that mean to you?

ERIC: Life would be empty. It would mean I was a failure. It would mean I was worthless.

In this brief dialogue, Eric showed that he believed it would be terrible to be disapproved of or to make a mistake or to fail. He seemed convinced that if one person looked down on him then everyone would. It was as if the word REJECT would suddenly be stamped on his forehead for everyone to see. He seemed to have no sense of self-esteem that was not contingent upon approval and/or success. He measured himself by the way others looked at him and by what he had achieved. If his cravings for approval and accomplishment were not satisfied, Eric sensed he would be nothing because there would be no true support from within.

If you feel that Eric's perfectionistic drive for achievement and approval is self-defeating and unrealistic, you are right. But to Eric, this drive was *realistic* and *reasonable*. If you are now depressed or have ever been depressed, you may find it much harder to recognize the illogical thinking patterns which cause you to look down on yourself. In fact, you are probably convinced that you really are inferior or worthless. And any suggestion to the contrary is likely to sound foolish and dishonest.

Unfortunately, when you are depressed you may not be alone in your conviction about your personal inadequacy. In many cases you will be so *persuasive* and *persistent* in your maladaptive belief that you are defective and no good, you may lead your friends, family, and even your therapist into accepting this idea of yourself. For many years psychiatrists have tended to "buy into" the negative self-evaluation system of depressed individuals without probing the validity of what the patients are saying about themselves. This is illustrated in the writings of such a keen observer as Sigmund Freud

in his treatise “Mourning and Melancholia,” which forms the basis for the orthodox psychoanalytic approach to treating depression. In this classic study Freud said that when the patient says he is worthless, unable to achieve, and morally despicable, he *must be right*. Consequently, it was fruitless for the therapist to disagree with the patient. Freud believed the therapist should agree that the patient is, in fact, uninteresting, unlovable, petty, self-centered, and dishonest. These qualities describe a human being’s true self, according to Freud, and the disease process simply makes the truth more obvious:

The patient represents his ego to us as worthless, incapable of any achievement and morally despicable; he reproaches himself, vilifies himself and expects to be cast out and punished.... It would be equally fruitless from a scientific and therapeutic point of view to contradict a patient who brings these accusations against his ego. He must *surely be right in some way* [emphasis mine] and be describing something that is as it seems to him to be. Indeed we must at once confirm some of his statements without reservation. *He really is as lacking in interest and incapable of love and achievement as he says* [emphasis mine].... He also seems to us justified in certain other self-accusations; *it is merely that he has a keener eye for the truth than other people who are not melancholic* [emphasis mine]. When in his heightened self-criticism he describes himself as petty, egoistic, dishonest, lacking in independence, one whose sole aim has been to hide the weaknesses of his own nature, it may be so far as we know, that *he has come pretty near to understanding himself* [emphasis mine]; we only wonder why a man has to be ill before he can be accessible to truth of this kind.

—SIGMUND FREUD, “*Mourning and Melancholia*”\*

The way a therapist handles your feelings of inadequacy is crucial to the cure, as your sense of worthlessness is a key to depression. The question also has considerable philosophical relevance—is human nature *inherently* defective? Are depressed patients actually facing the ultimate truth about themselves? And what, in the final analysis, is the source of genuine self-esteem? This, in my opinion, is the most important question you will ever confront.

First, you *cannot earn* worth through what you do. Achievements can bring you satisfaction but not happiness. Self-worth based on accomplishments is a “pseudo-esteem,” not the genuine thing! My many successful but depressed patients would all agree. Nor can you base a valid sense of self-worth on your looks, talent, fame, or fortune. Marilyn Monroe, Mark Rothko, Freddie Prinz, and a multitude of famous suicide victims attest to this grim truth. Nor can love, approval, friendship, or a capacity for close, caring human relationships add one iota to your inherent worth. The great majority of depressed individuals are in fact very much loved, but it doesn’t help one bit because *self-love* and *self-esteem* are missing. At the bottom line, only your own sense of self-worth determines how you feel.

“So,” you may now be asking with some exasperation, “how *do I get* a sense of self-worth? The fact is, *I feel* damn inadequate, and I’m convinced I’m really not as good as other people. I don’t believe there’s anything I can do to change those rotten feelings because that’s the way I basically am.”

One of the cardinal features of cognitive therapy is that it stubbornly refuses to buy into your sense of worthlessness. In my practice I lead my patients through a systematic reevaluation of their negative self-image. I raise the same question over and over again: “Are you really *right* when you insist that somewhere inside you are essentially a loser?”

The first step is to take a close look at what you say about yourself when you insist you are no good. The evidence you present in defense of your worthlessness will usually, if not always, make no sense.

This opinion is based on a recent study by Drs. Aaron Beck and David Bruff which indicated that there is actually a formal thinking disturbance in depressed patients. Depressed individuals were compared with schizophrenic patients and with undepressed persons in their ability to interpret the meaning of a number of proverbs, such as “A stitch in time saves nine.” Both the schizophrenic and depressed patients made many logical errors and had difficulty in extracting the meaning of the proverbs. They were overly concrete and couldn’t make accurate generalizations. Although the severity of the defect was obviously less profound and bizarre in the depressed patients than in the schizophrenic group, the depressed individuals were clearly abnormal as compared with the normal subjects.

In practical terms the study indicated that during periods of depression you lose some of your capacity for clear thinking; you have trouble putting things

into proper perspective. Negative events grow in importance until they dominate your entire reality—and you can't really tell that what is happening is distorted. It all seems very *real* to you. The illusion of hell you create is *very convincing*.

The more depressed and miserable you feel, the more twisted your thinking becomes. And, conversely, in the absence of mental distortion, you *cannot* experience low self-worth or depression!

What types of mental errors do you make most generally when you look down on yourself? A good place to begin is with the list of distortions you began to master in Chapter 3. The most usual mental distortion to look out for when you are feeling worthless is all-or-nothing thinking. If you see life only in such extreme categories, you will believe your performance will be either great or terrible—nothing else will exist. As a salesman told me, “Achieving 95 percent or better of my goal for monthly sales is acceptable. Ninety-four percent or below is the equivalent of total failure.”

Not only is this all-or-nothing system of self-evaluation highly unrealistic and self-defeating, it creates overwhelming anxiety and frequent disappointment. A depressed psychiatrist who was referred to me noticed a lack of sexual drive and a difficulty in maintaining erections during a two-week period when he was feeling blue. His perfectionistic tendencies had dominated not only his illustrious professional career but also his sexual life. Consequently, he had intercourse regularly with his wife every other day precisely on schedule for the twenty years of their married life. In spite of his decreased sex drive—which is a common symptom of depression—he told himself, “I *must* continue to perform intercourse on schedule.” This thought created such anxiety that he became increasingly unable to achieve a satisfactory erection. Because his perfect intercourse track record was broken, he now began clubbing himself with the “nothing” side of his all-or-nothing system and concluded, “I’m not a full marriage partner anymore. I’m a failure as a husband. I’m not even a man. I’m a worthless nothing.” Although he was a competent (and some might even say brilliant) psychiatrist, he confided to me tearfully, “Dr. Burns, you and I both know it is an undeniable fact that I will never be able to have intercourse again.” In spite of his years of medical training, he could actually convince himself of such a thought.

## **Overcoming the Sense of Worthlessness**

By now you might be saying, “Okay, I can see that there is a certain illogic which lurks behind the sense of worthlessness. At least for *some* people. But they are basically winners; they’re not like me. You seem to be treating famous physicians and successful businessmen. Anyone could have told you that their lack of self-esteem was illogical. But I really *am* a mediocre nothing. Others *are*, in fact, better looking and more popular and successful than I am. So what can I do about it? Nothing, that’s what! My feeling of worthlessness is very valid. It’s based on reality, so there is little consolation in being told to *think* logically. I don’t think there’s any way to make these awful feelings go away unless I try to fool myself, and you and I both know that won’t work.” Let me first show you a couple of popular approaches, used by many therapists, which I feel do *not* represent satisfactory solutions to your problem of worthlessness. Then I’ll show you some approaches that will make sense and help you.

In keeping with the belief that there is some deep truth in your conviction you are basically worthless, some psychotherapists may allow you to ventilate these feelings of inadequacy during a therapy session. There is undoubtedly some benefit to getting such feelings off your chest. The cathartic release may sometimes, but not always, result in a temporary mood elevation. However, if the therapist does not provide objective feedback about the validity of your self-evaluation, you may conclude that he agrees with you. And you may be right! You may, in fact, have fooled him as well as yourself! As a result you probably will feel even more inadequate.

Prolonged silences during therapy sessions may cause you to become more upset and preoccupied with your critical internal voice—much like a sensory-deprivation experiment. This kind of nondirective therapy, in which the therapist adopts a passive role, frequently produces greater anxiety and depression for the patient. And even when you do feel better as a result of achieving emotional release with an empathetic and caring therapist, the sense of improvement is likely to be short-lived if you haven’t significantly transformed the way you evaluate yourself and your life. Unless you substantially reverse your self-defeating thinking and behavior patterns, you are likely to slip back again into depression.

Just as emotional ventilation for its own sake is usually not enough to overcome the sense of worthlessness, insight and psychological interpretation generally don’t help either. For example, Jennifer was a writer who came for

treatment for panic she experienced before publication of her novel. In the first session she told me, “I have been to several therapists. They have told me that my problem is *perfectionism* and impossible expectations and demands on myself. I also have learned that I probably picked up this trait from my mother, who is compulsive and perfectionistic. She can find nineteen things wrong with an incredibly clean room. I always tried to please her, but rarely felt I succeeded no matter how well I did. Therapists have told me, ‘Stop seeing everyone as your mother! Stop being so perfectionistic.’ But how do I *do* this? I’d like to, I want to, but no one ever was able to tell me how to go about it.”

Jennifer’s complaint is one I hear nearly every day in my practice. Pinpointing the nature or origin of your problem may give you insight, but usually fails to change the way you act. That is not surprising. You have been practicing for years and years the bad mental habits that helped create your low self-esteem. It will take systematic and ongoing effort to turn the problem around. Does a stutterer stop stuttering because of his insight into the fact that he doesn’t vocalize properly? Does a tennis player’s game improve just because the coach tells him he hits the ball into the net too often?

Since ventilation of emotions and insight—the two staples of the standard psychotherapeutic diet—won’t help, what will? As a cognitive therapist, I have three aims in dealing with your sense of worthlessness: a rapid and decisive transformation in the way you *think, feel, and behave*. These results will be brought about in a systematic training program that employs simple concrete methods you can apply on a daily basis. If you are willing to commit some regular time and effort to this program, you can expect success proportionate to the effort you put in.

Are you willing? If so, we’ve come to the beginning. You’re about to take the first crucial step toward an improved mood and self-image.

I have developed many specific and easily applied techniques that can help you develop your sense of worth. As you read the following sections, keep in mind that simply reading them is not guaranteed to bolster your self-esteem—at least not for long. You will have to work at it and practice the various exercises. In fact, I recommend that you set some time aside each day to work at improving your self-image because *only* in this way can you experience the fastest and most enduring personal growth.

## Specific Methods for Boosting Self-Esteem

*1. Talk Back to That Internal Critic!* A sense of worthlessness is created by your internal self-critical dialogue. It is self-degrading statements, such as “I’m no damn good,” “I’m a shit,” “I’m inferior to other people,” and so on, that create and feed your feelings of despair and poor self-esteem. In order to overcome this bad mental habit, three steps are necessary:

- a. Train yourself to recognize and write down the self-critical thoughts as they go through your mind;
- b. Learn why these thoughts are distorted; and
- c. Practice talking back to them so as to develop a more realistic self-evaluation system.

One effective method for accomplishing this is the “triple-column technique.” Simply draw two lines down the center of a piece of paper to divide it into thirds (see Figure 4–1, page 63). Label the left-hand column “Automatic Thoughts (Self-Criticism),” the middle column “Cognitive Distortion,” and the right-hand column “Rational Response (Self-Defense).” In the left-hand column write down all those hurtful self-criticisms you make when you are feeling worthless and down on yourself.

Suppose, for example, you suddenly realize you’re late for an important meeting. Your heart sinks and you’re gripped with panic. Now ask yourself, “What thoughts are going through my mind right now? What am I saying to myself? Why is this upsetting me?” Then write these thoughts down in the left-hand column.

You might have been thinking, “I never do anything right,” and “I’m always late.” Write these thoughts down in the left-hand column and number them (see Figure 4–1). You might also have thought, “Everyone will look down at me. This shows what a jerk I am.” Just as fast as these thoughts cross your mind, jot them down. Why? Because they are the very *cause* of your emotional upset. They rip away at you like knives tearing into your flesh. I’m sure you know what I mean because you’ve *felt* it.

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<i>Automatic Thought</i>	<i>Cognitive Distortion</i>	<i>Rational Response</i>
(SELF-CRITICISM)		(SELF-DEFENSE)
1. I never do anything right.	1. Overgeneralization	1. Nonsense! I do a lot of things right.
2. I'm always late.	2. Overgeneralization	2. I'm not always late. That's ridiculous. Think of all the times I've been on time. If I'm late more often than I'd like, I'll work on this problem and develop a method for being more punctual.
3. Everyone will look down on me.	3. Mind reading Overgeneralization All-or-nothing thinking Fortune teller error	3. Someone may be disappointed that I'm late but it's not the end of the world. Maybe the meeting won't even start on time.
4. This shows what a jerk I am.	4. Labeling	4. Come on, now, I'm not "a jerk."
5. I'll make a fool of myself.	5. Labeling Fortune teller error	5. Ditto. I'm not "a fool" either. I may appear foolish if I come in late, but this doesn't make me a fool. Everyone is late sometimes.

**Figure 4–1.** The “triple-column technique” can be used to restructure the way you think about yourself when you have goofed up in some way. The aim is to substitute more objective rational thoughts for the illogical, harsh self-criticisms that automatically flood your mind when a negative event occurs.

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What’s the second step? You already began to prepare for this when you read Chapter 3. Using the list of ten cognitive distortions (page 42), see if you can identify the thinking errors in each of your negative automatic thoughts. For instance, “I never do anything right” is an example of overgeneralization. Write this down in the middle column. Continue to pinpoint the distortions in your other automatic thoughts, as shown in Figure 4–1.

You are now ready for the crucial step in mood transformation—substituting a more rational, less upsetting thought in the right-hand column. You do not try to cheer yourself up by rationalizing or saying things you do not believe are objectively valid. Instead, try to recognize *the truth*. If what you write down in the Rational Response column is not convincing and realistic, it won’t help you one bit. Make sure you believe in your rebuttal to self-criticism. This rational response can take into account what was illogical and erroneous about your self-critical automatic thought.

For example, in answer to “I never do anything right,” you could write, “Forget that! I do some things right and some wrong, just like everyone else. I fouled up on my appointment, but let’s not blow this up out of proportion.”

Suppose you cannot think of a rational response to a particular negative thought. Then just forget about it for a few days and come back to it later.

You will usually be able to see the other side of the coin. As you work at the triple-column technique for fifteen minutes every day over a period of a month or two, you will find it gets easier and easier. Don't be afraid to ask other people how they would answer an upsetting thought if you can't figure out the appropriate rational response on your own.

*One note of caution:* Do not use words describing your emotional reactions in the Automatic Thought column. Just write the thoughts that created the emotion. For example, suppose you notice your car has a flat tire. Don't write "I feel crappy" because you can't disprove that with a rational response. The fact is, you *do* feel crappy. Instead, write down the thoughts that automatically flashed through your mind the moment you saw the tire; for example, "I'm so stupid—I should have gotten a new tire this last month," or "Oh, hell! This is just my rotten luck!" Then you can substitute rational responses such as "It might have been better to get a new tire, but I'm not stupid and no one can predict the future with certainty." This process won't put air in the tire, but at least you won't have to change it with a deflated ego.

While it's best not to describe your emotions in the Automatic Thought column, it can be quite helpful to do some "emotional accounting" before and after you use the triple-column technique to determine how much your feelings actually improve. You can do this very easily if you record how upset you are between 0 and 100 percent before you pinpoint and answer your automatic thoughts. In the previous example, you might note that you were 80 percent frustrated and angry at the moment you saw the flat tire. Then, once you complete the written exercise, you can record how much relief you experienced, say, to 40 percent or so. If there's a decrease, you'll know that the method has worked for you.

A slightly more elaborate form developed by Dr. Aaron Beck called the Daily Record of Dysfunctional Thoughts allows you to record not only your upsetting thoughts but also your feelings and the negative event that triggered them (see Figure 4–2, page 66).

For example, suppose you are selling insurance and a potential customer insults you without provocation and hangs up on you. Describe the actual event in the Situation column, but *not* in the Automatic Thought(s) column. Then write down your feelings and the negative distorted thoughts that created them in the appropriate column. Finally, talk back to these thoughts and do your emotional accounting. Some individuals prefer to use the Daily

Record of Dysfunctional Thoughts because it allows them to analyze negative events, thoughts, and feelings in a systematic way. Be sure to use the technique that feels most comfortable to you.

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<b>Situation</b> Briefly describe the actual event leading to the unpleasant emotion.	<b>Emotion(s)</b> 1. Specify sad/anxious/angry, etc. 2. Rate degree of emotion, 1–100%.	<b>Automatic Thought(s)</b> Write the automatic thought(s) that accompany the emotion(s).	<b>Cognitive Distortion(s)</b> Identify the distortion(s) present in each automatic thought.	<b>Rational Response(s)</b> Write rational response(s) to the automatic thought(s).	<b>Outcome</b> Specify and rate subsequent emotions, 0–100%.
Potential customer hangs up on me when I call to describe our new insurance program. He said, "Get out of my god-dam hair!"	Angry, 99% Sad, 50%	1. I'll never sell a policy. 2. I'd like to strangle the bastard. 3. I must have said the wrong thing.	1. Overgeneralization 2. Magnification; labeling 3. Jumping to conclusions; personalization	1. I've sold a lot of policies. 2. He acted like a pain in the butt. We all do at times. Why let this get to me? 3. I actually didn't do anything different from the way I usually approach a new customer. So why sweat it?	Angry, 50% Sad, 10%

**Figure 4–2.** Daily Record of Dysfunctional Thoughts\*

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate it. Then, note the automatic thought associated with the emotion. In rating degree of emotion, 1 = a trace; 100 = the most intense possible.

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Writing down your negative thoughts and rational responses may strike you as simplistic, ineffective, or even gimmicky. You might even share the feelings of some patients who initially refused to do this, saying, “What’s the point? It won’t work—it couldn’t work because I really am hopeless and worthless.”

This attitude can only serve as a self-fulfilling prophecy. If you are unwilling to pick up the tool and use it, you won’t be able to do the job. Start by writing down your automatic thoughts and rational responses for fifteen minutes every day for two weeks and see the effect this has on your mood, as measured by the Burns Depression Checklist. You may be surprised to note

the beginning of a period of personal growth and a healthy change in your self-image.

This was the experience of Gail, a young secretary whose sense of self-esteem was so low that she felt in constant danger of being criticized by friends. She was so sensitive to her roommate's request to help clean up their apartment after a party that she felt rejected and worthless. She was initially so pessimistic about her chances for feeling better that I could barely persuade her to give the triple-column technique a try. When she reluctantly decided to try it, she was surprised to see how her self-esteem and mood began to undergo a rapid transformation. She reported that *writing down* the many negative thoughts that flowed through her mind during the day helped her gain objectivity. She stopped taking these thoughts so seriously. As a result of Gail's daily written exercises, she began to feel better, and her interpersonal relationships improved by a quantum leap. An excerpt from her written homework is included in Figure 4-3.

Gail's experience is not unusual. The simple exercise of answering your negative thoughts with rational responses on a daily basis is at the heart of the cognitive method. It is one of the most important approaches to changing your thinking. It is crucial to *write down* your automatic thoughts and rational responses; do not try to do the exercise in your head. Writing them down forces you to develop much more objectivity than you could ever achieve by letting responses swirl through your mind. It also helps you locate the mental errors that depress you. The triple-column technique is not limited to problems of personal inadequacy, but can be applied to a great range of emotional difficulties in which distorted thinking plays a central role. You can take the major sting out of problems you would ordinarily assume are entirely "realistic," such as bankruptcy, divorce, or severe mental illness. Finally, in the section on prophylaxis and personal growth, you will learn how to apply a slight variation of the automatic-thought method to penetrate to the part of your psyche where the causes of mood swings lurk. You will be able to expose and transform those "pressure points" in your mind that cause you to be vulnerable to depression in the first place.

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<i>Automatic Thoughts (SELF-CRITICISM)</i>	<i>Cognitive Distortion</i>	<i>Rational Response (SELF-DEFENSE)</i>
1. Everyone knows how disorganized and selfish I am.	Jumping to conclusions (mind reading); overgeneralization	1. I'm disorganized at times and I'm organized at times. Everybody doesn't think the same way about me.
2. I'm completely self-centered and thoughtless. I'm just no good.	All-or-nothing thinking	2. I'm thoughtless at times, and at times I can be quite thoughtful. I probably do act overly self-centered at times. I can work on this. I may be imperfect but I'm not "no good!"
3. My roommate probably hates me. I have no real friends.	Jumping to conclusions (mind reading); all-or-nothing thinking	3. My friendships are just as real as anyone's. At times I take criticism as rejection of <i>me</i> , Gail, the person. But others are usually not rejecting <i>me</i> . They're just expressing dislike for what <i>I did</i> (or said)—and they still accept me afterward.

**Figure 4–3.** Excerpts from Gail's daily written homework using the "triple-column technique." In the left column she recorded the negative thoughts that automatically flowed through her mind when her roommate asked her to clean up the apartment. In the middle column she identified her distortions, and in the right-hand column she wrote down more realistic interpretations. This daily written exercise greatly accelerated her personal growth and resulted in substantial emotional relief.

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2. *Mental Biofeedback.* A second method which can be very useful involves monitoring your negative thoughts with a wrist counter. You can buy one at a sporting-goods store or a golf shop; it looks like a wristwatch, is inexpensive, and every time you push the button, the number changes on the dial. Click the button each time a negative thought about yourself crosses

your mind; be on the constant alert for such thoughts. At the end of the day, note your daily total score and write it down in a log book.

At first you will notice that the number increases; this will continue for several days as you get better and better at identifying your critical thoughts. Soon you will begin to notice that the daily total reaches a plateau for a week to ten days, and then it will begin to go *down*. This indicates that your harmful thoughts are diminishing and that you are getting better. This approach usually requires three weeks.

It is not known with certainty why such a simple technique works so well, but systematic self-monitoring frequently helps develop increased self-control. As you learn to stop haranguing yourself, you will begin to feel much better.

In case you decide to use a wrist counter, I want to emphasize it is not intended to be a substitute for setting aside ten to fifteen minutes each day to write down your distorted negative thoughts and answering them as outlined in the previous pages. The written method cannot be bypassed because it exposes to the light of day the illogical nature of the thoughts that trouble you. Once you are doing this regularly, you can then use your wrist counter to nip your painful cognitions in the bud at other times.

3. *Cope, Don't Mope!—The Woman Who Thought She Was a “Bad Mother.”* As you read the previous sections, the following objection may have occurred to you: “All this deals with is my *thoughts*. But what if my problems are realistic? What good will it do me to think differently? I have some real inadequacies that need to be dealt with.”

Nancy is a thirty-four-year-old mother of two who felt this way. Six years ago she divorced her first husband and has just recently remarried. She is completing her college degree on a part-time basis. Nancy is usually animated and enthusiastic and quite committed to her family. However, she has experienced episodic depressions for many years. During those low periods she becomes extremely critical of herself and others, and expresses self-doubt and insecurity. She was referred to me during such a period of depression.

I was struck by the vehemence of her self-reproach. She had received a note from her son’s teacher stating that he was having some difficulty in

school. Her immediate reaction was to mope and blame herself. The following is an excerpt from our therapy session:

NANCY: I should have worked with Bobby on his homework because now he is disorganized and not ready for school. I spoke to Bobby's teacher, who said Bobby lacks self-confidence and doesn't follow directions adequately. Consequently, his school work has been deteriorating. I had a number of self-critical thoughts after the call and I felt suddenly dejected. I began to tell myself that a good mother spends time with her kids on some activity every night. I'm responsible for his poor behavior—lying, not doing well in school. I just can't figure out how to handle him. I'm really a bad mother. I began to think he was stupid and about to flunk and how it was all my fault.

My first strategy was to teach her how to attack the statement "I am a bad mother," because I felt this self-criticism was hurtful and unrealistic, creating a paralyzing internal anguish which would not help her in her efforts to guide Bobby through his crisis.

DAVID: Okay. What's wrong with this statement, "I am a bad mother"?

NANCY: Well...

DAVID: Is there any such thing as a "bad mother"?

NANCY: Of course.

DAVID: What is your definition of a "bad mother"?

NANCY: A bad mother is one who does a bad job of raising her kids. She isn't as effective as other mothers, so her kids turn out bad. It seems obvious.

DAVID: So you would say a "bad mother" is one who is low on mothering skills? That's your definition?

NANCY: Some mothers lack mothering skills.

DAVID: But all mothers lack mothering skills to some extent.

NANCY: They do?

DAVID: There's no mother in this world who is perfect in all mothering skills. So they all lack mothering skills in some part. According to

your definition, it would seem that all mothers are bad mothers.

NANCY: I feel that *I'm* a bad mother, but not everybody is.

DAVID: Well, define it again. What is a "bad mother"?

NANCY: A bad mother is someone who does not understand her children c  
is constantly making damaging errors. Errors that are detrimental.

DAVID: According to this new definition, you're not a "bad mother," an  
there are no "bad mothers" because no one constantly make  
damaging errors.

NANCY: No one...?

DAVID: You said that a bad mother *constantly* makes damaging errors.  
There is no such person who constantly makes damaging error  
twenty-four hours a day. Every mother is capable of doing *som*  
things right.

NANCY: Well, there can be abusive parents who are always punishing  
hitting—you read about them in the papers. Their children end u  
battered. That could certainly be a bad mother.

DAVID: There are parents who resort to abusive behavior, that's true. An  
these individuals could improve their behavior, which might mak  
them feel better about themselves and their children. But it's nc  
realistic to say that such parents are *constantly* doing abusing c  
damaging things, and it's not going to help matters by attachin  
the label "bad" to them. Such individuals do have a problem wit  
aggression and need training in self-control, but it would onl  
make matters worse if you tried to convince them that thei  
problem was badness. They usually already believe they are rotte  
human beings, and that is part of their problem. Labeling them a  
"bad mothers" would be inaccurate, and it would also b  
irresponsible, like trying to put out a fire by throwing gasoline o  
it.

At this point I was trying to show Nancy that she was just defeating herself  
by labeling herself as a "bad mother." I hoped to show her that no matter how  
she defined "bad mother," the definition would be unrealistic. Once she gave  
up the destructive tendency to mope and label herself as worthless, we could

then go on to coping strategies for helping her son with his problems at school.

NANCY: But I still have the feeling I am a “bad mother.”

DAVID: Well, once again, what is your definition?

NANCY: Someone who doesn’t give her child enough attention, positive attention. I’m so busy in school. And when I do pay attention, I’m afraid it may be all negative attention. Who knows? That’s what I’m saying.

DAVID: A “bad mother” is one who doesn’t give her child enough attention, you say? Enough for what?

NANCY: For her child to do well in life.

DAVID: Do well in *everything*, or in some things?

NANCY: In some things. No one can do well at everything.

DAVID: Does Bobby do well at some things? Does he have any redeeming virtues?

NANCY: Oh yes. There are many things he enjoys and does well at.

DAVID: Then you can’t be a “bad mother” according to your definition because your son does well at many things.

NANCY: Then why do I feel like a bad mother?

DAVID: It seems that you’re labeling yourself as a “bad mother” because you’d like to spend more time with your son, and because you sometimes feel inadequate, and because there is a clear-cut need to improve your communication with Bobby. But it won’t help you solve these problems if you conclude automatically you are a “bad mother.” Does that make sense to you?

NANCY: If I paid more attention to him and gave him more help, he could do better at school and he could be a whole lot happier. I feel it’s my fault when he doesn’t do well.

DAVID: So you are willing to take the blame for his mistakes?

NANCY: Yes, it’s my fault. So I’m a bad mother.

DAVID: And you also take the credit for his achievements? And for his happiness?

NANCY: No—he should get the credit for that, not me.

DAVID: Does that make sense? That you're responsible for his faults but not his strengths?

NANCY: No.

DAVID: Do you understand the point I'm trying to make?

NANCY: Yep.

DAVID: "Bad mother" is an abstraction; there is no such thing as a "bad mother" in this universe.

NANCY: Right. But mothers can do bad things.

DAVID: They're just people, and people do a whole variety of things—good, bad, and neutral. "Bad mother" is just a fantasy; there's no such thing. The chair is a thing. A "bad mother" is an abstraction. You understand that?

NANCY: I got it, but some mothers are more experienced and more effective than others.

DAVID: Yes, there are all degrees of effectiveness at parenting skills. Almost everyone has plenty of room for improvement. The meaningful question is not "Am I a good or bad mother?" but rather "What are my relative skills and weaknesses, and what can I do to improve?"

NANCY: I understand. That approach makes more sense and it feels much better. When I label myself "bad mother," I just feel inadequate and depressed, and I don't do anything productive. Now I see what you've been driving at. Once I give up criticizing myself, I'll feel better, and maybe I can be more helpful to Bobby.

DAVID: Right! So when you look at it that way, you're talking about coping strategies. For example, what are your parenting skills? How can you begin to improve on those skills? Now that's the type of thing I would suggest with regard to Bobby. Seeing yourself as a "bad mother" eats up emotional energy and distracts you from the task of improving your mothering skills. It's irresponsible.

NANCY: Right. If I can stop punishing myself with that statement, I'll be much better off and I can start working toward helping Bobby. The moment I stop calling myself a bad mother, I'll start feeling better.

DAVID: Yes, now what can you say to yourself when you have the urge to

say “I’m a bad mother”?

NANCY: I can say I don’t have to hate my whole self if there is a particular thing I find I dislike about Bobby, or if he has a problem at school I can try to *define* that problem, and *attack* that problem, and work toward solving it.

DAVID: Right. Now, that’s a positive approach. I like it. You refute the negative statement and then add a positive statement. I like that.

We then worked on answering several “automatic thoughts” she had written down after the call from Bobby’s teacher (see Figure 4–4, below). As Nancy learned to refute her self-critical thoughts, she experienced much-needed emotional relief. She was then able to develop some specific coping strategies designed to help Bobby with his difficulties.

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<i>Automatic Thought (SELF-CRITICISM)</i>	<i>Rational Response (SELF-DEFENSE)</i>
1. I didn’t pay attention to Bobby.	1. I really spend <i>too much</i> time with him; I’m overprotective.
2. I should have worked with him on his homework, and now he is disorganized and not ready for school.	2. Homework is his responsibility, not mine. I can explain to him how to get organized. What are my responsibilities? a. Check homework; b. Insist it be done at a certain time; c. Ask if he’s having any difficulties; d. Set up a reward system.
3. A good mother spends time with her kids on some activity every night.	3. Not true. I spend time when I can and want to, but it isn’t feasible always. Besides, his schedule is his.
4. I’m responsible for his poor behavior and not doing well in school.	4. I can only guide Bobby. It’s up to him to do the rest.

- |   |   |
|---|---|
| 5. He wouldn't have gotten into trouble at school if I had helped him. If I had supervised his homework earlier, this problem wouldn't have occurred. | 5. That is not so. Problems will occur even if I'm around to oversee things.  |
| 6. I'm a bad mother. I'm the cause of his problems.   | 6. I'm not a bad mother; I try. I can't control what goes on in all areas of his life. Maybe I can talk to him and his teacher and find out how to help him. Why punish myself whenever someone I love has a problem? |
| 7. All other mothers work with their kids, but I don't know how to get along with Bobby.  | 7. Overgeneralization! Not true. Stop moping and start coping.  |

**Figure 4–4.** Nancy's written homework concerning Bobby's difficulties at school. This is similar to the “triple-column technique,” except that she did not find it necessary to write down the cognitive distortions contained in her automatic thoughts.

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The first step of her coping plan was to talk to Bobby about the difficulties he had been having so as to find out what the real problem was. Was he having difficulties as his teacher had suggested? What was his understanding of the problem? Was it true that he was feeling tense and low in confidence? Had his homework been particularly hard for him recently? Once Nancy had obtained this information and defined the real problem, she realized she would then be in a position to work toward an appropriate solution. For example, if Bobby said he found some of his courses particularly difficult, she could develop a reward system at home to encourage him to do extra homework. She also decided to read several books on parenting skills. Her relationship with Bobby improved, and his grades and behavior at school underwent a rapid turnaround.

Nancy's mistake had been to view herself in a global way, making the moralistic judgment that she was a bad mother. This type of criticism incapacitated her because it created the impression that she had a personal problem so big and bad that no one could do anything about it. The emotional upset this labeling caused prevented her from *defining* the real problem, *breaking it down* into its specific parts, and *applying appropriate solutions*. If

she had continued to mope, there was the distinct possibility that Bobby would have continued to do poorly, and she would have become increasingly ineffectual.

How can you apply what Nancy learned to your own situation? When you are down on yourself, you might find it helpful to ask what you actually mean when you try to define your true identity with a negative label such as “a fool,” “a sham,” “a stupid dope,” etc. Once you begin to pick these destructive labels apart, you will find they are arbitrary and meaningless. They actually cloud the issue, creating confusion and despair. Once rid of them, you can define and cope with any real problems that exist.

*Summary.* When you are experiencing a blue mood, the chances are that you are telling yourself you are inherently inadequate or just plain “no good.” You will become convinced that you have a bad core or are essentially worthless. To the extent that you believe such thoughts, you will experience a severe emotional reaction of despair and self-hatred. You may even feel that you’d be better off dead because you are so unbearably uncomfortable and self-denigrating. You may become inactive and paralyzed, afraid and unwilling to participate in the normal flow of life.

Because of the negative emotional and behavioral consequences of your harsh thinking, the first step is to stop telling yourself you are worthless. However, you probably won’t be able to do this until you become absolutely convinced that these statements are *incorrect* and *unrealistic*.

How can this be accomplished? You must first consider that a human life is an ongoing process that involves a constantly changing physical body as well as an enormous number of rapidly changing thoughts, feelings, and behaviors. Your life therefore is an evolving experience, a continual flow. You are not a thing; that’s why any label is constricting, highly inaccurate, and global. Abstract labels such as “worthless” or “inferior” *communicate nothing* and *mean nothing*.

But you may still be convinced you are second-rate. What is your evidence? You may reason, “I feel inadequate. Therefore, I must *be* inadequate. Otherwise, why would I be filled with such unbearable emotions?” Your error is in emotional reasoning. Your feelings do not determine your worth, simply your relative state of comfort or discomfort. Rotten, miserable internal states do not prove that you are a rotten, worthless

person, merely that you think you are; because you are in a temporarily depressed mood, you are thinking illogically and unreasonably about yourself.

Would you say that states of mood elevation and happiness prove you are great or especially worthy? Or do they simply mean that you are feeling good?

Just as your feelings do not determine your worth, neither do your thoughts or behaviors. Some may be positive, creative, and enhancing; the great majority are neutral. Others may be irrational, self-defeating, and maladaptive. These can be modified if you are willing to exert the effort, but they certainly do not and cannot mean that you are no good. There is no such thing in this universe as a worthless human being.

“Then how can I develop a sense of self-esteem?” you may ask. The answer is—you don’t have to! You don’t have to do anything especially worthy to create or deserve self-esteem; all you have to do is turn off that critical, haranguing, inner voice. Why? *Because that critical inner voice is wrong!* Your internal self-abuse springs from illogical, distorted thinking. Your sense of worthlessness is not based on truth, it is just the abscess which lies at the core of depressive illness.

So remember three crucial steps when you are upset:

1. Zero in on those automatic negative thoughts and write them down. Don’t let them buzz around in your head; snare them on paper!
2. Read over the list of ten cognitive distortions. Learn precisely how you are twisting things and blowing them out of proportion.
3. Substitute a more objective thought that puts the lie to the one which made you look down on yourself. As you do this, you’ll begin to feel better. You’ll be boosting your self-esteem, and your sense of worthlessness (and, of course, your depression) will disappear.

## Chapter 5

### **Do-Nothingism: How to Beat It**

In the last chapter you learned that you can change your mood by changing how you *think*. There is a second major approach to mood elevation that is enormously effective. People are not only thinkers, they are doers, so it is not surprising that you can substantially change the way you feel by changing the way you act. There's only one hitch—when you're depressed, you don't feel like doing much.

One of the most destructive aspects of depression is the way it paralyzes your willpower. In its mildest form you may simply procrastinate about doing a few odious chores. As your lack of motivation intensifies, virtually any activity appears so difficult that you become overwhelmed by the urge to do nothing. Because you accomplish very little, you feel worse and worse. Not only do you cut yourself off from your normal sources of stimulation and pleasure, but your lack of productivity aggravates your self-hatred, resulting in further isolation and incapacitation.

If you don't recognize the emotional prison in which you are trapped, this situation can go on for weeks, months, or even years. Your inactivity will be all the more frustrating if you once took pride in the energy you had for life. Your do-nothingism can also affect your family and friends, who, like yourself, cannot understand your behavior. They may say that you must want to be depressed or else you'd "get off your behind." Such a comment only worsens your anguish and paralysis.

Do-nothingism represents one of the great paradoxes of human nature. Some people naturally throw themselves into life with great zest, while others always hang back, defeating themselves at every turn as if they were involved in a plot against themselves. Do you ever wonder why?

If a person were condemned to spend months in isolation, cut off from all normal activities and interpersonal relationships, a substantial depression would result. Even young monkeys slip into a retarded, withdrawn state if

they are separated from their peers and confined to a small cage. Why do you voluntarily impose a similar punishment on yourself? Do you want to suffer? Using cognitive techniques, you can discover the precise reasons for your difficulties in motivating yourself.

In my practice I find that the great majority of the depressed patients referred to me improve substantially if they try to help themselves. Sometimes it hardly seems to matter what you do as long as you do something with the attitude of self-help. I know of two presumably “hopeless” cases who were helped enormously simply by putting a mark on a piece of paper. One patient was an artist who had been convinced for years that he couldn’t even draw a straight line. Consequently he didn’t even try to draw. When his therapist suggested he test his conviction by actually attempting to draw a line, it came out so straight he began drawing again and soon was symptom-free! And yet many depressed individuals will go through a phase in which they *stubbornly refuse* to do anything to help themselves. The moment this crucial motivational problem has been solved, the depression typically begins to diminish. You can therefore understand why much of our research has been directed to locating the causes of this paralysis of the will. Using this knowledge, we have developed some specific methods to help you deal with procrastination.

Let me describe two perplexing patients I treated recently. You might think their do-nothingism is extreme and wrongly conclude they must be “crazies” with whom you would have little in common. In fact, I believe their problems are caused by attitudes similar to yours, so don’t write them off.

Patient A, a twenty-eight-year-old woman, has done an experiment to see how her mood would respond to a variety of activities. It turns out that she feels substantially better when she does nearly *anything*. The list of things that will reliably give her a mood lift includes cleaning the house, playing tennis, going to work, practicing her guitar, shopping for dinner, etc. Only one thing makes her feel reliably worse; this single activity nearly always makes her intensely miserable. Can you guess what it is? DO-NOTHINGISM: lying around in bed all day long, staring at the ceiling and courting negative thoughts. And guess what she does weekends. Right! She crawls right into bed on Saturday morning and begins her descent into inner hell. Do you think she really wants to suffer?

Patient B, a physician, gives me a clear, definite message early in her therapy. She says she understands that the speed of improvement is dependent on her willingness to work between sessions, and insists she wants to get well more than anything else in the world, having been wracked by depression for over sixteen years. She emphasizes she'll be happy to come to therapy sessions, but I must not ask her to lift one finger to help herself. She says that if I push her to spend five minutes on self-help assignments, she'll kill herself. As she describes in detail the lethal, gruesome method of self-destruction she had carefully planned in her hospital's operating room, it becomes obvious that she is deadly serious. Why is she so determined not to help herself?

I know your procrastination is probably less severe and only deals with minor things, like paying bills, a trip to the dentist, etc. Or maybe you've had trouble finishing a relatively straightforward report that is crucial to your career. But the perplexing question is the same—why do we frequently behave in ways that are not in our self-interest?

Procrastinating and self-defeating behavior can seem funny, frustrating, puzzling, infuriating, or pathetic, depending on your perspective. I find it a very human trait, so widespread that we all bump into it nearly every day. Writers, philosophers, and students of human nature throughout history have tried to formulate some explanation for self-defeating behavior, including such popular theories as:

1. You're basically lazy; it's just your "nature."
2. You *want* to hurt yourself and suffer. You either like feeling depressed, or you have a self-destructive drive, a "death wish."
3. You're passive-aggressive, and you want to frustrate the people around you by doing nothing.
4. You must be getting some "payoff" from your procrastination and do-nothingism. For example, you enjoy getting all that attention when you are depressed.

Each of these famous explanations represents a different psychological theory, and each is inaccurate! The first is a "trait" model; your inactivity is seen as a fixed personality trait and stems from your "lazy streak." The problem with this theory is that it just labels the problem without explaining it. Labeling yourself as "lazy" is useless and self-defeating because it creates

the false impression that your lack of motivation is an irreversible, innate part of your makeup. This kind of thinking does not represent a valid scientific theory, but is an example of a cognitive distortion (labeling).

The second model implies you want to hurt yourself and suffer because there is something enjoyable or desirable about procrastination. This theory is so ludicrous I hesitate to include it, except that it is widespread and vigorously supported by a substantial percentage of psychotherapists. If you have the hunch that you or someone else likes being depressed and doing nothing, then remind yourself that depression is the most agonizing form of human suffering. Tell me—what is so great about it? I haven't yet met a patient who really enjoys the misery.

If you aren't convinced but think you really do enjoy pain and suffering, then give yourself the paper-clip test. Straighten out one end of a paper clip and push it under your fingernail. As you push harder and harder, you may notice how the pain becomes more and more excruciating. Now ask yourself—is this really enjoyable? Do I *really* like to suffer?

The third hypothesis—you're “passive-aggressive”—represents the thinking of many therapists, who believe that depressive behavior can be explained on the basis of “internalized anger.” Your procrastination could be seen as an expression of that pent-up hostility because your inaction often annoys the people around you. One problem with this theory is that most depressed or procrastinating individuals simply do not feel particularly angry. Resentment can sometimes contribute to your lack of motivation, but is usually not central to the problem. Although your family may feel frustrated about your depression, you probably do not intend them to react this way. In fact, it is more often the case that you *fear* displeasing them. The implication that you are *intentionally* doing nothing in order to frustrate them is insulting and untrue; such a suggestion will only make you feel worse.

The last theory—you must be getting some “payoff” from procrastination—reflects more recent, behaviorally oriented psychology. Your moods and actions are seen as the result of rewards and punishments from your environment. If you are feeling depressed and doing nothing about it, it follows that your behavior is being rewarded in some way.

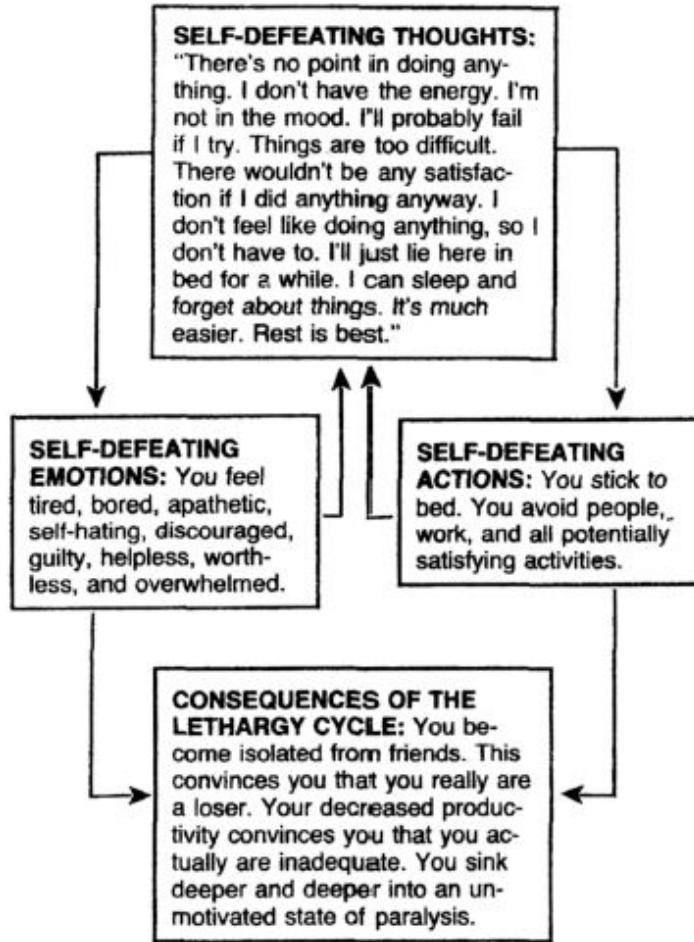
There is a grain of truth in this; depressed people do sometimes receive substantial support and reassurance from others who try to help them. However, the depressed person rarely enjoys all the attention he receives

because of his profound tendency to disqualify it. If you are depressed and someone tells you they like you, you will probably think, “He doesn’t know how rotten I am. I don’t deserve this praise.” Depression and lethargy have no real rewards. Theory number four bites the dust with the others.

How can you find the real cause of motivational paralysis? The study of mood disorders gives us the unique opportunity to observe extraordinary transformations in levels of personal motivation within short periods of time. The same individual who ordinarily bursts with creative energy and optimism may be reduced during an episode of depression to pathetic, bedridden immobility. By tracing dramatic mood swings, we can gather valuable clues that unlock many of the mysteries of human motivation. Simply ask yourself, “When I think about that undone task, what thoughts immediately come to mind?” Then write those thoughts down on a piece of paper. What you write will reflect a number of maladaptive attitudes, misconceptions, and faulty assumptions. You will learn that the feelings that impede your motivation, such as apathy, anxiety, or the sense of being overwhelmed, are the result of distortions in your thinking.

Figure 5–1 shows a typical Lethargy Cycle. The thoughts on this patient’s mind are negative; he says to himself, “There’s no point in doing anything because I am a born loser and so I’m bound to fail.” Such a thought sounds very convincing when you are depressed, immobilizing you and making you feel inadequate, overwhelmed, self-hating, and helpless. You then take these negative emotions as proof that your pessimistic attitudes are valid, and you begin to change your approach to life. Because you are convinced you will botch up anything, you don’t even try; you stay in bed instead. You lie back passively and stare at the ceiling, hoping to drift into sleep, painfully aware you are letting your career go down the drain while your business dwindles into bankruptcy. You may refuse to answer the phone for fear of hearing bad news; life becomes a treadmill of boredom, apprehension, and misery. This vicious cycle can go on indefinitely unless you know how to beat it.

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**Figure 5–1.** The Lethargy Cycle. Your self-defeating negative thoughts make you feel miserable. Your painful emotions in turn convince you that your distorted, pessimistic thoughts are actually valid. Similarly, self-defeating thoughts and actions reinforce each other in a circular manner. The unpleasant consequences of do-nothingism make your problems even worse.

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As indicated in Figure 5–1, the relationship between your thoughts, feelings, and behaviors is reciprocal—all your emotions and actions are the results of your thoughts and attitudes. Similarly, your feelings and behavior patterns influence your perceptions in a wide variety of ways. It follows from this model that all emotional change is ultimately brought about by cognitions; changing your behavior will help you feel better about yourself if it exerts a positive influence on the way you are *thinking*. Thus, you can

modify your self-defeating mental set if you change your behavior in such a way that you are simultaneously putting the lie to the self-defeating attitudes that represent the core of your motivational problem. Similarly, as you change the way you think, you will feel more in the mood to do things, and this will have an even stronger positive effect on your thinking patterns. Thus, you can transform your lethargy cycle into a productivity cycle.

The following are the types of mind-sets most commonly associated with procrastination and do-nothingism. You may see yourself in one or more of them.

1. *Hopelessness*. When you are depressed, you get so frozen in the pain of the present moment that you forget entirely that you ever felt better in the past and find it inconceivable that you might feel more positive in the future. Therefore, any activity will seem pointless because you are absolutely certain your lack of motivation and sense of oppression are unending and irreversible. From this perspective the suggestion that you do something to “help yourself” might sound as ludicrous and insensitive as telling a dying man to cheer up.

2. *Helplessness*. You can’t possibly do anything that will make yourself feel better because you are convinced that your moods are caused by factors beyond your control, such as fate, hormone cycles, dietary factors, luck, and other people’s evaluations of you.

3. *Overwhelming Yourself*. There are several ways you may overwhelm yourself into doing nothing. You may magnify a task to the degree that it seems impossible to tackle. You may assume you must do everything at once instead of breaking each job down into small, discrete, manageable units which you can complete one step at a time. You might also inadvertently distract yourself from the task at hand by obsessing about endless other things you haven’t gotten around to doing yet. To illustrate how irrational this is, imagine that every time you sat down to eat, you thought about all the food you would have to eat during your lifetime. Just imagine for a moment that all piled up in front of you are tons of meat, vegetables, ice cream, and thousands of gallons of fluids! And you have to eat every bit of this food before you die! Now, suppose that before every meal you said to yourself, “This meal is just a drop in the bucket. How can I ever get all that food

eaten? There's just no point in eating one pitiful hamburger tonight." You'd feel so nauseated and overwhelmed your appetite would vanish and your stomach would turn into a knot. When you think about all the things you are putting off, you do this very same thing without being aware of it.

4. *Jumping to Conclusions.* You sense that it's not within your power to take effective action that will result in satisfaction because you are in the habit of saying, "I can't," or "I would but ..." Thus when I suggested that a depressed woman bake an apple pie, she responded, "I can't cook anymore." What she really meant to say was, "I have the feeling I wouldn't enjoy cooking and it seems like it would be awfully difficult." When she tested these assumptions by attempting to bake a pie, she found it surprisingly satisfying and not at all difficult.

5. *Self-labeling.* The more you procrastinate, the more you condemn yourself as inferior. This saps your self-confidence further. The problem is compounded when you label yourself "a procrastinator" or "a lazy person." This causes you to see your lack of effective action as the "real you" so that you automatically expect little or nothing from yourself.

6. *Undervaluing the Rewards.* When you are depressed you may fail to initiate any meaningful activity not only because you conceive of any task as terribly difficult, but also because you feel the reward simply wouldn't be worth the effort.

"Anhedonia" is the technical name for a diminished ability to experience satisfaction and pleasure. A common thinking error—your tendency to "disqualify the positive"—may be at the root of this problem. Do you recall what this thinking error consists of?

A businessman complained to me that nothing he did all day was satisfying. He explained that in the morning he had attempted to return a call from a client, but found the line was busy. As he hung up, he told himself, "That was a waste of time." Later in the morning he successfully completed an important business negotiation. This time he told himself, "Anyone in our firm could have handled it just as well or better. It was an easy problem, and so my role wasn't really important." His lack of satisfaction results from the fact that he always finds a way to discredit his efforts. His bad habit of saying "It doesn't count" successfully torpedoes any sense of fulfillment.

7. *Perfectionism.* You defeat yourself with inappropriate goals and standards. You will settle for nothing short of a magnificent performance in anything you do, so you frequently end up having to settle for just that—*nothing*.

8. *Fear of Failure.* Another mind-set which paralyzes you is the fear of failure. Because you imagine that putting in the effort and not succeeding would be an overwhelming personal defeat, you refuse to try at all. Several thinking errors are involved in the fear of failure. One of the most common is overgeneralization. You reason, “If I fail at this, it means I will fail at anything.” This, of course, is impossible. Nobody can fail at everything. We all have our share of victories and defeats. While it is true that victory tastes sweet and defeat is often bitter, failing at any task need not be a fatal poison, and the bad taste will not linger forever.

A second mind-set that contributes to the fear of defeat is when you evaluate your performance exclusively on the outcome regardless of your individual effort. This is illogical and reflects a “product orientation” rather than a “process orientation.” Let me explain this with a personal example. As a psychotherapist I can control only what I say and how I interact with each patient. I cannot control how any particular patient will respond to my efforts during a given therapy session. What I say and how I interact is the process; how each individual reacts is the product. In any given day, several patients will report that they have benefited greatly from that day’s session, while a couple of others will tell me that their session was not particularly helpful. If I evaluated my work exclusively on the outcome or product, I would experience a sense of exhilaration whenever a patient did well, and feel defeated and defective whenever a patient reacted negatively. This would make my emotional life a roller coaster, and my self-esteem would go up and down in an exhausting and unpredictable manner all day long. But if I admit to myself that all I can control is the input I provide in the therapeutic process, I can pride myself on good consistent work regardless of the outcome of any particular session. It was a great personal victory when I learned to evaluate my work based on the process rather than on the product. If a patient gives me a negative report, I try to learn from it. If I did make an error, I attempt to correct it, but I don’t need to jump out the window.

*9. Fear of Success.* Because of your lack of confidence, success may seem even more risky than failure because you are certain it is based on chance. Therefore, you are convinced you couldn't keep it up, and you feel your accomplishments will falsely raise the expectations of others. Then when the awful truth that you are basically "a loser" ultimately comes out, the disappointment, rejection, and pain will be all the more bitter. Since you feel sure you will eventually fall off the cliff, it seems safer not to go mountain climbing at all.

You may also fear success because you anticipate that people will make even greater demands on you. Because you are convinced you *must* and *can't* meet their expectations, success would put you into a dangerous and impossible situation. Therefore, you try to maintain control by avoiding any commitment or involvement.

*10. Fear of Disapproval or Criticism.* You imagine that if you try something new, any mistake or flub will be met with strong disapproval and criticism because the people you care about won't accept you if you are human and imperfect. The risk of rejection seems so dangerous that to protect yourself you adopt as low a profile as possible. If you don't make any effort, you can't goof up!

*11. Coercion and Resentment.* A deadly enemy of motivation is a sense of coercion. You feel under intense pressure to perform—generated from within and without. This happens when you try to motivate yourself with moralistic "shoulds" and "oughts." You tell yourself, "I *should* do this" and "I *have* to do that." Then you feel obliged, burdened, tense, resentful, and guilty. You feel like a delinquent child under the discipline of a tyrannical probation officer. Every task becomes colored with such unpleasantness that you can't stand to face it. Then as you procrastinate, you condemn yourself as a lazy, no-good bum. This further drains your energies.

*12. Low Frustration Tolerance.* You assume that you should be able to solve your problems and reach your goals rapidly and easily, so you go into a frenzied state of panic and rage when life presents you with obstacles. Rather than persist patiently over a period of time, you may retaliate against the "unfairness" of it all when things get tough, so you give up completely. I also

call this the “entitlement syndrome” because you feel and act as if you were entitled to success, love, approval, perfect health, happiness, etc.

Your frustration results from your habit of comparing reality with an ideal in your head. When the two don’t match, you condemn reality. It doesn’t occur to you that it might be infinitely easier simply to change your expectations than to bend and twist reality.

This frustration is frequently generated by should statements. While jogging, you might complain, “For all the miles I’ve gone, I should be in better shape by now.” Indeed? Why should you? You may have the illusion that such punishing, demanding statements will help you by driving you on to try harder and to put out more effort. It rarely works this way. The frustration just adds to your sense of futility and increases your urge to give up and do nothing.

*13. Guilt and Self-blame.* If you are frozen in the conviction you are bad or have let others down, you will naturally feel unmotivated to pursue your daily life. I recently treated a lonely elderly woman who spent her days in bed in spite of the fact that she felt better when she shopped, cooked, and socialized with her friends. Why? This sweet woman was holding herself responsible for her daughter’s divorce five years earlier. She explained, “When I visited them, I should have sat down and talked things over with my son-in-law. I should have asked him how things were going. Maybe I could have helped. I wanted to and yet I didn’t take the opportunity. Now I feel I failed them.” After we reviewed the illogic in her thinking, she felt better immediately and became active again. Because she was human and not God, she could not have been expected to predict the future or to know precisely how to intervene.

By now you may be thinking, “So what? I know that my do-nothingism is in a way illogical and self-defeating. I can see myself in several of the mental sets you’ve described. But I feel like I’m trying to wade through a pool of molasses. I just can’t get myself going. You may say all this oppression just results from my attitudes, but it feels like a ton of bricks. So what can I do about it?”

Do you know why virtually *any* meaningful activity has a decent chance of brightening your mood? If you do nothing, you will become preoccupied with the flood of negative, destructive thoughts. If you do something, you

will be temporarily distracted from that internal dialogue of self-denigration. What is even more important, the sense of mastery you will experience will disprove many of the distorted thoughts that slowed you down in the first place.

As you review the following self-activation techniques, choose a couple that appeal most to you and work at them for a week or two. Remember you don't have to master them all! One man's salvation can be another's curse. Use the methods that seem the most tailored to your particular brand of procrastination.

*The Daily Activity Schedule.* The Daily Activity Schedule (see Figure 5–2, page 95) is simple but effective, and can help you get organized in your fight against lethargy and apathy. The schedule consists of two parts. In the Prospective column, write out an hour-by-hour plan for what you would like to accomplish each day. Even though you may actually carry out only a portion of your plan, the simple act of creating a method of action every day can be immensely helpful. Your plans need not be elaborate. Just put one or two words in each time slot to indicate what you'd like to do, such as "dress," "eat lunch," "prepare résumé," etc. It should not require more than five minutes to do this.

At the end of the day, fill out the Retrospective column. Record in each time slot what you actually did during the day. This may be the same as or different from what you actually planned; nevertheless, even if it was just staring at the wall, write it down. In addition, label each activity with the letter M for mastery or the letter P for pleasure. Mastery activities are those which represent some accomplishment, such as brushing your teeth, cooking dinner, driving to work, etc. Pleasure might include reading a book, eating, going to a movie, etc. After you have written M or P for each activity, estimate the actual amount of pleasure, or the degree of difficulty in the task by using a zero to five rating. For example, you could give yourself a score of M-1 for particularly easy tasks like getting dressed, while M-4 or M-5 would indicate you did something more difficult and challenging, such as not eating too much or applying for a job. You can rate the pleasure activities in a similar manner. If any activity was pleasurable in the past when you were not depressed, but today it was nearly or totally devoid of pleasure, put a P-½ or a P-0. Some activities, such as cooking dinner, can be labeled M and P.

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<b><u>PROSPECTIVE:</u></b>		<b><u>RETROSPECTIVE:</u></b>
Plan your activities on an hour-by-hour basis at the start of the day		At the end of the day, record what you actually did and rate each activity with an M for mastery or a P for pleasure.*
Date _____		
<b><u>TIME</u></b>		
8-9		
9-10		
10-11		
11-12		
12-1		
1-2		
2-3		
3-4		
4-5		
5-6		
6-7		
7-8		
8-9		
9-12		

**Figure 5–2.** Daily Activity Schedule.

\*Mastery and pleasure activities must be rated from 0 to 5: the higher the number, the greater the sense of satisfaction.

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Why is this simple activity schedule likely to be helpful? First, it will undercut your tendency to obsess endlessly about the value of various activities and to debate counter-productively about whether or not to do something. Accomplishing even a part of your scheduled activities will in all probability give you some satisfaction and will combat your depression.

As you plan your day, develop a balanced program that provides for enjoyable leisure activities as well as work. If you are feeling blue, you may want to put a special emphasis on fun, even if you doubt you can enjoy things as much as usual. You may be depleted from having asked too much of yourself, causing an imbalance in your “give-and-get” system. If so, take a few days of “vacation” and schedule only those things you *want* to do.

If you adhere to the schedule, you will find your motivation increasing. As you start doing things, you will begin to disprove your belief that you are incapable of functioning effectively. As one procrastinator reported, “By scheduling my day and comparing the results, I have become aware of how I spend my time. This has helped me take charge of my life once again. I realize that I can be in control if I want to.”

Keep this Daily Activity Schedule for at least a week. As you review the activities in which you participated during the previous week, you will see that some have given you a greater sense of mastery and pleasure, as indicated by higher scores. As you continue planning each upcoming day, use this information to schedule more of those activities, and avoid others which are associated with lower satisfaction levels.

The Daily Activity Schedule can be especially helpful for a common syndrome I call the “weekend/holiday blues.” This is a pattern of depression most often reflected in people who are single and have their greatest emotional difficulties when alone. If you fit this description, you probably assume these periods are bound to be unbearable, so you do very little to care for yourself creatively. You stare at the walls and mope, or lie in bed all day Saturday and Sunday; or, for good times, you watch a boring TV show and eat a meager dinner of a peanut-butter sandwich and a cup of instant coffee. No wonder your weekends are tough! Not only are you depressed and alone but you treat yourself in a way that can only inflict pain. Would you treat someone else in such a sadistic manner?

These weekend blues can be overcome by using the Daily Activity Schedule. On Friday night, schedule some plans for Saturday on an hourly basis. You may resist this, saying, “What’s the point? I’m all alone.” The fact that you are all alone is the very reason for using the schedule. Why assume you’re bound to be miserable? This prediction can function only as a self-fulfilling prophecy! Put it to the test by adopting a productive approach. Your plans need not be elaborate in order to be helpful. You can schedule going to

the hairdresser, shopping, visiting an art museum, reading a book, or walking through the park. You will discover that laying out and adhering to a simple plan for the day can go a long way toward lifting your mood. And who knows—if you are willing to care for yourself, you may suddenly notice that others will act more interested in you as well!

At the end of the day before you go to bed, write down what you actually did each hour and rate each activity for Mastery and Pleasure. Then make out a new schedule for the following day. This simple procedure may be the first step toward a sense of self-respect and genuine self-reliance.

*The Antiprocrastination Sheet.* In Figure 5–3 is a form I have found effective in breaking the habit of procrastination. You may be avoiding a particular activity because you predict it will be too difficult and unrewarding. Using the Antiprocrastination Sheet, you can train yourself to test these negative predictions. Each day write down in the appropriate column one or more tasks you have been putting off. If the task requires substantial time and effort, it is best to break it down into a series of small steps so that each one can be completed in fifteen minutes or less. Now write down in the next column how difficult you predict each step of the task will be, using a 0-to-100 percent scale. If you imagine the task will be easy, you can write down a low estimate such as 10 to 20 percent; for harder tasks, use 80 to 90 percent. In the next column, write down your prediction of how satisfying and rewarding it will be to complete each phase of the task, again using the percentage system. Once you've recorded these predictions, go ahead and complete the first step of the task. After you've completed each step, take note of how difficult it actually turned out to be, as well as the amount of pleasure you gained from doing it. Record this information in the last two columns, again using the percentage system.

Figure 5–3 shows how a college professor used this form to overcome several months of putting off writing a letter applying for a teaching position opening up at another university. As you can see, he anticipated that writing the letter would be difficult and unrewarding. After he recorded his pessimistic predictions, he became curious to outline the letter and prepare a rough draft to see if it would be as tedious and unrewarding as he thought. He found to his great surprise that it turned out to be easy and satisfying, and he felt sufficiently motivated that he went on to complete the letter. He recorded

this data in the last two columns. The information gained from this experiment so greatly astonished him that he used the Antiprocrastination Sheet in many other areas in his life. Consequently, his productivity and self-confidence underwent a dramatic increase, and his depression disappeared.

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The Antiprocrastination Sheet					
(Write down the predicted difficulty and satisfaction <i>before</i> you attempt the task. Write down the actual difficulty and satisfaction <i>after</i> you have completed each step.)					
Date	Activity (Break each task down into small steps)	Predicted Difficulty (0–100%)	Predicted Satisfaction (0–100%)	Actual Difficulty (0–100%)	Actual Satisfaction (0–100%)
6/10/99	1. Outline letter.	90	10	10	60
	2. Write rough draft.	90	10	10	75
	3. Type up final draft.	75	10	5	80
	4. Address the envelope and mail the letter.	50	5	0	95

**Figure 5–3.** A professor procrastinated for several months in writing a letter because he imagined it would be difficult and unrewarding. He decided to break the task down into small steps and to predict on a 0-to-100 percent scale how difficult and rewarding each step would be (see the appropriate columns). After completing each step, he wrote down how difficult and rewarding it actually was. He was amazed to see how off-base his negative expectations really were.

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*Daily Record of Dysfunctional Thoughts.* This record, introduced in Chapter 4, can be used to great advantage when you are overwhelmed by the urge to do nothing. Simply write down the thoughts that run through your mind when you think about a particular task. This will immediately show you what your problem is. Then write down appropriate rational responses that show these thoughts are unrealistic. This will help you mobilize enough energy to take that first difficult step. Once you've done that, you will gain momentum and be on your way.

An example of this approach is indicated in Figure 5–4. Annette is an attractive, young single woman who owns and operates a successful boutique (she is Patient A, described on page 83). She does well during the week because of all the bustle at her store. On weekends she tends to hide away in bed unless she has social activities lined up. The moment she gets into bed,

she becomes despondent, yet claims it is beyond her control to get out of bed. As Annette recorded her automatic thoughts one Sunday evening (Figure 5–4), it became obvious what her problems were: She was waiting around until she felt the desire, interest, and energy to do something; she was assuming that there was no point in doing anything since she was alone; and she was persecuting and insulting herself because of her inactivity.

When she talked back to her thoughts, she reported that the clouds lifted just a bit so that she was able to get up, take a shower, and get dressed. She then felt even better and arranged to meet a friend for dinner and a movie. As she predicted in the Rational Responses column, the more she did, the better she felt.

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<i>Date</i>	<i>Situation</i>	<i>Emotions</i>	<i>Automatic Thoughts</i>	<i>Rational Responses</i>	<i>Outcome</i>
7/15/99	I stayed in bed all day Sunday—slept off and on—no desire or energy to get up or do anything productive.	Depressed Exhausted Guilty Self-hatred Lonely	I have no desire to do anything.  I don't have the energy to get out of bed.  I'm a failure as a person.  I have no real interests.	That's because I'm doing nothing. Remember motivation follows action!  I can get out of bed; I'm not crippled.  I do succeed at things when I want to. Doing nothing makes me depressed and bored, but it doesn't mean I'm "a failure as a person" because there is <i>no such thing</i> !  I do have interests, but not when I'm doing nothing. If I get started at something, I'll probably get more interested.	Felt some relief and decided to get up and take a shower at least.

I'm self-centered because I don't care about anything that's going on around me.	I do care about other things when I'm feeling really good. It's natural to be less interested when you're depressed.
Most people are out enjoying themselves.	So what does that have to do with me? I'm free to do anything I want to.
I don't enjoy anything.	I enjoy things when I feel good. If I do something I'll probably enjoy it once I get started, even though it doesn't seem that way when I'm lying in bed.
I'll never have a normal energy level.	I have no proof of that; I'm working on it now and seeing some results. When I feel good, I'm full of energy. When I get involved in things, I get more energetic.
I don't want to talk to anyone or see anyone.	So don't! No one's forcing me to talk. So, decide to do something on my own. At least I can get out of bed and start doing things.

**Figure 5–4.** Daily Record of Dysfunctional Thoughts.

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If you decide to use this method, be sure you actually write down upsetting thoughts. If you try to figure them out in your head, you will in all probability get nowhere because the thoughts that stymie you are slippery and complex. When you try to talk back to them, they'll come at you even harder from all angles with such speed that you won't even know what hit you. But when you write them down, they become exposed to the light of reason. This way you can reflect on them, pinpoint the distortions, and come up with some helpful answers.

*The Pleasure-Predicting Sheet.* One of Annette's self-defeating attitudes is her assumption that there is no point in doing anything productive if she is

alone. Because of this belief, she does nothing and feels miserable, which just confirms her attitude that it's terrible to be alone.

Solution: Test your belief that there is no point in doing anything by using the Pleasure-Predicting Sheet shown in Figure 5–5, page 105. Over a period of weeks, schedule a number of activities that contain a potential for personal growth or satisfaction. Do some of them by yourself and some with others. Record who you did each activity with in the appropriate column, and predict how satisfying each will be—between 0 and 100 percent. Then go and do them. In the Actual Satisfaction column, write down how enjoyable each activity really turned out to be. You may be surprised to learn that things you do on your own are more gratifying than you thought.

Make sure that the things you do by yourself are of equal quality as those you do with others so that your comparisons will be valid. If you choose to eat a TV dinner alone, for example, don't compare it with the fancy French restaurant dinner you share with a friend!

Figure 5–5 shows the activities of a young man who learned that his girl friend (who lived 200 miles away) had a new boyfriend and didn't want to see him. Instead of moping in self-pity, he became involved with life. You will notice in the last column that the satisfaction levels he experienced by himself ranged from 60 to 90 percent, while those with other people ranged from 30 to 90 percent. This knowledge strengthened his self-reliance because he realized that he wasn't condemned to misery because he lost his girl, and that he didn't need to depend on others to enjoy himself.

Date	Activity for Satisfaction. (Sense of Achievement or Pleasure)	Who Did You Do This With? (If Alone, Specify Self)	Predicted Satisfaction (0-100%). (Write This Before the Activity)	Actual Satisfaction (0-100%). (Record This After the Activity)
8/2/99	Reading (1 hour)	self	50%	60%
8/3/99	Dinner + bar w/Ben	Ben	80%	90%
8/4/99	Susan's party	self	80%	85%
8/5/99	N.Y.C. and Aunt Helen	parents and grandma	40%	30%
8/5/99	Nancy's house	Nancy and Joelle	75%	65%
8/6/99	Dinner at Nancy's	12 people	60%	80%
8/6/99	Luci's party	Luci + 5 people	70%	70%
8/7/99	Jogging	self	60%	90%
8/8/99	Theater	Luci	80%	70%
8/9/99	Harry's	Harry, Jack, Ben and Jim	60%	85%
8/10/99	Jogging	self	70%	80%
8/10/99	Phillies game	Dad	50%	70%
8/11/99	Dinner	Susan and Ben	70%	70%
8/12/99	Art museum	self	60%	70%
8/12/99	Peabody's	Fred	80%	85%
8/13/99	Jogging	self	70%	80%

## **Figure 5–5.** The Pleasure-Predicting Sheet.

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You can use the Pleasure-Predicting Sheet to test a number of assumptions you might make that lead to procrastination. These include:

1. I can't enjoy anything when I'm alone.
2. There's no point in doing anything because I failed at something important to me (e.g., I didn't get the job or promotion I had my heart set on).
3. Since I'm not rich, successful, or famous, I can't really enjoy things to the hilt.
4. I can't enjoy things unless I'm the center of attention.
5. Things won't be particularly satisfying unless I can do them perfectly (or successfully).
6. I wouldn't feel very fulfilled if I did just a part of my work. I've got to get it *all* done today.

All of these attitudes will produce a round of self-fulfilling prophecies if you don't put them to the test. If, however, you check them out using the Pleasure-Predicting Sheet, you may be amazed to learn that life can offer you enormous fulfillment. Help yourself!

A question that commonly comes up about the Pleasure-Predicting Sheet is: "Suppose I do schedule a number of activities, and I find out they are just as unpleasant as I had anticipated?" This might happen. If so, try noting your negative thoughts and write them down, answering them with the Daily Record of Dysfunctional Thoughts. For example, suppose you go to a restaurant on your own and feel tense. You might be thinking, "These people probably think I'm a loser because I'm here all alone."

How would you answer this? You might remind yourself that other people's thoughts do not affect your mood one iota. I have demonstrated this to patients by telling them I will think two thoughts about them for fifteen seconds each. One thought will be extremely positive, and the other will be intensely negative and insulting. They are to tell me how each of my thoughts affects them. I close my eyes and think, "Jack here is a fine person and I like him." Then I think, "Jack is the worst person in Pennsylvania." Since Jack doesn't know which thought is which, they have no effect on him!

Does that brief experiment strike you as trivial? It's not—because only *your* thoughts can ever affect you. For example, if you are in a restaurant feeling miserable because you are alone, you really have no idea what people are thinking. It's your thoughts and only yours that are making you feel terrible; *you're the only person in the world who can effectively persecute yourself*. Why do you label yourself a "loser" because you're in a restaurant alone? Would you be so cruel to someone else? Stop insulting yourself like that! Talk back to that automatic thought with a rational response: "Going to a restaurant alone doesn't make me a loser. I have just as much right to be here as anyone else. If someone doesn't like it, so what? As long as I respect myself, I don't need to be concerned with others' opinions."

*How to Get off Your "But"—the But Rebuttal.* Your "but" may represent the greatest obstacle to effective action. The moment you think of doing something productive, you give yourself excuses in the form of buts. For example, "I could go out and jog today, BUT ..."

1. I'm really too tired to;
  2. I'm just too lazy;
  3. I'm not particularly in the mood, etc.
- 

<i>But Column</i>	<i>But Rebuttal</i>
I really <i>should</i> mow the lawn, but I'm just not in the mood.	I'll feel more like it once I get started. When I'm done I'll feel terrific.
But now it's so long it would take forever.	It won't take that much extra time with the power mower. I can always do a part of it now.
But I'm too tired.	So just do some of it and rest.
I'd rather rest now or watch TV.	I can, but I won't feel very good about it knowing this chore is hanging over my head.
But I'm just too lazy to do it today.	That can't be true—I've done it on numerous occasions in the past.

**Figure 5–6.** The But-Rebuttal Method. The zigzag arrows trace your thinking pattern as you debate the issue in your mind.

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Here's another example. "I *could* cut down on my smoking, BUT ..."

1. I don't have that kind of self-discipline;
2. I don't really feel like going cold turkey, and cutting down gradually would be slow torture;
3. I've been too nervous lately.

If you really want to motivate yourself, you'll have to learn how to get off your but. One way to do this is with the "But-Rebuttal Method" shown in Figure 5–6. Suppose it's Saturday and you've scheduled mowing the lawn. You've procrastinated for three weeks, and it looks like a jungle. You tell yourself, "I really should, BUT I'm just not in the mood." Record this in the But column. Now fight back by writing a But Rubuttal: "I'll feel more like it once I get started. When I'm done, I'll feel terrific." Your next impulse will probably be to dream up a new objection: "BUT it's so long it will take forever." Now fight back with a new rebuttal, as shown in Figure 5–6, and continue this process until you've run out of excuses.

*Learn to Endorse Yourself.* Do you frequently convince yourself that what you do doesn't count? If you have this bad habit, you will naturally feel that you never do anything worthwhile. It won't make any difference if you are a Nobel laureate or a gardener—life will seem empty because your sour attitude will take the joy out of all your endeavors and defeat you before you even begin. No wonder you feel unmotivated!

To reverse this destructive tendency, a good first step would be to pinpoint the self-downing thoughts that cause you to feel this way in the first place. Talk back to these thoughts and replace them with ones that are more objective and self-endorsing. Some examples of this are shown in Figure 5–7. Once you get the knack of it, practice consciously endorsing yourself all day long for the things you do even if they seem trivial. You may not feel a pleasant emotional lift in the beginning, but keep practicing even if it seems mechanical. After a few days you will begin to experience some mood lift, and you will feel more pride about what you're doing.

You may object, “Why should I have to pat myself on the back for everything I do? My family, friends, and business associates should be more appreciative of me.” There are several problems here. In the first place, even if people are overlooking your efforts, you are guilty of the same crime if you also neglect yourself, and pouting won’t improve the situation.

Even when someone does stroke you, you can’t absorb the praise unless you decide to believe and therefore validate what is being said. How many genuine compliments fall on your deaf ears because you mentally discredit them? When you do this, other people feel frustrated because you don’t respond positively to what they are saying. Naturally, they give up trying to combat your self-downing habit. Ultimately, only what you think about what you do will affect your mood.

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<i>Self-Downing Statement</i>	<i>Self-Endorsing Statement</i>
Anybody could wash these dishes.	If it’s a routine, boring job, I deserve extra credit for doing it.
There was no point in washing these dishes. They’ll just get dirty again.	That’s just the point. They’ll be clean when we need them.
I could have done a better job straightening up.	Nothing in the universe is perfect, but I did make the room look a hell of a lot better.
It was just luck the way my speech turned out.	It wasn’t a matter of luck. I prepared well and delivered my talk effectively. I did a darn good job.
I waxed the car, but it still doesn’t look as good as my neighbor’s new car.	The car looks a heck of a lot better than it did. I’ll enjoy driving it around.

**Figure 5–7.**

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It can be helpful simply to make a written or mental list of the things you do each day. Then give yourself a mental credit for each of them, however small. This will help you focus on what you *have* done instead of what you haven’t gotten around to doing. It may sound simplistic, but it works!

**TIC-TOC Technique.** If you are procrastinating about getting down to a specific task, take note of the way you are thinking about it. These TICs, or

Task-Interfering Cognitions, will lose much of their power over you if you simply write them down and substitute more adaptive TOCs, or Task-Oriented Cognitions, using the double-column technique. A number of examples are shown in Figure 5–8. When you record your TIC-TOCs, be sure to pinpoint the distortion in the TIC that defeats you. You may find, for example, that your worst enemy is all-or-nothing thinking or disqualifying the positive, or you may be in the bad habit of making arbitrary negative predictions. Once you become aware of the type of distortion that most commonly thwarts you, you will be able to correct it. Your procrastination and time-wasting will give way to action and creativity.

You can also apply this principle to mental images and daydreams as well as to thoughts. When you avoid a task, you probably automatically fantasize about it in a negative, defeatist fashion. This creates unnecessary tension and apprehension, which impairs your performance and increases the likelihood that your dreaded fear will actually come true.

For example, if you have to give a speech to a group of associates, you may fret and worry for weeks ahead of time because in your mind's eye you see yourself forgetting what you have to say or reacting defensively to a pushy question from the audience. By the time you give the speech, you have effectively programmed yourself to behave just this way, and you're such a nervous wreck it turns out just as badly as you had imagined!

If you dare to give it a try, here's a solution: For ten minutes every night before you go to sleep, practice fantasizing that you deliver the speech in a positive way. Imagine that you appear confident, that you present your material in an energetic manner, and that you handle all questions from the audience warmly and capably. You may be surprised that this simple exercise can go a long way to improving how you feel about what you do. Obviously there is no guarantee things will always come out exactly as you imagine, but there's *no* doubt that your expectations and mood will profoundly *influence* what actually does happen.

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<i>TICs</i> <i>(Task-interfering Cognitions)</i>	<i>TOCs</i> <i>(Task-oriented Cognitions)</i>
<i>Housewife:</i> I'll never be able to get the garage cleaned out. The junk's been piling up for years.	Overgeneralization; all-or-nothing thinking. Just do a little bit and get started. There's no reason I have to do it all today.
<i>Bank Clerk:</i> My work isn't very important or exciting.	Disqualifying the positive. It may seem routine to me, but it's quite important to the people who use the bank. When I'm not depressed, it can be very enjoyable. Many people do routine work but this doesn't make them unimportant human beings. Maybe I could do something more exciting in my free time.
<i>Student:</i> Writing this term paper is pointless. The subject is boring.	All-or-nothing thinking. Just do a routine job. It doesn't have to be a masterpiece. I might learn something, and it will make me feel better to get it done.
<i>Secretary:</i> I'll probably flub typing this and make a bunch of typos. Then my boss will yell at me.	Fortune teller error. I don't have to type perfectly. I can correct the errors. If he's overly critical, I can disarm him, or tell him I'd do better if he were more supportive and less demanding.
<i>Politician:</i> If I lose this race for governor, I'll be a laughing stock.	Fortune teller error; labeling. It's not shameful to lose a political contest. A lot of people respect me for trying and taking an honest stand on some

<i>Insurance Salesman:</i> What's the point in calling this guy back? He didn't sound interested.	important issues. Unfortunately, the best man often doesn't win, but I can believe in myself whether or not I come out on top.
<i>Shy Single Man:</i> If I call up an attractive girl, she'll just dump on me, so what's the point? I'll just wait around until some girl makes it real obvious that she likes me. Then I won't have to take a risk.	Mind reading. I have no way of knowing. Give it a try. At least he asked me to call back. Some people will be interested and I have to sift the chaff from the wheat. I can feel productive even when someone turns me down. I'll sell one policy on the average for every five people who turn me down, so it's to my advantage to get as many turndowns as possible! The more turndowns, the more sales!
<i>Author:</i> This chapter has to be great. But I don't feel very creative.	Fortune teller error; overgeneralization. They can't <i>all</i> turn me down, and it's not shameful to try. I can learn from any rejection. I've got to start practicing to improve my style, so take the big plunge! It took courage to jump off the high dive the first time, but I did it and survived. I can do this too!
<i>Athlete:</i> I can't discipline myself. I have no self-control. I'll never get in shape.	All-or-nothing thinking. Just prepare an adequate draft. I can improve it later. Disqualifying the positive; all-or-nothing thinking. I must have self-control because I've done well. Just work out for a while and call it quits if I get exhausted.

**Figure 5–8.** The TIC-TOC Technique. In the left-hand column, record the thoughts that inhibit your motivation for a specific task. In the right-hand column, pinpoint the distortions and substitute more objective, productive attitudes.

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*Little Steps for Little Feet.* A simple and obvious self-activation method involves learning to break any proposed task down into its tiny component parts. This will combat your tendency to overwhelm yourself by dwelling on all the things you have to do.

Suppose your job involves attending lots of meetings, but you find it difficult to concentrate due to anxiety, depression, or daydreaming. You can't concentrate effectively because you think, "I don't understand this as I should. Gosh, this is boring. I'd really prefer to be making love or fishing right now."

Here's how you can beat the boredom, defeat the distraction, and increase your ability to concentrate: Break the task down into its smallest component parts! For example, decide to listen for only three minutes, and then take a one-minute break to daydream intensively. At the end of this mental vacation, listen for another three minutes, and do not entertain any distracting thoughts for this brief period. Then give yourself another one-minute break to daydream.

This technique will enable you to maintain a more effective level of overall concentration. Giving yourself permission to dwell on distracting thoughts for short periods will diminish their power over you. After a while, they will seem ludicrous.

An extremely useful way to divide a task into manageable units is through time limitation. Decide how much time you will devote to a particular task, and then stop at the end of the allotted time and go on to something more enjoyable, whether or not you're finished. As simple as this sounds, it can work wonders. For example, the wife of a political VIP spent years harboring resentment toward her husband for his successful, glamorous life. She felt her life consisted of an oppressive load of child-rearing and housecleaning. Because she was compulsive she never felt she had enough time to complete her dreary chores. Life was a treadmill. She was straddled by depression, and had been unsuccessfully treated by a long string of famous therapists for over a decade as she looked in vain for the elusive key to personal happiness.

After consulting twice with one of my colleagues (Dr. Aaron T. Beck), she experienced a rapid mood swing out of her depression (his therapeutic wizardry never ceases to astonish me). How did he perform this seeming miracle? Easy. He suggested to her that her depression was due in part to the fact that she wasn't pursuing goals that were meaningful to her because she didn't believe in herself. Instead of acknowledging and confronting her fear of taking risks, she blamed her lack of direction on her husband and complained about all the undone housework.

The first step was to decide how much time she felt she wanted to spend on the housework each day; she was to spend no more than this amount even if the house wasn't perfect, and she was to budget the rest of the day to pursue activities that interested her. She decided that one hour of housework would be fair, and enrolled in a graduate program so she could develop her own career. This gave her a feeling of liberation. Like magic, the depression vanished along with the anger she harbored toward her husband.

I don't want to give you the idea that depression is usually so easy to eliminate. Even in the above case, this patient will probably have to fight off a number of depressive recurrences. She may at times fall back temporarily into the same trap of trying to do too much, blaming others, and feeling overwhelmed. Then she will have to apply the same solution again. The important thing is—she has found a method that works for her.

The same approach might work for you. Do you tend to bite off bigger pieces than you can comfortably chew? *Dare* to put modest time limits on what you do! *Have the courage* to walk away from an unfinished task! You may be amazed that you will experience a substantial increase in your productivity and mood, and your procrastination may become a thing of the past.

*Motivation Without Coercion.* A possible source of your procrastination is an inappropriate system for self-motivation. You may inadvertently undermine what you attempt by flagellating yourself with so many "oughts," "shoulds," and "musts" that you end up drained of any desire to get moving. You are defeating yourself by the way you *kill* yourself to get moving! Dr. Albert Ellis describes this mental trap as "*musterbation*."

Reformulate the way you tell yourself to do things by eliminating those coercive words from your vocabulary. An alternative to pushing yourself to get up in the morning would be to say, "It will make me feel better to get out of bed, even though it will be hard at first. Although I'm not *obliged* to, I might end up being glad I did. If, on the other hand, I'm really benefiting from the rest and relaxation, I may as well go ahead and enjoy it!" If you translate shoulds into wants, you will be treating yourself with a sense of respect. This will produce a feeling of freedom of choice and personal dignity. You will find that a reward system works better and lasts longer than a whip. Ask yourself, "What do I *want* to do? What course of action would

be to my best advantage?” I think you will find that this way of looking at things will enhance your motivation.

If you still have the desire to lie in bed, mope, and feel doubtful that getting up is really what you want to do, make a list of the advantages and disadvantages of staying in bed for another day. For example, an accountant who was far behind in his work around tax time found it hard to get up each day. His customers began to complain about the undone work, and in order to avoid these embarrassing confrontations, he lay in bed for weeks trying to escape, not even answering the phone. Many customers fired him, and his business began to fail.

His mistake was in telling himself, “I know I *should* go to work but I don’t want to. And I don’t have to either! So I won’t!” Essentially, the word “should” created the illusion that the only reason for him to get out of bed was to please a bunch of angry, demanding customers. This was so unpleasant that he *resisted*. The absurdity of what he was doing to himself became apparent when he made a list of the advantages and disadvantages of staying in bed (Figure 5–9, above). After preparing this list, he realized it was to his advantage to get out of bed. As he subsequently became more involved with his work, his mood rapidly improved in spite of the fact that he had lost many accounts during the period of inactivity.

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<i>Advantages of Lying in Bed</i>	<i>Disadvantages of Lying in Bed</i>
1. It's easy.	1. While it seems easy, it gets awfully boring and painful after a while. It's actually not so easy to do nothing and to lie here moping and criticizing myself hour after hour.
2. I won't have to do anything or face my problems.	2. I won't be obliged to do anything if I get out of bed either, but it might feel better. If I avoid my problems they won't go away, they'll just get worse, and I won't have the satisfaction of trying to solve them. The short-term discomfort of facing up to things is probably less depressing than the endless anguish of staying in bed.
3. I can sleep and escape.	3. I can't sleep forever, and I really don't need any more sleep since I have been sleeping nearly sixteen hours a day. I will probably feel less fatigued if I get up and get my arms and legs moving rather than lie around in bed like a cripple waiting for my arms and legs to rot!

**Figure 5–9.**

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*Disarming Technique.* Your sense of paralysis will be intensified if your family and friends are in the habit of pushing and cajoling you. Their nagging should statements reinforce the insulting thoughts already echoing through your head. Why is their pushy approach doomed to failure? It's a basic law of physics that for every action there's an equal and opposite reaction. Any time you feel shoved, whether by someone's hand actually on your chest or by someone trying to boss you around, you will naturally tighten up and resist so as to maintain your equilibrium and balance. You will attempt to exert your self-control and preserve your dignity by refusing to do the thing that you are being pushed to do. The paradox is that you often end up hurting yourself.

It can be very confusing when someone obnoxiously insists you do something that actually would be to your advantage. This puts you in a "can't win" situation because if you refuse to do what the person tells you, you end up defeating yourself just in order to spite him or her. In contrast, if you do what the person tells you to do, you feel had. Because you gave in to those

pushy demands, you get the feeling the individual controlled you, and this robs you of self-respect. No one likes to be coerced.

For example, Mary is a woman in her late teens who was referred to us by her parents after many years of depression. Mary was a real “hibernator,” and had the capacity to sit alone in her room watching TV soap operas for months at a time. This was due in part to her irrational belief that she looked “peculiar,” and that people would stare at her if she went out in public, and also by her feeling of being coerced by her domineering mother. Mary admitted that doing things might help her feel better, but this would mean giving in to her mother, who kept telling her to get off her duff and do something. The harder Mom pushed, the more stubbornly Mary resisted.

It is an unfortunate fact of human nature that it can be extremely difficult to do something when you sense you are being forced into it. Fortunately, it's very easy to learn how to handle people who nag and harangue you and try to run your life. Suppose you are Mary, and after thinking things over, you decide you would be better off if you got involved in doing a number of things. You've just made this decision when your mother comes into your bedroom and announces, “Don't you lie around any longer! Your life is going down the drain. Get moving! Get involved in things the way the other girls your age do!” At that moment, in spite of the fact that you already have decided to do just that, you develop a tremendous aversion to it!

The disarming technique is an assertive method that will solve this problem for you (other applications of this verbal maneuver will be described in the next chapter). The essence of the disarming technique is to agree with your mother, but to do so in a way that you remind her you are agreeing with her based on your own decision, and not because she was telling you what to do. So, you might answer this way: “Yes, Mom, I just thought the situation over myself and decided it *would* be to my advantage to get moving on things. Because of *my own* decision, I'm going to do it.” Now you can start doing things and not feel bad. Or if you wish to put more of a barb in your comments, you can always say, “Yes, Mom, I *have* in fact decided to get out of bed in spite of the fact that you've been telling me to!”

**Visualize Success.** A powerful self-motivation method involves making a list of the advantages of a productive action you've been avoiding because it requires more self-discipline than you have been able to muster. Such a list

will train you to look at the positive consequences of doing it. It's only human to go after what you want. Furthermore, clubbing yourself into effective action doesn't usually work nearly as well as a fat, fresh carrot.

Suppose, for example, you want to quit smoking. You may be reminding yourself about cancer and all the other dangers of smoking. These fear tactics make you so nervous that you immediately reach for another cigarette; they don't work. Here's a three-step method that *does work*.

The first step is to make a list of all the positive consequences that will result when you become a nonsmoker. List as many as you can think of, including:

1. Improved health.
2. I'll respect myself.
3. I'll have greater self-discipline. With my new self-confidence, I may be able to do a whole lot of other things I've been putting off.
4. I will be able to run and dance actively, and still feel good about my body. I'll have lots of stamina and extra energy.
5. My lungs and heart will become strong. My blood pressure will go down.
6. My breath will be fresh.
7. I'll have extra spending money.
8. I'll live longer.
9. The air around me will be clean.
10. I'll be able to tell people that I've become a non-smoker.

Once you have prepared the list, you're ready for the second step. Every night before you go to sleep, fantasize you are in your favorite spot—walking through the woods in the mountains, on a crisp autumn day, or maybe lying on a quiet beach near a crystal-blue ocean, with the sun warming your skin. Whatever fantasy you choose, visualize every enjoyable detail as vividly as possible, and let your body relax and let go. Allow every muscle to unwind. Let the tension flow out of your arms and legs and leave your body. Notice how your muscles begin to feel limp and loose. Notice how peaceful you feel. Now you are ready for the third step.

Fantasize that you are still in that scene, and you have become a nonsmoker. Go through your list of benefits and repeat each one to yourself in the following way: "Now I have improved health and I like it. I can run

along the beach, and I want this. The air around me is clean and fresh, and I feel good about myself. I respect myself. Now I have greater self-discipline, and I can take on other challenges if I want to. I have extra spending money,” etc.

This method of habit management through the power of positive suggestion works amazingly well. It enabled me and many of my patients to quit smoking after a single treatment session. You can do it easily, and you’ll find it’s well worth your efforts. It can be used for self-improvement in losing weight, lawn mowing, getting up on time in the morning, adhering to a jogging routine, or for any other habit you’d like to modify.

*Count What Counts.* A three-year-old boy named Stevie stood by the edge of the children’s pool, afraid to jump in. His mother sat in the water in front of him, urging him to take the leap. He held back; she cajoled. The power struggle went on for thirty minutes. Finally, he jumped. The water felt fine. It wasn’t so difficult, and there was actually nothing to fear. But his mother’s efforts backfired. The unfortunate message imprinted on Stevie’s mind was “I have to be *pushed* before I can do anything risky. I don’t have the gumption to jump in on my own like the other kids.” His mother and father got the same idea; they began to think, “Left to his own devices, Stevie would never dare go into the water at all. If he isn’t constantly pushed, he’ll do nothing by himself. Raising him is going to be a long, hard struggle.”

Sure enough, as Stevie grew up, the drama was repeated over and over. He had to be *persuaded* and *pushed* to go to school, to join the baseball team, to go to parties, and so on. He rarely initiated any action on his own. By the time he was referred to me at age twenty-one, he was chronically depressed, living with his parents, and not doing much with his life. He was still waiting around for people to tell him what to do and how to do it. But by now his parents were fed up trying to motivate him.

After each therapy session, he would leave the office charged with my enthusiasm to follow through on whatever self-help assignment we had discussed. For example, one week he decided to smile or say hello to three people he didn’t know as a small first step in breaking his isolation. But the next week he would come into my office with a drooping head and a sheepish look that let me know he had “forgotten” to say hello to anyone. Another week, his assignment was to read a three-page article I had written for a

singles magazine on how an unmarried man learned to overcome his loneliness. Steve came back the next week and said he had lost the manuscript before having a chance to read it. Each week as he left, he would feel a great surge of eagerness to help himself, but by the time he was in the elevator, he would “know” in his heart of hearts that the week’s assignment, however simple, would just be too *hard* to do!

What was Stevie’s problem? The explanation goes back to that day at the swimming pool. He still carries in his mind the powerfully imprinted idea that “I really can’t do anything on my own. I’m the kind of guy who’s got to be pushed.” Because it never occurred to him to challenge this belief, it continued to function as a self-fulfilling prophecy, and he had over fifteen years of procrastination to back up his belief that he “really was” like that.

What was the solution? First Stevie had to become aware of the two mental errors that were the key to his problem: mental filter and labeling. His mind was dominated by thoughts about the various things he put off doing, and he *ignored* the hundreds of things he did each week that did *not* involve his being pushed by someone else.

“All of that is well and good,” Stevie said after we discussed this. “You seem to have explained my problem, and I think that’s correct. But how can I *change* the situation?”

The solution turned out to be simpler than he anticipated. I suggested he obtain a wrist counter (as discussed in the last chapter), so that each day he could count the things he did on his own without prodding or encouragement from anyone. At the end of the day he was to write down the total number of clicks he scored and keep a daily log.

Over a several-week period, he began to notice that his daily score increased. Every time he clicked the counter, he reminded himself that *he* was in control of his life, and in this way he trained himself to *notice what he did do*. Stevie began to feel increased self-confidence, and to view himself as a more capable human being.

Does it sound simple? It is! Will it work for you? You probably don’t think so. But why not put it to the test? If you have a negative reaction and are convinced the wrist counter won’t work for you, why not evaluate your pessimistic prediction with an experiment? Learn to count what counts; you may be surprised at the results!

*Test Your “Can’ts.”* An important key to successful self-activation involves learning to adopt a scientific attitude toward the self-defeating predictions you make about your performance and abilities. If you put these pessimistic thoughts to the test, you can discover what the truth is.

One common self-defeating thought pattern when you are depressed or procrastinating is to “can’t” yourself every time you think of something productive to do. Perhaps this stems from your fear of being blamed for your do-nothingism. You try to save face by creating the illusion that you are just too inadequate and incompetent to do a single thing. The problem with defending your lethargy in this manner is that you may really start believing what you are telling yourself! If you say, “I can’t,” over and over often enough it becomes like a hypnotic suggestion, and after a while you become genuinely convinced you really are a paralytic invalid who can’t do anything. Typical “can’t” thoughts include: “I can’t cook,” “I can’t function,” “I can’t work,” “I can’t concentrate,” “I can’t read,” “I can’t get out of bed,” and “I can’t clean my apartment.”

Not only do such thoughts defeat you, they will sour your relationships with those you love because they will see all your “I can’t” statements as annoying whining. They won’t perceive that it *really looks and seems* impossible for you to do anything. They will nag you, and set up frustrating power struggles with you.

An extremely successful cognitive technique involves testing your negative predictions with actual experiments. Suppose, for example, you’ve been telling yourself: “I’m so upset I can’t concentrate well enough to read anything at all.” As a way of testing this hypothesis, sit down with today’s newspaper and read one sentence, and then see if you can summarize the sentence out loud. You might then predict—“But I could never read and understand a whole paragraph.” Again—put this to the test. Read a paragraph and summarize. Many severe, chronic depressions have been cracked open with this powerful method.

*The “Can’t Lose” System.* You may feel hesitant to put your “can’ts” to the test because you don’t want to run the risk of failure. If you don’t run any risks, at least you can maintain the secret belief that you’re basically a terrific person who’s decided for the time being not to get involved. Behind your

aloofness and lack of commitment lurks a powerful sense of inadequacy and the fear of failure.

The “Can’t Lose” System will help you combat this fear. Make a list of the negative consequences you might have to deal with if you took a risk and actually did fail. Then expose the distortions in your fears, and show how you could cope productively even if you did experience a disappointment.

The venture that you have been avoiding may involve a financial, personal, or scholastic risk. Remember that even if you do fail, some good can come from it. After all, this is how you learned how to walk. You didn’t just jump up from your crib one day and waltz gracefully across the room. You stumbled and fell on your face and got up and tried again. At what age are you suddenly expected to know everything and never make any more mistakes? If you can love and respect yourself in failure, worlds of adventure and new experiences will open up before you, and your fears will vanish. An example of a written “Can’t Lose” System is shown in Figure 5–10.

### **Don’t Put the Cart Before the Horse!**

I’ll bet you still may not know for sure where motivation comes from. What, in your opinion, comes first—motivation or action?

If you said motivation, you made an excellent, logical choice. Unfortunately, you’re wrong. Motivation does *not* come first, *action* does! You have to prime the pump. Then you will begin to get motivated, and the fluids will flow spontaneously.

Individuals who procrastinate frequently confuse motivation and action. You foolishly wait until you feel in the mood to do something. Since you don’t feel like doing it, you automatically put it off.

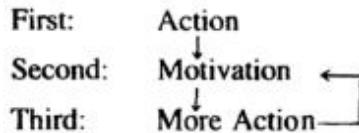
Your error is your belief that motivation comes first, and then leads to activation and success. But it is usually the other way around; action must come first, and the motivation comes later on.

Take this chapter, for example. The first draft of this chapter was overwritten, clumsy, and stale. It was so long and boring that a true procrastinator would never even have the fortitude to read it. The task of revising it seemed to me like trying to go swimming with concrete shoes. When the day I had scheduled for revising it came—I had to push myself to sit down and get started. My motivation was about 1 percent, and my urge to avoid the task was 99 percent. What a hideous chore!

<i>Negative Consequences of Being Turned Down for a Job</i>	<i>Positive Thoughts and Coping Strategies</i>
1. This means I'll never get a job.	1. Overgeneralization. This is unlikely. I can test this by applying for a series of other jobs and putting my best foot forward to see what happens.
2. My husband will look down on me.	2. Fortune teller error. Ask him. Maybe he will be sympathetic.
3. But what if he's not sympathetic? He might say this shows I belong in the kitchen and don't have what it takes.	3. Point out to him I'm doing my best and that his rejecting attitude doesn't help. Tell him that I am disappointed, but that I credit myself for trying.
4. But we're nearly broke. We need the money.	4. We've survived so far and haven't missed a single meal.
5. If I don't get a job, I won't be able to afford some decent new school clothes for the kids. They'll look scraggly.	5. I can get some clothes later on. We'll have to learn to get along with what we have for a while. Happiness doesn't come from clothes but from our self-respect.
6. A lot of my friends have jobs. They'll see I can't cut the mustard in the business world.	6. They're not all employed, and even my friends who do have jobs can probably remember a time when they were out of work. They haven't done anything so far to indicate they look down on me.

**Figure 5–10.** The “Can’t Lose” System. A housewife used this technique to overcome her fear of applying for a part-time job.

After I got involved in the task, I became highly motivated, and the job seems easy now. Writing became fun after all! It works like this:



If you are a procrastinator, you probably aren't aware of this. So you lie around in bed waiting for inspiration to strike. When someone suggests you do something, you whine, "I don't *feel* like it." Well, who said you were supposed to feel like it? If you wait until you're "in the mood," you may wait forever!

The following table will help you review the various activation techniques and select what's most helpful to you.

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**Table 5-1.** Synopsis of Self-Activation Methods

<i>Target Symptoms</i>	<i>Self-Activation Techniques</i>	<i>Purpose of the Method</i>
1. You feel disorganized. You have nothing to do. You get lonely and bored on weekends.	1. Daily Activity Schedule	1. Plan things one hour at a time and record the amount of mastery and pleasure. Virtually any activity will make you feel better than lying in bed and will undercut your sense of inadequacy.
2. You procrastinate because tasks seem too difficult and unrewarding.	2. The Antiprocrastination Sheet	2. You put your negative predictions to the test.
3. You feel overwhelmed by the urge to do nothing.	3. Daily Record of Dysfunctional Thoughts	3. You expose the illogical thoughts that paralyze you. You learn that motivation follows action, not <i>vice versa</i> .
4. You feel there's no point in doing anything when you're alone.	4. Pleasure-Predicting Sheet	4. Schedule activities with the potential for personal growth or satisfaction, and predict how rewarding they will be. Compare the actual satisfaction you experience

		when you are alone and when you are with others.
5. You give yourself excuses for avoiding things.	5. But-Rebuttal	5. You get off your “but” by combatting your “buts” with realistic rebuttals.
6. You have the idea that whatever you do isn’t worth much.	6. Self-Endorsement	6. Write down the self-downing thoughts and talk back to them. Look for distorted thought patterns, such as “all-or-nothing thinking.” Make a list of things you do accomplish each day.
7. You think about a task in a self-defeating manner.	7. TIC-TOC Technique	7. You substitute task-oriented cognitions (TOCS) for task interfering cognitions (TICS).
8. You feel overwhelmed by the magnitude of everything you have to do.	8. Little Steps for Little Feet	8. Break the task down into its tiny component parts, and do these one step at a time.
9. You feel guilty, oppressed, obliged, and duty-bound.	9. Motivation Without Coercion	<p>9. a. You eliminate “shoulds,” “musts,” and “oughts” when you give yourself instructions.</p> <p>b. You list the advantages and disadvantages of any activity so you can begin to think in terms of what you <i>want</i> to do rather than what you <i>must</i> do.</p>
10. Someone else	10. Disarming	10. You assertively agree

	nags and harangues you. You feel pressured and resentful, so you refuse to do anything at all.	Technique	with them and remind them that you are capable of doing your own thinking.
11.	You have difficulty modifying a habit such as smoking.	11. Visualize Success	11. You make a list of the positive benefits of having changed the habit. You visualize these after inducing a state of deep relaxation.
12.	You feel unable to do anything on your own initiative because you see yourself as “a procrastinator.”	12. Count What Counts	12. You count the things you do each day on your own initiative, using a wrist counter. This helps you overcome your bad habit of constantly dwelling on your inadequacies.
13.	You feel inadequate and incompetent because you say, “I can’t.”	13. Test Your Can’ts	13. You set up an experiment in which you challenge and disprove your negative predictions.
14.	You are afraid to fail, so you risk nothing.	14. “Can’t Lose” System	14. Write down any negative consequences of failure and develop a coping strategy ahead of time.

## Chapter 6

### **Verbal Judo: Learn to Talk Back When You're Under the Fire of Criticism**

You are learning that the cause of your sense of worthlessness is your ongoing self-criticism. This takes the form of an upsetting *internal* conversation in which you constantly harangue and persecute yourself in a harsh, unrealistic manner. Frequently your inner criticism will be triggered by someone else's sharp remark. You may dread criticism simply because you have never learned effective techniques for handling it. Because it is relatively *easy* to do, I want to emphasize the importance of mastering the art of handling verbal abuse and disapproval nondefensively and without a loss of self-esteem.

Many depressive episodes are set in motion by external criticism. Even psychiatrists, who are supposedly professional abuse-takers, can react adversely to criticism. A psychiatric resident called Art received negative feedback intended to be helpful from his supervisor. A patient had complained that several comments Art made during a therapy session were abrasive. The resident reacted with a wave of panic and depression when he heard this, due to his thought, "Oh God! The truth is out about me. Even my patients can see what a worthless, insensitive person I am. They'll probably kick me out of the residency program and *drum* me out of the state."

Why is criticism so hurtful to some people, while others can remain unperturbed in the face of the most abusive attack? In this chapter you will learn the secrets of people who face disapproval fearlessly, and you will be shown specific, concrete steps to overcome and eliminate your own exquisite vulnerability to criticism. As you read the following sections, keep this in mind: Overcoming your fear of criticism will require a moderate amount of practice. But it is not difficult to develop and master this skill, and the positive impact on your self-esteem will be tremendous.

Before I show you the way out of the trap of crumbling inwardly when criticized, let me show you why criticism is more upsetting to some people than to others. In the first place, you must realize that it is *not* other people, or the critical comments they make, that upset you. To repeat, there has never been a single time in your life when the critical comments of some other person upset you—even to a small extent. No matter how vicious, heartless, or cruel these comments may be, they have *no* power to disturb you or to create even a *little bit* of discomfort.

After reading that paragraph you may get the impression that I am cracking up, mistaken, highly unrealistic, or some combination thereof. But I assure you I am not when I say: Only one person in this world has the power to *put you down*—and *you* are that person, no one else!

Here's how it works. When another person criticizes you, certain negative thoughts are automatically triggered in your head. Your emotional reaction will be created by these thoughts and not by what the other person says. The thoughts which upset you will invariably contain the same types of mental errors described in Chapter 3: overgeneralization, all-or-nothing thinking, the mental filter, labeling, etc.

For example, let's take a look at Art's thoughts. His panic was the result of his catastrophic interpretation: "This criticism shows how worthless I am." What mental errors is he making? In the first place, Art is jumping to conclusions when he arbitrarily concludes the patient's criticism is valid and reasonable. This may or may not be the case. Furthermore, he is *exaggerating* the importance of whatever he actually said to the patient that may have been undiplomatic (magnification), and he is *assuming* he could do nothing to correct any errors in his behavior (the fortune teller error). He unrealistically predicted he would be rejected and ruined professionally because he would repeat endlessly whatever error he made with this one patient (overgeneralization). He focused exclusively on his error (the mental filter) and over-looked his numerous other therapeutic successes (disqualifying or overlooking the positive). He identified with his erroneous behavior and concluded he was a "worthless and insensitive human being" (labeling).

The first step in overcoming your fear of criticism concerns your own mental processes: Learn to identify the negative thoughts you have when you are being criticized. It will be most helpful to write them down using the double-column technique described in the two previous chapters. This will

enable you to analyze your thoughts and recognize where your thinking is illogical or wrong. Finally, write down rational responses that are more reasonable and less upsetting.

An excerpt from Art's written homework using the double-column technique is included (Figure 6–1). As he learned to *think* about the situation in a more realistic manner, he stopped wasting mental and emotional effort in catastrophizing, and was able to channel his energy into creative, goal-oriented problem solving. After evaluating precisely what he had said that was offensive or hurtful, he was able to take steps to modify his clinical style with patients so as to minimize future similar mistakes. As a result, he learned from the situation, and his clinical skills and maturity increased. This gave his self-confidence a boost and helped him overcome his fear of being imperfect.

To put it succinctly, if people criticize you the comments they make will be *right* or *wrong*. If the comments are wrong, there is really nothing for you to be upset about. Think about that for a minute! Many patients have come to me in tears, angry and upset because a loved one made a critical comment to them that was thoughtless and inaccurate. Such a reaction is unnecessary. Why should you be disturbed if someone else makes the mistake of criticizing you in an unjust manner? That's the other guy's error, not yours. Why upset yourself? Did you expect that other people would be perfect? On the other hand, if the criticism is *accurate*, there is still *no reason* for you to feel overwhelmed. You're not expected to be perfect. Just acknowledge your error and take whatever steps you can to correct it. It sounds *simple* (and it is!), but it may take some effort to transform this insight into an emotional reality.

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<i>Automatic Thoughts (SELF-CRITICISM)</i>	<i>Rational Responses (SELF-DEFENSE)</i>
1. Oh, God! The truth is out about me. Even the patients can see what a worthless, insensitive individual I am.	1. Just because one patient complains it doesn't mean that I am a "worthless, insensitive individual." The majority of my patients do, in fact, like me. Making a mistake doesn't reveal my "true essence." Everyone is entitled to make mistakes.
2. They'll probably kick me out of the residency program.	2. This is silly and rests on several erroneous assumptions: (a) all I do is bad things; (b) I have no capacity to grow. Since (a) and (b) are absurd, it is extremely unlikely my position here is threatened. I have on many occasions received praise from my supervisor.

**Figure 6–1.** Excerpt from Art's written homework, using the double-column technique. He initially experienced a wave of panic when he received critical feedback from his supervisor about the way he handled a difficult patient. After writing down his negative thoughts, he realized they were quite unrealistic. Consequently, he felt substantial relief.

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Of course, you may fear criticism because you feel you need the love and approval of other people in order to be worthwhile and happy. The problem with this point of view is that you'll have to devote all your energies to trying to please people, and you won't have much left for creative, productive living. Paradoxically, many people may find you less interesting and desirable than your more self-assured friends.

Thus far, what I have told you is a review of the cognitive techniques introduced in the previous chapter. The crux of the matter is that only *your* thoughts can upset you and if you learn to *think* more realistically, you will *feel* less upset. Right now, write down the negative thoughts that ordinarily go through your head when someone criticizes you. Then identify the distortions and substitute more objective rational responses. This will help you feel less angry and threatened.

Now I would like to teach you some simple verbal techniques which may have considerable practical relevance. What can you say when someone is attacking you? How can you handle these difficult situations in a way that will enhance your sense of mastery and self-confidence?

*Step One—Empathy.* When someone is criticizing or attacking you, his (or her) motives may be to help you or to hurt you. What the critic says may be *right* or *wrong*, or *somewhere in between*. But it is not wise to focus on these issues initially. Instead, ask the person a series of specific questions designed to find out *exactly* what he or she means. Try to avoid being judgmental or defensive as you ask the questions. Constantly ask for more and more specific information. Attempt to see the world through the critic's eyes. If the person attacks you with vague, insulting labels, ask him or her to be more specific and to point out exactly what it is about you the person dislikes. This initial maneuver can itself go a long way to getting the critic off your back, and will help transform an attack-defense interaction into one of collaboration and mutual respect.

I often illustrate how to do this in a therapy session by role-playing an imaginary situation with the patient so that I can model this particular skill. I'll show you how to role-play; it's a useful skill to develop. In the dialogue that follows, I want you to imagine you are an angry critic. Say the most brutal and upsetting thing to me you can think of. What you say can be true, false, or partly both. I will respond to each of your assaults with the empathy technique.

YOU (playing the role of angry critic): Dr. Burns, you're a no-good shit.

DAVID: What about me is shitty?

YOU: Everything you say and do. You're insensitive, self-centered, an incompetent.

DAVID: Let's take each of these. I want you to try to be specific. Apparently I've done or said a number of things that upset you. Just *what* did say that sounded insensitive? What gave you the impression I was self-centered? What did I *do* that seemed incompetent?

YOU: When I called to change my appointment the other day, you sounded rushed and irritable, as if you were in a big hurry and didn't give a damn about me.

DAVID: Okay, I came across in a rushed, uncaring way on the phone. What else have I done that irritated you?

YOU: You always seem to hurry me out at the end of the session—just like this was a big production line to make money.

DAVID: Okay, you feel I've been too rushed during sessions as well. I may have given you the impression I'm more interested in your money than in you. What else have I done? Can you think of other ways might have goofed up or offended you?

What I am doing is simple. By asking you specific questions I minimize the possibility that you will reject me completely. You—and I—become aware of some specific concrete problems that we can deal with. Furthermore, I am giving you your day in court by *listening* to you so as to understand the situation *as you see it*. This tends to defuse any anger and hostility and introduces a problem-solving orientation in the place of blame casting or debate. Remember the first rule—even if you feel the criticism is *totally* unjust, respond with empathy by asking specific questions. Find out precisely what your critic means. If the person is very hot under the collar, he or she may be hurling labels at you, perhaps even obscenities. Nevertheless, ask for more information. What do those words mean? Why does the person call you a “no-good shit”? *How* did you offend this individual? *What* did you do? *When* did you do it? *How often* have you done it? *What else* does the person dislike about you? Find out what your action means to him or her. Try to see the world through your critic's eyes. This approach will frequently calm the roaring lion and lay the groundwork for a more sensible discussion.

*Step Two—Disarming the Critic.* If someone is shooting at you, you have three choices: You can stand and shoot back—this usually leads to warfare and mutual destruction; you can run away or try to dodge the bullets—this often results in humiliation and a loss of self-esteem; or you can stay put and skillfully disarm your opponent. I have found that this third solution is by far the most satisfying. When you take the wind out of the other person's sails, you end up the winner, and your opponent more often than not will also feel like a winner.

How is this accomplished? It's simple: Whether your critic is right or wrong, initially *find some way to agree with him or her*. Let me illustrate the

easiest situation first. Let's assume the critic is primarily correct. In the previous example when you angrily accused me of sounding rushed and indifferent on several occasions, I might go on to say: "You're absolutely right. I was rushed when you called, and I probably *did* sound impersonal. Other people have also pointed this out to me at times. I want to emphasize that I didn't intend to hurt your feelings. You're also right that we *have* been rushed during several of our sessions. You might recall that sessions can be any length you like, as long as we decide this ahead of time so that the scheduling can be appropriately adjusted. Perhaps you'd like to schedule sessions that are fifteen or thirty minutes longer, and see if that's more comfortable."

Now, suppose the person who's attacking you is making criticisms you feel are unfair and not valid. What if it would be unrealistic for you to change? How can you agree with someone when you feel certain that what is being said is utter nonsense? It's easy—you can agree *in principle* with the criticism, or you can find some *grain* of truth in the statement and agree with that, or you can acknowledge that the person's upset is understandable because it is based on how he or she views the situation. I can best illustrate this by continuing the role-playing; you attack me, but this time say things that are primarily false. According to the rules of the game, I must (1) find some way to agree with *whatever* you say; (2) avoid sarcasm or defensiveness; (3) always speak the truth. Your statements can be as bizarre and as ruthless as you like, and I guarantee I will stick by these rules! Let's go!

YOU (continuing to play the role of angry critic): Dr. Burns, you're shit.

DAVID: I feel that way at times. I often goof up at things.

YOU: This cognitive therapy is no damn good!

DAVID: There's certainly plenty of room for improvement.

YOU: And you're stupid.

DAVID: There are lots of people who are brighter than I am. I'm sure not the smartest person in the world.

YOU: You have no real feelings for your patients. Your approach to therapy is superficial and gimmicky.

DAVID: I'm not always as warm and open as I'd like to be. Some of my methods might seem gimmicky at first.

YOU: You're not a real psychiatrist. This book is pure trash. You're not trustworthy or competent to manage my case.

DAVID: I'm terribly sorry I seem incompetent to you. It must be quite disturbing to you. You seem to find it difficult to trust me, and you are genuinely skeptical about whether we can work together effectively. You're absolutely right—we can't work together successfully unless we have a sense of mutual respect and teamwork.

By this time (or sooner) the angry critic will usually lose steam. Because I do not fight back but instead find a way to agree with my opponent, the person quickly seems to run out of ammunition, having been successfully disarmed. You might think of this as winning by avoiding battle. As the critic begins to calm down, he or she will be in a better mood to communicate.

Once I have demonstrated these first two steps to a patient in my office, I usually propose we reverse roles to give the patient the chance to master the method. Let's do this. I will criticize and attack you, and you will practice the empathy and make up your own answers. Then see how closely they are accurate or nonsensical. To make the following dialogue a more useful exercise, cover up the responses called "You" and make up your own answers. Then see how closely they correspond with what I have written. Remember to ask questions using the empathy method and find valid ways to agree with me using the disarming technique.

DAVID (playing the role of angry critic): You're not here to get better. You're just looking for sympathy.

YOU (playing the role of the one under attack): What gives you the impression I'm just looking for sympathy?

DAVID: You don't do anything to help yourself between sessions. All you want to do is come here and complain.

YOU: It's true that I haven't been doing *some* of the written homework you suggested. Do you feel I shouldn't complain during sessions?

DAVID: You can do whatever you want. Just admit you don't give a damn.

YOU: You mean you think I don't want to get better, or what?

DAVID: You're no good! You're just a piece of garbage!

YOU: I've been feeling that way for years! Do you have some ideas about what I can do to feel differently?

DAVID: I give up. You win.

YOU: You're right. I *did* win!

I strongly suggest you practice this with a friend. The role-playing format will help you master the necessary skills needed when a real situation arises. If there is no one you feel comfortable with who could role-play with you effectively, a good alternative would be to write out imaginary dialogues between you and a hostile critic, similar to the ones you've been reading. After each harangue write down how you might answer using the empathy and disarming technique. It may seem difficult at first, but I think you'll catch on quite readily. It's really quite easy once you get the gist of it.

You will notice you have a profound, almost irresistible tendency to *defend* yourself when you are unjustly accused. This is a MAJOR mistake! If you give in to this tendency, you will find that the intensity of your opponent's attack *increases*! You will paradoxically be adding bullets to that person's arsenal every time you defend yourself. For example, you be the critic again, and this time I'll *defend* myself against your absurd accusations. You'll see how quickly our interaction will escalate to full-scale warfare.

YOU (in the role of critic again): Dr. Burns, you don't care about your patients.

DAVID (responding in a defensive manner): That's untrue and unfair. You don't know what you're talking about! My patients respect all the hard work I put in.

YOU: Well, here's one who doesn't! Good-bye! (You exit, having decided to fire me. My defensiveness leads to a total loss.)

In contrast, if I respond with empathy and disarm your hostility, more often than not you will feel I am *listening* to you and *respecting* you. As a result you lose your ardor to do battle and quiet down. This paves the way for step three—feedback and negotiation.

You may find initially that in spite of your determination to apply these techniques, when a real situation arises in which you are criticized, you will be caught up by your emotions and your old behavior patterns. You may find yourself sulking, arguing, defending yourself vehemently, etc. This is understandable. You're not expected to learn it all overnight, and you don't have to win every battle. It is important, however, to analyze your mistakes afterward so that you can review how you might have handled the situation differently along the lines suggested. It can be immensely helpful to find a friend to role-play the difficult situation with you afterward so that you can practice a variety of responses until you have mastered an approach you are comfortable with.

*Step Three—Feedback and Negotiation.* Once you have *listened* to your critic, using the empathy method, and *disarmed* him by finding some way to agree with him, you will then be in a position to explain your position and emotions *tactfully* but *assertively*, and to negotiate any real differences.

Let's assume that the critic is just plain wrong. How can you express this in a nondestructive manner? This is simple: You can express your point of view objectively with an acknowledgment you *might* be wrong. Make the conflict one based on fact rather than personality or pride. Avoid directing destructive labels at your critic. Remember, his error does *not* make him stupid, worthless, or inferior.

For example, a patient recently claimed that I sent a bill for a session for which she had already paid. She assaulted me with "Why don't you get your bookkeeping straight!" Knowing she was in error, I responded, "My records may indeed be wrong. I seem to recall that you forgot your checkbook that day, but I might be confused on this point. I hope you'll allow for the possibility that you or I *will* make errors at times. Then we can be more relaxed with each other. Why not see if you have a canceled check? That way we can find out the truth and make appropriate adjustments."

In this case my nonpolarizing response allowed her to save face and avoided a confrontation in which her self-respect was at risk. Although it turned out she was wrong, she later expressed relief that I acknowledged I do make mistakes. This helped her feel better about me, as she was afraid I would be as perfectionistic and demanding with her as she was with herself.

Sometimes you and the critic will differ not on a matter of fact but of taste. Once again, you will be a winner if you present your point of view with diplomacy. For example, I have found that no matter how I dress, some patients respond favorably and some negatively. I feel most comfortable in a suit and tie, or in a sports coat and tie. Suppose a patient criticizes me because my clothes are too formal and this is irritating because it makes me appear to be part of the “Establishment.” After eliciting further specific information about other things this person might dislike about me, I could then respond, “I can certainly agree with you that suits are a bit formal. You *would* be more comfortable with me if I dressed more casually. I’m sure you’ll understand that after dressing in a variety of ways, I have found that a nice suit or sports coat is most acceptable to the majority of the people I work with, and that’s why I’ve decided to stick with this style of dressing. I’m hopeful you won’t let this interfere with our continued work together.”

You have a number of options when you negotiate with the critic. If he or she continues to harangue you, making the same point again and again, you can simply repeat your assertive response politely but firmly over and over until the person tires out. For example, if my critic continued to insist I stop wearing suits, I might continue to say each time, “I understand your point entirely, and there *is* some truth to it. Nevertheless, I’ve decided to stick with more formal attire at this time.”

Sometimes the solution will be in between. In this case negotiation and compromise are indicated. You may have to settle for *part* of what you want. But if you have conscientiously applied the *empathy* and *disarming techniques* first, you will probably get *more* of what you want.

In many cases you will be just plain wrong, and the critic will be right. In such a situation your critic’s respect for you will probably increase by an orbital jump if you assertively *agree with the criticism*, thank the person for providing you with the information, and apologize for any hurt you might have caused. It sounds like old-fashioned common sense (and it is), but it can be amazingly effective.

By now you may be saying, “But don’t I have a *right* to defend myself when someone criticizes me? Why should I always have to empathize with the other person? After all, *he* may be the ninny, not I. Isn’t it *human* just to get angry and blow your stack? Why should I always have to *smooth* things out?”

Well, there is considerable truth in what you say. You *do* have the right to defend yourself vigorously from criticism and to get angry at anyone you choose whenever you like. And you are right on target when you point out that it is often your critic, and not you, whose thinking is fouled up. And there is more than a grain of truth behind the slogan “Better mad than sad.” After all, if you’re going to conclude that someone is “no damn good,” why not let it be the other fellow? And furthermore, sometimes it *does* feel so much better to be mad at the other person.

Many psychotherapists would agree with you on this point. Freud felt that depression was “anger turned inward.” In other words he believed depressed individuals direct their rage against themselves. In keeping with this view, many therapists urge their patients to get in touch with their anger and to express it more frequently to others. They might even say that some of the methods described in this section amount to a repressive cop-out.

This is a false issue. The crucial point is not whether or not you express your feelings, but the manner in which you do it. If your message is “I’m angry because you’re criticizing me and you’re no damn good,” you will poison your relationship with that person. If you defend yourself from negative feedback in a defensive and vengeful way, you will reduce the prospect for productive interaction in the future. Thus, while your angry outburst momentarily *feels good*, you may defeat yourself in the long run by burning your bridges. You have polarized the situation prematurely and unnecessarily, and eliminated your chance to learn what the critic was trying to convey. And what is worse, you may experience a depressive backlash and punish yourself inordinately for your burst of temper.

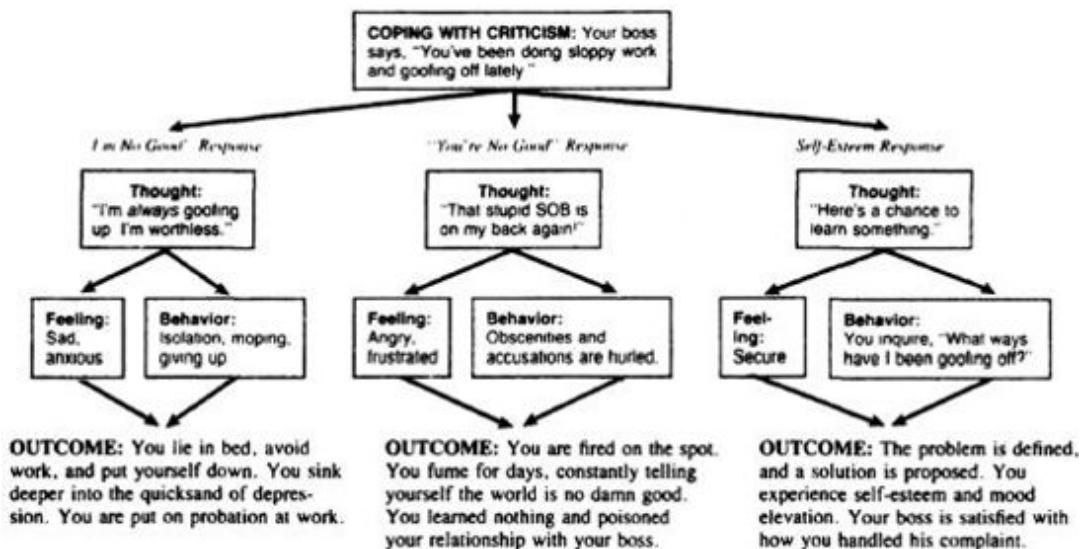
*Antiheckler Technique.* A specialized application of the techniques discussed in this chapter might be particularly helpful for those of you who are involved in lecturing or teaching. I developed the “antiheckler technique” when I began lecturing to university and professional groups on current depression research. Although my lectures are usually well received, I occasionally find there is a single heckler in the audience. The heckler’s comments usually have several characteristics: (1) They are intensely critical, but seem inaccurate or irrelevant to the material presented; (2) they often come from a person who is not well accepted or regarded among his or her local peers; and (3) they are expressed in a haranguing, abusive style.

I therefore had to develop an antiheckler technique which I could use to silence such a person in an inoffensive manner so that the rest of the audience could have an equal opportunity to ask questions. I find that the following method is highly effective: (1) I immediately *thank* the person for his or her comments; (2) acknowledge that the points brought up *are indeed* important; and (3) I emphasize that there is a *need for more knowledge* about the points raised, and I encourage my critic to pursue meaningful research and investigation of the topic. Finally, I invite the heckler to share his or her views with me further after the close of the session.

Although no verbal technique is guaranteed to bring a particular result, I have rarely failed to achieve a favorable effect when using this upbeat approach. In fact, these heckling individuals have frequently approached me after the lecture to compliment and thank me for my kind comments. It is sometimes the heckler who turns out to be most demonstrative and appreciative of my lecture!

**Summary.** The various cognitive and verbal principles for coping with criticism are summarized in the accompanying diagram (see Figure 6–2, page 146). As a general rule, when someone insults you, you will immediately go down one of three pathways—the *sad* route, the *mad* route, or the *glad* route. Whichever option you choose will be a total experience, and will involve your thinking, your feelings, your behavior, and even the way your body functions.

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**Figure 6–2.** The three ways that you might react to criticism. Depending on how you think about the situation, you will feel sad, mad, or glad. Your behavior and the outcome will also be greatly influenced by your mental set.

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Most people with a tendency to depression choose the sad route. You *automatically* conclude the critic is right. Without any systematic investigation, you jump to the conclusion that you were in the wrong and made a mistake. You then magnify the importance of the criticism with a series of thinking errors. You might *overgeneralize* and wrongly conclude that your whole life consists of nothing but a string of errors. Or you might *label* yourself a “total goof-up.” And because of your perfectionistic expectation that you are supposed to be flawless, you will probably feel convinced that your (presumed) error indicates you are worthless. As a result of these mental errors, you will experience depression and a loss of self-esteem. Your verbal responses will be ineffectual and passive, characterized by avoidance and withdrawal.

In contrast, you may choose the mad route. You will *defend* yourself from the horrors of being imperfect by trying to convince the critic that he or she is a monster. You will stubbornly refuse to admit any error because according to your perfectionistic standards, this would be tantamount to admitting you are a worthless worm. So you hurl accusations back on the assumption that the best defense is a good offense. Your heart beats rapidly, and hormones pour into your bloodstream as you prepare for battle. Every muscle tightens and your jaws are clenched. You may feel a temporary exhilaration as you tell your critic off in self-righteous indignation. You’ll show him what a no-good piece of crap he is! Unfortunately, he doesn’t agree, and in the long run your outburst is self-defeating because you’ve poisoned the relationship.

The third option requires that you either *have* self-esteem or at least act as *if you did*. It is based on the premise that you are a worthwhile human being and have no need to be perfect. When you are criticized, your initial response is *investigative*. Does the criticism contain a grain of truth? Just what did you do that was objectionable? Did you in fact goof up?

Having defined the problem by asking a series of non-judgmental questions, you are in a position to propose a solution. If a compromise is

indicated, you can negotiate. If you were clearly in the wrong, you can admit it. If the critic was mistaken, you can point this out in a tactful manner. But whether your behavior was right or wrong, you will know that you are *right* as a human being, because you have finally perceived that your self-esteem was never at issue in the first place.

## Chapter 7

### Feeling Angry? What's Your IQ?

What's your IQ? I'm not interested in knowing how smart you are because your intelligence has little, if anything, to do with your capacity for happiness. What I want to know is what your *Irritability Quotient* is. This refers to the amount of anger and annoyance you tend to absorb and harbor in your daily life. If you have a particularly high IQ, it puts you at a great disadvantage because you overreact to frustrations and disappointments by creating feelings of resentment that blacken your disposition and make your life a joyless hassle.

Here's how to measure your IQ. Read the list of twenty-five potentially upsetting situations described below. In the space provided after each incident, estimate the degree it would ordinarily anger or provoke you, using this simple rating scale:

- 0—You would feel very little or no annoyance.
- 1—You would feel a little irritated.
- 2—You would feel moderately upset.
- 3—You would feel quite angry.
- 4—You would feel very angry.

Mark your answer after each question as in this example:

You are driving to pick up a friend at the airport, and you are forced to wait for a long freight train. 2

The individual who answered this question estimated his reaction as a two because he would feel moderately irritated, but this would quickly pass as soon as the train was gone. As you describe how you would ordinarily react to each of the following provocations, make your best general estimate even

though many potentially important details are omitted (such as what kind of day you were having, who was involved in the situation, etc.).

Traditionally psychotherapists (*and* the general public) have conceptualized two primary ways to deal with anger: (a) anger turned “inward”; or (b) anger turned “outward.” The former solution is felt to be the “sick” one—you internalize your aggression and absorb resentment like a sponge. Ultimately it corrodes you and leads to, guilt and depression. Early psychoanalysts such as Freud felt that internalized anger was the cause of depression. Unfortunately, there is no convincing evidence in support of this notion.

The second solution is said to be the “healthy” one—you express your anger, and as you ventilate your feelings, you presumably feel better. The problem with this simplistic approach is that it doesn’t work very well. If you go around ventilating all your anger, people will soon regard you as loony. And at the same time you aren’t learning how to deal with people in society *without* getting angry.

The cognitive solution transcends both of these. You have a third option: *Stop creating* your anger. You don’t have to choose between holding it in or letting it out because it won’t exist.

In this chapter I provide guidelines to help you assess the pros and cons of experiencing anger in a variety of situations so you can decide when anger is and isn’t in your best self-interest. If you choose, you can develop control over your feelings; you will gradually cease to be plagued by excessive irritability and frustration that sour your life for no good reason.

## **Just Who Is Making You Angry?**

“People!

Shit!

I’m fed up with them!

I need a vacation from people.”

The woman who recorded this thought at 2:00 A.M. couldn’t sleep. How could the dogs and noisy neighbors in her apartment building be so thoughtless? Like her, I’ll bet you’re convinced it’s other people’s stupid, self-centered actions that make you angry.

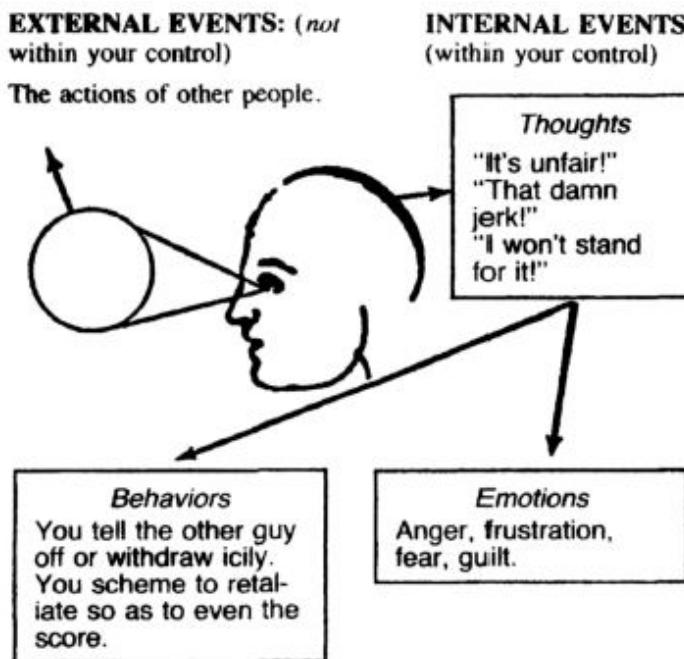
It’s natural to believe that external events upset you. When you’re mad at someone, you automatically make them the cause of all your bad feelings.

You say, “*You’re* annoying me! *You’re* getting on my nerves.” When you think like this, you’re actually fooling yourself because other people really cannot make you angry. Yes—you heard me right. A pushy teenager might crowd in front of you in line at the movie theater. A con artist might sell you a fake ancient coin at an antique shop. A “friend” might screw you out of your share of a profitable business deal. Your boyfriend might always show up late for dates in spite of his knowing how important promptness is to you. No matter how outrageous or unfair others might appear to you, *they* do not, never did, and never will upset you. The bitter truth is that you’re the one who’s *creating* every last ounce of the outrage you experience.

Does that sound like heresy or stupidity to you? If you think I’m contradicting the obvious, you may feel like burning this book or throwing it down in disgust. If so, I dare you to read on, because—

Anger, like all emotions, is created by your cognitions. The relationship between your thoughts and your anger is shown in Figure 7–1. As you will note, before you can feel irritated by any event you must first become aware of what is occurring and come to your own interpretation of it. Your feelings result from the meaning you give to the event, *not* from the event itself.

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**Figure 7–1.** It is not negative events but your perceptions and thoughts about these events that create your emotional response.

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For example, suppose that after a hectic day you put your two-year-old child to sleep in his crib for the night. You close his bedroom door and sit down to relax and watch television. Twenty minutes later he suddenly opens the door to his room and walks out giggling. You might react to this in a variety of ways, depending on the meaning you attach to it. If you feel irritated, you're probably thinking, "Damn it! He's always a bother. Why can't he stay in bed and behave like he should? He never gives me a minute's rest!" On the other hand, you could be delighted to see him pop out of his room because you're thinking, "Great! He just crawled out of his crib on his own for the first time. He's growing up and getting more independent." The event is the same in both cases. Your emotional reaction is determined entirely by the way you are thinking about the situation.

I'll bet I know what you're thinking now: "That example with the baby is not applicable. When *I* get angry there's a justifiable provocation. There's plenty of *genuine* unfairness and cruelty in this world. There's no valid way I can think about all the crap I have to put up with each day without getting uptight. Do you want to perform a lobotomy and turn me into an unfeeling zombie? NO THANKS!"

You are certainly right that plenty of genuinely negative events *do* go on every day, but your feelings about them are still created by the interpretations you place on them. Take a careful look at these interpretations because anger can be a two-edged sword. The consequences of an impulsive outburst will frequently defeat you in the long run. Even if you are being genuinely wronged, it may not be to your advantage to feel angry about it. The pain and suffering you inflict on yourself by feeling outraged may far exceed the impact of the original insult. As a woman who runs a restaurant put it, "Sure—I have the *right* to fly off the handle. The other day I realized the chefs forgot to order ham again even though I had specifically reminded them, so I exploded and threw a cauldron of hot soup across the kitchen floor in disgust. Two minutes later I knew I'd acted like the biggest asshole in the world, but I didn't want to admit it, so I had to spend all my energy for the next forty-eight hours trying to convince myself I had the right to make a jackass of myself in front of twenty employees! It wasn't worth it!"

In many cases your anger is created by subtle cognitive distortions. As with depression, many of your perceptions are twisted, one-sided, or just

plain wrong. As you learn to replace these distorted thoughts with others that are more realistic and functional, you will feel less irritable and gain greater self-control.

What kinds of distortion occur most often when you are angry? One of the greatest offenders is *labeling*. When you describe the person you're mad at as “a jerk” or “a bum” or “a piece of shit,” you see him in a totally negative way. You could call this extreme form of overgeneralization “globalizing” or “monsterizing.” Someone may in fact have betrayed your trust, and it is absolutely right to resent what that person *did*. In contrast, when you label someone, you create the impression that he or she has a bad essence. You are directing your anger toward what that person “is.”

When you write people off this way, you catalog in your mind’s eye every single thing about them you don’t like (the mental filter) and ignore or discount their good points (disqualifying the positive). This is how you set up a false target for your anger. In reality, every human being is a complex mix of positive, negative, and neutral attributes.

Labeling is a distorted thinking process that causes you to feel inappropriately indignant and morally superior. It’s destructive to build your self-image this way: Your labeling will inevitably give way to your need to blame the other person. Your thirst for retaliation intensifies the conflict and brings out similar attitudes and feelings in the person you’re mad at. Labeling inevitably functions as a self-fulfilling prophecy. You polarize the other person and bring about a state of interpersonal warfare.

What’s the battle really all about? Often you’re involved in a defense of your self-esteem. The other person may have threatened you by insulting or criticizing you, or by not loving or liking you, or by not agreeing with your ideas. Consequently, you may perceive yourself in a duel of honor to the death. The problem with this is that the other person is *not* a totally worthless shit, no matter how much you insist! And, furthermore, you cannot enhance your own esteem by denigrating someone else even if it does feel good temporarily. Ultimately only your own negative, distorted thoughts can take away your self-respect, as pointed out in Chapter 4. There is *one and only one* person in this world who has the power to threaten your self-esteem—and that is you. Your sense of worth can go down *only* if you put yourself down. The real solution is to put an end to your absurd inner harangue.

Another distortion characteristic of anger-generating thoughts is *mind reading*—you invent motives that explains to *your* satisfaction why the other person did what he or she did. These hypotheses are frequently erroneous because they will not describe the actual thoughts and perceptions that motivated the other person. Due to your indignation, it may not occur to you to check out what you are saying to yourself.

Common explanations you might offer for the other person's objectionable behavior would be "He has a mean streak"; "She's unfair"; "He's just like that"; "She's stupid"; "They're bad kids"; and so forth. The problem with these so-called explanations is that they are just additional labels that don't really provide any valid information. In fact, they are downright misleading.

Here's an example: Joan got hot under the collar when her husband told her he'd prefer to watch the Sunday football game on TV rather than go with her to a concert. She felt miffed because she told herself, "He doesn't love me! He always has to get his own way! It's unfair!"

The problem with Joan's interpretation is that it is not valid. He *does* love her, he doesn't always get his way, and he isn't intentionally being "unfair." On this particular Sunday the Dallas Cowboys are locking spurs with the Pittsburgh Steelers, and he *really* wants to see that game! There's no way he's going to want to get dressed and go to a concert.

When Joan thinks about her husband's motivations in such an illogical fashion, she creates two problems for the price of one. She has to put up with the self-created illusion that she's unloved in addition to missing out on his company at the concert.

The third form of distortion that leads to anger is *magnification*. If you exaggerate the importance of the negative event, the intensity and duration of your emotional reaction may get blown up out of all proportion. For example, if you are waiting for a late bus and you have an important appointment, you might tell yourself, "I can't take this!" Isn't that a slight exaggeration? Since you are taking it, you *can* take it, so why tell yourself you *can't*? The inconvenience of waiting for the bus is bad enough without creating additional discomfort and self-pity in this way. Do you really want to fume like that?

Inappropriate *should* and *shouldn't* statements represent the fourth type of distortion that feeds your anger. When you find that some people's actions are not to your liking, you tell yourself they "shouldn't" have done what they

did, or they “should have” done something they failed to do. For example, suppose you register at a hotel and discover they lost the record of your reservation, and now there are no rooms available. You furiously insist, “This *shouldn’t* have happened! Those stupid goddam clerks!”

Does the actual deprivation cause your anger? No. The deprivation can only create a sense of loss, disappointment, or inconvenience. Before you can feel anger, you must necessarily make the interpretation you are *entitled* to get what you want in this situation. Consequently, you see the goof-up on your reservation as an injustice. This perception leads to your feeling angry.

So what’s wrong with that? When you say the clerks *shouldn’t* have made a mistake, you are creating unnecessary frustration for yourself. It’s unfortunate your reservation was lost, but it’s highly unlikely anyone intended to treat you unjustly, or that the clerks are especially stupid. But they *did* make an error. When you insist on perfection from others, you will simply make *yourself* miserable and become immobilized. Here’s the rub: Your anger probably won’t cause a room to appear magically, and the inconvenience of going to another hotel will be far less than the misery you inflict on yourself by brooding for hours or days about the lost reservation.

Irrational should statements rest on your assumption that you are *entitled* to instant gratification at all times. So on those occasions when you don’t get what you want, you go into panic or rage because of your attitude that unless you get X, you will either die or be tragically deprived of joy forever (X can represent love, affection, status, respect, promptness, perfection, niceness, etc.). This insistence that your wants be gratified at all times is the basis for much self-defeating anger. People who are anger-prone often formulate their desires in moralistic terms such as this: If I’m nice to someone, they *should* be appreciative.

Other people have free will, and often think and act in ways that aren’t to your liking. All of your insistence that they must fall in line with your desires and wishes will not produce this result. The opposite is more often true. Your attempts to coerce and manipulate people with angry demands most often will alienate and polarize them and make them much less likely to want to please you. This is because other people don’t like being controlled or dominated any more than you do. Your anger will simply limit the creative possibilities for problem solving.

The perception of unfairness or injustice is the ultimate cause of most, if not all, anger. In fact, we could define anger as the emotion which corresponds in a one-to-one manner to your belief that you are being treated unfairly.

Now we come to a truth you may see either as a bitter pill or an enlightening revelation. There is no such thing as a universally accepted concept of fairness and justice. There is an undeniable *relativity* of fairness, just as Einstein showed the relativity of time and space. Einstein postulated—and it has since been experimentally validated—there is no “absolute time” that is standard throughout the universe. Time can appear to “speed up” and “slow down,” and is relative to the frame of reference of the observer. Similarly, “absolute fairness” does not exist. “Fairness” is relative to the observer, and what is fair to one person can appear quite unfair to another. Even social rules and moral strictures which are accepted within one culture can vary substantially in another. You can protest that this is not the case and insist that your own personal moral system is universal, but it just ain’t so!

Here’s proof: When a lion devours a sheep, is this unfair? From the point of view of the sheep, it is *unfair*; he’s being viciously and intentionally murdered with no provocation. From the point of view of the lion, it is *fair*. He’s hungry, and this is the daily bread he feels entitled to. Who is “right”? There is *no ultimate or universal answer* to this question because there’s no “absolute fairness” floating around to resolve the issue. In fact, fairness is simply a perceptual interpretation, an abstraction, a self-created concept. How about when *you* eat a hamburger? Is this “unfair”? To you, it’s not. From the point of view of the cow, it certainly is (or was)! Who’s “right”? There is no ultimate “true” answer.

In spite of the fact that “absolute fairness” does not exist, personal and social moral codes are important and useful. I am not recommending anarchy. I am saying that moral statements and judgments about fairness are stipulations, not objective facts. Social moral systems, such as the Ten Commandments, are essentially sets of rules that groups decide to abide by. One basis for such systems is the enlightened self-interest of each member of the group. If you fail to act in a manner that takes into account the feelings and interests of others you are likely to end up less happy because sooner or later they will retaliate when they notice you are taking advantage of them.

A system which defines “fairness” varies in its generality depending on how many people accept it. When a rule of behavior is unique to one person, other people may see it as eccentric. An example of this would be my patient who washes her hands ritualistically over fifty times a day to “set things right” and to avoid extreme feelings of guilt and anxiety. When a rule is nearly universally accepted it becomes part of a general moral code and may become a part of the body of law. The prohibition against murder is an example. Nevertheless, no amount of general acceptance can make such systems “absolute” or “ultimately valid” for everyone under all circumstances.

Much everyday anger results when we confuse our own personal wants with general moral codes. When you get mad at someone and you claim that they are acting “unfairly,” more often than not what is really going on is that they are acting “fairly” relative to a set of standards and a frame of reference that differs from yours. Your assumption that they are “being unfair” implies that your way of looking at things is universally accepted. For this to be the case, everyone would have to be the same. But we aren’t. We all think differently. When you overlook this and blame the other person for being “unfair” you are unnecessarily polarizing the interaction because the other person will feel insulted and defensive. Then the two of you will argue fruitlessly about who is “right.” The whole dispute is based on the illusion of “absolute fairness.”

Because of your relativity of fairness, there is a logical fallacy that is inherent in your anger. Although you feel convinced the other guy is acting *unfairly*, you must realize he is only acting unfairly relative to *your* value system. But he is operating from *his* value system, not yours. More often than not, his objectionable action will seem quite fair and reasonable to him. Therefore, from his point of view—which is his only possible basis for action—what he does is “fair.” Do you want people to act fairly? Then you should *want* him to act as he does even though you *dislike* what he does, since he is acting fairly within his system! You can work to try to convince him to change his attitudes and ultimately modify his standards and his actions, and in the meantime you can take steps to make certain you won’t suffer as a result of what he does. But when you tell yourself, “He’s acting unfairly,” you are fooling yourself and you are chasing a mirage!

Does this mean that all anger is inappropriate and that the concepts of “fairness” and “morality” are useless because they are relative? Some popular writers do give this impression. Dr. Wayne Dyer writes:

We are conditioned to look for justice in life and when it doesn’t appear, we tend to feel anger, anxiety or frustration. Actually, it would be equally productive to search for the fountain of youth, or some such myth. Justice does not exist. It never has, and it never will. The world is simply not put together that way. Robins eat worms. That’s not fair to the worms.... You have only to look at nature to realize there is no justice in the world. Tornadoes, floods, tidal waves, droughts are all unfair.\*

This position represents the opposite extreme, and is an example of all-or-nothing thinking. It’s like saying—throw your watches and clocks away because Einstein showed that absolute time does not exist. The concepts of time and fairness are socially *useful* even though they do not exist in an absolute sense.

In addition to this contention that the concept of fairness is an illusion, Dr. Dyer seems to suggest that anger is useless:

You may accept anger as a part of your life, but do you realize it serves no utilitarian purpose? ... You do not have to possess it, and it serves no purpose that has anything to do with being a happy, fulfilled person.... The irony of anger is that it never works in changing others .... \*\*

Again, his arguments seem to be based on cognitive distortion. To say anger serves *no* purpose is just more all-or-nothing thinking, and to say it never works is an overgeneralization. Actually, anger can be adaptive and productive in certain situations. So the real question is not “Should I or should I not feel anger?” but rather “Where will I draw the line?”

The following two guidelines will help you to determine when your anger is productive and when it is not. These two criteria can help you synthesize what you are learning and to evolve a meaningful personal philosophy about anger:

1. Is my anger directed toward someone who has *knowingly*, *intentionally*, and *unnecessarily* acted in a hurtful manner?
2. Is my anger useful? Does it help me achieve a desired goal or does it simply defeat me?

Example: You are playing basketball, and a fellow on the other team elbows you in the stomach intentionally so as to upset you and get you off your game. You may be able to channel your anger productively so you will play harder and win. So far your anger is *adaptive*.<sup>\*</sup> Once the game is over, you may no longer want that anger. Now it's *maladaptive*.

Suppose your three-year-old son runs mindlessly into the street and risks his life. In this case he is *not* intentionally inflicting harm. Nevertheless, the angry mode in which you express yourself may be adaptive. The emotional arousal in your voice conveys a message of alarm and importance that might not come across if you were to deal with him in a calm, totally objective manner. In both these examples, you *chose* to be angry, and the magnitude and expression of the emotion were under your control. The *adaptive and positive* effects of your anger differentiate it from hostility, which is impulsive and uncontrolled and leads to aggression.

Suppose you are enraged about some senseless violence you read about in the paper. Here the act seems clearly hurtful and immoral. Nevertheless, your anger may not be adaptive if—as is usually the case—there is nothing you plan to do about it. If, in contrast, you choose to help the victims or begin a campaign to fight crime in some way, your anger might again be adaptive.

Keeping these two criteria in mind, let me give you a series of methods you can use to reduce your anger in those situations where it is not in your best interest.

*Develop the Desire.* Anger can be the most difficult emotion to modify, because when you get mad you will be like a furious bulldog, and persuading you to stop sinking your teeth into the other person's leg can be extremely tough. You *won't really want* to rid yourself of those feelings because you will be consumed by the desire for revenge. After all, because anger is caused by what you perceive to be unfair, it is a *moral emotion*, and you will be extremely hesitant to let go of the righteous feeling. You will have the nearly irresistible urge to defend and justify your anger with *religious zeal*. Overcoming this will require an act of great willpower. So why bother?

The first step: Use the double-column technique to make a list of the advantages and disadvantages of feeling angry and acting in a retaliatory manner. Consider both the short-and long-term consequences of your anger. Then review the list and ask yourself which are greater, the costs or the benefits? This will help you determine if your resentment is really in your best self-interest. Since most of us ultimately want what's best for us, this can pave the way for a more peaceful and productive attitude.

Here's how it works. Sue is a thirty-one-year-old woman with two daughters from a previous marriage. Her husband, John, is a hard-working lawyer with one teenage daughter from his prior marriage. Because John's time is very limited, Sue often feels deprived and resentful. She told me she felt he wasn't giving her a fair shake in the marriage because he was not giving her enough of his time and attention. She listed the advantages and disadvantages of her irritability in Figure 7-2.

She also made a list of the positive consequences that might result from eliminating her anger: (1) People will like me better. They will want to be near me; (2) I will be more predictable; (3) I will be in better control of my emotions; (4) I will be more relaxed; (5) I will be more comfortable with myself; (6) I will be viewed as a positive, nonjudgmental, practical person; (7) I will behave more often as an adult than as a child who has to get what it wants; (8) I will influence people more effectively, and I'll get more of what I want through assertive, calm, rational negotiation than through tantrums and demands; and (9) my kids, husband, and parents will respect me more. As a result of this assessment, Sue told me she was convinced that the price of her anger substantially exceeded the benefits.

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<i>Advantages of My Anger</i>	<i>Disadvantages of My Anger</i>
1. It feels good	1 I will be souring my relationship with John even more
2. John will understand that I strongly disapprove of him.	2. He will want to reject me.
3. I have the <i>right</i> to blow my stack if I want to.	3 I will often feel guilty and down on myself after I blow my stack
4. He'll know I'm not a doormat.	4 He will probably retaliate against me and get angry right back, since he doesn't like being taken advantage of either
5. I'll show him I won't stand for being taken advantage of	5 My anger inhibits both of us from correcting the problem that caused the anger in the first place. It prevents resolution and sidetracks us from dealing with the issues.
6. Even though I don't get what I want, I can at least have the satisfaction of getting revenge. I can make him squirm and feel hurt like I do. Then he'll have to shape up.	6. One minute I'm up, one minute I'm down. My irritability makes John and the people around me never know what to expect. I get labeled as moody and cranky and spoiled and immature. They see me as a childish brat
	7. I might make neurotics out of my kids. As they grow up, they may resent my explosions and see me as someone to stay away from rather than to go to for help.
	8. John may leave me if he gets enough of my nagging and bitching.
	9. The unpleasant feelings I create make me feel miserable. Life becomes a sour and bitter experience, and I miss out on the joy and creativity I used to prize so highly.

**Figure 7–2.** The Anger Cost-Benefit Analysis.

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It is crucial that you perform this same type of analysis as a first step in coping with your anger. After you list the advantages and disadvantages of your anger, give yourself the same test. Ask yourself, if the upsetting situation that provokes me doesn't change immediately, would I be willing to cope with it instead of getting angry? If you can answer yes, then you are clearly motivated to change. You will probably succeed in gaining greater inner peace and self-esteem, and you will increase your effectiveness in life. This choice is up to you.

*Cool Those Hot Thoughts.* Once you've decided to cool down, an invaluable method that can help you is to write down the various "hot thoughts" that are going through your mind when you are upset. Then substitute less upsetting, more objective "cool thoughts," using the double-column method (Figure 7–3). Listen for those "hot thoughts" with your "third

ear” so as to tune in to the antagonistic statements that go through your head. Record this private dialogue without any censorship. I’m sure you’ll notice all kinds of highly colorful language and vengeful fantasies—write them all down. Then substitute “cool thoughts” that are more objective and less inflammatory. This will help you feel less aroused and overwhelmed.

Sue used this technique to deal with the frustration she felt when John’s daughter, Sandy, acted manipulative and wrapped John around her finger. Sue kept telling him to be more assertive with Sandy and less of a soft touch, but he often reacted negatively to her suggestions. He felt Sue was nagging and making demands to get her way. This made him want to spend even *less* time with her, which contributed to a vicious cycle.

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<i>Hot Thoughts</i>	<i>Cool Thoughts</i>
1. How dare he not listen to me!	1. Easily. He's not obliged to do everything my way. Besides he <i>is</i> listening, but he's being defensive because I'm acting so pushy.
2. Sandy lies. She says she's working, but she's not. Then she expects John's help.	2. It's her nature to lie and to be lazy and to use people when it comes to work in school. She hates work. That's her problem.
3. John doesn't have much free time and if he spends it helping her, I will have to be alone and take care of my kids by myself.	3. So what. I like being alone. I'm capable of taking care of my kids by myself. I'm not helpless. I can do it. Maybe he'll want to be with me more if I learn not to get angry all the time.
4. Sandy's taking time away from me.	4. That's true. But I'm a big girl. I can tolerate some time alone. I wouldn't be so upset if he were working with my kids.
5. John's a schmuck. Sandy uses people.	5. He's a big boy. If he wants to help her he can. Stay out of it. It's not my business.
6. I can't stand it!	6. I can. It's only temporary. I've stood worse.
7. I'm a baby brat. I deserve to feel guilty.	7. I'm entitled to be immature at times. I'm not perfect and I don't need to be. It's not necessary to feel guilty. This won't help.

**Figure 7–3.** Sue wrote down her “Hot Thoughts” when her husband acted like a soft touch in response to his teenage daughter’s selfish

manipulations. When she substituted less upsetting “Cool Thoughts,” her jealousy and resentment diminished.

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Sue wrote down the “hot thoughts” that made her feel jealous and guilty (see Figure 7–3). As she substituted “cool thoughts,” she felt better, and this served as an antidote to her urge to try to control John. Although she still felt he was wrong in letting Sandy manipulate him, she decided he had the “right” to be “wrong.” Consequently, Sue pushed John less, and he began to feel less pressured. Their relationship improved and ripened in a climate of mutual freedom and respect. Simply talking back to her “hot thoughts” was, of course, not the only ingredient that led to a successful second marriage for Sue and John, but it was a necessary and gigantic first step without which both of them could have easily ended up stalemated again!

You can also use the more elaborate chart, the “Daily Record of Dysfunctional Thoughts,” to deal with your anger (see Figure 7–4, page 170). You can describe the provocative situation and assess how angry you feel before and after you do the exercise. Figure 7–4 shows how a young woman coped with her frustration when she was dealt with tersely by a prospective employer over the telephone. She reported that pinpointing her “hot thoughts” and putting the lie to them helped her nip an emotional explosion in the bud. This prevented the fretting and fuming that normally would have soured her entire day. She told me, “Before I did the exercise I thought my enemy was the man on the other end of the phone. But I learned that *I* was treating myself ten times worse than he was. Once I recognized this, it was relatively easy to substitute cooler thoughts, and I surprised myself by feeling a whole lot better right away!”

*Imagining Techniques.* Those negative “hot thoughts” that go through your mind when you are angry represent the script of a private movie (usually X-rated) that you project onto your mind. Have you ever noticed the picture on the screen? The images, daydreams, and fantasies of revenge and violence can be quite colorful indeed!

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<i>Provocative Situation</i>	<i>Emotions</i>	<i>Hot Thoughts</i>	<i>Cool Thoughts</i>	<i>Outcome</i>
Called ad in paper for part-time medical transcriptionist. Ad said—needs "some experience." First, the man wouldn't even tell me what kind of company it was. Then he turned me down for job 'cause he didn't think I had enough experience!	Anger hatred frustration 98%	1. That jerk! Who the hell does he think he is! I have more than enough experience 2. That was the best ad in the paper. 3. My parents will kill me. 4. I'm going to cry.	1. Why am I getting so excited? I didn't like the tone of his voice anyway. So he didn't allow me to really explain my experience. I know I'm good. So it's not my fault I didn't get the job—it's his. Besides, would I want to work for someone like that? 2. I'm blowing things out of proportion. There are many other jobs I can get. 3. Of course they won't. At least I'm trying. 4. Now isn't that ridiculous? Why should someone make me cry? This isn't worth crying over. I know my worth—that's what counts.	Anger hatred frustration 15%

**Figure 7–4.** Daily Record of Dysfunctional Thoughts.

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You may not be aware of these mental pictures unless you look for them. Let me illustrate. Suppose I ask you to visualize a red apple in a brown basket right now. You can do this with your eyes open or closed. There! Do you see it now? That's what I'm referring to. Most of us have these visual images all day long. They are a part of normal consciousness, the pictorial illustrations of our thoughts. For example, memories sometimes occur to us as mental pictures. Conjure up an image now of some vivid past event—your high-school graduation, your first kiss (do you still remember it?), a long hike, etc. Do you see it now?

These images can affect you strongly, and their influence can be positively or negatively arousing, just like erotic dreams or nightmares. The exhilarating effect of a positive image can be intense. For instance, on your way to an amusement park you might have an image of that first dazzling descent down the roller coaster, and you may experience the excited rush in your belly. The daydream actually creates the pleasurable anticipation. Similarly, negative images play a powerful role in your level of emotional arousal. Visualize right now someone whom you've gotten good and mad at sometime in your life. What images come to mind? Do you imagine punching them in the nose or tossing them into a vat of boiling oil?

These daydreams actually keep your anger alive *long* after the initial insult has occurred. Your sense of rage may eat away at you for hours, days, months, or even years after the irritating event has long since passed. Your fantasies help keep the pain alive. Every time you fantasize about the

occurrence you shoot new doses of arousal into your system. You become like a cow chewing on poison cud.

And who is creating this anger? You are because you chose to put those images in your mind! For all you know, the person you are mad at lives in Timbuktu, or maybe isn't even alive anymore, so he or she could hardly be the culprit! You are the director and producer of the film now, and, what's worse, you're the only one in the audience. Who has to watch and experience all the arousal? YOU DO! You're the one who's subjected to a continual clenching, a tightening of back muscles, and an outpouring of adrenal hormones into the bloodstream. You're the one whose blood pressure is going up. IN A NUTSHELL: *You're making yourself hurt.* Do you want to keep this up?

If not, you will want to do something to reduce the anger-generating images that you are projecting onto your mind. One helpful technique is to transform them in a creative way so they become less upsetting. Humor represents one powerful tool you can use. For example, instead of imagining wringing the neck of the person you are furious with, fantasize that he is walking around in diapers in a crowded department store. Visualize all the details: the potbelly, the diaper pins, the hairy legs. Now what's happening to your anger? Is that a broad smile spreading across your face?

A second method involves thought stoppage. As you notice the images crossing your mind each day, remind yourself that you have the right to turn the projector off. Think about something else. Find someone and engage him or her in conversation. Read a good book. Bake bread. Go jogging. When you don't reward the anger images with your arousal, they will recur less and less often. Instead of dwelling on them, think about an upcoming event that excites you, or switch to an erotic fantasy. If the upsetting memory is persistent, engage in vigorous physical exercise such as pushups, rapid jogging, or swimming. These have the additional benefit of rechanneling your potentially hurtful arousal in a highly beneficial way.

*Rewrite the Rules.* You may frustrate and upset yourself needlessly because you have an unrealistic rule about personal relationships that causes you to be let down all the time. The key to Sue's anger was her belief she was *entitled* to John's love because of her rule "If I'm a good and faithful wife, I deserve to be loved."

As a result of this innocent-sounding assumption, Sue experienced a constant sense of danger in her marriage because anytime John wasn't giving her an appropriate helping of love and attention, she would experience it as a confirmation of her inadequacy. She would then manipulate and demand attention and respect in a constant battle to defend herself against a loss of self-esteem. Intimacy with him became like slipping slowly toward the edge of an icy cliff. No wonder she was desperately grabbing onto John, and no wonder she would explode when she sensed his indifference—didn't he realize her life was at stake?

In addition to the intense unpleasantness that her “love” rule created, it didn’t work well in the long run. For a while Sue’s manipulations did, in fact, get her some of the attention she craved. After all, she could *intimidate* John with her emotional explosions, she could *punish* him with her icy withdrawal, and she could *manipulate* him by arousing his guilt.

But the price Sue pays is that the love she receives isn’t—and can’t—be given freely and spontaneously. He will feel exhausted, trapped, and controlled. The resentment he’s been storing up will press for release. When he stops buying into her belief that he *has* to give in to her demands, his desire for freedom will overpower him, and he will explode. The destructive effects of what passes for love never cease to amaze me!

If your relationships are characterized by this cyclic tension and tyranny, you may be better off rewriting the rules. If you adopt a more realistic attitude, you can end your frustration. It’s much easier than trying to change the world. Sue decided to revise her “love” rule in the following way: “If I behave in a positive manner toward John, he will respond in a loving way a good bit of the time. I can still respect myself and function effectively when he doesn’t.” This formulation of her expectations was more realistic and didn’t put her moods and self-esteem at the mercy of her husband.

The rules that get you into interpersonal difficulty often won’t appear to be malignant. On the contrary, they often seem highly moral and humanistic. I recently treated a woman named Margaret who had the notion that “marriages *should* be fifty-fifty. Each partner *should* do for the other equally.” She applied this rule to all human relationships. “If I do nice things for people, they *should* reciprocate.”

So what’s wrong with that? It certainly sounds “reasonable” and “fair.” It’s kind of a spin-off from the Golden Rule. Here’s what’s wrong with it: It’s an

undeniable fact that human relationships, including marriages, are rarely spontaneously “reciprocal” because people are different. Reciprocity is a transient and inherently unstable ideal that can only be approximated through continued effort. This involves mutual consensus, communication, compromise, and growth. It requires negotiation and hard work.

Margaret’s problem was that she didn’t recognize this. She lived in a fairytale world where reciprocity existed as an assumed reality. She went around always doing good things for her husband and others and then waited for their reciprocity. Unfortunately, these unilateral contracts fell apart because other people usually weren’t aware that she expected to be repaid.

For example, a local charity organization advertised for a salaried assistant director to start in several months. Margaret was quite interested in this position and submitted her application. She then gave large amounts of her time doing volunteer work for the organization and assumed that the other employees would “reciprocate” by liking and respecting her, and that the director would “reciprocate” by giving her the job. In reality, the other employees did not respond to her warmly. Perhaps they sensed and resented her attempt to control them with her “niceness” and virtue. When the director chose another candidate for the position, she hit the roof and felt bitter and disillusioned because her “reciprocity” rule had been violated!

Since her rule caused her so much trouble and disappointment she opted to rewrite it, and to view reciprocity not as a *given* but as a goal she could work toward by pursuing her own self-interest. At the same time she relinquished her demand that others read her mind and respond as she wanted. Paradoxically, as she learned to *expect* less, she *got* more!

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<i>Self-Defeating Should Rule</i>	<i>Revised Version</i>
1. If I'm nice to someone, they should be appreciative.	1. It would be nice if people were always appreciative, but this isn't realistic. They will often be appreciative, but sometimes they won't be.
2. Strangers should treat me courteously.	2. Most strangers will treat me courteously if I don't act like I have a chip on my shoulder. Occasionally some sourpuss will act obnoxious. Why let this bother me? Life is too short to waste time concentrating on negative details.
3. If I work hard for something, I should get it.	3. This is ridiculous. I have no guarantee I'll <i>always</i> be successful in everything. I'm not perfect and I don't have to be.
4. If someone treats me unfairly, I should get mad because I have the right to get mad and because it makes me more human.	4. All human beings have the right to get mad whether or not they're treated unfairly. The real issue is—is it to my advantage to get mad? Do I want to feel angry? What are the costs and benefits?
5. People shouldn't treat me in ways I wouldn't treat them.	5. Hogwash. Everyone doesn't live by my rules, so why expect they will? People will <i>often</i> treat me as well as I treat them, but not <i>always</i> .

**Figure 7–5.** Revising "Should Rules."

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If you have a “should” or “shouldn’t” rule that has been causing you disappointment and frustration, rewrite it in more realistic terms. A number of examples to help you do this are shown in Figure 7–5. You will notice that the substitution of one word—“it would be nice *if*” in place of “should”—can be a useful first step.

*Learn to Expect Craziness.* As the anger in Sue's relationship with John cooled down, they became closer and more loving. However, John's daughter, Sandy, responded to his increased intimacy by even greater manipulations. She began to lie, borrowed money without returning it; she sneaked into Sue's bedroom, went through drawers, and stole Sue's personal items; she left the kitchen messy, etc. All these actions effectively got Sue's

goat because she told herself, “Sandy shouldn’t act so sneaky. She’s crazy! It’s unfair!” Sue’s sense of frustration was the product of two necessary ingredients:

1. Sandy’s obnoxious behavior;
2. Sue’s expectation that she should act in a more mature way.

Since the evidence suggested that Sandy *wasn’t* about to change, Sue had only one alternative: She could discard her unrealistic expectation that Sandy behave in an adult, ladylike fashion! She decided to write the following memo to herself entitled:

### **Why Sandy Should Act Obnoxiously**

It is Sandy’s nature to be manipulative because she believes that she’s entitled to love and attention. She believes that getting love and attention is a matter of life and death. She thinks she needs to be the center of attention in order to survive. Therefore, she will see any lack of love as unfair and a great danger to her sense of self-esteem.

Because she feels she has to manipulate in order to get attention, she *should* act in a manipulative way. Therefore, I can expect and predict that she will continue to act this way until she changes. Since it is unlikely that she will change in the near future, I can expect her to continue to behave this way for a period of time. Therefore, I will have no reason to feel frustrated or surprised because she will be acting the way she *should* act.

Furthermore, I want all humans including Sandy to act in a manner that they believe to be fair. Sandy feels she’s entitled to more attention. Since her obnoxious behavior is based on her sense of entitlement, I can remind myself that what she does is fair from her point of view.

Finally, I want my moods to be under my control, not hers. Do I want to make myself feel upset and angry at her “fair, obnoxious” behavior? No! Therefore, I can begin to change the way I react to her:

1. I can thank her for stealing since this is what she “should” do!
2. I can laugh to myself about her manipulations since they are childish.
3. I can choose not to be angry unless it is my decision to use the anger to accomplish a specific goal.

4. If I feel a loss of self-esteem due to Sandy's manipulations, I can ask myself, Do I want to give a child such power over me?

What is the desired effect of such a memorandum? Sandy's provocative actions are probably knowingly malicious. Sandy consciously targets Sue because of the resentment and helpless frustration she feels. When Sue gets upset, she paradoxically gives Sandy exactly what she wants! She can greatly reduce her frustration as she changes her expectations.

*Enlightened Manipulation.* You may fear that you will be a pushover if you change your expectations and give up your anger. You might sense that other people would take advantage of you. This apprehension reflects your sense of inadequacy as well as the fact that you probably have not been trained in more enlightened methods of going after what you want. You probably believe that if you didn't make demands on people you'd end up empty-handed.

So what's the alternative? Well, as a starting point let's review the work of Dr. Mark K. Goldstein, a psychologist who has done some brilliant and creative clinical research on the behavioral conditioning of husbands by wives. In his work with neglected and angry wives, he became aware of the self-defeating methods they used to get what they wanted from their husbands. He asked himself: What have we learned in the laboratory about the most effective scientific methods for influencing *all* living organisms, including bacteria, plants, and rats? Can we apply these principles to wayward and sometimes brutal husbands?

The answer to these questions was straightforward—*reward* the desired behavior instead of *punishing* the undesired behavior. Punishment causes aversion and resentment and brings about alienation and avoidance. Most of the deprived and abandoned wives he treated were misguidedly trying to punish their husbands into doing what they wanted. By switching them to a reward model in which the desired behavior got copious attention, he observed some dramatic turnabouts.

The wives Dr. Goldstein treated were not unique. They were ensnarled in the ordinary marital conflicts that most of us confront. These women had a long history of giving their spouses attention either indiscriminately or, in some cases, primarily in response to undesirable behavior. A major shift had to occur in order for them to elicit the kind of response they desired from

their husbands but were not getting. By keeping meticulous scientific records of their interactions with their husbands, the women were able to achieve control over how they responded.

Here's how it worked for one of Dr. Goldstein's patients. After years of fighting, wife X reported she lost her husband. He abandoned her and moved in with his girl friend. His primary interactions with wife X had centered around abuse and indifference. It appeared on the surface as if he didn't care much about her. Nevertheless, he did call her occasionally, indicating he might have some interest in her. She had the choice of cultivating this attention or crushing it further by continued inappropriate responses.

Wife X defined her goals. She would experiment to see if she *could* in fact get her husband back. The first milestone would be to determine if she could effectively increase his rate of contact with her. She measured meticulously the frequency and duration of his every telephone call and visit home, recording this information on a piece of graph paper taped to the refrigerator door. She carefully assessed the crucial relationship between her behavior (the stimulus) and the frequency of his contacts (the response).

She initiated no contacts with him at all on her own, but instead responded positively and affectionately to his calls. Her strategy was straightforward. Rather than noticing and reacting to all the things about him that she didn't like, she began to reinforce systematically those that she did like. The rewards she used were all the things that turned him on—praise, food, sex, affection, etc.

She began by responding to his rare calls in an upbeat, positive, complimentary manner. She flattered and encouraged him. She avoided any criticism, argument, demands, or hostility, and found a way to *agree* with everything he said, using the disarming technique described in Chapter 7. Initially she terminated all these calls after five to ten minutes to ensure the likelihood the conversations would not deteriorate into an argument or become boring to him. This guaranteed that her feedback would be pleasant to him, and that his response to it would not be suppressed or eliminated.

After she did this a few times, she noticed her husband began to call more and more frequently because the calls were positive, rewarding experiences for him. She noted this increased rate of telephoning on her graph paper just as a scientist observes and documents the actions of an experimental rat. As

his phone calls increased, she began to feel encouraged, and some of her irritation and resentment melted away.

One day he appeared at the house and according to her plan, she announced, “I’m so happy you dropped by because I just happen to have a fresh, fancy imported Cuban cigar in the freezer for you. It’s the expensive type you really like.” She actually had a whole box of them waiting so she was able to repeat this each time he visited—regardless of why or when he came. She noticed the frequency of his visits substantially increased.

In a similar manner, she continued to “shape” his behavior using *rewards* rather than coercion. She realized how successful she had been when her husband decided to leave his girl friend and asked if he could move back in with her.

Am I saying that is the *only* way to relate and to influence people? No—that would be absurd. It’s just a pleasant spice, not the whole banquet or even the main course. But it’s a frequently overlooked delicacy that few appetites can resist. There’s no *guarantee* it will work—some situations may be irreversible, and you can’t always get what you want.

At any rate, try the upbeat reward system. You may be pleasantly surprised at the remarkable effectiveness of your secret strategy. In addition to motivating the people you care about to want to be around you, it will improve your mood because you learn to notice and focus on the positive things that others do rather than dwell on their negatives.

**“Should” Reduction.** Because many of the thoughts which generate your anger involve moralistic “should” statements, it will help you to master some “should” removal methods. One way is to make a list, using the double-column method, of all the reasons why you believe the other person “shouldn’t” have acted as he did. Then challenge these reasons until you can see why they are unrealistic and don’t actually make good sense.

Example: Suppose the carpenter on your new house did a sloppy job on the kitchen cabinets. The doors are poorly aligned and don’t close properly. You feel irate because you see this as “unfair.” After all, you paid full union wages, so you feel entitled to excellent workmanship from a top craftsman. You fume as you tell yourself, “The lazy bastard should take some pride in his work. What’s the world coming to?” You list the reasons and rebuttals detailed in Figure 7–6.

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<i>Reasons He Should Have Taken More Pride in His Work</i>	<i>Rebuttals</i>
1. Because I paid top dollar.	1. He gets paid the same wage whether or not he takes extra pride in his work.
2. Because it's only decent to do a good job.	2. He probably felt he did an adequate job. And the paneling he did actually looks quite decent.
3. Because he should make sure he gets it done <i>right</i> .	3. Why should he?
4. Because I would if I were a carpenter.	4. But he's not me—he's not trying to meet my standards.
5. Because he should care more about his product.	5. There's no reason for him to care more. Some carpenters care a lot about their work, and for others it's just a job.
6. So why must I get the one who does sloppy work?	6. All the people who worked on your house didn't do sloppy work. You can't expect to get 100 percent top-notch people. That would just be unrealistic.

**Figure 7–6.**

The rationale for eliminating your “should” statement is simple: It’s not true that you are entitled to get what you want just because you want it. You’ll have to negotiate. Call the carpenter, complain, and insist the job be corrected. But don’t double your trouble by making yourself excessively hot and bothered. The carpenter probably wasn’t *trying* to hurt you, and your anger might simply polarize him and put him on the defensive. After all, half of all the carpenters (and psychiatrists, secretaries, writers, and dentists, etc.) throughout human history have been below average. Do you believe that? It’s true by definition because “average” is *defined* as the halfway point! It’s ludicrous to fume and complain that this particular carpenter’s average talent is “unfair,” or that he “should” be other than he is.

*Negotiating Strategies.* At this point you may be bristling because you are thinking, “Well! That’s a fine kettle of fish! Dr. Bums seems to be telling me I can find happiness by believing that lazy, incompetent carpenters *should* do

mediocre work. After all, it's their nature, the good doctor claims! What weak-spined hogwash! I'm not going to be stripped of my human dignity and let people walk all over me and get away with second-rate crappy work I'm paying a fortune for."

Cool down! Nobody's asking you to let the carpenter pull the wool over your eyes. If you want to exert your influence in an effective way instead of moping angrily and creating inner turmoil, a calm, firm, assertive approach will usually be the most successful. Moralistic "shoulding," in contrast, will simply aggravate you and polarize him, and cause him to feel defensive and to counterattack. Remember—fighting is a form of intimacy. Do you really want to be so *intimate* with this carpenter? Wouldn't you prefer to get what you want instead?

As you stop consuming your energy in anger, you can focus your efforts on getting what you want. The following negotiating principles can work effectively in such a situation:

1. Instead of telling him off, *compliment* him on what he did right. It's an undeniable fact of human nature that few people can resist flattery even if it's blatantly insincere. However, since you can find *something* good about him or his work, you can make your compliment honest. Then mention the problem with the cupboard doors tactfully, and calmly explain why you want him to come back and correct the alignment.
2. *Disarm him* if he argues by finding a way to agree with him regardless of how absurd his statements are. This will shut him up and take the wind out of his sails. Then immediately—
3. *Clarify* your point of view again calmly and firmly.

Repeat the above three techniques over and over in varying combinations until the carpenter finally gives in or an acceptable compromise is reached. Use ultimatums and intimidating threats only as a last resort, and make sure you are ready and willing to follow through when you do. As a general principle, use diplomacy in expressing your dissatisfaction with his work. Avoid labeling him in an insulting way or implying he is bad, evil, malignant, etc. If you decide to tell him about your negative feelings, do so objectively without magnification or an excess of inflammatory language. For example, "I resent shoddy work when I feel you have the ability to do a good

professional job" is far preferable to "You mother——! Your——work is an outrage."

In the following dialogue I will identify each of these techniques.

YOU: I was pleased with how some of the work came out, and I'm hopeful I'll be able to tell other people I was happy with the whole job. The paneling was especially well done. I'm a little concerned about the kitchen cabinets, however. (Compliment)

CARPENTER: What seems to be the trouble?

YOU: The doors aren't lined up, and many of the handles are on crooked.

CARPENTER: Well, that's about the best I can do on those kinds of cabinets. They're mass-produced, and they just aren't made the best.

YOU: Well, that's true. They aren't as well made as a more expensive type might be. (Disarming technique) Nevertheless, they aren't acceptable this way, and I'd appreciate it if you'd do something to make them more presentable. (Clarification; tact)

CARPENTER: You'll have to talk to the manufacturer or the builder. There's nothing I can do about it.

YOU: I can understand your frustration (Disarming technique), but it's your responsibility to complete these cabinets to our satisfaction. They're simply not acceptable. They look shoddy, and they don't close properly. I know it's an inconvenience, but my position is that the job can't be considered complete and the bill won't be paid until you've corrected it. (Ultimatum) I can see from your other work that you have the skill to make them look right in spite of the extra time it will take. That way we'll be completely satisfied with your work, and we can give you a good recommendation. (Compliment)

Try these negotiating techniques when you are at loggerheads with someone. I think you'll find they work more effectively than blowing your stack, and you'll feel better because you'll usually end up getting more of what you want.

*Accurate Empathy.* Empathy is the ultimate anger antidote. It's the highest form of magic described in this book, and its spectacular effects are firmly entrenched in *reality*. No trick mirrors are needed.

Let's define the word. By empathy, I do *not* mean the capacity to feel the same way someone else feels. This is sympathy. Sympathy is highly touted but is, in my opinion, somewhat overrated. By empathy, I do *not* mean acting in a tender, understanding manner. This is support. Support is also highly valued and overrated.

So what is empathy? Empathy is the ability to comprehend with accuracy the precise thoughts and motivations of other people in such a way that they would say, "Yes, that *is exactly* where I'm coming from!" When you have this extraordinary knowledge, you will understand and accept without anger why others act as they do even though their actions might not be to your liking.

Remember, it is actually *your* thoughts that create your anger and not the other person's behavior. The amazing thing is that the moment you grasp why the other person is acting that way, this knowledge tends to put the lie to your anger-producing thoughts.

You might ask, If it's so easy to eliminate anger through empathy, why do people get so damn mad at each other every day? The answer is that empathy is difficult to acquire. As humans we are trapped in our own perceptions, and we react automatically to the meanings we attach to what people do. Getting inside the other person's skull requires hard work, and most people don't even know how to do this. Do you? You will learn how in the next few pages.

Let's start with an example. A businessman recently sought help because of his frequent episodes of angry out-bursts and abusive behavior. When his family or employees didn't do what he wanted, he'd bite their heads off. He usually succeeded in intimidating people, and he enjoyed dominating and humiliating them. But he sensed that his impulsive explosions ultimately caused problems for him because of his reputation as a sadistic hothead.

He described a dinner party he attended where the waiter forgot to fill his wineglass. He felt a surge of rage due to his thought, “The waiter thinks I’m unimportant. Who the hell does he think he is anyway? I’d like to wring the mother—’s neck.”

I used the empathy method to demonstrate to him how illogical and unrealistic his angry thoughts were. I suggested that we do some role-playing. He was to play the waiter, and I would act the part of a friend. He was to try to answer my questions as truthfully as possible. The following dialogue evolved:

DAVID (playing the role of the waiter’s friend): I noticed that you didn’t fill the wineglass of that businessman there.

PATIENT (playing the role of waiter): Oh, I see that I didn’t fill his glass.

DAVID: Why didn’t you fill his glass? Do you think he is an unimportant person?

PATIENT (after a pause): Well, no, it wasn’t that. I actually don’t know much about him.

DAVID: But didn’t you decide that he was an unimportant person and refuse to give him any wine because of that?

PATIENT (laughing): No, *that* isn’t why I didn’t give him any wine.

DAVID: Then why didn’t you give him wine?

PATIENT (after thinking): Well, I was daydreaming about my date for tonight. Furthermore, I was looking at that pretty girl across the table. I was distracted by her low-cut dress, and I just overlooked his wineglass.

This role-playing episode created great relief for the patient because by placing himself in the waiter’s shoes he was able to see how unrealistic his interpretation had been. His cognitive distortion was jumping to conclusions (mind reading). He automatically concluded the waiter was being *unfair*, which made him feel he had to retaliate to maintain his self-pride. Once he acquired some empathy, he was able to see that his righteous indignation was

caused entirely and exclusively by his own distorted thoughts and *not* the waiter's actions. It is often extremely difficult for angry-prone individuals to accept this at first because they have a nearly irresistible urge to blame others and to retaliate. How about you? Does the idea that many of your angry thoughts are invalid seem abhorrent and unacceptable?

The empathy technique can also be quite useful when the other person's actions appear more obviously and intentionally hurtful. A twenty-eight-year-old woman named Melissa sought counseling around the time she was separating from her husband, Howard. Five years earlier Melissa discovered that Howard was having an affair with Ann, an attractive secretary who worked in his building. This revelation was a heavy blow to Melissa, but to make matters even worse, Howard was hesitant to make a clean break with Ann, and so the affair dragged on for eight additional months. The humiliation and rage Melissa felt during this period was a major factor that led to her ultimate decision to leave him. Her thoughts ran along these lines: (1) He had no right to act like that. (2) He was self-centered. (3) It was unfair. (4) He was a bad, rotten person. (5) I must have failed.

In the course of a therapy session, I asked Melissa to play Howard's role, and then I cross-examined her to see if she could explain precisely why he had had the affair with Ann and acted as he did. She reported that as the role-playing evolved, she suddenly saw where Howard had been coming from, and at that moment her anger toward him completely vanished. After the session she wrote a description of the dramatic disappearance of the anger she had harbored for years:

After Howard's affair with Ann presumably ended, he insisted on continuing to see her and was still very much bound up with her. This was painful to me. It made me feel that Howard really didn't respect me and considered himself more important than I was. I felt that if he really did love me he wouldn't put me through this. How could he continue to see Ann when he knew how miserable it made me feel? I felt really angry at Howard and down on myself. When I tried the empathy approach and played the role of Howard, I saw the "whole." I suddenly saw things differently. When I imagined I was Howard, I could see where he was coming from. Putting myself in his place, I saw the problem of loving Melissa my wife, as well as Ann my lover. It dawned

on me that Howard was really trapped in a “can’t-win” system created by his thoughts and feelings. He loved me but was desperately attracted to Ann. As much as he wanted to he couldn’t stop seeing her. He felt very guilty and couldn’t stop himself. He felt he would lose if he left Ann, and he would lose if he left me. He was unwilling and unable to come to terms with either form of loss, and it was *his indecisiveness rather than any inadequacy on my part* which caused him to be slow in making up his mind.

The experience was a revelation for me. I really saw what had happened for the first time. I knew Howard had not done anything deliberately to hurt me, but had been incapable of doing anything other than what he did. I felt good being able to see and understand this.

I told Howard when I spoke to him next. We both felt a lot better about this. I also got a really good feeling from the experience with the empathy technique. It was very exciting. More real than what I had seen before.

The key to Melissa’s anger was her fear of losing self-esteem. Although Howard had indeed acted in a genuinely negative manner, it was the *meaning* she attached to the experience that caused her sense of grief and rage. She assumed that as a “good wife” she was entitled to a “good marriage.” This is the logic that got her into emotional trouble:

Premise: If I am a good and adequate wife, my husband is bound to love me and be faithful to me.

Observation: My husband is not acting in a loving, faithful way.

Conclusion: Therefore, either I am not a good and adequate wife, or else Howard is a bad, immoral person because he is breaking my “rule.”

Thus, Melissa’s anger represented a feeble attempt to save the day because within her system of assumptions, this was actually the *only* alternative to suffering a loss of self-esteem. The only problems with her solution were (a) she wasn’t *really* convinced he was “no good”; (b) she didn’t really *want* to write him off since she loved him; and (c) her chronic sour anger didn’t *feel* good, it didn’t *look* good, and it drove him farther away.

Her premise that he would love her as long as she was good was a fairy tale she had never thought to question. The empathy method transformed her thinking in a highly beneficial way by allowing her to relinquish the *grandiosity* inherent in her premise. His misbehavior was caused by *his* distorted cognitions, not her inadequacy. Thus, *he* was responsible for the jam he was in, not she!

This sudden insight struck her like a lightning bolt. The moment she saw the world through *his* eyes, her anger vanished. She became a much *smaller* person in the sense that she no longer saw herself as responsible for the actions of her husband and the people around her. But at the same time she experienced a sudden increase in self-esteem.

In the next session I decided to put her new insight to the acid test. I confronted her with the negative thoughts that had originally upset her to see if she could answer them effectively:

DAVID: Howard could have stopped seeing her sooner. He made a *foc* out of you.

MELISSA: No—he couldn't stop because he was trapped. He felt a tremendous obsession, and he was attracted to Ann.

DAVID: But then he *should've* gone off with her and broken up with you so he could stop torturing you. That would've been the *only decent thing* to do!

MELISSA: He felt he couldn't break off with me either because he loved me and was committed to me and to our children.

DAVID: But that was unfair, to keep you dangling so long.

MELISSA: He didn't mean to be unfair. It just happened.

DAVID: It just happened! What Pollyanna nonsense! The fact is, *he shouldn't have* gotten into such a situation in the first place.

MELISSA: But that's where he was at. Ann represented excitement, and he felt bored and overwhelmed by life at the time. Eventually one day he just couldn't resist her flirting any more. He took

one small step over the line in a moment of weakness, and then the affair was off and running.

DAVID: Well, you are less of a person because he wasn't faithful to you. This makes you inferior.

MELISSA: It has nothing to do with being less of a person. I don't have to get what I want all the time to be worthwhile.

DAVID: But he never would have sought excitement elsewhere if you were an adequate wife. You're undesirable and unlovable. You're second-rate, and that's why your husband had an affair.

MELISSA: The fact is, he ultimately chose me over Ann, but that doesn't make me any better than Ann, does it? Similarly, the fact that he chose to deal with his problems by escaping doesn't mean that I'm unlovable or less desirable.

I could see that Melissa was clearly unruffled by my vigorous attempts to get her goat, and this proved she had transcended this painful period of her life. She traded in her anger for joy and self-esteem. Empathy was the key that freed her from being trapped in hostility, self-doubt, and despair.

*Putting It All Together: Cognitive Rehearsal.* When you get angry, you may feel you react too rapidly to be able to sit down and assess the situation objectively and apply the various techniques described in this chapter. This is one of the characteristics of anger. Unlike depression, which tends to be steady and chronic, anger is much more eruptive and episodic. By the time you are aware you are upset you may already feel out of control.

“Cognitive rehearsal” is an effective method for solving this problem and for synthesizing and using the tools you have learned thus far. This technique will help you learn to overcome your anger ahead of time without actually experiencing the situation. Then when the real thing happens, you'll be prepared to handle it.

Begin by listing an “anger hierarchy” of the situations that most commonly trigger you off and rank these from + 1 (the least upsetting) to + 10 (the most infuriating), as shown in Figure 7–7. The provocations should be ones that

you'd like to handle more effectively because your anger is maladaptive and undesirable.

Start with the first item on the hierarchy list that is the least upsetting to you, and fantasize as vividly as you can that you are *in* that situation. Then verbalize your “hot thoughts” and write them down. In the example given in Figure 7–7, you’re feeling annoyed because you’re telling yourself, “The goddamn mother—ing waiters don’t know what the—they’re doing! Why don’t the lazy bastards get off their butts and move? Who the hell do they think they are? Am I supposed to starve to death before they’ll give me a menu and a glass of water?”

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- + 1—I sit in a restaurant for fifteen minutes, and the waiter doesn’t come.
- + 2—I call a friend who doesn’t return the call.
- + 3—A client cancels an appointment at the last minute without explanation.
- + 4—A client fails to show up for an appointment without informing me.
- + 5—Someone criticizes me nastily.
- + 6—An obnoxious group of juveniles crowd in front of me in line at a theater.
- + 7—I read in the paper about senseless violence, such as rape.
- + 8—A customer refuses to pay a bill for goods I’ve delivered and skips town so that I can’t collect.
- + 9—Local delinquents repeatedly knock down my mailbox in the middle of the night over a several-month period. There’s nothing I can do to catch them or stop them.
- + 10—I see a television report that someone—presumably a group of teenagers—have broken into the zoo at night, and stoned a number of small birds and animals to death and mutilated others.

**Figure 7–7.** The Anger Hierarchy.

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Next fantasize flying off the handle, telling off the maître d’, and storming out and slamming the restaurant door. Now record how upset you feel between 0 and 100 percent.

Then go through the same mental scenario, but substitute more appropriate “cool thoughts” and fantasize that you feel *relaxed* and unperturbed; imagine that you handle the situation tactfully, assertively, and effectively. For

example, you might tell yourself, “The waiters don’t seem to be noticing me. Perhaps they’re busy and overlooked the fact that I haven’t gotten a menu yet. No point in getting hot under the collar about this.”

Then instruct yourself to approach the headwaiter and explain the situation assertively, following these principles: Point out tactfully that you’ve been waiting; if he explains they are busy, disarm him by *agreeing* with him; compliment him on the good business they are doing; and repeat your request for better service in a firm but friendly way. Finally, imagine that he responds by sending a waiter who apologizes and gives you top-notch VIP service. You feel good and enjoy the meal.

Now practice going through this version of the scenario each night until you have mastered it and can fantasize handling the situation effectively and calmly in this manner. This cognitive rehearsal will enable you to program yourself to respond in a more assertive and relaxed way when the actual situation confronts you again.

You might have one objection to this procedure: You may feel it is unrealistic to fantasize a positive outcome in the restaurant since there is no guarantee the staff will in reality respond in a friendly way and give you what you want. The answer to this objection is simple. There’s no guarantee they’ll respond abrasively either, but if you *expect* a negative response, you’ll enhance the probability of getting one because your anger will have an enormous capacity to act as a self-fulfilling prophecy. In contrast, if you expect and fantasize a positive outcome and apply an upbeat approach, it will be much more likely to occur.

You can, of course, also prepare for a negative outcome in a similar way, using the cognitive rehearsal method. Imagine you *do* approach the waiter, and he acts snotty and superior and gives you poor service. Now record your hot thoughts, then substitute cool thoughts and develop a new coping strategy as you did before.

You can continue to work your way up your hierarchy list in this way until you have learned to think, feel, and act more peacefully and effectively in the majority of the provocative situations you encounter. Your approach to these situations will have to be flexible, and different coping techniques may be required for the different types of provocations listed. Empathy might be the answer in one situation, verbal assertiveness could be the key to another, and changing your expectations might be the most useful approach to a third.

It will be crucial not to evaluate your progress in your anger-reduction program in an all-or-nothing way because emotional growth takes some time, especially when it comes to anger. If you ordinarily react to a particular provocation with 99 percent anger and then find you become 70 percent upset next time, you could view this as a successful first try. Now keep working at it, using your cognitive rehearsal method, and see if you can reduce it to 50 percent and then to 30 percent. Eventually you will make it vanish altogether, or at least you will have brought it down to an acceptable, irreducible minimum.

Remember that the wisdom of friends and associates can be a potential gold mine you can utilize when you're stuck. They may see clearly in any area where you have a blind spot. Ask them how *they* think and behave in a particular situation that makes you feel frustrated, helpless, and enraged. What would they tell themselves? What would they actually do? You can learn a surprising amount rapidly if you are willing to ask.

### **Ten Things You Should Know About Your Anger**

1. The events of this world don't make you angry. Your "hot thoughts" create your anger. Even when a genuinely negative event occurs, it is the meaning you attach to it that determines your emotional response.

The idea that you are responsible for your anger is ultimately to your advantage because it gives you the opportunity to achieve control and make a free choice about how you want to feel. If it weren't for this, you would be helpless to control your emotions; they would be irreversibly bound up with every external event of this world, most of which are ultimately out of your control.

2. Most of the time your anger will not help you. It will immobilize you, and you will become frozen in your hostility to no productive purpose. You will feel better if you place your emphasis on the active search for creative solutions. What can you do to correct the difficulty or at least reduce the chance that you'll get burned in the same way in the future? This attitude will eliminate to a certain extent the helplessness and frustration that eat you up when you feel you can't deal with a situation effectively.

If no solution is possible because the provocation is totally beyond your control, you will only make yourself miserable with your

resentment, so why not get rid of it? It's difficult if not impossible to feel anger and joy simultaneously. If you think your angry feelings are especially precious and important, then think about one of the happiest moments of your life. Now ask yourself. How many minutes of that period of peace or jubilation would I be willing to trade in for feeling frustration and irritation instead?

3. The thoughts that generate anger more often than not will contain distortions. Correcting these distortions will reduce your anger.
4. Ultimately your anger is caused by your belief that someone is acting unfairly or some event is unjust. The intensity of the anger will increase in proportion to the severity of the maliciousness perceived and if the act is seen as intentional.
5. If you learn to see the world through other people's eyes, you will often be surprised to realize their actions are *not* unfair from their point of view. The unfairness in these cases turns out to be an illusion that exists *only in your mind!* If you are willing to let go of the unrealistic notion that your concepts of truth, justice, and fairness are shared by everyone, much of your resentment and frustration will vanish.
6. Other people usually do not feel they deserve your punishment. Therefore, your retaliation is unlikely to help you achieve any positive goals in your interactions with them. Your rage will often just cause further deterioration and polarization, and will function as a self-fulfilling prophecy. Even if you temporarily get what you want, any short-term gains from such hostile manipulation will often be more than counterbalanced by a long-term resentment and retaliation from the people you are coercing. No one likes to be controlled or forced. This is why a positive reward system works better.
7. A great deal of your anger involves your defense against loss of self-esteem when people criticize you, disagree with you, or fail to behave as you want them to. Such anger is *always* inappropriate because only your own negative distorted thoughts can cause you to lose self-esteem. When you blame the other guy for your feelings of worthlessness, you are always fooling yourself.
8. Frustration results from unmet expectations. Since the event that disappointed you was a part of "reality," it was "realistic." Thus, your frustration always results from your *unrealistic* expectation. You have

the right to try to influence reality to bring it more in line with your expectations, but this is not always practical, especially when these expectations represent ideals that don't correspond to everyone else's concept of human nature. The simplest solution would be to *change* your expectations. For example, some unrealistic expectations that lead to frustration include:

- a. If I want something (love, happiness, a promotion, etc.), I deserve it.
  - b. If I work hard at something, I *should* be successful.
  - c. Other people *should* try to measure up to my standards and believe in my concept of "fairness."
  - d. I *should* be able to solve any problems quickly and easily.
  - e. If I'm a good wife, my husband is *bound* to love me.
  - f. People *should* think and act the way I do.
  - g. If I'm nice to someone, they *should* reciprocate.
9. It is just childish pouting to insist you have the *right* to be angry. Of course you do! Anger is legally permitted in the United States. The crucial issue is—is it to your advantage to feel angry? Will you or the world really benefit from your rage?
  10. You rarely need your anger in order to be human. It is not true that you will be an unfeeling robot without it. In fact, when you rid yourself of that sour irritability, you will feel greater zest, joy, peace, and productivity. You will experience liberation and enlightenment.

## Chapter 8

### Ways of Defeating Guilt

No book on depression would be complete without a chapter on guilt. What is the function of guilt? Writers, spiritual leaders, psychologists, and philosophers have grappled forever with this question. What is the basis of guilt? Does it evolve from the concept of “original sin”? Or from Oedipal incestuous fantasies and the other taboos that Freud postulated? Is it a realistic and helpful component of human experience? Or is it a “useless emotion” that mankind would be better off without, as suggested by some recent pop psychology writers?

When the mathematics of calculus was developed, scientists found they could readily solve complex problems of motion and acceleration that were extremely difficult to handle using older methods. The cognitive theory has similarly provided us with a kind of “emotional calculus” that makes certain thorny philosophical and psychological questions much easier to resolve.

Let’s see what we can learn from a cognitive approach. Guilt is the emotion you will experience when you have the following thoughts:

1. I have done something I shouldn’t have (or I have failed to do something that I should have) because my actions fall short of my moral standards and violate my concept of fairness.
2. This “bad behavior” shows that I am a bad person (or that I have an evil streak, or a tainted character, or a rotten core, etc.).

This concept of the “badness” of self is central to guilt. In its absence, your hurtful action might lead to a healthy feeling of remorse but not guilt. Remorse stems from the undistorted awareness that you have willfully and unnecessarily acted in a hurtful manner toward yourself or another person that violates your personal ethical standards. Remorse differs from guilt because there is no implication your transgression indicates you are

inherently bad, evil, or immoral. To put it in a nutshell, remorse or regret are aimed at behavior, whereas guilt is targeted toward the “self.”

If in addition to your guilt you feel depression, shame, or anxiety, you are probably making one of the following assumptions:

1. Because of my “bad behavior,” I am inferior or worthless (this interpretation leads to depression).
2. If others found out what I did, they would look down on me (this cognition leads to shame).
3. I’m in danger of retaliation or punishment (this thought provokes anxiety).

The simplest way to assess whether the feelings created by such thoughts are useful or destructive is to determine if they contain any of the ten cognitive distortions described in Chapter 3. To the extent that these thinking errors are present, your guilt, anxiety, depression, or shame certainly cannot be valid or realistic. I suspect you will find that a great many of your negative feelings are in fact based on such thinking errors.

The first potential distortion when you are feeling guilty is your assumption you have done something wrong. This may or may not actually be the case. Is the behavior you condemn in yourself in reality so terrible, immoral, or wrong? Or are you *magnifying* things out of proportion? A charming medical technologist recently brought me a sealed envelope containing a piece of paper on which she had written something about herself which was so terrible she couldn’t bear to say it out loud. As she trembling handed the envelope to me, she made me promise not to read it out loud or laugh at her. The message inside was—“I pick my nose and eat it!” The apprehension and horror on her face in contrast to the triviality of what she had written struck me as so funny I lost all professional composure and burst into laughter. Fortunately, she too broke into a belly laugh and expressed a sense of relief.

Am I claiming that you *never* behave badly? No. That position would be extreme and unrealistic. I am simply insisting that to the extent your perception of goofing up is unrealistically magnified, your anguish and self-persecution are inappropriate and unnecessary.

A second key distortion that leads to guilt is when you *label* yourself a “bad person” because of what you did. This is actually the kind of

superstitious destructive thinking that led to the medieval witch hunts! You may have engaged in a bad, angry, hurtful action, but it is counterproductive to label yourself a “bad” or “rotten” person because your energy gets channeled into rumination and self-persecution instead of creative problem-solving strategies.

Another common guilt-provoking distortion is *personalization*. You inappropriately assume responsibility for an event you did not cause. Suppose you offer a constructive criticism to your boyfriend, who reacts in a defensive and hurt manner. You may blame yourself—for his emotional upset and arbitrarily conclude that your comment was inappropriate. In fact, his negative *thoughts* upset him, not your comment. Furthermore, these thoughts are probably distorted. He might be thinking that your criticism means he’s no good and conclude that you don’t respect him. Now—did *you* put that illogical thought into his head? Obviously not. *He* did it, so you can’t assume responsibility for his reaction.

Because cognitive therapy asserts that only your thoughts create your feelings, you might come to the nihilistic belief that you cannot hurt anybody no matter what you do, and hence you have license to do *anything*. After all, why not run out on your family, cheat on your wife, and screw your partner financially? If they’re upset, it’s their problem because it’s their thoughts, right?

Wrong! Here we come again to the importance of the concept of cognitive distortion. To the extent that a person’s emotional upset is caused by his distorted thoughts, then you can say he is responsible for his suffering. If you blame yourself for that individual’s pain, it is a personalization error. In contrast, if a person’s suffering is caused by valid, undistorted thoughts, then the suffering is real and may in fact have an external cause. For example, you might kick me in the stomach, and I could have the thoughts, “I’ve been kicked! It hurts!\_\_\_\_\_!” In this case the responsibility for my pain rests with *you*, and your perception that you have hurt me is not distorted in any way. Your remorse and my discomfort are real and valid.

*Inappropriate “should” statements* represent the “final common pathway” to your guilt. Irrational should statements imply you are expected to be perfect, all-knowing, or all-powerful. Perfectionistic shoulds include rules for living that defeat you by creating impossible expectations and rigidity. One example of this would be, “I *should* be happy at all times.” The consequence

of this rule is that you will feel like a failure every time you are upset. Since it is obviously unrealistic for any human being to achieve the goal of perpetual happiness, the rule is self-defeating and irresponsible.

A should statement that is based on the premise you are all-knowing assumes you have all the knowledge in the universe and that you can predict the future with absolute certainty. For example, you might think, “I shouldn’t have gone to the beach this weekend because I was coming down with the flu. What a jerk I am! Now I’m so sick I’ll be in bed for a week.” Berating yourself this way is unrealistic because you didn’t know for certain that going to the beach would make you so ill. If you *had* known this, you would have acted differently. Being human, you made a decision, and your hunch turned out to be wrong.

Should statements based on the premise you are all-powerful assume that, like God, you are omnipotent and have the ability to control yourself and other people so as to achieve each and every goal. You miss your tennis serve and wince, exclaiming, “*I shouldn’t* have missed that serve!” Why shouldn’t you? Is your tennis so superb that you can’t possibly miss a serve?

It is clear that these three categories of should statements create an inappropriate sense of guilt because they do not represent sensible moral standards.

In addition to distortion, several other criteria can be helpful in distinguishing abnormal guilt from a healthy sense of remorse or regret. These include the *intensity*, *duration*, and *consequences* of your negative emotion. Let’s use these criteria to evaluate the incapacitating guilt of a married fifty-two-year-old grammar-school teacher named Janice. Janice had been severely depressed for many years. Her problem was that she continually obsessed about two episodes of shoplifting that had occurred when she was fifteen. Although she had led a scrupulously honest life since that time, she could not shake the memory of those two incidents. Guilt-provoking thoughts constantly plagued her: “I’m a thief. I’m a liar. I’m no good. I’m a fake.” The agony of her guilt was so enormous that every night she prayed that God would let her die in her sleep. Every morning when she woke up still alive, she was bitterly disappointed and told herself, “I’m such a bad person even God doesn’t want me.” In frustration she finally loaded her husband’s pistol, aimed it at her heart, and pulled the trigger. The gun misfired and did not go off. She had not cocked it properly. She felt the

ultimate defeat: She couldn't even kill herself! She put the gun down and wept in despair.

Janice's guilt is inappropriate not only because of the obvious distortions, but also because of the *intensity*, *duration*, and *consequences* of what she was feeling and telling herself. What she feels cannot be described as a healthy remorse or regret about the actual shoplifting, but an irresponsible degradation of her self-esteem that blinds her to living in the here and now, and is far out of proportion to any actual transgression. The consequences of her guilt created the ultimate irony—her belief that she was a bad person caused her to attempt to murder herself, a most destructive and pointless act.

## The Guilt Cycle

Even if your guilt is unhealthy and based on distortion, once you begin to feel guilty, you may become trapped in an illusion that makes the guilt appear valid. Such illusions can be powerful and convincing. You reason:

1. I feel guilty and worthy of condemnation. This means I've been bad.
2. Since I'm bad, I deserve to suffer.

Thus, your guilt convinces you of your badness and leads to further guilt. This cognitive-emotional connection locks your thoughts and feelings into each other. You end up trapped in a circular system which I call the “guilt cycle.”

Emotional reasoning fuels this cycle. You automatically assume that because you're feeling guilty, you *must* have fallen short in some way and that you deserve to suffer. You reason, “*I feel* bad, therefore I must *be* bad.” This is irrational because your self-loathing does not necessarily prove that you did anything wrong. Your guilt just reflects the fact that you *believe* you behaved badly. This *might* be the case, but it often is not. For example, children are frequently punished inappropriately when parents are feeling tired and irritable and misinterpret their behavior. Under these conditions, the poor child's guilt obviously does not prove he or she did anything wrong.

Your self-punishing behavior patterns intensify the guilt cycle. Your guilt-provoking thoughts lead to unproductive actions that reinforce your belief in your badness. For example, a guilt-prone neurologist was trying to prepare for her medical-board certification examination. She had difficulty studying

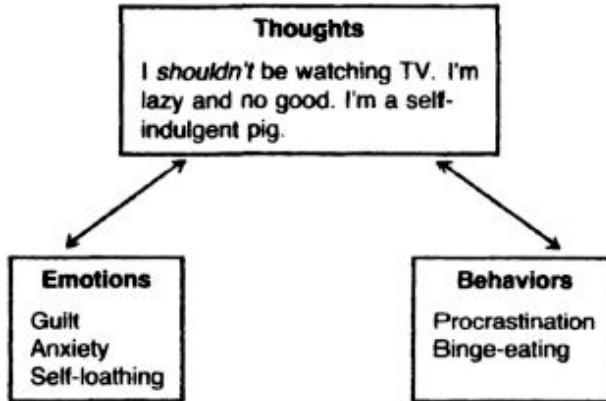
for the test, and felt guilty about the fact that she wasn't studying. So she wasted time each night watching television while the following thoughts raced through her mind: "I *shouldn't* be watching TV. I *should* be preparing for my boards. I'm lazy. I don't deserve to be a doctor. I'm too self-centered. I ought to be punished." These thoughts made her feel intensely guilty. She then reasoned, "This guilt proves what a lazy no-good person I am." Thus, her self-punishing thoughts and her guilty feelings reinforced each other.

Like many guilt-prone people, she had the idea that if she punished herself enough she would eventually get moving. Unfortunately, quite the opposite was true. Her guilt simply drained her energy and reinforced her belief that she was lazy and inadequate. The only actions that resulted from her self-loathing were the nightly compulsive trips to the refrigerator to "pig out" on ice cream or peanut butter.

The vicious cycle that she trapped herself in is shown in Figure 8–1. Her negative thoughts, feelings, and behaviors all interacted in the creation of the self-defeating, cruel illusion that she was "bad" and uncontrollable.

*The Irresponsibility of Guilt.* If you have actually done something inappropriate or hurtful, does it follow that you deserve to suffer? If you feel the answer to this question is yes, then ask yourself, "How long must I suffer? One day? A year? For the rest of my life?" What sentence will you choose to impose on yourself? Are you willing to stop suffering and making yourself miserable when your sentence has expired? This would at least be a *responsible* way to punish yourself because it would be time-limited. But what is the point of abusing yourself with guilt in the first place? If you did make a mistake and act in a hurtful way, your guilt won't reverse your blunder in some magical manner. It won't speed your learning processes so as to reduce the chance you'll make the same mistake in the future. Other people won't love and respect you more because you are feeling guilty and putting yourself down in this manner. Nor will your guilt lead to productive living. So what's the point?

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**Figure 8–1.** A neurologist's self-critical thoughts caused her to feel so guilty that she had difficulty preparing for her certification examination. Her procrastination strengthened her conviction that she was bad and deserved punishment. This further undermined her motivation to solve the problem.

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Many people ask, “But how could I behave morally and control my impulses if I don’t feel guilt?” This is the probation-officer approach to living. Apparently you view yourself as so willful and uncontrollable that you must constantly castigate yourself in order to keep from going wild. Certainly, if your behavior has a needlessly hurtful impact on others, a small amount of painful remorse will add to your awareness more effectively than a sterile recognition of your goof-up with no emotional arousal. But it certainly never helped *anyone* to view himself as a bad person. More often than not, the belief that you are bad contributes to the “bad” behavior.

Change and learning occur most readily when you (a) recognize that an error has occurred and (b) develop a strategy for correcting the problem. An attitude of self-love and relaxation facilitates this, whereas guilt often interferes.

For example, occasionally patients criticize me for making a sharp comment that rubs them the wrong way. This criticism usually only hurts my feelings and arouses my guilt if it contains a grain of truth. To the extent that I feel guilty and label myself as “bad,” I tend to react defensively. I have the urge to either deny or justify my error, or to counterattack because that feeling of being a “bad person” is so odious. This makes it much more difficult for me to admit and correct the error. If, in contrast, I do not

harangue myself or experience any loss of self-respect, it is easy to admit my mistake. Then I can readily correct the problem and learn from it. The less guilt I have, the more effectively I can do this.

Thus, what is called for when you do goof up is a process of recognition, learning, and change. Does guilt help you with any of these? I don't believe it does. Rather than facilitating your recognition of your error, guilt engages you in a coverup operation. You want to close your ears to any criticism. You can't bear to be in the wrong because it feels so terrible. This is why guilt is counterproductive.

You may protest, "How can I know I've done something wrong if I don't feel guilty? Wouldn't I just indulge in a blind rampage of uncontrolled, destructive selfishness if it weren't for my guilt?"

Anything is possible, but I honestly doubt this would happen. You can replace your guilt with a more enlightened basis for moral behavior—empathy. Empathy is the ability to visualize the consequences, good and bad, of your behavior. Empathy is the capacity to conceptualize the impact of what you do on yourself and on the other person, and to feel appropriate and genuine sorrow and regret without labeling yourself as inherently bad. Empathy gives you the necessary mental and emotional climate to guide your behavior in a moral and self-enhancing manner in the absence of the whip of guilt.

Using these criteria, you can now readily determine whether your feelings represent a normal and healthy sense of remorse or a self-defeating, distorted sense of guilt. Ask yourself:

1. Did I consciously and willfully do something "bad," "unfair," or needlessly hurtful that I shouldn't have? Or am I irrationally expecting myself to be perfect, all-knowing, or all-powerful?
2. Am I labeling myself a *bad* or *tainted person* because of this action? Do my thoughts contain other cognitive distortions, such as magnification, overgeneralization, etc.?
3. Am I feeling a realistic regret or remorse, which results from an empathic awareness of the negative impact of my action? Are the intensity and duration of my painful emotional response appropriate to what I actually did?

4. Am I learning from my error and developing a strategy for change, or am I moping and ruminating nonproductively or even punishing myself in a destructive manner?

Now, let's review some methods that will allow you to rid yourself of inappropriate guilty feelings and maximize your self-respect.

1. *Daily Record of Dysfunctional Thoughts.* In earlier chapters you were introduced to a Daily Record of Dysfunctional Thoughts for overcoming low self-esteem and inadequacy. This method works handsomely for a variety of unwanted emotions, including guilt. Record the activating event that leads to your guilt in the column labeled "Situation." You may write, "I spoke sharply to an associate," or "Instead of contributing ten dollars, I threw my alumni fund-raising appeal in the wastebasket." Then "tune in" to that tyrannical loudspeaker in your head and identify the accusations that create your guilt. Finally, identify the distortions and write down more objective thoughts. This leads to relief.

An example of this is demonstrated in Figure 8–2. Shirley was a high-strung young woman who decided to move to New York to pursue her acting career. After she and her mother had spent a long and tiring day looking for apartments, they took a train back to Philadelphia. After boarding, they discovered they had mistakenly taken a train without food service or a lounge car. Shirley's mother began to complain about the lack of cocktail service, and Shirley felt flooded with guilt and self-criticism. As she recorded and talked back to her guilt-provoking thoughts, she felt substantial relief. She told me that by overcoming her guilt, she avoided the temper tantrum she would normally have thrown in such a frustrating situation (see Figure 8–2, page 209).

2. *Should Removal Techniques.* Here are some methods for reducing all those irrational "should" statements you've been hitting yourself with. The first is to ask yourself, "Who says I should? Where is it written that I should?" The point of this is to make you aware that you are being critical of yourself unnecessarily. Since you are ultimately making your own rules, once you decide that a rule is not useful you can revise it or get rid of it. Suppose you are telling yourself that you should be able to make your spouse happy all the time. If your experience teaches you that this is neither realistic nor

helpful, you can rewrite the rule to make it more valid. You might say, “I can make my spouse happy some of the time, but I certainly can’t at all times. Ultimately, happiness is up to him or her. And I’m not perfect any more than he or she is. Therefore, I will not anticipate that what I do will always be appreciated.”

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<i>Situation</i>	<i>Emotions</i>	<i>Guilt-provoking Thoughts</i>	<i>Cognitive Distortions</i>	<i>Rational Responses</i>	<i>Outcome</i>
My mother is very tired and due to her lack of understanding of the train schedule, we take a train without comforts.	Extreme guilt; frustration, anger; self-pity	<p>1. Gee, Mom walked all over New York with me today, and now she can't even get a drink because <i>I really didn't explain the schedule properly</i>. I should have explained that "no food" did not mean snacks.</p> <p>2. Now I feel terrible—I'm so selfish.</p> <p>3. Why do I always foul up everything?</p> <p>4. She's so good to me, and I'm a louse.</p>	<p>1. Personalization; mental filter; should statement.</p> <p>2. Emotional reasoning</p> <p>3. Overgeneralization, personalization.</p> <p>4. Labeling; all-or-nothing thinking.</p>	<p>1. I feel bad for Mom—but the train ride is only 1½ hours. I thought I explained everything. I guess we all make mistakes sometimes.</p> <p>2. I am more upset than Mom. What's done is done—don't cry over spilt milk.</p> <p>3. I don't foul up everything. It's not my fault she misunderstood.</p> <p>4. One incident does not make a louse.</p>	Substantial relief

**Figure 8–2.**

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In deciding about the usefulness of a particular rule, it can be helpful to ask yourself, “What are the advantages and disadvantages of having that rule for myself?” “How will it help me believe I *should always* be able to make my spouse happy, and what will the price be for believing this?” You can assess the costs and benefits, using the double-column method shown in Figure 8–3.

Another simple but effective way to rid yourself of should statements involves substituting other words for “should,” using the double-column technique. The terms “It would be nice if” or “I wish I could” work well, and often sound more realistic and less upsetting. For example, instead of saying, “*I should* be able to make my wife happy,” you could substitute “*It would be nice if* I could make my wife happy now because she seems upset. I can ask what she’s upset about and see if there might be a way I could help.” Or instead of “*I shouldn’t* have eaten the ice cream,” you can say, “*It would have been better if* I hadn’t eaten the ice cream, but it’s not the end of the world that I did.”

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<i>Advantages</i>	<i>Disadvantages</i>
1. When she is happy, I will feel I'm doing what I'm supposed to.	1. When she's unhappy, I'll feel guilty and I'll blame myself.
2. I'll work very hard to be a good husband.	2. She'll be able to manipulate me with my guilt. Anytime she wants her way she can act unhappy, and then I'll feel so bad I'll have to back down.
	3. Since she is unhappy a good bit of the time, I'll often feel like a failure. Since her unhappiness often has nothing to do with me, this will be a waste of energy.
	4. I'll end up feeling resentful that I'm paradoxically giving <i>her</i> so much power over <i>my</i> moods!

**Figure 8–3.** The advantages and disadvantages of believing "I should be able to make my wife happy all the time."

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Another anti-should method involves showing yourself that a should statement doesn't fit reality. For example, when you say, "I shouldn't have done X," you assume (1) it is a fact that you *shouldn't have*, and (2) it is going to help you to say this. The "reality method" reveals—to your surprise—that the truth is usually just the opposite: (a) In point of fact, you *should have* done what you did; and (b) it is going to hurt you to say you *shouldn't have*.

Incredulous? Let me demonstrate. Assume you've been trying to diet and you ate some ice cream. So you have the thought, "I *shouldn't* have eaten this ice cream." In our dialogue I want you to argue that it's *really true* that you *shouldn't have* eaten the ice cream, and I will try to put the lie to your arguments. The following is modeled after an actual conversation, which I hope you find as delightful and helpful as I did:

DAVID: I understand you're on a diet, and you ate some ice cream. I believe you *should have* eaten the ice cream.

YOU: Oh, no. That's impossible. I *shouldn't have* eaten it because I'm on a diet. You see, I'm trying to lose weight.

DAVID: Well, I believe you *should have* eaten the ice cream.

YOU: Burns, are you dense? I *shouldn't have* because I'm trying to los

weight. That's what I'm trying to tell you. How can I lose weight if I'm eating ice cream?

DAVID: But in point of fact you did eat it.

YOU: Yeah. That's the problem. I *shouldn't have* done that. Now do you see the light?

DAVID: And apparently you're claiming that "things should have been different" than they were. But things were the way they were. And things usually are the way they are for a good reason. Why do you think you did what you did? What's the reason you ate the ice cream?

YOU: Well, I was upset and I was nervous and I'm basically a pig.

DAVID: Okay, you were upset and you were nervous. Have you had a pattern in your life of eating when you've been upset and nervous?

YOU: Yeah. Right. I've never had any self-control.

DAVID: So, wouldn't it be natural to expect then that last week when you were nervous you would do what you have habitually done?

YOU: Yeah.

DAVID: So, wouldn't it be sensible therefore to conclude that you *should* have done that because you had a very long-standing habit of doing it?

YOU: I feel like you're telling me that I *should* just keep eating ice cream and end up like a fat pig or something.

DAVID: Most of my clients aren't as difficult as you! At any rate, I'm not telling you to act like a pig, and I'm not recommending you continue this bad habit of eating when you're upset. What I'm saying is that you're giving yourself two problems for the price of one. One is that you did in fact break your diet. If you're going to lose weight, this will slow you down. And the second problem is that you're being hard on yourself about having done that. The second headache you don't need.

YOU: So you're saying that because I have a habit of eating when I'm nervous it's predictable that until I learn some methods for changing the habit, I'll continue to do it.

DAVID: I wish I'd said it that well myself!

YOU: Therefore, I *should have* eaten the ice cream because I haven't changed the habit yet. As long as the habit continues, I *will* and *should* keep overeating when I'm nervous. I see what you mean. I feel a whole lot better. Doctor, except for one thing. How can I learn to stop doing this? How can I develop some strategies for modifying my behavior in a more productive way?

DAVID: You can motivate yourself with a whip or a carrot. When you tell yourself, "I *should do* this" or "I *shouldn't* do that" all day long you get bogged down with a shouly approach to life. And you already know what you end up with—emotional constipation. If you'd rather get things moving instead, I suggest you try to motivate yourself through rewards rather than punishment. You might find that these work more effectively.

In my case I used the "Dots and doughnuts" diet. Mason Dots (a gum candy) and glazed doughnuts are two of my favorite sweets. I found that the most difficult time to control my eating was in the evening when I was studying or watching TV. I'd have an urge to eat ice cream. So, I told myself that if I controlled this urge, I could reward myself with a big, fresh, glazed doughnut in the morning and a box of Mason Dots in the evening. Then I'd concentrate on how good they'd taste, and this helped me forget the ice cream. Incidentally, I also had the rule that if I *did* goof up and eat the ice cream, I could *still* have the Dots and the doughnut as a reward for trying or as a commiseration for slipping back. Either way it helped me, and I lost over fifty pounds this way.

I also made up the following syllogism:

- (A) Human beings on diets goof up from time to time.
- (B) I'm a human being.
- (C) Therefore, I *should* goof up from time to time.

This helped me greatly too, and it enabled me to binge on weekends and feel good about it. I usually lost more during the week than I gained on weekends; so, overall I lost weight and enjoyed myself. Every time I goofed up in my diet I didn't allow myself to criticize the lapse or feel guilty. I began to think about it as the "Binge-on-whatever-you want-when-ever-you-want-to-without-

guilt-and-enjoy-it diet,” and it was so much fun it was a mild disappointment when I finally achieved my aimed-for weight. I actually lost over ten more pounds at that point because the diet was so enjoyable. I believe that the proper *attitude* and *feelings* are the key. With them you can move mountains—even mountains of flesh.

The major thing that holds you back when you’re trying to change a bad habit like eating, smoking, or drinking too much is your belief you are out of control. The cause of this lack of control is those should statements. They defeat you. Suppose, for example, you are trying to avoid eating ice cream. There you are watching TV, saying, “Oh, I really *should* study and I *shouldn’t* eat any ice cream.” Now ask yourself, “How do I feel when I say these things to myself?” I think you know the answer: You feel guilty and nervous. Then what do you do? You go and eat! That is the point. The reason you’re eating is that you’re telling yourself you *shouldn’t*! Then you try to bury your guilt and anxiety under more piles of food.

Another simple should removal technique involves your wrist counter. Once you become convinced that the shoulds are not to your advantage, you can count them. Every time you make a should statement, click the counter. If you do this, be sure to set up a reward system based on the daily total. The more shoulds you spot this way, the greater the reward you deserve. Over a period of several weeks, your daily total of should statements will begin to go down, and you’ll notice you’re feeling less guilty.

Another should removal technique zeroes in on the fact that you don’t really trust yourself. You may believe that without all these should statements you would just turn wild and go on a rampage of destruction or murder, or even icecream eating. A way to evaluate this is to ask yourself if there was any period in your life when you were particularly happy and felt reasonably fulfilled, productive, and under control. Think it over for a moment before you read on, and make sure you have a mental picture of this time. Now ask yourself, “During that period in my life, was I whipping myself with a lot of should statements?” I believe your answer will be no. Now tell me—were you doing all these wild, terrible things then? I think you’ll realize you were “should-free” and under control. This is proof that you can lead a productive, happy life without all those shoulds.

You can test this hypothesis with an experiment in the next couple of weeks. Try reducing your should statements using these various techniques,

and then see what happens to your mood and self-control. I think you'll be pleased.

Another method that you can fall back on is the obsessional-filibuster technique described in Chapter 4. Schedule two minutes three times a day to recite all your should statements and self-persecutions out loud: "I *should* have gone to the market before it closed," and "I *shouldn't* have picked my nose at the country club," and "I'm such a rotten bum," etc. Just rattle off all the most abusive self-criticisms you can think of. It might be especially helpful to write them down or dictate them into a tape recorder. Then read them later out loud, or listen to the tape. I think this will help you see how ludicrous these statements are. Try to limit your shoulds to these scheduled periods so you won't be bothered by them at other times.

Another technique to combat should statements involves getting in touch with the limits of your knowledge. When I was growing up, I often heard people say, "Learn to accept your limits and you'll become a happier person," but no one ever bothered to explain what this meant or how to go about doing it. Furthermore, it always sounded like a bit of a put-down, as if they were saying, "Learn what a second-rate dud you actually are."

In reality, it's not as bad as all that. Suppose you frequently look into the past and mope about your mistakes. For example, as you review the financial section of the paper, you tell yourself, "I *shouldn't* have bought that stock. It's gone down two points." As a way out of this trap, ask yourself, "Now, at the time I bought the stock, did I know it was going to go down in value?" I suspect you'll say no. Now ask, "If I'd known it was going down, would I have bought it?" Again you'll answer no. So what you're really saying is that if you'd known this at the time, you'd have acted differently. To do this you would have to be able to predict the future with absolute certainty. Can you predict the future with absolute certainty? Again your answer must be no. You have two options: You can either decide to accept yourself as an imperfect human being with limited knowledge and realize that you will at times make mistakes, or you can hate yourself for it.

Another effective way to combat shoulds is to ask, "Why should I?" Then you can challenge the evidence you come up with so as to expose the faulty logic. In this way you can reduce your should statement to the level of absurdity. Suppose, for example, you hire someone to do some work for you. It could be lawn work, or a painting job, or anything. When he submits his

bill, it seems higher than you understood it would be, but he gives you some fast talk, so you give in and end up paying his price. You feel taken advantage of. You begin to berate yourself for not acting more firmly. Let's do some role-playing, and you can pretend that you're the poor sucker who paid too much.

YOU: Yesterday I *should* have told that guy that his bill was too high.

DAVID: You I should have told him that he gave you a lower estimate?

YOU: Yeah. I *should have* been more assertive.

DAVID: Why *should you* have? I agree that it would have been to you advantage to speak up for yourself. You can work on developing your assertive skills so that in the future you'll do better in situations like that. But the point is: Why *should you* have been more effective yesterday?

YOU: Well, because I'm always letting people take advantage of me.

DAVID: Okay, let's think about your line of reasoning. "Because I'm always letting people take advantage of me, I *should have* been more assertive yesterday." Now—what is the rational response to this? Is there anything about your statement that seems a little bit illogical? Is there anything fishy about your reasoning?

YOU: Mmmm ... let me think. Well, in the first place, it's not exactly true that I'm *always* letting people take advantage of me. That would be an overgeneralization. I sometimes do get my way. In fact, I can be quite demanding at times. Furthermore, if it *were* true that I was *always* getting taken advantage of in certain situations, then it would follow that I *should have* behaved exactly as I did since this is my habit. Until I've mastered some new ways to deal with people, I'll probably continue to have this problem.

DAVID: Great. I couldn't have put it better. I see you've been absorbing what I've been telling you about *should* statements! I hope *all* my readers are as smart and attentive as you are! Are there any other reasons you think you *should have* behaved differently?

YOU: Uh, well, let me see. How about: I *should have* been more assertive because I wouldn't have had to pay more than I owed?

DAVID: Okay. Now what's the rational response to that? What is illogical?

about that argument?

YOU: Well, since I'm human I won't always do the right thing.

DAVID: Exactly. In fact, the following syllogism may help you. First premise: All human beings make mistakes, like sometimes paying too much. Do you agree with me so far?

YOU: Yes.

DAVID: And what are you?

YOU: A human being.

DAVID: And what follows?

YOU: I should make mistakes.

DAVID: Right.

That should be enough should removal techniques for you. Oops! I just did it myself! Let me say—it would be nice if you found those methods helpful. I think you'll find that by reducing this mental tyranny, you'll feel better because you won't be berating yourself. Instead of feeling guilty, you can use your energy to make necessary changes and enhance your self-control and productivity.

3. *Learn to Stick to Your Guns.* One of the big disadvantages of being guilt-prone is that others can and will use this guilt to manipulate you. If you feel obligated to please everyone, your family and friends will be able to coerce you effectively into doing many things that may not be in your best self-interest. To cite a trivial example, how many social invitations have you halfheartedly accepted so as not to hurt someone's feelings? In this case the price you pay for saying yes when you really would have preferred to say no is not great. You only end up wasting one evening. And there is a payoff. You will avoid feeling guilty, and you can fantasize that you are an especially nice person. Furthermore, if you try to decline the invitation, the disappointed host may say, "But we are *expecting* you. Do you mean you are going to let the old gang down? Aw, come on." And *then* what would you say? How would you feel?

Your obsession with pleasing others becomes more tragic when your decisions become so dominated by guilt that you end up trapped and miserable. The irony is that, more often than not, the consequences of letting

someone manipulate you with guilt end up being destructive not only to you but to the other person. Although your guilt-motivated actions are often based on your idealism, the inevitable effects of giving in turn out to be quite the opposite.

For example, Margaret was a happily married twenty-seven-year-old woman whose obese brother, a gambler, tended to take advantage of her in a variety of ways. He borrowed money when he ran short and often forgot to repay it. When he was in town (often for several months at a time) he assumed it was his right to eat dinner with her family every night, to drink up the liquor, and to use her new car whenever he wanted. She rationalized giving in to his demands by saying: "If I asked him for a favor or needed his help, he'd do the same for me. After all, a loving brother and sister *should* help each other out. And besides, if I tried to say no to him he'd explode and I might lose him. Then I'd feel like *I* did something wrong."

At the same time, she was able to see the negative consequences of continually giving in: (1) She was supporting his dependent, self-defeating life-style and gambling addiction; (2) She felt trapped and taken advantage of; (3) The basis of the relationship was not love but blackmail—she was constantly having to say yes to his demands to avoid the tyranny of his temper and her own sense of guilt.

Margaret and I did some role-playing so she could learn to say no and stick to her guns in a tactful but firm manner. I played Margaret's role, and she pretended to be her brother:

BROTHER (played by Margaret): Are you using the car tonight?

MARGARET (played by me): I'm not planning to now.

BROTHER: Do you mind if I borrow it later?

MARGARET: I'd prefer that you don't.

BROTHER: Why not? You're not going to use it. It'll just be sitting there

MARGARET: Do you feel I'm obliged to loan it to you?

BROTHER: Well, I'd do the same for you if I had a car and you needed it

MARGARET: I'm glad you feel that way. Although I'm not planning to us the car, I'd like to have it available in case I decide to g somewhere later on.

BROTHER: But you're not planning to use it! Haven't we been brought

up to *help* each other?

MARGARET: Yes we have. Do you think that means I always have to say yes to you? We both do a great deal for each other. You have made a lot of use of my car and from now on I'd feel more comfortable if you'd begin to arrange your own transportation.

BROTHER: I'm just planning to use it for an hour, so I'll get it back in case you need it. It's very important and it's only a half mile away, so I won't wear your car out, don't worry.

MARGARET: It sounds like it is something important to you. Perhaps you can arrange some other transportation. Could you walk that distance?

BROTHER: Oh, that's fine! If that's how you feel, don't come to me for any favors!

MARGARET: It sounds like you're pretty mad because I'm not doing what you want. Do you feel I'm always obliged to say yes?

BROTHER: You and your philosophy! Shove It! I refuse to listen to any more of this hogwash! (Begins to storm off).

MARGARET: Let's not talk about it any further then. Maybe in a couple of days you'll feel more like talking about it. I think we do need to talk things over.

After this dialogue we reversed roles so that Margaret could practice being more assertive. When I played her brother's role, I gave her as tough a time as I could, and she learned how to handle me. This practice boosted her courage. She felt it was helpful to keep certain principles in mind when standing up to her brother's manipulations. These were: (1) She could remind him it was her right not to say yes to all his demands. (2) She could find a grain of truth in his arguments (the disarming technique) so as to take the wind out of his sails, but she could then come back to her position that love did not mean always giving in. (3) She was to adopt a strong, decisive and uncompromising position as tactfully as possible. (4) She was not to buy into his role as a weak, inadequate little boy who couldn't stand on his own feet. (5) She was not to respond to his anger by getting angry herself, because this would reinforce his belief he was a victim who was being unjustly deprived

by a cruel, selfish witch. (6) She had to risk the possibility he would temporarily withdraw and thwart her by refusing to talk to her or to consider her point of view. When he did this, she was to let him storm off but she could let him know there were some things she wanted to talk over with him later on when he was more in the mood to communicate.

When Margaret did confront him she found he was not nearly as tough a customer as she imagined. He actually seemed relieved and began to act more adult when she put some limits on the relationship.

If you choose to apply this technique, you will have to be determined to stick to your guns because the other guy (or gal) may try to bluff you into believing that you're mortally wounding them by not giving in to their requests. Remember that the hurt you inflict in the long run by not following your best self-interest is usually far greater.

Practicing ahead of time is the key to success. A friend will usually be happy to role-play with you and provide some useful feedback. If such a person is not available to you, or you feel too shy to ask, write out an imaginary dialogue of the type illustrated. This will go a long way to firing up the appropriate circuits in your brain so you'll have the necessary courage and skill to say no diplomatically but forcefully and make it stick when the time actually comes!

*4. Antiwhiner Technique.* This is one of the most surprising, delightfully effective methods in this book. It works like a charm in situations where someone—usually a loved one—makes you feel frustrated, guilty, and helpless through whining, complaining, and nagging. The typical pattern works like this: The whiner complains to you about something or someone. You feel the sincere desire to be helpful, so you make a suggestion. The person immediately squashes your suggestion and complains again. You feel tense and inadequate, so you try harder and make another suggestion. You get the same response. Anytime you try to break loose from the conversation, the other person implies he or she is being abandoned, and you are flooded with guilt.

Shiba lived with her mother while she completed graduate school. Shiba loved her mother, but found her constant harangues about her divorce, the lack of money, etc., so intolerable she sought treatment. I taught her the antiwhiner method the first session, as follows: Regardless of what her

mother said, Shiba was to find some way to *agree* (the disarming technique), and then instead of offering advice, she was to say something genuinely complimentary. Shiba initially found this approach astonishing and rather bizarre because it differed radically from her usual approach, in the following dialogue, I asked Shiba to play the role of Mother while I played her role so I could demonstrate this technique:

SHIBA (as her mother): Do you know that during the divorce proceeding it came out that your dad sold his share in the business, and I was the last person to know about it?

DAVID (as Shiba): That's absolutely correct. You didn't hear about it until the divorce proceedings. You really deserve better.

SHIBA: I don't know what we're going to do for money. How am I going to put your brothers through college?

DAVID: That is a problem. We are short on money.

SHIBA: It was just like your father to pull something like this. His head isn't screwed on straight.

DAVID: He never was too good at budgeting. You've always been much better at that.

SHIBA: He's a louse! Here we are on the verge of poverty. What if I get sick? We'll end up in the poorhouse!

DAVID: You're right! It's no fun *at all* to live in the poorhouse. I agree with you completely.

Shiba reported that in her role as Mother she found it was "no fun" to complain because I kept agreeing with her. We did a role-reversal so she could master the technique.

In fact, it is your urge to *help* complainers that maintains the monotonous interaction. Paradoxically, when you agree with their pessimistic whining, they quickly run out of steam. Perhaps an explanation will make this seem less puzzling. When people whine and complain, they are usually feeling irritated, overwhelmed, and insecure. When you try to *help* them, this sounds to them like criticism because it implies they aren't handling things properly. In contrast, when you agree with them and add a compliment, they feel *endorsed*, and they then usually relax and quiet down.

5. *Moorey Moaner Method.* A useful modification of this technique was proposed by Stirling Moorey, a brilliant British medical student who studied with our group in Philadelphia and sat in with me during therapy sessions during the summer of 1979. He worked with a chronically severely depressed fifty-two-year-old sculptor named Harriet with a heart of gold. Harriet's problem was her friends would often bend her ear with gossip and personal problems. She found these problems upsetting because of her excessive capacity for empathy. Because she wouldn't know how to help her friends, she felt trapped and resentful until she learned the "Moorey Moaner Method." Stirling simply instructed her to find a way to agree with what the person was saying, and then to distract the moaner by finding something positive in the complaint and commenting on it. Here are several examples:

1.           Oh, what in the world can I ever do about my daughter? I'm  
MOANER: afraid she's been smoking pot again.

RESPONSE: There sure is a lot of pot going around these days. Is your daughter still doing that outstanding art work? I heard she recently got an important award.

2.           My boss didn't give me my raise, and my last raise was nearly  
MOANER: a year ago. I've been here for twenty years, and I think deserve better.

RESPONSE: You certainly do have seniority here and you've made tremendous contributions. Tell me, what was it like when you first started working twenty years ago? I'll bet things were a lot different then.

3.           My husband never seems to have enough time at home. Every  
MOANER: night he's out with that darned bowling league.

RESPONSE: Weren't you also doing some bowling recently? I heard you got some pretty high scores yourself!

Harriet mastered the Moorey Moaner Method quickly and reported a dramatic change in her mood and outlook because it gave her a simple, effective way to handle a problem that had been very real and overwhelming. When she returned for the next session, her depression—which had crippled her for over a decade—had lifted and was entirely gone. She was bubbling and joyous, and heaped well-deserved praise on Stirling's head. If you have a

similar problem with your mother, mother-in-law, or friends, try Stirling's method. Like Harriet, you'll soon be smiling!

*6. Developing Perspective.* One of the commonest distortions that leads to a sense of guilt is personalization—the misguided notion that you are ultimately responsible for other people's feelings and actions or for naturally occurring events. An obvious example would be your sense of guilt when it rained unexpectedly on the day of a large picnic you had organized to honor the retiring president of your club. In this case you could probably shake your absurd reaction off without a great deal of effort because you clearly cannot control the weather.

Guilt becomes much more difficult to overcome when someone suffers substantial pain and discomfort and insists it results from their personal interaction with you. In such cases it can be helpful to clarify the extent to which you can realistically assume responsibility. Where does your responsibility end and the other person's begin? The technical name for this is "disattribution," but you might call it putting things into perspective.

Here's how it works. Jed was a mildly depressed college student whose twin brother, Ted, was so seriously depressed he dropped out of school and began to live like a recluse with his parents. Jed felt guilty about his brother's depression. Why? Jed told me he had always been more outgoing and hardworking than his brother. Consequently, from early childhood he always made better grades and had more friends than Ted. Jed reasoned that the social and academic success he enjoyed caused his brother to feel inferior and left out. Consequently, Jed concluded that he was the cause of Ted's depression.

He then carried this line of reasoning to its illogical extreme and hypothesized that by feeling depressed himself, he might help Ted stop feeling depressed and inferior through some type of reverse (or perverse) psychology. When he went home for the holidays, Jed avoided the usual social activities, minimized his academic success, and emphasized how blue he was feeling. Jed made sure he gave his brother the loud and clear message that he too was down and out.

Jed took his plan so seriously that he was quite hesitant to apply the mood-control techniques I was trying to teach him. In fact, he was downright

*resistant* at first because he felt guilty about getting better and feared his recovery might have a devastating impact on Ted.

Like most personalization errors, Jed's painful illusion that he was at fault for his brother's depression contained enough half-truths to sound persuasive. After all, his brother probably had felt inferior and inadequate since early childhood and undoubtedly did harbor some jealous resentment of Jed's success and happiness. But the crucial questions were: Did it follow that Jed caused his brother's depression, and could Jed effectively reverse the situation by making himself miserable?

In order to help him assess his role in a more objective way, I suggested Jed use the triple-column technique (Figure 8-4). As a result of the exercise, he was able to see that his guilty thoughts were self-defeating and illogical. He reasoned that Ted's depression and sense of inferiority were ultimately caused by Ted's distorted thinking and not by his own happiness or success. For Jed to try to correct this by making himself miserable was as illogical as trying to put out a fire with gasoline. As Jed grasped this, his guilt and depression rapidly lifted, and he was soon back to normal functioning.

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<i>Automatic Thoughts</i>	<i>Cognitive Distortion</i>	<i>Rational Responses</i>
1. I am part of the cause for Ted's depression due to our relationship since early childhood. I have always worked harder and been more successful.	1. Jumping to conclusions (mind reading); personalization	1. I myself am not the cause of Ted's depression. It is Ted's illogical thoughts and attitudes that are causing his depression. The only responsibility that I can take is that of being part of the environment that Ted is interpreting in a negative, distorted manner.
2. I feel it would upset Ted if I told him I was having a good time at school while he is home alone doing nothing.	2. Jumping to conclusions (fortune teller error)	2. It might cheer Ted up and give him some hope if he knows I'm feeling better and having a good time. It probably only depresses Ted more if I act as miserable as he does because this takes away his hope.
3. If Ted is sitting around doing nothing, it is my responsibility to correct the situation.	3. Personalization	3. I can encourage him to do things, but I cannot force him. Ultimately this is his responsibility.

<i>Automatic Thoughts</i>	<i>Cognitive Distortion</i>	<i>Rational Responses</i>
4. I will be doing something for him by not doing anything for myself. In fact, it will help him if I am depressed.	4. Jumping to conclusions (mind reading)	4. My actions are totally independent of his actions. There is no reason to think that my depression will be helpful to him. He has even told me he doesn't want me to be dragged down. If he sees that I am improving, this might actually encourage him. I can possibly be a good role model for him by showing him that I can be happy. I can't eliminate his sense of inadequacy by botching up my life.

**Figure 8–4.**

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Part III  
**“Realistic” Depressions**

## Chapter 9

### Sadness Is Not Depression

“Dr. Burns, you seem to be claiming that distorted thinking is the only cause of depression. But what if my problems are real?” This is one of the most frequent questions I encounter during lectures and workshops on cognitive therapy. Many patients raise it at the start of treatment, and list a number of “realistic” problems which they are convinced cause “realistic depressions.” The most common are:

- bankruptcy or poverty;
- old age (some people also view infancy, childhood, adolescence, young adulthood and mid-life as periods of inevitable crisis);
- permanent physical disability;
- terminal illness;
- the tragic loss of a loved one.

I’m sure you could add to the list. However, none of the above can lead to a “realistic depression.” There is, in fact, no such thing! The real question here is how to draw the line between desirable and undesirable negative feelings. What is the difference between “healthy sadness” and depression?

The distinction is simple. Sadness is a normal emotion created by realistic perceptions that describe a negative event involving loss or disappointment in an undistorted way. Depression is an illness that *always* results from thoughts that are distorted in some way. For example, when a loved one dies, you validly think, “I lost him (or her), and I will miss the companionship and love we shared.” The feelings such a thought creates are tender, realistic, and desirable. Your emotions will enhance your humanity and add depth to the meaning of life. In this way you *gain* from your loss.

In contrast, you might tell yourself, “I’ll never again be happy because he (or she) died. It’s unfair!” These thoughts will trigger in you feelings of self-pity and hopelessness. Because these emotions are based entirely on distortion, they will defeat you.

Either depression or sadness can develop after a loss or a failure in your efforts to reach a goal of great personal importance. Sadness comes, however, without distortion. It involves a flow of feeling and therefore has a time limit. It never involves a lessening of your self-esteem. Depression is frozen—it tends to persist or recur indefinitely, and always involves loss of self-esteem.

When a depression clearly appears after an obvious stress, such as ill health, the death of a loved one, or a business reversal, it is sometimes called a “reactive depression.” At times it can be more difficult to identify the stressful event that triggered the episode. Those depressions are often called “endogenous” because the symptoms seem to be generated entirely out of thin air. In both cases, however, the cause of the depression is identical—your distorted, negative thoughts. It has no adaptive or positive function whatsoever, and represents one of the worst forms of suffering. Its only redeeming value is the growth you experience when you recover from it.

My point is this: When a genuinely negative event occurs, your emotions will be created exclusively by your thoughts and perceptions. Your feelings will result from the meaning you attach to what happens. A substantial portion of your suffering will be due to the *distortions* in your thoughts. When you eliminate these distortions, you will find that coping with the “real problem” will become less painful.

Let’s see how this works. One clearly realistic problem involves serious illness, such as a malignancy. It is unfortunate that the family and friends of the afflicted person are often so convinced that it is normal for the patient to feel depressed, they fail to inquire about the cause of the depression, which more often than not turns out to be completely reversible. In fact, some of the *easiest* depressions to resolve are those found in people facing probable death. Do you know why? These courageous individuals are often “supercopers” who haven’t made misery their life-style. They are usually willing to help themselves in any way they can. This attitude rarely fails to transform apparently irreversible and “real” difficulties into opportunities for personal growth. This is why I find the concept of “realistic depressions” so personally abhorrent. The attitude that depression is necessary strikes me as

destructive, inhuman, and victimizing. Let's get down to some specifics, and you can judge for yourself.

*Loss of Life.* Naomi was in her mid-forties when she received a report from her doctor that a “spot” had appeared on her chest X ray. She was a firm believer that going to doctors was a way of asking for trouble, so she procrastinated many months in checking this report out. When she did, her worst suspicions were validated. A painful needle biopsy confirmed the presence of malignant cells, and subsequent lung removal indicated that a spread of the cancer had already occurred.

This news hit Naomi and her family like a hand grenade. As the months wore on, she became increasingly despondent over her weakened state. Why? It was not so much the physical discomfort from the disease process or the chemotherapy, although these were genuinely uncomfortable, but the fact that she was sufficiently weak that she had to give up the daily activities that had meant a great deal to her sense of identity and pride. She could no longer work around the house (now her husband had to do most of the chores), and she had to give up her two part-time jobs, one of which was volunteer reading for the blind.

You might insist, “Naomi’s problems are *real*. Her misery is not caused by distortion. It’s caused by the situation.”

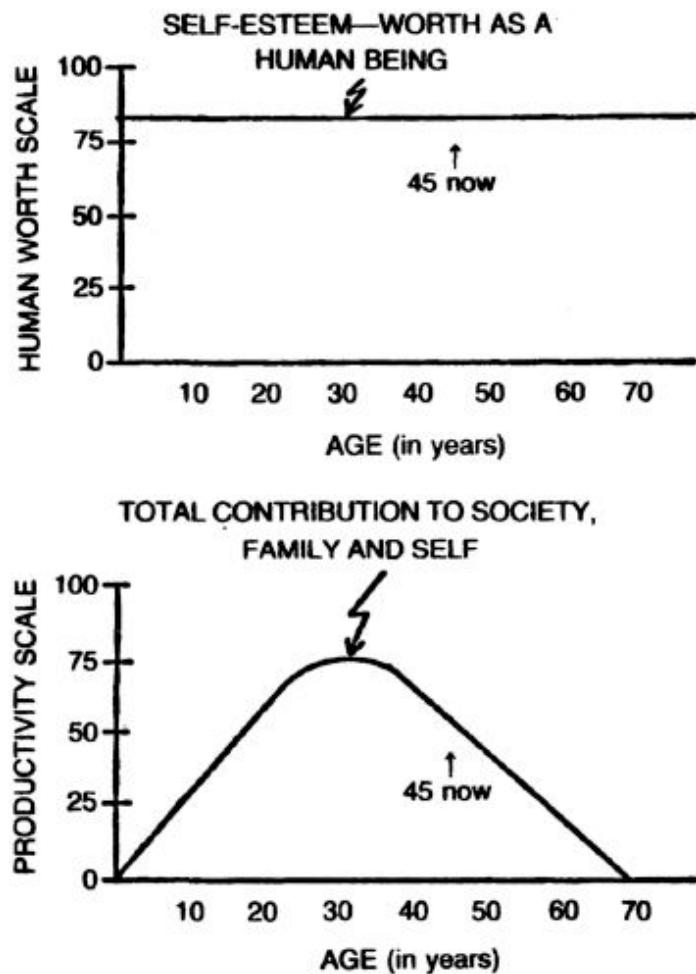
But was her depression so inevitable? I asked Naomi why her lack of activity was so upsetting. I explained the concept of “automatic thoughts,” and she wrote down the following negative cognitions: (1) I’m not contributing to society; (2) I’m not accomplishing in my own personal realm; (3) I’m not able to participate in *active* fun; and (4) I am a drain and drag on my husband. The emotions associated with these thoughts were: anger, sadness, frustration, and guilt.

When I saw what she had written down, my heart leaped for joy! These thoughts were no different from the thoughts of physically healthy depressed patients I see every day in my practice. Naomi’s depression was *not* caused by her malignancy, but the malignant *attitude* that caused her to measure her sense of worth by the amount she produced! Because she had always equated her personal worth with her achievements, the cancer meant—“You’re over the hill! You’re ready for the refuse heap!” This gave me a way to intervene!

I suggested that she make a graph of her personal “worth” from the moment of birth to the moment of death (see Figure 9–1, page 235). She saw her worth as a constant, estimating it at 85 percent on an imaginary scale from 0 to 100 percent. I also asked her to estimate her *productivity* over the same period on a similar scale. She drew a curve with low productivity in infancy, increasing to a maximum plateau in adulthood, and finally decreasing again later in life (see Figure 9–1). So far, so good. Then two things suddenly dawned on her. First, while her illness had reduced her productivity, she still contributed to herself and her family in numerous small but nevertheless important and precious ways. Only all-or-nothing thinking could make her think her contributions were a zero. Second, and much more important, she realized her personal worth was constant and steady; it was a *given* that was unrelated to her achievements. This meant that her human worth did *not* have to be earned, and she was every bit as precious in her weakened state. A smile spread across her face, and her depression melted in that moment. It was a real pleasure for me to witness and participate in this small miracle. It did *not* eliminate the tumor, but it did restore her missing self-esteem, and that made all the difference in the way she *felt*.

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**Figure 9–1.** Naomi's worth and work graphs. In the upper figure Naomi plotted her human "worth" from the time of her birth to the time of her death. She estimated this at 85 percent. In the lower figure she plotted her estimated productivity and achievement over the course of her life. Her productivity began low in childhood, reached a plateau in adulthood, and would ultimately fall to zero at the time of death. This graph helped her comprehend that her "worth" and "achievement" were unrelated and had no correlation with each other.

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Naomi was not a patient, but someone I spoke with while vacationing in my home state of California during the winter of 1976. I received a letter from her soon after which I share with you here:

David—

An incredibly belated, but really important “P.S.” to my last letter to you. To wit: the simple little “graphs” you did of productivity as opposed to self-worth or self-esteem or whatever we shall call it: It has been *especially* sustaining to me, a plus which I dose out liberally! It really turned me into a psychologist without having to go for my Ph.D. I find that it works with lots of things that badger and bother people. I’ve tried these ideas out on some of my friends. Stephanie is treated like a piece of furniture by a chit of a secretary one-third her age; Sue is put down constantly by her 14 year old twins; Becky’s husband has just walked out; Ilga is being made to feel like an interloper by her boy friend’s 17 year old son, etc. To them all I say “Yes, but your personal worth is a *CONSTANT*, and all the garbage the world heaps on you doesn’t touch it!” Of course in many cases I realize it’s an over-simplification and cannot be an anodyne for all things, but boy is it helpful and useful!

Again, thank you, sir!

As ever, Naomi

She died in pain but with dignity six months later.

*Loss of Limb.* Physical handicaps represent a second category of problems felt to be “realistic.” The afflicted individual—or the family members—automatically assume that the limitations imposed by old age or by a physical disability, such as an amputation or blindness, necessarily imply a decreased capacity for happiness. Friends tend to offer understanding and sympathy, thinking this represents a humane and “realistic” response. The case can be quite the opposite, however. The emotional suffering may be caused by twisted thinking rather than by a twisted body. In such a situation, a sympathetic response can have the undesirable effect of reinforcing self-pity as well as feeding into the attitude that the handicapped individual is doomed to less joy and satisfaction than others. In contrast, when the afflicted individual or family members learn to correct the distortions in their thinking, a full and gratifying emotional life can frequently result.

For example, Fran is a thirty-five-year-old married mother of two, who began to experience symptoms of depression around the time her husband’s right leg became irreversibly paralyzed because of a spinal injury. For six

years she sought relief from her intensifying sense of despair, and received a variety of treatments in and out of hospitals, including antidepressant drugs as well as electroshock therapy. Nothing helped. She was in a severe depression when she came to me, and she felt her problems were insoluble.

In tears she described the frustration she experienced in trying to cope with her husband's decreased mobility:

Every time I see other couples doing things we can't do tears come to my eyes. I look at couples taking walks, jumping in the swimming pool or the ocean, riding bikes together, and it just hurts. Things like that would be pretty tough for me and John to do. They take it for granted just like we used to. Now it would be so good and wonderful if we could do it. But you know, and I know, and John knows—we can't.

At first, I too had the feeling Fran's problem was realistic. After all, they *couldn't* do many things that most of us can do. And the same could be said of old people, as well as those who are blind or deaf or who have had a limb amputated.

In fact, when you think of it, we *all* have limitations. So perhaps we should all be miserable ...? As I puzzled over this, Fran's distortion suddenly came to my mind. Do you know what it is? Look at the list on page 42 right now and see if you can pick it out ... that's right, the distortion that led to Fran's needless misery was the mental filter. Fran was picking out and dwelling on each and every activity that was unavailable to her. At the same time the many things she and John *could* or might do together did not enter her conscious mind. No wonder she felt life was empty and dreary.

The solution turned out to be surprisingly simple. I proposed the following to Fran: "Suppose at home between sessions you were to make a list of all the things that you and John, *can* do together. Rather than focus on things that you and John *can't* do, learn to focus on the ones you *can* do. I, for example, would love to go to the moon, but I don't happen to be an astronaut, so it's not likely I'll ever get the opportunity. Now, if I focused on the fact that in my profession and at my age it is extremely unlikely I could ever get to the moon, I could make myself very upset. On the other hand, there are many things I *can* do, and if I focus on these, then I won't feel disappointed. Now, what would be some things you and John *can* do as a couple?"

FRAN: Well, we enjoy each other's company still. We go out to dinner and we're buddies.

DAVID: Okay. What else?

FRAN: We go for rides together, we play cards. Movies, Bingo. He's teaching me how to drive...

DAVID: You see, in less than thirty seconds you've already listed six things you can do together. suppose I gave you between now and next session to continue the list. How many items do you think you could come up with?

FRAN: Quite a lot of them. I could come up with things we've never thought of, maybe something unusual like skydiving.

DAVID: Right. You might even come up with some more adventurous ideas. Keep in mind that you and John might in fact be able to do many things you are assuming you can't do. For example, you told me you can't go to the beach. You mentioned how much you'd like to go swimming. Could you go to a beach that's a little more secluded so you wouldn't have to feel quite so self-conscious? If I were on a beach and you and John were there, his physical disability wouldn't make one darn bit of difference to me. In fact, I recently visited a fine beach on the North Shore of Lake Tahoe in California with my wife and her family. As we were swimming, we suddenly happened upon a cove that had a nude beach, and here were all these young people with no clothes on. Of course, I didn't actually *look* at any of them, I want you to understand! But in spite of this I did happen to notice that one young man had his right leg missing from the knee down, and he was there having fun with the rest of them. So I'm not absolutely convinced that just because someone is crippled or missing a limb they can't go to the beach and have fun. What do you think?

Some people might scoff at the idea that such a "difficult and real" problem could be so easily resolved, or that an intractable depression like

Fran's could turn around in response to such a simple intervention. She did in fact report a complete disappearance of her uncomfortable feelings and said she felt the best she had in years at the end of the session. In order to maintain such improvement, she will obviously need to make a consistent effort to change her thinking patterns over a period of time so she can overcome her bad habit of spinning an intricate mental web and getting trapped in it.

*Loss of Job.* Most people find the threat of a career reversal or the loss of livelihood a potentially incapacitating emotional blow because of the widespread assumption in Western culture that individual worth and one's capacity for happiness are directly linked with professional success. Given this value system, it seems obvious and realistic to anticipate that emotional depression would be inevitably linked with financial loss, career failure, or bankruptcy.

If this is how you feel, I think you would be interested in knowing Hal. Hal is a personable forty-five-year-old father of three, who worked for seventeen years with his wife's father in a successful merchandising firm. Three years before he was referred to me for treatment, Hal and his father-in-law had a series of disputes about the management of the firm. Hal resigned in a moment of anger, thus giving up his interests in the company. For the next three years, he bounced around from job to job, but had difficulty finding satisfactory employment. He didn't seem to be able to succeed at anything and began to view himself as a failure. His wife started working full time to make ends meet, and this added to Hal's sense of humiliation because he had always prided himself on being the breadwinner. As the months and years rolled on, his financial situation worsened, and he experienced increasing depression as his self-esteem bottomed out.

When I first met Hal, he had been attempting to work for three months as a trainee in commercial real-estate sales. He had rented several buildings, but had not yet finalized a sale. Because he was working on a strict commission basis, his income during this break-in period was quite low. He was plagued by depression and procrastination. He would at times stay at home in bed all day, thinking to himself, "What's the use? I'm just a loser. There's no point in going to work. It's less painful to stay in bed."

Hal volunteered to permit the psychiatric residents in our training program at the University of Pennsylvania to observe one of our psychotherapy sessions through a one-way mirror. During this session, Hal described a conversation in the locker room of his club. A well-to-do friend had informed Hal of his interest in the purchase of a particular building. You might think he would have jumped for joy on learning this, since the commission from such a sale would have given his career, confidence, and bank account a much needed boost. Instead of pursuing the contact, Hal procrastinated several weeks. Why? Because of his thought, "It's too complicated to sell a commercial property. I've never done this before. Anyway, he'll probably back out at the last minute. That would mean I couldn't make it in this business. It would mean I was a failure."

Afterward, I reviewed the session with the residents. I wanted to know what they thought about Hal's pessimistic, self-defeating attitudes. They felt that Hal did in fact have a good aptitude for sales work, and that he was being unrealistically hard on himself. I used this as ammunition during the next session. Hal admitted that he was more critical of himself than he would ever be toward anyone else. For example, if one of his associates lost a big sale, he'd simply say, "It's not the end of the world; keep plugging." But if it happened to him he'd say, "I'm a loser." Essentially, Hal admitted he was operating on a "double standard"—tolerant and supportive toward other people but harsh, critical, and punitive toward himself. You may have the same tendency. Hal initially defended his double standard by arguing it would be helpful to him:

HAL: Well, first of all, the responsibility and interest that I have in the other person is not the same as the responsibility that I have for myself.

DAVID: Okay. Tell me more.

HAL: If they don't succeed, it's not going to be bread off my table, or create any negative feelings within my family unit. So the only reason I'm interested in them is because it's nice to have everybody succeed, but there...

DAVID: Wait—wait—wait! You're interested in them because it's nice to have them succeed?

HAL: Yeah. I said ...

DAVID: The standard you apply to them is one that you think would help them succeed?

HAL: Right.

DAVID: And is the standard you apply to yourself the one that will help you succeed? How do you feel when you say, "One missed sale means I'm a failure"?

HAL: Discouraged.

DAVID: Is this helpful?

HAL: Well, it hasn't produced positive results, so apparently it's not helpful.

DAVID: And is it *realistic* to say "One missed sale and I'm a failure"?

HAL: Not really.

DAVID: So why are you using this all-or-nothing standard on yourself? Why would you apply helpful and realistic standards to these other people who you don't care so much about and self-defeating, hurtful standards to yourself who you do care something about?

Hal was beginning to grasp that it wasn't helping him to live by a double standard. He judged himself by harsh rules that he would never apply to anyone else. He initially defended this tendency—as many demanding perfectionists will—by claiming it would *help* him in some way to be so much harder on himself than on others. However, he then quickly owned up to the fact that his personal standards were actually unrealistic and self-defeating because if he did try to sell the building and didn't succeed, he would view it as a catastrophe. His bad habit of all-or-nothing thinking was the key to the fear that paralyzed him and kept him from trying. Consequently, he spent most of his time in bed, moping.

Hal asked for some specific guidelines concerning things he might do to rid himself of his perfectionistic double standards so that he could judge all individuals, including himself, by *one* objective set of standards. I proposed that as a first step, Hal might use the automatic-thought, rational-response technique. For example, if he were sitting at home procrastinating about work, he might be thinking, "If I don't go to work early and stay all day and get caught up on all my work, there's no point in even trying. I might as well lie in bed." After writing this down, he would substitute a rational response, "This is just all-or-nothing thinking, and it's baloney. Even going to work for a half day could be an important step and might make me feel better."

Hal agreed to write down a number of upsetting thoughts before the next therapy session at those times he felt worthless and down on himself. (See Figure 9-2, page 244.) Two days later he received a layoff notice from his employer, and he came to the next session highly convinced his self-critical thoughts were absolutely valid and realistic. He'd been unable to come up with a single rational response. The notice implied that his failure to show up at work necessitated his release from his job. During the session, we discussed how he could learn to talk back to his critical voice.

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<b><i>Negative Thoughts (SELF-CRITICISM)</i></b>	<b><i>Rational Responses (SELF-DEFENSE)</i></b>
1. I am lazy.	1. I have worked hard much of my life.
2. I enjoy being ill.	2. It's not fun.
3. I am inadequate. I am a failure.	3. I've had some degree of success. We've had a good home. We've reared three outstanding children. People admire and respect me. I have involved myself in community activity.
4. This lying around doing nothing represents the real me.	4. I am experiencing symptoms of an illness. It's not the "real me."
5. I could have done more.	5. At least I did more than most people. It's meaningless and pointless to say, "I could have done more" because anyone could say this.

**Figure 9–2.** Hal’s homework for recording and challenging his self-critical thoughts. He wrote down the Rational Responses during the therapy session (see text).

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DAVID: Okay, now let’s see if we can write down some answers to your negative thoughts in the Rational Response column. Can you think of any answer based on what we talked about last session? Consider your statement “I am inadequate.” Would this in any way result from your all-or-nothing thinking and perfectionist standards?

The answer might be clearer to you if we do a role-reversal. It’s sometimes easier to speak objectively about someone else. Suppose I came to you with your story and told you that I was employed by my wife’s father. Three years ago we had a fight. I felt I was being taken advantage of. I walked out. I’ve kinda been feeling blue ever since that time, and I’ve been tossing around from job to job. Now I’ve been fired from a job that was purely on a commission basis, and that’s really a double defeat for me. In the first place, they didn’t pay me anything, and then in the second place, they didn’t even figure I was worth that much, so they fired me. I’ve concluded that I’m inadequate—an inadequate human being. What would you say to me?

HAL: Well, I ... assuming that you’d gotten up to that point, say the first forty years or more of your life, you obviously *were* doing something.

DAVID: Okay, write that down in the Rational Response column. Make a list of all the good, adequate things you did for the first forty years of your life. You’ve earned money, you’ve raised children who were successful, etc., etc.

HAL: Okay. I can write down that I’ve had some success. We’ve had a good home. We’ve reared three outstanding children. People admire and respect me, and I have involved myself in community activities.

DAVID: Okay, now those are all the things you've done. How do you reconcile this with your belief that you are inadequate?

HAL: Well, I could have done more.

DAVID: Great! I was certain you'd figure out a clever way to disqualify your good points. Now write that down as another negative thought: "I could have done more." Beautiful!

HAL: Okay, I've written it down as number five.

DAVID: Okay, now what's the answer to that one? (long silence)

DAVID: What is it? What's the distortion in that thought?

HAL: You're a tricky bugger!

DAVID: What is the answer?

HAL: At least I did more than most people.

DAVID: Right, and what percent do you believe that?

HAL: That I believe one hundred percent.

DAVID: Great! Put it down in the Rational Response column. Now, let's go back to this "I could have done more." Suppose you were Howard Hughes sitting up in his tower, with all those millions and billions. What could you say to yourself to make yourself unhappy?

HAL: Well, I'm trying to think.

DAVID: Just read what you wrote down on the paper.

HAL: Oh. "I could have done more."

DAVID: You can always say that, can't you?

HAL: Yeah.

DAVID: And that's why a lot of people who have won fame and fortune

are unhappy. It's just an example of perfectionistic standards. You can go on and on and on, and no matter how much achievement you experience, you can always say, "I could have done more." This is an arbitrary way of punishing yourself. Do you agree or not?

HAL: Well, yeah. I can see that. It takes more than one element really to be happy. Because if it was money, then every millionaire and billionaire would be euphoric. But there are more circumstances that involve being happy or satisfied with yourself than making money. That's not the drive that paralyzes me. I've never had a drive to go after money.

DAVID: What were your drives? Did you have a drive to raise a family?

HAL: That was very important to me. Very important. And I participated in the rearing of the children.

DAVID: And what would you do in raising your children?

HAL: Well, I would work with them, teach them, play with them.

DAVID: And how did they come out?

HAL: I think they're great!

DAVID: NOW, you were writing down, "I'm inadequate. I'm a failure." How can you reconcile this with the fact that your aim was to raise three children and you did it?

HAL: Again, I guess I wasn't taking that into account.

DAVID: So how can you call yourself a failure?

HAL: I have not functioned as a wage earner ... as an effective money-maker for several years.

DAVID: Is it realistic to call yourself a "failure" based on that? Here's a man who has had a depression for three years, and he finds it

difficult to go to work, and now it's realistic to call him a failure? People with depressions are failures?

HAL: Well, if I knew more of what caused depression, I would be better able to make a value judgment.

DAVID: Well, we're not going to know the ultimate cause of depression for some time yet. But our understanding is that the immediate cause of depression is punitive, hurtful statements that you hit yourself with. Why this happens more to some people than others we don't know. The biochemical and genetic influences have not yet been worked out. Your upbringing undoubtedly contributed, and we can deal with that in another session if you like.

HAL: Since there is no final proof yet of the ultimate cause of depression, can't we think of that in terms of a failure in itself? I mean, we don't know where it's coming from ... It must be something wrong with me that caused it ... some way that I have failed myself that causes the depression.

DAVID: What evidence do you have for that?

HAL: I don't. It's just a possibility.

DAVID: Okay. But to make an assumption as punishing as that ... *anything* is a possibility. But there is no *evidence* for that. When patients get over depressions, then they become just as productive as they ever were. Seems to me that if their problem was that they were failures, when they got over the depression they would still be failures. I've had college professors and corporate presidents who have come to me. They were just sitting and staring at the wall, but it was because of their depression. When they got over the depression, they started giving conferences and managing their businesses like before. So how can you possibly say that depression is due to the fact that they are failures? Seems to me that it's more the other way around—that the failure is due to the depression.

HAL: I can't answer that.

DAVID: It's *arbitrary* to say that you're a failure. You have had a depression, and people with depression don't do as much as when they are undepressed.

HAL: Then I'm a successful depressive.

DAVID: Right! Right! And part of being a successful depressive means to get better. So I hope that's what we're doing now. Imagine that you had pneumonia for the past six months. You wouldn't have earned any dough. You could also say, "This makes me a failure." Would that be realistic?

HAL: I don't see how I could claim that. Because I certainly wouldn't have willfully created the pneumonia.

DAVID: Okay, can you apply the same logic to your depression?

HAL: Yeah, I can see it. I don't honestly feel that my depression was willfully induced either.

DAVID: Of course it wasn't. Did you *want* to bring this on?

HAL: Oh boy, no!

DAVID: Did you consciously *do* anything to bring it on?

HAL: Not that I know of.

DAVID: And if we knew what was causing depression, then we could put the finger someplace. Since we don't know, isn't it silly to blame Hal for his own depression? What we do know is that depressed people get this negative view of themselves. And they feel and behave in accord with this negative vision of everything. You didn't bring that on purposely or *choose* to be incapacitated. And when you get over that vision and when you have switched back to a nondepressed way of looking at things, you are going to be just as productive or more so than you've ever been, if you're

typical of other patients that I've worked with. You see what I mean?

HAL: Yeah, I *can* see.

It was a relief for Hal to realize that although he had been financially unsuccessful for several years, it was nonsensical to label himself as "a failure." This negative self-image and his sense of paralysis resulted from his all-or-nothing thinking. His sense of worthlessness was based on his tendency to focus only on the negatives in his life (the mental filter) and to overlook the many areas where he had experienced success (discounting the positive). He was able to see that he was aggravating himself unnecessarily by saying, "I could have done more," and he realized that financial value is not the same as human worth. Finally, Hal was able to admit that the *symptoms* he was experiencing—lethargy and procrastination—were simply manifestations of a temporary disease process and not indications of his "true self." It was absurd for him to think his depression was just punishment for some personal inadequacy, any more than pneumonia would be.

At the end of the session, the Beck Depression Inventory test indicated that Hal had experienced a 50 percent improvement. In the weeks that followed, he continued to help himself, using the double-column technique. As he trained himself to talk back to his upsetting thoughts, he was able to reduce the distortions in his harsh way of evaluating himself, and his mood continued to improve.

Hal left the real-estate business and opened a paperback bookstore. He was able to break even; but in spite of considerable personal effort, he was unable to show enough profit to justify continuing beyond the first year's trial period. Thus, the marks of external success had not changed appreciably during this time. In spite of this, Hal managed to avoid significant depression and maintained his self-esteem. The day he decided to "throw in the towel" on the bookstore, he was still below the zero point financially, but his self-respect did *not* suffer. He wrote the following brief essay which he decided to read each morning while he was looking for a new job:

### **Why Am I Not Worthless?**

As long as I have something to contribute to the well-being of myself and others, I am not worthless.

As long as what I do can have a positive effect, I am not worthless.

As long as my being alive makes a difference to even one person, I am not worthless (and this one person can be me if necessary).

If giving love, understanding, companionship, encouragement, sociability, counsel, solace means anything, I am not worthless.

If I can respect my opinions, my intelligence, I am not worthless. If others also respect me, that is a bonus.

If I have self-respect and dignity, I am not worthless.

If helping to contribute to the livelihood of my employees' families is a plus, I am not worthless.

If I do my best to help my customers and vendors through my productivity and creativity, I am not worthless.

If my presence in this milieu does makes a difference to others, I am not worthless.

I am not worthless. I am eminently worthwhile!

*Loss of a Loved One.* One of the most severely depressed patients I treated early in my career was Kay, a thirty-one-year-old pediatrician whose younger brother had committed suicide in a grisly way outside her apartment six weeks earlier. What was particularly painful for Kay was that she held herself responsible for his suicide, and the arguments she proposed in support of this point of view were quite convincing. Kay felt she was confronted by an excruciating problem that was entirely realistic and insoluble. She felt that she too deserved to die and was actively suicidal at the time of referral.

A frequent problem that plagues the family and friends of an individual who successfully commits suicide is die sense of guilt. There is a tendency to torture yourself with such thoughts as, "Why didn't I prevent this? Why was I so stupid?" Even psychotherapists and counselors are not immune to such reactions and may castigate themselves: "It's really my fault. *If only* I had talked to him differently in that last session. Why didn't I pin him down on whether or not he was suicidal? I should have intervened more forcefully. I murdered him!" What adds to the tragedy and irony is that in the vast majority of instances, the suicide occurs because of the victim's distorted belief that he has some insoluble problem which, viewed from a more

objective perspective, would seem much less overwhelming and certainly not worth suicide.

Kay's self-criticism was all the more intense because she felt that she had gotten a better break in life than her brother, and so she had gone out of her way to try to compensate for this by providing emotional and financial support for him during his long bout with depression. She arranged for his psychotherapy, helped pay for it, and even got him an apartment near hers so that he could call her whenever he was very down.

Her brother was a physiology student in Philadelphia. On the day of his suicide, he called Kay to ask about the effects of carbon monoxide on the blood for a talk he was to give in class. Because Kay is a blood specialist, she thought the question was innocent and gave him the information without thinking. She didn't talk to him very long because she was preparing a major lecture to deliver the following morning at the hospital where she worked. He used her information to make his fourth and final attempt outside her apartment window while she was preparing her lecture. Kay held herself responsible for his death.

She was understandably miserable, given the tragic situation she confronted. During the first few therapy sessions she outlined why she blamed herself and why she was convinced that she would be better off dead: "I had assumed the responsibility for my brother's life. I failed, so I feel I am responsible for his death. It proves that I did not adequately support him as I should have. I should have known that he was in an acute situation, and I failed to intervene. In retrospect, it's obvious that he was getting suicidal again. He'd had three prior serious suicide attempts. If I had just asked him when he called me, I could have saved his life. I was angry with him on many occasions during the month before he died, and in all honesty he could be a burden and a frustration at times. At one time I remember feeling annoyed and saying to myself that perhaps he *would* be better off dead. I feel terrible guilt for this. Maybe I *wanted* him to die! I know that I let him down, and so I feel that I deserve to die."

Kay was convinced that her guilt and agony were appropriate and valid. Being a highly moral person with a strict Catholic upbringing, she felt that punishment and suffering were expected of her. I knew there was something fishy about her line of reasoning, but I couldn't quite penetrate her illogic for several sessions because she was bright and persuasive and made a

convincing case against herself. I almost began to buy her belief that her emotional pain was “realistic.” Then, the key that I hoped might free her from her mental prison suddenly dawned on me. The error she was making was number ten discussed in Chapter 3—personalization.

At the fifth therapy session, I used this insight to challenge the misconceptions in Kay’s point of view. First of all, I emphasized that if she were responsible for her brother’s death, she would have had to be the cause of it. Since the cause of suicide is not known, even by experts, there was no reason to conclude that she was the cause.

I told her that if we had to guess the cause of his suicide, it would be his erroneous conviction that he was hopeless and worthless and that his life was not worth living. Since she did not control his thinking, she could not be responsible for the illogical assumptions that caused him to end his life. They were his errors, not hers. Thus, in assuming responsibility for his mood and actions, she was doing so for something that was not within her domain of control. The most that anyone could or would expect of her was to try to be a helping agent, as she had been within the limits of her ability.

I emphasized that it was unfortunate she did not have the knowledge necessary to prevent his death. If it had dawned on her that he was about to make a suicide attempt, she *would* have intervened in whatever manner possible. However, since she did not have this knowledge, it was not possible for her to intervene. Therefore, in blaming herself for his death she was illogically assuming that she could predict the future with absolute certainty, and that she had all the knowledge in the universe at her disposal. Since both these expectations were highly unrealistic, there was no reason for her to despise herself. I pointed out that even professional therapists are not infallible in their knowledge of human nature, and are frequently fooled by suicidal patients in spite of their presumed expertise.

For all these reasons, it was a major error to hold herself responsible for his behavior because she was not ultimately in control of him. I emphasized that she *was* responsible for her own life and well-being. At this point it dawned on her that she was acting irresponsibly, *not* because she “let him down” but because she was allowing herself to become depressed and was contemplating her own suicide. The responsible thing to do was to *refuse* to feel any guilt and to end the depression, and then to pursue a life of happiness and satisfaction. This would be acting in a responsible manner.

This discussion was followed by a rapid improvement in her mood. Kay attributed this to a profound change in her attitude. She realized we had exposed the misconceptions that made her want to kill herself. She then elected to remain in therapy for a period of time in order to work on enhancing the quality of her own life, and to dispel the chronic sense of oppression that had plagued her for many years prior to her brother's suicide.

*Sadness Without Suffering.* The question then arises. What is the nature of "healthy sadness" when it is not at all contaminated by distortion? Or to put it another way—does sadness really need to involve suffering?

While I cannot claim to know the definitive answer to this question, I would like to share an experience which occurred when I was an insecure medical student, and I was on my clinical rounds on the urology service in the hospital at Stanford University Medical Center in California. I was assigned to an elderly man who recently had had a tumor successfully removed from his kidney. The staff anticipated his rapid discharge from the hospital, but his liver function suddenly began to deteriorate, and it was discovered that the tumor had metastasized to his liver. This sad complication was untreatable, and his health began to fail rapidly over several days. As his liver function worsened, he slowly began to get groggier, slipping toward an unconscious state. His wife, aware of the seriousness of the situation, came and sat by his side night and day for over forty-eight hours. When she was tired, her head would fall on his bed, but she never left his side. At times she would stroke his head and tell him, "You're my man and I love you." Because he was placed on the critical list, the members of his large family, including children, grandchildren, and great-grandchildren, began to arrive at the hospital from various parts of California.

In the evening the resident in charge asked me to stay with the patient and attend the case. As I entered the room, I realized that he was slipping into a coma. There were eight or ten relatives there, some of them very old and others very young. Although they were vaguely aware of the seriousness of his condition, they had not been informed of just how grave the imminent situation was. One of his sons, sensing the old gentleman was nearing the end, asked me if I would be willing to remove the catheter which was draining his bladder. I realized the removal of the catheter would indicate to the family that he was dying, so I went to ask the nursing staff if this would

be appropriate to do. The nursing staff told me that it would because he was indeed dying. After they showed me how to remove a catheter, I went back to the patient and did this while the family waited. Once I was done, they realized that a certain support had been removed, and the son said, "Thank you. I know it was uncomfortable for him, and he would have appreciated this." Then the son turned to me as if to confirm the meaning of the sign and asked. "Doctor, what is his condition? What can we expect?"

I felt a sudden surge of grief. I had felt close to this gentle, courteous man because he reminded me of my own grandfather, and I realized that tears were running down my cheeks. I had to make a decision either to stand there and let the family see my tears as I spoke with them or to leave and try to hide my feelings. I chose to stay and said with considerable emotion, "He is a beautiful man. He can still hear you, although he is nearly in a coma, and it is time to be close to him and say good-bye to him tonight." I then left the room and wept. The family members also cried and sat on the bed, while they talked to him and said good-bye. Within the next hour his coma deepened until he lost consciousness and died.

Although his death was profoundly sad for the family and for me, there was a tenderness and a beauty to the experience that I will never forget. The sense of loss and the weeping reminded me—"You can love. You can care." This made the grief an elevating experience that was entirely devoid of pain or suffering for me. Since then, I have had a number of experiences that brought me to tears in this same way. For me the grief represents an elevation, an experience of the highest magnitude.

Because I was a medical student, I was concerned that my behavior might be seen as inappropriate by the staff. The chairman of the department later took me aside and informed me that the patient's family had asked him to extend their appreciation to me for being available to them and for helping make the occasion of his passing intimate and beautiful. He told me that he too had always felt strongly toward this particular individual, and showed me a painting of a horse the elderly man had done which was hanging on his wall.

The episode involved a letting go, a feeling of closure, and a sense of good-bye. This was in no way frightening or terrible; but in fact, it was peaceful and warm, and added a sense of richness to my experience of life.

Part IV

**Prevention and Personal Growth**

## Chapter 10

### The Cause of It All

When your depression has vanished, it's a temptation to *enjoy* yourself and relax. Certainly you're entitled. Toward the end of therapy, many patients tell me they feel the best they've ever felt in their lives. It sometimes seems that the more hopeless and severe and intractable the depression seemed, the more extraordinary and delicious the taste of happiness and self-esteem once it is over. As you begin to feel better, your pessimistic thinking pattern will recede as dramatically and predictably as the melting of winter's snow when spring arrives. You may even wonder how in the world you came to believe such unrealistic thoughts in the first place. This profound transformation of the human spirit never ceases to amaze me. Over and over I have the opportunity to observe this magical metamorphosis in my daily practice.

Because your change in outlook can be so dramatic, you may feel convinced that your blues have vanished forever. But there is an invisible residue of the mood disorder that remains. If this is not corrected and eliminated, you will be vulnerable to attacks of depression in the future.

There are several differences between *feeling* better and *getting* better. Feeling better simply indicates that the painful symptoms have temporarily disappeared. Getting better implies:

1. Understanding *why* you got depressed.
2. Knowing *why* and *how* you got better. This involves a mastery of the particular self-help techniques that worked specifically for you so that you can reapply them and make them work again whenever you choose.
3. Acquiring self-confidence and self-esteem. Self-confidence is based on the knowledge that you have a good chance of being reasonably successful in personal relationships and in your career. Self-esteem is

the capacity to experience maximal self-love and joy whether or not you are successful at any point in your life.

#### 4. Locating the deeper causes of your depression.

Parts I, II, and III of this book were designed to help you achieve the first two goals. The next several chapters will help you with the third and fourth goals.

Although your distorted negative thoughts will be substantially reduced or entirely eliminated after you have recovered from a bout of depression, there are certain “silent assumptions” that probably still lurk in your mind. These silent assumptions explain in large part *why* you became depressed in the first place and can help you predict *when* you might again be vulnerable. And they contain therefore the key to relapse prevention.

Just what is a silent assumption? A silent assumption is an equation with which you define your personal worth. It represents your value system, your personal philosophy, the stuff on which you base your self-esteem. Examples: (1) “If someone criticizes me, I feel miserable because this automatically means there is something wrong with me.” (2) “To be a truly fulfilled human being, I must be loved. If I am alone, I am bound to be lonely and miserable.” (3) “My worth as a human being is proportional to what I’ve achieved.” (4) “If I don’t perform (or feel or act) perfectly, I have failed.” As you will learn, these illogical assumptions can be utterly self-defeating. They create a vulnerability that predisposes you to uncomfortable mood swings. They represent your psychological Achilles’ heel.

In the next several chapters you will learn to identify and evaluate your own silent assumptions. You might find that an addiction to approval, love, achievement, or perfection forms the basis of your mood swings. As you learn to expose and challenge your own self-defeating belief system, you will lay the foundation for a personal philosophy that is valid and self-enhancing. You will be on the road to joy and emotional enlightenment.

In order to unearth the origins of your mood swings, most psychiatrists, as well as the general public, assume that a long and painfully slow (several years) therapeutic process is necessary, after which most patients would find it difficult to explain the cause of their depression. One of the greatest contributions of cognitive therapy has been to circumvent this.

In this chapter you will learn two different ways to identify silent assumptions. The first is a startlingly effective method called the “vertical-arrow technique,” which allows you to probe your inner psyche.

The vertical-arrow technique is actually a spin-off of the double-column method introduced in Chapter 4, in which you learned how to write down your upsetting automatic thoughts in the left-hand column and substitute more objective rational responses. This method helps you feel better because you deprogram the distortions in your thinking patterns. A brief example is shown in Figure 10–1. It was written by Art, the psychiatric resident described in Chapter 7, who became upset after his supervisor tried to offer a constructive criticism.

Putting the lie to his upsetting thoughts reduced Art’s feelings of guilt and anxiety, but he wanted to know how and why he made such an illogical interpretation in the first place. Perhaps you’ve also begun to ask yourself—is there a *pattern* inherent in my negative thoughts? Is there some psychic kink that exists on a deeper level of my mind?

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<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. Dr. B said the patient found my comment abrasive. He probably thinks I'm a lousy therapist.	1. Mind reading; mental filter; labeling. → Just because Dr. B pointed out my error it doesn't follow he thinks I'm a "lousy therapist." I'd have to ask him to see what he really thinks, but on many occasions he has praised me and said I had outstanding talent.

**Figure 10–1.**

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Art used the vertical-arrow technique to answer these questions. First, he drew a short downward arrow directly *beneath* his automatic thought (see Figure 10–2, page 265). This downward arrow is a form of shorthand which tells Art to ask himself, “If this automatic thought were actually true, what would it mean to me? Why would it be upsetting to me?” Then Art wrote down the next automatic thought that immediately came to mind. As you can

see, he wrote, "If Dr. B. thinks I'm a lousy therapist, it would mean I was a lousy therapist because Dr. B. is an expert." Next Art drew a second downward arrow beneath this thought and repeated the same process so as to generate yet another automatic thought, as shown in Figure 10-2. Every time he came up with a new automatic thought, he immediately drew a vertical arrow beneath it and asked himself, "If that were true, why would it upset me?" As he did this over and over, he was able to generate a chain of automatic thoughts, which led to the silent assumptions that gave rise to his problems. The downward-arrow method is analogous to peeling successive layers of skin off an onion to expose the ones beneath. It is actually quite simple and straightforward, as you will see in Figure 10-2.

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<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. Dr. B. probably thinks I'm a lousy therapist. ↓ "If he <i>did</i> think this, why would it be upsetting to me?"	→
2. That would mean I was a lousy therapist because he's an expert. ↓ "Suppose I <i>was</i> a lousy therapist, what would this mean to me?"	→
3. That would mean I was a total failure. It would mean I was no good. ↓ "Suppose I <i>was</i> no good. Why would this be a problem? What would it mean to me?"	→
4. Then the word would spread and everyone would find out what a bad person I was. Then no one would respect me. I'd get drummed out of the medical society, and I'd have to move to another state. ↓ "And what would that mean?"	→
5. It would mean I was worthless. I'd feel so miserable I'd want to die.	→

**Figure 10–2.** Exposing the silent assumption(s) that give rise to your automatic thoughts with the use of the vertical-arrow method. The downward arrow is a form of shorthand for the following questions: “If that thought were true, why would it upset me? What would it mean to me?” The question represented by each downward arrow in the example appears in quotation marks next to the arrow. This is what you might ask yourself if you had written down the automatic thought. This process leads to a chain of automatic thoughts that will reveal the root cause of the problem.

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You will notice that the vertical-arrow technique is the *opposite* of the usual strategy you use when recording your automatic thoughts. Ordinarily you substitute a rational response that shows why your automatic thought is *distorted* and *invalid* (Figure 10–1). This helps you change your thinking patterns in the here and now so that you can think about life more objectively and feel better. In the vertical-arrow method you imagine instead that your distorted automatic thought is absolutely valid, and you look for the *grain of truth* in it. This enables you to penetrate the core of your problems.

Now review Art’s chain of automatic thoughts in Figure 10–2 and ask yourself—what are the silent assumptions that predispose him to anxiety, guilt, and depression? There are several:

1. If someone criticizes me, they’re bound to be correct.
2. My worth is determined by my achievement.
3. One mistake and the whole is ruined. If I’m not successful at *all* times, I’m a total zero.
4. Others won’t tolerate my imperfection. I have to be perfect to get people to respect and like me. When I goof up, I’ll encounter fierce disapproval and be punished.
5. This disapproval will mean I am a bad, worthless person.

Once you have generated your own chain of automatic thoughts and clarified your silent assumptions, it is crucial to pinpoint the distortions and substitute rational responses as you usually do (see Figure 10–3, page 268).

The beauty of the downward-arrow method is that it is inductive and Socratic: Through a process of thoughtful questioning, you discover on your

own the beliefs that defeat you. You unearth the origin of your problems by repeating the following questions over and over “If that negative thought were true, what would it mean to me? Why would it upset me?” *Without introducing some therapist’s subjective bias or personal beliefs or theoretical leanings*, you can *objectively* and systematically go right to the root of your problems. This circumvents a difficulty that has plagued the history of psychiatry. Therapists from all schools of thought have been notorious for interpreting patients’ experiences in terms of preconceived notions that may have little or no experimental validation. If you don’t “buy” your therapist’s explanation of the origin of your problems, this is likely to be interpreted as “resistance” to the “truth.” In this subtle way, your troubles get forced into your therapist’s mold regardless of what you say. Imagine the bewildering array of explanations for suffering that you would hear if you went to a religious counselor (spiritual factors), a psychiatrist in a Communist country (the social-political-economic environment), a Freudian analyst (internalized anger), a behavior therapist (a low rate of positive reinforcement), a drug-oriented psychiatrist (genetic factors and brain-chemistry imbalance), a family therapist (disturbed interpersonal relationships), etc.!

A word of caution when you apply the vertical-arrow method. You will short-circuit the process if you write down thoughts that contain descriptions of your emotional reactions. Instead, write down the negative thoughts that *cause* your emotional reactions. Here’s an example of the *wrong* way to do it:

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<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. Dr. B. probably thinks I'm a lousy therapist. ↓ "If he <i>did</i> think this, why would it be upsetting to me?"	1. Just because Dr. B. pointed out my error it doesn't follow he thinks I'm a "lousy therapist." I'd have to ask him to see what he really thinks, but on many occasions he has praised me and said I had outstanding talent.
2. That would mean I was a lousy therapist because he's an expert. ↓ "Suppose I was a lousy therapist, what would this mean to me?"	2. An expert can only point out my specific strengths and weaknesses as a therapist. Any time anyone labels me as "lousy" they are simply making a global, destructive, useless statement. I have had a lot of success with most of my patients, so it <i>can't</i> be true I'm "lousy" no matter who says it.
3. That would mean I was a total failure. It would mean I was no good. ↓ "Suppose I was no good. Why would this be a problem? What would it mean to me?"	3. Overgeneralization. Even if I was relatively unskilled and ineffective as a therapist, it wouldn't mean I was "a total failure" or "no good." I have many other interests, strengths, and desirable qualities that aren't related to my career.
4. Then the word would spread and everyone	4. This is absurd. If I made a mistake, I can correct
would find out what a bad person I was. Then no one would respect me. I'd get drummed out of the medical society, and I'd have to move to another state. ↓ "And what would that mean?"	it. "The word" isn't going to spread around the state like wildfire just because I made an error! What are they going to do, publish a headline in the newspaper: "NOTED PSYCHIATRIST MAKES MISTAKE"?
5. It would mean I was worthless. I'd feel so → miserable I'd want to die.	5. Even if everyone in the world disapproves of me or criticizes me, it can't make me worthless because <i>I'm not worthless</i> . If I'm not worthless, I must be quite worthwhile. So, what is there to feel miserable about?

**Figure 10–3.** After eliciting his chain of automatic thoughts, using the downward-arrow method, Art identified the cognitive distortions and substituted more objective responses.

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First Automatic Thought: My boyfriend didn't call me this weekend as he promised he would.

↓ “Why is that upsetting to me? What does it mean to me?”

Second Automatic Thought: Oh, it's awful and terrible because I can't stand it.

This is useless. We already *know* you feel awful and terrible. The question is—what *thoughts* automatically crossed your mind that *caused* you to feel so upset? What would it mean to you if he *had* neglected you?

Here's the correct way to do it:

1. My boyfriend didn't call me this weekend as he promised he would.

↓ “Why would that be upsetting to me? What does it mean to me?”

2. That means he's neglecting me. That means he really doesn't love me.

↓ “And suppose that were true. What would that mean to me?”

3. That would mean there's something wrong with me. Otherwise he'd be more attentive.

↓ “And suppose that were true. What would that mean to me?”

4. That would mean I was going to be rejected.

- ↓ “And if I were in fact rejected, what then? What would that mean to me?”
- 5. That would mean I was unlovable and I would always be rejected.
  - ↓ “And if that happened, why would it upset me?”
- 6. That would mean I’d end up alone and miserable.

Thus, by pursuing the *meaning* rather than your *feelings*, your silent assumptions became obvious: (1) If I’m not loved I’m not worthwhile; and (2) I’m bound to be miserable if I’m alone.

This is *not* to say your feelings aren’t important. The whole point is to deliver the real McCoy—valid emotional transformation.

*The Dysfunctional Attitude Scale (DAS).* Because of the crucial importance of eliciting the silent assumptions that give rise to your mood swings, a second, simpler method for eliciting them called the “Dysfunctional Attitude Scale” (DAS) has been developed by a member of our group. Dr. Arlene Weissman. She has compiled a list of one hundred self-defeating attitudes that commonly occur in individuals predisposed to emotional disorders. Her research has indicated that while negative automatic thoughts are reduced dramatically between episodes of depression, a self-defeating belief system remains more or less constant during episodes of depression and remission. Dr. Weissman’s studies confirm the concept that your silent assumptions represent a predisposition to emotional turbulence that you carry with you at all times.

Although a complete presentation of the lengthy Dysfunctional Attitude Scale would be beyond the scope of this book, I have selected a number of the more common attitudes and have added several others which will be useful. As you fill out the questionnaire, indicate how much you agree or disagree with each attitude. When you are finished, an answer key will let you score your answers and generate a profile of your personal value systems. This will show your areas of psychological strength and vulnerability.

Answering the test is quite simple. After each of the thirty-five attitudes, put a check in the column that represents your estimate of how you think *most* of the time. Be sure to choose only one answer for each attitude. Because we are all different, there is no “right” or “wrong” answer to any statement. To decide whether a given attitude is typical of your own philosophy, recall how you look at things *most of the time*.

**EXAMPLE:**

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
35. People who have the marks of success (good looks, social status, wealth, or fame) are bound to be happier than those who do not.		✓			

In this example the checkmark in the Agree Slightly column indicates that the statement is somewhat typical of the attitudes of the person completing the inventory. Now go ahead.

The Dysfunctional Attitude Scale\*

	Agree Strongly	Agree Slightly	Neutral	Disagree Slightly	Disagree Very Much
1. Criticism will obviously upset the person who receives the criticism.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
2. It is best to give up my own interests in order to please other people.					
3. I need other people's approval in order to be happy.					
4. If someone important to me expects me to do something, then I really should do it.					
5. My value as a person depends greatly on what others think of me.					
6. I cannot find happiness without being loved by another person.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
7. If others dislike you, you are bound to be less happy.					
8. If people whom I care about reject me, it means there is something wrong with me.					
9. If a person I love does not love me, it means I am unlovable.					
10. Being isolated from others is bound to lead to unhappiness.					
11. If I am to be a worthwhile person, I must be truly outstanding in at least one major respect.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
12. I must be a useful, productive, creative person or life has no purpose.					
13. People who have good ideas are more worthy than those who do not.					
14. If I do not do as well as other people, it means I am inferior.					
15. If I fail at my work, then I am a failure as a person.					
16. If you cannot do something well, there is little point in doing it at all.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
17. It is shameful for a person to display his weaknesses.					
18. A person should try to be the best at everything he undertakes.					
19. I should be upset if I make a mistake.					
20. If I don't set the highest standards for myself, I am likely to end up a second-rate person.					
21. If I strongly believe I deserve something, I have reason to expect that I should get it.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
22. It is necessary to become frustrated if you find obstacles to getting what you want.					
23. If I put other people's needs before my own, they should help me when I need something from them.					
24. If I am a good husband (or wife), then my spouse is bound to love me.					
25. If I do nice things for someone, I can anticipate that they will respect me and treat me just as well as I treat them.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
26. I should assume responsibility for how people feel and behave if they are close to me.					
27. If I criticize the way someone does something and they become angry or depressed, this means I have upset them.					
28. To be a good, worthwhile, moral person, I must try to help everyone who needs it.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
29. If a child is having emotional or behavioral difficulties, this shows that the child's parents have failed in some important respect.					
30. I should be able to please everybody.					
31. I cannot expect to control how I feel when something bad happens.					
32. There is no point in trying to change upsetting emotions because they are a valid and inevitable part of daily living.					

	<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
33. My moods are primarily created by factors that are largely beyond my control, such as the past, or body chemistry, or hormone cycles, or biorhythms, or chance, or fate.					
34. My happiness is largely dependent on what happens to me.					
35. People who have the marks of success (good looks, social status, wealth, or fame) are bound to be happier than those who do not.					

Now that you have completed the DAS, you can score it in the following way. Score your answer to each of the thirty-five attitudes according to this key:

<i>Agree Strongly</i>	<i>Agree Slightly</i>	<i>Neutral</i>	<i>Disagree Slightly</i>	<i>Disagree Very Much</i>
-2	-1	0	+1	+2

Now add up your score on the first five attitudes. These measure your tendency to measure your worth in terms of the opinions of others and the amount of approval or criticism you receive. Suppose your scores on these five items were +2; + 1; - 1; + 2; 0. Then your total score for these five questions would be +4.

Proceed in this way to add up your score for items 1 through 5, 6 through 10, 11 through 15, 16 through 20, 21 through 25, 26 through 30, and 31 through 35, and record these as illustrated in the following example:

#### SCORING EXAMPLE:

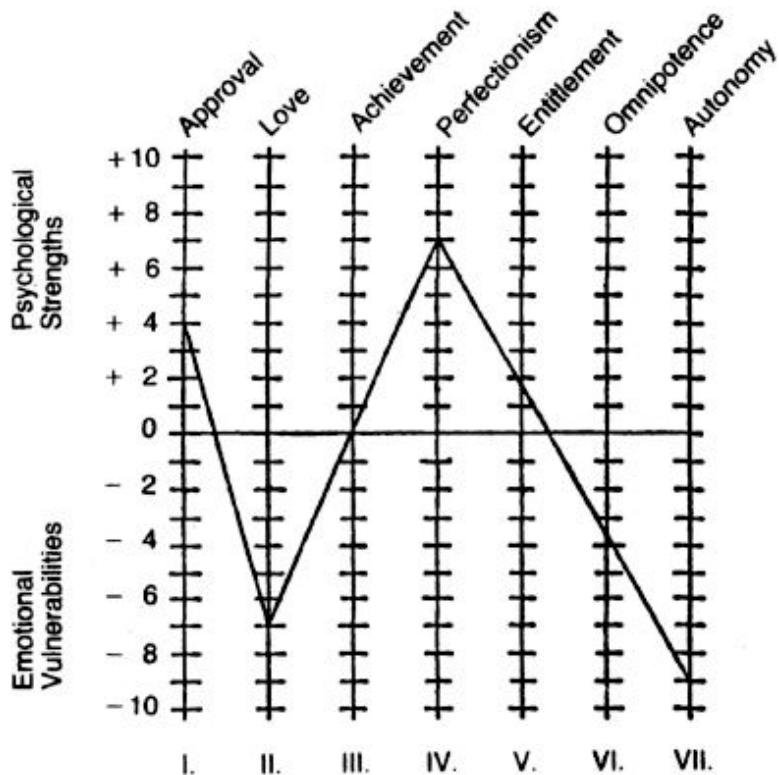
<i>Value System</i>	<i>Attitudes</i>	<i>Individual Scores</i>	<i>Total Scores</i>
I. Approval	1 through 5	+2, +1, -1, +2, 0	+4
II. Love	6 through 10	-2, -1, -2, -2, 0	-7
III. Achievement	11 through 15	+1, +1, 0, 0, -2	0
IV. Perfectionism	16 through 20	+2, +2, +1, +1, +1	+7
V. Entitlement	21 through 25	+1, +1, -1, +1, 0	+2
VI. Omnipotence	26 through 30	-2, -1, 0, -1, +1	-3
VII. Autonomy	31 through 35	-2, -2, -1, -2, -2	-9

RECORD YOUR ACTUAL SCORES HERE:

<i>Value System</i>	<i>Attitudes</i>	<i>Individual Scores</i>	<i>Total Scores</i>
I. Approval	1 through 5		
II. Love	6 through 10		
III. Achievement	11 through 15		
IV. Perfectionism	16 through 20		
V. Entitlement	21 through 25		
VI. Omnipotence	26 through 30		
VII. Autonomy	31 through 35		

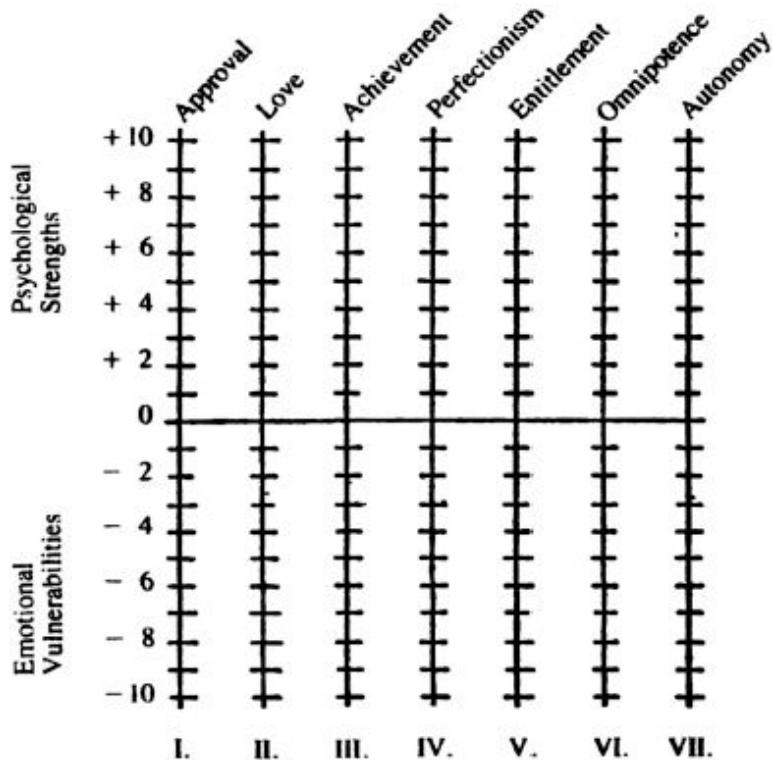
Each cluster of five items from the scale measures one of seven value systems. Your total score for each cluster of five items can range from + 10 to – 10. Now plot your total scores on each of the seven variables so as to develop your “personal-philosophy profile” as follows:

#### SCORING EXAMPLE:



As you can see, a positive score represents an area where you are psychologically *strong*. A negative score represents an area where you're emotionally *vulnerable*.

This individual has strengths in the areas of approval, perfectionism, and entitlement. His vulnerabilities lie in the areas of love, omnipotence, and autonomy. The meanings of these concepts will be described. First, plot your own personal-philosophy profile here.



### Interpreting Your DAS Scores

*I. Approval.* The first five attitudes on the DAS test probe your tendency to measure your self-esteem based on how people react to you and what they think of you. A positive score between zero and ten indicates you are independent, with a healthy sense of your own worth even when confronted with criticism and disapproval. A negative score between zero and minus ten indicates you are excessively dependent because you evaluate yourself through other people's eyes. If someone insults you or puts you down, you automatically tend to look down on yourself. Since your emotional well-being is exquisitely sensitive to what you imagine people think of you, you

can be easily manipulated, and you are vulnerable to anxiety and depression when others criticize you or are angry with you.

*II. Love.* The second five attitudes on the test assess your tendency to base your worth on whether or not you are loved. A positive score indicates you see love as desirable, but you have a wide range of other interests you also find gratifying and fulfilling. Hence, love is not a requirement for your happiness or self-esteem. People are likely to find you attractive because you radiate a healthy sense of self-love and are interested in many aspects of living.

A negative score indicates you are a “love junkie.” You see love as a “need” without which you cannot survive, much less be happy. The closer your score is to minus ten, the more dependent on love you are. You tend to adopt inferior, put-down roles in relationships with people you care about for fear of alienating them. The result of this, more often than not, is that they lose respect for you and consider you a burden because of your attitude that without their love you would collapse. As you sense that people drift away from you, you become gripped by a painful, terrifying withdrawal syndrome. You realize you may not be able to “shoot up” with your daily dose of affection and attention. You then become consumed by the driving compulsion to “get love.” Like most junkies, you may even resort to coercive, manipulative behavior to get your “stuff.” Ironically, your needy, greedy love addiction drives many people away, thus intensifying your loneliness.

*III. Achievement* Your score on attitudes 11 through 15 will help you measure a different type of addiction. A negative score indicates you are a workaholic. You have a constricted sense of your own humanity, and you see yourself as a commodity in the marketplace. The more negative your score, the more your sense of self-worth and your capacity for joy are dependent on your productivity. If you go on vacation, if your business slumps, if you retire or become ill and inactive, you will be in danger of an emotional crash. Economic and emotional depressions will seem identical to you. A positive score, in contrast, indicates that you enjoy creativity and productivity, but do not see them as an exclusive or necessary road to self-esteem and satisfaction.

*IV. Perfectionism.* Items 16 through 20 measure your tendency to perfectionism. A negative score indicates you are hooked on searching for the Holy Grail. You demand perfection in yourself—mistakes are taboo, failure is worse than death, and even negative emotions are a disaster. You’re supposed to look, feel, think, and behave superbly at all times. You sense that being less than spectacular means burning in the flames of hell. Although you drive yourself at an intense pace, your satisfactions are meager. Once you do achieve a goal, another more distant goal instantly replaces it, so you never experience the reward of getting to the top of the mountain. Eventually you begin to wonder why the promised payoff from all your effort never seems to materialize. Your life becomes a joyless, tedious treadmill. You are living with unrealistic, impossible personal standards, and you need to reevaluate them. Your problem does *not* lie in your performance, but in the yardstick you use to measure it. If you bring your expectations in line with reality, you will be regularly *pleased* and *rewarded* instead of *frustrated*.

A positive score suggests you have the capacity to set meaningful, flexible, appropriate standards. You get great satisfaction from processes and experiences, and you are not exclusively fixated on outcomes. You don’t have to be outstanding at everything, and you don’t always have to “try your best.” You don’t fear mistakes, but you see them as golden opportunities to learn and to endorse your humanity. Paradoxically, you are likely to be much more productive than your perfectionistic associates because you do not become compulsively preoccupied with detail and correctness. Your life is like a flowing river or a geyser compared with your rigid perfectionistic friends who appear more like icy glaciers.

*V. Entitlement* Attitudes 21 through 25 measure your sense of “entitlement.” A negative score indicates that you feel “entitled” to things—success, love, happiness, etc. You expect and demand that your wants be met by other people and by the universe at large because of your inherent goodness or hard work. When this does *not* happen—as is often the case—you are locked into one of two reactions. Either you feel depressed and inadequate or you become irate. Thus, you consume enormous amounts of energy being frustrated, sad, and mad. Much of the time you see life as a sour, rotten experience. You complain loudly and often, but you do little to solve problems. After all, you’re *entitled* to have them solved, so why should

you have to put out any effort? As a result of your bitter, demanding attitudes, you invariably get far *less* of what you want from life.

A positive score suggests you don't feel automatically entitled to things, so you *negotiate* for what you want and often get it. Because of your awareness that other people are unique and different, you realize there is no inherent reason why things should always go your way. You experience a negative outcome as a disappointment but not a tragedy because you are a percentage player, and you don't expect perfect reciprocity or "justice" at all times. You are patient and persistent, and you have a high frustration tolerance. As a result, you often end up ahead of the pack.

**VI. Omnipotence.** Attitudes 26 through 30 measure your tendency to see yourself as the center of your personal universe and to hold yourself responsible for much of what goes on around you. A negative score indicates you often make the personalization error discussed in Chapters 3 and 6. You blame yourself inappropriately for the negative actions and attitudes of others who are not really under your control. Consequently, you are plagued by guilt and self-condemnation. Paradoxically, the attitude that you should be omnipotent and all-powerful cripples you and leaves you anxious and ineffectual.

A positive score, in contrast, indicates you know die joy that comes from accepting that you are *not* the center of the universe. Since you are *not* in control of other adults, you are not ultimately responsible for them but only for yourself. This attitude does not isolate you from others. Quite the opposite is true. You relate to people effectively as a friendly collaborator, and you are not threatened when they disagree with your ideas or fail to follow your advice. Because your attitude gives people a sense of freedom and dignity, you paradoxically become a human magnet. Others often want to be close to you because you have relinquished any attempt to control them. People frequently listen to and respect your ideas because you do not polarize them with an angry insistence they *must* agree with you. As you give up your drive for *power*, people repay you by making you a person of *influence*. Your relationships with your children and friends and associates are characterized by mutuality instead of dependency. Because you don't try to dominate people, they admire, love, and respect you.

*VII. Autonomy.* Items 31 through 35 measure your autonomy. This refers to your ability to find happiness within yourself. A positive score indicates that all your moods are ultimately the children of your thoughts and attitudes. You assume responsibility for your feelings because you recognize they are ultimately created by you. This *sounds* as if you might be lonely and isolated because you realize that all meaning and feelings are created only in your head. Paradoxically, however, this vision of autonomy frees you from the petty confines of your mind and delivers the world to you with a full measure of all the satisfaction, mystery, and excitement that it can offer.

A negative score suggests you are still trapped in the belief that-your potential for joy and self-esteem comes from the outside. This puts you at a great disadvantage because everything outside is ultimately beyond your control. Your moods end up the victim of external factors. Do you want this? If not, you can eventually free yourself from this attitude as surely as a snake sheds its skin, but you will have to work at it with the various methods outlined in this book. When it's finally your turn to experience the transformation to autonomy and personal responsibility, you will be amazed—or awestruck—or pleased—or delightfully overwhelmed. It's well worth a major personal commitment.

In the following chapters a number of these attitudes and value systems will be examined in detail. As you study each one, ask yourself: (1) Is it to my advantage to maintain this particular belief? (2) Is this belief really true and valid? (3) What specific steps can I take that will allow me to rid myself of attitudes that are self-defeating and unrealistic, and substitute others that are more objective and more self-enhancing?

## Chapter 11

### The Approval Addiction

Let's consider your belief that it would be *terrible* if someone disapproved of you. Why does disapproval pose such a threat? Perhaps your reasoning goes like this: "If one person disapproves of me, it means that everyone would disapprove of me. It would mean there was something wrong with me."

If these thoughts apply to you, your moods will shoot up every time you are being stroked. You reason, "I got some positive feedback so I can feel good about myself."

Why is this illogical? Because you are overlooking the fact that it is only your thoughts and beliefs which have the power to elevate your spirits. Another person's approval has no ability to affect your mood unless you believe what he or she says is valid. But if you believe the compliment is earned, it is *your belief* which makes you feel good. You must validate external approval before you experience mood elevation. This validation represents your personal self-approval.

Suppose you were visiting the psychiatric ward of a hospital. A confused, hallucinating patient approaches you and says, "You are wonderful. I had a vision from God. He told me the thirteenth person to walk through the door would be the Special Messenger. You are the thirteenth, so I know you are God's Chosen One, the Prince of Peace, the Holy of Holies. Let me kiss your shoe." Would this extreme approval elevate your mood? You'd probably feel nervous and uncomfortable. That's because you don't believe what the patient is saying is valid. You discredit the comments. It is only *your* beliefs about yourself that can affect the way you feel. Others can say or think whatever they want about you, good or bad, but only your thoughts will influence your emotions.

The price you pay for your addiction to praise will be an extreme vulnerability to the opinions of others. Like any addict, you will find you must continue to feed your habit with approval in order to avoid withdrawal

pangs. The moment someone who is important to you expresses disapproval, you will crash painfully, just like the junkie who can no longer get his “stuff.” Others will be able to use this vulnerability to manipulate you. You will have to give in to their demands more often than you want to because you fear they might reject or look down on you. You set yourself up for emotional blackmail.

You may come to see that your addiction to approval is not to your advantage, but still believe that other people *really do* have the right to judge not only the merit of what you do and say but also your worth as a human being. Imagine that you made a second visit to the psychiatric hospital ward. This time a different hallucinating patient approaches you and says, “You’re wearing a red shirt. This shows you are the Devil! You are evil!” Would you feel bad because of this criticism and disapproval? Of course not. Why would these disapproving words not upset you? It’s simple—because you don’t believe the statements are true. You must “buy into” the other person’s criticism—and believe that you are in fact no good—in order to feel bad about yourself.

Did it ever occur to you that if someone disapproves of you, it might be *his* or *her* problem? Disapproval often reflects other people’s irrational beliefs. To take an extreme example. Hitler’s hateful doctrine that Jews were inferior did not reflect anything about the inner worth of the people he intended to destroy.

There will, of course, be many occasions when disapproval will result from an actual error on your part. Does it follow that you are a worthless, no-good person? Obviously not. The other person’s negative reaction can only be directed toward a *specific* thing you did, not at your worth. A human being *cannot* do wrong things *all* the time!

Let’s look at the other side of the coin. Many well-known criminals have had bands of fervent admirers regardless of how repulsive and abhorrent their crimes. Consider Charles Manson. He promoted sadism and murder, yet was regarded as a messiah by his numerous followers, who seemed to do whatever he suggested. I want to make it abundantly clear that I am not advocating atrocious behavior, nor am I an admirer of Charles Manson. But ask yourself these questions: If Charles Manson did not end up totally rejected for what he did or said, what have *you* ever done that was so terrible that you will be rejected by everyone? And do you still believe in the

equation: approval = worth? After all, Charles Manson enjoyed the intense adulation of his “family.” Did the approval he received make him an especially worthy person? This is obvious nonsense.

It’s a fact that approval *feels good*. There’s nothing wrong with that; it’s natural and healthy. It is also a fact that disapproval and rejection usually taste bitter and unpleasant. This is human and understandable. But you are swimming in deep, turbulent waters if you continue to believe that approval and disapproval are the proper and ultimate yardsticks with which to measure your worth.

Did you ever criticize someone? Did you ever disagree with a friend’s opinion? Did you ever scold a child because of his or her behavior? Did you ever snap at a loved one when you were feeling irritable? Did you ever choose not to associate with someone whose behavior was distasteful to you? Then ask yourself—when you disagreed, or criticized, or disapproved—were you making the ultimate moral judgment that the other person was a totally worthless, no-good human being? Do you have the power to make such sweeping judgments about other people? Or were you simply expressing the fact that you held a different point of view and were upset with what the other person did or said?

For example, in the heat of anger you may have blurted out to your spouse, “You’re no damn good!” But when the flame cools down a day or two later, didn’t you admit to yourself that you were exaggerating the extent of his or her “badness”? Sure, your loved one may have many faults, but isn’t it absurd to think your outburst of disapproval or criticism makes him or her totally and forever worthless? If you admit your disapproval does not contain enough moral atomic power to devastate the meaning and value of another person’s life, why give *their* disapproval the power to wipe out *your* sense of self-worth? What makes *them* so special? When you tremble in terror because someone dislikes you, you magnify the wisdom and knowledge that person possesses, and you have simultaneously sold yourself short as being unable to make sound judgments about yourself. Of course, someone might point out a flaw in your behavior or an error in your thinking. I hope they will because you can learn this way. After all, we’re all imperfect, and others have the *right* to tell us about it from time to time. But are you obliged to make yourself miserable and hate yourself every time someone flies off the handle or puts you down?

*The Origin of the Problem.* Where did you get this approval addiction in the first place? We can only speculate that the answer may lie in your interactions with people who were important to you when you were a child. You may have had a parent who was unduly critical when you misbehaved, or who was irritable even at times when you weren't doing anything particularly wrong. Your mother may have snapped, "You're *bad* for doing that!" or your father may have blurted out, "You're *always* goofing up. You'll never learn."

As a small child you probably saw your parents as gods. They taught you how to speak and tie your shoes, and *most* of what they told you was valid. If Daddy said, "You will be killed if you walk out into traffic," this was *literally true*. Like most children, you might have assumed that nearly everything your parents said was true. So when you heard "You're *no good*" and "You'll *never learn*," you literally *believed* it and this hurt badly. You were too young to be able to reason, "Daddy is *exaggerating* and *overgeneralizing*." And you didn't have the emotional maturity to see that Daddy was irritable and tired that day, or perhaps had been drinking and wanted to be left alone. You couldn't determine whether his outburst was *his* problem or yours. And if you were old enough to suggest he was being unreasonable, your attempts to put things into a sane perspective may have been rapidly deprogrammed and discouraged with a swift smack on the behind.

No wonder you developed the bad habit of automatically looking down on yourself every time someone disapproved of you. It wasn't your fault that you picked up this tendency as a child, and you can't be blamed for growing up with this blind spot. But it *is* your responsibility as an adult to think the issue through realistically, and to take specific steps to outgrow this particular vulnerability.

Just how does this fear of disapproval predispose you to anxiety and depression? John is an unmarried, soft-spoken fifty-two-year-old architect who lives in fear of criticism. He was referred for treatment because of a severe recurring depression, which had not diminished in spite of several years of therapy. One day when he was feeling particularly good about himself, he approached his boss enthusiastically with some new ideas about an important project. The boss snapped, "Later, John. *Can't you see I'm busy!*" John's self-esteem collapsed instantly. He dragged himself back to his

office, drowning in despair and self-hatred, telling himself he was no good. “How could I have been so thoughtless?” he asked himself.

As John shared this episode with me, I asked him the simple and obvious questions, “Who was the one who was acting goofy—you or your boss? Were you actually behaving in an inappropriate manner, or was your boss acting irritable and unpleasant?” After a moment’s reflection, he was able to identify the true culprit. The possibility that the boss was acting obnoxiously had not occurred to him because of his automatic habit of blaming himself. He felt relief when he suddenly realized he had absolutely nothing to be ashamed of in how he had acted. His boss, who was aloof, was probably under pressure himself and off the mark that day.

John then raised the question, “Why am I always struggling so hard for approval? Why do I fall apart like this?” He then remembered an event that occurred when he was twelve. His only sibling, a younger brother, had tragically died after a long bout with leukemia. After the funeral he overheard his mother and grandmother talking in the bedroom. His mother was weeping bitterly and said, “Now I’ve got *nothing* to live for.” His grandmother responded, “Shush. Johnny is just down the hall! He might hear you!”

As John shared this with me, he began to weep. He *had* heard these comments, and they meant to him, “This proves I’m not worth much. My brother was the important one. My mother doesn’t really love me.” He never let on that he had been listening, and through the years he tried to push the memory out of his mind by telling himself, “It really isn’t important whether or not she loves me anyway.” But he struggled intensely to please his mother with his achievements and his career in a desperate bid to win her approval. In his heart he didn’t believe he had any true worth, and perceived himself as inferior and unlovable. He tried to compensate for his missing self-esteem by earning other people’s admiration and approval. His life was like a constant effort to inflate a balloon with a hole in it.

After recalling this incident, John was able to see the irrationality of his reaction to the comments he had overheard in the hall. His mother’s bitterness, and the emptiness she felt, were a natural part of the grieving process that any parent goes through when a child dies. Her comments had *nothing to do with John*, but only with her temporary depression and despair.

Putting this memory into a new perspective helped John see how illogical and self-defeating it was to link his worth to the opinions of others. Perhaps

you too are beginning to see that your belief in the importance of external approval is highly unrealistic. Ultimately you, and only you, can make yourself consistently happy. No one else can. Now, let's review some simple steps that you can take to put these principles into practice so you can transform your desire for self-esteem and self-respect into an emotional reality.

## The Path to Independence and Self-Respect

*Cost-Benefit Analysis.* The first step in overcoming your belief in any of the self-defeating assumptions from the DAS test is to perform a cost-benefit analysis. Ask yourself, what are the advantages and disadvantages of telling myself that disapproval makes me less worthwhile? After listing all the ways this attitude hurts you and helps you, you will be in a position to make an enlightened decision to develop a healthier value system.

For example, a thirty-three-year-old married woman named Susan found she was overly involved with church and community activities because she was a responsible and capable worker and was frequently selected for various committees. She felt enormously pleased every time she was chosen for a new job and she feared saying no to any request because that would mean risking someone's disapproval. Because she was terrified about letting people down, she became more and more addicted to the cycle of giving up her own interests and desires in order to please others.

The DAS test and the "Vertical Arrow Technique" described in the previous chapter revealed one of her silent assumptions to be: "I must always do what people expect me to do." She seemed reluctant to give up this belief, so she performed a cost-benefit analysis (Figure 11–1). Because the disadvantages of her approval addiction greatly outweighed the advantages, she became much more open to changing her personal philosophy. Try this simple technique with regard to one of your self-defeating assumptions about disapproval. It can be an important first step to personal growth.

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<i>Advantages of Believing This</i>	<i>Disadvantages of Believing This</i>
1. If I'm able to meet people's expectations, I can feel I'm in control. This feels good.	1. I sometimes compromise and end up doing things that are not in my best interest that I don't really want to do.
2. When I please people I will feel secure and safe.	2. This assumption keeps me from testing relationships—I never know if I could be accepted just for me. Thus, I always have to earn love and the right to be close to people by doing what people want me to do. I become like a slave.
3. I can avoid a lot of guilt and confusion. I don't have to think things out, since all I have to do is what others want me to.	3. It gives people too much power over me—they can coerce me with the threat of disapproval.
4. I don't have to worry about people being upset with me or looking down on me.	4. It makes it hard for me to know what I really want. I'm not used to setting priorities for myself and making independent decisions.
5. I can avoid conflict and I don't have to be assertive and speak up for myself.	5. When people do disapprove of me, as is inevitable at times, then I conclude I've done something to displease them, and I experience severe guilt and depression. This puts my moods under the control of other people instead of myself.
	6. What other people want me to do may not always be what's best for me, since they often have their own interests at heart. Their expectations for me may not always be realistic and valid.
	7. I end up seeing other people as so weak and fragile that they are dependent on me and would be hurt and miserable if I let them down.
	8. Because I fear taking risks and having someone upset with me, my life becomes static. I don't feel motivated to change, to grow or to do things differently so as to enhance my range of experiences.

**Figure 11–1.** The Cost-Benefit Method for Evaluating “Silent Assumptions.” ASSUMPTION: “I must always do what people expect me to do.”

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*Rewrite the Assumption.* If, based on your cost-benefit analysis, you see that your fear of disapproval hurts you more than it helps, the second step is to rewrite your silent assumption so that it becomes more realistic and more self-enhancing (you can do this with any of the 35 attitudes on the DAS test that represent areas of psychological vulnerability for you). In the above example, Susan decided to revise her belief as follows: “It can be enjoyable to have someone approve of me, but I don't need approval in order to be a

worthwhile person or to respect myself. Disapproval can be uncomfortable, but it doesn't mean I'm less of a person."

*The Self-Respect Blueprint.* As a third step it might help you to write a brief essay entitled "Why It Is Irrational and Unnecessary to Live in Fear of Disapproval or Criticism." This can be your personal blueprint for achieving greater self-reliance and autonomy. Prepare a list of all the reasons why disapproval is unpleasant but not fatal. A few have already been mentioned in this chapter, and you might review them before you begin to write. In your essay include only what seems convincing and helpful to you. Make sure you believe each argument you write down so your new sense of independence will be realistic. *Don't rationalize!* For example, the statement, "If someone disapproves of me, I don't need to get upset because they're really not the kind of person I'd care to have as a friend," won't work because it's a distortion. You are trying to preserve your self-esteem by writing the other person off as no good. Stick with what you know to be the truth.

As new ideas come to you, add them to your list. Read it over every morning for several weeks. This might be a first step in helping you trim other people's negative opinions and comments about you down to life-size.

Here are a few ideas that have worked well for a lot of people. You might use some of them in your own essay.

1. Remember that when someone reacts negatively to you, it may be his or her irrational thinking that is at the heart of the disapproval.
2. If the criticism is valid, this need not destroy you. You can pinpoint your error and take steps to correct it. You can *learn* from your mistakes, and you don't have to be ashamed of them. If you are human, then you *should* and *must* make mistakes at times.
3. If you have goofed up, it does not follow that you are a BORN LOSER. It is impossible to be wrong *all* the time or even *most* of the time. Think about the thousands of things you have done *right* in your life! Furthermore, you can change and grow.
4. Other people cannot judge your worth as a human being, only the validity or merit of specific things you do or say.
5. Everyone will judge you differently no matter how well you do or how badly you might behave. Disapproval cannot spread like wildfire, and one rejection cannot lead to a never-ending series of rejections. So

even if worse comes to worst and you do get rejected by someone, you can't end up totally alone.

6. Disapproval and criticism are usually uncomfortable, but the discomfort will pass. Stop moping. Get involved in an activity you've enjoyed in the past even though you feel certain it's absolutely pointless to start.
7. Criticism and disapproval can upset you *only* to the extent that you "buy into" the accusations being brought against you.
8. Disapproval is rarely permanent. It doesn't follow that your relationship with the person who disapproves of you will necessarily end just because you are being criticized. Arguments are a part of living, and in the majority of cases you can come to a common understanding later on.
9. If you are criticizing someone else, it doesn't make that person totally bad. Why give another individual the power and right to judge you? We're all just human beings, not Supreme Court justices. Don't magnify other people until they are larger than life.

Can you come up with some additional ideas? Think about this topic over the next few days. Jot your ideas down on a piece of paper. Develop your own philosophy about disapproval. You'll be surprised to find how much this can help you change your perspective and enhance your sense of independence.

*Verbal Techniques.* In addition to learning to think differently about disapproval, it can be a lot of help to learn to behave differently toward individuals who express disapproval. As a first step, review the assertive methods such as the disarming technique presented in Chapter 6. Now we will discuss some additional approaches to help you build your skills in coping with disapproval.

First of all, if you fear someone's disapproval, have you ever thought of asking the person if he or she, in fact, *does* look down on you? You might be pleasantly surprised to learn that the disapproval existed only in your head. Although it requires some courage, the payoff can be tremendous.

Remember Art, the psychiatrist described in Chapter 6, who was receiving training at the University of Pennsylvania? Art had no suspicion that a particular patient of his might be suicidal. The patient had no history or

symptoms of depression, but felt hopelessly trapped in an intolerable marriage. Art received a call one morning that his patient had been found dead with a bullet hole through his head. Although the suspicion of homicide was raised, the probable cause of death was suicide. Art had never lost a patient in this way. His reaction included sadness, because of his fondness for this particular patient, and anxiety, for fear that his supervisor and peers would disapprove of him and look down on him for his “mistake” and lack of foresight. After discussing the death with his supervisor, he asked frankly, “Do you feel I have let you down?” His supervisor’s response conveyed a sense of warmth and empathy, not rejection. Art was relieved when his supervisor told him that he too had experienced a similar disappointment in the past. He emphasized that this was an opportunity for Art to learn to cope with one of the professional hazards of being a psychiatrist. By discussing the case and refusing to give in to his fear of disapproval, Art learned that he *had* made an “error”—he had overlooked the fact that a feeling of “hopelessness” can lead to suicide in individuals who are not clinically depressed. But he also learned that others did not demand perfection of him, and that he wasn’t expected to guarantee a successful outcome for any patient.

Suppose it had not turned out so well and his supervisor or peers had condemned him for being thoughtless or incompetent. What then? The worst possible outcome would have been rejection. Let’s talk about some strategies for coping with the worst conceivable eventuality.

*Refection Is Never Your Fault!* Aside from bodily injury or a destruction of your assets, the greatest pain a person can try to inflict on you is through rejection. This threat is the source of your fear when you are being “put down.”

There are several types of rejection. The most common and obvious is called “adolescent rejection,” although it is not limited to the adolescent age-group. Suppose you have a romantic interest in someone you are dating or have met, and it turns out you’re not his or her cup of tea. Perhaps it’s your looks, race, religion, or personality style that are the problem. Or maybe you are too tall, short, fat, thin, old, young, smart, dull, aggressive, passive, etc. Since you don’t fit that person’s mental image of an ideal mate closely enough, he or she rebuffs your advances and gives you the cold shoulder.

Is this your fault? Obviously not! The individual is simply turning you down because of subjective preferences and tastes. One person may like apple pie better than cherry pie. Does this mean that cherry pie is inherently undesirable? Romantic interests are almost infinitely variable. If you are one of those toothpaste-commercial types who is blessed with what our culture defines as “good looks” and an appealing personality, it will be much easier for you to attract potential dates and mates. But you will learn this mutual attraction is a far cry from developing a loving permanent relationship, and even the beautiful and handsome types will have to cope with rejection sometimes. No one can turn on each and every person they meet.

If you are only average or below average in appearance and personality, you will have to work harder initially to attract people, and you may have to cope with more frequent turn downs. You will have to develop your social skills and master some powerful secrets of making people feel attracted to you. These are: (1) Don’t sell yourself short by looking down on yourself. Refuse to persecute yourself. Boost your self-esteem to the hilt with the methods outlined in Chapter 4. If you love yourself, people will respond to this sense of joy you radiate and want to be close to you. (2) Express genuine compliments to people. Instead of waiting around nervously to find out if they will like you or reject you, like them first and let them know about it. (3) Show an interest in other people by learning about what turns them on. Get them to talk about what excites them most, and respond to their comments in an upbeat manner.

If you persevere along these lines, you will eventually discover there *are* people who find you attractive, and you in turn will discover you have a great capacity for happiness. Adolescent rejection is an uncomfortable nuisance, but it’s not the end of the world and it’s not your fault.

“Ah ha!” you retort. “But how about the situation where a lot of people reject you because you turn them off with your abrasive mannerisms? Suppose you’re conceited and self-centered. Certainly that’s your fault, isn’t it?” This is a second type of rejection, which I call “angry rejection.” Again, I think you will see that it’s not your fault if you are angrily rejected because of a personal fault.

In the first place, other people aren’t obliged to reject you just because they find things about you they don’t like—they have other options. They can be assertive and point out what they don’t like about your behavior, or they can

learn not to let it bother them so much. Of course, they have the right to avoid and reject you if they want, and they are free to choose any friends they prefer. But this doesn't mean that you are an inherently "bad" human being, and it is definitely not the case that everyone will react to you in the same negative way. You will experience a spontaneous chemistry with some people, whereas you will tend to clash with others. This is no one's fault, it's just a fact of life.

If you have a personality quirk that alienates more people than you would like—such as being excessively critical or losing your temper frequently—it would definitely be to your advantage to modify your style. But it's ridiculous to blame yourself if someone rejects you based on this imperfection. We're all imperfect, and your tendency to fault yourself—or to "buy into" the hostility that someone else directs at you—is self-defeating and pointless.

The third type of rejection is "manipulative rejection." In this case the other person uses the threat of withdrawal or rejection to manipulate you in some way. Unhappy spouses, and even frustrated psychotherapists, sometimes resort to this ploy to coerce you into changing. The formula goes like this: "Either you do such and such or we're all through!" This is a highly irrational and usually self-defeating way of trying to influence people. Such manipulative rejection is simply a culturally taught coping pattern, and it is usually ineffective. It rarely leads to an enhanced relationship because it generates tension and resentment. What it really indicates is a low frustration tolerance and poor interpersonal skills on the part of the individual making the threat. It certainly isn't *your* fault that they do this, and it usually isn't to your advantage to let yourself be manipulated this way.

So much for the theoretical aspects. Now, what can you say and do when you are actually getting rejected? One effective way to learn is to use role-playing. To make the dialogue more entertaining and challenging, I will play the role of the rejector and confront you with the worst things about you I can think of. Since I'm acting caustic and insulting, begin by asking if I am in fact rejecting you because of the way I've been treating you lately:

YOU: Dr. Bums, I notice you've been acting somewhat cool and distant.  
You seem to be avoiding me. When I try to talk to you, you either

ignore me or snap at me. I wonder if you're upset with me or if you've had thoughts of rejecting me.

*Comment:* You don't accuse me initially of rejecting you. That would put me on the defensive. Furthermore, I might *not* be rejecting you—I might be upset about the fact that nobody's buying my book, so I'm just generally irritable. Just for practice, let's assume the worst—that I am trying to dump you.

DAVID: I'm glad we got it out in the open. I have in fact decided to reject you.

YOU: Why? Apparently I've been turning you off a lot.

DAVID: You're a no-good piece of rot.

YOU: I can see you're upset with me. Just what have I been doing wrong?

*Comment:* You avoid defending yourself. Since you know you are not a "piece of rot," there's no point in insisting to me that you're not. It will just fire me up more, and our dialogue will quickly deteriorate into a shouting match. (This "empathy method" was presented in detail in Chapter 6.)

DAVID: Everything about you stinks.

YOU: Can you be specific? Did I forget to use deodorant? Are you upset by the way I talk, something I've said lately, my clothes, or what?

*Comment:* Again, you resist getting sucked into an argument. By urging me to pinpoint what I dislike about you, you are forcing me to fire my best shot and say something meaningful or end up looking like an ass.

DAVID: Well, you hurt my feelings when you put me down the other day.

You don't give a damn about me. I'm just a "thing" to you, not a human being.

*Comment:* This is a common criticism. It tips you off that the rejector basically cares for you, but feels deprived and fears losing you. The rejector decides to lash out at you to protect his shaky self-esteem. The rejector might also say you're too stupid, too fat, too selfish, etc. *Whatever* the nature of the

criticism, your strategy is now twofold: (a) Find some grain of truth in the criticism and let the rejector know you agree in part (see the “disarming technique,” Chapter 6); (b) apologize or offer to try to correct any actual error you actually did make (see “feedback and negotiation,” Chapter 6).

YOU: I’m really sorry I said something that rubbed you the wrong way.  
What was it?

DAVID: You told me I was a no-good jerk. So I’ve had it with you—this is the end.

YOU: I can see that was a thoughtless, hurtful comment I made. What other things have I said that hurt your feelings? Was that all? Or have I done this many times? Go ahead and say all the bad things you think about me.

DAVID: You’re unpredictable. You can be sweet as sugar, and then all of a sudden you’re cutting me to shreds with your sharp tongue. When you get mad, you turn into a foul-mouthed pig. I can’t stand you, and I can’t see how anyone else puts up with you. You’re arrogant and cocky, and don’t give a damn about anyone but yourself. You’re a selfish snot, and it’s time you woke up and learned the hard way. I’m sorry I’ve got to be the one to put you down, but it’s the only way you’re going to learn. You have no real feelings for anyone but yourself, and we’re through for good!

YOU: Well, I can see there are numerous problems in our relationship we’ve never looked at, and it sounds like I’ve really been missing the boat. I can see that I have been acting irritable and thoughtless. I can see how unpleasant I’ve been and how uncomfortable it’s been for you. Tell me more about this side of me.

*Comment:* You then continue to extract negative comments from the rejector. Avoid being defensive and continue to find some grain of truth in what the rejector says. After you have elicited all the criticisms and agreed with whatever was true about them, you are ready to fire the sharpest arrow straight into the rejector’s balloon. Point out that you have acknowledged your imperfections and that you are willing to try to correct your errors. Then ask the rejector why he is rejecting you. This maneuver will help you see why rejection is never your fault! You are responsible for your errors, and you will

assume responsibility for trying to correct them. But if someone rejects you for your imperfections, that's their goofiness, not yours! Here's how this works.

YOU: I can see I've done and said a number of things you don't like. I'm certainly willing to try to correct these problems to the greatest extent possible. I can't promise miracles, but if we work at it together, I see no reason why things can't improve. Just by talking this way, our communications are already better. So why are you going to reject me?

DAVID: Because you infuriate me.

YOU: Well, sometimes differences come up between people, but I don't see that this has to destroy our relationship. Are you rejecting me because you feel infuriated or what?

DAVID: You're a no-good bum, and I refuse to talk to you again.

YOU: I'm sorry you feel that way. I'd much prefer to continue our friendship in spite of these hurt feelings. Do we need to break off entirely? Maybe this discussion was just what we needed to understand each other better. I don't really know why you've decided to reject me. Can you tell me why?

DAVID: Oh, no! I'm not being tricked by you. You goofed up once too often, and that's it! No second chances! Good-bye!

*Comment:* Now whose goofy behavior is this? Yours or the one who is rejecting you? Whose fault is it that the rejection occurs? After all, you offer to try to correct your errors and to improve the relationship through frank communication and compromise. So how can you be blamed for the rejection? Obviously you can't.

Using the above approach may not prevent all actual rejections, but you will enhance the probability of a positive outcome sooner or later.

*Recovering from Disapproval or Rejection.* You actually have been disapproved of or rejected in spite of your efforts to improve the relationship with the other person. How can you most quickly overcome the emotional upset you understandably feel? First, you must realize that life goes on, so this particular disappointment need not impair the quality of your happiness

forever. Following the rejection or disapproval it will be your *thoughts* which are doing the emotional damage, and if you fight these thoughts and stubbornly refuse to give in to distorted self-abuse, the upset will pass.

One method which might be quite helpful is one that has aided people who experience prolonged grief reactions following the loss of a loved one. If bereaved individuals schedule periods each day to allow themselves to be flooded by the painful memories and thoughts of the deceased loved one, this can accelerate and complete the grieving process. If you do this when you are alone, it will be most helpful. Sympathy from another person often backfires; some studies have reported that it prolongs the painful period of mourning.

You can use this “grieving” method to cope with rejection or disapproval. Schedule one or more periods of time each day—five to ten minutes are probably enough—to think all the sad, angry, and despairing thoughts you want. If you feel sad, cry. If you feel mad, pound a pillow. Keep flooding yourself with painful memories and thoughts for the full time period you have set aside. Bitch, moan and complain nonstop! When your scheduled sad period is over, STOP IT and carry on with life until your next scheduled cry session. In the meantime, if you have negative thoughts, write them down, pinpoint the distortions, and substitute rational responses as outlined in previous chapters. You may find this will help you gain partial control over your disappointment and hasten your return to full self-esteem more quickly than you anticipated.

### **Turning on the “Inner Light”**

The key to emotional enlightenment is the knowledge that only your thoughts can affect your moods. If you are an approval addict, you are in the bad habit of flicking your inner switch *only* when someone else shines their light on you first. And you mistakenly confuse their approval with your own self-approval because the two occur almost simultaneously. You mistakenly conclude that the other person has made you feel good! The fact that you do at times enjoy praise and compliments proves that *you know how to approve of yourself!* But if you are an approval addict, you have developed the self-defeating habit of endorsing yourself *only* when someone you respect approves of you first.

Here’s a simple way to break that habit. Obtain the wrist counter described in earlier chapters and wear it for at least two or three weeks. Every day try to

notice positive things about yourself—things you do well whether or not you get an external reward. Each time you do something you approve of, click the counter. For example, if you smile warmly at an associate one morning, click whether he scowls or smiles back. If you make that phone call you were putting off—click the counter! You can “endorse” yourself for big or trivial things. You can even click it if you *remember* positive things you did in the past. For example, you might recall the day you got your driver’s license or your first job. Click the counter whether or not you have a positive emotional arousal. Initially you may have to *force* yourself to notice good things about yourself, and it may seem mechanical. Persist anyway because after several days I think you will notice that the inner light is beginning to glow—dimly at first and then more brightly. Every night look at the digits on the counter and record the total number of personal endorsements on your daily log. After two or three weeks, I suspect you will begin to learn the art of self-respect, and you will feel much better about yourself. This simple procedure can be a big first step toward achieving independence and self-approval. It sounds easy—and it is. It’s surprisingly powerful, and the rewards will be well worth the small amount of time and effort involved.

## Chapter 12

### The Love Addiction

The “silent assumption” which often goes hand in hand with the fear of disapproval is “I cannot be a truly happy and fulfilled human being unless I am loved by a member of the opposite sex. True love is necessary for ultimate happiness.”

The *demand* or *need* for love before you can feel happy is called “dependency.” Dependency means that you are unable to assume responsibility for your emotional life.

*The Disadvantages of Being a Love Junkie.* Is being loved an absolute necessity or a desirable option?

Roberta is a thirty-three-year-old single woman who moped around her apartment evenings and weekends because she told herself, “It’s a couple’s world. Without a man I am nothing.” She came to my office attractively groomed, but her comments were bitter. She was brimming with resentment because she was sure that being loved was as crucial as the oxygen she breathed. However, she was so needy and greedy that this tended to drive people away.

I suggested that she start by preparing a list of the advantages and disadvantages of believing that “without a man (or woman) I am nothing.” The disadvantages on Roberta’s list were clear-cut: “(1) This belief makes me despondent since I have no lover. (2) Furthermore, it takes away any incentive I might have to do things and go places. (3) It makes me feel lazy. (4) It brings on a sense of self-pity. (5) It robs me of self-pride and confidence, and makes me envious of others and bitter. (6) Finally, it brings on self-destructive feelings and a terrible fear of being alone.”

Then she listed what she thought were the advantages of believing that being loved was an absolute necessity for happiness: “(1) This belief will

bring me a companion, love, and security. (2) It will give purpose to my life and a reason to live. (3) It will give me events to look forward to.” These advantages reflected Roberta’s belief that telling herself she couldn’t live without a man would somehow bring a companion into her life.

Were these advantages real or imaginary? Although Roberta had believed for many years that she couldn’t exist without a man, this attitude still hadn’t brought a desirable mate. She admitted that making men so totally important in her life was not the magic charm that would bring one to her doorstep. She acknowledged that clinging and dependent individuals often demand so much attention from other people and appear so needy that they have great difficulty not only initially attracting people of the opposite sex but also maintaining an ongoing relationship. Roberta was able to grasp the idea that people who have found happiness within themselves are usually the most desirable to members of the opposite sex and become like magnets because they are at peace and generate a sense of joy. Ironically, it is usually the dependent woman, the “man-aholic,” who ends up alone.

This really isn’t so surprising. If you take the position you “need” someone else for a sense of worth, you broadcast the following: “Take me! I have no inherent worth! I can’t stand myself!” No wonder there are so few buyers! Of course, your unstated demand does not endear people to you either: “Since you’re *obliged* to love me, you’re rotten shit if you don’t.”

You may cling to your dependency because of the erroneous notion that if you do achieve independence, others will see you as a rejecting person and you will end up alone. If this is your fear, you are equating dependency with warmth. Nothing could be farther from the truth. If you are lonely and dependent, your anger and resentment stem from the fact that you feel deprived of the love you believe you are entitled to receive from others. This attitude drives you farther into isolation. If you are more independent, you are not *obliged* to be alone—you simply have the capacity to feel happy when you are alone. The more independent you are, the more secure you will be in your feelings. Furthermore, your moods will not go up and down at someone else’s mercy. After all, the amount of love that someone can feel for you is often quite unpredictable. They may not appreciate everything about you, and they may not act in an affectionate way all the time. If you are willing to learn to love yourself, you will have a far more dependable and continuous source of self-esteem.

The first step is to find out if you *want* independence. All of us have a much greater chance of achieving our goals if we understand what they are. It helped Roberta to realize that her dependency was condemning her to an empty existence. If you are still clinging to the notion that it is desirable to be “dependent,” list the advantages, using the double-column technique. Spell out how you benefit if you let love determine your personal worth. Then in order to assess the situation objectively, write down the counterarguments, or rational responses, in the right-hand column. You may learn that the advantages of your love addiction are partially or totally illusory. Figure 12–1 shows how a woman with a problem similar to Roberta’s assessed these issues. This written exercise motivated her to look within herself for what she had been seeking in others, and enabled her to see that her dependency was the real enemy because it incapacitated her.

*Perceiving the Difference Between Loneliness and Being Alone.* As you read the previous section you may have concluded that it would be to your advantage if you could learn to regulate your moods and find happiness within yourself. This would give you the capacity to feel as alive when you are alone as when you are with someone you love. But you may be thinking, “That all sounds well and good, Dr. Burns, but it is not realistic. The truth is that it is undeniably emotionally inferior to be alone. All my life I have known that love and happiness are identical, and all my friends agree. You can philosophize until you’re blue in the face. But when it comes down to the bottom line, love is where it’s at and being alone is a curse!”

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<i>Advantages of Being Dependent on Love to Be Happy</i>	<i>Rational Responses</i>
1. Someone will take care of me when I'm hurt.	1. This is also true of independent people. If I am in an auto accident, they will take me to an emergency room. The doctors will care for me whether I am a dependent or independent person. It is nonsense that only dependent people get help when they are hurt.
2. But if I am dependent, I won't have to make decisions.	2. But as a dependent person, I will have much less control over my life. It is unreliable to depend on other people to make decisions for me. For example, do I want someone else to tell me what to wear today or what to eat for dinner? They might not choose the thing that is my first choice.
3. But as an independent person, I might make the wrong decision. Then I'd have to pay the consequences.	3. So pay the consequences—you can learn from your mistakes if you are independent. No one can be perfect, and there are no guarantees of absolute certainty in life. The uncertainty can be part of the spice of life. It's how I cope—not whether I am right all the time—that forms the basis of self-respect. And besides, I will be able to take the credit when things work out well.
4. But if I am a dependent person, I won't have to think. I can just react to things.	4. Independent people can also choose not to think if they want to. There is no rule that says that only dependent people have the right to stop thinking.

5. But if I am dependent, I will be gratified. It will be like eating candy. It feels good to have someone to care for me and to lean on.
5. Candy gets nauseating after a while. The person I choose to depend on may not be willing to love and stroke me, and take care of me forever. He may get tired of it after a while. And if he withdraws from me either through anger or resentment, I will then feel miserable because I'll have nothing else to rely on. They will be able to manipulate me if I am dependent, just like a slave or robot.
6. But if I am a dependent person, I will be loved. Without love I couldn't live.
6. As an independent person, I can learn to love myself and this may make me even more desirable to others, and if I can learn to love myself, I can *always* be loved. My dependency in the past has driven others away from me more frequently than it has attracted people to me. Babies can't survive without love and support, but I won't die without love.
7. But some men are looking for dependent women.
7. There's some truth to this, but relationships which are based on dependency frequently fall apart and culminate in divorce because you are asking the other person to give you something which they are not in the position to give: namely, self-esteem and self-respect. Only I can make myself happy, and if I rely on someone else to do this for me, I am likely to be bitterly disappointed in the end.

**Figure 12–1.** An Analysis of the Presumed “Advantages” of Being a “Love Junkie.”

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In fact, many people are convinced that love makes the world go around. You see this message in ads, you hear it in popular songs, you read it in poems.

You can however convincingly disprove your assumption that love is necessary before you can experience happiness. Let's take a hard look at the equation, alone = lonely.

Consider, first, that we get many of life's basic satisfactions by ourselves. For example, when you climb a mountain, pick a flower, read a book, or eat

a hot fudge sundae, you do not require someone else's company for these experiences to be enjoyable. A physician can enjoy the satisfaction of treating a patient whether or not he and the patient are involved in a meaningful personal relationship. When writing a book, an author is generally by himself or herself. As most students know, you do most of your learning when you are alone. The list of pleasures and satisfactions that you can enjoy when alone is endless.

This indicates that many sources of gratification are accessible to you whether or not you are with someone else. Can you add to that list? What are some pleasures that you can have alone? Do you ever listen to good music on your stereo? Do you enjoy gardening? Jogging? Carpentry? Hiking? A lonely bank teller named Janet, who was recently separated from her husband, enrolled in a creative dancing class and found (to her surprise) that she could derive enormous pleasure from practicing by herself at home. As she became caught up in the rhythm of the movements, she felt at peace with herself in spite of the fact that she had no one to love.

Perhaps you are thinking now, "Oh, Dr. Burns, is that your point? Well, it's *trivial!*.. Of course, I can experience temporary moments of mediocre distraction by doing things when I'm alone. This might take the edge off the blues, but those things are just some crumbs from the table that might keep me from starving totally. I want the banquet, the real thing! Love! True and complete happiness!"

That was exactly what Janet told me before she enrolled in the dancing class. Because she assumed it was miserable to be alone, it hadn't occurred to her to do enjoyable things and care for herself during the separation from her husband. She had been living according to a double standard whereby if she was with her husband, she would go to great lengths to plan pleasurable activities, but when she was alone, she would simply mope and do very little. This pattern obviously functioned as a self-fulfilling prophecy, and she did in fact find it unpleasant to be alone. Why? Simply because she failed to treat herself in a caring way. It had never occurred to her to challenge her lifelong assumption that all her activities would be unsatisfactory unless she had someone to share them with. On another occasion, instead of heating a TV dinner after work, Janet decided to plan a special meal, just as if she were going to entertain a man she cared a lot about. She carefully prepared her dinner and set the table with candles. She

began with a glass of fine wine. After dinner she read a good book and listened to her favorite music. To her amazement, she found the evening a total pleasure. The next day, which was Saturday, Janet decided to go to the art museum alone. She was surprised to discover that she got more enjoyment out of this excursion alone than she had in the past when dragging her reluctant and disinterested husband along.

As a result of adopting an active, compassionate attitude toward herself, Janet discovered for the first time in her life that she could not only make it on her own but could really enjoy herself.

As is so often the case, she began to generate an infectious joy of living that caused many individuals to feel attracted to her, and she began to date. In the meantime her husband began to get disillusioned with his girl friend and wanted his wife back. He noticed Janet was happy as a lark without him, and at this point the tables began to turn. After Janet told him she no longer wanted him back, he suffered a severe depression. She ultimately established a very satisfying relationship with another man and remarried. The key to her success was simple—as a first step, she proved that she could develop a relationship with herself. After this, the rest was easy.

### **The Pleasure-Predicting Method**

I don't expect you to rely on my word on this topic, or even on the reports of others like Janet who have learned how to experience the joys of self-reliance. Instead, I propose you perform a series of experiments, just as Janet did, to test out your belief that "being alone is a curse." If you are willing to do this, you can arrive at the truth in an objective, scientific manner.

To help you, I have developed the "Pleasure-Predicting Sheet" shown in Figure 12-2. This form is divided into a series of columns in which you predict and record the actual amount of satisfaction you derive from various work and recreational activities you engage in when alone, as well as from those you share with other people. In the first column, record the date of each experiment. In the second column, write down several activities that you plan to do as a part of that day's experiments. I suggest that you carry out a series of forty or fifty experiments over a two- to three-week period. Choose activities that would ordinarily give you a sense of accomplishment

or pleasure, or which have the potential for learning or personal growth. In the third column, record who you do the activity with. If you do it alone, write “self” in this column. (This word will remind you that you are never really alone, since you are always with yourself!) In the fourth column, predict the satisfaction you think you will derive from this activity, estimating it on a scale of between 0 and 100 percent. The higher the number, the greater the anticipated satisfaction. Fill in the fourth column *before* you do each planned activity, not after!

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Date	Activity for Satisfaction. (Sense of Achievement or Pleasure)	Who Did You Do This With? (If Alone, Specify Self)	Predicted Satisfaction (0–100%). (Write This Before the Activity)	Actual Satisfaction (0–100%). (Record This After the Activity)
8/18/99	Visit arts and crafts center	self	20%	65%
8/19/99	Go to rock concert	self	15%	75%
8/26/99	Movie	Sharon	85%	80%
8/30/99	Party	Many invited guests	60%	75%
9/2/99	Read novel	self	75%	85%
9/6/99	Jogging	self	60%	80%
9/9/99	Go shopping for blouse at boutique	self	50%	85%
9/10/99	Go to market	mother	40%	30% (argument)
9/10/99	Walk to the park	Sharon	60%	70%
9/14/99	Date	Bill	95%	80%
9/15/99	Study for exam	self	70%	65%
9/16/99	Go for driving test	mother	40%	95% (passed test!)
9/16/99	Ride bicycle to ice cream store	self	80%	95%

**Figure 12–2.** The Pleasure-Predicting Sheet.

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Once you have filled in the columns, proceed with the activities. Once they are completed, record the actual satisfaction in the last column, using the same 0- to 100-percent rating system.

After you have performed a series of such experiments, you will be able to interpret the data you have collected. You can learn many things. First, by comparing the predicted satisfaction (column four) with the actual satisfaction (column five), you will be able to find out how accurate your predictions are. You may find that you typically underestimate the amount of satisfaction you anticipate experiencing, especially when doing things alone. You might also be surprised to learn that activities with others are not always as satisfying as anticipated. In fact, you may even find that there are many times when it was *more* enjoyable to be alone, and you might

discover that the highest ratings you received when you were alone were equal to or higher than those for activities involving others. It can be helpful to compare the amount of satisfaction you derived from work activities versus pleasurable activities. This information can help you achieve an optimal balance between work and fun as you continue to plan your activities.

Questions are probably now crossing your mind, “Suppose I do something and it *isn’t* as satisfying as I predicted? Or suppose I make a low prediction and it really comes out that way?” In this case try to pinpoint the automatic negative thoughts that dampen the experience for you. Then talk back to these thoughts. For example, a lonely sixty-five-year-old woman whose children were all grown and married decided to enroll in an evening course. All the other students were of college freshman age. She felt tense the first week of classes because of her thought, “They probably think I’m an old bag with no right to be here.” When she reminded herself she had no idea what the other students thought of her, she felt some relief. After talking to another student, she found out that some of them admired her gumption. She then felt much better, and her satisfaction levels began to climb.

Now let’s see how the Pleasure-Predicting Sheet can be used to overcome dependency. Joanie was a fifteen-year-old high-school student who had suffered from a chronic depression for several years after her parents moved to a new town. She had difficulty making friends in the new high school, and believed, as many teenage girls do, that she had to have a boyfriend and be a member of the “in crowd” before she could be happy. She spent nearly all her free time at home alone, studying and feeling sorry for herself. She resisted and resented the suggestion she start going out and doing things because she claimed there would simply be no point in doing them alone. Until a circle of friends magically dropped into her lap, she seemed determined to sit and brood.

I persuaded Joanie to use the Pleasure-Predicting Sheet. Figure 12–2 shows that Joanie scheduled a variety of activities, such as visiting an arts and crafts center on a Saturday, going to a rock concert, etc. Because she did them alone, she anticipated they would be unrewarding, as indicated by her low predictions in column four. She was surprised to find she actually did have a reasonably good time. As this pattern tended to repeat itself, she

began to realize that she was predicting things in an unrealistic negative way. As she did more and more on her own, her mood began to improve. She still *wanted* friends, but no longer felt condemned to misery when she was alone. Because she proved she could make it on her own, her self-confidence went up. She then became more assertive with her peers, and invited several people to a party. This helped her develop a network of friends, and she found that boys as well as girls in her high-school class were interested in her. Joanie continued to use the Pleasure-Predicting Sheet to evaluate the levels of satisfaction she experienced in dates and activities with her new friends. She was surprised to find that they were comparable to the enjoyment levels she experienced in doing things alone.

There is a difference between wanting and needing something. Oxygen is a *need*, but love is a *want*. I repeat: LOVE IS NOT AN ADULT HUMAN NEED! It's okay to *want* a loving relationship with another human being. There is nothing wrong with that. It is a delicious pleasure to be involved in a good relationship with someone you love. But you do not *need* that external approval, love, or attention in order to survive *or* to experience maximal levels of happiness.

*Attitude Modification.* Just as love, companionship, and marriage are not necessary for happiness and self-esteem, they are not sufficient either. The proof of this is the millions of men and women who are married and miserable. If love were the antidote to depression, then I would soon be out of business because the vast majority of the suicidal individuals I treat are in fact loved very dearly by their spouses, children, parents, and friends. Love is not an effective antidepressant. Like tranquilizers, alcohol, and sleeping pills, it often makes the symptoms worse.

In addition to restructuring your activities more creatively, challenge the upsetting negative thoughts that flow through your mind when you are alone.

This was helpful to Maria, a lovely thirty-year-old single woman, who found that when she did activities on her own, she sometimes soured the experience unnecessarily by telling herself, “Being alone is a curse.” In order to combat the feelings of self-pity and resentment this thought created, she wrote a list of counterarguments (see Figure 12–3, page 323).

She reported this was very helpful in breaking the cycle of loneliness and depression.

Over a year after terminating my work with her I sent her an early draft of this chapter, and she wrote back: "Last night I read very thoroughly the chapter ... It proves that it is not being alone that is so bad or so good, but rather *how one thinks* regarding that or any other condition of being. *Thoughts* are so powerful! They can make or break you, right? ... It is almost funny, but now I am almost afraid to 'have a man.' I do rather well, maybe better, without one ... Dave, did you ever think you would hear this from me?"

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1. Being alone gives a person the opportunity to explore what she or he really thinks, feels, and knows.
2. Being alone gives the person a chance to try all sorts of new things that might be harder to try if one had ties to a housemate, spouse, etc.
3. Being alone forces you to develop your personal strengths.
4. Being alone enables you to put aside excuses for taking responsibility for yourself.
5. Being a woman alone is better than being a woman with an unsuitable male mate. The same applies to a man.
6. Being a woman alone can be an opportunity to develop into a full human being and not be an appendage to a man.
7. Being a woman alone can be helpful in making you more understanding of the problems women in different situations face. This can help you learn to be more supportive of other women and can enable you to develop more meaningful relationships with them. The same could also apply to men and their understanding of various male problems.
8. Being a woman alone can show a woman that even if she later lived with a man, she need not be constantly afraid of his leaving her or dying. She knows that she can live alone and has the potential for happiness within herself; thus, the relationship can be one of mutual enhancement rather than one of mutual dependency and demandingness.

**Figure 12–3.** "Being alone is a curse." Counterarguments: The advantages of being alone.

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The double-column technique can be especially useful in helping you overcome the negative thinking pattern that makes you fear standing on your own two feet. For example, a divorced woman with one child contemplated suicide because her lover—a married man—had broken off

with her. She had an intensely negative self-image, and didn't believe that she would ever be capable of sustaining an ongoing relationship. She was sure she would always end up a reject and a loner. She wrote in her journal the following thoughts as she contemplated a suicide attempt:

The empty place in the bed next to me silently mocks me. I am alone—alone—my greatest fear, my most dreaded fate, a reality. I am a woman alone and in my mind that means I am nothing. The logic I am operating on goes something like this:

1. If I were desirable and attractive there would be a man beside me now.
2. There is no man beside me.
3. Therefore I am undesirable and unattractive.
4. Therefore there is no point in living.

She went on to ask herself in her journal, “Why do I need a man? A man would solve all my problems. He would take care of me. He would give my life direction and most importantly he would provide me with a reason to get out of bed each morning when all I now want to do is put my head under the covers and sink into oblivion.”

She then utilized the double-column technique as a way of challenging the upsetting thoughts in her mind. She labeled the left-hand column “Accusations of My Dependent Self,” and labeled the right-hand column “Counterarguments of My Independent Self.” She then carried out a dialogue with herself to determine what the truth of the matter really was (see Figure 12–4, page 325).

After doing the written exercise, she decided to read it over each morning in order to develop the motivation to get out of bed. She wrote the following outcome in her personal diary:

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1. I need a man.	1. Why do you need a man?
2. Because I can't cope on my own.	2. Have you been coping so far in life?
3. Okay. But I'm lonely.	3. Yes, but you have a child and you do have friends, and you have enjoyed being with them very much.
4. Yes, but they don't count.	4. They don't count because you dismiss them.
5. But people will think no man wants me.	5. People will think what they want to think. What is important is what you think. Only your thoughts and beliefs can affect your moods.
6. I think I am nothing without a man.	6. What did you accomplish having a man that you couldn't accomplish on your own?
7. Actually nothing. Everything important I've done on my own.	7. Then why do you need a man?
8. I guess I don't need a man. I just want one.	8. It's fine to want things. They just can't become so important that life loses its meaning without them.

**Figure 12–4.**

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I learned to see that there is a big difference between wanting and needing. I want a man but I no longer feel that I must have a man to survive. By maintaining a more realistic inner dialogue with myself and by looking at my own strengths, by listing and reading and reading again the things that I have obtained on my own, I slowly am beginning to develop a sense of confidence in my ability to handle what might come. I find that I am taking better care of myself. I am treating myself as I would have treated a beloved friend in the past with kindness and compassion, with a tolerance for flaws and an appreciation of assets. Now I can view a difficult situation not as a pestilence especially contrived to plague me but as an opportunity to practice the skills I am learning, to challenge my negative thoughts, to reaffirm my strengths and to enhance my confidence in my ability to deal with life.

## Chapter 13

### **Your Work Is Not Your Worth**

A third silent assumption that leads to anxiety and depression is “My worth as a human being is proportional to what I have achieved in my life.” This attitude is at the core of Western culture and the Protestant work ethic. It sounds innocent enough. In fact, it is self-defeating, grossly inaccurate, and malignant.

Ned, the physician described in earlier chapters, called me at home one recent Sunday evening. He had been feeling panicky all weekend. His upset was triggered by plans to attend the twentieth reunion of his college class (he graduated from an Ivy League college). He had been invited to give the keynote address to the alumni. Why was Ned in such a state of apprehension? He was concerned that he might meet up with some classmate at his reunion who had achieved more than he had. He explained why this was so threatening: “It would mean I was a failure.”

Ned’s exaggerated preoccupation with his achievements is particularly common among men. While women are not immune to career concerns, they are more likely to be depressed after the loss of love or approval. Men, in contrast, are especially vulnerable to concerns about career failure because they’ve been programmed from childhood to base their worth on their accomplishments.

The first step in changing any personal value is to determine if it works more to your advantage or disadvantage. Deciding that it will not really help you to measure your worth by what you produce is the crucial first step in changing your philosophy. Let’s begin with a pragmatic approach, a cost-benefit analysis.

Clearly, there *can be* some advantage to equating your self-esteem with your accomplishments. In the first place, you can say “I’m okay” and feel good about yourself when you have achieved something. For example, if you win a golf game, you can pat yourself on the back and feel a little smug and

superior to your partner because he missed his putt on the last hole. When you go jogging with a friend and he runs out of breath before you do, you can puff up with pride and tell yourself, “He’s a good guy for sure, but *I’m just a little better!*” When you make a big sale at work, you can say, “I’m producing today. I’m doing a good job. My boss will be pleased and *I can respect myself.*” Essentially, your work ethic allows you to feel you’ve earned personal worth and the right to feel happy.

This belief system may make you especially motivated to produce. You might put extra effort into your career because you’re convinced this will give you extra worthiness units, and you will therefore see yourself as a more desirable person. You can avoid the horrors of being “just average.” In a nutshell, you may work harder to win, and when you win you may like yourself better.

Let’s look at the other side of the coin. What are the disadvantages of your philosophy of “worth equals achievement”? First, if your business or career is going well, you may become so preoccupied with it that you may inadvertently cut yourself off from other potential sources of satisfaction and enjoyment as you slave away from early morning to late night. As you become more and more of a workaholic, you will feel excessively driven to produce because if you fail to keep up the pace, you will experience a severe withdrawal characterized by inner emptiness and despair. In the absence of achievement, you’ll feel worthless and bored because you’ll have no other basis for self-respect and fulfillment.

Suppose as a result of illness, business reversal, retirement, or some other factor beyond your control, you find you are unable to produce at the same high level for a period of time. Now you may pay the price of a severe depression, triggered by the conviction that because you are less productive it means you are no good. You’ll feel like a tin can that’s been used and is now ready for the trash. Your lack of self-esteem might even culminate in a suicide attempt, the ultimate payment for measuring your worth exclusively by the standards of the marketplace. Do you want this? Do you need this?

There may be other prices to pay. If your family suffers from your neglect, a certain resentment may build up. For a long time they may hold it in, but sooner or later you’ll get the bill. Your wife has been having an affair and is talking about divorce. Your fourteen-year-old son has been arrested for burglary. When you try to talk with him, he snubs you: “Where’ve you been

all these years, Dad?" Even if these unfortunate developments do not happen to you, you will still have one great disadvantage—the lack of true self-esteem.

I have recently begun treating a very successful businessman. He claims to be one of the top money earners in the world in his profession. Yet he is victimized by episodic states of fear and anxiety. What if he should fall off the pinnacle? What if he had to give up his Rolls-Royce Silver Cloud and drive a Chevrolet instead? That would be unbearable! Could he survive? Could he still love himself? He doesn't know if he could find happiness without the glamour or glory. His nerves are constantly on edge because he can't answer these questions. What would *your* answer be? Would you still respect and love yourself if you experienced a substantial failure?

As with any addiction, you find that greater and greater doses of your "upper" will be needed in order to become "high." This tolerance phenomenon occurs with heroin, "speed" (amphetamines), alcohol, and sleeping pills. It also happens with riches, fame, and success. Why? Perhaps because you automatically set your expectations higher and higher once you have achieved a particular level. The excitement quickly wears off. Why doesn't the aura last? Why do you keep needing more and more? The answer is obvious: Success does not guarantee happiness. The two are not identical and are not causally related. So you end up chasing a mirage. Since your *thoughts* are the true key to your moods and not success, the thrill of victory fades quickly. The old achievements soon become old hat—you begin to feel sadly bored and empty as you stare at your trophy case.

If you do not get the message that happiness does not reliably and necessarily follow from success, you may work even harder to try to recapture the feeling you once had from being on top. This is the basis for your addiction to work.

Many individuals seek guidance or therapy because of the disillusionment that begins to dawn on them in their middle or later years. Eventually these questions may confront you as well: What's my life all about? What's the meaning of it all? You may believe your success makes you worthwhile, but the promised payoff seems elusive, just beyond your grasp.

As you read the above paragraphs, you may suspect that the disadvantages of being a success junkie outweigh the advantages. But you may still believe it is basically *true* that people who are superachievers are more worthwhile—

the big shots seem “special” in some way. You may be convinced that true happiness, as well as the respect of others, comes primarily from achievement. But is this really the case?

In the first place, consider the fact that most human beings are not great achievers, yet most people are happy and well respected. In fact, one could say that the majority of the people in the United States are loved and happy, yet by definition most of them are pretty much average. Thus, it *cannot* be the case that happiness and love come only through great achievement. Depression, like the plague, is no respecter of status and strikes those who live in fancy neighborhoods as often—if not more frequently—as it does those of average or below-average means. Clearly, happiness and great achievement have no necessary connection.

## **Does Work = Worth?**

Okay, let’s assume you’ve decided that it’s not to your advantage to link your work and your worth, and you also admit that achievement will not reliably bring you love, respect, or happiness. You may still feel convinced that on *some level*, people who achieve a lot are somehow better than others. Let’s take a hard look at this notion.

First, would you say that everybody who achieves is particularly worthwhile just because of their achievement? Adolf Hitler was clearly a great achiever at the height of his career. Would you say that made him particularly worthwhile? Obviously not. Of course, Hitler would have insisted he was a great human being because he was a successful leader and because he equated his worth and achievements. In fact, he was probably convinced that he and his fellow Nazis were supermen because they were achieving so much. Would you agree with them?

Perhaps you can think of a neighbor or someone you don’t like very much who does achieve a lot and yet seems overly grasping and aggressive. Now, is that person especially worthwhile in your opinion just because he or she is an achiever? In contrast, perhaps you know someone you care for or respect who is not a particularly great achiever. Would you say that person is still worthwhile? If you answer yes, then ask yourself—if they can be worthwhile without great achievement, then why can’t I be?

Here’s a second method. If you insist your worth is determined by your achievement, you are creating a self-esteem equation: worth = achievement.

What is the basis for making this equation? What objective proof do you have that it is valid? Could you experimentally measure people's worth as well as their achievement so as to find out if they were in fact equal? What units would you use to measure it? The whole idea is nonsense.

You can't prove the equation because it is just a stipulation, a *value system*. You're defining worth as achievement and achievement as worth. Why define them as each other? Why not say worth is worth and achievement is achievement? Worth and achievement are different words with different meanings.

In spite of the above arguments, you may still be convinced that people who achieve more are better in some way. If so, I'm going to hit you now with a most powerful method which, like dynamite, can shatter this attitude even when it appears to be etched in granite.

First, I would like you to play the role of Sonia (or Bob), an old friend from high-school days. You have a family and teach school. I have pursued a more ambitious career. In the dialogue you will assume that human worth is determined by achievement, and I will push the implications of this to their obvious, logical, and obnoxious conclusion. Are you ready? I hope so because you're about to be assaulted in a most unpleasant way by a belief you apparently still cherish.

DAVID: Sonia (or Bob), how are you doing?

YOU (playing the role of my old friend): Just fine, David. How are you?

DAVID: Oh, great. I haven't seen you since high school. What's been happening?

YOU: Oh, well, I got married, and I'm teaching at Parks High School and I have a little family at home. Things are great.

DAVID: Well, gee. I'm sorry to hear that. I turned out a lot better than you.

YOU: How's that? Come again?

DAVID: I went to graduate school and I got my Ph.D. and I have become quite successful in business. I'm earning a lot of money. In fact, I'm one of the wealthier people in town now. I've achieved a great deal more than you by a long shot. I don't mean to insult you or anything, but I guess that means I'm a lot better person than you, huh?

YOU: Well, gee, Dave, I'm not sure what to say. I thought I was a rather happy person before I started to talk to you.

DAVID: I can understand that. You're at a loss for words, but you might as well face facts. I've got what it takes, and you don't. I'm *glad* you're happy, though. Mediocre, average people are entitled to a little happiness too. After all, I certainly don't begrudge you a few crumbs from the banquet table. But it's just too bad you couldn't have done more with your life.

YOU: Dave, you seem to have changed. You were such a nice person in high school. I get the feeling you don't like me anymore.

DAVID: Oh, no! we can still be friends as long as you admit you're an inferior, second-rate person. I just want to remind you to look up to me from now on, and I want you to realize that I'll look down on you because I'm more worthwhile. This follows from the assumption that we have—worth equals achievement. Remember that attitude you cherish? I've *achieved* more, so I'm worth more.

YOU: Well, I sure hope I don't run into you soon again, Dave. It's not been such a pleasure talking to you.

That dialogue cools most people off very quickly because it illustrates how the inferior-superior system follows logically from equating your worth with your achievement. Actually, many people do feel inferior. The role-playing can help you see how ludicrous the assumption is. In the above dialogue, who was acting jerky? The happy housewife/schoolteacher or the arrogant businessman trying to make a case that he was better than other people? I hope this imaginary conversation will help you see clearly how screwball the whole system is.

If you like, we can do a role-reversal to put the icing on the cake. This time *you* play the role of the very successful person, and I want you to try to put me down as sadistically as you can. You can pretend to be the editor of *Cosmopolitan* magazine, Helen Gurley Brown.\* I went to high school with you; I'm just an average high-school teacher now, and it's your job to argue that you're better than I am.

YOU (playing the role of Helen Gurley Brown): Dave, how have you been? It's been a long time.

DAVID: (playing the role of a high-school teacher): Well, fine. I have a little family, and I'm teaching high school here. I'm a physical education teacher and really enjoying life. I understand you've made it big.

YOU: Yeah. Well, I really have been kind of lucky. I'm editor of *Cosmopolitan* now. Perhaps you heard.

DAVID: Of course I have. I've seen you on TV on the talk shows plenty of times. I hear you make a huge income, and you even have your own agent.

YOU: Life's been good. Yeah. It's really been terrific.

DAVID: Now there's just one thing I heard about you that I really didn't understand. You were talking to a friend of ours, and you were saying how you're so much better than I am now that you've made it big, whereas my career is just average. What did you mean by that?

YOU: Well, Dave, I mean, just think about all the things I've accomplished in my life. Here I am influencing millions, and whoever heard of Dave Burns in Philadelphia? I'm hobnobbing with the stars, and you're bouncing a basketball around in the court with a bunch of kids. Don't get me wrong. You're certainly a fine, sincere, average person. It's just that you never made it, so you might as well face facts!

DAVID: You've made a great impact, and you're a woman of influence and fame. I respect that a lot, and it sounds quite rewarding and exciting. But please forgive me if I'm dense. I just don't understand how that makes you a better person. How does that make me inferior to you or make you more worthwhile? With my little local mind, I must be missing something obvious.

YOU: Face it, you just sit around and interact with no particular purpose or destiny. I have charisma. I'm a mover and shaker. That gives me a bit of an edge, wouldn't you say?

DAVID: Well, I don't interact to *no* purpose, but my purposes may seem modest in comparison with yours. I teach phys ed, and I coach the local football games and that kind of thing. Your orbit is certainly big and fancy in comparison with mine. But I don't understand how

that makes you a better person than I am, or how it follows that I'm inferior to you.

YOU: I'm just more highly developed and more elaborate. I think about more important things. I go on the lecture circuit, and people flock to hear me by the thousands. Famous authors work for me. Who do you lecture to? The local PTA?

DAVID: Certainly in achievement, money, and influence you're way ahead of me. You've done very well. You were very bright to begin with, and you've worked very hard. You're a big success now. But how does that make you more worthwhile than I am? You must forgive me, but I still don't grasp your logic.

YOU: I'm more *interesting*. It's like an amoeba versus a highly developed biological structure. Amoebas are kind of boring after a while. I mean your life must be like an amoeba's. You're just bumbling around aimlessly. I'm a more interesting, dynamic, desirable person; you're second-rate. You're the burnt toast; I'm the caviar. Your life is a bore. I don't see how I can say it more clearly.

DAVID: My life isn't as boring as you might think. Take a close look at it. I'd be surprised to hear what you have to say here because I can't find *anything* boring about my life. What I do is exciting and vital to me. The people I teach are every bit as important to me as the glamorous movie stars you interact with. But even if it *were* true that my life was more tedious and routine and less interesting than yours, how would that make you a better person or more worthwhile?

YOU: Well, I suppose it just really boils down to the fact that if you have an amoeba existence, then you can only judge it on the basis of your amoeba mentality. I can judge your situation, but you can't judge mine.

DAVID: What is the basis for your judgment? You can call me an amoeba, but I don't know what that means. You seem to be reduced to name-calling. All it means is that apparently my life is not especially interesting to you. Certainly I'm not nearly as successful or glamorous, but how does that make you a better or more worthwhile person?

YOU: I'm almost starting to give up.

DAVID: Don't give up here. Press on. Perhaps you *are* a better person!

YOU: Well, certainly society values me more. That's what makes me better.

DAVID: It makes you more highly valued by society. That's undoubtedly the case. I mean Johnny Carson hasn't contacted me for any appearances recently.

YOU: I've noticed that.

DAVID: But how does being more highly valued by society make you a more worthwhile person?

YOU: I'm earning a huge salary. I'm worth millions. Just how much *are* you worth, Mr. School-teacher?

DAVID: You clearly have more financial worth. But how does that make you a more *worthwhile human being*? How does commercial success make you a better person?

YOU: Dave, if you're not going to worship me, I'm not going to talk to you.

DAVID: Well, I don't see how that would make me less worthwhile either. Unless you have the idea that you're going to go around deciding who's worth-while based on who worships you!

YOU: Of course I do!

DAVID: Does that go along with being editor of *Cosmopolitan*? If so, please tell me how you make these decisions. If I'm not worthwhile, I'd definitely like to know why so that I can give up feeling good and considering myself equal to other people.

YOU: Well, it must be that your orbit is rather small and dreary. While I'm on my Lear jet to Paris, you're in a crowded school bus going to She-boyan.

DAVID: My orbit may be small, but it's very gratifying. I enjoy the teaching. I enjoy the kids. I like to see them develop. I like to see them learn. At times they make mistakes, and I have to let them know. There's a lot of real love and humanity that goes on there. A lot of drama. What about that seems dreary to you?

YOU: Well, there's not as much to learn. No real challenge. It seems to m

that in a world as small as yours you learn just about everything there is to learn, and then you just repeat things over and over.

DAVID: Your work presents quite a challenge as it turns out. How could I know everything there is to know about even one student? They all seem complex and exciting to me. I don't think I have *anybody* figured out completely. Do you? Working with even one student is a complex challenge to *all* my abilities. Having so many young people to work with is a challenge beyond what I could ask for. I don't understand what you mean when you say my world is small and boring and everything is figured out.

YOU: Well, it just seems to me that you are unlikely to run into many people in your world who are going to develop as highly as I have.

DAVID: I don't know. Some of my students have high IQ's and may develop the same way you did, and some of them are mentally subnormal and will only develop to a modest level. Most are average and each one is fascinating to me. What did you mean when you said they were boring? Why is it that only the great achievers are interesting to you?

YOU: I give in! Uncle!

I hope you did in fact "give in" when you played the role of the successful snob. The method I used to thwart your claim you were better than I was quite simple. When-ever you claimed you were a better or more worthy person because of some specific quality such as intelligence, influence, status, or whatever, I immediately *agreed* with you that you are better *in that particular quality* (or set of qualities) and then I asked you—"But how does that make you a better (or more worthwhile) *person*?" This question *can-not be answered*. It will take the wind out of the sails of *any* system of values that sets some people up as being superior to others.

The technical name for this method is "operationalization." In it you must *spell out* just what quality makes anyone more or less worthwhile than anyone else. You can't do it!

Of course, other people would rarely think or say such insulting things to you as were said in the dialogues. The real put-down goes on in your head. You are the one who's telling yourself your lack of status, or achievement, or popularity, or love, etc., makes you less worthwhile and desirable; so you're

the one who's going to have to put an end to the persecution. You can do this in the following way: Carry on a similar dialogue with yourself. Your imaginary opponent, who we'll name the Persecutor, will try to argue that you are inherently inferior or less worthwhile because of some imperfection or lack. You simply assertively agree with the grain of truth in his criticism, but raise the question of how it follows that you are less worthwhile. Here are several examples:

1. Persecutor: You're not a very good lover. Sometimes you don't even get a firm erection. This means you're less of a man and an inferior person.

You: It certainly shows that I'm nervous about sex and not a particularly skilled or confident lover. But how does this make me less of a man or less of a person? Since only a man can feel nervous about an erection, this would seem to be an especially "manly" experience; doing it well makes you more of a man! Furthermore, there's a great deal more to being a man than just having sex.

2. Persecutor: You're not as hardworking or as successful as most of your friends. You're lazy and no good. You: This means I'm less ambitious and hardworking. I may even be less talented, but how does it follow that I'm "lazy and no good"?

3. Persecutor: You're not worth much because you're not outstanding in *anything*.

You: I agree that I don't hold a single world championship. I'm not even second best at anything. In fact, at most things I'm pretty much average. How does it follow that I'm not worth much?

4. Persecutor: You're not popular, you don't even have many close friends, and no one cares about you much. You have no family and not even any casual lovers. So you're a loser. You're an inadequate person. There's obviously something wrong with you. You're worthless.

You: It's true I have no lover at this time, and there are just a few friends I feel close to. How many do I need to be an "adequate person"? Four? Eleven? If I'm not popular, it may be that I'm relatively un-skilled socially, and I may have to work harder at this. But how does it follow that I'm a "loser"? Why am I worthless?

I suggest you try out the method illustrated above. Write down the worst persecutory insults you can level at yourself and then answer them. It may be hard at first, but eventually the truth will dawn on you—you can be imperfect or unsuccessful or unloved by others, but *not* one iota less worth-while.

## Four Paths to Self-Esteem

You might ask, “How *can* I attain self-esteem if my worth doesn’t come from my success or from love or approval? If you peel all these criteria away one by one and expose them as invalid bases for personal worth, it seems there will be nothing left. Just what is it that I have to do?” Here are four valid paths to self-esteem. Choose the one that seems most useful to you.

The first path is both pragmatic and philosophical. Essentially, you must acknowledge that human “worth” is just an abstraction; it doesn’t exist. Hence, there is actually no such thing as human worth. Therefore, you cannot have it or fail to have it, and it cannot be measured. Worth is not a “thing,” it is just a global concept. It is so generalized it has no concrete practical meaning. Nor is it a useful and enhancing concept. It is simply self-defeating. It doesn’t do you any good. It only causes suffering and misery. So rid yourself *immediately* of *any* claim to being “worthy,” and you’ll *never have to measure up* again or fear being “worthless.”

Realize that “worthy” and “worthless” are just empty concepts when applied to a human being. Like the concept of your “true self,” your “personal worth” is just meaningless hot air. Dump your “worth” in the garbage can!(You can put your “true self” in there too, if you like.) You’ll find you’ve got nothing to lose! Then you can focus on living in the here and now instead. What problems do you face in life? How will you deal with them? *That’s* where the action is, not in the elusive mirage of “worth.”

You may be afraid to give up your “self” or your “worth.” What are you afraid of? What terrible thing will happen? Nothing! The following imaginary dialogue may make this clearer. Let’s assume that I am worthless. I want you to rub it in and try to make me feel upset.

YOU: Burns, you’re worthless!

DAVID: Of course I’m worthless. I fully agree. I realize that there is nothing about me that makes me “worthy.” Love, approval, and achievement can’t give me any “worth,” so I’ll accept the fact that

*have none!* Should this be a problem for me? Is something bad going to happen now?

YOU: Well, you must be miserable. You're just "no good."

DAVID: Assuming I am "no good," so what? What specifically do I have to be miserable about? Does being "worthless" put me at a disadvantage in some way?

YOU: Well, how can you respect yourself? How could anyone? You're just a scum!

DAVID: You may think I'm a scum, but I do respect myself, and so do lots of other people. I see no valid reason not to respect myself. *You* may not respect me, but I don't see that as a problem.

YOU: But worthless people *can't* be happy or have any fun. You're supposed to be depressed and despicable. My panel of experts met and determined that you're a total zero.

DAVID: So, call the papers and let them know. I can see the headline: "Philadelphia Physician Found to Be Worthless." If I'm really that bad off, it's reassuring because now I have nothing to lose. I can live my life fearlessly. Furthermore, I *am* happy and I *am* having fun, so being a "total zero" *can't* be bad. My motto is—"Worthless is Wonderful!" In fact, I'm thinking of having a T-shirt made up like that. Perhaps I'm missing out on something, though.

Apparently you're *worthwhile*, whereas I'm not. What good does this "worth" do you? Does it make you better than people like me, or what?

The question may occur to you—"If I gave up my belief that success adds to my personal worth, then what would be the point in doing anything?" If you stay in bed all day, the probability that you will bump into something or someone that will make your day a little brighter is very small. Furthermore, there can be enormous satisfactions from daily living that are totally independent of any concept of personal worth. For example, as I am writing this I feel very turned on, but it isn't due to my belief that I am particularly "worthwhile" because I'm writing it. The exhilaration comes from the creative process, pulling ideas together, editing, watching clumsy sentences sharpen up, and wondering how you will react when you read this. This

process is an exciting adventure. Involvement, commitment, and taking a risk can be quite stimulating. This is an adequate payoff, to my way of thinking.

You might also wonder—"What is the *purpose* and *meaning* of life without a concept of worth?" It's simple. Rather than grasp for "worth," aim for satisfaction, pleasure, learning, mastery, personal growth and communication with others every day of your life. Set realistic goals for yourself and work toward them. I think you will find this so abundantly gratifying you'll forget all about "worth," which in the last analysis has no more buying power than fool's gold.

"But I'm a humanistic or spiritual person," you might argue. "I've always been taught that *all* human beings have worth, and I just don't want to give up this concept." Very well, if you want to look at it that way, I'll agree with you, and this brings us to the second path to self-esteem. Acknowledge that everyone has one "unit of worth" from the time they are born until the time they die. As an infant you may achieve very little, and yet you are still precious and worthwhile. And when you are old or ill, relaxed or asleep, or just doing "nothing," you still have "worth." Your "unit of worth" can't be measured and can *never* change, and it is the same for everyone. During your lifetime, you can enhance your happiness and satisfaction through productive living, or you can act in a destructive manner and make yourself miserable. But your "unit of worth" is always there, along with your potential for self-esteem and joy. Since you can't measure it or change it, there is no point in dealing with it or being concerned about it. Leave that up to God.

Paradoxically, this solution comes down to the same bottom line as the previous solution. It becomes pointless and irresponsible to deal with your "worth," so you might as well focus on living life productively instead! What problems do you confront today? How will you go about solving them? Questions such as these are meaningful and useful, whereas rumination about your personal "worth" just causes you to spin your wheels.

Here is the third path to self-esteem: Recognize that there is only one way you can *lose* a sense of self-worth—by persecuting yourself with unreasonable, illogical negative thoughts. Self-esteem can be defined as the state that exists when you are not arbitrarily haranguing and abusing yourself but choose to fight back against those automatic thoughts with meaningful rational responses. When you do this effectively, you will experience a

natural sense of jubilation and self-endorsement. Essentially, you don't have to get the river flowing, you just have to avoid damming it.

Since only distortion can rob you of self-esteem, this means that nothing in "reality" can take away your sense of worth. As evidence for this, many individuals under conditions of extreme and realistic deprivation do not experience a loss of self-esteem. Indeed, some individuals who were imprisoned by the Nazis during World War II refused to belittle themselves or buy into the persecutions of their captors. They reported an actual enhancement of self-esteem in spite of the miseries they were subjected to, and in some cases described experiences of spiritual awakening.

Here is the fourth solution: Self-esteem can be viewed as your decision to treat yourself like a beloved friend. Imagine that some VIP you respect came unexpectedly to visit you one day. How might you treat that person? You would wear your best clothes and offer your finest wine and food, and you would do everything you could to make him feel comfortable and pleased with his visit. You would be sure to let him know how highly you valued him, and how honored you were that he chose to spend some time with you. Now—why not treat *yourself* like that? Do it *all* the time if you can! After all, in the final analysis, no matter how impressed you are with your favorite VIP, you are more important to you than he is. So why not treat yourself at *least* as well? Would you insult and harangue such a guest with vicious, distorted put-downs? Would you peck away at his weaknesses and imperfections? Then why do this to yourself? Your self-torment becomes pretty silly when you look at it this way.

Do you have to *earn* the right to treat yourself in this loving, caring way? No, this attitude of self-esteem will be an *assertion* that you make, based on a full awareness and acceptance of your strengths and imperfections. You will fully acknowledge your positive attributes without false humility or a sense of superiority, and will freely admit to all your errors and inadequacies without any sense of inferiority or self-depreciation whatever. This attitude embodies the essence of self-love and self-respect. It does not have to be earned, and it *cannot* be earned in any way.

## **Escape from the Achievement Trap**

You might be thinking, "All that philosophizing about achievement and self-worth is well and good. After all, Dr. Bums has a good career and a book

on the market, so it's easy for him to tell *me* to forget about achievement. It sounds about as genuine as a rich man trying to explain to a beggar that money isn't important. The raw fact is, I *still feel bad* about myself when I do poorly, and I believe that life would be a whole lot more exciting and meaningful if I had more success. The truly happy people are the big shots, the executives. I'm only average. I've never done anything really outstanding, so I'm *bound* to be less happy and satisfied. If this isn't right, then prove it to me! Show me what I can do to change the way I feel, and only then will I be a true believer."

Let's review several steps you might take to liberate yourself from the trap of feeling you must perform in an outstanding manner in order to earn your right to feel worthwhile and happy.

*Remember to Talk Back.* The first useful method is to keep practicing the habit of talking back to those negative, distorted thoughts which cause you to feel inadequate. This will help you realize that the problem is not your actual performance, but the critical way in which you put yourself down. As you learn to evaluate what you do realistically, you will experience increased satisfaction and self-acceptance.

Here's how it worked for Len, a young man pursuing a career playing the guitar in rock bands. He sought treatment because he felt like a "second-rate" musician. From the time he was young, he was convinced he had to be a "genius" in order to be appreciated. He was easily hurt by criticism, and often made himself miserable by comparing himself with better-known musicians. He would feel deflated when he told himself, "I'm a nobody in comparison with X." He was certain that his friends and fans also viewed him as a mediocre person, and he concluded that he could never receive his fair share of the good things in life: praise, admiration, love, etc.

Len utilized the double-column technique to expose the nonsense and illogic in what he was saying to himself (Figure 13-1). This helped him to see that it was *not* a lack of musical talent that was the cause of his problems, but his unrealistic thinking patterns. As he began to correct this distorted thinking, his self-confidence improved. He described the effect of this: "Writing down my thoughts and answering them helped me to see how hard I was being on myself, and it gave me a sense there was something I could do

to change. Instead of sitting there getting bombed by what I was telling myself, I suddenly had some antiaircraft artillery to fight back with.”

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<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. If I'm not “the greatest,” it means I won't get any attention from people.	1. (All-or-nothing thinking). Whether or not I'm “the greatest,” people <i>will</i> listen to me, they <i>will</i> see me perform, and many <i>will</i> respond positively to my music.
2. But <i>everybody</i> doesn't like the kind of music I play.	2. This is true of all musicians, even Beethoven or Bob Dylan. No musician can please <i>everybody</i> . Quite a few people do respond to my music. If I enjoy my music, then that should be enough.
3. But how can <i>I</i> enjoy my music if I know I'm not “the greatest”?	3. By playing music that turns me on, just as I <i>always have!</i> Besides, there's no such thing as “the world's greatest musician.” So stop trying to be <i>it</i> !
4. But if I were <i>more</i> famous and talented, then I'd have <i>more</i> fans. How can I be happy on the sidelines when the big-name performers with charisma are in the spotlight?	4. How many fans and how many girl friends do I need before I'll be happy?
5. But I feel that no girl could really love me until I become a big-name talent.	5. Other people are loved who are just “average” in their work. Do I really have to be a big shot before someone will love me? Many of the guys I know get plenty of dates and they're not so unusual.

**Figure 13–1.** Len's homework form for recording and answering his upsetting thoughts about being “the greatest.”

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*Tune In to What Turns You On.* One assumption which might be driving you to constant preoccupation with achievement is the idea that true happiness comes only through success in your career. This is unrealistic because the majority of life's satisfactions do not require great achievement at all. It takes no special talent to enjoy an average walk through the woods on an autumn day. You don't have to be “outstanding” to relish the affectionate hug of your young son. You can enjoy a good game of volley ball tremendously even though you're just an average player. What are some of life's pleasures that have turned you on? Music? Hiking? Swimming? Food?

Travel? Conversation? Reading? Learning? Sports? Sex? You don't have to be famous or a top performer to enjoy these to the hilt. Here's how you can turn up the volume so that this kind of music comes in loud and clear.

Josh is a fifty-eight-year-old man with a history of destructive, manic mood swings as well as incapacitating depressions. When he was a child, Josh's parents emphasized over and over that his career was destined to be extraordinary, so he always felt he had to be number one. He eventually did make an exceptional contribution in his chosen field, electrical engineering. He won numerous awards, was appointed to presidential commissions, and was credited with many patents. However, as his cyclic mood disorder became increasingly severe, Josh began to have "high" episodes. During these periods, his judgment became grossly impaired and his behavior was so bizarre and disruptive that he had to be hospitalized on several occasions. Sadly, he came down off one high to learn he had lost his family as well as his prestigious career. His wife had filed for divorce, and he had been forced into an early retirement by the company he worked for. Twenty years of achievement went down the drain.

In the years that followed, Josh was treated with lithium and developed a modest consulting business. Eventually he was referred to me for treatment because he still experienced uncomfortable mood swings, especially depression, in spite of the lithium.

The crux of his depression was clear-cut. He was discouraged about his life because his career no longer measured up in terms of the money and prestige he had experienced in the past. While he had enjoyed the role of charismatic "charger" as a young man, he was now approaching sixty and felt alone and "over the hill." Because he still believed the only way to true happiness and personal worth was through superlative, creative achievements, he felt certain that his constricted career and modest life-style made him second-rate.

Since he was still a good scientist at heart, Josh decided to test his hypothesis that his life was destined to be mediocre by using the Pleasure-Predicting Sheet (described in previous chapters). Each day he agreed to schedule various activities that might give him a sense of pleasure, satisfaction, or personal growth. These activities could be related to his consulting business as well as hobbies and recreational pursuits. Before each activity he was to write down his prediction of how enjoyable it would be and

mark it between 0 percent (no satisfaction at all) and 99 percent (the maximum enjoyment a human being can experience).

After filling out these forms for several days, Josh was surprised to find that life had just as much potential for joy and satisfaction as it ever had (see Figure 13–2). His discovery that work was at times quite rewarding and that numerous other activities could be just as enjoyable, if not more so, was a revelation to him. He was amazed one Saturday night when he went roller-skating with his girl friend. As they moved to the music, Josh found he began to tune into the beat and the melody, and as he became absorbed in the rhythm, he experienced a great sense of exhilaration. The data he collected on the Pleasure-Predicting Sheet indicated he didn't need a trip to Stockholm to receive the Nobel Prize to experience the ultimate in satisfaction—he didn't have to go any farther than the skating rink! His experiment proved that life was still filled with abundant opportunities for pleasure and fulfillment if he would enlarge his mental focus from a microscopic fixation on work and open himself up to the broad range of rich experiences that living can offer.

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Date	Activity for Pleasure or Satisfaction	Who Did You Do This With? (If Alone, Specify Self)	Predicted Satisfaction (0–100%). (Record This Before the Activity)	Actual Satisfaction (0–100%). (Record This After the Activity)
4/18/99	Work on consulting project	self	70%	75%
4/19/99	Take long walk before breakfast	self	40%	85%
4/19/99	Prepare written report	self	50%	50%
4/19/99	Make a "missionary call" on a potential customer	self	60%	40% (no new business)
4/20/99	Roller-skating	girl friend	50%	99%!

**Figure 13–2.** The Pleasure-Predicting Sheet.

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I am not arguing that success and achievement are undesirable. That would be unrealistic. Being productive and doing well can be enormously satisfying and enjoyable. However, it is neither *necessary* nor *sufficient* to be a great achiever in order to be maximally happy. You don't have to earn love or respect on the treadmill, and you don't have to be number one before you can feel fulfilled and know the meaning of inner peace and self-esteem. Now doesn't that make good sense?

## Chapter 14

### Dare to Be Average: Ways to Overcome Perfectionism

I dare you to try to be “average.” Does the prospect seem blah and boring? Very well—I dare you to try it for just one day. Will you accept the challenge? If you agree, I predict two things will happen. First, you won’t be particularly successful at being “average.” Second, in spite of this you will receive substantial satisfaction from what you do. More than usual. And if you try to keep this “averageness” up, I suspect your satisfaction will magnify and turn to joy. That’s what this chapter is all about—learning to defeat perfectionism and enjoy the spoils of pure joy.

Think of it this way—there are two doors to enlightenment. One is marked “Perfection,” and the other is marked “Average.” The “Perfection” door is ornate, fancy, and seductive. It tempts you. You want very much to go through. The “Average” door seems drab and plain. Ugh! Who wants it?

So you try to go through the “Perfection” door and always discover a brick wall on the other side. As you insist on trying to break through, you only end up with a sore nose and a headache. On the other side of the “Average” door, in contrast, there’s a magic garden. But it may never have occurred to you to open this door to take a look!

You don’t believe me? I didn’t think so, and you don’t have to. I want you to maintain your skepticism! It’s healthy—but at the same time I dare you to check me out. Prove me wrong! Put my claim to the test. Walk through that “Average” door just *one day* in your life. You may end up amazed!

Let me explain why: “Perfection” is man’s ultimate illusion. It simply doesn’t exist in the universe. There is no perfection. It’s really the world’s greatest con game; it promises riches and delivers misery. The harder you strive for perfection, the worse your disappointment will become because it’s only an abstraction, a concept that doesn’t fit reality. Everything can be improved if you look at it closely and critically enough—every person, every

idea, every work of art, every experience, everything. So if you are a perfectionist, you are guaranteed to be a loser in whatever you do.

“Averageness” is another kind of illusion, but it’s a benign deception, a useful construct. It’s like a slot machine that pays a dollar fifty for every dollar you put in. It makes you rich—on all levels.

If you’re willing to explore this bizarre-sounding hypothesis, let’s begin. But beware—don’t let yourself become *too* average because you may not be used to so much euphoria. After all, a lion can eat only so much meat after the kill!

Do you remember Jennifer, the perfectionistic writer-student mentioned in Chapter 4? She complained that friends and psychotherapists kept telling her to stop being such a perfectionist, but no one ever bothered to tell her how to go about doing this. This chapter is dedicated to Jennifer. She’s not the only one who feels in a quandry about this. At my lectures and workshops, psychotherapists have often asked me to prepare a how-to-do-it manual that illustrates the fifteen techniques I have developed for overcoming perfectionism. Well—here’s the manual. These methods work. You have nothing to fear or lose because the effects are not irreversible.

1. The best place to begin your fight against perfectionism is with your motivation for maintaining this approach. Make a list of the advantages and disadvantages of being perfectionistic. You may be surprised to learn that it is not actually to your advantage. Once you understand that it does *not* in fact help you in any way, you’ll be much more likely to give it up.

Jennifer’s list is shown in Figure 14–1. She concluded that her perfectionism was clearly not to her advantage. Now make *your* list. After you have completed it, read on.

2. Using your list of the advantages and disadvantages of perfectionism, you might want to do some experiments to test some of your assumptions about the advantages. Like many people, you may believe “Without my perfectionism I’d be nothing. I couldn’t perform effectively.” I’ll bet you never put this hypothesis to the test because your belief in your inadequacy is such an automatic habit it has never even occurred to you to question it. Did you ever think that maybe you’ve been as successful as you are *in spite of* your perfectionism and not because of it! Here’s an experiment that will allow you to come to the truth of the matter. Try altering your standards in

various activities so you can see how your performance responds to high standards, middle standards, and low standards. The results may surprise you. I've done this with my writing, my psychotherapy with patients, and my jogging. And in all cases I have been pleasantly shocked to discover that by *lowering* my standards not only do I feel better about what I do but I tend to do it more effectively.

For example, I began jogging in January 1979 for the first time in my life. I live in a very hilly region, and initially I couldn't run more than two or three hundred yards without having to stop and walk because there are hills in all directions from my driveway. Each day I made it my aim to run a little less far than the day before. The effect of this was that I could always accomplish my goal easily. Then I would feel so good it would spur me on farther—and every step was gravy, more than I had aimed for. Over a period of months I built up to the point at which I could run seven miles over a steep terrain at a fairly rapid pace. I have never abandoned my basic principles—to try to accomplish less than the day before. Because of this rule I never feel frustrated or disappointed in my running. There have been many days when due to sickness or fatigue, I actually *didn't* run far or fast. Today, for example, I could only run a quarter mile because I had a cold and my lungs said NO FARTHER! So I told myself, "This is as far as I was *supposed* to go." I felt good because I achieved my goal.

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<i>Advantages of Perfectionism</i>	<i>Disadvantages</i>
<p>1. It can produce fine work. I'll try hard to come up with an exceptional result.</p>	<p>1. It makes me so "tight" and nervous I can't produce fine work.</p> <p>2. I become afraid and unwilling to risk the mistakes necessary to come up with a fine product.</p> <p>3. It makes me very critical of myself. I can't enjoy life because I can't admit my successes or allow myself to revel in them.</p> <p>4. I can't ever relax because I'll always be able to find something somewhere that <i>isn't perfect</i>, and then I'll get self-critical.</p> <p>5. Since I can never be perfect, I'll always be depressed.</p> <p>6. It makes me intolerant of others. I end up without many friends because people don't appreciate being criticized. I find so many faults in people I lose my capacity to feel warm and to like them.</p> <p>7. Another disadvantage is that my perfectionism keeps me from trying new things and making discoveries. I'm so afraid of making mistakes that I don't do much at all besides the same familiar things I'm good at. The result is that it narrows my world and makes me bored and restless because I have no new challenges.</p>

**Figure 14–1.** Jennifer's list of advantages and disadvantages of perfectionism. She concluded, "Clearly the disadvantages outweigh the one possible advantage."

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Try this. Choose any activity, and instead of aiming for 100 percent, try for 80 percent, 60 percent, or 40 percent. Then see how much you enjoy the activity and how productive you become. Dare to aim at being average! It takes courage, but you may amaze yourself!

3. If you are a compulsive perfectionist you may believe that without aiming for perfection you couldn't enjoy life to the maximum or find true happiness. You can put this notion to the test by using the Antiperfectionism

Sheet (Figure 14–2). Record the actual amount of satisfaction you get from a wide range of activities, such as brushing your teeth, eating an apple, walking in the woods, mowing the lawn, sunbathing, writing a report for work, etc. Now estimate how *perfectly* you did each activity between 0 and 100 percent, as well as marking how *satisfying* each was between 0 and 100 percent. This will help you break the illusory connection between perfection and satisfaction.

Here's how it works. In Chapter 4 I referred to a physician who was convinced he had to be perfect at all times. No matter how much he accomplished he would always raise his standards slightly higher, and then he'd feel miserable. I told him he was the Philadelphia all-or-nothing thinking champion! He agreed but protested he didn't know how to change. I persuaded him to do some research on his moods and accomplishments, using the Antiperfectionism Sheet. One weekend he did some plumbing at home because a pipe broke and flooded the kitchen. He was a novice plumber, but did manage to fix the leak and clean up the mess. On the sheet he recorded this as 99 percent satisfaction (see Figure 14–2). Since it was the first time he'd ever tried to fix a pipe, he recorded his expertise as only 20 percent. He got the job done, but it was time-consuming and required considerable guidance from a neighbor. In contrast, he received low degrees of satisfaction from some activities he did an outstanding job on.

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Activity	Record How Effectively You Did This Between 0% and 100%	Record How Satisfying This Was Between 0% and 100%
Fix broken pipe in kitchen	20% (I took a long time and made a lot of mistakes.)	99% (I actually did it!)
Give lecture to medical school class	98% (I got a standing ovation.)	50% (I usually get a standing ovation. I wasn't particularly thrilled with my performance.)
Play tennis after work	60% (I lost the match but played okay.)	95% (Really felt good. Enjoyed the game and the exercise.)
Edit draft of my latest paper for one hour	75% (I stuck with it and corrected many errors, and smoothed out the sentences.)	15% (I kept telling myself it wasn't <i>the definitive paper</i> and felt quite frustrated.)
Talk to student about his career options	50% (I didn't do anything special. I just listened to him and offered a few obvious suggestions.)	90% (He really seemed to appreciate our talk, so I felt turned on.)

**Figure 14–2.** The Antiperfectionism Sheet.

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This experience with the Antiperfectionism Sheet persuaded him that he did not have to be perfect at something to enjoy it, and, furthermore, that striving for perfection and performing exceptionally did not guarantee happiness, but indeed tended to be associated more frequently with less satisfaction. He concluded he could either give up his compulsive drive for perfection and settle for joyous living and high productivity, or make his happiness of secondary importance and constantly push for greatness, and settle for emotional anguish and modest productivity. Which would you choose? Try out the Antiperfectionism Sheet and put yourself to the test.

4. Let's assume that you've decided to give up your perfectionism at least on a trial basis just to see what happens. However, you have the lingering notion that you *really could* be perfect in at least some areas if you tried hard enough, and that when you achieve this, something magical will happen. Let's take a hard look at whether this goal is realistic. Does a model of

perfection *ever* really fit reality? Is there *anything* you have personally encountered that is so perfect it could not be improved?

To test this, look around you *right now* and see how things could be improved. For example, take someone's clothing, a flower arrangement, the color and clarity of a television picture, the quality of a singer's voice, the effectiveness of this chapter, *anything* at all. I believe you can *always* find some way in which something could be improved. When I first did this exercise, I was riding on a train. Most things, such as the dirty, rusty old tracks, were so obviously imperfect I could easily find many ways to improve them. Then I came to a problem area. A young black man had his hair in one of those fuzzy naturals. It looked perfectly smooth and sculptured, and I couldn't think of any way it could possibly be improved. I began to panic and saw my whole antiperfectionist philosophy going down the drain! Then I suddenly noticed some spots of gray on his head. I felt instant relief! His hair was imperfect after all! As I looked more closely, I noticed a few hairs that were too long and out of place. The closer I examined the young man, the more uneven hairs I could see—hundreds in fact! This helped convince me that any standard of perfection just doesn't fit reality. So why not give it up? You are guaranteed to be a sure loser if you maintain a standard for evaluating your performance that you can't *ever* meet. Why persecute yourself any longer?

5. Another method for overcoming perfectionism involves a confrontation with fear. You may not be aware that fear always lurks behind perfectionism. Fear is the fuel that drives your compulsion to polish things to the ultimate. If you choose to give up your perfectionism, you may initially have to confront this fear. Are you willing? There is, after all, a payoff in perfectionism—it protects you. It may protect you from risking criticism, failure, or disapproval. If you decide to start doing things less perfectly, at first you may feel as shaky as if a big California earthquake were about to hit.

If you don't appreciate the powerful role that fear plays in maintaining perfectionistic habits, the exacting behavior patterns of perfectionistic people can seem incomprehensible or infuriating. There is, for example, a bizarre illness known as "compulsive slowness," in which the victim becomes so totally bound up with getting things "just right" that simple everyday tasks can become totally consuming. An attorney with this brutal disorder became

preoccupied with how his hair looked. For hours each day he would stand before a mirror with a comb and scissors trying to make adjustments. He became so involved in this, he had to cut back on his legal practice so he could have more and more time to work on his hair. Each day his hair got shorter and shorter because of all his furious clipping. Eventually it was only an eighth of an inch long all over his head. Then he became preoccupied with balancing the hairline along his forehead, and started shaving it to get it “just right.” Each day the hairline receded farther and farther until eventually he had shaved his head totally bald! Then he felt a sense of relief and let it all grow back again, hoping it would come in “even.” After the hair grew back, he would start clipping it again, and the whole cycle would be repeated. This ludicrous routine went on for years and left him a substantially disabled person.

His case may seem extreme but cannot be considered severe. Far worse forms of the disorder exist. Although the victims’ strange habits may seem absurd, the effects are tragic. Like alcoholics, these individuals may sacrifice career and family to their miserable compulsions. You too may be paying heavily for your perfectionism.

What motivates these exacting, overcontrolled individuals? Are they insane? Usually not. What traps them in the senseless drive for perfection is fear. The moment they try to *stop* what they are doing, they are gripped by a powerful uneasiness that rapidly escalates to raw terror. This drives them back to their compulsive ritual in a pathetic attempt to find relief. Getting them to give up their perfectionistic malignancy is like trying to persuade a man hanging by his fingers from the edge of a cliff to let go.

You may have noticed compulsive tendencies in yourself to a much less severe degree. Have you ever pushed relentlessly to look for an important item like a pencil or a key you misplaced when you knew it was best to forget about it and wait for it to show up? You do this because it’s *tough to stop*. The moment you try, you become uneasy and nervous. You feel somehow “not right” without the lost item, as if the whole meaning of your life were in the balance!

One method of confronting and conquering this fear is called “response prevention.” The basic principle is simple and obvious. You *refuse* to give in to the perfectionistic habit, and you allow yourself to become flooded with fear and discomfort. Stubbornly stick it out and do not give in no matter how

upset you become. Hang in there and allow your upset to reach its maximum. After a period of time the compulsion will begin to diminish until it disappears completely. At this point—which might require as much as several hours or as little as ten to fifteen minutes—you have won! You've defeated your compulsive habit.

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Time	Percent of Anxiety or Uneasiness	Automatic Thoughts
4:00	80%	What if someone steals the car?
4:02	95%	This is ridiculous. Why not just go and make sure the car is okay?
4:04	95%	Someone may be in it right now. I can't stand this!
4:06	80%	
4:08	70%	
4:10	50%	
4:12	20%	This is boring. The car will probably be okay.
4:14	5%	
4:16	0%	Hey—I did it!

**Figure 14–3.** The Response-Prevention Form. Record the degree of anxiety and any automatic thoughts every one or two minutes until you feel completely relaxed. The following experiment was performed by someone who wanted to end a bad habit of compulsively checking door locks.

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Let's take a simple example. Suppose you are in the habit of double-checking the house or car locks several times. Certainly it's okay to check things *once*, but more often than that is redundant and pointless. Drive your car to a parking lot, lock the doors, and walk away. Now—refuse to check them! You will feel uneasy. You'll try to persuade yourself to go back and “just make sure.” DON’T. Instead, record your degree of anxiety every minute on the “Response-Prevention Form” (see Figure 14–3) until the anxiety has vanished. At this point, you win. Often, one such exposure is sufficient to break a habit permanently, or you may need numerous exposures as well as a booster shot from time to time. Many bad habits lend themselves

to this format, including various “checking rituals” (checking to see if the stove is turned off or if the mail has fallen into the mailbox, etc.), cleaning rituals (compulsive handwashing or excessive housecleaning), and others. If you are ready and willing to break free of these tendencies, I think you’ll find the response-prevention technique quite helpful.

6. You may be asking yourself about the origin of the crazy fear that drives you to compulsive perfectionizing. You can use the vertical-arrow method described in Chapter 10 to expose the silent assumption that causes your rigid, tense approach to living. Fred is a college student who was so preoccupied with getting a term paper “just right” that he dropped out of college to work on it for an entire year to avoid the horrors of turning in a product he wasn’t entirely satisfied with. Fred finally enrolled in college again when he felt ready to turn the paper in, but sought treatment for his perfectionism because he realized it might take too long to complete college this way!

He had his confrontation with fear when he was required to turn in another term paper at the end of his first semester back in school. This time the professor gave him the ultimatum of either turning it in by six P.M. on the due date, or getting docked one full grade for every day it was late. Since Fred had an adequate draft of the paper, he realized it wouldn’t be wise for him to try to polish it and revise it, so he reluctantly turned it in at 4:55, knowing that there were a number of uncorrected typographical errors as well as some sections he wasn’t entirely satisfied with. The moment he turned it in, his anxiety began to mount. Minute by minute it increased, and soon Fred was gripped by such a severe panic attack that he called me at home late in the evening. He was convinced that something terrible was about to happen to him because he had turned in an imperfect paper.

I suggested he use the vertical-arrow method to pinpoint just what he was so afraid of. His first automatic thought was, “I didn’t do an excellent job on the paper.” He wrote this down (see Figure 14–4, page 363), and then asked himself, “If that were true, why would it be a problem for me?” This question generated the upsetting thought lurking behind it, as demonstrated in Figure 14–4. Fred wrote down the next thought that came to mind, and continued to use the downward-arrow technique to reveal his fears at a deeper and deeper level. He continued peeling the layers off the onion in this way until the

deepest origin of his panic and perfectionism was uncovered. This required only a few minutes. His silent assumption then became obvious: (1) One mistake and my career will be ruined. (2) Others demand perfection and success from me, and will ostracize me if I fall short.

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<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. I didn't do an excellent job on the paper. ↓ "If that were true, why would it be a problem for me?"	1. All-or-nothing thinking. The paper is pretty good even though it's not perfect.
2. The professor will notice all the typos and the weak sections. ↓ "And why would that be a problem?"	2. Mental filter. He probably will notice typos, but he'll read the whole paper. There are some fairly good sections.
3. He'll feel that I didn't care about it. ↓ "Suppose he does. What then?"	3. Mind reading. I don't know that he will think this. If he <i>did</i> , it wouldn't be the end of the world. A lot of students don't care about their papers. Besides I <i>do</i> care about it, so if he thought this he'd be wrong.
4. I'll be letting him down. ↓ "If that were true and he did feel that way, why would it be upsetting to me?"	4. All-or-nothing thinking; fortune teller error. I can't please everyone all the time. He's liked most of my work. If he does feel disappointed in this paper he can survive.
5. I'll get a D or an F on the paper. ↓ "Suppose I did—what then?"	5. Emotional reasoning; fortune teller error. I <i>feel</i> this way because I'm upset. But I can't predict the future. I might get a B or a C, but a D or an F isn't very likely.

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| <p>6. That would ruin my academic record.<br/>       ↓ "And then what would happen?"</p> <p>7. That would mean I wasn't the kind of student I was supposed to be.<br/>       ↓ "Why would that be upsetting to me?"</p> <p>8. People will be angry with me. I'll be a failure.<br/>       ↓ "And suppose they <i>were</i> angry and I was a failure? Why would that be so terrible?"</p> <p>9. Then I would be ostracized and alone.<br/>       ↓ "And then what?"</p> <p>10. If I'm alone, I'm bound to be miserable.</p> | <p>6. All-or-nothing thinking; fortune teller error. Other people goof up at times, and it doesn't seem to ruin their lives. Why can't I goof up at times?</p> <p>7. Should statement. Who ever laid down the rule I was "supposed" to be a certain way at all times? Who said I was predestined and morally obliged to live up to some particular standard?</p> <p>8. The fortune teller error. If someone is angry with me, it's their problem. I can't be pleasing people all the time—it's too exhausting. It makes my life a tense, constricted, rigid mess. Maybe I'd do better to set my own standards and risk someone's anger. If I fail at the paper, it certainly doesn't make me "A FAILURE."</p> <p>9. The fortune teller error. <i>Everyone</i> won't ostracize me!</p> <p>10. Disqualifying positive data. Some of my happiest times have been when I'm alone. My "misery" has nothing to do with being alone, but comes from the fear of disapproval and from persecuting myself for not living up to perfectionistic standards.</p> |
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**Figure 14–4.** Fred used the vertical-arrow method to uncover the origin of his fears about turning in an "imperfect" paper for a class. This helped relieve some of the terror he was experiencing. The question next to each vertical arrow represents what Fred asked himself in order to uncover the next automatic thought at a deeper level. By unpeeling the onion in this way, he was able to expose the silent assumptions which represented the origin and root of his perfectionism (see text).

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Once he wrote down his upsetting automatic thoughts, he was in a position to pinpoint his thinking errors. Three distortions appeared most often—all-or-nothing thinking, mind reading, and the fortune teller error. These distortions had trapped him in a rigid, coercive, perfectionistic, approval-seeking

approach to life. Substituting rational responses helped him recognize how unrealistic his fears were and took the edge off his panic.

Fred was skeptical, however, because he wasn't entirely convinced a catastrophe was not about to strike. He needed some actual evidence to be convinced. Since he'd been keeping the elephants away by blowing the trumpet all his life, he couldn't be *absolutely* sure a stampede wouldn't occur once he decided to set the trumpet down.

Two days later Fred got the needed evidence: He picked up his paper, and there was an A – at the top. The typographical errors had been corrected by the professor, who wrote a thoughtful note at the end that contained substantial praise along with some helpful suggestions.

If you are going to let go of your perfectionism, then you may also have to expose yourself to a certain amount of initial unpleasantness just as Fred did. This can be your golden opportunity to learn about the origin of your fears, using the vertical-arrow technique. Rather than run from your fear, sit still and *confront* the bogeyman! Ask yourself, "What am I afraid of?" "What's the worst that could happen?" Then write down your automatic thoughts as Fred did, and call their bluff. It *will* be frightening, but if you tough it out and endure the discomfort, you will conquer your fears because they are ultimately based on illusions. The exhilaration you experience when you make this transformation from worrier to warrior can be the start of a more confident assertive approach to living.

The thought may have occurred to you—but suppose Fred *did* end up with a B, C, D, or an F? What then? In reality, this *usually* doesn't happen because in your perfectionism, you are in the habit of leaving yourself such an excessively wide margin of safety that you can usually relax your efforts considerably without a measurable reduction in the quality of the actual performance. However, failures *can* and *do* occur in life, and none of us is totally immune. It can be useful to prepare ahead of time for this possibility so that you can benefit from the experience. You can do this if you set things up in a "can't lose" fashion.

How can you benefit from an actual failure? It's simple! You remind yourself that your life won't be destroyed. Getting a B, in fact, is one of the best things that can happen to you if you are a straight A student because it will force you to confront and accept your humanness. This will lead to personal growth. The real tragedy occurs when a student is so bright and

compulsive that he or she successfully wards off any chance of failure through overwhelming personal effort, and ends up graduating with a perfect straight A average. The paradox in this situation is that success has a dangerous effect of turning these students into cripples or slaves whose lives become obsessively rigid attempts to ward off the fear of being less than perfect. Their careers are rich in achievement but frequently impoverished in joy.

7. Another method for overcoming perfectionism involves developing a process orientation. This means you focus on processes rather than outcomes as a basis for evaluating things. When I first opened my practice, I had the feeling I had to do outstanding work with each patient every session. I thought my patients and peers expected this of me, and so I worked my tail off all day long. When a patient indicated he benefited from a session, I'd tell myself I was successful and I'd feel on top of the world. In contrast, when a patient gave me the runaround or responded negatively to that day's session, I'd feel miserable and tell myself I had failed.

I got tired of the roller-coaster effect and reviewed the problem with my colleague, Dr. Beck. His comments were extremely helpful, so I'll pass them on to you. He suggested I imagine I had a job driving a car to City Hall each day. Some days I'd hit mostly green lights and I'd make fast time. Other days I'd hit a lot of red lights and traffic jams, and the trip would take much longer. My driving skill would be the same each day, so why not feel equally satisfied with the job I did?

He proposed I could facilitate this new way of looking at things by refusing to try to do an excellent job with any patient. Instead, I could aim for a good, consistent effort at each session regardless of how the patient responded, and in this way I could guarantee 100 percent success forever.

How could you set up process goals as a student? You could make it your aim to (1) attend lectures; (2) pay attention and take notes; (3) ask appropriate questions; (4) study each course between classes a certain amount each day; (5) review class study notes every two or three weeks. All these processes are within your control, so you can *guarantee* success. In contrast, your final grade is not under your control. It depends on how the professor feels that day, how well the other students did, where he sets the curve, etc.

How could you set up process goals if you were applying for a job? You could (1) dress in a confident, appealing manner; (2) have your résumé edited by a knowledgeable friend and typed professionally; (3) give the prospective employer one or more compliments during the interview; (4) express an interest in the company and encourage the interviewer to talk about himself; (5) when the prospective employer tells you about his work, say something positive, using an upbeat approach; (6) if the interviewer makes a critical or negative comment about you, immediately *agree*, using the disarming technique introduced in Chapter 6.

For example, in my negotiations with a prospective publisher about this book, I noticed the editor expressed a number of negative reactions in addition to a few positive ones. I found the use of the disarming technique worked extremely well in keeping the waters flowing nonturbulently during potentially difficult discussions. For example,

EDITOR One of my concerns, Dr. Burns, involves the emphasis on symptomatic improvement in the here and now. Aren't you overlooking the causes and origins of depressions?

(In the first draft of this book, I had written several chapters on the silent assumptions that give rise to depression, but apparently the editor was not adequately impressed with this material or had not read it. I had the option of counterattacking in a defensive manner—which would have only polarized the editor and made her feel defensive. Instead, I chose to disarm her in the following way.)

DAVID: That's an excellent suggestion, and you're absolutely right. I can see you've been doing your homework on the manuscript, and appreciate hearing about your ideas. The readers obviously would want to learn more about *why* they get depressed. This might help them avoid future depressions. What would you think about expanding the section on silent assumptions and introducing it with a new chapter we could call "Getting Down to Root Causes"?

EDITOR: That sounds great!

DAVID: What other negative reactions do you have to the book? I'd like to

learn as much as I can from you.

I then continued to find a way to *agree* with each criticism and to praise Editor X for each and every suggestion. This was not insincere because I was a greenhorn in popular writing, and Editor X was a very talented, well-established individual who was in a position to give me some much-needed guidance. My negotiating style made it clear to her that I respected her, and let her know that we would be able to have a productive working relationship.

Suppose instead that I had been fixed on the *outcome* rather than on the negotiating process when the editor interviewed me. I would have been tense and preoccupied with only one thing—would she or would she not make an offer for the book? Then I would have seen her every criticism as a danger, and the whole interpersonal process would have fallen into unpleasant focus.

Thus, when you are applying for work, do *not* make it your aim to *get* the job! Especially if you *want* the job! The outcome depends on numerous factors that are ultimately out of your control, including the number of applicants, their qualifications, who knows the boss's daughter, etc. In fact, you would do better to try to get as many rejections as possible for the following reason: Suppose on the average it takes about ten to fifteen interviews for each acceptable job offer you receive in your profession (a typical batting average for people I know who have been recently looking for work). This means you've got to go out and get those nine to fourteen rejections over with in order to get the job you want! So each morning say, "I'll try to get as many rejections as possible today." And each time you *do* get rejected you can say, "I was successfully rejected. This brings me one important step closer to my goal."

8. Another way to overcome perfectionism involves assuming responsibility for your life by setting strict time limits on all your activities for one week. This will help you change your perspective so you can focus on the flow of life and enjoy it.

If you are a perfectionist, you are probably a real procrastinator because you insist on doing things so thoroughly. The secret to happiness is to set modest goals to accomplish them. If you want misery, then by all means cling to your perfectionism and procrastination. If you would like to change, then

as you schedule your day in the morning, decide on the amount of time you will budget on each activity. Quit at the end of the time you have set aside whether or not you have completed it, and go onto the next project. If you play the piano and tend to play for many hours or not at all, decide instead to play only an hour a day. I think you'll enhance your satisfaction and output substantially this way.

9. I'll bet you're afraid of making mistakes! What's so terrible about making mistakes? Will the world come to an end if you're wrong? Show me a man who can't stand to be wrong, and I'll show you a man who is afraid to take *risks* and has given up the capacity for growth. A particularly powerful method for defeating perfectionism involves learning to make mistakes.

Here's how you can do this. Write an essay in which you spell out why it is both *irrational* and *self-defeating* to try to be perfect or to fear making mistakes. The following was written by Jennifer, the student mentioned earlier:

### **Why It's Great to Be Able to Make Mistakes**

1. I fear making mistakes because I see everything in absolutist, perfectionistic terms—*one mistake and the whole is ruined*. This is erroneous. A small mistake certainly doesn't ruin an otherwise fine whole.
2. It's good to make mistakes because then we learn—in fact, we won't learn *unless* we make mistakes. No one can avoid making mistakes—and since it's going to happen in any case, we may as well accept it and learn from it.
3. Recognizing our mistakes helps us to adjust our behavior so that we can get results we're more pleased with—so we might say that mistakes ultimately operate *to make us happier and make things better*.
4. *If we fear making mistakes, we become paralyzed*—we're afraid to do or try anything, since we might (in fact, probably will) make some mistakes. If we restrict our activities so that we won't make mistakes, then we are really defeating ourselves. The more we try and the more mistakes we make, the faster we'll learn and the happier we'll be ultimately.

5. Most people aren't going to be mad at us or dislike us because we make mistakes—they all make mistakes, and most people feel uncomfortable around "perfect" people.
6. We don't die if we make mistakes.

Although such an essay does not *guarantee* that you will change, it can help get you started in the right direction. Jennifer reported an enormous improvement the week after she wrote the essay. She found it useful in her studies to focus on learning rather than obsessing constantly about whether or not she was great. As a result, her anxiety decreased and her ability to get things done increased. This relaxed, confident mood persisted through the final examination period at the end of the first semester—a time of extreme anxiety for the majority of her classmates. As she explained, "I realized I didn't *have* to be perfect. I'm going to make my share of mistakes. So what? I can learn from my mistakes, so there's *nothing* to worry about." And she was right!

Write a memo to yourself along these lines. Remind yourself that the world won't come to an end if you make a mistake, and point out the potential benefits. Then read the memo every morning for two weeks. I think this will go a long way toward helping you join the human race!

10. In your perfectionism you are undoubtedly great at focusing on all the ways you fall short. You have the bad habit of picking out the things you haven't done and ignoring those you have. You spend your life cataloging every mistake and shortcoming. No wonder you feel inadequate! Is somebody forcing you to do this? Do you *like* feeling that way?

Here's a simple method of reversing this absurd and painful tendency. Use your wrist counter to click off the things you do *right* each day. See how many points you can accumulate. This may sound so unsophisticated that you are convinced it couldn't help you. If so, experiment with it for two weeks. I predict you'll discover that you will begin to focus more on the positives in your life and will consequently feel better about yourself. It sounds simplistic because it is! But who cares, if it works?

11. Another helpful method involves exposing the absurdity in the all-or-nothing thinking that gives rise to your perfectionism. Look around you and ask yourself how many things in the world can be broken down into all-or-

nothing categories. Are the walls around you totally clean? Or do they have at least *some* dirt? Am I totally effective with all of my writing? Or partially effective? Certainly every single paragraph of this book isn't polished to perfection and breathtakingly helpful. Do you know anyone who is *totally* calm and confident *all* the time? Is your favorite movie star perfectly beautiful?

Once you recognize that all-or-nothing thinking doesn't fit reality very often, then look out for your all-or-nothing thoughts throughout the day, and when you notice one, talk back to it and shoot it down. You'll feel better. Some examples of how a number of different individuals combat all-or-nothing thoughts appear in Figure 14–5.

12. The next method to combat perfectionism involves personal disclosure. If you feel nervous or inadequate in a situation, then share it with people. Point out the things you feel you've done inadequately instead of covering them up. Ask people for suggestions on how to improve, and if they're going to reject you for being imperfect, let them do it and get it over with. If in doubt as to where you stand, ask if they think less of you when you make a mistake.

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<i>All-or-Nothing Thinking</i>	<i>Realistic Thoughts</i>
1. What a lousy day!	1. A couple of bad things have happened, but everything hasn't been a disaster.
2. This meal I cooked really turned out terrible.	2. It's not the best meal I ever cooked, but it's okay.
3. I'm too old.	3. Too old for what? Too old to have fun? No. Too old for occasional sex? No. Too old to enjoy friends? No. Too old to love or be loved? No. Too old to enjoy music? No. Too old to do some productive work? No. So what am I "too old" for? It really has no meaning!
4. Nobody loves me.	4. Nonsense. I have many friends and family. I may not get <i>as much</i> love as I want when I want it, but I can work on this.
5. I'm a failure.	5. I've succeeded at some things and failed at others, just like everybody.
6. My career is over the hill.	6. I can't do as much as when I was younger, but I can still work and produce and create, so why not enjoy it?
7. My lecture was a flop!	7. It wasn't the best lecture I ever gave. In fact, it was below my average. But I did get some points across, and I can work to improve my next lectures. Remember—half my lectures will be below my average, and half will be above!
8. My boyfriend doesn't like me!	8. He doesn't like me enough for what? He may not want to marry me, but he takes me out on dates, so he <i>must</i> like me partially.

**Figure 14–5.** How to replace all-or-nothing thoughts with others that are more in tune with reality. These examples were contributed by a variety of individuals.

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If you do this, you must of course be prepared to handle the possibility that people *will* look down on you because of your imperfections. This actually happened to me during a teaching session I was conducting for a group of therapists. I pointed out an error I felt I had made in reacting angrily to a difficult, manipulative patient. I then asked if any of the therapists present thought less of me after hearing about my foible. I was taken aback when one replied in the affirmative, and the following conversation took place:

THERAPIST (in the audience): I have two thoughts. One thought is positive one. I appreciate your taking that risk to point out your error in front of the group because I would have been scared to do it. I think it takes great courage on your part to do this. But I have to admit I'm ambivalent about you now. Now I know that you *do* make mistakes, which is realistic but ... I feel disappointed in you. In all honesty, I do.

DAVID: Well, I *knew* how to handle the patient, but I was so overcome with my anger that I just got caught up in the moment and retaliated. I was overly abrupt in the way I reacted to her. I admit I handled it quite poorly.

THERAPIST: I guess in the context that you see so many patients each week for so many years, if you make one blunder like that it's definitely not earthshattering. It's not going to kill her or anything. But I do feel let down, I have to admit.

DAVID: But it *isn't* just one rare error. I believe that all therapists make many blunders every single day. Either obvious ones or subtle ones. At least I do. How will you come to terms with that? It seems you're quite disappointed in me because I didn't handle that patient effectively.

THERAPIST: Well, I am. I thought you had a sufficiently wide behavioral repertoire that you could easily handle nearly *anything* the patient said to you.

DAVID: Well, that's untrue. I *sometimes* come up with very helpful things to say in difficult situations, but sometimes I'm not as effective as I'd like to be. I still have a lot to learn. Now with that knowledge, do you think less of me?

THERAPIST: Yeah. I really do. I have to say that. Because now I see that there's a reasonably easy kind of conflict that can upset you. You were unable to handle it without showing your vulnerabilities.

DAVID: That's true. At least *that time* I didn't handle it well. It's an area where I need to focus my efforts and grow as a therapist.

THERAPIST: Well, it shows that at least in that case, and I assume in others, that you don't handle things as well as I thought you did.

DAVID: I think that's correct. But the question is, why do you think less of me because I am imperfect? Why are you looking down on me? Does it make me less a person to you?

THERAPIST: You're exaggerating the whole thing now, and I don't feel that you are necessarily of less value as a human or anything like that. But on the other hand, I think you're not as good as a therapist as I thought you were.

DAVID: That's true. Do you think less of me because of that?

THERAPIST: As a therapist?

DAVID: As a therapist *or* as a person. Do you think less of me?

THERAPIST: Yes, I suppose I do.

DAVID: Why?

THERAPIST: Well, I don't know how to say this. I think "therapist" is the primary role that I know you in. I'm disappointed to find you're so imperfect. I had a higher expectation of you. But perhaps you're better in other areas of your life.

DAVID: I hate to disappoint you, but you'll discover that in many other aspects of my life I'm even *more* imperfect. So if you're looking down on me as a therapist, I presume you'll look down on me more as a person.

THERAPIST: Well, I do think less of you as a person. I think that's an accurate description of how I'm feeling about you.

DAVID: Why do you think less of me because I don't measure up to your standard of perfection? I'm a human and not a robot.

THERAPIST: I'm not sure I understand that question. I judge people in terms of their performance. You goofed up, so you have to face the fact I'll judge you negatively. It's tough, but it's reality. I thought you should perform better because you're our preceptor and our teacher. I expected *more* of you. Now it sounds like I could have handled that patient better than you did!

DAVID: Well, I think you *could* have done better than I did with the patient that day, and this is an area where I think I can learn from you. But why do you look down on me for this? If you

get disappointed and lose respect each time you notice I've made a mistake, pretty soon you'll be totally miserable, and you'll have no respect for me at all because I've been making errors every day since I was born. Do you want all that discomfort? If you want to continue and enjoy our friendship and I hope you will, you'll just have to accept the fact that I'm not perfect. Maybe you'd be willing to look for mistakes I make and point them out to me so I can learn from you while I'm teaching you. When I stop making mistakes, I'll lose much of my capacity to grow. Recognizing and correcting my errors and learning from them is one of my greatest assets. And if you can accept my humanity and imperfection, maybe you can also accept your own. Maybe you'll want to feel that it's okay for you to make mistakes too.

This kind of dialogue transcends the possibility you will feel put down. Asserting your right to make mistakes will paradoxically make you a greater human being. If the other person feels disappointed, the fault is really his for having set up the unrealistic expectation you are more than human. If you don't buy into that foolish expectation, you won't have to become angry or defensive when you do goof up—nor will you have to feel any sense of shame or embarrassment. The choice is clear-cut: You can either try to be perfect and end up miserable, or you can aim to be human and imperfect and feel enhanced. Which do you choose?

13. The next method is to focus mentally on a time in your life when you were really happy. What image comes to mind? For me the image is of climbing down into Havasupai Canyon one summer vacation when I was a college student. This canyon is an isolated part of the Grand Canyon, and you have to hike into it or arrange for horses. I went with a friend. Havasupai, an Indian word meaning "blue-green water people," is the name of a turquoise river that bubbles out of the desert floor and turns the narrow canyon into a lush paradise many miles long. Ultimately, the Havasupai River empties into the Colorado River. There are a number of waterfalls several hundred feet high, and at the bottom of each, a green chemical in the water precipitates out and makes the river's bottom and edges smooth and polished, just like a

turquoise swimming pool. Cottonwood trees and Jimsohweed with purple flowers like trumpets line the river in abundance. The Indians who live there are easygoing and friendly. It is a blissful memory. Perhaps you have a similar happy memory. Now ask yourself—what was *perfect* about that experience? In my case, *nothing!* There were no toilet facilities, and we slept in sleeping bags outdoors. I didn't hike perfectly or swim perfectly, and nothing was perfect. There was no electricity available in most of the village because of its remoteness, and the only available food in the store was canned beans and fruit cocktail—no meat or vegetables. But the food tasted darn good after a day of hiking and swimming. So who needs perfection?

How can you use such a happy memory? When you are having a presumably pleasurable experience—eating out, taking a trip, going to a movie, etc.—you may unnecessarily sour the experience by making an inventory of all the ways it falls short and telling yourself you can't possibly enjoy it. But this is hogwash—it's your *expectation* that upsets you. Suppose the motel bed is too lumpy and you paid fifty-six dollars for the room. You called the front desk, and they have no other beds or rooms available. Tough! Now you can double your trouble by demanding perfection, or you can conjure up your “happy, imperfect” memory. Remember the time you camped out and slept on the ground and loved it? So you can certainly enjoy yourself in this motel room if you choose! Again, it's up to you.

14. Another method for overcoming perfectionism is the “greed technique.” This is based on the simple fact that most of us try to be perfect so we can get ahead in life. It may not have occurred to you that you might end up much more successful if your standards were lower. For example, when I started my academic career, I spent over two years writing the first research paper I published. It was an excellent product, and I'm still quite proud of it. But I noticed that in the same time period, many of my peers who were of equal intelligence wrote and published numerous papers. So I asked myself—am I better off with one publication that contains ninety-eight “units of excellence,” or ten papers that are each worth only eighty “units of excellence”? In the latter case, I would actually end up with 800 “excellenceunits,” and I would be way ahead of the game. This realization was a strong personal persuader, and I decided to lower my standards a bit.

My productivity then became dramatically enhanced, as well as my levels of satisfaction.

How can this work for you? Suppose you have a task and you notice you're moving slowly. You may find that you've already reached the point of diminishing returns, and you'd do better by moving on to the next task. I'm not advocating that you slough off, but you may find that you as well as others will be equally if not more pleased with many good, solid performances than with one stress-producing masterpiece.

15. Here's the last approach. It involves simple logic. Premise one: All human beings make mistakes. Do you agree? Okay, now tell me: What are you? A human being, you say? Okay. Now, what follows? Of course—you *will* and *should* make mistakes! Now tell yourself this every time you persecute yourself because you made an error. Just say, “I was *supposed* to make that mistake because I’m human!” or “How human of me to have made that mistake.”

In addition, ask yourself, “What can I learn from my mistake? Is there some good that could come from this?” As an experiment, think about some error you’ve made and write down everything you learned from it. Some of the best things can be learned only through making mistakes and learning from them. After all, this is how you learned to talk and walk and do just about everything. Would you be willing to give up that kind of growth? You may even go so far as to say your imperfections and goof-ups are some of your greatest assets. Cherish them! Never give up your capacity for being wrong because then you lose the ability to move forward. In fact, just think what it would be like if you *were* perfect. There’d be *nothing* to learn, *no way* to improve, and life would be completely void of challenge and the satisfaction that comes from mastering something that takes effort. It would be like going to kindergarten for the rest of your life. You’d know all the answers and win every game. Every project would be a guaranteed success because you would do everything correctly. People’s conversations would offer you nothing because you’d already know it all. And most important, nobody could love or relate to you. It would be impossible to feel any love for someone who was flawless and knew it all. Doesn’t that sound lonely, boring, and miserable? Are you so sure you still want perfection?

Part V

**Defeating Hopelessness and Suicide**

## Chapter 15

### The Ultimate Victory: Choosing to Live

Dr. Aaron T. Beck reported in a study that suicidal wishes were present in approximately one-third of individuals with a mild case of depression, and in nearly three-quarters of people who were severely depressed.\* It has been estimated that as many as 5 percent of depressed patients do actually die as a result of suicide. This is approximately twenty-five times the suicide rate within the general population. In fact, when a person with a depressive illness dies, the chances are one in six that suicide was the cause of death.

No age group or social or professional class is exempt from suicide; think of the famous people you know of who have killed themselves. Particularly shocking and grotesque—but by no means rare—is suicide among the very young. In a study of seventh- and eighth-grade students in a suburban Philadelphia parochial school, nearly one third of the youngsters were significantly depressed and had suicidal thoughts. Even *infants* who undergo maternal separation can develop a depressive syndrome in which failure to thrive and even self-imposed death from starvation can result.

Before you get overwhelmed, let me emphasize the positive side of the coin. First, suicide is unnecessary, and the impulse can be rapidly overcome and eliminated with cognitive techniques. In our study, suicidal urges were reduced substantially in patients treated with cognitive therapy *or* with antidepressant drugs. The improved outlook on life occurred within the first week or two of treatment in many cognitively treated patients. The current intensive emphasis on the prevention of depressive episodes in individuals prone to mood swings should also result in a long-term reduction in suicidal impulses.

Why do depressed individuals so frequently think of suicide, and what can be done to prevent these impulses? You will understand this if you examine the thinking of people who are actively suicidal. A pervasive, pessimistic vision dominates their thoughts. Life seems to be nothing but a hellish

nightmare. As they look into the past, all they can remember are moments of depression and suffering.

When you feel down in the dumps, you may also feel so low at times that you get the feeling you were never really happy and never will be. If a friend or relative points out to you that, except for such periods of depression, you were quite happy, you may conclude they're mistaken or only trying to cheer you up. This is because while you are depressed you actually distort your memories of the past. You just can't conjure up any memories of periods of satisfaction or joy, so you erroneously conclude they did not exist. Thus, you mistakenly conclude that you always have been and always will be miserable. If someone insists that you have been happy, you may respond as a young patient recently did in my office, "Well, that period of time doesn't count. Happiness is an illusion of some kind. The real me is depressed and inadequate. I was just fooling myself if I thought I was happy."

No matter how bad you feel, it would be bearable if you had the conviction that things would eventually improve. The critical decision to commit suicide results from your illogical conviction that your mood *can't* improve. You feel certain that the future holds only more pain and turmoil! Like some depressed patients, you may be able to support your pessimistic prediction with a wealth of data which seems to you to be overwhelmingly convincing.

A depressed forty-nine-year-old stockbroker recently told me, "Doctor, I have already been treated by six psychiatrists over a ten-year-period. I have had shock treatments and all types of antidepressants, tranquilizers, and other drugs. But in spite of it all, this depression won't let up for one minute. I have spent over eighty thousand dollars trying to get well. Now I am emotionally and financially depleted. Every doctor has said to me. 'You'll beat this thing. Keep your chin up.' But now I realize it wasn't true. They were all lying to me. I'm a fighter, so I fought hard. You'd better realize when you are defeated. I've got to admit I'd be better off dead."

Research studies have shown that your unrealistic sense of hopelessness is one of the most crucial factors in the development of a serious suicidal wish. Because of your twisted thinking, you see yourself in a trap from which there seems to be no escape. You jump to the conclusion that your problems are insoluble. Because your suffering feels unbearable and appears unending, you may erroneously conclude that suicide is your only way of escape.

If you have had such thoughts in the past, or if you are seriously thinking this way at present, let me state the message of this chapter loud and clear:

### You Are Wrong in Your Belief That Suicide Is the Only Solution or the Best Solution to Your Problem.

Let me repeat that. *You Are Wrong!* When you think that you are trapped and hopeless, your thinking is illogical, distorted, and skewed. No matter how thoroughly you have convinced yourself, and even if you get other people to agree with you, you are just plain *mistaken* in your belief that it is ever advisable to commit suicide because of depressive illness. This is not the most rational solution to your misery. I will explain this position and help point the way out of the suicide trap.

### Assessing Your Suicidal Impulses

Although suicidal thoughts are common even in individuals who are not depressed, the occurrence of a suicidal impulse if you *are* depressed is always to be regarded as a dangerous symptom. It is important for you to know how to pinpoint those suicidal impulses which are the most threatening. In the Burns Depression Checklist in Chapter 2, questions 23, 24, and 25 refer to your suicidal thoughts and impulses. If you have checked a one, two, three, or four on these questions, suicidal fantasies are present, and it is important to evaluate their seriousness and to intervene if necessary (see page 21).

The most serious error you could make with regard to your suicidal impulses is to be overly inhibited in talking them over with a counselor. Many people are afraid to talk about suicidal fantasies and urges for fear of disapproval or because they believe that even talking about them will bring on a suicide attempt. This point of view is unwarranted. You are more likely to feel a great sense of relief in discussing suicidal thoughts with a professional therapist, and consequently you have a much better chance of defusing them.

If you do have suicidal thoughts, ask yourself if you are taking such thoughts seriously. Are there times when you wish you were dead? If the answer is yes, is your death wish active or passive? A passive death wish exists if you would prefer to be dead, but you are unwilling to take active steps to bring this about. One young man confessed to me, "Doctor, every

night when I go to bed I pray to God to let me wake up with cancer. Then I could die in peace, and my family would understand."

An *active* death wish is more dangerous. If you are seriously planning an actual suicide attempt, then it's important to know the following: Have you thought about a method? What is your method? Have you made plans? What specific preparations have you made? As a general rule, the more concrete and well-formulated your plans are, the more likely you may actually make a suicide attempt. The time to seek professional help is now!

Have you ever made a suicide attempt in the past? If so, you should view any suicidal impulse as a danger signal to seek help immediately. For many people these previous attempts seem to be "warm-ups," in which they flirt with suicide but have not mastered the particular method they have selected. The fact that an individual has made this attempt unsuccessfully on several occasions in the past indicates an increased risk of success in the future. It is a dangerous myth that unsuccessful suicide attempts are simply gestures or attention-getting devices and are therefore not to be taken seriously. Current thinking suggests that all suicidal thoughts or actions are to be taken seriously. It can be highly misleading to view suicidal thoughts and actions as a "plea for help." Many suicidal patients want help *least* of all because they are 100 percent convinced they are hopeless and beyond help. Because of this illogical belief, what they really want is death.

Your degree of hopelessness is of the greatest importance in assessing whether or not you are at risk for making an active suicide attempt at any time. This one factor seems more closely linked with actual suicide attempts than any other. You must ask yourself, "Do I believe that I have absolutely no chance of getting better? Do I feel that I have exhausted all treatment possibilities and that nothing could possibly help? Do I feel convinced beyond all doubt that my suffering is unbearable and could never come to an end?" If you answer yes to these questions, then your degree of hopelessness is high, and professional treatment is indicated *now!* I would like to emphasize that hopelessness is as much a symptom of depression as a cough is a symptom of pneumonia. The feeling of hopelessness does *not* in fact prove that you are hopeless, any more than a cough proves you are doomed to succumb to pneumonia. It just proves that you are suffering from an illness, in this case, depression. This sense of hopelessness is *not* a reason to make a

suicide attempt, but gives you a clear signal to seek competent treatment. So, if you feel hopeless, seek help! Do not consider suicide for one more minute!

The last important factor concerns deterrents. Ask yourself, “Is there anything that is preventing me from committing suicide? Would I hold back because of my family, friends, or religious beliefs?” If you have no deterrents, the possibility is greater that you would consider an actual suicide attempt.

**SUMMARY:** If you are suicidal, it is of great importance for you to evaluate these impulses in a matter-of-fact manner, using your common sense. The following factors put you in a high-risk group:

1. If you are severely depressed and feel hopeless;
2. If you have a past history of suicide attempts;
3. If you have made concrete plans and preparations for suicide; and
4. If no deterrents are holding you back.

If one or more of these factors apply to you, then it is vital to get professional intervention and treatment immediately. While I firmly believe that the attitude of self-help is important for all people with depression, you clearly must seek professional guidance right away.

## **The Illogic of Suicide**

Do you think depressed people have the “right” to commit suicide? Some misguided individuals and novice therapists are unduly concerned with this issue. If you are counseling or trying to help a chronically depressed individual who is hopeless and threatening self-destruction, you may ask yourself, “Should I intervene aggressively, or should I let him go ahead? What are his rights as a human being in this regard? Am I responsible for preventing this attempt, or should I tell him to go ahead and exercise his freedom of choice?”

I regard this as an absurd and cruel issue that misses the point entirely. The real question is not whether a depressed individual has the right to commit suicide, but whether he is *realistic* in his thoughts when he is considering it. When I talk to a suicidal person, I try to find out why he is feeling that way. I might ask, “What is your motive for wanting to kill yourself? What problem in your life is so terrible that there is no solution?” Then I would help that

person expose the illogical thinking that lurks behind the suicidal impulse as quickly as possible. When you begin to think more realistically, your sense of hopelessness and the desire to end your life will fade away and you will have the urge to live. Thus, I recommend joy rather than death to suicidal individuals, and I try to show them how to achieve it as fast as possible! Let's see how this can be done.

Holly was a nineteen-year-old woman who was referred to me for treatment by a child psychoanalyst in New York City. He had treated her unsuccessfully with analytic therapy for many years since the onset of a severe unremitting depression in her early teens. Other doctors had also been unable to help her. Her depression originated during a period of family turbulence that led to her parents' separation and divorce.

Holly's chronic blue mood was punctuated by numerous wrist-slashing episodes. She said that when periods of frustration and hopelessness would build up, she would be overcome by the urge to rip into her flesh and would experience relief only when she saw the blood flowing across her skin. When I first met Holly, I noticed a mass of white scar tissue across her wrists that attested to this behavior. In addition to these episodes of self-mutilation, which were not suicide attempts, she had tried to kill herself on a number of occasions.

In spite of all the treatment she had received, her depression would not let up. At times it became so severe that she had to be hospitalized. Holly had been confined to a closed ward of a New York hospital for several months at the time she was referred to me. The referring doctor recommended a minimum of three years of additional continuous hospitalization, and appeared to agree with Holly that her prognosis for substantial improvement, at least in the near future, was poor.

Ironically, she was bright, articulate, and personable. She had done well in high school, in spite of being unable to go to classes during the times she was confined to hospitals. She had to take some courses with the help of tutors. Like a number of adolescent patients, Holly's dream was to become a mental-health professional, but she had been told by her previous therapist that this was unrealistic because of the nature of her own explosive, intractable emotional problems. This opinion was just one more crushing blow for Holly.

After graduation from high school, she spent the majority of her time in inpatient mental-hospital facilities because she was considered too ill and

uncontrollable for outpatient therapy. In a desperate attempt to find help, her father contacted the University of Pennsylvania because he had read about our work in depression. He requested a consultation to determine whether any promising treatment alternatives existed for his daughter.

After speaking to me by phone, Holly's father obtained custody of her and drove to Philadelphia so that I could talk to her and review the possibilities for treatment. When I met them, their personalities contrasted with my expectations. He proved to be a relaxed, mild-mannered individual; she was strikingly attractive, pleasant, and cooperative.

I administered several psychological tests to Holly. The Beck Depression Inventory indicated severe depression, and other tests confirmed a high degree of hopelessness and serious suicidal intent. Holly put it to me bluntly, "I want to kill myself." The family history indicated that several relatives had attempted suicide—two of them successfully. When I asked Holly why she wanted to kill herself, she told me that she was a lazy human being. She explained that because she was lazy, she was worthless and so deserved to die.

I wanted to find out if she would react favorably to cognitive therapy, so I used a technique that I hoped would capture her attention. I proposed we do some role-playing, and she was to imagine that two attorneys were arguing her case in court. Her father, by the way, happened to be an attorney who specialized in medical malpractice suits! Because I was a novice therapist at the time, this intensified my own anxious, insecure feelings about tackling such a tough case. I told Holly to play the role of the prosecutor, and she was to try to convince the jury that she deserved a death sentence. I told her I would play the role of the defense attorney, and that I would challenge the validity of every accusation she made. I told her that this way we could review her reasons for living and her reasons for dying, and see where the truth lay:

HOLLY: For this individual, suicide would be an escape from life.

DAVID: That argument could apply to anyone in the world. By itself, it is not a convincing reason to die.

HOLLY: The prosecutor replies that the patient's life is so miserable, she cannot stand it one minute longer.

DAVID: She has been able to stand it up until now, so maybe she can stan

it a while longer. She was not always miserable in the past, and there is no proof that she will always be miserable in the future.

HOLLY: The prosecutor points out that her life is a burden to her family.

DAVID: The defense emphasizes that suicide will not solve this problem since her death by suicide may prove to be an even more crushing blow to her family.

HOLLY: But she is self-centered and lazy and worthless, and deserves to die!

DAVID: What percentage of the population is lazy?

HOLLY: Probably twenty percent ... no, I'd say only ten percent.

DAVID: That means twenty million Americans are lazy. The defense points out that they don't have to die for this, so there is no reason the patient should be singled out for death. Do you think laziness and apathy are symptoms of depression?

HOLLY: Probably.

DAVID: The defense points out that individuals in our culture are not sentenced to death for the symptoms of illness, whether it be pneumonia, depression, or any other disease. Furthermore, the laziness may disappear when the depression goes away.

Holly appeared to be involved in this repartee and amused by it. After a series of such accusations and defenses, she conceded that there was no convincing reason she should have to die, and that any reasonable jury would have to rule in favor of the defense. What was more important was that Holly was learning to challenge and answer her negative thoughts about herself. This process brought her partial but immediate emotional relief, the first she had experienced in many years. At the end of the consultation session, she said to me, "This is the best that I have felt in as long as I can remember. But now the negative thought crosses my mind, 'This new therapy may not prove to be as good as it seems.'" In response to this she felt a sudden surge of depression again. I assured her, "Holly, the defense attorney points out that this is no real problem. If the therapy isn't as good as it seems to be, you'll find out in a few weeks, and you'll still have the alternative of a long-term hospitalization. You'll have lost nothing. Furthermore, the therapy may be partially as good as it seems, or conceivably even better. Perhaps you would

be willing to give it a try.” In response to this proposal, she decided to come to Philadelphia for treatment.

Holly’s urge to commit suicide was simply the result of cognitive distortions. She confused the symptoms of her illness, such as lethargy and loss of interest in life, with her true identity and labeled herself as a “lazy person.” Because Holly equated her worth as a human being with her achievement, she concluded she was worthless and deserved to die. She jumped to the conclusion that she could never recover, and that her family would be better off without her. She magnified her discomfort by saying, “I can’t stand it.” Her sense of hopelessness was the result of the fortune-telling error—she illogically jumped to the conclusion that she could not improve. When Holly saw that she was simply trapping herself with unrealistic thoughts, she felt a sudden relief. In order to maintain such improvement, Holly had to learn to correct her negative thinking on an ongoing basis and that took hard work! She wasn’t going to give in that easily!

Following our initial consultation, Holly was transferred to a hospital in Philadelphia, where I visited her twice a week to initiate cognitive therapy. She had a stormy course in the hospital with dramatic mood swings, but was able to be discharged after a five-week period, and I persuaded her to enroll as a part-time summer-school student. For a while her moods continued to oscillate like a yo-yo, but she showed an overall improvement. At times Holly would report feeling very good for several days. This constituted a real breakthrough, since these were the first happy periods she had experienced since the age of thirteen. Then she would suddenly relapse into a severe depressive state. At these times she would again become actively suicidal, and would try her best to convince me that life was not worth living. Like many adolescents, she seemed to carry a grudge against all mankind, and insisted there was no point in living any longer.

In addition to feeling negative about her own sense of worth, Holly had developed an intensely negative and disillusioned view of the entire world. Not only did she see herself as trapped by an endless, untreatable depression, but like many of today’s adolescents, she had adopted a personal theory of nihilism. This is the most extreme form of pessimism. Nihilism is the belief that there is no truth or meaning to anything, and that *all* of life involves suffering and agony. To a nihilist like Holly, the world offers *nothing* but misery. She had become convinced that the very essence of every person and

object in the universe was evil and horrible. Her depression was thus the experience of hell on earth. Holly envisioned death as the *only* possible surcease, and she longed for death. She constantly complained and harangued cynically about the cruelties and miseries of living. She insisted that life was totally unbearable at all times, and that all human beings were totally lacking in redeeming qualities.

The task of getting such an intelligent and persistent young woman to see and admit how distorted her thinking was provided a real challenge to this therapist! The following lengthy dialogue illustrates her intensely negative attitudes as well as my struggles to help her penetrate the illogic in her thinking:

HOLLY: Life is not worth living because there is more bad than good in the world.

DAVID: Suppose I was the depressed patient and you were my therapist and I told you that, what would you say?

(I used this maneuver with Holly because I knew her goal in life was to be a therapist. I figured she'd say something reasonable and upbeat, but she outfoxed me in her next statement.)

HOLLY: I'd say that I can't argue with you!

DAVID: SO, if I were your depressed patient and told you that life is not worth living, you'd advise me to jump out the window?

HOLLY (laughing): Yes. When I think about it, that's the best thing to do. If you think about all the bad things that are going on in the world, the right thing to do is to get really upset about them and be depressed.

DAVID: And what are the advantages to that? Does that help you correct the bad things in the world or what?

HOLLY: No. But you *can't* correct them.

DAVID: You can't correct *all* the bad things in the world, or you can't correct *some* of them?

HOLLY: You can't correct anything of importance. I guess you can correct small things. You can't really make a dent in the badness of thi

universe.

DAVID: Now, at the end of each day if I said that to myself when I were home, I could really become upset. In other words, I could either think about the people that I did help during the day and feel good or I could think of all the thousands of people that I will never get chance to see and work with, and I could feel hopeless and helpless. That would incapacitate me, and I don't think that it is to my advantage to be incapacitated. Is it to your advantage to be incapacitated?

HOLLY: Not really. Well, I don't know.

DAVID: You *like* being incapacitated?

HOLLY: No. Not unless I were completely incapacitated.

DAVID: What would that be like?

HOLLY: I would be dead, and I think I would be better off being that way.

DAVID: Do you think being dead is enjoyable?

HOLLY: Well, I don't even know what it's like. I suppose it might be horrible to be dead and to experience nothing. Who knows?

DAVID: So it might be horrible, or it might be nothing. Now the closest thing to nothing is when you are being anesthetized. Is that enjoyable?

HOLLY: It's not enjoyable, but it's not unenjoyable either.

DAVID: I'm glad you admit that it's not enjoyable. And you're right, there's really nothing enjoyable about nothing. But there are some things enjoyable about life.

(At this point I thought I had really made a mark. But again, in her adolescent insistence that things were no good, she continued to outmaneuver me and contradict everything I said. Her contrariness made my work with her challenging and more than a bit frustrating at times.)

HOLLY: But you see, there are so *few* things that are enjoyable about life and there is so much other stuff that you have to go through to get those few enjoyable things that it seems to me it just doesn't weigh out.

DAVID: How do you feel when you're feeling good? Do you feel that it doesn't weigh out then, or do you just feel this way when you're feeling bad?

HOLLY: It all depends on what I want to focus on, right? The only way I get myself not to be depressed is if I don't think about all the lousy things in this universe that make me depressed. Right? So when I am feeling good, that means I'm focusing on the good things. But all the bad things are still there. Since there is so much more bad than good, it is dishonest and phony to look only at the good and feel good or feel happy, and that's why suicide is the best thing to do.

DAVID: Well, there are two kinds of bad things in this universe. One is the pseudo-bad. This is the unreal bad that we create as a figment of our imagination by the way we think about things.

HOLLY: (interrupting): Well, when I read the newspapers, I see rapes and murders. That seems to me to be the *real* bad.

DAVID: Right. That's what I call the real bad. But let's look at the pseudo-bad first.

HOLLY: Like what? What do you mean by pseudo-bad?

DAVID: Well, take your statement that life is no good. That statement is an inaccurate exaggeration. As you pointed out, life has its good elements, its bad elements, and its neutral elements. So the statement that life is no good or that everything is hopeless is just exaggerated and unrealistic. This is what I mean by the pseudo-bad. On the other hand, there are the real problems in life. It's true that people do get murdered and that people do get cancer, but in my experience these unpleasant things can be coped with. In fact, in your life you will probably make the decision to commit yourself to some aspect of the world's problems where you think you can make a contribution to a solution. But even there, the meaningful approach involves interaction with the problem in a positive way rather than getting overwhelmed by it and sitting back and moping.

HOLLY: Well, see, that's what I do. I just get immediately overwhelmed with the bad things I encounter, and then I feel like I ought to kill

myself.

DAVID: Right. Well, it might be nice if there were a universe where there were no problems and no suffering, but then there would be no opportunity for people to grow or solve these problems either. On of these days you'll probably take one of the problems in the world, and contributing to its solution will become a source of satisfaction to you.

HOLLY: Well, that's not fair to use problems in that way.

DAVID: Why don't you test it out? I wouldn't want you to believe anything that I say unless you test it out for yourself and find out if it's true. The way to test it out is to begin getting involved in things, to go to classes, do your work, and establish relationships with people.

HOLLY: That's what I am beginning to do.

DAVID: Well, you can see how it works out over a period of time, and you may find that going to summer school and making a contribution to this world, and meeting with friends and getting involved with activities, and doing your work and getting adequate grades, and experiencing a sense of achievement and pleasure in doing what you can—all of this might not be satisfying to you, and you might conclude, "Hey, depression was better than this." And "I don't like being happy." You might say, "Hey, I don't like being involved in life." If that's true, you can always go back to being depressed and hopeless. I'm not going to take anything away from you. But don't knock happiness until you've tried it. Check it out. See what life is like when you get involved and make an effort. Then we'll see where the chips fall at that time.

Holly again experienced a substantial emotional relief as she realized, at least in part, that her intense conviction that the world was no good and life was not worth living was simply the result of her illogical way of looking at things. She was making the mistake of focusing only on negatives (the mental filter) and arbitrarily insisting that the positive things in the world didn't count (disqualifying the positive). Consequently, she got the impression that everything was negative and that life was not worth living. As she learned to correct this error in her thinking, she began to experience

some improvement. Although she continued to have a number of ups and downs, the frequency and severity of her mood swings diminished with time. She was so successful in her summer-school work that she was accepted in the fall as a full-time student at a top Ivy League college. Although she made many pessimistic predictions that she would flunk out because she didn't have the brains to make it in academics, to her great surprise she did outstandingly well in her classes. As she learned to transform her intense negativity into productive activity, she became a top-notch student.

Holly and I had a parting of the ways after less than a year of weekly sessions. In the middle of an argument, she fled from the office, slammed the door, and vowed never to return. Maybe she didn't know any other way to say goodbye I believe she felt she was ready to try and make it on her own. Perhaps she finally got tired of trying to batter me down; after all, I was just as stubborn as she was! She called me recently to let me know how things turned out. Although she still struggles with her moods at times, she is now a senior and at the top of her class. Her dream of going to graduate school to pursue a professional career appears to be a certainty. God bless you. Holly!

Holly's thinking represents many of the mental traps that can lead to a suicidal impulse. Nearly all suicidal patients have in common an illogical sense of hopelessness and the conviction they are facing an insoluble dilemma. Once you expose the distortions in your thinking, you will experience considerable emotional relief. This can give you a basis for hope and can help you avert a dangerous suicide attempt. In addition, the emotional relief can give you some breathing room so you can continue to make more substantive changes in your life.

You may find it difficult to identify with a turbulent adolescent like Holly, so let's take a brief look at another more common cause for suicidal thoughts and attempts—the sense of disillusionment and despair that sometimes hits us in middle age or in our senior years. As you review the past, you may conclude that your life hasn't really amounted to much in comparison with the starry-eyed expectations of your youth. This has been called the mid-life crisis—that stage in which you review what you have actually done with your life compared with your hopes and plans. If you cannot resolve this crisis successfully, you may experience such intense bitterness and such profound disappointment that you may attempt suicide. Once again, the problem turns

out to have little, if anything, to do with reality. Instead, your turmoil is based on twisted thinking.

Louise was a married woman in her fifties who had emigrated from Europe to the United States during World War II. Her family brought her to my office one day after she had been discharged from an intensive care unit, where she had been treated for an almost successful and totally unexpected suicide attempt. The family was unaware she had been experiencing serious depression, so her sudden suicide attempt was a complete surprise. As I spoke with Louise, she told me bitterly that her life had not measured up. She had never experienced the joy and fulfillment that she dreamed of as a girl: she complained of a sense of inadequacy and was convinced she was a failure as a human being. She told me that she had accomplished nothing worthwhile and concluded her life was not worth living.

Because I felt a rapid intervention was necessary in order to prevent a second suicide attempt, I used cognitive techniques to demonstrate to her as fast as possible the illogic of what she was saying to herself. I first asked her to give me a list of things she *had* accomplished in life as a way of testing her belief that she hadn't succeeded at anything worthwhile.

LOUISE: Well, I helped my family escape from the Nazi terrorism and relocate in this country during World War II. In addition, I learned to speak many languages fluently—five of them—when I was growing up. When we came to the United States, I worked at an unpleasant job so that enough money would be available for my family. My husband and I raised a fine young son, who went on to college and is now a highly successful businessman. I'm a good cook; and in addition to perhaps being a good mother, my grandchildren seem to think I'm a good grandmother. These would be the things which I feel I have accomplished during my life.

DAVID: In light of all these accomplishments, how can you tell me you have accomplished nothing?

LOUISE: You see, *everyone* in my family spoke five languages. Getting out of Europe was just a matter of survival. My job was ordinary and required no special talent. It is a mother's duty to raise her family and any good housewife should learn to cook. Because these are all the things I was supposed to do, or that anyone could have

done, they are not real accomplishments. They are just ordinary and this is why I have decided to commit suicide. My life is not worthwhile.

I realized that Louise was upsetting herself unnecessarily by saying, “It doesn’t count” with regard to anything good about herself. This common cognitive distortion, called “disqualifying the positive,” was her main enemy. Louise focused *only* on her inadequacies or errors, and insisted that her successes weren’t worth anything. If you discount your achievements in this way, you will create the mental illusion that you are a worthless zero.

In order to demonstrate her mental error in a dramatic fashion, I proposed that Louise and I do some role-playing. I told her that I would play the role of a depressed psychiatrist, and she was to be my therapist, who would try to find out why I have been feeling so depressed.

LOUISE (as therapist): Why is it you feel depressed, Dr. Burns?

DAVID (as depressed psychiatrist): Well, I realize that I’ve accomplished nothing with my life.

LOUISE: So you feel you’ve accomplished nothing? But that doesn’t make sense. You must have accomplished something. For example, you care for many sick depressed patients, and I understand you publish articles about your research and give lectures. It sounds like you have accomplished a great deal at such a young age.

DAVID: No. None of those things count. You see, it is every doctor’s obligation to care for his patients. So that doesn’t count. I’m just doing what I’m supposed to do. Furthermore, it is my duty at the university to do research and publish the results. So these are not *real* accomplishments. All the faculty members do this, and my research is not very important, at any rate. My ideas are just ordinary. My life is basically a failure.

LOUISE (laughing at herself—no longer being the therapist): I can see that I have been criticizing myself like that for the past ten years.

DAVID (as therapist again): Now, how does it feel when you continually say to yourself, “It doesn’t count” whenever you think about the things you have accomplished?

LOUISE: I feel depressed when I say this to myself.

DAVID: And how much sense does it make to think of the things that you haven't done that you might have liked to do, and to overlook the things that you have done which turned out well and were the result of substantial effort and determination?

LOUISE: It doesn't make any sense at all.

As a result of this intervention, Louise was able to see she had been arbitrarily upsetting herself by saying over and over, "What I have done isn't good enough." When she recognized how arbitrary it was to do this to herself, she experienced immediate emotional relief, and her urge to commit suicide disappeared. Louise realized that no matter how much she had accomplished in her life, if she wanted to upset herself she would always be able to look back and say, "It wasn't enough." This indicated to her that her problem was not *realistic* but simply a mental trap she had fallen into. The role-reversal seemed to evoke a sense of amusement and laughter in her. This stimulation of her sense of humor appeared to help her recognize the absurdity of her self-criticism, and she achieved a much needed sense of compassion for herself.

Let's review why your conviction that you are "hopeless" is both irrational and self-defeating. First, remember that depressive illness is usually, if not always, self-limiting, and in most cases eventually disappears even without treatment. The purpose of treatment is to speed the recovery process. Many effective methods of drug therapy and psychotherapy now exist, and others are being rapidly developed. Medical science is in a constant state of evolution. We are currently experiencing a renaissance in our approaches to depressive illness. Because we cannot predict yet with complete certainty which psychological intervention or medication will be most helpful for a particular patient, a number of techniques must sometimes be applied until the right key to the locked-up potential for happiness is found. Although this does require patience and hard work, it is crucial to keep in mind that nonresponse to one or even to several techniques does not indicate that all methods will fail. In fact, the opposite is more often true. For example, recent drug research has shown that patients who do not respond to one antidepressant medication often have a better than average chance of responding to another. This means if you fail to respond to one of the agents,

your chances for improvement when you are given another may actually be enhanced. When you consider that there are large numbers of effective antidepressants, psychotherapeutic interventions, and self-help techniques, the probability for eventual recovery becomes tremendously high.

When you are depressed, you may have a tendency to confuse feeling with facts. Your feelings of hopelessness and total despair are just *symptoms* of depressive illness, not facts. If you think you are hopeless, you will naturally feel this way. Your feelings only trace the illogical pattern of your thinking. Only an expert, who has treated hundreds of depressed individuals, would be in a position to give a meaningful prognosis for recovery. Your suicidal urge merely indicates the need for treatment. Thus, your conviction that you are “hopeless” nearly always proves you are not. Therapy, not suicide, is indicated. Although generalizations can be misleading, I let the following rule of thumb guide me: Patients who *feel* hopeless *never actually are* hopeless.

The conviction of hopelessness is one of the most curious aspects of depressive illness. In fact, the degree of hopelessness experienced by seriously depressed patients who have an excellent prognosis is usually greater than in terminal malignancy patients with a poor prognosis. It is of great importance to expose the illogic that lurks behind your hopelessness as soon as possible in order to prevent an actual suicide attempt. You may feel convinced that you have an insoluble problem in your life. You may feel that you are caught in a trap from which there is no exit. This may lead to extreme frustration and even to the urge to kill yourself as the only escape. However, when I confront a depressed patient with respect to precisely what kind of trap he or she is in, and I zero in on the person’s “insoluble problem,” I invariably find that the patient is deluded. In this situation, you are like an evil magician, and you create a hellish illusion with mental magic. Your suicidal thoughts are illogical, distorted, and erroneous. Your twisted thoughts and faulty assumptions, not reality, create your suffering. When you learn to look behind the mirrors, you will see that you are fooling yourself, and your suicidal urge will disappear.

It would be naive to say that depressed and suicidal individuals never have “real” problems. We *all* have real problems, including finances, interpersonal relationships, health, etc. But such difficulties can nearly always be coped with in a reasonable manner without suicide. In fact, meeting such challenges

can be a source of mood elevation and personal growth. Furthermore, as pointed out in Chapter 9, real problems can never depress you even to a small extent. Only distorted thoughts can rob you of valid hopes or self-esteem. I have never seen a “real” problem in a depressed patient which was so “totally insoluble” that suicide was indicated.

Part VI

**Coping with the Stresses and Strains of Daily Living**

## Chapter 16

### How I Practice What I Preach

**“Physician, heal thyself.”—Luke 4:23**

A recent study of stress has indicated that one of the world's most demanding jobs—in terms of the emotional tension and the incidence of heart attacks—is that of an air-traffic controller in an airport tower. The work involves precision, and the traffic controller must be constantly alert—a blunder could result in tragedy. I wonder however if that job is more taxing than mine. After all, the pilots are cooperative and intend to take off or land safely. But the ships I guide are sometimes on an intentional crash course.

Here's what happened during one thirty-minute period last Thursday morning. At 10:25 I received the mail, and skimmed a long, rambling, angry letter from a patient named Felix just prior to the beginning of my 10:30 session. Felix announced his plans to carry out a “blood bath,” in which he would murder three doctors, including two psychiatrists who had treated him in the past! In his letter Felix stated, “I'm just waiting until I get enough energy to drive to the store and purchase the pistol and the bullets.” I was unable to reach Felix by phone, so I began my 10:30 session with Harry. Harry was emaciated and looked like a concentration camp victim. He was unwilling to eat because of a delusion that his bowels had “closed off,” and he had lost seventy pounds. As I was discussing the unwelcome option of hospitalizing Harry for forced tube feeding to prevent his death from starvation, I received an emergency telephone call from a patient named Jerome, which interrupted the session. Jerome informed me he had placed a noose around his neck and was seriously considering hanging himself before his wife came home from work. He announced his unwillingness to continue outpatient treatment and insisted that hospitalization would be pointless.

I straightened out these three emergencies by the end of the day, and went home to unwind. At just about bedtime I received a call from a new referral —a well-known woman VIP referred by another patient of mine. She indicated she'd been depressed for several months, and that earlier in the evening she'd been standing in front of a mirror practicing slitting her throat with a razor blade. She explained she was calling me only to pacify the friend who referred her to me, but was unwilling to schedule an appointment because she was convinced her case was "hopeless."

Every day is not as nerve-racking as that one! But at times it does seem like I'm living in a pressure cooker. This gives me a wealth of opportunities to learn to cope with intense uncertainty, worry, frustration, irritation, disappointment, and guilt. It affords me the chance to put my cognitive techniques to work on myself and see firsthand if they're actually effective. There are many sublime and joyous moments too.

If you have ever gone to a psychotherapist or counselor, the chances are that the therapist did nearly all the listening and expected you to do most of the talking. This is because many therapists are trained to be relatively passive and non-directive—a kind of "human mirror" who simply reflects what you are saying.\* This one-way style of communication may have seemed unproductive and frustrating to you. You may have wondered—"What is my psychiatrist really like? What kinds of feelings does he have? How does he deal with them? What pressures does he feel in dealing with me or with other patients?"

Many patients have asked me directly, "Dr. Burns, do you actually practice what you preach?" The fact is, I often do pull out a sheet of paper on the train ride home in the evening, and draw a line down the center from top to bottom so I can utilize the double-column technique to cope with any nagging emotional hangovers from the day. If you are curious to take a look behind the scenes, I'll be glad to share some of my self-help homework with you. This is your chance to sit back and listen while the *psychiatrist* does the talking! At the same time, you can get an idea of how the cognitive techniques you have mastered to overcome clinical depression can be applied to all sorts of daily frustrations and tensions that are an inevitable part of living for all of us.

## Coping With Hostility: The Man Who Fired Twenty Doctors

One high-pressure situation I often face involves dealing with angry, demanding, unreasonable individuals. I suspect I have treated a few of the East Coast's top anger champions. These people often take their resentment out on the people who care the most about them, and sometimes this includes me.

Hank was an angry young man. He had fired twenty doctors before he was referred to me. Hank complained of episodic back pain, and was convinced he suffered from some severe medical disorder. Because no evidence for any physical abnormality had ever surfaced, in spite of lengthy, elaborate medical evaluations, numerous physicians told him that his aches and pains were in all likelihood the result of emotional tension, much like a headache. Hank had difficulty accepting this, and he felt his doctors were writing him off and just didn't give a damn about him. Over and over he'd explode in a fury, fire his doctor, and seek out someone new. Finally, he consented to see a psychiatrist. He resented this referral, and after making no progress for about a year, he fired his psychiatrist and sought treatment at our Mood Clinic.

Hank was quite depressed, and I began to train him in cognitive techniques. At night when his back pain flared up. Hank would work himself up into a frustrated rage and impulsively call me at home (he had persuaded me to give him my home number so he wouldn't have to go through the answering service). He would begin by swearing and accusing me of misdiagnosing his illness. He'd insist he had a medical, not a psychiatric, problem. Then he'd deliver some unreasonable demand in the form of an ultimatum: "Dr. Burns, either you arrange for me to get shock treatments tomorrow or I'll go out and commit suicide tonight." It was usually difficult, if not impossible, for me to comply with most of his demands. For example, I don't give shock treatments, and furthermore I didn't feel this type of treatment was indicated for Hank. When I would try to explain this diplomatically, he would explode and threaten some impulsive destructive action.

During our psychotherapy sessions Hank had the habit of pointing out each of my imperfections (which are real enough). He'd often storm around the office, pound on the furniture, heaping insults and abuse on me. What used to get me in particular was Hank's accusation that I didn't care about him. He said that all I cared about was money and maintaining a high

therapy success rate. This put me in a dilemma, because there was a grain of truth in his criticisms—he was often several months behind in making payments for his therapy, and I was concerned that he might drop out of treatment prematurely and end up even more disillusioned. Furthermore, I was eager to add him to my list of successfully treated individuals. Because there was some truth in Hank's haranguing attacks, I felt guilty and defensive when he would zero in on me. He, of course, would sense this, and consequently the volume of his criticism would increase.

I sought some guidance from my associates at the Mood Clinic as to how I might handle Hank's outbursts and my own feelings of frustration more effectively. The advice I received from Dr. Beck was especially useful. First, he emphasized that I was "unusually fortunate" because Hank was giving me a golden opportunity to learn to cope with criticism and anger effectively. This came as a complete surprise to me; I hadn't realized what good fortune I had. In addition to urging me to use cognitive techniques to reduce and eliminate my own sense of irritation, Dr. Beck proposed I try out an unusual strategy for interacting with Hank when he was in an angry mood. The essence of this method was: (1) Don't turn Hank off by defending yourself. Instead, do the opposite—urge him to say all the worst things he can say about you. (2) Try to find a grain of truth in all his criticisms and then agree with him. (3) After this, point out any areas of disagreement in a straightforward, tactful, nonargumentative manner. (4) Emphasize the importance of sticking together, in spite of these occasional disagreements. I could remind Hank that frustration and fighting might slow down our therapy at times, but this need not destroy the relationship or prevent our work from ultimately becoming fruitful.

I applied this strategy the next time Hank started storming around the office screaming at me. Just as I had planned, I urged Hank to keep it up and say all the worst things he could think of about me. The result was immediate and dramatic. Within a few moments, all the wind went out of his sails—all his vengeance seemed to melt away. He began communicating sensibly and calmly, and sat down. In fact, when I agreed with some of his criticisms, he suddenly began to defend me and say some nice things about me! I was so impressed with this result that I began using the same approach with other angry, explosive individuals, and I actually did begin to enjoy his hostile outbursts because I had an effective way to handle them.

I also used the double-column technique for recording and talking back to my automatic thoughts after one of Hank's midnight calls (see Figure 16–1, page 415). As my associates suggested, I tried to see the world through Hank's eyes in order to gain a certain degree of empathy. This was a specific antidote that in part dissolved my own frustration and anger, and I felt much less defensive and upset. It helped me to see his outbursts more as a defense of his own self-esteem than as an attack on me, and I was able to comprehend his feelings of futility and desperation. I reminded myself that much of the time he was damn hardworking and cooperative, and how foolish it was for me to demand he be totally cooperative at all times. As I began to feel more calm and confident in my work with Hank, our relationship continually improved.

Eventually, Hank's depression and pain subsided, and he terminated his work with me. I hadn't seen him for many months when I received a message from my answering service that Hank wanted me to call him. I suddenly felt apprehensive; memories of his turbulent tirades flooded my mind, and my stomach muscles tensed up. With some hesitation and mixed feelings, I dialed his number. It was a sunny Saturday afternoon, and I'd been looking forward to a much needed rest after an especially taxing week. Hank answered the phone: "Dr. Burns, this is Hank. Do you remember me? There's something I've been meaning to tell you for some time ..." He paused, and I braced for the impending explosion. "I've been essentially free of pain and depression since we finished up a year ago. I went off disability and I've gotten a job. I'm also the leader of a self-help group in my own hometown."

This wasn't the Hank I remembered! I felt a wave of relief and delight as he went on to explain, "But that's not why I'm calling. What I want to say to you is ..." There was another moment of silence—"I'm grateful for your efforts, and I now know you were right all along. There was nothing dreadfully wrong with me, I was just upsetting myself with my irrational thinking. I just couldn't admit it until I knew for sure. Now, I feel like a whole man, and I had to call you up and let you know where I stood ... It was hard for me to do this, and I'm sorry it took so long for me to get around to telling you."

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**Figure 16–1.** Coping with Hostility.

<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. I've put more energy into working with Hank than nearly anyone, and this is what I get—abuse!	1. Stop complaining. You sound like Hank! He's frightened and frustrated, and he's trapped in his resentment. Just because you work hard for someone, it doesn't necessarily follow that they'll feel appreciative. Maybe he will some day.
2. Why doesn't he trust me about his diagnosis and treatment?	2. Because he's in a panic, he's extremely uncomfortable and in pain, and he hasn't yet gotten any substantial results. He'll believe you once he starts getting well.
3. But in the meantime, he should at least treat me with respect!	3. Do you expect him to show respect <i>all</i> the time or <i>part</i> of the time? In general, he exerts tremendous effort in his self-help program and does treat you with respect. He's determined to get well—if you don't expect perfection, you won't have to feel frustrated.
4. But is it fair for him to call me so often at home at night? And does he have to be so abusive?	4. Talk it over with him when you're both feeling more relaxed. Suggest that he supplement his individual therapy by joining a self-help group in which the various patients call each other for moral support. This will make it easier for him to cut down on calls to you. But for now, remember that he doesn't <i>plan</i> these emergencies, and they are very terrifying and real to him.

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Thank you, Hank! I want you to know that some tears of joy and pride in you come to my eyes as I write this. It was worth the anguish we both went through a hundred times over!

### **Coping With Ingratitude: The Woman Who Couldn't Say Thank You**

Did you ever go out of your way to do a favor for someone only to have the person respond to your efforts with indifference or nastiness? People *shouldn't* be so unappreciative, right? If you tell yourself this, you will probably stew for days as you mull the incident over and over. The more inflammatory your thoughts and fantasies become, the more disturbed and angry you will feel.

Let me tell you about Susan. After high-school graduation, Susan sought treatment for a recurrent depression. She was very skeptical that I could help her and continually reminded me that she was hopeless. She had been in a hysterical state for several weeks because she couldn't decide which of two colleges to attend. She acted as though the world would come to an end if she didn't make the "right" decision, and yet the choice was simply not clear-cut. Her insistence on eliminating all uncertainty was bound to cause her endless frustration because it simply couldn't be done.

She cried and sobbed excessively. She was insulting and abusive to her boyfriend and her family. One day she called me on the phone, pleading for help. She just had to make up her mind. She rejected every suggestion I made, and angrily demanded I come up with some better approach. She kept insisting, "Since I can't make this decision, it proves your cognitive therapy won't work for me. Your methods are no damn good. I'll never be able to decide, and I can't get better." Because she was so upset, I arranged my afternoon schedule so that I could have an emergency consultation with a colleague. He offered several outstanding suggestions; I called her right back and gave her some tips on how to resolve her indeciseness. She was then able to come to a satisfactory decision within fifteen minutes, and felt an instantaneous wave of relief.

When she came in for her next regularly scheduled session, she reported she had been feeling relaxed since our talk, and had finalized the arrangements to attend the college that she chose. I anticipated waves of gratitude because of my strenuous efforts on her behalf, and I asked her if she was still convinced that cognitive techniques would be ineffective for her. She reported, "Yes, indeed! This just proves my point. My back was up against the wall, and I *had* to make a decision. The fact that I'm feeling good now doesn't count because it can't last. This stupid therapy can't help me. I'll be depressed for the rest of my life." My thought: "My God! How illogical can you get? I could turn mud into gold, and she wouldn't even notice!" My blood was boiling, so I decided to use the double-column technique later that day to try and calm my troubled and insulted spirits (see Figure 16-2, page 418).

After writing down my automatic thoughts, I was able to pinpoint the irrational assumption that caused me to get upset over her ingratitude. It was, "If I do something to help someone, they are duty-bound to feel

grateful and reward me for it.” It would be nice if things worked like this, but it’s simply not the case. No one has a moral or legal obligation to credit me for my cleverness or praise my good efforts on their behalf. So why expect it or demand it? I decided to tune in to reality and adopt a more realistic attitude: “If I do something to help someone, the chances are the person *will* be appreciative, and that will feel good. But every now and then, someone will not respond the way I want. If the response is unreasonable, this is a reflection on that person, not me, so why get upset over it?” This attitude has made life much sweeter for me, and overall I have been blessed with as much gratitude from patients as I could desire. Incidentally, Susan gave me a call just the other day. She’d done well at college and was about to graduate. Her father had been depressed, and she wanted a referral to a good cognitive therapist! Maybe that was her way of saying thank you!

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**Figure 16–2.** Coping with Ingratitude.

<i>Automatic Thoughts</i>	<i>Rational Responses</i>
1. How can such a brilliant girl be so illogical?	1. Easily! Her illogical thinking is the cause of her depression. If she didn't continually focus on negatives and disqualify positives, she wouldn't be depressed so often. It's your job to train her in how to get over this.
2. But I can't. She's determined to beat me down. She won't give me an ounce of satisfaction.	2. She doesn't have to give you any satisfaction. Only you can do this. Don't you recall that only <i>your</i> thoughts affect your moods? Why not credit yourself for what you did? Don't wait around for her. You just learned some exciting things about how to guide people in making decisions. Doesn't that count?
3. But she should admit I helped her! She should be grateful!	3. Why "should" she? That's a fairy tale. If she could she probably would, but she can't yet. In time she'll come around, but she'll have to reverse an ingrained pattern of illogical thinking that's been dominating her mind for over a decade. She may be <i>afraid</i> to admit she's getting help so she won't end up disillusioned again. Or she might be afraid you'll say, "I told you so." Be like Sherlock Holmes and see if you can figure out this puzzle. It's pointless to demand that she be different from the way she is.

## Coping With Uncertainty and Helplessness: The Woman Who Decided to Commit Suicide

On my way to the office on Monday, I always wonder what the week will hold in store. One Monday morning I was in for an abrupt shock. As I unlocked the office, I found some papers had been slipped under the door over the weekend—a twenty-page letter from a patient named Annie. Annie had been referred to me several months earlier on her twentieth birthday, after having received eight years of completely successful treatment from several therapists for a horrible, grotesque mood disorder. From age twelve on, Annie's life had deteriorated into a nightmarish pattern of depression

and self-mutilation. She loved to slash her arms to shreds with sharp objects, one time requiring 200 stitches. She also made a number of nearly successful suicide attempts.

I tensed as I picked up her note. Annie had recently expressed a deep sense of despair. In addition to depression, she suffered from a severe eating disorder, and the previous week had engaged in a bizarre three-day spree of compulsive, uncontrollable binge-eating. Going from restaurant to restaurant, she would stuff herself for hours nonstop. Then she'd vomit it all up and eat some more. In her note she described herself as a "human garbage disposal," and explained that she was beyond hope. She indicated that she had decided to give up trying because she realized she was basically "a nothing."

Without reading further, I called her apartment. Her roommates told me that she had packed up and "left town" for three days without giving any indication of where or why. Alarms sounded in my head! This is exactly what she had done on her last several suicide attempts prior to treatment—she'd drive to a motel, sign in under an assumed name, and overdose. I continued to read her letter. In it she stated, "I'm drained, I'm like a burnt-out light bulb. You can pipe electricity into it, but it just won't light up. I'm sorry but I guess it's just too late. I'm not going to feel false hope any longer ... During the last few moments I do not feel particularly sad. Once every so often I try to grasp onto life, hoping to clench my hands around something, anything—but I keep grasping nothing, empty."

It sounded like a bona fide suicide note, although no explicit intention was announced. I suddenly became submerged by a massive uncertainty and helplessness—she had disappeared and left no traces. I felt angry and anxious. Because I could do nothing for her, I decided to write down the automatic thoughts that flowed through my mind. I hoped some rational responses would help me cope with the intense uncertainty I was facing (see Figure 16–3, page 421).

After recording my thoughts, I decided to call my associate, Dr. Beck, for a consultation. He agreed that I should assume she was alive unless it was proved otherwise. He suggested that if she were found dead, I could then learn to cope with one of the professional hazards of working with depression. If she was alive, as we assumed, he emphasized the importance of persisting with treatment until her depression finally broke.

The effect of this conversation and the written exercise was magnificent. I realized I was under no obligation to assume “the worst,” and that it was my right to choose not to make myself miserable over her possible suicide attempt. I decided I couldn’t take on responsibility for her actions, only for mine, and that I had done well with her and would stubbornly continue to do so until she and I had finally defeated her depression and tasted victory.

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Automatic Thoughts	Rational Responses
1. She's probably made a suicide attempt—and succeeded.	1. There's no proof she's dead. Why not assume she's alive until proven otherwise? Then you won't have to worry and obsess in the meantime.
2. If she's dead, it means I killed her.	2. No, you're not a killer. You're trying to help.
3. If I'd done something different last week, I could have prevented this. It's my fault.	3. You're not a fortune teller—you can't predict the future. You do the best you can based on what you know—draw the line there and respect yourself on this basis.
4. This shouldn't have happened—I tried so hard.	4. Whatever happened did happen. Just because you make maximal efforts, there's no guarantee about the results. You can't control her, only your efforts.
5. This means my approach is second-rate.	5. Your approach is one of the finest ever developed, and you apply yourself with great effort and commitment, and get outstanding results. You are <i>not</i> second-rate.
6. Her parents will be angry with me.	6. They may and they may not. They know how you've knocked yourself out for her.
7. Dr. Beck and my associates will be angry with me—they'll know I'm incompetent, and they'll look down on me.	7. Extremely unlikely. We'll all be disappointed to lose a patient we've gone to such extreme lengths to help, but your peers won't feel you've let them down. If you're at all concerned, call them! Practice what you preach, Burns.
8. I'll feel miserable and guilty until I find out what happened. I'm expected to feel that way.	8. You'll only feel miserable if you make a negative assumption. Odds are (a) she's alive and (b) she'll get better. Assume this and you'll feel good! You have no obligation to feel bad—you have the <i>right</i> to refuse to get upset.

**Figure 16–3.** Coping with Uncertainty.

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My anxiety and anger disappeared completely, and I felt relaxed and peaceful until I received the news by telephone on Wednesday morning.

She had been found unconscious in a motel room fifty miles from Philadelphia. This was her eighth suicide attempt, but she was alive and complaining as usual in the Intensive Care Unit of an outlying hospital. She would survive, but would require plastic surgery to replace the skin over her elbows and ankles because of sores which had developed during the long period of unconsciousness. I arranged for her transfer to the University of Pennsylvania, where she would be back in my relentless, cognitive clutches again!

When I spoke with her, she was enormously bitter and hopeless. The next couple of months of therapy were especially turbulent. But the depression finally began to lift in her eleventh month, and exactly one year to the day of her referral, her twenty-first birthday, the symptoms of depression disappeared.

*The Payoff.* My joy was enormous. Women must have this feeling when they first see their child after delivery—all the discomfort of pregnancy and the pain of delivery are forgotten. It's the celebration of life—quite a heady experience. I find that the more chronic and severe the depression, the more intense the therapeutic struggle becomes. But when the patient and I at last discover the combination that unlocks the door to their inner peace, the riches inside far exceed any effort or frustration that occurred along the way.

## Part VII

### **The Chemistry of Mood**

NOTE: Numbered Notes and References for Chapters 17–20 can be found on pages 682–687. Because some References are cited more than once, the superscript numbers assigned to those References will appear in these chapters more than once.

## Chapter 17

### The Search for “Black Bile”

*(Notes and References appear on pages 682–687.)*

Some day, scientists may provide us with frightening technology that will allow us to change our moods at will. This technology may be in the form of a safe, fast-acting medication that relieves depression in a matter of hours with few or no side effects. This breakthrough will represent one of the most extraordinary and philosophically confusing developments in human history. In a sense, it will almost be like discovering the Garden of Eden again—and we may face new ethical dilemmas. People will probably ask questions like these: When should we use this pill? Are we entitled to be happy all the time? Is sadness sometimes a normal and healthy emotion, or should it always be considered an abnormality that needs treatment? Where do we draw the line?

Some people think such technology has already arrived in the form of a pill called Prozac. When you read the next few chapters, you will see that this is not really the case. Although we have large numbers of antidepressant medications that work for some people, many people do not respond to antidepressant medications in a satisfactory way, and when they do improve, the improvement is often incomplete. Clearly, we are still a long way from our goal.

In addition, we still do not really know how the brain creates emotions. We do not know why some people are more prone to negative thinking and gloomy moods throughout their lives, whereas others seem to be eternal optimists who always have a positive outlook and a cheerful disposition. Is depression partially genetic? Is it due to some type of chemical or hormonal imbalance? Is it something we’re born with, or something we learn? The answers to these questions still elude us. Many people wrongly believe we already have the answers.

The answers to questions about treatment are equally unclear. Which patients should be treated with medications? Which patients need psychotherapy? Is the combination better than either type of treatment alone? You will see that the answers to questions as basic as these are more controversial than you might expect.

In this chapter, I address these issues. I discuss whether depression is caused more by biology (nature) or the environment (nurture). I explain how the brain works, and review evidence that depression might be caused by a chemical imbalance in the brain. I also describe how antidepressant drugs attempt to correct this imbalance.

In Chapter 18, I discuss the “mind-body problem” and address the current controversies about treatments that affect the “mind” (for instance, cognitive therapy) versus treatments that affect the “body” (for instance, antidepressants.) In Chapters 19 and 20, I will give you practical information about all the antidepressant drugs that are currently prescribed for mood problems.

## **Do Genetic or Environmental Influences Play a Greater Role in Depression?**

Although much research is being conducted to try to tease out the relative strengths of the genetic and environmental influences on depression, scientists do not yet know which influences are the most important. With regard to bipolar (manic-depressive) illness, the evidence is quite strong: genetic factors seem to play a strong role. For example, if one identical twin develops bipolar manic-depressive illness, the odds are high that the other twin will also develop this disorder (50 percent to 75 percent). In contrast, when one of two nonidentical twins develops bipolar (manic-depressive) illness, the odds that the other twin will develop the same illness are lower (15 percent to 25 percent). The odds of developing bipolar illness if a parent or nontwin sibling has this disorder are around 10 percent. All these odds are considerably higher than the odds that someone in the general population will develop bipolar illness—the lifetime risk is estimated at less than 1 percent.

Keep in mind that identical twins have identical genes, whereas nonidentical twins share only half their genes. This is probably why the

likelihood of bipolar (manic-depressive) illness is so much higher if you have an identical twin than if you have a nonidentical twin with this disorder, and why these rates are so much higher than the rates for bipolar illness in the general population. The increased risk for bipolar illness among identical twins is even true if the identical twins are separated at birth and raised by different families. Although the adoption of identical twins by separate families is rare, it does happen on occasion. In some cases, scientists have been able to locate the twins later in life to determine how similar or different they are. These “natural” experiments can tell us a great deal about the relative importance of genes versus environment because the separately raised identical twins have identical genes but their environments are different. Such studies highlight the importance of strong genetic influences in bipolar disorder.

With regard to the far more common garden-variety depression without episodes of uncontrollable mania, the evidence for genetic factors is still quite fuzzy. Part of the problem facing genetic researchers is that the diagnosis of depression is much less clear-cut than the diagnosis of bipolar (manic-depressive) illness. Bipolar manic-depressive illness is such an unusual disorder, at least in its more severe forms, that the diagnosis is often obvious. The patient has a sudden and alarming change in personality that comes on without drugs or alcohol, along with symptoms such as:

- intense euphoria, often with irritability;
- incredible energy with constant exercising or restless, agitated body movements;
- very little need for sleep;
- nonstop, pressured talking;
- racing thoughts that skip from subject to subject;
- grandiose delusions (for example, the sudden belief that one has a plan for world peace);
  - impulsive, reckless, and inappropriate behaviors (such as spending money foolishly);
- inappropriate, excessive flirtatiousness and sexual activity;
- hallucinations (in severe cases).

These symptoms are usually unmistakable and often so uncontrollable that the patient may require hospitalization with medication treatment. Following recovery, the individual usually returns to absolutely normal functioning again. These distinct features of bipolar illness make genetic research relatively straightforward, since it is usually not difficult to determine when individuals have the disorder and when they do not. In addition, this disorder usually begins fairly early in life, with the first episode often occurring by the age of twenty to twenty-five.

In contrast, the diagnosis of depression is much less obvious. Where does normal sadness end and clinical depression begin? The answer is somewhat arbitrary, but the decision will have a big impact on the results of research. Another difficult question genetic researchers face is this: How long should we wait before we decide whether or not a person has developed a clinical depression during his or her life? Suppose, for example, that an individual with a strong family history of depression dies in an auto accident at the age of twenty-one without ever having had an episode of clinical depression. We might conclude that she or he did not inherit the tendency for depression. But if that individual had not died, she or he might have developed an episode of depression later on in life, since a first episode of depression can often occur when you are older than twenty-one.

Problems like this are not insurmountable, but they do make genetic research on depression difficult. In fact, many previously published studies on the genetics of depression are quite flawed and do not permit us to make any unambiguous conclusions about the importance of heredity versus environment in this disorder. Fortunately, more sophisticated studies are now under way, and we may have better answers to these questions during the next five to ten years.

### **Is Depression Caused by a “Chemical Imbalance” in the Brain?**

Throughout the ages, humans have searched for the causes of depression. Even in ancient times there was some suspicion that blue moods were due to an imbalance in body chemistry. Hippocrates (460–377 B.C.) thought that “black bile” was the culprit. In recent years scientists have spearheaded an intensive search for the elusive black bile. They have tried to pinpoint the imbalances in brain chemistry that might cause depression. There are hints

about the answer, but in spite of increasingly sophisticated research tools, scientists have not yet discovered the causes of depression.

At least two major arguments have been advanced to support the notion that some type of chemical imbalance or brain abnormality may play a role in clinical depression. First, the physical (somatic) symptoms of severe depression support the notion that organic changes might be involved. These physical symptoms include agitation (increased nervous activity such as pacing or hand-wringing) or enormous fatigue (motionless apathy—you feel like a ton of bricks and do nothing). You also may experience a “diurnal” variation in your mood. This refers to a worsening of the symptoms of depression in the morning and an improvement toward the end of the day. Other physical symptoms of depression include disturbed sleep patterns (insomnia is the most common), constipation, changes in appetite (usually decreased, sometimes increased), trouble concentrating, and a loss of interest in sex. Because these symptoms of depression “feel” quite physical, there is a tendency to think that the causes of depression are physical.

A second argument for a physiologic cause for depression is that at least some mood disorders seem to run in families, suggesting a role for genetic factors. If there is an inherited abnormality that predisposes some individuals to depression, it could be in the form of a disturbance in body chemistry, as with so many genetic diseases.

The genetic argument is interesting but the data are inconclusive. The evidence for genetic influences in bipolar manic-depressive illness is much stronger than the evidence for genetic influences in the more common forms of depression that afflict most people. In addition, lots of things that do not have genetic causes run in families. For example, families in the United States nearly always speak English, and families in Mexico nearly always speak Spanish. We can say that the tendency to speak a certain language also runs in families, but the language you speak is learned and not inherited.

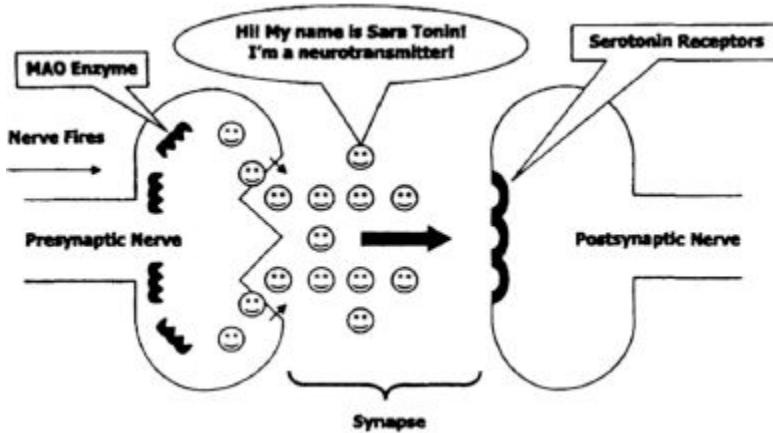
I don’t mean to discount the importance of genetic factors. Recent studies of identical twins who were separated at birth and raised in different families show that many traits we think of as being learned are actually inherited. Even such personality traits as a tendency toward shyness or sociability appear to be partly inherited. Personal preferences, such as liking

a particular flavor of ice cream, may also be strongly influenced by our genes. It seems plausible that we may also inherit a tendency to look at things either in a positive, optimistic way or in a negative, gloomy way. Much more research will be needed to sort out this possibility.

## **How Does the Brain Work?**

The brain is essentially an electrical system that is similar in some ways to a computer. Different portions of the brain are specialized for different kinds of functions. For example, the surface of the brain toward the back of your head is called the “occipital cortex.” This is where vision takes place. If you had a stroke that affected this region of the brain, you would have trouble with your vision. A small region on the surface of the left half of your brain is called “Broca’s area.” This is the part of your brain that allows you to talk to other people. If this part of your brain were injured by a stroke, you would have difficulty talking. You might be able to think of what you wanted to say, but find that you had “forgotten” how to speak the words. A primitive part of your brain called the “limbic system” is thought to be involved in the control of emotions such as joy, sadness, fear, or anger. However, our knowledge of where and how the brain creates positive and negative emotions is still very limited.

We do know that nerves are the “wires” that make up the electrical circuits in the brain. The long thin part of a nerve is called the “axon.” When a nerve is stimulated, it sends an electrical signal along the axon to the end of the nerve. A nerve is much more complex than a simple wire, however. For example, a nerve may receive input from tens of thousands of other nerves. Once it is stimulated, its axon may send out signals to tens of thousands of other nerves.



**Figure 17–1.** When the presynaptic nerve fires, packets of serotonin molecules (neurotransmitters) are released into the synapse. They swim over to the receptors on the surface of the postsynaptic nerve.

This is because the axon can divide and send out many branches. Each of these branches also divides into even more branches, in much the same way that the trunk of a tree divides into more and more branches. Because of this branching tendency, a single nerve in the brain may send out signals to as many as 25,000 other nerves that are located throughout the entire brain.

How do the nerves in your brain communicate their electrical signals to other nerves? To understand this, take a look at Figure 17–1 above. You can see a simplified diagram of two nerves. The region where they meet is called the “synapse.” You may not be familiar with that term, but don’t feel intimidated by it. It just means the space between two nerves. The left-hand nerve is called the “presynaptic nerve” and the right-hand nerve is called the “postsynaptic nerve.” Again, these terms do not have any other fancy or special meanings. They merely refer to the nerve that ends (presynaptic nerve) or begins (postsynaptic nerve) on the left or right edge of the synapse in the figure.

The communication of the electrical signal across this synapse is important to our understanding of how the brain works. The synaptic region between the presynaptic nerve on the left and the postsynaptic nerve on the right is filled with fluid. This discovery was a major breakthrough in the history of neuroscience. When you think of it, this discovery is not so surprising since our bodies are made up primarily of water. However, scientists were puzzled because they knew that the electrical impulses of

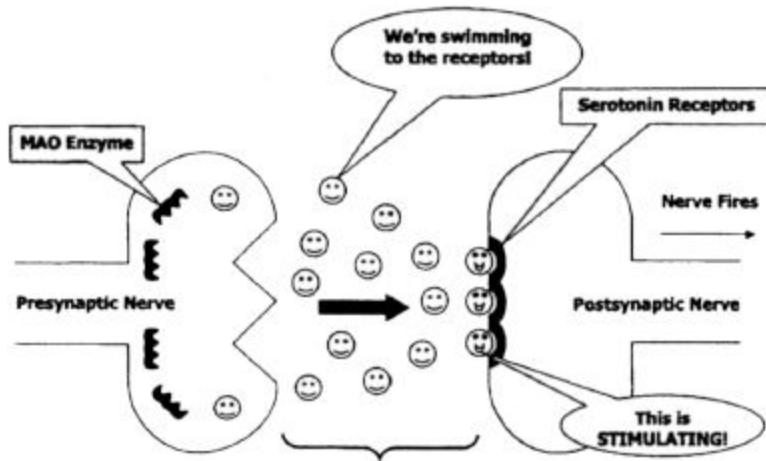
nerves were too weak to travel across the synaptic fluid. So how does the presynaptic nerve on the left in Figure 17–1 send its electrical signal across the fluid-filled synapse to the postsynaptic nerve?

As an analogy, imagine that you are hiking and you come to a river. You really need to get to the other side, but the water is too deep. Furthermore, there's no bridge and it's too far to jump. How do you get to the other side? You might need a canoe, or you might have to swim for it.

Nerves face a similar problem. Because their electrical impulses are too weak to jump across synapses, the nerves send little swimmers across with their messages. These little swimmers are chemicals called “neurotransmitters.” The nerve in Figure 17–1 uses a neurotransmitter called serotonin.

You can see in Figure 17–1 that when the presynaptic nerve fires, it releases many tiny packets of serotonin into the synapse. Once released, these chemical messengers migrate or “swim” through a process called diffusion across the fluid-filled synapse. At the other side of the synapse, the serotonin molecules become attached to receptors on the surface of the postsynaptic nerve. This signal tells the postsynaptic nerve to fire, as illustrated in Figure 17–2 on page 436.

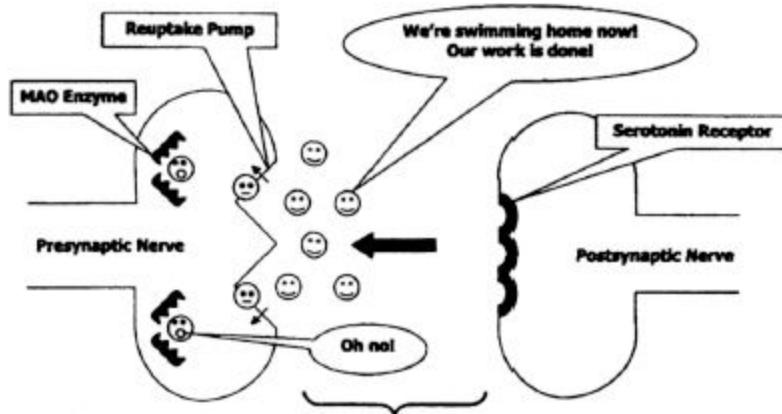
Different kinds of nerves use different kinds of neurotransmitters. There are a great many of these neurotransmitters in the brain. Chemically, many of them are categorized as “biogenic amines” because they are manufactured from amino acids in the foods we eat. These amine transmitters are the brain’s biochemical messengers. Three of the amine transmitters in the limbic (emotional) regions of the brain are called serotonin, norepinephrine, and dopamine. These three transmitters have been theorized to play a role in many psychiatric disorders and have been intensively studied by psychiatric researchers. Because these chemical messengers are called biogenic amines, the theories linking them to depression or mania are sometimes referred to as the biogenic amine theories. But we are getting ahead of ourselves.



**Figure 17–2.** The serotonin molecules become attached to the receptors on the postsynaptic nerve. This stimulates the nerve to fire.

How does a chemical messenger cause the postsynaptic nerve to fire once it becomes attached to the nerve? Let's imagine for a moment that the chemical transmitter in the presynaptic nerve is serotonin. (I could have chosen any of them, since they all work in a similar manner.) On the surface of the postsynaptic nerve there are tiny areas called "serotonin receptors." You can think of these receptors as locks because they cannot be opened up without the right key. These receptors are on the membranes that form the outer surface of nerves. These nerve membranes are something like the skin that covers your body.

Now, think of the serotonin as the key to the lock on the postsynaptic nerve. Just like a real key, the serotonin works only because it has a specific shape. There are many other chemicals floating around in the synaptic region, but they will not open the serotonin lock because they do not have the right molecular shape. Once the key fits into the lock, the lock opens up. This triggers additional chemical reactions that cause the postsynaptic nerve to fire electrically. When the nerve fires, the serotonin (the key) is released from the receptor (the lock) on the postsynaptic nerve and ends in the synaptic fluid again. Finally, it "swims" back to the presynaptic nerve (again, through a process called diffusion), as illustrated in Figure 17–3 above.



**Figure 17–3.** The serotonin molecules swim back to the presynaptic nerve where they are pumped back inside. Once inside, MAO destroys them.

The serotonin has done its job, and the presynaptic nerve needs to get rid of it; otherwise it will hang around in the synapse and it might swim back to the postsynaptic nerve again. This could create confusion, because the postsynaptic nerve may think there is a new signal and it may get stimulated to fire again.

To solve this problem, the presynaptic nerve has a pump on its surface. Once the serotonin swims back, it attaches to a receptor (another “lock”) on the surface of the presynaptic nerve and it is pumped back into the nerve by something called the “membrane pump” or the “reuptake pump,” as you can see in Figure 17–3.

After the serotonin is pumped back inside, the presynaptic nerve can recycle it or it can destroy the excess serotonin if it already has enough saved up for the next electrical signal. It destroys the excess serotonin through a process called “metabolism,” which means changing one chemical into another chemical. In this case, the serotonin is changed into a chemical that can be absorbed into the bloodstream. The enzyme in the nerve that performs this service is called monoamine oxidase, or MAO for short. The MAO enzyme transforms the serotonin into a new chemical called “5-hydroxyindoleacetic acid,” or 5-HIAA. That is another big name, but you can simply think of 5-HIAA as the waste product of the serotonin. The 5-HIAA leaves your brain, enters your bloodstream, and is carried to

your kidneys. Your kidneys remove the 5-HIAA from your blood and send it to your bladder. Finally, you get rid of the 5-HIAA when you urinate.

That's the end of the serotonin cycle. Of course, the presynaptic nerve must continually manufacture a new supply of serotonin to use in nerve-firing so that the total amount of serotonin does not get depleted.

## What Goes Wrong in Depression?

First of all, let me reemphasize that scientists do not yet know the cause of depression or any other psychiatric disorder. There are lots of interesting theories, but none of them has yet been proven. One day, we may have the answer and look back on the thinking of this era as a quaint historical curiosity. However, science has to start somewhere, and research on the brain is moving forward at an explosive rate. New and very different theories will undoubtedly emerge in the next decade.

The explanations in this section will be very simplified. The brain is enormously complex and our knowledge about how it works is still extremely primitive. There is a vast amount we do not know about the brain's hardware and software. How does the firing of a nerve or a series of nerves get translated into a thought or a feeling? This is one of the deepest mysteries of science, as amazing to me as questions about the origin of the universe.

We won't even attempt to answer those questions here; for the moment, our goals are much more humble. If you understood Figures 17–1 to 17–3, it should be pretty easy for you to understand current theories about what goes wrong in depression.

You have already learned that nerves in the brain send messages to each other with chemical messengers called neurotransmitters. You also know that some of the nerves in the limbic system of the brain use serotonin, norepinephrine, and dopamine as their chemical messengers. Some scientists have hypothesized that depression may result from a deficiency of one or more of these biogenic amine transmitter substances in the brain, while mania (states of extreme euphoria or elation) may result from an excess of one or more of them. Some researchers believe that serotonin plays the most important role in depression and mania; others believe that abnormalities in norepinephrine or dopamine also play a role.

A corollary of these biogenic amine theories is that antidepressant drugs may work by boosting the levels or activity of serotonin, norepinephrine, or dopamine in depressed patients. We will talk some more about how these drugs work in a little while.

What would happen if a chemical messenger such as serotonin became depleted from the presynaptic nerve in Figure 17–1? Then this nerve could not send its nerve signals properly across the synapses to the postsynaptic nerve. The wiring in the brain would develop faulty connections, and the result would be mental and emotional static, much like the music that comes out of a radio with a loose wire in the tuner. One type of emotional static (serotonin deficiency) would cause depression, and another type of static (serotonin excess) would cause mania.

Recently, these amine theories have been modified quite a bit. Some scientists no longer believe that a deficiency or excess of serotonin causes depression or mania. Instead, they postulate that abnormalities in one or more of the receptors on the nerve membranes may lead to mood abnormalities. Examine Figure 17–2 again, and imagine that there is something wrong with the serotonin receptors on the postsynaptic nerve. For example, there might not be enough of them. What would happen to the communication between the nerves? Although there might be plenty of serotonin molecules in the synapse, the postsynaptic nerves might not fire consistently when the presynaptic nerves fired. And if there were too many serotonin receptors, this could have the opposite effect of causing overactivity in the serotonin system.

To date, at least fifteen different kinds of serotonin receptors have been identified throughout the brain and more are being identified all the time. All these receptors probably have different effects on hormones, feelings, and behavior. Scientists do not have a very clear picture of what any of these different receptors do, nor do they know if abnormalities in any of them play a causal role in depression or mania. Research in this area is evolving at an extremely rapid pace, and we will have better information about the physiologic and psychological effects of these many serotonin receptors in the near future.

Although our knowledge about the role of serotonin receptors in brain function is still quite limited, there is evidence that the number of receptors on the postsynaptic nerves may change in response to antidepressant drug

therapy. For example, if you give a drug that boosts the levels of serotonin in the synapses between the nerves, the number of serotonin receptors on the postsynaptic nerve membranes will decrease after a few weeks. This might be a way that the nerves attempt to compensate for the excess stimulation—the nerves are trying to turn down the volume of the signal, so to speak. This kind of reaction is called “down-regulation.” In contrast, if you deplete the serotonin from the presynaptic nerve in Figure 17–1, much less serotonin will be released into the synapse. After several weeks, the postsynaptic nerves may compensate by increasing the number of serotonin receptors. The nerves are trying to turn up the volume of the signal. This kind of reaction is called “up-regulation.”

Again, these are big words with simple meanings. “Up-regulation” means “more receptors,” and “down-regulation” means “fewer receptors.” We could also say that up-regulation means turning the system up, and down-regulation means turning the system down—just like a radio.

It is known that antidepressant drugs usually require several weeks or more to become effective. Researchers have been trying to figure out why. Some researchers have speculated that down-regulation may account for the antidepressant effects of these drugs. In other words, antidepressants may work not because they boost the serotonin system, as originally proposed, but because they turn the serotonin system down after several weeks. This would imply that decreased serotonin levels might not be the cause of depression after all. Depression might instead be due to *increased* serotonin activity in the brain. Antidepressant drugs may correct this after several weeks because they turn the serotonin system down.

How well established and proven are these theories? Not at all. As I have suggested, it is awfully easy to make up a theory, but much harder to prove it. To date, it has not been possible to validate or disprove any of these theories in a convincing way. In addition, there are no clinical or laboratory tests we could give to groups of patients or to individual patients that will reliably detect any chemical imbalance that causes depression.

The main value of the current theories is to stimulate research so that our knowledge of brain function will become more sophisticated over time. Eventually, I believe we will develop much more refined theories and far better tools for testing them.

Now you may be thinking, “Is that all there is to it?” Do scientists just sit around and say, “Depression could be due to an excess or a deficiency of this or that transmitter or receptor in the brain?” On some level, that really is all there is to it. Part of the problem is that our models of the brain are still very primitive, and so our theories of depression are not yet very sophisticated either.

It may turn out that depression is not due to problems with any transmitter chemical or receptor. We may one day discover that depression is actually more of a “software” problem, and not a “hardware” problem. In other words, if you have a computer, you know that computers crash all the time. Sometimes this results from a problem with the hardware. For example, your hard drive may become defective. But more often, there’s a problem with the software—a bug that makes the program work poorly in certain situations. So with regard to brain research on depression, we may be looking for a problem in the “hardware” (for example, a chemical imbalance we are born with) whereas the real problem is in the “software” (for example, a negative thinking pattern based on learning). Both kinds of problems would be “organic,” since brain tissue is involved, but the solutions to them would be radically different.

Another major problem facing depression researchers is the chicken-versus-the-egg dilemma. Are changes we measure in the brain the cause of the depression or the result? To illustrate this problem, let’s conduct a thought experiment involving a deer in a forest. The deer is happy and contented. Imagine that we have a special machine that allows us to visualize the chemical and electrical activity in the deer’s brain. We might have, for example, a futuristic portable brain imaging machine that can work from a distance, like the laser guns the police use to see how fast you’re driving. However, the deer does not know we are monitoring its brain activity. Suddenly, the deer spots a pack of hungry wolves approaching. Panic strikes! Our brain imaging machine detects instantaneous massive changes in the electrical and chemical activity in the deer’s brain. Are these chemical and electrical changes the cause of the fear or the result of the fear? Would we say the deer is afraid because it has developed a sudden “chemical imbalance” in its brain?

Similarly, there are all kinds of chemical and electrical changes in the brains of depressed patients. Our brains change quite dramatically when we

feel happy, angry, or frightened. Which brain changes result from the strong emotions we feel, and which brain changes are the causes? Separating cause from effect is one of the thorniest challenges facing depression researchers. This problem is not impossible to solve, but it is not easy, and those eager to endorse the current theories about depression do not always acknowledge it.

Clearly, the research necessary to test any of these theories can be daunting. One significant problem is that it is still very difficult to get accurate information about the chemical and electrical process in the human brain. We can't just open up the brain of a depressed individual and look inside! And even if we could, we really wouldn't know where or how to look. But new tools, such as PET (positron emission tomography) scanning and MRI (magnetic resonance imaging), do make such research possible. For the first time, scientists can begin to "see" the activity of nerves and chemical processes inside the brains of human beings. This research is still in its infancy, and we can look forward to a great deal of progress in the next decade.

## **How Do Antidepressant Drugs Work?**

The modern era of research on the chemistry of depression got a big boost accidentally in the early 1950s when researchers were testing a new drug for tuberculosis called iproniazid.<sup>1</sup> As it turned out, iproniazid was not an effective treatment for tuberculosis. However, the investigators noticed pronounced mood elevations in a number of patients who received this drug, and hypothesized that iproniazid might have antidepressant properties. This led to an explosion of research by drug companies who wanted to be the first to develop and market antidepressant drugs.

Researchers knew that iproniazid was an inhibitor of the MAO enzyme discussed previously. The drug was therefore categorized as an MAO inhibitor, or MAOI for short. Several new MAOI drugs that were similar in chemical structure to iproniazid were developed. Two of them, phenylzine (Nardil) and tranylcypromine (Parnate), are still in use today. A third MAOI called selegiline (trade name Eldepryl) has been approved for the treatment of Parkinson's disease. This drug is also occasionally used in the treatment of mood disorders. Other new MAOIs in use abroad may eventually be marketed in the United States.

The MAOIs are no longer prescribed nearly as frequently as they used to be. This is because they can cause dangerous elevations of blood pressure if the patient combines them with certain foods such as cheese. The MAOIs can also cause toxic reactions when combined with certain drugs. Because of these hazards, newer and safer antidepressants have been developed. These new drugs work quite differently from the MAOIs. Nevertheless, the MAOIs can be extremely helpful for some depressed patients who do not respond to other medications, and they can be used safely if the patient and doctor follow a number of guidelines that I will spell out in Chapter 20.

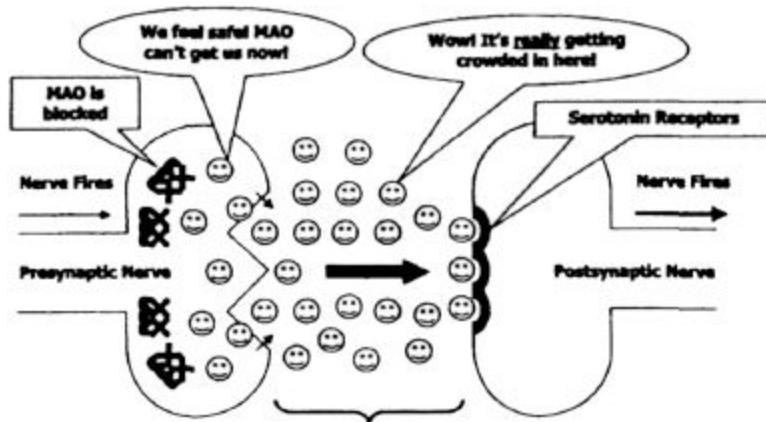
The iproniazid discovery helped to usher in a new era of biological research on depression. Scientists were eager to find out how the MAOIs worked. It was known that the MAOIs prevented the breakdown of serotonin, norepinephrine, and dopamine, the three chemical messengers that are concentrated in the limbic regions of the brain. Scientists hypothesized that a deficiency in one or more of these substances might cause depression and that antidepressant drugs might work by increasing the levels of these substances. This is how the biogenic amine theories actually originated.

Now let's see how much you've learned about how the brain works. Look at Figures 17–1 to 17–3 again. When the presynaptic nerve fires, serotonin is released into the synapse. After it attaches to a receptor on the postsynaptic nerve, it swims back to the presynaptic nerve, where it is pumped back inside this nerve and destroyed by the MAO enzyme. Now ask yourself this question: What would happen if we prevented the MAO enzyme from destroying the serotonin?

As you have probably guessed, the serotonin would accumulate in the presynaptic nerve, because this nerve is always manufacturing new serotonin. If this nerve could not get rid of its serotonin, the concentration of serotonin in the nerve would continue to increase. Whenever the presynaptic nerve fired, it would release much more serotonin than usual into the fluid-filled synaptic region. The excess serotonin in the synapse would cause a greater-than-expected stimulation of the postsynaptic nerve. This would be the chemical equivalent of turning up the volume on the radio. These effects of the MAOI antidepressants are illustrated in Figure 17–4 on page 446.

Could this be the reason the MAOI drugs cause a mood elevation? This is possible, and scientists have hypothesized that this is exactly how these MAOI drugs work. Research studies have confirmed that when these MAOI drugs are given to humans or animals, brain levels of serotonin, norepinephrine, and dopamine do increase. However, it is not known for certain if the antidepressant effects result from an increase in one of these biogenic amines, or from some other effect of these drugs on the brain.

Can you think of another theory about why or how these MAOI drugs might work? Does the increase in mood have to result from the extra stimulation of the postsynaptic nerve, or could there be another possible explanation? Think about what you read about down-regulation in the previous section and see if you can come up with an answer before you read any further.



**Figure 17–4.** MAOIs block the MAO enzyme inside the presynaptic nerve, so serotonin levels increase. The excess serotonin is released into the synaptic region whenever the nerve fires. This provides a stronger stimulation of the postsynaptic nerve.

You probably recall that the effects on the postsynaptic nerves after several weeks can be the opposite of the effects on these nerves when you first take a drug. All the extra serotonin in the synapse may cause a down-regulation of the postsynaptic serotonin receptors after several weeks, and this down-regulation may correspond to the antidepressant effects. (Remember that although some scientists think depression results from a serotonin deficiency, others believe depression results from increased brain

serotonin activity.) If you thought of this, it shows you are really learning your neurochemistry. You get an A-plus on this pop quiz!

If you said that the antidepressant effects of the MAOI drug could result from effects on some other system in the brain, you also get an A-plus. These theories about how the antidepressant drugs relieve depression are not proven facts. The effects of the MAOIs on the brain are vastly more complex than the simple model depicted in Figure 17–4. The effects of any antidepressant are probably not limited to one specific region or one specific type of nerve in the brain. Remember that each nerve in the brain connects with many thousands of other nerves, and all of them in turn connect with thousands of others. When you take an antidepressant, there are massive changes in numerous chemical and electrical systems throughout your brain. Any of these changes could be responsible for the improvement in your mood. Trying to figure out exactly how these drugs work is still a little like looking for a needle in a haystack. But the important thing for the moment is that these drugs do seem to help some depressed patients, regardless of how or why they work.

As I have mentioned, many new and different kinds of antidepressant drugs have been developed and marketed since the 1950s. Unlike the MAOIs, the newer antidepressants do not cause a buildup of transmitters like serotonin in the presynaptic nerve depicted in Figure 17–4. Instead, they mimic the effects of the brain's natural transmitter substances by attaching to receptors on the surfaces of the presynaptic or postsynaptic nerves.

To understand how these newer antidepressants can do this, remember our analogy of the lock and the key. A natural transmitter substance is like a key, and the receptor on the surface of the nerve is like a lock. The key is able to unlock the lock only because it has a certain shape. But if you were a magician, like the famous Harry Houdini, you could easily pick the lock and open it without the key.

An antidepressant medication is like a counterfeit key that a drug company has manufactured. Because the chemists know the three-dimensional shape of a natural transmitter like serotonin, norepinephrine, or dopamine, they can create new drugs that have a very similar shape. These drugs will fit into the receptors on the surfaces of nerves and mimic the effects of the natural transmitters. The brain does not know that an

antidepressant is in the lock—the brain has been tricked into thinking that the natural transmitter chemical is attached to the receptor on the surface of the nerve.

In theory, the artificial key (the antidepressant) can do one of two things when it becomes attached to the receptor. It can either open the lock, or it can jam the lock without actually opening it. Drugs that open the locks are called “agonists.” Agonists are simply drugs that mimic the effects of the natural transmitters. Drugs that jam up these locks are called “antagonists.” Antagonists block the effects of the natural transmitters and prevent them from being effective.

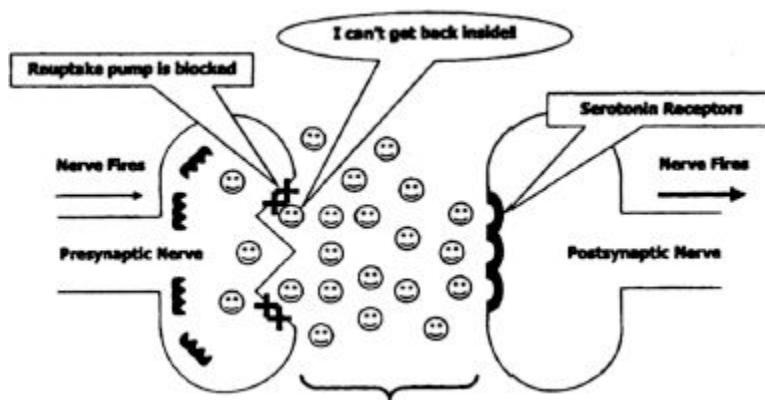
We can imagine several different ways that antidepressant drugs could influence the receptors on the presynaptic and postsynaptic nerves. For the purpose of this discussion, imagine that the transmitter used by the presynaptic nerve is serotonin, but the same considerations apply to any transmitter. What would happen if we blocked the receptors on the reuptake pump? The presynaptic nerve could no longer pump the serotonin from the synapse back inside. Each time the nerve fired, more and more serotonin would be released into the synaptic region. As a result, the synapse would get flooded with serotonin.

This is precisely how most of the currently prescribed antidepressants work. As you can see in Figure 17–5 on page 449, they block the receptors for the reuptake pumps on presynaptic nerves, and so the transmitters build up in the synaptic region. The end result of this process is similar to the effects of giving the MAOI drugs discussed above. In both instances, the levels of serotonin build up in the synaptic region. When the presynaptic nerve fires, more serotonin than normal will “swim” to the postsynaptic nerve and stimulate it to fire. Once again, we have “turned up” the serotonin system, so to speak.

Is this good? Is this why these antidepressant drugs can improve our moods? That’s the current theory, but no one really knows the answers to this question yet.

Different antidepressants block different amine pumps and some of them have more specific effects than others. The older “tricyclic” antidepressants, such as amitriptyline (Elavil) or imipramine (Tofranil) and others, block the reuptake pumps for serotonin and norepinephrine. (Tricyclic means “three wheels,” like a tricycle, because the chemical structure of these drugs

resembles three linked rings.) Therefore, these transmitters build up in the brain if you take one of these drugs. Some tricyclic antidepressants have relatively stronger effects on the serotonin pump, and some of them have relatively stronger effects on the norepinephrine pump. Drugs with stronger effects on the serotonin pump are called “serotonergic” and drugs with relatively stronger effects on the norepinephrine pump are called “noradrenergic.” What do you think we would call a drug with a strong effect on the dopamine pump? If you guessed “dopaminergic,” you would be correct!



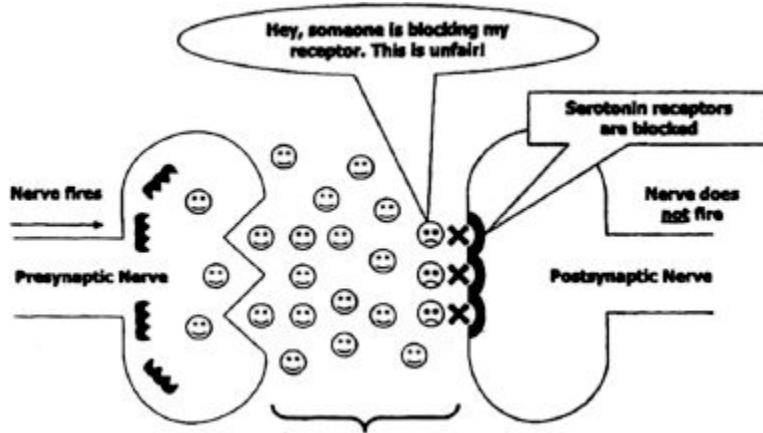
**Figure 17–5.** Most antidepressants block the reuptake pumps, so serotonin remains in the synapse after the nerve fires. Because serotonin builds up in the synaptic region, the stimulation of the postsynaptic nerve is stronger.

Some of the newer antidepressants, such as fluoxetine (Prozac), differ from the older tricyclic compounds in that they have highly selective and specific effects on the serotonin pump. If we want to use one of our new words, we can say that Prozac is highly “serotonergic” because levels of serotonin will build up in the brain when you take it. However, because Prozac blocks only the serotonin pump, the levels of other transmitters, such as norepinephrine and dopamine, will not build up. Prozac is classified as a selective serotonin reuptake inhibitor (SSRI for short) because of its selective and specific effects on the serotonin pump. Again, SSRI is an intimidating name with a humble meaning. SSRI means, “this drug blocks only, the serotonin pump and it doesn’t block any other pumps.” Five SSRIs

are currently prescribed in the United States and I will discuss them in detail in Chapter 20.

Some new antidepressants are not so selective—they block more than one type of reuptake pump. For example, venlafaxine (Effexor) blocks the serotonin and norepinephrine pumps, so it has been called a dual reuptake inhibitor. The drug company that manufactures venlafaxine promotes the idea that this drug may be more effective because the levels of two transmitters (serotonin and norepinephrine) increase, rather than just one. Actually, this is not such a novel feature. As you just learned, most of the older (and much cheaper) antidepressants do exactly the same thing. In addition, there is no evidence that venlafaxine works any better or any faster than the older drugs. However, venlafaxine has fewer side effects than some of the older tricyclic antidepressants. This might justify the increased cost of venlafaxine in some instances.

So far you have learned about the MAOIs and the pump inhibitors, such as the tricyclics and the SSRIs. Are there any other ways that antidepressant drugs might work? If you were a chemist working for a drug company and you wanted to create a completely novel antidepressant, what kinds of effects would your new drug have? One possibility would be to create a drug that directly stimulated the serotonin receptors on the postsynaptic nerves. A drug like this would mimic the effect of the natural serotonin. It would be a kind of counterfeit serotonin. Buspirone (BuSpar) works like this. This drug directly stimulates serotonin receptors on postsynaptic nerves. Buspirone was marketed a number of years ago as the first nonaddictive drug for anxiety, but it also has some mild antidepressant effects. However, its antidepressant and antianxiety properties are not especially strong. As a result, buspirone has not emerged as a particularly popular drug for anxiety or depression.



**Figure 17–6.** Serotonin antagonists block the serotonin receptors on the postsynaptic nerve, so the serotonin cannot stimulate the postsynaptic nerve after the presynaptic nerve fires.

Why is it that buspirone is not more effective for depression? Scientists don't actually know the answer. Remember, though, that there are at least fifteen different kinds of serotonin receptors throughout the brain. All of these receptors have different functions that are not yet fully understood. Perhaps drugs that stimulated different kinds of serotonin receptors would have stronger antidepressant effects. As you might have gathered, things get complicated fairly quickly as we learn more and more about how the brain works.

If you were a drug company chemist, you could also create drugs that blocked the serotonin receptors on the postsynaptic nerves, as illustrated in Figure 17–6 above. Because such drugs would prevent the natural serotonin from having its effects, they would theoretically make depression worse. In fact, drugs that block serotonin receptors have been created. Two of them are called nefazodone (Serzone) and trazodone (Desyrel). Although they are categorized as "serotonin antagonists," these drugs are also used as antidepressants.

Some drugs have complex effects on several kinds of pre- and postsynaptic nerve receptors. Mirtazapine (Remeron) is another new antidepressant that has been available in the United States since 1996. Mirtazapine appears to block serotonin receptors on the postsynaptic nerves, but it also stimulates receptors on presynaptic nerves that use norepinephrine as a transmitter. This causes an increase in the release of

norepinephrine by these nerves. So when you take mirtazapine, the serotonin system gets turned down and the norepinephrine system gets turned up.

The antidepressant effects of nefazodone, trazodone, and mirtazapine are exactly the opposite of what you might predict from the serotonin theory. Although they turn the serotonin system off, they are antidepressants. How can this be possible? If you are starting to get confused, join the club! Remember that there are many types of serotonin receptors in the brain and they all have different kinds of effects. Remember, too, that there are many high-speed and complex interactions among the different circuits in the brain. When we perturb one system of nerves in one region of the brain, we almost instantly create changes in thousands or millions of other nerves in other regions of the brain. In the final analysis, even the world's top neuroscientists do not have a very clear understanding of why or how these drugs relieve depression.

In summary, most of the currently prescribed antidepressants have effects on the serotonin, norepinephrine, or dopamine systems. Some of them are highly selective for one transmitter system, and others have effects on many transmitter systems. However, the effects of the currently prescribed antidepressants on these three systems do not really account for their beneficial effects in a very consistent or convincing way. For example, you have learned that some antidepressants stimulate serotonin levels, some of them block serotonin receptors, and some of them seem to have no effects at all on serotonin. And yet they all work about equally well. Clearly, the models I have drawn in Figures 17–4 to 17–6 are overly simplified, and current theories about how antidepressant medications work appear to be incomplete at best.

I do not mean to sound overly negative. Keep in mind that I am not challenging the effectiveness of the currently prescribed antidepressant drugs; I am simply saying that our theories about how these drugs work do not account for all the facts.

Fortunately, most neuroscience researchers now acknowledge this. The focus of research has expanded greatly. Instead of focusing narrowly on levels of one or another biogenic amine, researchers are pursuing a wide variety of strategies which focus on regulatory mechanisms throughout the brain, and new theories have been proposed. These theories deal with other

transmitters in the brain, or with a variety of pre- or postsynaptic receptors, or with “second messenger” systems within the nerves, or with ion flux across nerve membranes, as well as with neuroendocrine systems, immune systems, and biological rhythm abnormalities. I believe the wider net that has now been cast will eventually lead to much better understanding of how the brain regulates moods.

Sophistication in brain research has accelerated tremendously and will accelerate even more rapidly in the next decade. This research will hopefully lead to improvements such as these:

- clinical tests for the chemical imbalance that causes depression (if, indeed, such an imbalance actually exists);
- tests to detect the genetic abnormalities that make certain individuals more vulnerable to depression as well as manic-depressive illness;
- safer medications with fewer side effects—as you will learn in Chapter 20, significant advances have already been made in this area;
- drugs and psychotherapeutic treatments that are more effective and faster-acting;
- drugs and psychotherapeutic treatments that minimize or entirely prevent relapses of depression following recovery.

Although our current level of understanding is still primitive, an important scientific effort has been launched. One day this effort may even lead us to the identification of the mysterious “black bile.”

## Chapter 18

### The Mind-Body Problem

(*Notes and References appear on pages 682–687.*)

Ever since the time of the French philosopher, René Descartes, scholars have been puzzled by the “mind-body problem.” This is the idea that as human beings we have at least two separate levels of existence—our minds and our bodies. Our minds consist of our thoughts and our feelings, which are invisible or ethereal. We know they are there because we can experience them, but we do not know why or how they exist.

In contrast, our bodies consist of tissue—blood, bones, muscle, fat, and so forth. The tissue ultimately consists of molecules, and the molecules are ultimately made up of atoms. These building blocks are inert—presumably, atoms have no consciousness. So how can the inert tissue in our brains give rise to our conscious minds, which can see, feel, hear, love, and hate?

According to Descartes, our minds and bodies must be connected in some manner. Descartes called the portion of the brain that links these two separate entities the “seat of the soul.” For centuries, philosophers have tried to locate the “seat of the soul.” In the modern era, neuroscientists continue this search as they attempt to figure out how our brains create emotions and conscious thoughts.

The belief that our minds and bodies are separate is reflected in our treatments for problems such as depression. We have biological treatments, which work on the “body,” and psychological treatments, which work on the “mind.” Biological treatments usually involve medications, and psychological treatments usually involve some type of talking therapy.

There is often intense competition between the “drug therapy” camp and the “talking therapy” camp. On the average, psychiatrists are more likely to be in the drug therapy camp. This is because psychiatrists are first trained as physicians (M.D.s). They can prescribe medications, and they are more likely to be influenced by the medical model of diagnosis and treatment. If

you are depressed and you go to a psychiatrist, there's a good chance that she or he will tell you that your depression is caused by a chemical imbalance in your brain, and will recommend treatment with an antidepressant medication. If your family physician treats your depression, drug treatment is also very likely. This is because many family physicians have little training in psychotherapy and very little time to talk to patients about the problems in their lives.

In contrast, psychologists, clinical social workers, and other types of counselors are more likely to be in the talking therapy camp. They do not have medical training and cannot prescribe medications.<sup>2</sup> Their education usually focuses more on the psychological and social factors that may cause depression. If you are depressed and you go to a therapist in the talking therapy camp, she or he is more likely to focus on your upbringing, your attitudes, or stressful events such as the loss of love or the loss of your job. Your therapist will probably also recommend psychotherapeutic treatment, such as cognitive behavioral therapy. However, there are many exceptions to this generalization. Many nonmedical therapists believe that biological factors do play a role in depression, and many psychiatrists are gifted psychotherapists. Psychiatrists and nonmedical therapists sometimes work together in teams so that their patients can benefit from both types of treatment.

Nevertheless, the split between the mind (psychological) and body (biological) schools is sharp, and the dialogue between them is often intense, combative, and bitter. Political and financial considerations sometimes seem to influence the tone of these discussions more than scientific findings. Some recent studies suggest that these arguments may amount to much ado about nothing and that the dichotomy between the mind and the brain may be illusory. These studies indicate that antidepressant drugs and psychotherapy may have similar effects on our minds and on our brains—in other words, they might work in the same way.

For example, in a classic study published in the *Archives of General Psychiatry* in 1992, Drs. Lewis R. Baxter, Jr., Jeffrey M. Schwartz, Kenneth S. Bergman, and their colleagues at UCLA School of Medicine studied changes in the brain chemistry of eighteen patients with obsessive-compulsive disorder (OCD). Half of these patients were treated with

cognitive behavioral therapy (and no drugs) and half were treated with antidepressant drugs (and no psychotherapy).<sup>3</sup> The patients in the no-drug group received individual and group psychotherapy that had two main components. The first component was exposure and response prevention. This is a behavior therapy technique which involves encouraging patients not to give in to their compulsive urges to check locks, to wash their hands repeatedly, and so forth. The second component was cognitive therapy along the lines described in this book. Remember that patients in this group did not receive any medications at all.

These investigators used positron emission tomography (PET scanning) to study the metabolic rate for sugar (glucose) in various brain regions before and after ten weeks of treatment with either drugs or psychotherapy. This method of brain scanning assesses the activity of the nerves in different areas of the brain. One brain region they were particularly interested in was the caudate nucleus on the right half of the brain.

Both treatments were effective: the majority of patients in both groups improved, and there were no significant differences in the two treatments. This was not surprising; previous researchers have also reported that drugs and cognitive behavioral psychotherapy have similar effects in the treatment of OCD. However, the results of the PET study were quite surprising. The investigators reported comparable reductions in the activity in the right caudate nucleus in the successfully treated patients regardless of whether they were treated with drugs and no psychotherapy, or psychotherapy and no drugs. In addition, the symptoms and thinking patterns of the two groups improved to a similar degree—neither treatment was superior. Finally, the amount of improvement in symptoms was significantly correlated with the degree of change in the right caudate nucleus. In other words, patients who improved the most had, on average, the greatest reductions in brain activity in the right caudate nucleus. The reduced activity meant that the nerves in this region of the brain had calmed down, regardless of whether they were treated with drugs or psychotherapy.

One implication of this study is that excessive activity in the right caudate nucleus might play a role in the development or maintenance of the symptoms of obsessive-compulsive disorder. A second important implication is that antidepressant medications and cognitive behavioral

therapy might be equally effective in restoring the structure and function of the brain back to normal.

Like most published studies, this one had some fairly significant flaws. One problem is that any brain changes you observe in a particular psychiatric disorder might simply represent “downstream” effects rather than true causal effects. In other words, the increased neural activity in the right caudate nuclei of patients with obsessive-compulsive disorder might simply reflect a more general pattern of distress throughout the brain and may not be the cause of the symptoms, as we have discussed above.

Another problem was that the number of patients studied was extremely small, and the number of brain regions the investigators studied was fairly large, so it is possible—even likely—that these findings were the result of chance. This possibility is consistent with the fact that other investigators have reported different patterns of brain activity in patients treated with antidepressant medications. This is why replications with more patients conducted by independent investigators are needed before the results of any study can be accepted. In spite of these limitations, the report by Dr. Baxter and his colleagues was the first of its kind and may open the door to an important new type of integrated research on the ways that drugs and psychotherapy can influence brain function and emotions.

Other studies have shown that antidepressants may actually work by helping depressed patients change their negative thinking patterns. Indeed, in an investigation conducted at Washington University School of Medicine in St. Louis, Drs. Anne D. Simons, Sol L. Garfield, and George E. Murphy randomly assigned depressed patients to treatment with either antidepressants alone or cognitive therapy alone. They studied changes in the negative thinking patterns of both groups of patients. They discovered that the negative thinking of patients who responded to the antidepressants improved as much as the negative thinking of depressed patients who responded to the cognitive therapy.<sup>4</sup> Remember that the drug patients received no psychotherapy and the cognitive therapy patients received no medications. Thus this study indicated that antidepressant drugs change negative thinking patterns in much the same way that cognitive therapy does. The effect of antidepressant drugs on attitudes and thoughts may explain their antidepressant effects just as well or even better than more

biological explanations of their effects on different transmitter systems in the brain.

These remarkable studies suggest that we might do better to let go of this “mind-body” split and begin to think about how these different treatments may be working in tandem on the mind and on the brain. This combined approach could foster a greater sense of teamwork among therapists and researchers approaching the problem from different angles and may lead to more rapid advances in our understanding of emotional disorders. Even if there is some type of genetic or biological disorder in at least some depressions, psychotherapy can often help to correct these problems, even without medications. Many research studies, as well as my own clinical experience, have confirmed that severely depressed patients who appear very “biologically” depressed with lots of physical symptoms often respond rapidly to cognitive therapy alone without any drugs.<sup>5</sup>

It can work the other way as well. I have worked with many depressed patients who were still stuck after I had tried numerous psychotherapeutic interventions. When I prescribed an antidepressant medication, many of these patients started to turn the corner, and the psychotherapy began to work better. It seemed as if the medication really did help them change their negative thinking patterns as they recovered from the depression.

### **If Depression Is Inherited, Doesn’t It Mean We Should Treat It with Drugs?**

In Chapter 17 we talked about the fact that we don’t yet know how strong the genetic influences are in the more common forms of depression that do not involve mania. But suppose scientists eventually discover that nearly all forms of depression are inherited, at least in part. Would it mean we should treat depression with drugs?

The answer is: not necessarily. For example, a blood phobia is thought to be at least partially genetic, but it can nearly always be treated quickly and easily with behavior therapy. The treatment of choice for most phobias is to expose the person to the frightening situation and to urge them to face it and endure the anxiety until the fear diminishes and disappears. Most patients are so frightened that they resist the treatment at first, but if they can be persuaded to hang in there, the success rate is extraordinarily high.

I can attest to this personally. While growing up, I was terrified of blood. When, in medical school, it was time to draw blood from each other's arms, I felt so unenthusiastic that I dropped out of medical school. For the next year, I decided to work in the clinical laboratory of the Stanford University Hospital so I could try to get over my fear. They gave me a job doing nothing but drawing blood out of people's arms and I had to do this all day long. The first few times I had to draw blood, it made me very anxious, but after those initial anxious moments, I got used to it. Pretty soon, I *loved* my new job. This shows that at least some genetic tendencies can respond to a behavioral treatment without drugs.

To state an even more commonplace example, we all inherit a tendency to have a particular type of body. Some of us are genetically taller or shorter than others. Some of us have larger frames, others have smaller frames. But our diets and habits hugely influence the types of bodies we have as adults. Many professional bodybuilders were skinny and embarrassed about their looks when growing up. This motivated them to go to the gym and work out. This intense effort transformed many of them into champions. Their genes may have greatly influenced what they were born with, but their behaviors and determination dominated where they ended up.

The opposite is also true. If it turned out that depression was entirely caused by the environment and that there were no genetic influences, this would not minimize the potential value of antidepressant drugs. For example, if you are exposed to someone with a strep throat, you may get a strep throat because streptococcal bacteria are so infectious. We can say that the causes of your strep throat are almost entirely environmental and not genetic. Nevertheless, we would still treat your strep throat with an antibiotic, and not with behavior therapy!

With regard to bipolar manic-depressive illness, the answer is clear. This disorder appears to have an extremely strong biological cause, and although we don't yet know exactly what this cause may be, treatment with a mood stabilizer such as lithium or valproic acid (Depakene) is usually a must. Other medications will also be used during episodes of depression or severe mania. However, good psychotherapy can also make a big contribution in the treatment of bipolar illness. In my experience, the combination of a drug like lithium or valproic acid along with cognitive therapy has been far more effective than treatment with medications alone.

From a practical point of view, the question I face as a clinician is this: How can I best treat each particular patient who is suffering from depression, regardless of the cause? Whether or not genes play a role, drugs can sometimes help and psychotherapy can sometimes help. Sometimes, a combination of psychotherapy and antidepressant medications seems to be the best approach.

### **Is It Better to Be Treated with Drugs or Psychotherapy?**

A number of studies have compared the effectiveness of antidepressant drug treatment with cognitive therapy.<sup>5–8</sup> On the whole, these studies have indicated that during the acute phase of treatment, when patients first seek treatment for their depressions, both treatments seem to work reasonably well. Following recovery, the picture is a little different. Several long-term studies indicate that patients who receive cognitive therapy, alone or in combination with antidepressant medications, appear to stay undepressed longer than patients who receive only antidepressant medication therapy and no psychotherapy.<sup>5</sup> This is probably because cognitively treated patients have learned many coping tools to help them to deal with any mood problems they might experience in the future.

If you would like to learn more about recent research on the effectiveness of drugs versus psychotherapy, you can read an excellent article on this topic by Drs. David O. Antonuccio and William G. Danton from the University of Nevada and Dr. Gurland Y. DeNelsky from the Cleveland Clinic.<sup>5</sup> These authors reviewed the world research literature on the effectiveness of psychotherapy versus medications for depression and came up with some rather startling conclusions that are quite different from the popular perceptions about these treatments. They argue that cognitive therapy appears to be at least as effective, if not more effective, than medications in the treatment of depression. They conclude that this is even true for severe depressions that appear to be “biological” because they have many physical side effects such as fatigue or a loss of interest in sex. The authors also question the methods used by drug companies to test new antidepressants. This scholarly and provocative article is clearly written, so look it up if you are curious.

My own clinical experience has convinced me that pure “test-tube treatment” with drugs alone is not the answer for most patients. There appears to be a definite role for effective psychological interventions, even if you have had the good fortune to respond to an antidepressant medication. If you learn cognitive therapy self-help techniques like those described in this book, I believe you will be better prepared to cope with any mood problems that develop again in the future.

My clinical practice has always been predicated on an integrated approach. At my clinic in Philadelphia, approximately 60 percent of our patients received cognitive therapy with no drugs, and approximately 40 percent of our patients received a combination of cognitive therapy along with antidepressants. Patients in both groups did well, and we found both types of treatment tools to be valuable. We did not treat patients with drugs alone and no psychotherapy because in my experience this approach has not been satisfactory.

It may be that for certain types of depression, the addition of the proper antidepressant to help your treatment program might make you more amenable to a rational self-help program and greatly speed up the therapy. As I have mentioned earlier above, I can think of many depressed individuals who seemed to “see the light” with regard to their illogical, twisted, negative thoughts more rapidly once they began taking an antidepressant. My own philosophy is this: I’m in favor of any reasonably safe tool that will help you!

I believe that your feelings about the type of treatment that you receive may be important to the outcome. If you are more biologically oriented, you may do better with drug treatment. In contrast, if you are more psychologically oriented, you may do better with psychotherapy. If you and your therapist do not see eye to eye, you may lose confidence and resist the treatment, and this can reduce the chances for a successful result. In contrast, if the treatment makes sense to you, you will feel more hope, trust and confidence in your doctor. Consequently your chances for a positive outcome will be increased.

I have also seen that certain negative attitudes and irrational thoughts can interfere with proper drug treatment or with psychotherapeutic treatment. I would like to expose twelve hurtful myths at this time. The first eight myths concern medication treatment and the last four myths concern

psychotherapy. With regard to medications, I believe that enlightened caution in taking any drug is well advised, but an excessively conservative attitude based on half-truths can be equally destructive. I also believe that one should be appropriately skeptical and cautious about psychotherapy, but that too much pessimism can also interfere with effective treatment.

*Myth Number 1.* “If I take this drug, I won’t be my true self. I’ll act strange and feel unusual.” Nothing could be further from the truth. Although these drugs can sometimes eliminate depression, they do not usually create abnormal mood elevations and, except in rare cases, they will not make you feel abnormal, strange, or “high.” In fact, many patients report that they feel much *more* like themselves after they take an antidepressant medication.

*Myth Number 2.* “These drugs are extremely dangerous.” Wrong. If you are receiving medical supervision and cooperate with your doctor, you will have no reason to fear most antidepressant drugs. Adverse reactions are rare and can usually be safely and effectively managed when you and your doctor work together as a team. The antidepressants are far safer than the depression itself. After all, depression, if left untreated, can kill—through suicide!

This does not mean you should be complacent about antidepressant drugs—or any drug you take, for that matter, including aspirin. In the following chapters, you will learn about the side effects and toxic effects of all the different antidepressants and mood-stabilizing agents. If you are taking one or more of these drugs, educate yourself and read about them in Chapter 20. This should not be difficult, and the information will enhance your chances of having a safe and effective experience with the antidepressant your doctor has prescribed.

*Myth Number 3.* “But the side effects will be intolerable.” No, the side effects are mild and can usually be made barely noticeable by adjusting the dose properly. If in spite of this you find the medication uncomfortable, you can usually switch to another medication that will be equally effective with fewer side effects.

Remember, too, that untreated depression also has many “side effects.” These include feelings of tiredness, increases or decreases in appetite, difficulties sleeping, a loss of motivation and energy, a loss of interest in sex, and so forth. And if you respond favorably to an antidepressant, these “side effects” will usually disappear.

*Myth Number 4.* “But I’m bound to get out of control and use these drugs to commit suicide.” Some of the antidepressant drugs *do* have a lethal potential if you take them in overdose or combine them with certain other drugs, but this need not be a problem if you discuss your concerns with your physician. If you feel actively suicidal, it might be helpful to obtain only a few days’ or one week’s supply at a time. Then you will not be likely to have a lethal supply on hand. Your doctor may also decide to treat you with one of the newer antidepressant drugs that are much safer than the older antidepressants if taken in accidental or intentional overdose. Remember that as the drug begins to work, you will feel less suicidal. You should also see your therapist frequently and receive intensive therapy, either as an outpatient or as an inpatient, until any suicidal urges have passed.

*Myth Number 5.* “I’ll become hooked and addicted, like the junkies on the street. If I ever try to go off the drug, I’ll fall apart again. I’ll be stuck with this crutch forever.” Wrong again. Unlike sleeping pills, opiates, barbiturates, and minor tranquilizers (benzodiazepines), the addictive potential of antidepressants is extremely low. Once the drug is working, you will *not* need to take larger doses to maintain the antidepressant effect. As noted above, if you are learning cognitive therapy techniques and focusing on relapse prevention, in most instances your depression will not return when you discontinue the drug.

When it is time to go off the medicine, it would be advisable to do this gradually, tapering off over a week or two. This will minimize any discomfort that might occur from abruptly stopping the medicine, and will help you nip any relapse in the bud before it becomes full blown.

Many doctors now advocate long-term maintenance therapy for patients with severe depressions that return on many occasions. A prophylactic effect can sometimes be achieved if you take the antidepressant over a

period of a year or two after you have recovered. That can minimize the probability of your depression returning. If you have had a significant problem with recurrences of depression over a period of years, this might be a wise step for you. But you should be reassured that antidepressant drugs are definitely *not* addictive. In my practice through the years, I have had very few patients who had to remain on antidepressant drugs for more than a year, and almost no patients who stayed on antidepressants indefinitely.

*Myth Number 6.* “I won’t take any psychiatric drug because that would mean I was crazy.” This is quite misleading. Antidepressants are given for depression, not for “craziness.” If your doctor recommends an antidepressant, this would indicate he or she is convinced you have a mood problem. It does *not* mean that she or he thinks you are crazy. However, it *is* crazy to refuse an antidepressant on this basis because you may bring about greater misery and suffering for yourself. Paradoxically, you may feel normal more quickly with the help of the medicine.

*Myth Number 7.* “But other people are bound to look down on me if I take an antidepressant. They’ll think I’m inferior.” This fear is unrealistic. Other people will not know you’re taking an antidepressant unless you tell them—there’s no other way they could know. If you do tell someone, they’re more likely to feel relieved. If they care about you, they’ll probably think *more* of you because you’re doing something to help eliminate your painful mood disorder.

Of course, it is possible that someone might question you about the advisability of taking a drug, or even criticize your decision. This will give you the golden opportunity to learn to cope with disapproval and criticism along the lines discussed in Chapter 6. Sooner or later, you’re going to have to decide to believe in yourself and stop giving in to the disabling terror that someone might or might not agree with something you do.

*Myth Number 8.* “It is shameful to have to take a pill. I should be able to eliminate the depression on my own.” Research on mood disorders conducted throughout the world has clearly shown that many individuals *can* recover without pills if they engage in an active, structured, self-help program of the type outlined in this book.<sup>5, 9–13</sup>

However, it is also clear that psychotherapy does not work for everyone, and that some depressed patients recover faster with the help of an antidepressant. In addition, in many cases an antidepressant can facilitate your efforts to help yourself, as described above.

Does it really make sense to mope and suffer endlessly, stubbornly insisting you must “do it on your own” without a medication? Obviously, you must do it yourself—with or without a pharmacological boost. An antidepressant may give you that little edge you need to begin to cope in a more productive manner. This can accelerate the natural healing process.

*Myth Number 9.* “I feel so severely depressed and overwhelmed that only a drug could help me.” Drugs and psychotherapy both have a lot to offer in the treatment of severe depression. I believe that the passive attitude of letting a drug do it for you is unwise. My own research has indicated that the willingness to do something to help yourself can have powerful antidepressant effects, whether or not you are also taking a medication. The self-help work patients complete between sessions also seems to speed recovery.<sup>14, 15</sup> So if you combine a medication with a good form of psychotherapy, you will have more weapons in your arsenal.

As I have already stated, many patients I have treated with drugs alone did not recover completely. When I added the cognitive therapy, many of them improved. I believe that the combination of drugs and psychotherapy can work better and quicker than drugs alone and frequently leads to better long-term results. This seems to be true for mildly depressed patients and for severely depressed patients as well. For example, we treat many severely depressed inpatients at the Stanford University Hospital with group cognitive therapy techniques. These techniques are similar to the ones you have learned about in this book. We have found that the group format can be especially helpful. I have seen many of these patients improve significantly during these therapy groups. The improvement often occurs within the actual therapy group. At the moment the patient sees how to talk back to his or her negative thoughts in a convincing manner, there is often a strong, immediate uplift in mood and outlook. Keep in mind that these inpatients also receive antidepressant drugs that their attending psychiatrists prescribe for them. So nearly all of them receive a combination of drugs

and psychotherapy—we are not purists devoted only to one approach or the other.

I can recall one woman who was so severely depressed that she would burst into tears almost every time she tried to speak. If you even looked at her, it seemed it was enough to trigger an outburst of uncontrollable sobbing. I asked what she was thinking about when she was sobbing. She said she was thinking about something that her psychiatrist told her. He said her depression was “biological” and the causes were genetic. She concluded that if the depression was genetic, it meant she must have passed it down to her children and her grandchildren. One of her sons was, in fact, having a hard time. She attributed this to his “depression gene” and blamed herself for ruining his life. She castigated herself for even having gotten married and given birth to children in the first place and felt certain they would all endure horrible suffering forever. As she explained this, she began sobbing again.

Now from your perspective, her self-blame may seem incredibly unrealistic. Her insistence that all her children and grandchildren would lead lives of endless and irreversible suffering may seem equally unrealistic. But from her perspective, all her self-criticisms seemed entirely justified and negative predictions seemed completely valid. Her self-loathing and suffering were incredibly intense.

After she stopped crying, I asked what she would say to another depressed woman with children. Would she be so hard on her? This intervention did not work. She did not even seem to comprehend what I said. Instead of answering my question, she sobbed so uncontrollably that her entire body shook as the tears streamed down her cheeks.

After a while she stopped crying again. I asked if two other patients would volunteer to do a role-play to help her out. I call this exercise “externalization of voices” because you verbalize the negative thoughts in your mind and learn to talk back to them. I wanted the other patients to illustrate how she might talk back to her own negative thoughts so that all she would have to do was watch. I told her to imagine that these other women were very similar to her. They were depressed and had children and grandchildren.

The first volunteer played the role of the negative part of her mind and said out loud the sort of things the depressed woman had been thinking: “If

my depression is partly genetic, then it means I am to blame for my son's depression." The second volunteer played the role of the more positive, realistic, self-loving part of her mind. This volunteer talked back to the negative thought along these lines: "I certainly wouldn't blame another depressed woman for her son's depression, so it makes no sense to blame myself, either. If there is a conflict with my son, or if he is having problems, I can try to be helpful to him. That's what any loving mother would try to do." Then they continued with this dialogue and modeled ways she could talk back to her other self-critical thoughts. The two volunteers took turns in the roles of the negative thoughts and the positive thoughts.

After the role-play was over, I asked the tearful patient which voice was winning and which voice was losing. Was it the negative voice or the positive voice? Which voice was more realistic, more believable? She said that the negative voice was unrealistic, and that the positive voice was winning. I pointed out that the volunteers were actually verbalizing her own self-criticisms.

Although her depression did not improve dramatically by the end of that group, it seemed that the clouds lifted just a little bit. The next time I saw her in a group, her mood had brightened up considerably. She was quite personable and could talk without crying for the first time since admission. She said she wanted to practice the role-playing in the group so she could learn how to do it. She said she was also intent on getting a referral to a cognitive therapist near her home after discharge so she could continue the work that was proving to be so helpful to her.

The method that helped this patient is also called the "double-standard technique." It is based on the idea that many of us operate on a double standard. We may judge ourselves in a harsh, critical, demanding way, and yet we judge others in a more compassionate and reasonable manner. The idea is to give up this double standard and agree to judge all human beings, including ourselves, by one set of standards that is based on truth and compassion instead of using a separate standard that is distorted and mean when we judge ourselves.

*Myth Number 10.* "It is shameful to receive psychotherapy because it means I am weak or neurotic. It is more acceptable to be treated with a drug because it means I have a medical illness, like diabetes." Actually, the sense

of shame is common in depressed patients who are treated with drugs *or* psychotherapy. Often, the double-standard technique just described above can be helpful. Imagine, for example, that you've just discovered that a dear friend of yours received psychotherapy for depression and found that the treatment was helpful. Ask yourself what you would say to your friend. Would you say: "Oh, the psychotherapy just shows what a weak and defective neurotic you are. You should have taken a drug instead. What you did was shameful." If you would not say this to a friend, then why give yourself these messages? That's the essence of the double-standard technique.

*Myth Number 11.* "My problems are real, so psychotherapy couldn't possibly help me." Actually, cognitive therapy seems to work the best with depressed individuals with real problems in their lives, including catastrophic medical problems such as terminal cancer or an amputation, bankruptcy, or severe personal relationship problems. In many cases, I have seen individuals with problems like this who improved in a handful of cognitive therapy sessions. In contrast, chronically depressed individuals without any obvious problems that triggered their depressions are often more difficult to treat. Although the prognosis is excellent, they may require more intensive and prolonged treatment.

*Myth Number 12.* "My problems are hopeless, so no psychotherapy or drug could possibly help me." This is your depression talking, and not reality. Hopelessness is a common but horrible symptom of depression that is based on twisted thinking, just as the other symptoms are. One of the distortions is called "emotional reasoning." The depressed individual may reason: *I feel* hopeless, therefore *I must be* hopeless. Another cognitive distortion that leads to feelings of hopeless is fortune-telling—you are making a negative prediction that you will never improve, and assuming this prediction is really a fact. Other distortions can lead to feelings of hopelessness as well. These include the following:

- all-or-nothing thinking—you think of yourself as completely happy or completely depressed; shades of gray do not count, so if you are not

completely happy or completely recovered, you assume you are completely depressed and hopeless;

- overgeneralization—you see your current feelings of depression as a never-ending pattern of defeat and suffering;
- mental filter—you selectively think of all the times you have been depressed, and end up thinking your whole life will be bad forever;
- discounting the positive—you insist that the times you were not depressed don't count;
- “should” statements—you use up all your energy telling yourself you “shouldn’t” be depressed (or you “shouldn’t” have gotten depressed again) instead of systematically working to overcome the feelings;
- labeling—you tell yourself you are hopelessly and irreversibly defective and conclude that you could never really feel whole, or happy, or worthwhile.

Other cognitive distortions, such as magnification or personalization, can also lead to feelings of hopelessness. Although these feelings are not realistic, they can act like self-fulfilling prophecies. If you give up, nothing will change and you will conclude that you really were hopeless.

Patients who feel hopeless usually cannot see that they are deceiving themselves. They are nearly always convinced these feelings are entirely valid. If I can persuade them to challenge these hopeless feelings and try to get better—even though they feel in their hearts that this is impossible—they usually do begin to improve, slowly at first and then more rapidly, until they feel a whole lot better.

One of the most important tasks of any therapist is to help depressed patients find the courage and determination to resist and fight these hopeless feelings. This battle is often fierce and rarely easy, but nearly always rewarding in the long run.

## Chapter 19

### **What You Need to Know about Commonly Prescribed Antidepressants**

*(Notes and References appear on pages 682–687.)*

This chapter contains practical general information about the use of antidepressants. You will learn who is the most—and least—likely to benefit from an antidepressant, how you can tell whether an antidepressant drug is really working, how much mood elevation you can anticipate, how long you should stay on it, and what you can do if it doesn't work. You will also learn how to monitor and minimize side effects and prevent potentially dangerous interactions between antidepressants and other drugs you may take, including prescription drugs as well as nonprescription (over-the-counter) drugs you can obtain at the drug store or grocery store. In the next chapter, I will provide specific information about each antidepressant and mood-stabilizing drug currently in use.

When you read this chapter, keep in mind that the use of antidepressants is still a blend of art and science. Each practitioner has a slightly different philosophy, and your doctor's approach may differ from mine. I will state my own biases up front.

First, I am quite demanding in terms of what I expect from an antidepressant. I believe that any antidepressant medication should have a pretty profound and dramatic effect in order to justify its continued use. In addition, I firmly believe that every patient taking antidepressants should take a mood test like the one in Chapter 2 at least once a week. Your score on this test (or any other good depression test) is a highly reliable measure of how well your antidepressant is working. I do not encourage patients to continue taking drugs that have only modest or questionable beneficial effects on mood. When the score on the test goes down only a little bit (for example, a 30 percent or 40 percent improvement), I would be inclined to call this a placebo effect and not a real drug effect. This amount of improvement could be due to the passage of time, the psychotherapy, or the

belief that the drug will work. If the improvement in mood is minimal, and assuming the patient has had a sufficient dose of the medication for a sufficient period of time, I would probably take the patient off the drug and try another medication, a combination of medication and psychotherapy, or psychotherapy alone.

Now some readers may think, “but a 40-percent improvement in my mood sounds pretty good. This sounds like *real* improvement. I’m almost half better.” Certainly, any improvement is desirable, but research studies indicate that inactive placebos can also have large antidepressant effects. A 40-percent improvement has been shown to be a typical placebo response. The only justification for taking any antidepressant drug is this: Is the drug doing its job? To my way of thinking, the goal of treatment is to recover from depression. Most patients want complete recovery, not just a slight or moderate improvement in their mood. If an antidepressant is not accomplishing this goal after a reasonable trial, then I would recommend switching to another drug or treatment approach.

Second, I never treat patients with medications alone. If I prescribe an antidepressant for a patient, I always combine the medication treatment with psychotherapy as well. Although I tried the medication-only approach with large numbers of patients early in my career, I almost never found this approach to be satisfactory.

For example, when I was a postdoctoral fellow following my residency training at the University of Pennsylvania, I ran the lithium clinic at the Philadelphia VA Hospital. I treated many depressed veterans suffering from bipolar manic-depressive illness with a combination of lithium and other antidepressant drugs. Although the medications appeared to be helpful, the results were not very encouraging. Most of these poor veterans were going in and out of the hospital almost constantly, and few were leading productive, joyous, stable lives. Later in my career, when I learned cognitive therapy, I treated all my manic-depressive patients with a combination of medications plus psychotherapy. The results were much better. From that point on, I can recall only one manic-depressive patient I treated who required hospitalization for an episode of mania.

The results with depressed patients were similar. Early in my career, I treated depressed patients with the drugs alone or drugs combined with traditional supportive psychotherapy. I administered a depression test like

the one in Chapter 2 to every patient every session. I could see very clearly that while some patients were helped a lot by antidepressants, many were not. A lot of patients improved only slightly, and some did not improve at all. Later in my career, I began to combine antidepressant drugs with the new cognitive therapy techniques I was learning, and saw much better results. Eventually, I gave up treating patients with drugs alone.

Third, I usually use one medication at a time, rather than a combination of many different kinds of drugs, although there are certainly many exceptions to this or any rule. The idea behind polypharmacy is that if one drug is good, two, three, or more will be even better. Some doctors also use additional drugs to try to combat the side effects of other drugs the patient is taking. The potential drawbacks to poly-pharmacy are many, including more side effects and more possible adverse drug interactions. I discuss polypharmacy in detail at the end of Chapter 20 and describe a number of specific situations in which the use of more than one drug may be justified.

Finally, I have usually not kept patients on antidepressant drugs indefinitely following recovery. Instead, I slowly taper patients off their antidepressants after they have been feeling really good for several months. I have found that in most cases, patients who have recovered can continue to remain undepressed without medications. Keep in mind that all my patients have received cognitive therapy, whether or not they also received an antidepressant. The cognitive therapy is probably responsible for the good long-term results, because patients learn tools they can use for the rest of their lives whenever they are feeling upset.

Many doctors practice very differently. They tell their patients that they must continue taking their antidepressants indefinitely to correct a “chemical imbalance in the brain” and to prevent relapses into depression. While relapse is an important issue, I have found that training patients to use their cognitive therapy tools whenever they need them seems to maintain improvement following recovery. In fact, a number of well-controlled long-term follow-up studies have confirmed that this works better than drugs to prevent relapses.

While this is my philosophy in a nutshell, remember that there is no single “correct” approach, and your doctor’s philosophy might differ from mine. In addition, there are many exceptions to any rule, and your own diagnosis or personal history may mandate a different approach from the

one I have just outlined. If you have questions about your treatment, discuss your concerns with your physician. In my experience, the sense of teamwork and mutual respect is still the most important ingredient in any successful treatment.

### **If I Am Depressed, Does It Mean that I Have a “Chemical Imbalance” in My Brain?**

There is an almost superstitious belief in our culture that depression results from a chemical or hormonal imbalance of some type in the brain. But this is an unproven theory and not a fact. As discussed in Chapter 17, we still do not know the cause of depression and we do not know how or why antidepressant drugs work. The theory that depression results from a chemical imbalance has been around for at least two thousand years, but there is still no proof of this, so we really do not know for sure. Furthermore, there is no test or clinical symptom that could demonstrate that a particular patient or group of patients has a “chemical imbalance” that is causing the depression.

### **If I Am Depressed, Does It Mean that I Should Take an Antidepressant?**

Many people also believe that if you are depressed you should be on an antidepressant. However, I do not insist that every depressed patient must take an antidepressant. Large numbers of well-controlled studies published in respected scientific journals indicate that the newer forms of psychotherapy can be just as effective as, and sometimes more effective than, antidepressants.

Certainly many depressed people have been treated successfully with antidepressants and swear by them. They are valuable tools and I am glad to have them available in my treatment arsenal. Sometimes antidepressants are helpful, but they are rarely total answers, and often they are not necessary.

### **How Can I Decide Whether or Not to Take an Antidepressant?**

I always ask my patients during their initial evaluations whether or not they would prefer to take an antidepressant. If a patient strongly feels that she or he would prefer to be treated without an antidepressant, I treat with

cognitive therapy alone, and this is usually successful. However, if the patient has been working hard in therapy for six to ten weeks without any improvement, I sometimes suggest we try to add an antidepressant to put some “high octane” in the tank, so to speak. In some cases, this makes the psychotherapy more effective.

If a patient feels strongly that she or he would like to receive an antidepressant at the initial evaluation, I treat with a combination of an antidepressant medication and psychotherapy right away. However, I almost never treat patients with antidepressant medications alone, as noted previously. In my experience, the drugs-only approach has not been satisfactory. The combination of medications with psychotherapy seems to produce better results in the short term and in the long term than treating patients with drugs alone.

It may sound unscientific to base the medication decision on the patient’s preferences, and certainly there are exceptional cases where I feel I have to make a recommendation that differs from my patient’s wishes. But the majority of time, I have found that patients do well when treated with the approach they are most comfortable with.

So if you are depressed and you have strong positive feelings that an antidepressant drug will help you, this increases the likelihood that you will be helped by one of these medications. And if you feel strongly that you would prefer to be treated with a drug-free form of therapy, the likelihood of a successful outcome is also good. But I would urge flexibility in your thinking. If you are receiving a medication, I strongly believe that cognitive or interpersonal psychotherapy can enhance your recovery. If you are receiving psychotherapy and your progress is slow, an antidepressant might accelerate your recovery.

## **Can Anyone Take an Antidepressant?**

Most people can, but competent medical supervision is a must. For example, special precautions are indicated if you have a history of epilepsy, heart, liver, or kidney disease, high blood pressure, or certain other disorders. For the very young and elderly, some medications should be avoided, and smaller dosages may be indicated. And, as noted above, if you are taking medicines in addition to an antidepressant, special precautions

are sometimes required. Properly administered, an antidepressant is safe and may be lifesaving. But don't try to regulate it or administer it on your own. Medical supervision is a must.

Should a pregnant woman use an antidepressant? This sensitive question often requires consultation between the psychiatrist and the obstetrician. Since fetal abnormalities might occur, the potential benefit, the severity of the depression, and the stage of pregnancy must all be taken into account. Other treatment approaches should usually be employed first, and an active self-help program of the type described in this book might eliminate the need for a medication. This would give optimal protection to the developing child, of course. On the other hand, if the depression is very severe, there may be cases where it makes sense to use an antidepressant.

## **Who Is Most—and Least—Likely to Benefit from an Antidepressant Drug?**

Your chance of responding to an appropriate drug may be enhanced:

1. If you are unable to carry on with your day-to-day activities because of your depression.
2. If your depression is characterized by many organic symptoms, such as insomnia, agitation, retardation, a worsening of symptoms in the morning, or an inability to feel cheered up by positive events.
3. If your depression is severe.
4. If your depression had a reasonably clear-cut beginning.
5. If your symptoms are substantially different from the way you normally feel.
6. If you have a family history of depression.
7. If you have had a beneficial response to antidepressant drugs in the past.
8. If you strongly feel that you would like to take an antidepressant drug.
9. If you are strongly motivated to recover.
10. If you are married.

Your chance of responding to an appropriate drug may be diminished:

1. If you are very angry.
2. If you have a tendency to complain and to blame others.
3. If you have a history of an exaggerated sensitivity to drug side effects.
4. If you have a history of multiple physical complaints that your doctor has been unable to diagnose, such as tiredness, stomach ache, headache, or pains in your chest, stomach, arms, or legs.
5. If you have a long history of another psychiatric disorder or hallucinations preceding your depression.
6. If you feel strongly that you do not want to take an antidepressant drug.
7. If you are abusing drugs or alcohol and you are unwilling to go into a recovery program.
8. If you are receiving financial compensation for your depression, or if you hope to receive financial compensation. For example, if you receive disability payments for depression, or if you are involved in a lawsuit and hope to receive financial compensation because of your depression, then any form of treatment is going to be difficult. This is because if you recover, you will lose money. This is a conflict of interest.
9. If you have failed to respond to other antidepressants you have been given.
10. If for any reason you have mixed feelings about getting better.

These guidelines are of a general nature and are not intended to be comprehensive or precise. Our ability to predict who will respond best to a medication or to psychotherapy is still extremely limited. Many people with all the positive indicators may fail to respond to antidepressants, and many people with all the negative indicators may respond beautifully to the first drug they receive. In the future, the use of antidepressant drugs will hopefully become more precise and scientific, just as the use of antibiotics has become.

If you have many of the negative indicators, is this bad? I don't think so. Most patients with all the negative indicators can be treated quite successfully, but it may sometimes take a little longer. In addition, as I have emphasized repeatedly, a combination of medication with good

psychotherapy along the lines described in this book is sometimes more effective than treatment with antidepressant drugs alone.

## **How Fast and How Well Do Antidepressant Drugs Work?**

Most studies indicate that approximately 60 percent to 70 percent of depressed patients will respond to an antidepressant medication. Since approximately 30 percent to 50 percent of depressed patients will also respond to a sugar pill (a placebo), these studies indicate that an antidepressant will increase your chances for recovery.

However, remember that the word “respond” is different from the word “recover,” and the improvement from an antidepressant is often only partial. In other words, your score on a mood test like the one in Chapter 2 may improve without going into the range considered truly happy (less than 5). This is why I nearly always combine antidepressant medication treatment with cognitive and behavioral techniques like those described in this book. Most people are not interested in just partial improvement. They want the real McCoy. They want to get up in the morning and say, “Hey, it’s great to be alive!”

As I have emphasized, most of the depressed and anxious people I have treated have problems in their lives such as a marital conflict or a career difficulty, and nearly all of them beat up on themselves with negative thinking patterns. In my experience, medication therapy is usually more effective—and more satisfying—when it is combined with psychotherapy. Many doctors do prescribe medications alone without psychotherapy, but I have not found this approach to be satisfactory.

## **Which Antidepressants Are the Most Effective?**

All of the currently prescribed antidepressant drugs tend to work about equally well, and equally rapidly, for most patients. So far, no new type of antidepressant medication has been shown to be more effective or faster-acting than the older drugs that have been available for several decades. However, there are dramatic differences in the costs of the different types of antidepressants and in the side effects they have. Essentially, the newer medications are much more expensive because they are still on patent. However, they are far more popular because they usually have fewer side

effects than the older, cheaper drugs. If you have certain kinds of medical conditions, some antidepressants will be relatively safer for you than others. I will discuss these issues in greater detail in Chapter 20.

Sometimes a patient will respond particularly well to one antidepressant or kind of antidepressant. Unfortunately, we cannot usually predict this ahead of time for the individual, and so most physicians use a trial-and-error approach. There are, however, a few generalizations about the kinds of antidepressants that work best for certain kinds of problems. For example, drugs that have stronger effects on the serotonin systems in the brain are generally considered to be effective for patients who suffer from obsessive-compulsive disorder (called OCD for short). These patients have recurrent illogical thoughts (like a fear that the stove will catch fire and burn the house down) and perform compulsive rituals over and over (such as checking repeatedly to make sure that the stove is turned off). Drugs often prescribed for OCD include several of the tricyclic antidepressants, including clomipramine (Anafranil), one of the SSRIs, such as fluoxetine (Prozac) or fluvoxamine (Luvox), or one of the MAOIs, such as tranylcypromine (Parnate).

If a depressed patient also has symptoms of anxiety, such as panic attacks or social anxiety, the physician might also choose one of the SSRI or MAOI antidepressants, since these often seem to be quite effective. Or the physician might choose one of the more sedative antidepressants, such as trazodone (Desyrel) or doxepin (Sinequan), thinking that the relaxation might help reduce the anxiety.

In my practice, I have treated many patients with a particularly difficult type of chronic and severe depression known as borderline personality disorder (called BPD for short). Patients with this disorder have intense and constantly fluctuating negative moods such as depression, anxiety, and anger. Patients with BPD also experience lots of turbulence in their personal relationships. In my experience, quite a few BPD patients have responded dramatically to the MAOI antidepressants, and so I might be more inclined to choose an MAOI for patients with these features. Of course, some patients with BPD have poor impulse control, and they may do better with one of the newer and safer antidepressants. This is because the MAOIs can be quite dangerous if patients mix these drugs with certain forbidden foods and medications that I will describe in detail in Chapter 20.

There are a number of other guidelines as well, but they should not be taken too literally because there are so many exceptions to them. The bottom line is this: any depressed patient has a reasonably good chance of having a positive response to almost any antidepressant medication if it is prescribed at the correct dose for a reasonable period of time. You can ask your physician if she or he has a reason for recommending a particular antidepressant. However, most physicians will prescribe antidepressants they are familiar with. This is good practice. Few doctors can master the myriad details about all the currently prescribed antidepressants, and so most doctors try to become familiar with the one or two agents they use most frequently. In this way, they will have the greatest expertise about the medication they are recommending for you.

### **How Can I Tell if My Antidepressant Is Really Working?**

My own philosophy is to use a depression test like the one in Chapter 2 as a guide. Take the test once or twice a week during treatment. This is *really* important. The test will show whether and to what extent you have improved. If you are not getting better, or if you are getting worse, your scores will not improve. If your scores are steadily improving, this indicates the drug is probably helping.

Unfortunately, most doctors do not require their patients to complete a mood test like the one in Chapter 2 between therapy sessions. Instead, they rely on their own clinical judgment to evaluate the effectiveness of the treatment. This is quite unfortunate, because studies have indicated that doctors are often poor judges of how patients feel inside.

### **How Much Mood Elevation Can I Anticipate?**

Your aim should be to reduce the score on the depression test in Chapter 2 until it is in the range considered normal and happy. This is true whether you are being treated with an antidepressant, with psychotherapy, or with a combination of the two. Treatment cannot be considered completely successful if your score remains in the depressed range.

### **If One Antidepressant Works Somewhat, Will It Be Even Better to Take Two or More Antidepressants at the Same Time?**

As a general rule, it is usually not necessary (or even beneficial) to take two or more different antidepressant drugs simultaneously. The two drugs may interact in ways that are unpredictable, and the side effects may increase substantially. There are exceptions to this, of course. For example, if you are restless and having trouble sleeping, your doctor may sometimes add a small dose of a second, more sedating antidepressant at night to help you get a good night's sleep. Or your doctor may add a small dose of a second antidepressant to try to increase the effectiveness of the first antidepressant. This is called an "augmentation" strategy, and I will discuss this approach in greater detail in Chapter 20. But on the average, one drug at a time usually works best.

### **How Long Will It Take Before I Can Expect to Feel Better?**

It typically requires a minimum of two or three weeks before an antidepressant medicine begins to improve your mood. Some drugs may take even longer. For example, Prozac may not become effective for five to eight weeks. It is not known why antidepressants have this delayed reaction (and whoever discovers the reason will probably be a good candidate for a Nobel prize). Many patients have the impulse to discontinue their antidepressants before three weeks have passed because they feel hopeless and believe the medicine is not working. This is illogical, since it is unusual for these agents to become effective right away.

### **What Can I Do if My Antidepressant Doesn't Work?**

I have seen many patients who failed to respond adequately to one or many antidepressants. In fact, at my clinic in Philadelphia, most of the patients were referred to me after unsuccessful treatments with a variety of antidepressant drugs and therapy as well. Most of the time we were eventually able to get an excellent antidepressant effect, often through a combination of cognitive therapy and another medication that the patient had not yet tried. The important thing is to keep persisting in your efforts until you recover. Sometimes this requires enormous dedication and faith. Patients often feel like giving up, but persistence nearly always pays off.

I have stated earlier that the feelings of hopelessness are probably the worst aspect of depression. These feelings sometimes lead to suicide

attempts because patients feel so convinced that things will never get any better. They think that things have always been this way and that their feelings of worthlessness and despair will go on forever. In addition, there is a kind of genius about depression. Patients can be so incredibly persuasive about their hopelessness that even their doctors and families may start believing them after a while. Early in my career I grappled with this and often felt tempted to give up on particularly difficult patients. But a trusted colleague urged me never to give in to the belief that any patient was hopeless. Throughout my career, this policy has paid off. No matter what type of treatment you receive, faith and persistence can be the keys to success. I cannot emphasize this enough.

## **How Long Should I Take an Antidepressant if It Doesn't Seem to Be Working?**

Of course, you should always check with your physician before making any changes in your medication, but on average, a trial of four or five weeks should be adequate. If you do not have a clear-cut and fairly dramatic improvement in your mood, then a switch to another drug is probably indicated. It is important, however, that the dose be adjusted correctly during this time, since doses that are too high or too low may not be effective. Sometimes your doctor may order a blood test to make sure the dose you are taking is adequate for you.

One of the commonest errors your doctor may make is to keep you on a particular antidepressant for many months (or even years) when there is no clear-cut evidence that you have improved. This makes absolutely no sense to me! However, I have seen many severely depressed individuals who reported that they had been treated continuously with the same antidepressant for many years but were not aware of any beneficial effects from the medication. Their scores on the mood test in Chapter 2 usually indicated they were still severely depressed. When I asked them why they were taking the drug for such a long time, they usually said that theirs doctors told them that they needed it, or that it was necessary because of their "chemical imbalance." If your mood has not improved, it seems clear that the drug has not worked, so why keep taking it? If a drug does not have fairly substantial beneficial effects, as indicated by a clear and continuing

improvement in your score on a depression test like the one in Chapter 2, then it is usually appropriate to switch to another antidepressant medication.

## **How Long Should I Continue to Take the Antidepressant if It Does Help Me?**

You and your doctor will have to make this decision together. If this is your first episode of depression, you can probably go off the medicine after six to twelve months and continue to feel undepressed. In some cases, I have discontinued antidepressants after only three months with good results, and rarely found that treatment for more than six months was necessary. But different doctors have different opinions about this.

One of the strongest predictors of relapse in research studies is the degree of improvement at the end of treatment. In other words, if you are happy and completely free of depression, and this is documented by a score below 5 on the depression test in Chapter 2, the likelihood of a prolonged depression-free period is high. On the other hand, if you are partially improved but your depression score is still somewhat elevated, the likelihood is much greater that the depression will worsen or return in the future, whether or not you continue to take an antidepressant medication.

This is another reason why I like to combine antidepressant medications with cognitive behavioral therapy. The patients usually have a much better response, and very few patients in my private practice appeared to relapse and return for additional treatment following recovery.

## **What if My Doctor Tells Me I Have to Stay on the Antidepressant Indefinitely?**

Patients with certain kinds of depressions will almost definitely need to take medications on a long-term basis. For example, if a patient has bipolar (manic-depressive) illness with uncontrollable highs as well as lows, long-term treatment with a mood-stabilizing medication such as lithium, valproic acid, or carbamazepine may be necessary.

If you have had many years of unremitting depression or if you have been prone to many recurrent attacks of depression, you might want to consider maintenance therapy for a longer period of time. Since doctors are becoming more aware of the relapsing nature of mood disorders, the use of

antidepressants on a long-term or prophylactic basis is gaining greater favor.

Some doctors routinely recommend therapy with antidepressants indefinitely, in much the same way they might insist that patients with diabetes must take daily insulin to regulate their blood sugar. Several research studies suggest that such maintenance therapy can reduce the incidence of depressive relapses. However, research studies also indicate that treatment with the cognitive therapy techniques described in this book can also reduce depressive relapses. In addition, these studies suggest that the preventive effect of cognitive therapy may be greater than the preventive effect of antidepressant medications. One important advantage of cognitive behavioral therapy is that you learn new skills to minimize or prevent future depressions. For example, the simple exercise of writing down and challenging your own negative thoughts when you are under stress can be invaluable.

In my private practice, the vast majority of the depressed patients I have treated have not had to stay on antidepressant drugs indefinitely following recovery. Most of them did extremely well with no medications simply by using the cognitive therapy skills they learned whenever they became upset again in the future. This is very encouraging, and it shows there is quite a bit you can do not only to treat your own depression, but also to minimize the probability of severe and prolonged depressions in the future. It also suggests that if you are taking an antidepressant, it might be very helpful for you to study and practice the methods in this book.

Once you discover how to change your own negative thinking patterns using the techniques I describe, you may find that you will be able to remain undepressed without any medications. But certainly, you will want to discuss this with your physician. It is never smart to go off a medicine or to change the dose of a medication unless you talk this over with your doctor first.

## **What if I Start Getting More Depressed When I Taper Off the Medication?**

This is actually pretty common, and I will tell you how I have handled it in my own practice. First, I make sure the patient continues to take the

depression test in Chapter 2 at least once or twice a week while she or he is tapering off the medication. Then we develop a plan for slowly reducing the dose of the antidepressant. I tell patients that if they start to feel depressed again while tapering off the drug, and this is reflected by an increased score on the depression test, then they should temporarily raise the dose slightly for a week or two. This usually leads to an improvement in mood again. Then they can slowly continue to taper off the drug again. This approach is reassuring because it puts the patient in control. After a couple tries like this, most patients have been able to taper off their antidepressants without becoming depressed again.

### **What Should I Do if the Depression Comes Back in the Future?**

If your depression returns, the chances are excellent that you will again respond to the same drug that helped you the first time. It may be the proper biological “key” for you. So you can probably use that drug again for any future episode of depression. If any blood relative of yours develops a depression, this drug might also be a good choice for them because a person’s response to antidepressants, like the depression itself, appears to be influenced by genetic factors.

The same reasoning applies to the psychotherapy techniques. I have found that for most people, the same kinds of events (for example, being criticized by an authority figure) tend to trigger depression, and the same kinds of cognitive therapy technique usually reverse the depression for a particular patient. In most cases patients have been able to reverse a new episode of depression fairly rapidly without having to take the medication again. I encourage my patients to come in for a little “tune-up” if they become depressed again in the future. Often these “tune-ups” consisted of only one or two therapy sessions, since we were usually able to reapply the same technique that had helped them so much the first time I treated them.

### **What Are the Most Common Side Effects of the Antidepressants?**

As discussed in Chapter 17, all the medications prescribed for depression, anxiety, and other psychiatric problems can cause different kinds of side effects. For example, many of the older antidepressants (such as amitriptyline, trade name Elavil) cause fairly noticeable side effects such

as dry mouth, sleepiness, dizziness, and weight gain, among others. Many of the newer antidepressants (such as fluoxetine, trade name Prozac) can cause nervousness, sweating, upset stomach, or a loss of interest in sex as well as difficulties having an orgasm.

I will describe the specific side effects of every antidepressant in Chapter 20. You will see that some medications produce lots of side effects whereas others produce very few.

The Side Effects Checklist on pages 494–496 can provide you and your physician with extremely accurate information about any side effects that you experience while you are taking a medication. If you take this test a couple times per week, this will show how the side effects change over time.

Remember, however, that many of these so-called side effects can occur even if you are not taking any medication, since many side effects are also symptoms of depression. Feeling tired, having trouble sleeping at night, or a loss of interest in sex would be good examples. So it can be very useful to complete the Side Effects Checklist at least once or twice before you start any medication. That way, you can see if a side effect began before or after you started the drug. Obviously, if you had the same side effect before you started taking a drug, then the drug is probably not to blame for it.

It is also good to remember that patients who only take placebo medications (sugar pills) during research studies tend to report lots of side effects. This is because they think they are taking a real drug. So there is no proof that a particular side effect is necessarily caused by the drug you are taking. When in doubt, talk this over with your physician.

Let me give you a particularly vivid example of how the mind can occasionally play tricks on us. I once treated a high school teacher for depression. She was not responding well to the psychotherapy and I had the hunch that she would respond to a particular antidepressant drug called tranylcypromine (Parnate) that is described in Chapter 20. However, she was somewhat stubborn and had a strong fear of taking any medication. She complained that she would not be able to tolerate the side effects. I explained that I planned to prescribe a low dose and that in my experience most patients did not have many side effects with this medication, especially when the dose was low. But my efforts were to no avail—she

insisted the side effects of the drug would be unbearable, and refused to accept a prescription.

### Side Effects Checklist\*

**Instructions:** Put a check (✓) after each item to indicate if you have had this type of side effect during the past several days. Please answer all the items.

0—Not At All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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Mouth and Stomach				
1. dry mouth				
2. frequently thirsty				
3. loss of appetite				
4. nausea or vomiting				
5. stomach cramps or upset stomach				
6. increase in appetite or eating too much				
7. weight gain or loss				
8. constipation				
9. diarrhea				
Eyes and Ears				
10. blurred vision				
11. overly sensitive to light				
12. changes in vision, such as halos around objects				
13. ringing in your ears				
Skin				
14. sweating too much				
15. rash				
16. excessive sunburn when exposed to sun				
17. change in skin color				
18. bleeding or bruising easily				
Sex				
19. loss of interest in sex				
20. difficulties getting sexually excited				
21. difficulties getting an erection (men)				

0—Not At All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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22. difficulties having an orgasm				
23. difficulties with your period (women)				
<b>Stimulation and Nervousness</b>				
24. stimulated				
25. agitated				
26. anxious, worried or nervous				
27. feeling strange or "spaced out"				
28. excess energy				
<b>Sleep Problems</b>				
29. feeling tired or exhausted				
30. loss of energy				
31. sleeping too much				
32. trouble falling asleep				
33. sleep that is restless or disturbed				
34. waking up too early in the morning				
35. nightmares or strange dreams				
<b>Muscles and Coordination</b>				
36. muscle jerks or twitches				
37. slurred speech				
38. tremor				
39. difficulty walking or loss of balance				
40. feeling slowed down				
41. stiffness of the arms, legs, or tongue				
42. feeling restless, like you have to keep moving your arms or legs				
43. hand-wringing				
44. constant, regular, rhythmic leg jiggling				
45. abnormal movements of your face, lips, tongue				

**Instructions:** Put a check (✓) after each item to indicate if you have had this type of side effect during the past several days. Please answer all the items.

0—Not At All	1—Somewhat	2—Moderately	3—A Lot	4—Extremely
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46. abnormal movements of other parts of your body, such as your fingers or shoulders					
47. muscle spasms of your tongue, jaw, or neck					
<b>Other</b>					
48. difficulty remembering things					
49. feeling dizzy, light-headed, or faint					
50. feeling your heart race or pound					
51. swelling in your arms or legs					
52. trouble starting urination					
53. headache					
54. breast swelling or enlargement					
55. milk secretion from the nipples					

Please describe any other side effects: \_\_\_\_\_

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I asked if she would be willing to do a little experiment to check this out. I told her I would give her two weeks' worth of pills in fourteen separate envelopes. Each envelope was labeled with the date and day of the week she was to take the pills inside it. I explained that some envelopes would contain placebo pills that could not have any side effects whatsoever. Half the pills would be yellow and half would be red, but she would not know whether she was taking the real medication or a placebo on any given day. The envelope for the first day contained one yellow pill and the envelope for the second day contained one red pill. The envelopes for the third and fourth days contained two yellow pills each, and the envelopes for the fifth and sixth days contained two red pills each. Finally, each envelope for the second week contained three yellow pills or three red pills.

I asked her to complete the Side Effects Checklist every day and to record the date. I explained how this experiment would help us determine whether any side effects she experienced on a given day were due to the real drug or the placebo effect. She reluctantly agreed, but insisted that her body was very sensitive to drugs and predicted the experiment would prove just how wrong I was.

Shortly after she started taking the pills she started calling me almost daily with alarming reports about severe side effects, especially on the days she was taking the yellow pills. She said these effects also spilled over to the days she took the red pills as well. I explained the side effects usually diminished over time and encouraged her to try to continue.

On Sunday evening she had the answering service page me at home for an emergency. She stated that the side effects did not diminish but were getting worse. In fact, they were so severe that she simply could no longer function. She was dizzy and confused and fatigued. Her mouth was as dry as cotton. She staggered when she tried to walk and could barely get out of bed. She had severe headaches. She said she would not take any more pills and wanted to know why I had put her through such grief.

I apologized, told her to stop the medications immediately and made an appointment to see her the first thing Monday morning for an emergency session. I reassured her that none of her symptoms sounded life-threatening, although she was obviously in great distress. I told her to bring her daily Side Effects Checklists to the session and promised that we would break the code together the next morning so we could find out which days she had taken the placebos and which days she had taken the real pills.

The next morning I explained that *all* the pills she had taken were placebos I had obtained from the hospital pharmacist. They were simply red placebos and yellow placebos—there were no Parnate pills in any of the envelopes.

This information surprised her, and tears began rolling down her cheeks. She acknowledged that she never would have believed that her mind could have such powerful effects on her body. She had been totally convinced the side effects were real. She then went ahead to take the Parnate in small doses and her mood improved substantially over the next month or two. She also started working very hard on her psychotherapy homework between

sessions. She continued to fill out the Depression Test and the Side Effects Checklist once a week, but she did not report many side effects.

I do not mean to imply that all side effects are in your mind. On rare occasions this can occur, but most of the time the side effects are quite real, and the vast majority of my patients have reported them accurately. If you use the Side Effects Checklist on a daily basis, it will help you and your doctor assess the specific type and severity of any symptoms you might experience. Then the appropriate medication adjustments can be made if the side effects are excessive or dangerous.

## **Why Do Antidepressant Drugs Have Side Effects?**

You learned in Chapter 17 that antidepressant drugs can stimulate or block the receptors for the neurotransmitter chemicals that nerves use to send messages to each other. In that chapter, we focused on serotonin, since this transmitter is felt to be involved in the regulation of mood. One of the most important and helpful discoveries of the past two decades is that antidepressants can also interact with the receptors for several additional chemical transmitters in the brain. These interactions appear to be responsible for many of the side effects of the antidepressants.

The three brain receptors that have been studied the most intensively are called histamine receptors, alpha-adrenergic receptors, and muscarinic receptors. These are located on nerves that use histamine, norepinephrine, and acetylcholine, respectively, as their chemical transmitters. Drugs that block histamine receptors are called “antihistamines,” a term you are probably familiar with. Drugs that block alpha-adrenergic receptors are called “alpha-blockers,” and drugs that block muscarinic receptors are called “anticholinergics.”

Each type of receptor is responsible for certain kinds of side effects. You can predict the side effects of any drug if you understand how strongly the drug affects each of these three brain systems. Antidepressant medications produce many of their side effects because they block histaminic receptors, alpha-adrenergic receptors, and cholinergic receptors (which are also called “muscarinic” receptors) that are located on the surfaces of nerves inside of your brain and throughout your body as well. In case you do not recall what a “receptor” is, it is simply an area on the surface of a nerve that can turn

the nerve on or off. The histamine receptors are located on nerves that use histamine as a chemical transmitter; the alpha-adrenergic receptors are located on nerves that use norepinephrine as a chemical transmitter; and the cholinergic receptors are located on nerves that use acetylcholine as a chemical transmitter. If you block any of these three types of receptors, you will turn the nerves off. The effects of different antidepressant medications on these three receptors help explain many of the side effects of these drugs.

For example, amitriptyline (Elavil) is an older antidepressant that can cause many side effects, including sleepiness, weight gain, dizziness, dry mouth, blurred vision, and forgetfulness, to name just a few of the more common ones. Most of these side effects are not dangerous, but they can be uncomfortable. Let's see if we can understand these side effects a little better by examining the effects of amitriptyline on the three kinds of nerve receptors.

Scientists have learned that amitriptyline blocks the cholinergic, histamine, and alpha-adrenergic receptors in the brain. Let's examine its anti-cholinergic effects first. What do these cholinergic nerves ordinarily do? Among other things, they control the amount of lubrication in your mouth. If you stimulate cholinergic nerves, more fluids will flow into your mouth from glands that are located in your cheeks.

What would happen if you turned off these nerves that normally lubricate your mouth? Your mouth would feel dry. You may have experienced a dry mouth when you were very nervous (cottonmouth) or when you were exercising for a long time in the sunshine without drinking any water. Cholinergic nerves also slow the heart, and so anti-cholinergic drugs like amitriptyline will cause the heart to speed up. Anticholinergic drugs can also cause forgetfulness, confusion, blurred vision, constipation, and difficulties getting your urine started.

Amitriptyline also blocks alpha-adrenergic receptors on nerves that use norepinephrine as a transmitter substance. If you stimulate these alpha-adrenergic receptors, your blood pressure will usually increase. Conversely, when you block them, your blood pressure will usually fall. This is why amitriptyline can cause a drop in blood pressure in certain individuals. This problem is especially noticeable when you suddenly stand up, because the drop in blood pressure makes you dizzy. Dizziness when standing is a common side effect of amitriptyline and many other antidepressants.

As noted above, amitriptyline also blocks histamine receptors in the brain. Drugs that block these receptors are called “antihistamines.” You’ve probably taken an antihistamine if you’ve had an allergy or a stuffy nose. Drugs that block histamine receptors can make you sleepy and hungry. This is why amitriptyline, as well as many other antidepressant drugs that block histamine receptors, causes tiredness and weight gain.

Many of the older antidepressant medications are categorized as “tricyclic” antidepressants. The tricyclics have relatively strong effects on these three kinds of brain receptors, and so they tend to cause quite a few side effects. In fact, on pages 530–532 in Chapter 20 you will find a table that lists each tricyclic and shows how strong its effects are on each of these three types of brain receptors. This information indicates how strong the different kinds of side effects will be for each medication.

In contrast, many of the newer antidepressants (such as Prozac and the other SSRIs) generally have only weak effects on the histaminic, alpha-adrenergic, and cholinergic receptors in the brain. Consequently, they usually produce fewer side effects than the older drugs like amitriptyline. For example, the SSRIs are less likely to cause sleepiness, excessive appetite, dizziness, dry mouth, constipation, and so forth. The SSRIs also have little effect on the rate or rhythm of the heart.

However, we are now discovering that the SSRIs such as Prozac have new and different side effects of their own. For example, as many as 30 percent to 40 percent of the patients taking these drugs experience sexual difficulties such as a loss of interest in sex or difficulties having an orgasm. They can also cause upset stomach, loss of appetite, weight gain, nervousness, difficulties sleeping, fatigue, tremor, and excessive sweating, and a number of other side effects.

## **What Can I Do to Prevent or Minimize these Side Effects?**

The likelihood and severity of any side effect usually depends on the dose of the medication you are taking. As a general rule, if you start out with a small dose and increase the dose gradually, the side effects can be minimized. In addition, many side effects tend to diminish over time. Sometimes a reduction in dose will minimize side effects without reducing the effectiveness of an antidepressant; sometimes a change to another type

of antidepressant medication will be needed. If you and your doctor work together, you can usually find a medication that will have a beneficial effect on your mood without excessive side effects.

Your doctor might also add a second medication to help combat the side effects of an antidepressant medication or a mood stabilizer. Sometimes this is necessary and justified and sometimes it is not necessary. I will discuss this issue in greater detail in Chapter 20 but I will give you a couple of specific examples here.

Let's assume that you are taking lithium for manic-depressive illness. A common side effect of lithium is a tremor of the hands. You may find it difficult to write your name clearly or your hand may shake while you are attempting to hold a cup of coffee. One of my patients trembled so much that the coffee would actually spill out of the cup. Obviously such a severe side effect is not acceptable.

Your doctor may add one of the drugs called beta-blockers to help combat the tremor. The drug propranolol (Inderal) is often used for this purpose. However, beta-blockers have potent effects on the heart and they can also have a number of side effects of their own. Furthermore, both lithium and beta-blockers have the potential for adverse interactions with other drugs your psychiatrist or family physician may prescribe, and so the situation rapidly becomes quite complex. In my mind, the question becomes: Is this tremor so severe and disabling that it justifies adding a potent cardiac drug? Is there another way to deal with this side effect without adding more drugs? Would a reduction in dose be indicated? Sometimes the beta-blocker may be justified; sometimes it may not be necessary.

The same kind of reasoning applies to antidepressants. Sometimes a second drug is necessary to combat a side effect, but often it is not the best choice. Let's assume that you are being treated with fluoxetine (Prozac) for depression. Three common side effects of Prozac include insomnia, anxiety, and sexual problems. Let's examine how your doctor might handle each of these.

- If you are overly stimulated from Prozac and you are having trouble sleeping, your doctor may add a small dose of a second, more sedative antidepressant at night. For example, 50 to 100 mg of trazodone

(Desyrel) is often used. This is a pretty good approach, because the trazodone differs from most sleeping pills in that it is not addictive. However, you may also be able to combat the excessive stimulation by taking a smaller dose of Prozac and by taking it earlier in the day. Then you might not need to add a second drug. Keep in mind, too, that the excessive stimulation from Prozac tends to occur when you first start taking it and may also disappear after a week or two.

- Prozac can cause anxiety or agitation, especially when you first start taking it. Your doctor may want to add a benzodiazepine (minor tranquilizer) such as clona-zepam (Klonopin) or alprazolam (Xanax) to combat the nervousness. But the benzodiazepines can be addictive when taken daily for more than three weeks, and anxiety can usually be managed without adding one of these agents. A reduction in the dose of the Prozac will often help. The effectiveness of the SSRI antidepressants such as Prozac does not seem to depend on the dose, so there is little justification for taking a dose that creates excessive discomfort. The passage of time will often help as well, since the anxiety from Prozac seems to diminish or disappear after the first few weeks.

Some patients develop a second wave of nervousness and restlessness after they have been on Prozac for a number of weeks or months. Sometimes this pattern of agitation is called “akathisia”—a syndrome in which your arms and legs become so extremely restless that you simply cannot sit still. This intensely uncomfortable side effect is quite common with the neuroleptic drugs used to treat schizophrenia but occurs much less often with most antidepressants. Prozac leaves your blood very slowly, however, so the levels increase more and more during the first five weeks that you are taking it. Even though a particular dose of Prozac, such as 20 mg or 40 mg per day, may have been fine at first, after a month or so that same dose may become much too high for you. A dramatic reduction in dose might greatly reduce the side effects without reducing the antidepressant effects at all. However, many patients with akathisia have to be taken off the Prozac and switched to another medication because the akathisia has become so severe and uncomfortable. Your doctor may

add another drug temporarily to combat akathisia, but it seems prudent to reduce the dose of Prozac or to go off the drug entirely if akathisia develops.

- As noted above, as many as 40 percent of men and women on Prozac (as well as the other SSRI antidepressants) develop sexual problems, including a loss of interest in sex as well as difficulties having an orgasm. Your doctor might want to add one of several drugs (bupropion, buspirone, yohimbine, or amantadine) currently being used to try to combat these sexual side effects. Once again, the potential benefit should be weighed against the hazards of these agents, and alternative strategies can be considered. I have rarely, if ever, kept a patient on an SSRI indefinitely, so most patients have elected just to put up with this side effect, knowing it would not be a long-term problem. If the SSRI is causing a dramatic improvement in mood and there are no other side effects, the loss of interest in sex for several months may be an acceptable trade-off. But of course these are subjective issues, and you will have to make your own decision about this after discussing your options with your physician.

In the next chapter, you will see that I recommend against combination drug therapies for most patients taking antidepressants. If you take more than one drug at a time, you increase the chances for dangerous drug interactions. In addition, the second medication may create new and different side effects. In most cases, if you and your doctor work together and use a little common sense, it will not be necessary to treat antidepressant drug side effects by adding additional drugs.

### **How Can I Prevent Potentially Dangerous Interactions between Antidepressants and Other Drugs, Including Nonprescription Drugs?**

In recent years doctors have become increasingly aware that certain types of drugs may interact with each other in ways that can be dangerous. Two drugs may be quite safe and have few or no side effects if you take either one separately; but if you take the two drugs at the same time, there could be serious consequences because of how the two drugs interact with each other.

This problem of drug interactions has become increasingly important in recent years for two reasons. First, there is an increasing trend among psychiatrists to prescribe more than one psychiatric drug at a time to many of their patients. This is not an approach with which I am entirely comfortable, but it is nevertheless very common. Each new drug raises the possibility of drug interactions, since different psychiatric drugs can interact with each other in potentially dangerous ways. And, as noted in the last chapter, more and more patients are being put on antidepressant drugs (as well as other types of psychiatric drugs) for prolonged periods of time, sometimes indefinitely. This is also not an approach with which I am comfortable, and I have found that long-term drug treatment for depression is not necessary for most patients. But many psychiatrists do prescribe drugs for prolonged times—the practice is in vogue. And if you do take a psychiatric drug for a long time, eventually you will probably receive one or more prescriptions from other doctors for other medical problems. For example, your doctor might prescribe a medication for an allergy, high blood pressure, pain, or an infection. In addition, you might take an over-the-counter medication for a cold, a cough, a headache, or an upset stomach. Now the possibility of drug interactions has to be considered, because these drugs may interact with the psychiatric drug you have been taking.

Of course, it goes without saying that psychiatric drugs can also interact with tobacco and alcohol as well as street drugs such as cocaine or amphetamines. In some cases these interactions can also be quite dangerous and even fatal. Some antidepressants interact in extremely dangerous ways with commonly used drugs, including over-the-counter medications. I am not trying to be overly alarmist here. With a little education and good teamwork with your physician, you can take an antidepressant safely.

In this section I will explain why and how drug interactions happen. In addition, in Chapter 20, I will describe a number of important drug interactions for each drug or category of drug you might be taking. Remember that knowledge about these drug interactions is rapidly evolving. New information comes out almost on a daily basis. Make certain each doctor you see has a complete and accurate list of every drug you are taking, including any over-the-counter (nonprescription) drugs you take. Ask your doctor if there are any drug interactions that could be important.

Ask your pharmacist the same thing. If they are not sure, ask them to check it out for you. It is virtually impossible to keep all potential drug interactions in your mind, because so much new information is constantly emerging. References and computer programs that list dangerous drug interactions are readily available to help with this task. If you are appropriately assertive and have a little education about the topic, you will be in a better position to have an intelligent discussion with your doctor about interactions among the drugs you are taking.

You will see in Chapter 20 that I have prepared detailed charts listing drug interactions for specific antidepressants or mood stabilizers you may be taking. So, for example, if you are taking Prozac, you can review the table that lists its drug interactions. This should take only a minute or two.

You may think that you shouldn't have to study these charts, because your doctor should know all about any dangerous drug interactions and ensure that nothing bad happens to you. There are several problems with this line of reasoning. First, though your doctor may be extremely knowledgeable, she or he is also human and cannot keep up with all the new information that is emerging, no matter how smart she or he may be. Second, even if your doctor told you about every conceivable drug interaction, there is no way you could remember all of them! And third, in this era of managed care, doctors are having to manage more and more patients, and you may get only a few minutes with your prescribing physician at infrequent intervals to review your symptoms and the dose of the medication. There may simply not be enough time to discuss all the possible drug interactions you need to know about.

## **How and Why Do These Drug Interactions Occur?**

There are four basic ways that two drugs can interact. First, one drug can cause the level of a second drug in your blood to increase—sometimes to an alarming degree, even though you are taking only a “normal” dose of both drugs. What are the consequences of a sudden increase in the level of a drug in your blood? First, you may experience more side effects, since they are usually related to the dose. Second, many psychiatric drugs lose their effectiveness when the dose is too high or too low. And third, there can be

toxic and even fatal reactions when the blood level of any drug becomes too high.

A second type of drug interaction is just the opposite. One drug can cause the level of another drug in your blood to decrease. This can cause the second drug to become ineffective, even though you are taking a normal dose. You and your doctor may wrongly conclude that the drug does not work for you when the real problem is that your blood level is too low.

A third type of interaction is when two drugs each have similar effects or side effects that intensify each other. Suppose, for example, that you are being treated for high blood pressure and then you begin to take a psychiatric drug that also lowers blood pressure as a side effect. The result could be that you might experience a sudden drop in blood pressure and possibly even faint when you suddenly stand up.

A fourth and more ominous type of drug interaction is not related to changes in blood levels but simply to toxic effects of certain drug combinations. In other words, two drugs that are safe when taken separately may lead to extremely dangerous interactions when you take them together.

Now let's examine the first two types of drug interactions in more detail. Why does one drug sometimes cause the level of a second drug to increase or fall dramatically? Well, a simple way to think about it would be to imagine that you are trying to fill a bathtub with water. If the plug is out, the water will have a tendency to go out as fast as it comes in. As a result, the water level in the tub will not go up high enough to take a bath, no matter how long you leave the faucet on. In contrast, if the plug is in the tub and you don't turn the water off, the tub will overflow.

Now compare your body to the bathtub. (I do not mean to imply that you have a bad figure!) The medicine you take each day is like the water coming into the tub. Certain enzyme systems in your liver can be compared to the hole in the bottom of the tub. These enzymes in your liver chemically change drugs into other substances (called "metabolites") that your kidneys can get rid of more easily. This process is called "metabolism." Metabolites of the drugs you take usually end up in your urine.

When you add a second drug, your liver may metabolize the first drug more slowly. This would be comparable to plugging up the hole at the bottom of the tub. And so, as you keep taking the first medicine, your blood level gets too high, in just the same way that the water in the tub gets too

high and eventually spills over the side. Or the second drug you take could have the opposite effect of making the hole in the bottom of the tub much bigger. In this case, your liver's metabolism speeds up and rids your body of the first drug much faster. In this case, you may keep taking the same dose of the first drug each day but your blood level remains too low to have the desired antidepressant effect. In this case, the water goes out of the tub just as fast as it comes in.

That's pretty much the basic principle. The drugs that are likely to interact with each other are those that are metabolized by the "cytochrome P450" enzyme systems in the liver. There are many of these enzyme systems, and different kinds of drugs are metabolized by different enzyme systems. Only certain drugs or combinations of drugs will stimulate or inhibit any of these enzyme systems. Psychiatric drugs can interact with other psychiatric and nonpsychiatric drugs, such as antibiotics, antihistamines, or painkillers. In other words, psychiatric drugs can affect other drugs your doctor may prescribe (such as a pill for high blood pressure), in exactly the same way that those other drugs can have an impact on any psychiatric drugs you may be taking. The bottom line is that the level of any drug you are taking might become too high or too low if you are also taking another drug at the same time.

Let me now give you some specific examples of these drug interactions. Suppose you are taking one of the new selective serotonin reuptake inhibitors called paroxetine (trade name Paxil). This drug is very similar to Prozac. Now suppose that the paroxetine is not working very well, which sometimes happens, and you are still feeling depressed. Your doctor might decide to add a second antidepressant. If your doctor chooses desipramine (trade name Norpramin), the paroxetine you are taking will have the effect of "plugging up the tub." Now your body will not be able to metabolize the new drug (desipramine) very well. As a result, your blood level of desipramine may increase to three to four times higher than expected. Most psychiatrists are aware of this drug interaction and will be careful to prescribe desipramine in a tiny dose if a patient is taking an SSRI like paroxetine. But if your psychiatrist was not aware of this particular drug interaction and decided to give you a "normal" dose of desipramine, you could develop a toxic level of desipramine in your blood.

Is this serious? Well, there are three potential problems. First, desipramine is not effective at excessively high blood levels. Second, there will be many more side effects at high levels. And third, in rare instances, excessive blood levels of desipramine can trigger abnormal heart rhythms and occasionally even cause death.

Is this type of drug interaction rare? No. The levels of antidepressants can sometimes increase or decrease quite dramatically when combined with common prescription or over-the-counter drugs you might take without thinking twice. The tables in Chapter 20 will delineate the interactions most important to any antidepressant you might be taking.

Finally, some toxic and dangerous drug interactions do not necessarily depend on doses or blood levels. For example, many of the newer antidepressants such as Prozac have powerful effects on the serotonin systems in the brain. The monoamine oxidase inhibitors (MAOIs) also affect the serotonin systems in the brain, but through a different mechanism. The antidepressant tranylcypromine (trade name Parnate) is an example of one of these MAOI drugs. If you take Prozac and Parnate at the same time, the combination could trigger an extremely dangerous reaction known as the “serotonin syndrome.” The symptoms can include fever, muscle rigidity, and rapid changes in blood pressure, along with agitation, delirium, seizures, coma, and death. Obviously, this combination of drugs should not be given!

You will see in Chapter 20 that many medications can be dangerous if you are taking an MAOI. The list of forbidden drugs includes many antidepressants, some decongestants (especially if they contain dextromethorphan, a common ingredient of cold preparations), antihistamines, local anesthetics, some anticonvulsants, some painkillers such as meperidine (Demerol), antispasmodics including cyclobenzaprine (Flexeril) and weight-loss preparations. Some of these drugs will cause the serotonin syndrome described above, and some of them will cause another dangerous reaction known as a “hypertensive crisis.” In extreme cases, the symptoms of a hypertensive crisis include brain hemorrhage, paralysis, coma, and death. Certain common foods such as cheese are also on the “forbidden” list if you are taking one of the MAOIs, because they can cause a hypertensive crisis as well.

Many doctors do not prescribe the MAOIs because of concerns about these toxic interactions. You may also think: "Well, I will just take a safer drug so I won't have to worry." This makes good sense, since many safer medications are available. However, many commonly prescribed antidepressants can cause dangerous interactions. For example, two common antidepressants, nefazodone (trade name Serzone) and fluvoxamine (trade name Luvox) should not be combined with several commonly prescribed drugs because these particular combinations can trigger an abnormal heart rhythm that may result in sudden death. The drugs include terfenadine (trade name Seldane and used for allergies), astemizole (trade name Hismanal and used for allergies), or cisapride (trade name Propulsid, a stimulant for the gastrointestinal tract).

I do not mean to give the impression that it is dangerous to take antidepressant drugs. To the contrary, they are usually quite safe and effective, and the catastrophic drug interactions I have described are fortunately rare. In addition, most psychiatrists go to great lengths to educate themselves about recent developments and try to keep up with new information about side effects and drug interactions. But in the real world we live in, no doctor is perfect and no doctor can have comprehensive knowledge about all possible drug interactions. For example, your primary care physician may not be familiar with some new antidepressant your psychiatrist has prescribed. And so a little research on your part will be helpful. As an enlightened consumer, you can read about any antidepressant medicine you are taking in Chapter 20 and in other readily available references such as the *Physician's Desk Reference* (*PDR*). You can find these books at any library, bookstore, or pharmacy. You can also find the *PDR* at your doctor's office. You can also review the drug insert that comes with the medication. It doesn't take more than five or ten minutes to review this information. Then you can ask informed questions and bring out the best in your physician. The teamwork can give you a safer and better experience with your antidepressant. This is definitely one case where an ounce of prevention can be worth more than a pound of cure.

## Chapter 20

### The Complete Consumer's Guide to Antidepressant Drug Therapy\*

(Notes and References appear on pages 682–687.)

In this chapter I will give you practical information about the costs, doses, side effects, and drug interactions for all the currently available antidepressant and mood-stabilizing drugs. I would recommend you use this chapter as a reference source rather than trying to read it all at once—there is just too much detailed information to digest at one sitting. If you want to learn about a particular drug that you or a family member may be taking, the Table of Antidepressants on pages 514–515 will help you locate the information you need in this chapter. Let's assume, for example, that you are taking fluoxetine (Prozac). You can read the section on the SSRI antidepressants starting on page 547. In addition, the section on drug costs starting on this page, as well as the information starting on page 659, should be of general interest to all readers.

**Table of Antidepressants**

<i>Antidepressant Drug Class</i>	<i>Chemical Name (and Trade Name)<sup>a</sup></i>	<i>Page #</i>
<b>Tricyclic Antidepressants</b>	amitriptyline (Elavil, Endep) clomipramine (Anafranil) desipramine (Norpramin, Pertofrane) doxepin (Adapin, Sinequan) imipramine (Tofranil) nortriptyline (Aventyl)	524

protriptyline (Vivactil)  
trimipramine (Surmontil)

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<b>Tetracyclic Antidepressants</b>	524
amoxapine (Asendin) maprotiline (Ludiomil)	
<b>SSRI Antidepressants</b>	547
citalopram (Celexa) fluoxetine (Prozac) fluvoxamine (Luvox) paroxetine (Paxil) sertraline (Zoloft)	
<b>MAO Inhibitors</b>	564
isocarboxazid (Marplan) phenelzine (Nardil) selegiline (Eldepryl) tranylcypromine (Parnate)	
<b>Serotonin Antagonists</b>	599
nefazodone (Serzone) trazodone (Desyrel)	
<b>Other Antidepressants</b>	605
bupropion (Wellbutrin)                          605 venlafaxine (Effexor)                          611 mirtazapine (Remeron)                          615	

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<b>Mood Stabilizers</b>	617
carbamazepine (Tegretol)	640
gabapentin (Neurontin)	651
lamotrigine (Lamictal)	652
lithium (Eskalith)	617
valproic acid (Depakene) and divalproex sodium (Depakote)	634

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<sup>a</sup>Many of the antidepressants are now available as generic brands (see Table 20–1). Only the trade names of the original brands are listed in this table.

### Costs of Antidepressant Medications

We often think that more expensive means better, but this is not always the case with antidepressants. As it turns out, there are some very dramatic differences in the costs of the different antidepressants that do not reflect differences in effectiveness. In other words, sometimes a drug that is much cheaper will be just as effective, or even more effective, than another drug that costs more than forty times more. Therefore, if the cost of the medication is a concern for you, then a little education may save you a great deal of money.

The costs and doses of the most commonly prescribed antidepressants and mood stabilizing agents are listed in Table 20–1 on pages 518–523. Note that I am quoting *the cheapest wholesale price* for each antidepressant drug in Table 20–1. The retail price you pay for the same medication at the drug store will probably be higher. If you choose a different brand of the same medication, it may be higher yet. Please keep this in mind in all of the following discussions of drug costs.

If you compare the costs of the different types of drugs and the different doses, it will provide you with some interesting information. You will see, for example, that many of the older tricyclic and tetracyclic drugs are now available generically. When a drug is first manufactured, the drug company gets a seventeen-year patent so it can market the drug exclusively. The relatively high cost of the newer drugs that are still protected by patents helps to cover the costs of the research, development, and testing. After the patent

expires, other companies can compete and manufacture the drug, and so the price goes down drastically.

You will see in Table 20–1 that these so-called “generic” medications are much less costly than the newer drugs that are still under patent. Let’s assume that your doctor prescribes a dose of 150 mg per day of imipramine for your depression. The cost of the three 50-mg pills you will take will be less than 10 cents per day, or roughly \$3 per month. This is because imipramine is now available generically. In contrast, if your doctor prescribes two 20-mg Prozac pills per day, your cost will be nearly \$4.50 per day or \$135 per month—over forty times more than the imipramine. And if she or he prescribes four Prozac pills—the maximum dose—your cost will be \$270 per month. This is a steep price for many people. Don’t forget these are *wholesale* prices—you may pay even more.

Is Prozac forty to a hundred times more effective than imipramine? Definitely not. As you will learn below, most of the antidepressants tend to be comparably effective. Research studies have not confirmed that Prozac is any more effective than imipramine—in fact it may be slightly less effective for severe depressions. However, the big advantage of Prozac is that it has fewer side effects (such as dry mouth or sleepiness) than imipramine. This may be quite important to some people and may make the price difference worthwhile. On the other hand, you will learn that Prozac has some side effects of its own, such as problems with sexual functioning (difficulty achieving orgasm) in as many as 30 percent to 40 percent of patients, and possibly more. People who don’t like this particular side effect might actually prefer the cheaper medication.

You will also see in Table 20–1 that pills which contain a larger quantity of a particular drug are not necessarily more expensive than pills which contain a smaller quantity. This is especially true if you are taking one of the newer drugs that is still under patent, so you may be able to save money by buying pills containing a larger dose. For example, you will see in Table 20–1 that the cost of a hundred nefazodone (Serzone) tablets is \$83.14 for the 100-mg size. The price for a hundred tablets of the larger sizes (150 mg to 250 mg) is exactly the same. So if you are taking a large dose, say 500 mg per day, you could either take five of the 100-mg pills (cost of \$4.16 per day) or two of the 250-mg pills (cost of \$1.66 per day).

In addition, you can often save money by buying a larger size of a medication and breaking a pill in half. So to continue with the same example, if you are taking 250-mg pills, it will cost you approximately half as much if you purchase 500-mg pills and break them in half.

For the generic drugs, things are different. On the average, the costs are low overall and depend on the dose, and the savings at higher doses are not so drastic. In addition, because so many different companies manufacture these drugs, the prices for the different doses are not always entirely consistent—sometimes a smaller dose will actually cost more than a larger dose. For example, look at the pricing structure for the tricyclic antidepressant, desipramine (trade name Norpramin) on page 518. You will see that a hundred of the 10-mg pills cost \$15.75, while a hundred of the 25-mg pills costs only \$7.14. So the larger pill is actually cheaper. This is because different companies manufacture the two sizes.

To make things even more confusing, there are other cases where a larger dose costs substantially more and you can save money by taking a smaller size. For example, take another look at the costs of desipramine on page 518. You will see that a hundred 75-mg desipramine pills cost \$12.42, and that a hundred 150-mg desipramine pills cost \$109.95 (again, because of different manufacturers). So you can save lots of money by taking two 75-mg pills instead of one 150-mg pill. Again, this is because different companies manufacture the 75-mg and 150-mg sizes. This may strike you as odd, but the pricing structure in some instances is completely out of whack.

**Table 20–1.** Names, Doses, and Costs of Antidepressant Medications

<i>Chemical Name<sup>a</sup></i>	<i>Trade (Brand) Name<sup>b</sup></i>	<i>Available Sizes (mg) &amp; Cheapest Wholesale Cost per 100 Pills<sup>c</sup></i>			<i>Daily Dose Range<sup>d</sup></i>	<i>Are Generics Available<sup>e</sup></i>
<b>Tricyclic Antidepressants</b>						
amitriptyline	Elavil	10 mg 25 mg 50 mg 75 mg 100 mg 150 mg	\$1.73 \$1.85 \$2.78 \$3.53 \$4.28 \$2.09	75-300 mg	Yes	
clomipramine	Anafranil	25 mg 50 mg 75 mg	\$78.29 \$105.57 \$138.97	150-250 mg	No	
desipramine	Norpramin	10 mg 25 mg 50 mg 75 mg 100 mg 150 mg	\$15.75 \$7.14 \$10.91 \$12.42 \$40.89 \$109.95	150-300 mg	Yes	
doxepin	Sinequan	10 mg 25 mg 50 mg 75 mg 100 mg 150 mg	\$3.98 \$4.43 \$6.60 \$8.93 \$11.25 \$14.96	150-300 mg	Yes	
imipramine hydrochloride	Tofranil	10 mg 25 mg 50 mg	\$1.88 \$2.33 \$3.08	150-300 mg	Yes	
imipramine pamoate	Tofranil-PM (sustained release)	75 mg 100 mg 125 mg 150 mg	\$103.67 \$136.29 \$169.95 \$193.73	150-300 mg	No	
nortriptyline	Aventyl	10 mg 25 mg 50 mg 75 mg	\$11.55 \$15.90 \$19.43 \$24.83	50-150 mg	Yes	
protriptyline	Vivactil	5 mg 10 mg	\$46.46 \$67.36	15-60 mg	No	
trimipramine	Surmontil	25 mg 50 mg 100 mg	\$64.08 \$108.14 \$157.20	150-300 mg	No	
<b>Tetracyclic Antidepressants</b>						
amoxapine	Asendin	25 mg 50 mg 100 mg 150 mg	\$32.87 \$53.44 \$89.16 \$43.87	150-450 mg	Yes	
maprotiline	Ludiomil	25 mg 50 mg 75 mg	\$19.43 \$29.10 \$40.88	150-225 mg <sup>f</sup>	Yes	
<i>Chemical Name<sup>a</sup></i>	<i>Trade (Brand) Name<sup>b</sup></i>	<i>Available Sizes (mg) &amp; Cheapest Wholesale Cost per 100 Pills<sup>c</sup></i>			<i>Daily Dose Range<sup>d</sup></i>	<i>Are Generics Available<sup>e</sup></i>
<b>SSRI Antidepressants</b>						
citalopram	Celexa	20 mg 40 mg	\$161.00 \$168.00	20-60 mg	No	
fluoxetine	Prozac	10 mg 20 mg	\$218.67 \$224.54	10-80 mg	No	
fluvoxamine	Luvox	50 mg 100 mg	\$198.67 \$204.37	50-300 mg	No	
paroxetine	Paxil	10 mg 20 mg 30 mg	\$189.33 \$189.20 \$214.80	10-50 mg	No	
sertraline	Zoloft	50 mg 100 mg	\$176.23 \$181.33	25-200 mg	No	
<b>MAO Inhibitors</b>						
phenelzine	Nardil	15 mg	\$40.24	15-90 mg	No	
selegiline	Eldepryl	5 mg	\$215.90	20-50 mg	No	
tranylcypromine	Parnate	10 mg	\$45.80	10-50 mg	No	
isocaboxazid	Marpian	10 mg	unavailable	10-50 mg	unavailable	

Serotonin Antagonists					
		100 mg	\$83.14	300–500 mg	No
nefazodone	Serzone	150 mg	\$83.14		
		200 mg	\$83.14		
		250 mg	\$83.14		
trazodone	Desyrel	50 mg	\$5.03	150–300 mg	Yes
		100 mg	\$11.70		
		150 mg	\$58.43		
Other Antidepressants					
bupropion	Wellbutrin	75 mg	\$62.17	200–450 mg	No
venlafaxine	Effexor	100 mg	\$82.96		
		25 mg	\$105.53	75–375 mg	No
		37.5 mg	\$108.68		
		50 mg	\$111.93		
	Effexor XR (Extended Release Capsules)	75 mg	\$118.66		
		100 mg	\$125.78		
		37.5 mg	\$193.88	75–375 mg	No
		75 mg	\$217.14		
mirtazapine	Remeron	150 mg	\$236.53		
		15 mg	\$198.00	15–45 mg	No
Chemical Name <sup>a</sup>	Trade (Brand) Name <sup>b</sup>	Available Sizes (mg) & Cheapest Wholesale Cost per 100 Pills <sup>c</sup>		Daily Dose Range <sup>d</sup>	Are Generics Available?
Mood Stabilizers <sup>e</sup>					
lithium	Eskalith	150 mg	\$7.63	900–1500 mg <sup>e</sup>	Yes
		300 mg	\$5.25		
		600 mg	\$13.23		
carbamazepine	Lithobid, Eskalith CR (sustained release)	300 mg	\$15.53		
	Tegretol	450 mg	\$35.80		
		100 mg	\$14.67	800–1200 mg	Yes
		200 mg	\$10.08		
valproic acid divalproex sodium	Depakene	250 mg	\$12.98	750–3000 mg	Yes
	Depakote <sup>f</sup>	125 mg	\$30.95	750–3000 mg	No
		250 mg	\$60.76		
		500 mg	\$112.08		
lamotrigine	Lamictal	25 mg <sup>g</sup>	—	50–150 mg <sup>g</sup>	No
		100 mg	\$175.54		
		150 mg	\$184.43		
		200 mg	\$193.33		
gabapentin	Neurontin	100 mg	\$37.80	900–2000 mg	No
		300 mg	\$94.50		
		400 mg	\$113.40		

<sup>a</sup>If your doctor prescribes the chemical or “generic” name on the prescription, your pharmacist can often substitute an inexpensive brand that can be much less costly than the trade-name drugs.

<sup>b</sup>Only the brand name of the original drug is listed. Generic versions of these drugs have their own brand names.

<sup>c</sup>Cost source: *Mosby's GenRx. 1998 (8th Edition): The Complete Reference Guide for Generic and Brand Drugs*. St. Louis: Mosby. The average wholesale price for 100 pills of the least expensive brand currently available is listed. This is the price your local retail pharmacist would have to pay for the product without any special discounts. Your cost will be more and will depend on the markup by your pharmacist.

<sup>d</sup>The doses would be used for the treatment of an episode of depression. Some patients may benefit from doses higher or lower than the normal range. If prolonged treatment is necessary following recovery, a smaller dose may be sufficient. Always consult with your doctor before changing the dose.

<sup>e</sup>These are drugs with generic brands available in 1998. More of the current antidepressant drugs will become available as generic brands when their original drug patents expire.

<sup>f</sup>Maprotiline should not exceed 175 mg per day if a patient is kept on the drug for an extended period. The manufacturer suggests that the dose should not exceed a maximum of 225 mg for periods of up to six weeks.

<sup>g</sup>The doses of several mood stabilizers must be monitored by blood tests and will therefore be highly individualized for each patient, depending on your age, gender, weight, diagnosis, and individual metabolism, as well as other medications you may be taking.

<sup>h</sup>Higher doses may be required during acute mania because the body appears to metabolize lithium more rapidly during manic episodes.

<sup>i</sup>This is also available as Depakote Sprinkle (125 mg), which can be sprinkled onto food.

<sup>j</sup>The price of the 25 mg Lamictal was not listed in *Mosby's GenRx* (1998 edition).

<sup>k</sup>This is the recommended dose range for epilepsy when given in conjunction with valproic acid. When given alone, the recommended dose range for epilepsy is 300 mg to 500 mg per day.

If you or a family member is taking an antidepressant, make sure you study Table 20–1 and discuss these cost issues with your druggist. A little quick and easy research on your part may result in large savings.

Another important point, not illustrated in the table, is that the cost of the same generic drug and dose can vary greatly because the generics often have so many different manufacturers. In Table 20–1, I have always listed the least costly generic brand of each pill; other more costly versions of the same pill are not listed. For example a hundred 50-mg imipramine pills manufactured by the drug company HCFA FFP will cost only \$3.08. Because this was the lowest-priced generic brand, I listed it in Table 20–1. In contrast, a hundred of the same size imipramine manufactured by Novartis, another drug company, will cost \$74.12—more than twenty times more. Keep in mind that

if your doctor prescribes the antidepressant by its chemical name (as listed in Table 20–1), your druggist will have the freedom to provide you with the least costly generic brand if one is available.

My goal is not to promote any one drug or class of drug. All antidepressants have merit, and they all have some drawbacks. The key point is this: more expensive does not always mean better. If you review the costs of these drugs, you can work with your doctor and pharmacist to choose the medication and brand that will make the most sense for you.

## Specific Kinds of Antidepressants

### Tricyclic and Tetracyclic Antidepressants

The first drugs listed in the Table of Antidepressants on page 514 are called “tricyclic” and “tetracyclic” antidepressants. The tricyclic and tetracyclic antidepressants differ slightly in their chemical structures. “Tri” means three and “tetra” means four. “Cyclic” refers to a circle or ring. The tricyclic compounds consist of three linked molecular rings, while the tetracyclines consist of four.

You will see that eight tricyclic and two tetracyclic antidepressants are listed in the Table of Antidepressants. The eight tricyclic drugs include amitriptyline (Elavil), clomipramine (Anafranil), desipramine (Norpramin), doxepin (Sinequan), imipramine (Tofranil), nortriptyline (Aventyl), protriptyline (Vivactil), and trimipramine (Surmontil). These eight tricyclic drugs used to be the most widely prescribed antidepressants. They are still among the most effective of all the antidepressants. Many of them are also the least expensive because generic brands have become available. However, tricyclics tend to have more side effects than the newer drugs, and so they are less popular than they used to be. By the same token, they have been prescribed for several decades and have a long track record of reasonably good effectiveness and safety.

The two tetracyclic antidepressant medications listed on the table are called amoxapine (Asendin) and maprotiline (Lu-diomil). These two tetracyclines were synthesized and released after the tricyclics had been in use for some time. It was hoped that they would represent significant improvements in treatment, either because of increased effectiveness for certain types of depression, or because of fewer side effects.

Unfortunately, these expected improvements did not really materialize. For the most part, the effectiveness, mechanism of action, and side effects of the eight tricyclic and the two tetracyclic antidepressants are quite similar.

*Doses for the Tricyclic and Tetracyclic Antidepressants.* Table 20–1 on pages 518–523 lists the costs and dose ranges of the eight tricyclic and the two tetracyclic antidepressant medications. As noted above, many of them are inexpensive because they are no longer on patent, and so generic brands are readily available. Don't be fooled into thinking the cheaper antidepressants are less effective, however. A number of studies suggest they may be slightly more effective than many of the newer antidepressants such as Prozac.

The most common error your doctor is likely to make is to prescribe a dose of a tricyclic antidepressant that is too low. This statement may run against your grain if you feel you should take the lowest dose possible. In the case of tricyclics, if the prescribed dose is too low, the medication will not be effective. If you insist on taking a dose that is too low, you may be wasting your time. It simply will not help you. On the other hand, dosages above those recommended in Table 20–1 can be dangerous and may lead to a worsening of your depression.

Having said that, let me also say that there are cases in which people do respond to doses that are smaller than those listed (especially the elderly), and there are also times when people may need larger doses. One reason for this is that there can be considerable differences in how rapidly people metabolize antidepressant drugs. These differences are partially genetic, and are due to levels of certain enzymes in your liver, as described previously. If you are a "fast metabolizer" you will need a larger dose to maintain an effective blood level, and if you are a "slow metabolizer" you will need a smaller dose. In addition, you will learn below about other drugs that can make tricyclic blood levels fall and lose their effectiveness or increase and become more toxic.

If you suspect you may be taking an inappropriately large or small dose, review the dose ranges in Table 20–1 and discuss your concerns with your physician. Blood-level testing for most of the tricyclic antidepressants is readily available, so your doctor may order a blood test to make sure that the dose you are taking is neither too high nor too low for you.

The best way to begin taking a tricyclic medicine is to start out with a small dose and to increase the amount each day until a dose within the normal therapeutic range is achieved. This buildup can usually be completed within one or two weeks. For example, a typical daily dose schedule for imipramine, one of the most commonly prescribed tricyclic antidepressant drugs listed in Table 20–1, might be the following:

Day one—50 mg at bedtime;  
Day two—75 mg at bedtime;  
Day three—100 mg at bedtime;  
Day four—125 mg at bedtime;  
Day five—150 mg at bedtime.

You and your doctor may prefer to build up the dose a bit more gradually. Doses of up to 150 mg per day can be conveniently taken once a day at night. The antidepressant effect will last all day long, and the most bothersome side effects will occur at night, when they will be least noticed. If doses larger than 150 mg per day are required, the additional medicine should be given in divided doses during the daytime.

For the more sedating tricyclic antidepressants, up to half the maximum indicated dose may be taken on a once-per-day basis before bedtime. This dosage promotes sleep. Several of the tricyclic antidepressants, including desipramine, nortriptyline, and protriptyline, can be stimulating. They can be taken in divided doses in the morning and at noon. If taken too late in the day, they may interfere with sleep.

If you reduce the dose of a tricyclic antidepressant or if you decide to stop taking the medicine, it is best to reduce the dose gradually and never abruptly. Sudden discontinuation of any antidepressant may result in side effects. These include upset stomach, sweating, headache, anxiety, or insomnia. Usually, you can go off a tricyclic antidepressant safely and comfortably by tapering the dose gradually over a one- or two-week period.

*Side Effects of the Tricyclic Antidepressants.* The most frequent side effects of the tricyclic antidepressants are listed in Table 20–2 on pages 530–532. You will see in this table that all the tricyclic antidepressants have quite a number of side effects, and this is their greatest drawback. The most common side effects include sleepiness, dry mouth, a mild hand tremor, temporary

light-headedness when you suddenly stand up, weight gain, and constipation. They can also cause excessive sweating, difficulties with sex, twitches or jerking when you fall asleep at night, and a number of other effects listed in Table 20–2. Most of these side effects are not dangerous, but they can be annoying.

You learned earlier that the side effects of antidepressant drugs can be predicted if you know how strongly they block histamine receptors, alpha-adrenergic receptors, and muscarinic receptors (also called cholinergic receptors) in the brain. You can see from Table 20–2 that each antidepressant has a different profile of side effects depending on its action on these three receptor systems in the brain.

Blockade of the brain's histamine receptors makes you hungry and sleepy. Table 20–2 indicates that four of the tricyclic antidepressants (amitriptyline, clomipramine, doxepin, and trimipramine) have rather strong effects on the histamine receptors. Consequently, these four antidepressants are more likely to make you feel sleepy and hungry. If you are having trouble sleeping, this side effect could be a benefit, but if you are already feeling sluggish and unmotivated, these drugs may make things worse for you. If you have been losing weight due to depression, the appetite boost could be beneficial. However, if you are overweight, you might have to pay more attention to your diet and exercise more in order to avoid weight gain, which can be demoralizing. Since there are now many available antidepressants that do not cause weight gain, it might be better to switch to one of them. You can see in Table 20–2 that three of the tricyclics (desipramine, nortriptyline, and protriptyline) have only weak effects on the histamine receptors. These antidepressants will be less likely to cause sleepiness and weight gain. There are many antidepressants in other categories as well that do not cause sleepiness and weight gain.

You may also recall that blockade of the brain's alphaadrenergic receptors causes a drop in blood pressure. This can result in temporary light-headedness or dizziness when you suddenly stand up because your leg veins become more relaxed, and blood temporarily pools in your legs. As a result, your heart temporarily does not have enough blood to pump up to your brain, and so your vision may get black and you may feel dizzy or woozy for a few seconds. Antidepressants with relatively strong effects on the brain's alpha-adrenergic receptors will be more likely to cause dizziness when you

suddenly stand up. You will see in Table 20–2 that many tricyclics have strong effects on alpha-adrenergic receptors, but that two of them (desipramine and nortriptyline) have only weak effects on them. Consequently, these two drugs are less likely to cause dizziness or a drop in blood pressure.

Finally, blockade of the brain's muscarinic receptors causes side effects such as dry mouth, constipation, blurred vision, difficulties getting your urine flow started, and a speeding up of the heart, even when you are resting. Because of these effects on the heart, the tricyclic medications in Table 20–2 with the strongest effects on these muscarinic receptors may not be advisable for patients with cardiac problems. Drugs with strong anticholinergic effects can also create problems with memory. Many patients have told me that they cannot remember a word they want to use, or they forget someone's name when they take these drugs. The memory effects are dose-related and should disappear when you stop taking the drug.

You can see that two of the tricyclic drugs in Table 20–2 (desipramine and nortriptyline) have relatively weak anticholinergic effects. These two drugs will be the least likely to cause side effects like dry mouth and forgetfulness. These two also tend to have weaker effects on the histamine and alpha-adrenergic receptors. Because they have fewer side effects, they are among the most popular tricyclic antidepressants.

The effects of antidepressant drugs on these three brain receptor systems do not completely explain all their side effects. In the right-hand column, I have listed many of the more common or significant side effects for each drug. For example, you will see that some of them can cause skin rashes. Some tricyclics, most notably clomipramine (Anafranil), can cause seizures, and so this drug would not be a good choice for individuals with epilepsy.

**Table 20–2.** Side Effects of Tricyclic Antidepressants<sup>a</sup>

**Note:** This list is not comprehensive. In general, side effects that occur in 5% or 10% or more of patients are listed, as well as rare but dangerous side effects.

Side Effect <sup>b</sup>	Sedation and Weight Gain <sup>c</sup>	Light-Headedness and Dizziness	Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention	Common or Significant Side Effects
Brain Receptor	histamine ( $H_1$ ) receptors	alpha-adrenergic ( $\alpha_1$ ) receptors	muscarinic ( $M_1$ ) receptors	
amitriptyline (Elavil, Endep)	+++	+++	+++	dizziness; speeded heart; abnormal ECG; dry mouth; constipation; weight gain; trouble urinating; blurred vision; ringing in ears; sweating; weakness; headache; tremor; tiredness; insomnia; confusion
clomipramine (Anafranil)	++ to +++	+++	++ to +++	dizziness; speeded heart; abnormal ECG; dry mouth; upset stomach; loss of appetite; constipation; weight gain; trouble urinating; menstrual changes; disturbed sexual
desipramine (Norpramin, Pertofrane)	+	+	+ to ++	functioning; blurred vision; sweating; weakness; muscle cramps; tremor; tiredness; insomnia; anxiety; headache; rash; seizures
doxepin (Adapin, Sinequan)	+++	+++	++ to +++	dry mouth; rashes; agitation; anxiety; headache; insomnia; stimulation
imipramine (Tofranil)	++	++ to +++	++ to +++	dizziness; speeded heart; abnormal ECG; dry mouth; constipation; weight gain; trouble urinating; blurred vision; sweating; weakness; headache; tiredness; insomnia; anxiety; stimulation; rash; seizures; sensitivity to light; stimulation
nortriptyline (Aventyl)	+ to ++	+	++	dry mouth; constipation; tremor; weakness; confusion; anxiety or stimulation

Side Effect <sup>b</sup>	Sedation and Weight Gain <sup>c</sup>	Light-Headedness and Dizziness	Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention	Common or Significant Side Effects
Brain Receptor	histamine ( $H_1$ ) receptors	alpha-adrenergic ( $\alpha_1$ ) receptors	muscarinic ( $M_1$ ) receptors	
protriptyline (Vivactil)	0 to +	+ to ++	+++	dizziness; decreased or increased blood pressure; abnormal ECG; nausea; constipation; blurred vision; sweating; weakness; insomnia; stimulation; headache
trimipramine (Surmontil)	+++	++ to +++	++ to +++	dizziness; decreased or increased blood pressure; abnormal ECG; dry mouth; constipation; weight gain; blurred vision; sweating; weakness; headache; tremor; sleepiness; confusion; intolerance to heat or cold

<sup>a</sup>The + to + + + ratings in this table refer to the likelihood that a particular side effect will develop. The actual intensity of the side effect will vary among individuals and will also depend on how large the dose is. Reducing the dose can often reduce side effects without reducing effectiveness.

<sup>b</sup>Many side effects, if troublesome, can be minimized by a reduction in dosage. Side effects are usually greatest in the first few days and tend to disappear later.

<sup>c</sup>The drugs that are the most sedative may also have greater antianxiety effects. In other words, they may calm you and make you less nervous. When given at night, the sedative agents help reduce insomnia.

If you and your doctor are choosing one of the antidepressants listed in Table 20–2, you might want to consider the side-effect profile when making your choice. This is because all these medications are comparably effective, so their side effects may be the most important criteria for you in deciding among them. So if you are having trouble sleeping at night, one of the more sedative antidepressants may be useful. These sedative agents are also somewhat calming and so they might be helpful if you are experiencing anxiety.

Many of the side effects of the tricyclic antidepressants listed in Table 20–2 occur in the first few days. With the exception of dry mouth and weight gain, these side effects frequently diminish as you become accustomed to the drug. If you can simply put up with the side effects, many of them will disappear after a few days. If the effects are strong enough to make you uncomfortable, your doctor may decide to reduce the dose, which usually helps.

Some side effects suggest you are taking an excessive dose. These include difficulty in urination, blurred vision, confusion, severe tremor, substantial dizziness, or increased sweating. A dose reduction for such symptoms is definitely indicated. A stool softener or laxative can help if constipation develops. As noted above, light-headedness is most likely to occur when you stand up suddenly, because the blood flow to your brain is temporarily diminished. The dizzy feeling usually persists for only a few seconds. If you get up more carefully and slowly, or if you exercise your legs before standing (by tightening and then relaxing your leg muscles, as when you run in place), this should not be a problem. The movement of your legs causes your leg

muscles to “pump” the blood back up to your brain. Support stockings can also help.

Some patients describe feeling “strange,” “spaced out,” or “unreal” for several days when they first start taking a tricyclic antidepressant. In my experience, one of the tricyclines called doxepin (Sinequan) seems more likely to cause this “spaced out” effect. When patients report feeling strange on the first day or two of taking an antidepressant, I usually advise them to stick with it. In nearly all cases the sensation disappears completely within a few days.

If you give patients sugar pills (placebos) they think are antidepressants, they will also report side effects that are similar to the side effects reported by patients taking antidepressants. For example, in one study, 25 percent of the patients taking clomipramine reported difficulties sleeping, so you might conclude that this drug causes insomnia in a quarter of those who take it. However, 15 percent of the patients in the same study who received only placebo also reported insomnia. So the likelihood of insomnia actually caused by clomipramine would be 25 percent minus 15 percent, or 10 percent. Clearly, this side effect is “real,” but it is somewhat less common than you might at first expect.

Such studies indicate that many “side effects” may not actually be caused by the medication you are taking. Some side effects may result from fears about the medication, or from the depression itself, or from other stressful events in your life such as a conflict with your spouse, rather than from the drug itself.

*Side Effects of the Tetracyclic Antidepressants.* You can see in Table 20–3 on pages 536–537 that the side effects of the tetracyclic antidepressants are similar to those of the tricyclic antidepressants. However, they have some special side effects of their own that should be considered if you are taking one of these drugs. Maprotiline (Ludiomil) appears to be more likely than the eight tricyclic antidepressant drugs to cause seizures, a particularly troublesome side effect. Although the likelihood of seizures is low, patients with a history of seizures or head trauma should probably avoid this drug. Recent studies suggest that the likelihood of seizures with maprotiline is significantly greater when the dose is increased too rapidly, or when patients are kept on higher-than-recommended doses (225 to 400 mg per day) for

more than six weeks.<sup>16</sup> Therefore the manufacturer has suggested that maprotiline should be started and increased very slowly, and that the dose should be maintained at no more than 175 mg per day if patients take this drug for more than six weeks.

Amoxapine (Asendin) has a distinct and troublesome type of side effect not shared with most other antidepressants. This is because one of its metabolites blocks dopamine receptors in the brain, much like antipsychotic drugs such as chlorpromazine (Thorazine) and many others which are used in the treatment of schizophrenia. Thus, patients who take amoxapine can in rare instances develop some of the same types of side effects that occur in patients who take antipsychotic drugs. For example, women may experience galactorrhea (the production of milk by the breast.) Any of several so-called “extrapyramidal” reactions can also develop. One of them, called akathisia, is a motor restlessness syndrome. This is an unusual kind of muscular “itchiness”—your arms or legs feel intensely restless and so you cannot sit still. You feel the compulsion to keep moving or pacing about. Akathisia is uncomfortable but not dangerous.

In rare instances amoxapine can also cause symptoms that mimic Parkinson’s disease. Symptoms include passive inactivity, a “pill-rolling” tremor of the thumb and fingers while at rest, decreased swinging of the arms when walking, stiffness, stooped posture, and others. If these symptoms develop, notify your doctor right away. She or he will probably want you to stop the drug and try an alternative medication. Although alarming, these symptoms are not dangerous and should disappear when you stop taking the amoxapine.

However, a more serious side effect of amoxapine (as well as many other antipsychotic drugs) is called “tardive dyskinesia.” Patients with tardive dyskinesia develop involuntary, repetitious movements of the face, especially the lips and tongue. The abnormal movements can also involve the arms and legs. Once it begins, tardive dyskinesia sometimes becomes irreversible or difficult to treat. The risk appears to be the highest among elderly women, but it can occur with any patient. The risk of tardive dyskinesia also increases the longer you have been on the drug, but it can develop after only a brief period of treatment at a low dose.

**Table 20–3.** Side Effects of Tetracyclic Antidepressants<sup>a</sup>

**Note:** This list is not comprehensive. In general, side effects that occur in 5% or 10% or more of patients are listed, as well as rare but dangerous side effects.

Side Effect	Sedation and Weight Gain	Light-Headedness and Dizziness	Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention	Common or Significant Side Effects
Brain Receptor	histamine ( $H_1$ ) receptors	alpha-adrenergic ( $\alpha_1$ ) receptors	muscarinic ( $M_3$ ) receptors	
amoxapine (Asendia)	++	++	+ to ++	dizziness; speeded heart; dry mouth; stomach upset; constipation; trouble urinating; blurred vision; rashes; tremor; tiredness; insomnia; EPS <sup>b</sup> ; lactation; restlessness; excessive stimulation; tardive dyskinesia; galactorrhea; NMS <sup>c</sup>
maprotiline (Ludiomil)	++	+	+	dry mouth; constipation; weight gain; blurred vision; rashes; sleepiness; seizures; stimulation; sensitivity to light; edema (swelling of ankles)

<sup>a</sup>The + to ++ ratings in this table refer to the likelihood that a particular side effect will develop. The actual intensity of the side effect will vary among individuals and will also depend on how large the dose is. Reducing the dose can often reduce side effects without reducing effectiveness.

<sup>b</sup>EPS = extrapyramidal symptoms (described in text) including akathisia and dystonic reactions and tardive dyskinesia.

<sup>c</sup>NMS = neuroleptic malignant syndrome. This is a potentially fatal reaction that also occurs in reaction to antipsychotic drugs (also known as neuroleptics). The symptoms include increased fever, rigid muscles, altered mental status, irregular pulse or blood pressure, rapid heart, profuse sweating, and abnormal heart rhythms.

Finally, as if that weren't enough to frighten you, amoxapine can, in rare cases, cause a dreaded complication known as neuroleptic malignant syndrome, or NMS. NMS consists of high fever, delirium, and muscle rigidity, along with changes in blood pressure, heart rate and rhythm, and sometimes death. All these risks should obviously be carefully balanced against any potential benefits of amoxapine; it may sometimes be difficult to justify using this medication when so many equally effective and safer drugs are readily available.

**Tricyclic and Tetracyclic Antidepressant (TCA) Drug Interactions.** I described the problem of drug interactions in Chapter 19. Briefly, when you are taking more than one drug, there is a possibility that the drugs may

interact in ways that will be detrimental to you. One drug may cause the level of the second drug to increase or decrease in your blood. As a result, the second drug may cause excessive side effects (if its blood level gets too high) or it may become ineffective (if its blood level falls). In addition, sometimes the interaction of two drugs can lead to toxic reactions that are quite dangerous.

A number of drug interactions for the tricyclic and tetracyclic antidepressants are listed in Table 20–4 on pages 540–547. This list is not comprehensive, but it does include many of the more common or important interactions. If you are taking any other medications along with a TCA, it would be wise to review this table. Note that both prescription and nonprescription drugs are listed, including many psychiatric and nonpsychiatric drugs as well. In addition, you should ask your physician and pharmacist if there are any drug interactions among the drugs you are taking.

You can see in Table 20–4 that smoking cigarettes and drinking alcohol can both cause the blood level of a TCA to fall, thus reducing the likelihood that the drug will be effective. Your doctor may need to do a blood test to find out if your blood level is adequate. In addition, alcohol can enhance the sedative effects of the tricyclic antidepressants, a combination that can be quite hazardous if you are driving or operating dangerous machinery.

Certain antidepressants can be particularly hazardous for individuals with specific medical conditions. In particular, the tricyclics can be dangerous to individuals with cardiovascular disease, including those with a previous heart attack, abnormalities in heart rhythm, or high blood pressure. Special precautions should also be taken for individuals with thyroid disease. Make sure you mention any medical problems you have to the doctor who is prescribing your antidepressant so that she or he can take the proper precautions.

As noted above, several of the tricyclic and tetracyclic antidepressants can cause seizures in rare instances. An incidence of seizures as high as 1 percent to 3 percent has been reported with clomipramine, imipramine, and maprotiline.<sup>17</sup> These estimates may be overly high. At any rate, the risk can be reduced by making sure the dose is not excessive and by raising the dose gradually. Nevertheless, these drugs should be used with caution, if at all, in individuals with a history of seizure disorders, head trauma, or other neurologic disorders associated with seizures. In addition, caution should be

used if these drugs are combined with other drugs that can lower the seizure threshold, such as the major tranquilizers (neuroleptics) and others. Rapid withdrawal from sedative agents, such as alcohol, minor tranquilizers, and barbiturates can also trigger seizures, and so clomipramine, imipramine, and maprotiline should be used with great caution in combination with these agents.

**Table 20–4.** Drug Interaction Guide for Tricyclic and Tetracyclic Antidepressants (TCAs)<sup>a</sup>

**Note:** The drugs in the left-hand column can interact with TCAs. The comments describe the types of interactions. This list is not exhaustive; new information about drug interactions comes out frequently. If you are taking a TCA and any other medication, ask your doctor and pharmacist if there are any drug interactions you should know about.

Antidepressants	
<i>Drug</i>	<i>Comment</i>
<b>tricyclic and tetracyclic antidepressants</b> (TCAs can interact with other TCAs)	desipramine causes an ↑ in other TCAs—abnormal heart rhythms can result
<b>SSRIs</b>	TCA levels can ↑ (as much as 2- to 10-fold); abnormal heart rhythms can result; SSRI levels can also ↑ serotonin syndrome <sup>b</sup> [especially clomipramine (Anafranil)]; low blood pressure; hypertensive reactions
<b>MAOIs</b>	nefazodone may cause low blood pressure
<b>serotonin antagonists</b> , including trazodone (Desyrel) and nefazodone (Serzone)	
<b>bupropion (Wellbutrin)</b>	↑ in risk of seizures; extreme caution required
<b>venlafaxine (Effexor)</b>	probably okay; in theory TCA could

<b>mirtazapine (Remeron)</b>	cause ↑ in venlafaxine blood levels information not yet available
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### Antibiotics

<i>Drug</i>	<i>Comment</i>
<b>chloramphenicol (Chloromycetin)</b>	TCA levels and toxicity may ↑
<b>doxycycline (Vibramycin)</b>	TCA levels and effectiveness may ↓
<b>isoniazid (INH, Nydrazid)</b>	TCA levels and toxicity may ↑

### Antifungal Agents

<i>Drug</i>	<i>Comment</i>
<b>imidazoles</b> such as fluconazole (Diflucan), itraconazole (Sporanox), ketoconazole (Nizoral) and miconazole (Monistat vaginal suppositories or cream)	TCA levels may ↑, especially nortriptyline
<b>griseofulvin (Fulvicin)</b>	TCA levels may ↓

### Diabetes Medications

<i>Drug</i>	<i>Comment</i>
<b>insulin</b>	greater-than-expected drop in blood sugar
<b>oral hypoglycemic drugs</b>	greater-than-expected drop in blood sugar

### Medical Conditions

<i>Condition</i>	<i>Comment</i>
<b>glaucoma</b>	highly anticholinergic TCA can trigger attacks of narrow-angle glaucoma; symptoms include eye pain, blurred vision, and halos around lights
<b>heart disease</b>	use TCA with extreme caution; may

<b>liver disease</b>	trigger abnormal heart rhythms use TCA with caution; the metabolism by the liver may be impaired, with excessively high blood levels and increased side effects and toxic effects
<b>seizure disorder</b>	use TCA with caution; TCA may cause ↑ in seizures (TCA lowers the seizure “threshold”)
<b>thyroid disease</b>	use TCA with caution in patients with thyroid disease or those taking thyroid medication; may trigger abnormal heart rhythms

### Medications for Abnormal Heart Rhythms

<i>Drug</i>	<i>Comment</i>
<b>disopyramide (Norpace)</b>	abnormal heart rhythms
<b>epinephrine</b>	TCA may enhance the effects, leading to rapid heart, abnormal heart rhythms, and ↑ in BP
<b>quinidine</b>	blood levels of quinidine and TCA may ↑; abnormal heart rhythms and weakened heart muscle can lead to congestive heart failure

### Medications for High Blood Pressure

<i>Drug</i>	<i>Comment</i>
<b>beta-blockers</b> such as propranolol (Inderal)	beta-blockers may cause increased depression; TCA may cause greater-than-expected drop in BP
<b>clonidine (Catapres)</b>	TCA [e.g., desipramine (Norpramin)] may reduce effectiveness of clonidine because blood levels ↓
<b>calcium channel blockers</b>	BP drop may be greater than expected

<b>guanethidine (Ismelin)</b>	may lose antihypertensive effect when combined with TCA [e.g., desipramine (Norpramin)]
<b>methyldopa (Aldomet)</b>	BP drop may be greater than expected, especially with amitriptyline (Elavil); some TCAs [e.g., desipramine (Norpramin)] may reduce the antihypertensive effect
<b>prazosin (Minipress)</b>	BP may ↑ because levels of prazosin may ↓
<b>reserpine (Serpasil)</b>	may cause greater-than-expected drop in BP; may also cause excessive stimulation
<b>thiazide diuretics</b> such as hydrochlorothiazide (Dyazide)	blood-pressure drop may be greater than expected; effects of TCA may increase

### Medications for Low Blood Pressure (for patients in shock)

<i>Drug</i>	<i>Comment</i>
<b>epinephrine</b>	TCA may enhance the effects, leading to rapid heart, abnormal heart rhythms, and ↑ in BP

### Mood Stabilizers and Anticonvulsants

<i>Drug</i>	<i>Comment</i>
<b>carbamazepine (Tegretol)</b>	blood levels of TCA and carbamazepine may ↓; TCA can make seizures more likely
<b>lithium (Eskalith)</b>	may enhance antidepressant effects
<b>phenytoin (Dilantin)</b>	blood levels of TCA may ↑ or ↓; TCA can make seizures more likely
<b>valproic acid (Depakene)</b>	↑ in blood levels of amitriptyline

(Elavil) and valproic acid

## Pain Medications and Anesthetics

<i>Drug</i>	<i>Comment</i>
<b>acetaminophen (Tylenol)</b>	TCA levels may ↑; acetaminophen levels may ↓
<b>aspirin</b>	TCA levels may ↑
<b>halothane (Fluothane)</b>	TCA levels may ↑; TCA with strong anticholinergic effects may cause abnormal heart rhythms
<b>cyclobenzaprine (Flexeril)</b> (a muscle relaxant used to treat muscle spasm)	may cause abnormal heart rhythms
<b>methadone (Dolophine)</b>	may have greater-than-expected narcotic effect; for example, desipramine (Norpramin) may double the blood level of methadone
<b>meperidine (Demerol)</b>	greater-than-expected narcotic effect; lower doses of meperidine or another painkiller may be needed
<b>morphine (MS Contin)</b>	greater-than-expected narcotic effect and sedation; TCA levels may ↓
<b>pancuronium (Pavulon)</b>	abnormal heart rhythms, especially TCA with strong anticholinergic effects

## Sedatives and Tranquilizers

<i>Drug</i>	<i>Comment</i>
<b>alcohol</b>	May have enhanced sedative effects. This could be hazardous when driving or operating dangerous machinery. May cause TCA levels to ↓

<b>barbiturates</b> (such as phenobarbital)	enhanced sedative effects; may cause TCA levels to ↓
<b>buspirone (BuSpar)</b>	enhanced sedative effects as described above
<b>chloral hydrate (Noctec)</b>	TCA levels may ↓
<b>ethchlorvynol (Placidyl)</b>	Temporary mental confusion has been reported when combined with amitriptyline (Elavil), but could conceivably occur with other TCAs as well
<b>major tranquilizers (neuroleptics)</b>	levels of TCA and phenothiazine neuroleptics [such as chlorpromazine (Thorazine)] may ↑, leading to more side effects and greater potency; abnormal heart rhythms have been observed with thioridazine (Mellaril), clozapine (Clozaril), and pimozide (Orap)
<b>minor tranquilizers (neuroleptics)</b>	enhanced sedative effects

### Stimulants (Pep Pills) and Street Drugs

<i>Drug</i>	<i>Comment</i>
<b>amphetamines</b> (“speed” or “crank”)	These drugs may boost the blood levels and effects of some TCA [(e.g., imipramine (Tofranil), clomipramine (Anafranil), desipramine (Norpramin)] and vice versa; abnormal heart rhythms and increased blood pressure have been observed with cocaine, but seem possible when any stimulants are combined with TCA
<b>cocaine</b>	
<b>benzedrine</b>	
<b>benzphetamine (Didrex)</b>	
<b>dextroamphetamine (Dexedrine)</b>	
<b>methamphetamine (Desoxyn)</b>	
<b>methylphenidate (Ritalin)</b>	

### Weight-Loss and Appetite-Suppression Medications

<i>Drug</i>	<i>Comment</i>
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**fenfluramine (Pondimin)**

Possible serotonin syndrome when combined with clomipramine; increased TCA levels

**Other Medications**

<i>Drug</i>	<i>Comment</i>
<b>antihistamines</b>	increased drowsiness; it is safer to use antihistamines that are not sedative
<b>acetazolamide (Diamox)</b>	TCA blood levels may ↑; blood pressure may fall
<b>birth control pills</b> and other medications containing estrogen	TCA blood levels may ↑, with greater side effects; higher doses of estrogen may reduce the effects of TCA
<b>caffeine</b> (in coffee, tea, soda, chocolate)	TCA blood levels may ↑
<b>charcoal tablets</b>	TCA blood levels may ↓ due to poor absorption from the stomach and intestinal tract
<b>cholestyramine (Questran)</b>	TCA blood levels may ↓
<b>cimetidine (Tagamet)</b>	TCA blood levels may ↑ (greater side effects)
<b>disulfiram (Antabuse)</b>	TCA blood levels may ↑ (greater side effects); in two reported cases, disulfiram plus amitriptyline (Elavil) caused a severe brain reaction (organic brain syndrome) with mental confusion and disorientation
<b>ephedrine</b> (can be found in Bronkaid, Marax, Primatene, Quadrinal, Vicks Vatronol nose drops, and several other asthma and cold medications)	TCA may block the ↑ in BP ordinarily caused by ephedrine; ephedrine levels and effects may ↓

<i>Drug</i>	<i>Comment</i>
<b>liothyronine (T3, Cytomel)</b>	TCA blood levels may ↓ due to poor absorption from the stomach and intestinal tract can enhance the effects of TCA; abnormal heart rhythms can result; TCA blood levels may ↑
<b>psyllium (Metamucil)</b>	TCA blood levels may ↑ with increased side effects and toxic effects
<b>scopolamine (Transderm)</b>	TCA blood levels may ↓ due to poor absorption from the stomach and intestinal tract
<b>L-dopa (Sinemet)</b>	may cause ↑ in TCA blood levels absorption of TCA from the stomach and intestinal tract into the blood may ↓; effects of both TCA and L-dopa may ↓
<b>theophylline (Bronkaid)</b>	TCA blood levels may ↑
<b>tobacco (smoking)</b>	TCA blood levels may ↓

<sup>a</sup>Information in this table was obtained from several sources including the *Manual of Clinical Psychopharmacology*<sup>1</sup> and *Psychotropic Drugs Fast Facts*.<sup>17</sup> These excellent references are highly recommended.

<sup>b</sup>This is a dangerous and potentially fatal syndrome which includes rapid changes in vital signs (fever, oscillations in blood pressure), sweating, nausea, vomiting, rigid muscles, myoclonus, agitation, delirium, seizures, and coma.

### ***Selective Serotonin Reuptake Inhibitors (SSRIs)***

Currently, the most popular antidepressant drugs are the selective serotonin reuptake inhibitors, or SSRIs. At this time, five SSRIs are prescribed in the United States. These include citalopram (Celexa), the newest SSRI which was released in the U.S. in 1998, fluoxetine (Prozac), the first SSRI which

was released in 1988, and fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft). The effects of these SSRIs on the brain are much more specific and selective than the older tricyclic and tetracyclic drugs discussed above. Instead of interacting with many different systems in the brain, these drugs have selective effects on nerves that use serotonin as a transmitter substance.

When it first appeared on the market, there was a great deal of excitement about Prozac because it was chemically quite different from the older antidepressants. Unlike the tricyclic and tetracyclic drugs, it has specific effects on the serotonergic nerves in the brain. Since a serotonin deficiency was hypothesized to be the cause of depression, it was hoped that Prozac would be dramatically more effective than the tricyclic and tetracyclic drugs which seemed to affect so many different systems in the brain in a less specific manner. It was also expected that Prozac (and the other SSRIs) would have fewer side effects than the tricyclic and tetracyclic drugs. This is because Prozac does not have such strong effects on the histaminic, alpha-adrenergic, and muscarinic receptors.

Only one of these two hopes was fulfilled. Prozac and the other four SSRIs do cause significantly fewer side effects than the tricyclic and tetracyclic antidepressants and are more pleasant to take. For example, they are less likely to cause sleepiness, weight gain, dry mouth, dizziness, and so on. They are also much safer since they are less likely to have adverse effects on the heart, and they are much less likely to result in death if a patient intentionally or unintentionally takes an overdose. The biochemists who created these new drugs deserve credit in this regard.

Unfortunately, the SSRIs are not more effective than the older drugs. As many as 60 percent to 70 percent of depressed patients will improve when treated with SSRIs, and these percentages are no better than the older drugs. Among chronically depressed patients, the probability of responding appears to be lower. The SSRIs also appear to be slightly less effective than the older tricyclic antidepressants for more severely depressed patients. In addition, the amount of improvement is often only partial—the patient may become less depressed, but may not return to full self-esteem and joyous daily living. This is a problem for all the antidepressants, and not just the SSRIs. Although they are no more effective, the SSRIs are dramatically more expensive than the

older drugs. In addition, the SSRIs have some new and different side effects described below that were not publicized when they were first released.

Because of their favorable safety record and diminished side effects, though, the SSRIs have truly captured the antidepressant market. More money was spent on Prozac in 1995 (\$2.5 billion) than was spent on all other antidepressants in 1991 (\$2.0 billion). One reason for the upsurge in popularity is that primary care physicians now feel comfortable prescribing antidepressants because the SSRIs are so safe. As a result, many depressed patients who would not think of going to a psychiatrist or psychologist receive SSRIs from their family physicians.

Because the SSRIs are used so widely and because they have received so much media attention, many people believe they are incredibly powerful and almost magically effective. But this is simply not the case, as noted above. For some depressed people, the SSRIs can be very effective. For many others, they are only somewhat effective. And often they do not seem to have any antidepressant effects at all. It is the same story with all of our currently available antidepressants—they are valuable tools to fight depression but they are often not the entire answer and they are certainly not a panacea for what ails you.

The fact that the SSRIs are not more effective than the older drugs has caused scientists to reconsider the validity of the “serotonin” theory of depression which I described in Chapter 17. You will recall that according to this theory, a deficiency of serotonin in the brain causes depression, and an increase in serotonin should reverse it. If this theory were valid, the SSRIs should cause depressed patients to become undepressed almost immediately—but Prozac can take as many as five to eight weeks to become effective. Regardless of what causes depression or why antidepressants work, the SSRIs have been helpful to many depressed individuals.

*Doses of SSRIs.* The doses of the five SSRIs are listed in Table 20–1 on page 520. Unlike the older antidepressants, which are often prescribed in doses that are too low, the SSRIs are often prescribed in doses that are unnecessarily high. Because they have so few side effects, doctors feel comfortable prescribing high doses and may prescribe more than is really needed. For example, although 20 mg to 80 mg per day was the dose range initially recommended for Prozac, a single dose of 10 mg per day will be

sufficient for many patients. Once they are feeling better, many patients need only 5 mg per day, or even less. These smaller doses are much less expensive and will produce fewer side effects.

These low doses are effective because Prozac stays in the body for a much longer period of time than most other drugs—as long as several weeks. When you take Prozac, your blood level continues to increase each day because the Prozac leaves your body so slowly. After a while your blood level becomes quite high. This is why you may need only a tiny dose if you have been taking Prozac for several weeks or more.

To understand this better, let's go back to the bathtub analogy I introduced in Chapter 19 to explain drug interactions. Let's imagine that the Prozac you are taking is like the water going into the bathtub, but the hole in the bottom of the tub is tiny. Over time, the water level increases, because more water goes into the tub than goes out. The water level can be compared to the level of the Prozac in your blood. After four to five weeks, the water level finally gets up to the correct therapeutic range. Now you can turn the faucet down quite a bit so that the level in the tub does not continue to increase and overflow. This would be analogous to reducing the dose of Prozac after you have been on it for several weeks. Paradoxically, you are now taking much smaller doses than when you first started taking the Prozac, but your blood level is far higher.

Technically, we say that “steady state” has been reached. Steady state means that the blood level remains more or less constant, because the amount you take each day is similar to the amount that your body eliminates each day. The other four SSRIs do not have this property, because they leave the body much faster than Prozac. You generally cannot reduce the doses after several weeks.

The effectiveness of very low doses of Prozac is now well known among the psychiatric profession, but I first learned this from my patients soon after Prozac was released onto the market. Many patients reported that after they had been on Prozac for a month or two, they seemed to need only tiny doses, often as little as one tenth of a pill per day, and sometimes even less. At first I thought these patients had overly lively imaginations, but soon many patients were reporting the same thing. I advised them to take one Prozac pill, grind it up, and dissolve it in water or apple juice to store in the refrigerator. Then they adjusted their dose of Prozac by drinking a certain amount of the fluid

each day. So, for example, if you have dissolved one 20 mg pill in some apple juice and you drink one tenth of the juice each day, this would correspond to a dose of 2 mg per day. But if you try this, make sure you label the juice clearly so that no one drinks your Prozac for breakfast! Also, make sure you talk it over with your doctor and that she or he approves of what you are doing.

It is also important for you to know that after you stop taking Prozac, it will stay in your body for a long time because it leaves your body so slowly. This would be like a bathtub that takes an extraordinarily long time to empty out after you pull the plug because the drain is plugged up. After you are no longer taking the Prozac, significant levels will remain in your blood for as many as five weeks or more before the drug is entirely cleared out of your system. Many medications can be dangerous to mix with Prozac. You must not take these specific medications until you have been off the Prozac entirely for at least five weeks. For example, tranylcypromine (Parnate) is an antidepressant known as an MAO inhibitor that will be discussed below. Tranylcypromine (as well as other MAO inhibitors) can cause dangerous and potentially fatal reactions if mixed with Prozac. After you stop taking Prozac, a delay of at least five to eight weeks will be necessary before you can safely start taking tranylcypromine.

The other SSRIs, such as citalopram (Celexa), fluvoxamine (Luvox), sertraline (Zoloft) and paroxetine (Paxil), leave the body more rapidly than Prozac but they are still metabolized rather slowly. For example, if you stop taking one of these drugs, it will take your body approximately one day to get rid of one half of the amount in your body. It will take approximately four to seven days for most or all of the drug to leave your body. This is much faster than Prozac. Therefore, these other SSRIs drugs do not build up to such high levels in your blood after you have been taking them for more than a few weeks. Because they go in and out of your blood more rapidly, they are usually taken several times per day, whereas Prozac can be taken once a day.

Age can also influence your dose requirements if you are taking an SSRI. For example, levels of citalopram (Celexa), fluoxetine (Prozac), and paroxetine (Paxil) are approximately twice as high in older individuals (over 65 years of age) than in younger individuals. If you are taking one of these drugs and you are over 65, you will need a lower dose. Blood levels of sertraline (Zoloft) are also higher in older individuals, although the

differences are not as pronounced. In contrast, fluvoxamine (Luvox) blood levels do not seem to be affected by age.

Sometimes gender can play a role as well. For example, the blood levels of fluoxetine (Prozac) are 40 percent to 50 percent lower in males than in females. Similarly, young men develop blood levels of sertraline (Zoloft) that are 30 percent to 40 percent lower, on the average, than young women. Men may need relatively higher doses of these drugs, whereas women may need relatively lower doses.

Health problems can also influence your dose requirements. Individuals with liver, kidney, or heart disease may not get rid of SSRIs as rapidly, and so smaller doses may be needed. Make sure you ask your doctor about this if you are being treated for a liver, kidney or heart ailment.

*Side Effects of SSRIs.* The most frequent side effects of the five SSRIs are listed in Table 20–5 on pages 553–554. As noted above, the side effects of the SSRIs are milder than the older drugs, and this is the reason for their enormous popularity. They are less likely than the tricyclic antidepressants to cause dry mouth, constipation, or dizziness. They do not stimulate the appetite when you first start taking them; if anything, some patients taking SSRIs lose weight in the beginning. Unfortunately, when the SSRIs are taken for a prolonged period of time, their side effects sometimes increase. For example, some patients taking these agents report increases in appetite and weight gain after a while, even though they lost weight at first.

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**Table 20–5.** Side Effects of SSRI Antidepressants

**Note:** This table was adapted with permission from Preskorn<sup>23</sup> and from the prescribing information for citalopram. Only the more common side effects of each drug are listed. The numbers in the table represent the percent of patients receiving the drug who reported each side effect minus the percent of patients on placebo who reported the same side effect. For example, if 20% of patients on Prozac reported nervousness as a side effect, while 10% of patients on placebo reported this same side effect, the number 10% would appear in this chart. This would be an estimate of the “true” nervousness actually caused by Prozac. For each side effect, the drug or drugs with the highest percentages are indicated in boldface.

	<i>fluoxetine</i> (Prozac)	<i>fluvoxamine</i> (Luvox)	<i>paroxetine</i> (Paxil)	<i>sertraline</i> (Zoloft)	<i>citalopram</i> (Celexa)
# of patients on drug	1730	222	421	861	1063
# of patients on placebo	799	192	421	853	466
<b>General Symptoms</b>					
headache	5%	3%	0%	1%	— <sup>a</sup>
dizziness	4%	1%	8%	5%	—
nervousness	10%	8%	5%	4%	1%
tiredness	6%	17%	14%	8%	8%
difficulty sleeping	7%	4%	7%	8%	1%
weak or fatigued muscles	6%	6%	10%	3%	—
tremor	6%	6%	6%	8%	2%
<b>Mouth, Stomach, and Intestinal Tract</b>					
dry mouth	4%	2%	6%	7%	6%
loss of appetite	7%	9%	5%	1%	2%
nausea or upset stomach	11%	26%	16%	14%	7%
diarrhea	5%	0%	4%	8%	3%
constipation	1%	11%	5%	2%	—
	<i>fluoxetine</i> (Prozac)	<i>fluvoxamine</i> (Luvox)	<i>paroxetine</i> (Paxil)	<i>sertraline</i> (Zoloft)	<i>citalopram</i> (Celexa)
<b>Other</b>					
excessive sweating	5%	0%	9%	6%	2%
<b>Sexual</b>					
loss of interest in sex delayed or no orgasm	Specific comparative data on the sexual side effects of the SSRIs were not available. However, it appears that 30% to 40% of patients receiving SSRIs do experience some sexual side effects. <sup>b</sup>				

<sup>a</sup>A dash means that the incidence of this side effect was not greater than placebo.

<sup>b</sup>During the initial drug testing studies patients were not explicitly asked about sexual side effects. Consequently, the estimates of sexual side effects in the *PDR* are too low.

Some of the most common and troublesome side effects of the SSRIs include nausea, diarrhea, cramping, heartburn, and other signs of stomach

upset. Approximately 20 percent to 30 percent of patients reported these symptoms in the earliest studies with the SSRIs.<sup>18</sup> You will see in Table 20–5 that fluvoxamine (Luvox) is the most likely to cause constipation, whereas sertraline (Zoloft) is more likely to cause diarrhea. Patients taking paroxetine (Paxil) and sertraline (Zoloft) are more likely to complain of a dry mouth because of the anticholinergic effects of these drugs. In some studies, as many as 20 percent of the patients taking paroxetine (Paxil) reported dry mouth. (However, the percentages in the table are much lower because the placebo effects have been subtracted out.)

Most of these effects on the stomach and intestinal tract tend to occur in the first week or two and then disappear as the body adjusts to the medicine. In addition, if you start the SSRI at a low dose and then increase the dose gradually, these side effects are less likely to occur. It can also help if you take the medication with meals. (The tricyclic and tetracyclic drugs discussed in the previous section can also be taken with meals to minimize any adverse effects on the stomach and gastrointestinal tract.)

The SSRI drugs can occasionally cause headaches when you first start to take them. In Table 20–5 the rates for headache seem to be the highest for fluoxetine (Prozac) and fluvoxamine (Luvox); in contrast, the rates for citalopram (Celexa), paroxetine (Paxil), and sertraline (Zoloft) appear to be no greater than the rates of headaches reported by patients who take placebos. Excessive sweating has also been reported, especially with paroxetine (Paxil), but this is not usually severe. Patients taking high doses of the SSRIs may also complain of tremor, and this side effect seems to be equally common among all of the SSRI drugs.

Although initially reported as a “rare” side effect, it is now clear that delayed time to orgasm is quite common for men and women taking SSRIs. Some patients also complain of a loss of interest in sex or an inability to achieve an erection. These side effects were reported in fewer than 5 percent of patients during the premarketing research trials. However, now that the drugs are widely used, it has become clear that these side effects are far more common than reported in clinical trials and can occur in 30 percent or more of patients. The sexual side effects may be a reasonable trade-off if the drug helps you overcome your depression. Keep in mind that a loss of interest in sex can also be a symptom of depression itself. In addition, you will probably

not need to stay on the drug indefinitely. Once you are feeling better and you stop taking the SSRI, your sexual functioning should return to normal.

You might wonder why these side effects were not noted in the premarketing research studies. At the 1998 Stanford Psychopharmacology Conference, one of the speakers jokingly mentioned that the drug companies seem to have a “don’t ask, don’t tell” policy about certain kinds of adverse effects, including sexual side effects. I guess the idea is that what you don’t know won’t hurt you. I think this policy is unfortunate, because the FDA (and potential consumers) may be given an overly rosy picture about the effectiveness, side effect profile, and safety of a new drug. After the drug has been in widespread use for several years, a different picture often emerges.

The effects on sex are so predictable that one of these drugs, paroxetine (Paxil) is now recognized as an effective treatment for men who experience premature ejaculation (having orgasms too rapidly during sex). Some people do not experience a delayed orgasm on SSRIs. Others experience it but are not bothered, and some actually view it as a benefit. What is important is that if this feels like a problem for you, you should discuss it with your doctor before discontinuing the medication on your own. It might be possible to reduce the dose without a loss of the antidepressant effects.

Several drugs can be combined with an SSRI in an attempt to combat the sexual difficulties. Four which show promise include bupropion (Wellbutrin, in doses of up to 225 mg to 300 mg per day), buspirone (BuSpar; 15 to 30 mg per day), yohimbine (5 mg three times daily), or amantadine (100 mg three times daily).

Citalopram (Celexa), one of the newest SSRIs on the American market, may have fewer sexual side effects than the other SSRIs. You can see in Table 20–5 that it does appear to have fewer side effects in general than the other four SSRIs. In addition, there is the hope that it will be more effective for severe depressions than the SSRIs. It will be interesting to see if citalopram (Celexa) is more effective and does actually have fewer side effects after the drug has been in widespread use for a period of time. Sometimes marketing claims when drugs are first released turn out not to be supported by clinical experience or by subsequent research by independent investigators.

Among the SSRIs, fluoxetine (Prozac) appears to be the most activating (stimulating), although fluvoxamine (Luvox) seems almost as likely to cause

this side effect. Because fluoxetine (Prozac) is stimulating, it is sometimes given in the morning and at noon, rather than at bedtime. The stimulation can often be a benefit to depressed patients who feel tired, sluggish, and unmotivated. On the other hand, fluoxetine (Prozac) and fluvoxamine (Luvox) can also cause anxiety or jitteriness in as many as 10 percent to 20 percent of patients. These side effects can sometimes create additional difficulties for depressed patients who already have these kinds of symptoms.

The stimulating effects of fluoxetine (Prozac) are not necessarily bad, even for anxious patients. Anxiety and depression nearly always go hand in hand to a certain extent, and many patients need treatment for both kinds of problems. Patients with significant anxiety, such as chronic worrying, panic attacks, or agoraphobia, are often the ones who complain that fluoxetine (Prozac) makes them feel more nervous initially. I often tell these patients that the nervousness they feel is a good thing, because it shows the drug is working in the brain. I encourage them to stick with it, because in a few weeks or less they may notice a significant improvement in their depression as well as their anxiety. Most anxious patients have been able to stick with the fluoxetine (Prozac), and the predicted improvement often does occur. This illustrates how a positive attitude can sometimes help patients overcome drug side effects.

Although any of the SSRIs can cause trouble with sleeping, not all of them are as stimulating as fluoxetine (Prozac). In fact, paroxetine (Paxil) and fluvoxamine (Luvox) can be quite sedating for some patients. In other words, these drugs will tend to relax or tire you, instead of stimulating you the way fluoxetine (Prozac) does. In fact, paroxetine (Paxil) is sometimes given two hours before bedtime so that the maximum sleepiness will occur at the time that you ordinarily go to sleep. Paroxetine (Paxil) or fluvoxamine (Luvox) might be good choices if insomnia is a major aspect of your depression. Note, however, that patients taking paroxetine (Paxil) are also somewhat more likely to complain of weak or fatigued muscles. Citalopram (Celexa) and sertraline (Zoloft) appear to be halfway in-between—they do not typically cause excessive stimulation or sedation, but are more neutral in this respect.

In the section below on serotonin antagonists, I will describe an antidepressant called trazodone (trade name Desyrel) which has calming, sedative properties. Trazodone can be given in small doses (50 to 100 mg at bedtime) to patients who are taking SSRIs. This has three potential benefits:

(1) the calming effects of trazodone will reduce the nervousness caused by the SSRIs; (2) the trazodone can be given at bedtime to improve sleep; (3) trazodone may sometimes boost the antidepressant effects of the SSRI and increase the likelihood of recovery.

In spite of these advantages, I usually try to treat patients with one drug at a time. This avoids any extra side effects and minimizes the possibility of adverse drug interactions. In my experience, treatment with one drug at a time is usually successful. If you reduce the dose of any SSRI, you can often minimize the side effects without having to add additional drugs. I will address the problem of using more than one drug at the same time toward the end of this chapter.

For example, if you are starting fluoxetine (Prozac) and you are bothered by nervousness, insomnia, or upset stomach, you can take a lower dose and increase the dose more gradually. In addition, if you have been on fluoxetine (Prozac) for several weeks or more, there is an excellent chance you can reduce the dose, often quite dramatically. This will often minimize the side effects without interfering with the antidepressant effects of this drug. As noted above, this is because levels of fluoxetine (Prozac) build up after a period of time, so the same dose may produce far more side effects because your blood level has become so much higher. There is really no need for large doses or excessively high blood levels of any of the SSRIs, because low doses have been shown to be just as effective as high doses.

*SSRI Drug Interactions.* A number of common drug interactions for the SSRIs are listed in Table 20–6 on pages 560–563. You will see in Table 20–6 that many other psychiatric drugs can interact with the SSRIs, including antidepressants, major and minor tranquilizers, and mood stabilizers. Important interactions with nonpsychiatric drugs are also listed. If you are taking an SSRI and one or more additional drugs at the same time, it would be wise to review this table. Make sure you also ask your physician and pharmacist if there are any drug interactions you should be aware of. This includes prescription drugs as well as nonprescription drugs that are sold over the counter.

As you can see, SSRIs have a tendency to cause the blood levels of other antidepressants to increase. This is because the SSRIs slow down the metabolism of these other drugs in the liver, as discussed in Chapter 19. In

some cases, this could be dangerous. For example, the combination of an SSRI with a tricyclic antidepressant can potentially cause abnormal heart rhythms. Although this complication is rare, the effects on the heart can be serious. The combination of an SSRI with bupropion (Wellbutrin) can increase the risk of seizures—an uncommon but serious side effect of bupropion. However, as noted above, bupropion is often added to an SSRI in low doses to try to minimize the sexual side effects of the SSRIs. This can usually be done safely. Make sure you inform your physician if you have any history of head trauma or seizures, because this particular drug combination may not be advisable for you.

As mentioned in Chapter 19, the interaction of an SSRI with an MAOI antidepressant is extremely dangerous regardless of the dose of either drug. This combination should be avoided because it can result in the potentially lethal “serotonin syndrome” described in Chapter 19. In addition, remember that both the SSRIs and the MAOIs can require a considerable period of time to clear out of your body after you have stopped taking them. If you stopped taking Prozac and then started an MAOI several weeks later, it could trigger the serotonin syndrome because Prozac would still be present in your bloodstream. Similarly, if you were to start Prozac within two weeks of stopping an MAOI, this might also trigger the serotonin syndrome. The effects of the MAOIs last only one to two weeks, so you will not have to wait as long when you switch from an MAOI to an SSRI as when you switch in the opposite direction.

**Table 20–6.** Drug Interaction Guide for SSRI Antidepressants.<sup>a</sup>

Antidepressants	
<i>Drug</i>	<i>Comment</i>
<b>tricyclic and tetracyclic antidepressants</b>	SSRIs can cause TCA levels to ↑; abnormal heart rhythms can result
<b>SSRI antidepressants</b>	not usually combined; ↑ in SSRI blood levels can result
<b>monoamine oxidase inhibitors (MAOIs)</b>	serotonin syndrome <sup>b</sup>

<b>serotonin antagonists</b> [trazodone (Desyrel) and nefazodone (Serzone)]	blood levels of nefazodone or trazodone and their metabolite (mCPP) may ↑ and cause anxiety
<b>bupropion (Wellbutrin)</b>	↑ risk of seizures; caution required
<b>venlafaxine (Effexor)</b>	may cause ↑ in levels of venlafaxine
<b>mirtazapine (Remeron)</b>	no information available as yet

### Antihistamines

<i>Drug</i>	<i>Comment</i>
<b>terfenadine (Seldane) and astemizole (Hismanal)</b>	fluvoxamine (Luvox) may ↑ levels of terfenadine and astemizole; fatal heart rhythms can occur
<b>ciproheptadine (Periactin)</b>	may reverse the effects of SSRIs

### Diabetes Medications

<i>Drug</i>	<i>Comment</i>
<b>tolbutamide (Orinase)</b>	fluvoxamine (Luvox) may ↑ levels of tolbutamide; low blood sugar may result
<b>insulin</b>	fluvoxamine (Luvox) may cause ↓ in blood sugar; insulin levels may need to be adjusted

### Heart and Blood Pressure Medications

<i>Drug</i>	<i>Comment</i>
<b>digoxin (Lanoxin) and digitoxin (Crystodigin)</b>	↑ in blood levels of digitoxin and potential toxic effects including mental confusion
<b>medications for high blood pressure</b>	levels of beta-blockers including metoprolol (Lopressor) and propranolol (Inderal) also used for angina may ↑, leading to excessive heart slowing and ECG

## **medications for abnormal heart rhythms**

abnormalities; calcium channel blockers including nifedipine (Procardia) and verapamil (Calan) may also ↑, leading to more potent effects on blood pressure

SSRI may ↑ risk of abnormal heart rhythms when combined with drugs to control heart rhythms, such as flecainide (Tambocor), encainide, mexiletine (Mexitil), and propafenone (Rythmol)

## **Other Psychiatric Drugs**

<i>Drug</i>	<i>Comment</i>
<b>benzodiazepines (minor tranquilizers)</b> including alprazolam (Xanax), diazepam (Valium) and others	levels of benzodiazepines may ↑; excessive drowsiness or confusion lower doses of benzodiazepines may be needed, fluvoxamine (Luvox) has strongest effect, but problems have also been reported with fluoxetine (Prozac); clonazepam (Klonopin) and temazepam (Restoril) may be safer than alprazolam (Xanax) and diazepam (Valium)
<b>buspirone (BuSpar)</b>	may enhance the effects of SSRIs; however, fluoxetine (Prozac) may reduce the effectiveness of BuSpar some patients with obsessive compulsive disorder who received this combination experienced a worsening of symptoms
<b>lithium</b>	↑ or ↓ levels may result; may lead to lithium toxicity at normal lithium levels

<b>L-tryptophan</b>	can cause agitation, restlessness, and upset stomach as well as the serotonin syndrome
<b>major tranquilizers (neuroleptics)</b> such as haloperidol (Haldol), perphenazine (Trilafon) and thioridazine (Mellaril)	blood levels of major tranquilizer may ↑ leading to increased side effects; fluvoxamine (Luvox) may be the safest SSRI to combine with neuroleptics; risperidone (Risperdal) and clozapine (Clozaril) may block the antidepressant effects of the SSRIs
<b>methadone (Dolophine)</b>	fluvoxamine (Luvox) leads to ↑ in blood levels
<b>mood stabilizers and anticonvulsants</b>	SSRIs, especially fluvoxamine (Luvox) and fluoxetine (Prozac), can cause ↑ in levels of carbamazepine (Tegretol) and phenytoin (Dilantin). The combination of either SSRI with phenytoin can cause phenytoin toxicity

### Other Medications

<i>Drug</i>	<i>Comment</i>
<b>alcohol</b>	increased drowsiness
<b>caffeine (in coffee, tea, soda, chocolate)</b>	fluvoxamine (Luvox) causes levels to ↑; excess nervousness may result
<b>cisapride (Propulsid)</b>	fluvoxamine (Luvox) may ↑ levels of cisapride; fatal heart rhythms can occur
<b>cyclosporine (Sandimmune; Neoral)</b> (an immunosuppressive drug used in organ transplants)	levels of cyclosporine may ↑
<b>dextromethorphan</b> (a cough	hallucinations reported with

suppressant in many over-the-counter medications)	fluoxetine (Prozac), possible with any SSRI
<b>tacrine (Cognex)</b>	fluvoxamine (Luvox) leads to ↑ in blood levels
<b>tobacco (smoking)</b>	levels of fluvoxamine (Luvox) may ↓
<b>theophylline (Bronkaid)</b>	fluvoxamine (Luvox) leads to ↑ in blood levels and can produce toxic effects, including excess nervousness
<b>warfarin (Coumadin) (a blood-thinner)</b>	fluvoxamine (Luvox) may ↑ levels of warfarin (Coumadin); increased bleeding may result. The increased bleeding can also result without any changes in the prothrombin test (this bleeding test is used to monitor the dose of warfarin). This is because the SSRIs can also impair clotting through their effect on blood platelets, whereas warfarin affects the clotting proteins

<sup>a</sup>Information in this table was obtained from several sources including the *Manual of Clinical Psychopharmacology*<sup>1</sup> and *Psychotropic Drugs Fast Facts*.<sup>17</sup> These excellent references are highly recommended.

<sup>b</sup>This is a dangerous and potentially fatal syndrome which includes rapid changes in vital signs (fever, oscillations in blood pressure), sweating, nausea, vomiting, rigid muscles, myoclonus, agitation, delirium, seizures, and coma.

A number of other important interactions which are listed in the table involve common drugs that many people might take for a cold or flu, diabetes, high blood pressure, allergies, and so on. For example, dextromethorphan is a cough suppressant in many over-the-counter cold preparations. When combined with an SSRI, dextromethorphan can cause visual hallucinations. This has been reported with fluoxetine (Prozac) but

could theoretically occur with any SSRI. You will also see that two common antihistamines, terfenadine (Seldane) and astemizole (Hismanal), can produce abnormal and potentially fatal heart rhythm abnormalities when combined with certain SSRIs, and a third antihistamine called cyproheptadine (Periactin) can block the antidepressant effects of an SSRI.

Make sure you review this table if you are taking an SSRI. If you have any questions, discuss them with your doctor and pharmacist. The SSRIs are safe for the overwhelming majority of individuals who take them. With a little good teamwork between you and your doctor, your experience with an SSRI can be positive.

## MAO Inhibitors

The Table of Antidepressants on pages 514–515 lists four drugs known as monoamine oxidase inhibitors (MAOIs). They include isocarboxazid (Marplan), phenelzine (Nardil), selegiline (Eldepryl), and tranylcypromine (Parnate). You may recall from Chapter 17 that the MAOIs fell into relative disuse when the newer and safer compounds were developed. They are probably vastly underutilized because they can be quite dangerous if mixed with a number of common foods (such as cheese) and medicines (including many common over-the-counter cold, cough, and hay fever drugs) and because they require fairly sophisticated medical skills on the part of the prescribing doctor.

In recent years the MAOIs have experienced a much-deserved resurgence of popularity because they are often remarkably effective for patients who do not respond to other kinds of antidepressants. Many of these patients have experienced so many years of chronic depression that their illness has become an unwelcome lifestyle. The beneficial effects of the MAOIs can sometimes be quite impressive.

The MAOIs can also be particularly effective in an “atypical depression” that is characterized by the following types of symptoms:

- overeating (as opposed to a loss of appetite in classic depression);
- fatigue and sleeping too much (rather than trouble with sleeping);
- irritability or hostility (in addition to the depression);
- extreme sensitivity to rejection.

Patients with this form of depression sometimes also emphasize chronic feelings of fatigue as well as a “leaden paralysis.” It is not clear whether this really represents a subtype of depression or simply a particular group of symptoms that any depressed individual might experience.

Nevertheless, studies conducted at Columbia University suggest that the MAOIs may actually be better than the cyclic antidepressants for patients with these kinds of symptoms. The MAOIs can also be remarkably effective when high levels of anxiety accompany the depression, including phobias (such as social phobia), panic attacks, or hypochondriacal complaints. Patients with recurrent obsessive thoughts and compulsive, ritualistic, nonsensical habits (such as recurrent hand-washing or repetitive checking of door locks) may also experience relief when treated with MAOIs.

The MAOIs can also be helpful when chronic anger or impulsive self-destructive behavior accompanies the depression. Patients with these features are sometimes diagnosed as having “borderline personality disorder.” Although these individuals can sometimes be quite difficult to treat, I have seen many who were dramatically helped by the MAOIs. Of course, all patients who take MAOIs must agree to follow the dietary restrictions and medication guidelines religiously. If a patient is unreliable or will not agree to this, other types of medications should be used instead.

The mechanism of action of the MAOIs is different from that of the other antidepressant drugs. You learned in Chapter 17 that most antidepressants act by blocking the pumps for neurotransmitters at the nerve endings. As a result, the levels of the chemical transmitters such as serotonin, norepinephrine, or dopamine build up in the synaptic regions. In contrast, the MAOIs seem to work by preventing the breakdown of chemical messengers within the nerves. As a result, levels of serotonin, norepinephrine, and dopamine build up inside the nerve terminals and these messengers are released into the synapses in much higher concentrations when the nerves fire. This results in a greater stimulation of the nerves at the other side of the synaptic junctions.

The MAOIs require careful medical management and close teamwork with your doctor. They are well worth the effort because they can sometimes lead to profound mood transformations, even when other drugs have been ineffective. Because they may cause increases in blood pressure, they are not usually recommended for individuals over sixty years of age or individuals with heart problems. In addition, they are not usually prescribed for

individuals with significant cerebrovascular disorders, such as strokes or aneurysms, or individuals with brain tumors. Paradoxically, though, they can sometimes be used with individuals with high blood pressure because they usually cause the blood pressure to fall.<sup>19</sup> Consultation with a cardiologist would be necessary to make sure there are no dangerous interactions with your other blood pressure medications.

Like other antidepressants, the MAOIs usually require at least two or three weeks to become effective. Your doctor will probably want to obtain a medical evaluation before starting you on this type of drug. This evaluation may include a physical examination, a chest X ray, an electrocardiogram, a blood count, blood chemistry tests, and a urinalysis.

*Doses of MAOIs.* The doses of the MAOIs are listed in Table 20–1 on page 520. The two most commonly prescribed drugs for depression and anxiety are tranylcypromine (Parnate) and phenelzine (Nardil). One of the MAOIs, isocarboxazid (Marplan), is no longer available in the United States but is available in some other countries including Canada. In addition, selegiline (Eldepryl) is rarely used for depression but is often used in small doses (5 mg to 10 mg per day) in the treatment of Parkinson’s disease. It is just starting to be used for depression and some other psychiatric disorders, although in higher doses than for Parkinson’s disease, as indicated in Table 20–1. Although the Food and Drug Administration (FDA) has not yet approved selegiline for use in psychiatric disorders, recent studies indicate that it can also be effective for patients with atypical depression as well as those with chronic, severe depression.

A common prescribing error with the MAOIs is to give too big a dose too soon. For example, you will see in Table 20–1 on page 520 that the usual dose range for tranylcypromine (Parnate) is 10 mg to 50 mg per day. Some doctors prescribe larger doses, but I have seen many patients respond to just one or two pills per day. Because the MAOIs can have some toxic side effects, I think it is prudent to start them at low doses, to increase very slowly, and not to push the dose too high. I usually start the patient on just one pill per day of an MAOI for the first week, and then increase to two pills per day. If the patient does not respond to a reasonable dose, say three or four pills per day of tranylcypromine or phenelzine, I usually do not increase the

dose further but instead try an alternative medication along with a different psychotherapeutic strategy.

How long should you stay on an MAOI if it does not seem to be working? It seems obvious to me that if you have not had a fairly dramatic response after three or four weeks, as confirmed by your weekly scores on the mood test in Chapter 2, then you have probably given the drug a fair trial. You might respond better to another type of drug or to the cognitive therapy techniques described in this book.

How long should you stay on an MAOI if you do respond favorably? As with any antidepressant, you will have to discuss this with your physician, and many different approaches are currently in vogue. Some physicians believe that patients need antidepressants indefinitely to correct a “chemical imbalance,” but I have not usually found it necessary to keep patients on MAOIs or other antidepressants indefinitely. I have found that patients nearly always do well when they discontinue their MAOIs after a reasonable period of feeling good. Sometimes this may be as short as three months, sometimes as long as six to twelve months.

As with most antidepressants, you should taper off an MAOI gradually so there will be no withdrawal effects. Tapering too rapidly has caused some patients to experience sudden manic reactions. Suddenly going off selegiline can cause nausea, dizziness, and hallucinations, so one has to be especially careful to taper slowly.

What if you go off the MAOI and then get depressed again in the future? If you have responded to an MAOI in the past, you may respond more rapidly if you take the same MAOI again in the future. In my practice I have had many patients who experienced a positive response to an MAOI (usually Parnate) and continued to feel undepressed for many years after they stopped taking the drug. Eventually, a few of them became depressed again and called for a “tune-up” appointment. I always gave them the first available appointments. If they sounded quite depressed, I told them to start the medication again. I also told them to start doing their psychotherapy homework again, especially the exercise of writing down and challenging their negative thoughts. When I saw them a few days later, many of them were already feeling better. Some of them told me that they began to improve in as little as one day or less when they took the MAOI for the second time. I believe that the medication as well as the cognitive therapy contributed to the rapid improvement.

I have not seen this rapid response with other types of antidepressants and do not know why it sometimes happens with MAOIs. Several patients explained that their bodies seemed to “recognize” the effects of the MAOI right away, especially the pleasurable stimulation that tranylcypromine (Parnate) causes. This helped them “remember” what it was like not to feel depressed. In a few cases, the improvement in mood came within an hour or two of the first pills they took. In the majority of cases, one or two cognitive therapy sessions seemed to reverse the relapse of depression.

*Side Effects of MAOIs.* The most frequent side effects are listed in Table 20–7 on pages 572–573. As noted above, tranylcypromine (Parnate) tends to be stimulating. The stimulating effects of tranylcypromine (Parnate) can be especially helpful to depressed individuals who feel tired, lethargic, and unmotivated. Tranylcypromine (Parnate) may provide them with some much-needed “go power.” Because tranylcypromine (Parnate) tends to be stimulating, it can also cause insomnia. In order to minimize the insomnia, the entire dose can be taken once a day in the morning or in divided doses in the morning and at noon. The latest recommended time to take tranylcypromine (Parnate) is 6:00 P.M. Phenelzine (Nardil) is less stimulating than tranylcypromine (Parnate) and may be an attractive option for patients who feel too stimulated by tranylcypromine (Parnate).

The other side effects of the MAOIs are similar to those of the tricyclic and tetracyclic drugs described previously, but they are usually mild, especially when the MAOIs are taken in low doses. As you can see in Table 20–7, the MAOIs do not have strong effects on the muscarinic receptors (you will recall that these are also called cholinergic receptors). Consequently, they are not likely to cause dry mouth, blurred vision, constipation, or a delay in starting the urine flow. Weight gain also does not seem to be so much of a problem with these drugs, although some patients experience an increased appetite. Weight gain appears to be less of a problem with tranylcypromine (Parnate) than phenelzine (Nardil). Because tranylcypromine is stimulating, it may actually reduce your appetite, as do some of the SSRIs including fluoxetine (Prozac).

Some patients experience light-headedness when standing suddenly because these drugs have relatively strong effects on the alpha-adrenergic receptors. If dizziness does develop, the interventions described previously

can help. These include: (1) ask your doctor if you can lower the dose—often you can still maintain the antidepressant effect; (2) get up more slowly and exercise your legs by walking in place immediately when you stand; (3) wear support stockings; (4) drink adequate fluids and make sure you eat enough foods with salt to maintain your body's electrolytes.

Like most antidepressants, the MAOIs can sometimes cause a rash, although I do not recall ever seeing this. A loosening of the stool or constipation might also occur. Some patients report an upset stomach. Taking the medication with meals can alleviate this. Some patients report muscle twitches, but this is usually not dangerous. If you experience muscle pains, cramps, or tingling fingers—side effects I have never observed—a daily dose of 50 to 100 mg of vitamin B<sub>6</sub> (pyridoxine) may help. This is because MAOI drugs may interfere with pyridoxine metabolism, so taking extra pyridoxine may compensate for this effect. Some doctors recommend taking vitamin B<sub>6</sub> routinely if you are on an MAOI.

The MAOIs can sometimes interfere with sexual functioning, especially in higher doses. Some patients experience a decreased interest in sex and difficulties maintaining an erection or achieving orgasm. In this regard, the MAOIs are a lot like the SSRIs described previously. The sexual side effects may result from their effects on the serotonin receptors in the brain, but this is not known for sure. Although the sexual side effects can be disconcerting, these difficulties may be a worthwhile trade-off if the medication is having a beneficial effect on your mood. You should be reassured that the sexual side effects are dose-related and usually disappear entirely when you are no longer taking the MAOI.

One young man I treated actually found the sexual side effects to be helpful. He reported that he had always had a problem with premature ejaculation. Once he started taking tranylcypromine (Parnate), the problem disappeared. In fact, he reported he could make love for prolonged periods without any danger at all of having a premature orgasm. He said his girlfriend thought this was a great miracle, and he advised me to buy stock in the company that manufactured the drug!

One pleasurable side effect of an MAOI is an excessively positive reaction to the drug. In other words, quite a number of patients not only overcome their depressions but begin to feel euphoric or high. This is not necessarily bad, but in some cases may become so extreme that the patient experiences

the symptoms of mild mania. In the rare patient with a history of bipolar manic-depressive illness (patients with previous extreme highs and lows that were not caused by drugs or alcohol), there is the possibility that an MAOI might trigger a full-blown manic episode. This is actually true of most antidepressants, and not just the MAOIs.

**Table 20–7.** Side Effects of Monoamine Oxidase Inhibitors<sup>a</sup>

Note: This list is not comprehensive. In general, side effects that occur in 5% or 10% or more of patients are listed, as well as rare but dangerous side effects.				
Side Effect	Sedation and Weight Gain	Light-Headedness and Dizziness	Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention	Common or Significant Side Effects <sup>b</sup>
Brain Receptor	histamine ( $H_1$ ) receptors	alpha-adrenergic ( $\alpha_1$ ) receptors	muscarinic ( $M_3$ ) receptors	
isocarboxazid (Marplan)	+	+++	0 to +	headache; changes in heart rhythm and rate; overactivity or mania; tremor; jittery; confusion; memory problems; insomnia; edema; weakness; sweating; upset stomach; delayed orgasm
phenelzine (Nardil)	+	+++	0 to +	dizziness; headache; fatigue; trouble sleeping; weakness; tremor; twitching; dry mouth; upset stomach; constipation; weight gain; delayed orgasm; jittery; euphoria; trouble starting urine; swelling; sweating; rash
selegiline (Eldepryl)	0	+	+	(limited information available); <sup>c</sup> nausea; weight loss; delayed orgasm; confusion; dry mouth; dizziness; possibly other side effects
tranylcypromine (Parnate)	0 to +	+++	0 to +	overstimulation; euphoric or manic feelings; restlessness; anxiety; trouble sleeping; tiredness or weakness; twitching; tremor; muscle spasms; upset stomach; loss of appetite; constipation; diarrhea; headache; delayed orgasm; numbness or tingling; swelling; racing heart; blurred vision

<sup>a</sup>The + to +++ ratings in this table refer to the likelihood that a particular side effect will develop. The actual intensity of the side effect will vary among individuals and will also depend on how large the dose is. Reducing the dose can often reduce side effects without reducing effectiveness.

<sup>b</sup>Many of the side effects of the MAOIs can often be reduced or eliminated by reducing the dose. They usually have very few side effects, and can often be quite effective, at small doses.

This is because this drug is usually prescribed for patients with Parkinsonism who take many other drugs, and also have many symptoms due to their illness. Therefore, it is difficult to determine how frequently selegiline would cause side effects in depressed individuals. At higher doses, the side effects of selegiline are probably very similar to the other MAOIs.

If you do start to feel unusually happy, it would be wise to keep in touch with your prescribing doctor to make sure these feelings do not get out of hand. In my experience, this is not usually a serious problem—the euphoric feelings provide a welcome relief from the depression and tend to diminish in a week or so. The euphoric feelings also respond to a reduction in dose.

Dr. Alan Schatzberg and his colleagues<sup>1</sup> have pointed out that some patients may seem drunk or intoxicated when taking MAOIs. Patients may also feel confused and have trouble with coordination. These adverse reactions are more likely when the doses are pushed to very high levels. Obviously, the dose should be reduced immediately if these toxic effects develop. I have personally never seen these effects because I have never pushed the doses of MAOIs to unusually high levels.

Two of the MAOI drugs, phenelzine (Nardil) and isocarboxazid (Marplan), can have negative effects on the liver. Therefore, your doctor may want to do a blood test to monitor levels of certain enzymes that reflect liver function before you start these drugs, and then again every few months while you are taking them. Patients with liver disease or abnormal liver function tests are usually advised not to take any of the MAOIs, including tranylcypromine (Parnate).

Dr. Alan F. Schatzberg and his colleagues<sup>1</sup> have pointed out that selegiline (Eldepryl) may have fewer side effects than the other MAOI drugs, at least at low doses. At low doses, selegiline seems less likely to cause dizziness when standing, sexual problems, or difficulties sleeping. However, selegiline is much more expensive than the other MAOIs, and in most cases the other MAOIs will do the job just as effectively. In addition, the side effects of all the MAOI antidepressants tend to be minimal at lower doses. In my experience, many patients have responded favorably to low doses of the MAOIs, so selegiline may not really have any significant advantages over the two older and cheaper drugs.

As you will learn next, all the MAOIs can cause dangerous blood pressure elevations when patients ingest the forbidden foods. Selegiline is less likely to have this effect, but only if the selegiline is taken in small doses (10 mg per day or less). Larger doses of selegiline are often needed for psychiatric problems. At these higher doses it is necessary to observe the same dietary precautions that you would observe with any of the MAOIs. This is unfortunate because it was initially hoped that depressed patients would be able to take selegiline and not have to restrict their diets so religiously.

*Hypertensive and Hyperpyretic Crises.* In rare cases, the MAOIs can produce two types of serious toxic reactions if they are not used properly. This is why so many doctors avoid using them. With good education and preventive medications, the MAOIs can be administered safely, but you will need to study this section quite carefully if you are taking an MAOI.

One of the dangerous reactions is called a “hypertensive crisis.” “Hyper” means high and “tensive” refers to blood pressure, so a hypertensive crisis is a sudden increase in your blood pressure. Increases in blood pressure are not usually dangerous and can occur in many normal situations even if you are not taking medications. For example, when you are lifting weights, your blood pressure can easily go into the range of 180/100 or higher at the moment you are straining and exerting maximum effort to raise the barbell. Our bodies are used to these temporary elevations in blood pressure. However, if you were on an MAOI and you ate one of the forbidden foods, your blood pressure might increase to dangerous levels and remain elevated for an hour or more. If you continued to eat the forbidden foods that interact with the MAOIs, sooner or later a vessel in your brain could rupture because of the mechanical stress. This would cause a stroke, certainly an excessive price to pay for taking an antidepressant.

The initial symptoms of a ruptured or leaking vessel in your brain can include an excruciating headache, a stiff neck, nausea, vomiting, and sweating. As the bleeding continues, paralysis, coma, and death can occur. Because of the danger of hypertensive reactions, your doctor will check your blood pressure at each session. The risk of a stroke is higher in individuals over sixty because our arteries become less resilient with age and are more likely to tear or rupture when subjected to the stress of a sudden increase in

blood pressure. Regardless of your age, you will need to monitor your blood pressure and watch your diet carefully when taking an MAOI.

These hypertensive crises are sometimes also called “noradrenergic crises” because they are thought to be due to an excessive release of norepinephrine. Norepinephrine is a transmitter substance used by nerves in your brain and in your body. Hypertensive crises usually occur if you eat certain forbidden foods containing a substance called tyramine or if you take one of the forbidden drugs that I will describe in detail below. If you are careful, the risk of a serious hypertensive crisis is very small.

The other dangerous reaction to an MAOI is called a “hyperpyretic crisis.” “Pyretic” refers to fire, or fever. The patient with a hyperpyretic crisis may develop a high fever along with a number of alarming symptoms that can include sensitivity to light, rapid changes in blood pressure, rapid breathing, sweating, nausea, vomiting, rigid muscles, jerking and twitching, confusion, agitation, delirium, seizures, shock, coma, and death. A hyperpyretic crisis is sometimes also called a “serotonin syndrome” because it is due to an abnormal and dangerous increase in levels of serotonin in the brain. A hyperpyretic crisis occurs when the patient takes certain forbidden medications that must not be combined with the MAOIs. These drugs cause an increase in levels of serotonin in the brain. Obviously, a hyperpyretic crisis requires immediate discontinuation of the MAOI along with emergency medical treatment. The treatment may include intravenous fluids and treatment with the serotonin antagonist, cyproheptadine (Periactin), at a dose of 4 mg to 12 mg.

Several decades ago when MAOIs were first available, doctors were not as aware of the blood pressure elevations that resulted from eating foods containing tyramine or from taking the kinds of drugs described below, and so these hypertensive reactions were more common and severe. Now doctors and patients are much more aware of the problem and the risk is much smaller. In fact, extreme hypertensive and hyperpyretic reactions are quite rare. I am personally aware of only one patient, treated by a colleague in Boston, who developed a stroke due to a hypertensive crisis (noradrenergic syndrome) while taking an MAOI. I have had about half a dozen patients over the years who paged me because they suddenly developed elevated blood pressure. I told each of them to go to a local hospital emergency room for observation. In every case, the blood pressure quickly subsided without

any treatment aside from observation. None of these patients experienced any adverse effects. I have never seen a patient who developed a hyperpyretic crisis (serotonin syndrome) while on an MAOI.

This is because we know a great deal about what causes these two kinds of reactions and how they can be avoided. If you are taking an MAOI, you will need to educate yourself by studying the following sections carefully. You will have to avoid taking certain types of drugs and exercise a little self-discipline in your diet in order to be safe. You will find it is well worth the extra effort required to protect yourself.

*How to Avoid a Hypertensive or Hyperpyretic Crisis.* There are two important keys to preventing a hypertensive or hyperpyretic crisis if you are taking an MAOI. First, you must obtain a blood-pressure cuff and monitor your own blood pressure carefully. Second, you must carefully avoid certain foods or medications (including some street drugs) that will predictably trigger these reactions. I will describe these forbidden foods and medicines in detail below. You will see that the substances that can trigger a hypertensive crisis are somewhat different from the substances that can trigger a hyperpyretic crisis.

You can obtain a blood-pressure cuff at your local pharmacy so you can monitor your own blood pressure whenever you want. Practice using the cuff. Although it may seem a little awkward or confusing at first, you will find that it gets pretty easy to take your blood pressure after you have practiced a few times. In my practice I have required every patient taking an MAOI to do this. In the rare situation where a patient did not want to go to the trouble of obtaining a cuff and learning how to use it, I have refused to prescribe an MAOI.

Initially you can monitor your blood pressure once a day or even twice a day if you are so inclined. After you have been taking the MAOI for a couple weeks, you will not need to monitor your blood pressure so frequently. Once a week will usually be sufficient. You can check your blood pressure if you forget and eat one of the forbidden foods. You can also check it if you feel woozy or nauseous or if you get an excruciating or severe headache. We all get headaches from time to time, and they rarely ever indicate a stroke. However, if you have a blood-pressure cuff, you can check your blood pressure and make sure it is not dangerously elevated.

If your blood pressure goes up to a dangerous level, you should call your doctor or go to an emergency room. How much elevation is dangerous? The blood pressure consists of two numbers. The higher number is called the “systolic” blood pressure and the lower number is called the “diastolic” blood pressure. A value of 120/80, for example, would be considered normal for most people. Most emergency room doctors would not be particularly concerned until these numbers reach the range of 190 to 200 over 105 to 110. At that level, they might observe you carefully and monitor your blood pressure every few minutes. Most of the time, the elevated blood pressure will subside without treatment. If your blood pressure continues to rise, the ER doctor could give you an antidote (such as phentolamine or prazosin) to lower your blood pressure back into a safe range.

The best time to take your blood pressure is about one to one and a half hours after you have taken the medication. About 25 percent of my patients have noted modest blood pressure elevations at this time even if they have not eaten any of the forbidden foods in Table 20–8 on pages 580–581 or taken the medicines in Table 20–9 on pages 584–590. These increases were not usually extreme or dangerous—a 20- or 30-point elevation in the systolic blood pressure was typical. Nevertheless, in those cases, I have recommended stopping the medication because these patients seemed overly sensitive to the effects of the MAOI on their blood pressure. It just did not seem worth the worry and risk, especially since a different antidepressant might be just as effective.

*Foods to Avoid.* Hypertensive crises may occur if you eat foods (see Table 20–8) that contain a substance known as tyramine. If you are taking an MAOI, too much tyramine can interfere with your brain’s ability to regulate your blood pressure. Tyramine causes nerves to release more norepinephrine into the synaptic regions that separate them from the postsynaptic nerves. These postsynaptic nerves may become overly stimulated when too much norepinephrine is released. Because these nerves help to regulate blood pressure, all the extra norepinephrine that is released can cause a dangerous and sudden increase in blood pressure.

You will recall from Chapter 17 that an enzyme called monoamine oxidase (MAO) is located inside the presynaptic nerves. This enzyme usually destroys any excess norepinephrine that builds up inside these nerves and

prevents these nerves from releasing too much norepinephrine when they fire. But the MAOI drugs block this enzyme, and so the norepinephrine levels inside these nerves increase substantially. When you eat foods containing tyramine, all that extra norepinephrine suddenly spills into the synaptic region, causing a massive stimulation of the nerves that regulate your blood pressure.

**Table 20–8.** Foods and Beverages to Avoid If You Are Taking a Monoamine Oxidase Inhibitor (MAOI)<sup>a</sup>

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### Foods to Avoid Completely

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Cheese, particularly strong or aged cheese (cottage cheese and cream cheese are allowed)

Beer and ale: particularly tap beers, beers from microbreweries and strong ales

Red wine: especially Chianti wine

Brewer's yeast tablets or yeast extracts (breads and cooked forms of yeast are safe. The yeast extracts from health food stores are dangerous. Yeast extracts may be found in certain soups. Some powdered protein diet supplements contain yeast extracts.)

Pods of fava beans, also called Italian green beans (regular green beans are safe)

Meat or fish that is smoked, dried, fermented, unrefrigerated, or spoiled, including:

- fermented or air-dried sausages, such as salami and mortadella (some experts state that bologna, pepperoni, summer sausage, corned beef, and liverwurst are safe)<sup>17</sup>
- pickled or salted herring
- liver (beef or chicken), especially old chicken liver (fresh chicken liver is safe)

Overripe bananas or avocados (most fruits are completely safe)

Sauerkraut

Some soups, including those made from beef bouillon or Asian soup stocks (e.g., miso soup). (Tinned and packet soups are felt to be safe, unless

made from bouillon or meat extracts)

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### **Foods or Beverages that May Cause Problems in Large Amounts**

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White wine or clear alcohol, such as vodka or gin

Sour cream

Yogurt: must be pasteurized and less than 5 days old to be safe

Soy sauce

NutraSweet (the artificial sweetener)

Chocolate

Caffeine in beverages (coffee, tea, and soda) and chocolate

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### **Foods or Beverages Once Thought to Cause Problems which Are Probably Safe in Small Amounts**

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Figs (avoid overripe figs)

Meat tenderizers

Caviar, snails, tinned fish, pate

Raisins

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<sup>a</sup>Modified from B. McCabe and M. T. Tsuang, "Dietary Considerations in MAO Inhibitor Regimens," *Journal of Clinical Psychiatry* 43 (1982): 178–181.

If you watch your diet carefully, the likelihood is good that you will experience no adverse blood-pressure elevation. The most common trigger is cheese, especially strong cheese. You will have to give up pizza and grilled cheese sandwiches for a while if you are taking an MAOI.

Most of the forbidden foods contain the breakdown products of protein—including tyramine. So, for example, freshly cooked chicken is perfectly safe, but cooked leftover chicken that has been sitting for a couple days can be

dangerous because tyramine forms when the meat decomposes. One of my patients on tranylcypromine (Parnate) ate some leftover chicken that had been in the refrigerator for several days. Soon after eating it, he experienced a significant elevation in blood pressure. This was because the chicken had partially decomposed due to effects of bacteria. Fortunately, he was not harmed, but this experience served as a useful warning to be careful. The fermented or partially decomposed meats on the list in Table 20–8, such as strong sausage or smoked fish, as well as strong cheese, may contain large amounts of tyramine and can be especially dangerous. Some experts also advise against eating Chinese food while taking MAOIs. This may be due to the soy sauce, the monosodium glutamate, or other ingredients.

How much tyramine is necessary to cause a hypertensive reaction? This varies quite a bit from person to person. On average, foods containing at least 10 mg of tyramine will be sufficient to cause a hypertensive crisis if you are taking phenelzine (Nardil). As little as 5 mg of tyramine may be sufficient if you are taking tranylcypromine (Parnate). What foods contain this amount of tyramine? Well, most beers contain less than 1.5 mg of tyramine, and many contain less than 1 mg, so you would have to drink several beers to run a significant risk. However, some ales contain 3 mg of tyramine per serving, and some tap beers can also be particularly risky. For example, one serving of Kronenbourg, Rotterdam's Lager, Rotterdam's Pilsner, or Upper Canadian Lager contains between 9 and 38 mg of tyramine<sup>17</sup>. So even one glass of these beers could be dangerous.

Cheeses can also vary greatly. Processed American cheese contains only about 1 mg of tyramine per serving, but Liederkranz, New York State cheddar, English Stilton, blue cheese, Swiss cheese, aged white cheese and Camembert all contain more than 10 mg per single serving.<sup>17</sup>

Suppose you eat one of the forbidden foods by accident, and then you check your blood pressure and discover that it does not go up. What does this mean? There is a lot of individual variation in the sensitivity to the effects of the forbidden foods. You may be one of those individuals who is significantly less likely to react with an elevation in blood pressure. However, you should not become complacent, because these hypertensive reactions are unpredictable. If you cheat and eat the forbidden foods from time to time, it is a lot like playing Russian roulette. You may get away with it for a while and then discover that you have experimented once too often. For example, you

may eat a piece of pizza on nine separate occasions without any increase in blood pressure, and conclude that it is safe to eat pizza. But this can be very misleading, because the tenth time you eat a piece of pizza you may experience a sudden and severe increase in blood pressure. It is not known why this happens, but it does underscore the importance of consistent self-discipline if you are taking an MAOI.

*Medications and Drugs to Avoid.* A number of prescription drugs, nonprescription drugs, and street drugs that can cause a hypertensive or hyperpyretic crisis when combined with MAOIs are listed in Table 20–9 on pages 584–590. These reactions are especially dangerous and so you must carefully avoid these drugs. Some of the medications that interact with MAOIs do not cause such severe reactions. For example, caffeine may cause you to become more jumpy and jittery than usual. Moderate amounts of caffeine are reasonably safe, however. (You may think of caffeine as more of a food than a drug, but it is a mild stimulant.)

The list of drugs that interact with MAOIs includes:

- most antidepressants—virtually any of them can be dangerous;
- many antiasthma drugs;
  - many common cold, cough allergy, sinus, decongestant, and hay fever medications that contain sympathomimetic agents (discussed in detail below) or dextromethorphan, the cough suppressant. You will have to check labels carefully, because many over-the-counter drugs contain these substances;
- drugs used in the treatment of diabetes—they may become more potent than usual if you are taking an MAOI, and can cause your blood sugar to fall more than expected;
- some drugs used in the treatment of low or high blood pressure—both types of drugs can in some cases cause blood pressure elevations when combined with MAOIs;
- mood stabilizers and anticonvulsants;
- some painkillers, including some local and general anesthetics;
  - sedatives (including alcohol) and tranquilizers—they may have more pronounced effects than usual when you are taking an MAOI. The increased sleepiness could be hazardous if you are driving;
- L-tryptophan—the natural amino acid;

- stimulants (pep pills) and street drugs;
- many weight-loss (appetite suppressing) medications;
  - caffeine, which is present in coffee, tea, many sodas, hot cocoa, and chocolate. Caffeine is also present in a number of prescription and nonprescription medications such as Cafegot suppositories and tablets, Darvon Compound-65, NōDōz, Fiorinal, Excedrin, and many other cold or pain preparations;
- Disulfiram (Antabuse), used to treat alcoholism;
- Levo-dopa, used in the treatment of Parkinson's disease.

**Table 20–9.** Prescription Drugs and Over-the-Counter Medications to Avoid If You Are Taking a Monoamine Oxidase Inhibitor (MAOI)<sup>a</sup>

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**Note:** This list is not exhaustive; new information about drug interactions comes out frequently. If you are taking an MAOI and any other medication, ask your doctor and pharmacist if there are any drug interactions.

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### Antidepressants

<i>Drug</i>	<i>Comment</i>
<b>tricyclic antidepressants,<sup>b</sup></b> especially desipramine (Norpramin, Pertofrane) and clomipramine (Anafranil)	Some (e.g., clomipramine) may cause a hyperpyretic crisis or seizures; others (e.g. desipramine) may cause a hypertensive crisis
<b>tetracyclic antidepressants,</b> especially bupropion (Wellbutrin)	hypertensive crisis (noradrenergic syndrome)
<b>SSRIs</b> (all are extremely dangerous)	hyperpyretic crisis (serotonin syndrome)
<b>other MAOIs</b>	hyperpyretic crisis (serotonin syndrome); hypertensive crisis (nonadrenergic syndrome)
<b>serotonin antagonists</b> , including trazodone (Desyrel) and nefazodone (Serzone)	hyperpyretic crisis (serotonin syndrome)

<b>mirtazapine</b> (Remeron)	hypertensive crisis (noradrenergic syndrome)
<b>venlafaxine</b> (Effexor)	hypertensive crisis (noradrenergic syndrome)

### Asthma Medicines

<i>Drug</i>	<i>Comment</i>
<b>ephedrine</b> , a bronchodilator contained in Marax, Quadrinal, and other asthma drugs	hypertensive crisis
<b>inhalants</b> which contain albuterol (Proventil, Ventolin), metaproterenol (Alupent, Metaprel), or other beta-adrenergic bronchodilators	blood pressure elevations and a rapid heart; beclomethasone and other nonsystemic steroid inhalers are generally safer
<b>theophylline (Theo-Dur)</b> , a common ingredient in asthma drugs	rapid heart and anxiety

### Cold, Cough, Allergy, Sinus, Decongestant, and Hay Fever Medications (including tablets, drops, or sprays)

<i>Drug</i>	<i>Comment</i>
<b>antihistamines:</b> terfenadine (Seldane-D)	can cause an increase in MAOI blood levels
<b>dextromethorphan</b> can be found in many cold and cough medications, especially any drug with DM or Tuss in its name. These include Bromarest-DM or -DX, Dimetane-DX cough syrup, Dristan Cold & Flu, Phenergan with Dextromethorphan, Robitussin-DM, several Tylenol cold, cough, and flu preparations, and many others	hyperpyretic crisis (serotonin syndrome); may also cause brief episodes of psychosis or bizarre behavior

<b>ephedrine</b> can be found in Bronkaid, Primatene, Vicks Vatronol nose drops and several other asthma and cold medications.	hypertensive crisis (noradrenergic syndrome)
<b>oxymetazoline (Afrin)</b> nose drops or sprays used to treat nasal decongestion	hypertensive crisis (noradrenergic syndrome)
<b>phenylephrine</b> can be found in Dimetane, Dristan decongestant, Neo-Synephrine nasal spray and nose drops, and many other similar preparations, including some eye drop medications	hypertensive crisis (noradrenergic syndrome)
<b>phenylpropanolamine</b> is contained in Alka-Seltzer Plus Cold and Night-Time Cold medicine, Allerest, Contac decongestants, Coricidin D decongestants, Dexatrim appetite pills, Dimetane-DC Cough syrup, Ornade Spansules, Robitussin-CF, Sinarest, St. Joseph Cold Tablets, Tylenol Cold medicine, and many others	hypertensive crisis (noradrenergic syndrome)
<b>pseudoephedrine</b> can be found in Actifed, Allerest No Drowsiness formula, Benadryl combinations, CoAdvil, Dimetane-DX Cough syrup, Dristan Cold Maximum Strength, Robitussin-DAC syrup, Robitussin-PE, Seldane-D tablets, Sinarest No Drowsiness, Sinutab, Sudafed, Triaminic Nite Light, and numerous Tylenol allergy, sinus, flu, and cold preparations, as well as several Vicks products including NyQuil, to mention just a few	hypertensive crisis (noradrenergic synarome)

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## Diabetes Medications

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<i>Drug</i>	<i>Comment</i>
<b>insulin</b>	may cause a greater drop in blood sugar
<b>oral hypoglycemic agents</b>	as above

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## Medications for Low Blood Pressure (for patients in shock)

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<i>Drug</i>	<i>Comment</i>
<b>sympathomimetic amines</b> including: • <b>dopamine (Intropin)</b> • <b>epinephrine (Adrenalin)</b> • <b>isoproterenol (Isuprel)</b> • <b>metaraminol (Aramine)</b> • <b>methyldopa (Aldomet)</b> • <b>norepinephrine (Levophed)</b>	hypertensive crisis (noradrenergic syndrome) because these drugs cause blood vessels to constrict

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## Medications for High Blood Pressure

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<i>Drug</i>	<i>Comment</i>
<b>guanadrel (Hylarel) guanethidine (Ismelin) hydralazine (Apresoline) methyldopa (Aldomet) reserpine (Serpasil)</b>	These blood-pressure medications may cause a paradoxical increase in blood pressure when combined with MAOIs.
<b>beta-blockers</b>	may be more potent when combined with MAOIs, leading to a greater-than-expected drop in blood pressure and dizziness when standing
<b>calcium channel blockers</b>	appear to be reasonably safe when combined with MAOIs. Check

<b>diuretics</b>	with your doctor and monitor blood pressure closely. Watch for a greater-than-expected drop in blood pressure  watch for a greater-than-expected drop in blood pressure. May increase blood level of MAOI
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### Mood Stabilizers

<i>Drug</i>	<i>Comment</i>
<b>carbamazepine (Tegretol)</b>	hyperpyretic crisis (serotonin syndrome); MAOI may cause carbamazepine levels to fall, so epileptics may experience seizures
<b>lithium (Eskalith)</b>	can cause hyperpyretic crisis (serotonin syndrome) in animal studies

### Painkillers and Anesthetics

<i>Drug</i>	<i>Comment</i>
<b>anesthetics: general</b>	Tell your anesthesiologist you are on an MAOI. If possible, discontinue the MAOI two weeks before elective surgery  Muscle relaxants such as succinylcholine and tubocurarine may have a more pronounced or prolonged effect. General anesthetics such as halothane may lead to excitement, excessive depression of the brain, or hyperpyretic reactions
<b>anesthetics: local</b>	Some contain epinephrine or other sympathomimetics—make sure

you tell your dentist you are taking an MAOI

### Pain Medications and Anesthetics cont.

<i>Drug</i>	<i>Comment</i>
<b>cyclobenzaprine (Flexeril)</b> (a muscle relaxant used to treat muscle spasm)	hyperpyretic crisis (serotonin syndrome) or severe seizures
<b>meperidine (Demerol)</b>	A single injection can cause seizures, coma, and death (serotonin syndrome). Most other narcotics, including morphine and codeine, have been used safely with MAOIs

### Sedatives and Tranquilizers

<i>Drug</i>	<i>Comment</i>
<b>alcohol</b>	May have enhanced sedative effects, especially when combined with phenelzine (Nardil). This could be hazardous when driving or operating dangerous machinery
<b>barbiturates</b> (such as phenobarbital)	enhanced sedative effects as described above
<b>buspirone (BuSpar)</b>	enhanced sedative effects as described above
<b>major tranquilizers</b> (neuroleptics)	enhanced sedative effects as described above; some neuroleptics may cause a drop in blood pressure when combined with MAOIs
<b>minor tranquilizers</b> (benzodiazepines) such as alprazolam (Xanax), diazepam (Valium) and others	enhanced sedative effects as described above
<b>sleeping pills</b>	enhanced sedative effects as

<b>L-tryptophan</b>	described above hyperpyretic crisis (serotonin syndrome); blood pressure elevations; disorientation, memory impairment, and other neurologic changes
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### Stimulants (Pep Pills) and Street Drugs

<i>Drug</i>	<i>Comment</i>
<b>amphetamines</b> (speed or crank)	
<b>cocaine</b>	
<b>benzedrine</b>	
<b>benzphetamine (Didrex)</b>	
<b>dextroamphetamine (Dexedrine)</b>	
<b>methamphetamine (Desoxyn)</b>	
<b>methylphenidate (Ritalin)</b>	the hypertensive crisis (noradrenergic syndrome) is possible; methylphenidate is considered somewhat less risky than the amphetamines

### Weight-Loss and Appetite-Suppression Medications

<i>Drug</i>	<i>Comment</i>
<b>pemoline (Cylert)</b>	drug interactions have not been studied in humans; great caution should be used; some experts report that pemoline has been combined with MAOIs in some cases <sup>1</sup>
<b>fenfluramine (Pondimin)</b>	hyperpyretic crisis (serotonin syndrome)
<b>phendimetrazine (Plegine)</b>	hypertensive crisis (noradrenergic syndrome)
<b>phentermine and some over-the-counter meds</b>	hypertensive crisis (noradrenergic syndrome)
<b>phenylpropanolamine (Acutrim)</b>	hypertensive crisis (noradrenergic syndrome)
<b>stimulants</b> (listed above)	hypertensive crisis (noradrenergic

syndrome)

## Other MAOI Drug Interactions

Drug	Comment
<b>caffeine</b> (in coffee, tea, soda, chocolate)	Probably safe in moderate amounts; avoid large amounts; may cause blood pressure elevations, a racing heart, and anxiety
<b>disulfiram (Antabuse)</b> (used to treat alcoholism)	Severe reactions when mixed with an MAOI
<b>L-dopa (Sinemet)</b> (used to treat Parkinson's disease)	hypertensive crisis (noradrenergic syndrome)

<sup>a</sup>Information in this table was obtained from several sources including the *Manual of Clinical Psychopharmacology*<sup>1</sup> and *Psychotropic Drugs Fast Facts*.<sup>17</sup> These excellent references are highly recommended.

<sup>b</sup>Many patients have been successfully treated with a combination of an MAOI and a tricyclic antidepressant under close observation, but such drug combinations are dangerous and require a high level of expert supervision.

Drugs that are categorized as sympathomimetics are particularly dangerous because they are contained in many over-the-counter drugs for common ailments such as colds. They are called sympathomimetics because they tend to mimic the effects of the sympathetic nervous system, which is involved in the control of blood pressure.

Several sympathomimetic drugs are found in large numbers of prescription and over-the-counter cold preparations, cough medicines, decongestants, and hay fever medications. These include ephedrine, phenylephrine, phenylpropanolamine and pseudoephedrine. For example, **ephedrine** can be found in Bronkaid, Primatene, Vicks' Vatronol nose drops, and several other cold and asthma medications. **Phenylephrine** can be found in Dimetane, Dristan decongestants, Neo-Synephrine nasal spray and nose drops, and many other similar preparations. **Phenylpropanolamine** is contained in Alka-Seltzer Plus Cold Medicines, Contac decongestants, Coricidin D decongestants, Dexatrim appetite suppressant pills, Dimetane-DC Cough

syrup, Ornade Spansules, Robitussin-CF, Sinarest, St. Joseph Cold Tablets, and many other cold medicines. **Pseudoephedrine** can be found in Actifed, Advil Cold & Sinus, Allerest No-Drowsiness formula, Benadryl combinations, Dimetane-DX Cough syrup, Dristan Cold Maximum Strength, Robitussin-DAC syrup, Robitussin-PE, Seldane-D tablets, Sinarest No Drowsiness, Sinutab, Sudafed, Triaminic Nite Light, and numerous Tylenol allergy, sinus, flu, and cold preparations, as well as several Vicks products including NyQuil, to mention just a few.

Some cold and cough preparations contain **dextromethorphan**. This is not a sympathomimetic drug, but a cough suppressant. Dextromethorphan is on the list of forbidden medications because it can cause a hyperpyretic crisis. Dextromethorphan can be found in any drug with "DM" or "Tuss" in its name, as well as many preparations without these suffixes. A few examples are Bromarest-DM or -DX, Dimetane-DX Cough syrup, Dristan Cold & Flu, Phenergan with Dextromethorphan, Robitussin-DM, several Tylenol cold, cough, and flu preparations, and many other medications as well.

Because so many common over-the-counter medications contain sympathomimetics or dextromethorphan, it is nearly impossible to keep up with all of them. You can best protect yourself by reading the warning labels that come with these medications and by checking with your doctor or pharmacist before you combine any with an MAOI.

Diabetics taking MAOIs need to know that the MAOIs may also cause blood levels of insulin as well as some oral hypoglycemic agents to increase. As a result, your blood sugar may fall more than expected. This can cause a hypoglycemic reaction, with dizziness, faintness, sweating, and so forth, because your brain does not get enough sugar from your blood. Your doctor may have to adjust the doses of your diabetic medications if you are on an MAOI.

Any of the MAOIs can lower your blood pressure, and so they can intensify the effects of other blood-pressure medications your doctor has prescribed, including diuretics and beta-blockers. The MAOIs can also cause the blood levels of a number of blood-pressure medications to increase. This also tends to intensify their effects. As noted above, some blood-pressure medications can have the paradoxical effect of causing an increase in blood pressure if you are taking an MAOI. Make sure you let your doctor know

about the MAOI. Many major tranquilizers (neuroleptics) can also cause blood pressure to fall, and MAOIs can increase this effect as well.

Some painkillers must be avoided if you are taking an MAOI. For example, a single injection of the painkiller meperidine (Demerol) has been known to cause seizures, coma, and death in patients taking MAOIs. Other opiates, including morphine, are thought to be safer. Most mild nonprescription painkillers, such as aspirin or Tylenol, are also thought to be safe as long as they contain no caffeine. However, cyclobenzaprine (Flexeril), which is commonly used to treat local muscle spasm, can cause fever, seizures, and death. This drug should be avoided entirely.

Many local and general anesthetics can also interact with the MAOIs. Some local anesthetics contain epinephrine or other sympathomimetic drugs that can create hypertensive reactions. Inform your dentist that you are taking an MAOI so she or he can choose a local anesthetic that will be safe for you. If you require elective surgery while on an MAOI, it would be best to discontinue the MAOI for one or two weeks prior to the surgery. Some general anesthetics, such as halothane, can cause excitement or excessive sedation as well as hyperpyretic reactions when combined with an MAOI. The muscle relaxants used by anesthesiologists, such as succinylcholine or tubocurarine, may also have more potent effects. Make sure you inform your anesthesiologist if you are taking an MAOI.

Sedative drugs, including alcohol, major tranquilizers (neuroleptics) and minor tranquilizers, barbiturates and sleeping pills, can interact with MAOIs. This is especially true for phenelzine (Nardil). Because phenelzine also tends to be sedating, it can enhance the effects of any other sedative agent. You should try to avoid combining MAOIs with sedative drugs because the sleepiness you experience could be hazardous, especially if you are driving or operating dangerous machinery.

L-tryptophan is another sedative agent that should not be combined with MAOIs because it can cause a hyperpyretic crisis (serotonin syndrome). L-tryptophan is an essential amino acid that is present in certain foods such as meats and dairy products. It used to be available in health food stores and has been actively promoted as a natural sedative agent to help people with insomnia. It has also been used as a treatment for depression, but the evidence for its antidepressant effects is meager at best. Following ingestion, L-tryptophan rapidly accumulates in the brain, where it is converted into

serotonin. If the dose of L-tryptophan is large enough, you will begin to feel sleepy. If you are taking an MAOI, the increase in brain serotonin may be massive. This is because your brain cannot metabolize the excess serotonin when you are on an MAOI, so the levels of serotonin can escalate to dangerous levels, triggering the serotonin syndrome.

However, some researchers have purposely treated depressed patients with an MAOI plus 2 to 6 grams per day of L-tryptophan in an attempt to make the MAOI treatment more effective. The purpose of these augmentation strategies is to convert a drug nonresponder into a drug responder. Some studies have indicated that this combination can be more potent than treatment with an MAOI alone. Such a treatment is somewhat dangerous, and should probably be administered by experts and reserved for patients with very difficult, resistant depressions.<sup>20</sup> Dr. Jonathan Cole and his colleagues have given doses of 3 to 6 grams of L-tryptophan to patients who had been taking an MAOI for several weeks or more.<sup>1</sup> They observed some early signs of the serotonin syndrome in these patients, suggesting the potential benefits of this drug combination may not be worth the risk.

In animal studies, the combination of lithium with an MAOI can also cause the serotonin syndrome. This is because lithium causes L-tryptophan to enter the brain more rapidly. L-tryptophan is present in the foods we eat, and a large meal can contain as much as 1 gram of L-tryptophan. If you combine lithium with an MAOI, you may get a large increase in serotonin in your brain following meals. However, some doctors have added lithium to an MAOI if the MAOI has not been effective, in just the same way they might add L-tryptophan to try to augment the antidepressant effect of the MAOI. If you receive lithium plus an MAOI, you must be monitored closely to make sure you do not develop any symptoms of the serotonin syndrome, such as fever, tremor, jerking of the muscles, or confusion.

MAOIs are often combined with lithium for another reason. Bipolar patients with abnormal episodic mood elevations as well as depression are often maintained indefinitely on lithium or another mood stabilizer, as described below. During the depressed phase of the cycle, many bipolar patients will need an antidepressant as well as lithium to reverse the depression. The MAOIs, as well as many other kinds of antidepressants, have been used safely and successfully in this way. However, patients need to be monitored closely for signs of hyperpyretic crises as well as episodes of

mania, which can occur on rare occasions when bipolar patients receive antidepressants.

Stimulants, pep pills, and weight-loss pills are especially dangerous when combined with MAOIs. Some of these drugs are categorized as sympathomimetics, and they can cause hypertensive crises. For example, methylphenidate (Ritalin), which is widely used for the treatment of attention deficit disorder in children and adults, is a sympathomimetic that could have this effect. Several commonly abused street or prescription drugs are also sympathomimetics. These include the amphetamines such as Benzedrine, Dexedrine, and Methedrine (also known as “speed” or “crank”) and cocaine. Amphetamines used to be prescribed for weight loss, but their abuse potential is so high that most doctors no longer prescribe them for this purpose. However, a number of the newer popular weight-loss drugs can also be quite dangerous when mixed with MAOIs. For example, phentermine (Adipex; Fastin) can cause hypertensive reactions and fenfluramine (Pondimin), the controversial weight-loss drug that was recently in vogue, can lead to hyperpyretic crises.

As you know, caffeine is also a mild stimulant. It can cause racing of the heart, an irregular heartbeat, or increased blood pressure if you are taking an MAOI. Although coffee, tea, soda, and chocolate all contain caffeine, they are not strictly forbidden, especially in moderate amounts, because their effects are usually mild. Nevertheless, you should avoid caffeine in large quantities because it could precipitate a hypertensive crisis. Some experts recommend a daily maximum of two cups of coffee or tea, or two sodas. In addition, if you monitor your blood pressure with your own blood-pressure cuff, as described above, you can see whether that cup or two of coffee you love in the morning is actually causing a rise in blood pressure. If so, then you should cut down or give up caffeine completely while you are on the MAOI.

You can see in Table 20–9 that L-dopa (levodopa), which is used in the treatment of Parkinson’s disease, can also cause increases in blood pressure when combined with an MAOI. However, patients with Parkinson’s disease are sometimes treated with the MAOI selegiline, as well as other medicines. If these patients receive an MAOI along with L-dopa, the L-dopa should be started at a very small dose and increased slowly while checking the blood pressure.

As noted above, most of the forbidden drugs have warning labels to indicate they can be dangerous when combined with some antidepressant medications. If you are taking an MAOI, check the warning labels carefully before you take any new drug, and always check with your druggist or doctor as well. For a detailed list of drugs that cause hypertensive reactions for patients on MAOIs, see pages 157–160 of *Psychotropic Drugs Fast Facts* by Drs. Jerrold S. Max-men and Nicholas G. Ward.<sup>17</sup> The *Physician's Desk Reference (PDR)*<sup>21</sup> also lists dangerous drug interactions for any prescription medication you may be taking. It is available in any library, drugstore, or medical clinic.

The lists of forbidden foods and medications may seem somewhat confusing or overwhelming. If your doctor prescribes an MAOI, she or he can give you a card to carry in your wallet that lists the foods and drugs to avoid. When in doubt, you can check the card. Some experts advise patients on MAOIs to carry Med-Alert cards so that any emergency room doctors will know that they are taking an MAOI in case they are in an accident or found unconscious and in need of emergency treatment. Then the doctors can take appropriate precautions when administering anesthesia or prescribing other drugs for you.

Remember that the chemical effects of an MAOI remain in your body for as much as one to two weeks after you stop taking it. This is why you must continue to observe the drug and dietary precautions for at least two weeks after you have taken your last MAOI. I would suggest that you actually wait a bit longer. Then you can begin to eat the forbidden foods, such as cheese, in small amounts at first, followed by blood-pressure checks. If your blood pressure is not affected, you can gradually increase the amount you eat until your diet is back to normal. Similarly, if you are switching from an MAOI to another antidepressant, you will have to be completely drug-free for two weeks after you take your last MAOI before starting the new antidepressant.

The same is true if you are starting an MAOI after you have taken another medication—you will have to wait for a period of time, depending on which medication you took. You will recall that you have to wait at least five weeks before starting an MAOI after going off Prozac because this drug remains in your blood for a prolonged time. Most of the other SSRIs are cleared out of your body more rapidly than Prozac, and so a two-week waiting period is usually sufficient. Some antidepressant drugs, such as nefazodone (Serzone)

and trazodone (Desyrel), leave your body even faster, and you may have to wait only one week after taking them before starting an MAOI. Always check with your physician before making any changes in your medications.

Well, by now you may be asking whether it is worth it to take a drug like an MAOI which may seem so complicated and dangerous. This question is especially relevant these days, when so many newer and safer drugs are available. Usually, I would try at least two other drugs first. The SSRI drugs, in particular, often help the same types of patients who used to benefit from the MAOIs. I would like to emphasize, however, that in my experience, the MAOIs can usually be administered safely. I have prescribed them for many patients over the years. When doses are kept at a modest level, the side effects tend to be minimal. And when the MAOIs do work, their effects can be quite phenomenal.

In fact, some of my most impressive successes with medications have been with these MAOI drugs, especially tranylcypromine (Parnate). In addition, I have used these drugs with difficult patients who had experienced many unsuccessful treatments with drugs as well as psychotherapy. When these individuals did improve, the degree of improvement was sometimes extreme. These positive experiences with MAOIs have made a strong impression on me. I believe the enthusiasm of the physicians who use the MAOIs is quite justified. If your physician suggests a medication of this type, it might prove to be well worth the necessary extra effort (taking your blood pressure daily), sacrifice (no pizza!), and self-discipline (avoiding certain foods and medicines).

One last note is that a newer and safer MAOI drug, moclobemide, is being marketed in other parts of the world, including Canada, Europe, and South America. Unlike the MAOIs described above, the effects of moclobemide do not persist after you stop taking it. In addition, it does not seem to interact with tyramine in the diet to nearly the same degree. Dr. Alan Schatzberg and his colleagues<sup>1</sup> have pointed out that moclobemide appears to have very few side effects and that the risk of serious drug interactions is relatively low. Psychiatrists hope that moclobemide or another new MAOI called brofaromine will eventually be marketed in the United States.

## Serotonin Antagonists

Two antidepressant drugs in the table on pages 514–515 are classified as “serotonin antagonists.” They are trazodone (Desyrel) and nefazodone (Serzone). Their mechanism of action appears to be somewhat different from most other antidepressants. Trazodone and nefazodone can boost serotonin by blocking its reuptake at nerve synapses, much like the SSRIs described above. However, these drugs have less potent effects on the serotonin pump than the SSRIs, or even the older tricyclic antidepressants, and this is probably not how these drugs work.

As described in Chapter 17, trazodone and nefazodone appear to block some of the serotonin receptor sites on postsynaptic nerve membranes. At least fifteen different kinds of serotonin receptors have been discovered in the brain. The two receptors that are blocked by trazodone and nefazodone are called 5-HT<sub>2A</sub> and 5-HT<sub>2C</sub> receptors. 5-HT is simply shorthand for serotonin; the number and letter after the 5-HT identify the specific type of receptor. Trazodone and nefazodone indirectly stimulate another type of serotonin receptor called the 5-HT<sub>1A</sub> receptor. This receptor is thought to be important in depression, anxiety, and violence. According to one theory, the stimulation of these 5-HT<sub>1A</sub> receptor sites might explain the antidepressant effects of trazodone and nefazodone. In addition, trazodone and nefazodone are effective antianxiety drugs. If you tend to be nervous and worried, like many depressed individuals, these medications may be especially helpful for you.

*Doses of Trazodone and Nefazodone.* The starting dose for trazodone is 50 to 100 mg per day. Most patients will do well on 150 mg to 300 mg per day. The starting dose for nefazodone is 50 mg twice per day. The doses of both drugs can be increased very slowly over several weeks to a maximum of 600 mg per day.

Nefazodone and trazodone have short half-lives. The half-life is the time it takes your body to get rid of half of the drug that is in your system. A drug with a short half-life leaves the blood fairly rapidly and must be taken two or three times per day. In contrast, a drug like Prozac, with an extremely long half-life, leaves your body slowly and needs to be taken only once per day.

As with any antidepressant, you should monitor your mood with a test like the one in Chapter 2 while taking trazodone and nefazodone. This will show whether the drugs are working, and to what extent. If you have not improved substantially after three or four weeks, it may be wise to switch to another

drug. Although withdrawal symptoms are quite rare for these medications, it is wise to taper off nefazodone and trazodone slowly, rather than stopping them suddenly. This is good advice with any antidepressant.

*Side Effects of Trazodone and Nefazodone.* The most common side effects of these two drugs are listed in Table 20–10 on page 601. One common side effect is stomach upset (such as nausea). This side effect is also common with the SSRIs and other drugs that stimulate the serotonin systems in the brain. The upset stomach is more likely when nefazodone and trazodone are taken on an empty stomach, and so it can be helpful to take them with food, just like the SSRIs.

Trazodone and nefazodone can also cause dry mouth in some patients. Both drugs can also cause a temporary drop in blood pressure when you stand up, resulting in dizziness or light-headedness. Trazodone is much more likely to cause these problems than nefazodone. Elderly people are more prone to dizziness and fainting, and so nefazodone may be a better choice for them. As discussed above, several things can alleviate this problem: get up more slowly; walk in place when you get up so as to “pump” blood back to your heart from your legs; use support stockings; and take adequate amounts of fluid and salt to prevent any dehydration. Talk to your doctor if you have problems with dizziness or other side effects; she or he may be able to lower the dose.

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**Table 20–10.** Side Effects of Serotonin Antagonists<sup>a</sup>

**Note:** This list is not comprehensive. In general, side effects that occur in 5% or 10% or more of patients are listed, as well as rare but dangerous side effects.

Side Effect	Sedation and Weight Gain	Light-Headedness and Dizziness	Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention	Common or Significant Side Effects
<i>Brain Receptor</i>	<i>histamine (<math>H_1</math>) receptors</i>	<i>alpha-adrenergic (<math>\alpha_1</math>) receptors</i>	<i>muscarinic (<math>M_3</math>) receptors</i>	
nefazodone (Serzone)	+ to ++	++	+	dry mouth and throat; headache; tiredness; insomnia; nausea; constipation; weakness; dizziness; blurred vision; abnormal vision; confusion
trazodone (Desyrel)	+++	++ to +++	0	dizziness; dry mouth and throat; upset stomach; constipation; blurred vision; headache; fatigue; sleepiness; confusion; anxiety; priapism (rare; see text)

<sup>a</sup>The + to + + + ratings in this table refer to the likelihood that a particular side effect will develop. The actual intensity of the side effect will vary among individuals and will also depend on how large the dose is. Reducing the dose can often reduce side effects without reducing effectiveness.

Another major side effect of trazodone is that it makes you sleepy. This is why it is best taken at night. If you are taking another antidepressant, your doctor may also prescribe a small dose of trazodone at bedtime in order to promote sleep. This is because some antidepressants, such as Prozac and the MAOIs, tend to be stimulating and may interfere with sleep. Trazodone is not addictive and it will not cause dependency or addiction the way some sleeping pills do. The calming, sedative effects of trazodone also help to reduce anxiety. If you tend to be worried and high-strung, this may be a good drug for you. Nefazodone is much less sedating than trazodone, and is not a useful medication for insomnia. In fact, it can occasionally have the opposite effect of causing restlessness, in much the same way that the SSRIs do.

Another adverse side effect of trazodone is called “priapism.” Priapism is an involuntary erection of the penis. Fortunately, this side effect is quite rare, occurring in approximately one male patient out of 6,000. It has been reported in only a few hundred cases so far. Personally, I have never seen a case of priapism, but men who take trazodone should be aware that it is remotely possible. If the priapism is not treated right away, it can lead to damage to the penis and permanent impotence (the inability to get an erection). Some patients require surgery to correct the priapism. Injecting a drug like epinephrine directly into the penis can sometimes counteract the priapism if you catch it quickly enough. If this unusual side effect does occur, or if you are beginning to notice an erection that will not go away, contact your doctor or go to an emergency room right away. Nefazodone, on the other hand, does not cause priapism.

Priapism sounds frightening, but I do not mean to discourage men from taking this medication. If you read the *Physician’s Desk Reference* carefully, you will see that there is a remote chance of a dangerous side effect from nearly any drug you might take, including aspirin. Priapism is a very unlikely side effect of trazodone and can be treated at any emergency room if you act rapidly when the symptom first develops.

Some patients taking these drugs report visual “trails” or afterimages when they are looking at objects that are moving. This side effect is also quite unusual and similar in some respects to the visual images reported by individuals who take LSD, but not dangerous. These visual trails are more common with nefazodone than with trazodone and occur in slightly more than 10 percent of patients taking this drug. They often improve over time.

*Drug Interactions for Trazodone and Nefazodone.* As noted earlier, some drug combinations can be dangerous because one drug causes the level of the other drug in your blood to become excessively high. Nefazodone has the effect of raising the blood level of a number of drugs. These include commonly prescribed drugs for anxiety, including many of the minor tranquilizers such as alprazolam (Xanax), triazolam (Halcion), buspirone (BuSpar) and others. As a result, you should be very cautious when combining these drugs with nefazodone, because you could become excessively sleepy.

Trazodone will also enhance the sedative effects of other sedative drugs because trazodone itself will make you sleepy. Consequently, trazodone or nefazodone can enhance the sedative effects of any drug that makes you sleepy, such as alcohol, barbiturates, sleeping pills, painkillers, some major tranquilizers (neuroleptics), and some antidepressants. Be very cautious if you combine any sedative agents with nefazodone or trazodone, especially if you are driving or operating dangerous machinery.

Nefazodone can increase the levels of several tricyclic antidepressants in your blood, especially amitriptyline (Elavil), clomipramine (Anafranil), and imipramine (Tofranil), so the doses of these drugs may need to be lower than usual.

If nefazodone is combined with one of the SSRIs, there is the possibility that a metabolite of nefazodone called mCPP (m-chlorophenylpiperazine) could build up in your blood. This substance may lead to agitation or feelings of panic or unhappiness. If you are switching from an SSRI to nefazodone, mCPP could also build up because the effects of the SSRIs can persist in your body for several weeks after you stop taking them. Neither trazodone nor nefazodone should be combined with an MAOI antidepressant because this combination could trigger the serotonin syndrome (hyperpyretic crisis) described previously.

If you are taking nefazodone, make sure you inform your psychiatrist about any blood-pressure medication you are taking, and inform your general medical doctor as well. Your blood pressure may drop more than expected if you combine trazodone with a blood-pressure medication. If your blood pressure does drop too much, you may notice dizziness when you suddenly stand up. Many psychiatric medications can also lower the blood pressure, including many of the tricyclic antidepressants as well as a number of the major tranquilizers (neuroleptics). If these drugs are combined with trazodone or nefazodone, the drop in blood pressure may be pronounced.

Trazodone can also cause increased blood levels of the anticonvulsant, phenytoin (Dilantin) as well as the heart medication, digoxin (Lanoxin). These combinations can lead to toxic blood levels of phenytoin or digoxin. Make sure your doctor monitors your blood levels of phenytoin or digoxin carefully if you take trazodone, as excessively high levels can be dangerous.

The effects of trazodone on the blood thinner, warfarin (Coumadin) are unpredictable. The levels of warfarin may increase or decrease. If the warfarin levels increase, you may have a greater tendency to bleed, and if the warfarin decreases, your blood may have a greater tendency to clot. Your doctor can monitor any changes with blood tests and adjust the dose of warfarin if necessary.

Even more dangerous are the previously described interactions between nefazodone and two commonly prescribed antihistamines that are given for allergies (terfenadine, trade name Seldane) and astemizole (trade name Hismanal). Nefazodone causes the levels of these two antihistamines to increase, which can result in potentially fatal changes in heart rhythms. Nefazodone should not be combined with cisapride (trade name Propulsid, a stimulant for the gastrointestinal tract) for the same reason—sudden fatal heart failure can result.

### **Bupropion (Wellbutrin)**

Three other types of antidepressant drugs are listed in the Table of Antidepressants on pages 514–515. These include bupropion (Wellbutrin), venlafaxine (Effexor), and mirtazapine (Remeron). They are somewhat different from each other and from the antidepressants already discussed.

Bupropion was supposed to be introduced in the United States in 1986, but its release was delayed until 1989 because a number of patients with bulimia

(binge-eating followed by vomiting) who were treated with this drug had seizures. Further studies indicated that the danger of seizures was related to the dose of bupropion and that the risk was much lower in patients who did not have eating disorders, so the drug was released again. Because of the increased seizure risk with bupropion, the manufacturer recommends that this drug not be prescribed to anyone with a history of epilepsy, a major head injury, a brain tumor, bulimia, or anorexia nervosa.

Bupropion does not affect the serotonin system in the brain. Instead, it seems to work by potentiating the norepinephrine system, much like the tricyclic antidepressant called desipramine (Norpramin). There is also some evidence that it may stimulate the dopamine system in the brain, but these effects are much weaker, and it is not clear whether they contribute to the antidepressant effects of bupropion. Nevertheless, bupropion is sometimes classified as a “combined noradrenergic-dopaminergic antidepressant,” because of its effects on the norepinephrine and dopamine systems.

Bupropion is used to treat depressed outpatients and inpatients over the entire range of depression severity. Preliminary studies suggest that it may also be useful for a number of other problems, including smoking cessation, social phobia, and attention deficit disorder. These widespread effects of bupropion do not mean this drug is special, however. Nearly all antidepressants have been reported to be at least partially effective for a wide array of problems including depression, all of the anxiety disorders, eating disorders, anger and violence, chronic pain, and many other problems as well. One possible interpretation for these findings is that these drugs may not really be specific antidepressants. Instead, they may have widespread effects throughout the brain.

A new use for bupropion is to enhance the effects of the SSRI antidepressants. Suppose, for example, that you are taking a drug like Prozac but you have not responded to it adequately. Instead of switching you to a new drug, your doctor may add a low dose of bupropion in an attempt to enhance the effect of the Prozac. Bupropion, in doses of up to 225 mg to 300 mg per day, has been added to SSRI antidepressants in an attempt to combat the sexual side effects of SSRIs, such as loss of libido and difficulties having orgasms.

In my clinical experience, the effects of these drug combinations have often been disappointing. I would usually prefer to try another medication

rather than combining drugs when a medication does not work. I am personally concerned that in some instances patients may be in danger of being overmedicated by physicians who are a bit too enthusiastic about adding more and more drugs in larger and larger doses. Also, because I rely so heavily on psychotherapeutic interventions in my own clinical work, I do not feel so much pressure to find a solution from drugs alone. Therefore I do not feel quite so much concern when one or more medications fails to work. I simply switch to another medication and continue to try a variety of new psychotherapeutic strategies, a combination that I find most successful.

*Doses of Bupropion.* You can see in Table 20–1 on pages 518–523 that the usual dose range for bupropion is 200 to 450 mg per day. At doses below 450 mg per day, the risk of seizures appears to be about four patients per 1000. However, the risk is ten times higher at doses above 450 mg per day—four patients per 100 will experience seizures. Whenever possible, it is good to keep the dose in the lower range to minimize the chance of seizures. In addition, no single dose should ever be greater than 150 mg.

*Side Effects of Bupropion.* The most common side effects of bupropion are listed in Table 20–11 on pages 608-609. Unlike the tricyclics, bupropion does not cause dry mouth, constipation, dizziness, or tiredness. It also does not stimulate the appetite. This is a big bonus for patients who have been bothered by weight gain. However, some patients have reported upset stomach (nausea).

Bupropion is also somewhat activating and can cause insomnia. Therefore, it may be relatively more effective for depressed patients who tend to feel tired, lethargic, and unmotivated—the stimulating effect may help get you moving. In this regard, it is similar to some of the tricyclic antidepressants (for example, desipramine), the SSRIs (for example, Prozac) and the MAOIs (for example, tranylcypromine).

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**Table 20–11.** Side Effects of Other Antidepressants<sup>a</sup>

**Note:** This list is not comprehensive. In general, side effects that occur in 5% or 10% or more of patients are listed, as well as rare but dangerous side effects.

<b>Side Effect</b>	<b>Sedation and Weight Gain</b>	<b>Light-Headedness and Dizziness</b>	<b>Blurred Vision, Constipation, Dry Mouth, Speeded Heart, Urinary Retention</b>	<b>Common or Significant Side Effects</b>
<b>Brain Receptor</b>	<b>histamine (<math>H_1</math>) receptors</b>	<b>alpha-adrenergic (<math>\alpha_2</math>) receptors</b>	<b>muscarinic (<math>M_3</math>) receptors</b>	
<b>bupropion (Wellbutrin)</b>	0 to +	0 to +	0 to +	dry mouth; sore throat; upset stomach; loss of appetite; stomach pain; sweating; headache; insomnia; restlessness; tremor; anxiety; sweating; dizziness; rash; ringing in ears; seizures
<b>venlafaxine (Effexor)</b>	0	0	0	dizziness; dry mouth and throat; upset stomach; loss of appetite; constipation; sweating; headache; drowsiness; insomnia; anxiety;
<b>mirtazapine (Remeron)</b>	+++	++	+ to +++	weakness; tremor; blurred vision; problems with orgasm; loss of interest in sex; abnormal dreams; increased blood pressure  dry mouth; increased appetite and weight gain; constipation; sleepiness; dizziness. Warning: Consult your M.D. if you develop signs of an infection (such as fever). This could indicate a rare fall in the white cell count, a rare but dangerous side effect. Can also cause increased blood levels of cholesterol and triglycerides

**a**The + to + + + ratings in this table refer to the likelihood that a particular side effect will develop. The actual intensity of the side effect will vary among individuals and will also depend on how large the dose is. Reducing the dose can often reduce side effects without reducing effectiveness.

*Drug Interactions for Bupropion.* Because bupropion can substantially increase the risk of seizures, it should not be combined with other drugs that can also make a person more vulnerable to seizures. This includes many psychiatric drugs such as the tricyclic and tetracyclic antidepressants, the SSRIs, the two serotonin antagonists (trazodone and nefazodone), and many of the major tranquilizers (neuroleptics). In addition, there is a greatly increased risk of seizures when alcoholics suddenly stop drinking or when individuals abruptly stop taking minor tranquilizers (benzodiazepines such as Xanax or Valium), barbiturates, or sleeping pills. Bupropion is therefore

especially risky for alcoholics and for individuals taking sedatives or tranquilizers regularly.

Many nonpsychiatric drugs (for instance, corticosteroids) can also increase the risk of seizures. Therefore, great caution must be exercised if bupropion is combined with any of these drugs, especially if the dose of bupropion is high. Make sure you check with your pharmacist or druggist about drug interactions if you are taking any other medication along with bupropion.

There are several other kinds of drug interactions you need to consider if you are taking bupropion:

- Barbiturates can cause the level of bupropion in the blood to fall. This could make the bupropion ineffective.
- Phenytoin (Dilantin) can also cause bupropion levels to fall, thus making the bupropion less effective. However, phenytoin is most often prescribed for epilepsy, and so patients taking phenytoin are not likely to receive bupropion.
- Cimetidine (Tagamet) may increase bupropion levels in the blood. This can increase the likelihood of side effects or toxic effects, including seizures.
- Bupropion must not be combined with the MAOIs because of the risk of a hypertensive crisis.
- L-dopa increases the side effects of bupropion; caution is required when these drugs are combined.

## **Venlafaxine (Effexor)**

This is a relatively new antidepressant that is in a distinct class from other antidepressant medications. Released in 1994, it is called a “dual uptake inhibitor” or “mixed uptake inhibitor.” This has a very simple meaning. It leads to increases in two types of chemical messengers (also called neurotransmitters) in the brain—serotonin and norepinephrine—by blocking the pumps that transport them back into the presynaptic nerves after they are released into the synapses.

As you will recall from Chapter 17, this capacity to increase levels of two different types of chemical messengers is not new. Many of the older and cheaper tricyclic antidepressants, such as Elavil (amitriptyline) also do this. The more important difference with venlafaxine is that it has fewer side effects because it does not stimulate the histaminic, alpha-adrenergic, and muscarinic brain receptors that cause tiredness, dizziness, dry mouth, and so forth. However, as you will see below, venlafaxine has quite a number of side effects of its own. Some of these, such as nausea, insomnia, and sexual difficulties, are similar to the SSRI antidepressants, and some (such as tiredness) are similar to the tricyclic antidepressants.

It has been claimed that the onset of action may be faster with venlafaxine because of its dual effects on serotonin and norepinephrine receptors. This does not seem likely, because the older tricyclic antidepressants also have dual effects on serotonin and norepinephrine receptors in the brain, but do not have rapid antidepressant effects. Research is now in progress to try to determine whether venlafaxine really does work any more rapidly.

Although a faster-acting antidepressant would represent an important breakthrough, we should probably not become too optimistic about this. Claims about the superior properties of new antidepressants have often not been substantiated by careful, systematic, independent research after the drugs have been available on the market for a period of time. In addition, you will see below that venlafaxine must be started at low doses and increased very slowly to prevent side effects from developing. For most patients, this will prevent the drug from having any rapid antidepressant effects.

Studies are in progress to examine the larger question of whether drugs with dual action have stronger antidepressant effects than SSRIs for certain types of patients, especially severely depressed patients who are hospitalized.

This is important because the SSRIs (such as Prozac) which are now so popular have not been particularly effective for these patients. In one study, venlafaxine was more effective than Prozac in the treatment of inpatients with “melancholic” depression. “Melancholic” depression refers to a more severe depression with many organic features, such as waking up too early and a loss of appetite and sexual drive. Individuals with melancholic depressions may also have anhedonia along with feelings of guilt that can become extreme or even delusional. Anhedonia refers to a severe loss of the capacity to experience pleasure or satisfaction.

Like all antidepressants, venlafaxine is beginning to be used for a number of other disorders as well. These include chronic pain disorder as well as adult attention deficit disorder (ADD). Remember that all, or nearly all, antidepressants have been used for a great variety of disorders, so it is not likely that the effects of venlafaxine are superior for chronic pain or for ADD.

*Doses of Venlafaxine.* Some experts recommend starting venlafaxine at 18.75 mg twice per day, which is only half the starting dose recommended by the manufacturer, in order to minimize the likelihood that nausea will develop.<sup>1</sup> Then the daily dose can be slowly increased by 37.5 mg every third day until a total dose of 150 mg per day or above is reached. Most patients respond to a total dose of 75 mg to 225 mg per day. Higher doses tend to be more effective, but they are associated with more side effects.

Earlier when discussing SSRIs, we talked about the half-life of drugs—this is the time required by the body to eliminate one half of the drug in your body. Venlafaxine has a short half-life—meaning that it leaves your body in a matter of hours. Therefore, you must take the medication two or three times per day to maintain an adequate level in your bloodstream.

The manufacturer has recently marketed an extended (slow) release version of venlafaxine (called Effexor XR) that you need to take only once per day, which is more convenient. As you can see in Table 20–1 on page 521, the extended release capsules appear to be more costly, but this is really an illusion. For example, you can see in the table that the average wholesale price of a hundred of the 75 mg capsule of Effexor is \$118.66, whereas the price of a hundred of the 75 mg extended-release capsules is \$217.14, or almost twice as much. When I first saw these figures, I naturally concluded

that the extended-release capsules were twice as expensive as the regular pills.

But let's see what happens in a real-life situation. Suppose your dose is 75 mg per day. You could take either one of the regular 37.5 mg pills in the morning and a second 37.5 mg pill in the evening, for a total cost of \$2.17 per day, or one of the 75 mg extended-release pills once per day. As noted above, the cost of the 75 mg extended-release pills will also be \$2.17 per day. Either way, Effexor is very expensive, since the daily dose may be as high as 375 mg per day. The high price is especially striking when you compare the cost of Effexor with the cost of many of the generic tricyclic antidepressants that are just as effective and available for less than ten cents per day.

As with any antidepressant, it is best to taper off venlafaxine slowly. At least two weeks are recommended, and some patients may require as much as four weeks.

*Side Effects of Venlafaxine.* The side effects of venlafaxine are listed in Table 20–11 on pages 608–609. As you can see, they are similar to the SSRI compounds described above. The most common side effects of venlafaxine are nausea, headache, sleepiness, insomnia, abnormal dreams, sweating, nervousness, and tremor. Venlafaxine can also cause the same types of sexual difficulties as the SSRIs, including a loss of interest in sex and difficulties achieving orgasm. These sexual side effects tend to be quite common, just as with the SSRIs. In spite of the claim that venlafaxine has fewer side effects than the older tricyclic antidepressants, this drug can nevertheless cause dry mouth and dizziness in some patients. The dizziness is particularly likely if you go off the drug too quickly.

One distinct type of side effect seen with venlafaxine is an increase in blood pressure. However, the blood-pressure increases are typically seen only at higher doses (225 mg per day or above). Nevertheless, if you have problems with your blood pressure, you and your doctor should monitor your blood pressure carefully, and this drug may not be a good choice for you. At doses less than 200 mg per day, the likelihood of an increase in blood pressure is only about 5 percent. The probability increases to 10 percent or 15 percent at doses greater than 300 mg per day. Blood-pressure increases of 20 to 30 mm of mercury have been observed, for example.

*Drug Interactions for Venlafaxine.* Because venlafaxine is relatively new, information about its interactions with other drugs is still relatively limited. Venlafaxine appears to be less likely to interact in adverse ways with other medications you are taking. Several drugs may cause blood levels of venlafaxine to increase, and so lower doses of venlafaxine may be needed. These include:

- some tricyclic antidepressants;
- the SSRI antidepressants;
- cimetidine (Tagamet).

Venlafaxine may cause the blood levels of several of the major tranquilizers to increase. These include trifluoperazine (Stelazine), haloperidol (Haldol), and risperidone (Risperdal), and so lower doses of these drugs may be needed. In theory, these drugs could also cause blood levels of Venlafaxine to increase.

Venlafaxine must not be combined with MAOI antidepressants because of the danger of the serotonin syndrome (hyperpyretic crisis) described on page 576. Remember that it takes up to two weeks for the effects of an MAOI to clear out of your body, so a two-week drug-free period will be required if you stop taking an MAOI and then start taking venlafaxine. In contrast, if you go off venlafaxine and then start taking an MAOI, a one-week drug-free period should be sufficient, because venlafaxine leaves the body fairly rapidly.

### **Mirtazapine (Remeron)**

Mirtazapine (Remeron) was released in the United States in 1996. It also enhances both norepinephrine and serotonin activity, but through a different mechanism from venlafaxine. Premarketing studies suggest that mirtazapine may be effective for mildly depressed outpatients and for more severely depressed inpatients as well. It may also be particularly helpful for depressed patients who are very anxious or nervous.

*Doses of Mirtazapine.* The dose range for mirtazapine is 15 to 45 mg per day. Most physicians will prescribe a smaller amount at first (7.5 mg per day) and then slowly increase the dose. Because mirtazapine causes sleepiness in more than 50 percent of the people who take it, it can be given once a day at bedtime, usually in doses of 15 to 45 mg per day. Some physicians report that

mirtazapine is less likely to cause less sleepiness when the dose is increased. This is the opposite of what you might expect intuitively. It is because the drug may have some stimulating effects at the higher doses. We will have to wait until there is more clinical experience with this drug to see if this is really true.

*Side Effects of Mirtazapine.* The side effects of mirtazapine are listed in Table 20–11 on pages 608–609. You can see that it blocks the histaminic, alpha-adrenergic, and muscarinic receptors in much the same way that the older tricyclic antidepressants do. Therefore, the side effect profile of mirtazapine is very similar to the tricyclics, especially amitriptyline, clomipramine, doxepin, imipramine and trimipramine (see Table 20–2). The more common side effects include tiredness (54 percent of patients) noted above, increased appetite (17 percent), weight gain (12 percent), dry mouth (25 percent), constipation (13 percent), and dizziness (7 percent). Keep in mind that these figures are somewhat inflated because they do not take into account the placebo effect. For example, 2 percent of patients on placebo also report weight gain, and so the true incidence of weight gain that can be attributed to the mirtazepine would be 12 percent minus 2 percent, or 10 percent. Mirtazepine is not likely to cause the stomach upset, insomnia, nervousness, and sexual problems commonly seen with the SSRIs such as Prozac.

Mirtazapine has some unique adverse effects not shared with other antidepressants. It can, in rare cases, cause your white blood cell count to fall. Because these cells are involved in fighting off infections, this could make you more vulnerable to a variety of infections. If you develop a fever while taking this drug, make sure you contact your physician immediately so that he or she can obtain a complete blood count. Mirtazapine can sometimes cause an increase in levels of blood fats such as cholesterol and triglycerides. This could be a problem if you are overweight or have a heart condition or if your cholesterol and triglycerides levels are already elevated.

*Drug Interactions for Mirtazapine.* Because mirtazapine is relatively new, very little information about its drug interactions is available. It must not be combined with the MAOI antidepressants because of the risk of the serotonin syndrome (hyperpyretic crisis). Because it can be quite sedating, it will enhance the effects of other sedative drugs. These include alcohol, major and

minor tranquilizers, sleeping pills, some antihistamines, barbiturates, many other antidepressants, and the antianxiety drug buspirone (BuSpar). The increased sleepiness you experience when these substances are combined with mirtazapine could lead to difficulties with coordination and concentration. This might be hazardous when driving or operating dangerous machinery.

## Mood Stabilizers

### *Lithium*

In 1949, an Australian psychiatrist named John Cade observed that lithium, a common salt, caused sedation in guinea pigs. He gave lithium to a patient with manic symptoms and observed dramatic calming effects. Tests of the effects of lithium in other manic patients yielded similar results. Since that time, lithium has slowly gained popularity throughout the world. It has been used successfully in the treatment of a number of conditions, including:

Acute manic states. Although lithium is used to treat patients with severe mania, they will usually be treated with more potent, faster-acting drugs at the same time until the severe symptoms of mania have subsided. These other drugs include the antipsychotics (also known as major tranquilizers or neuroleptics) such as chlorpromazine (Thorazine), as well as benzodiazepines (also called “minor tranquilizers”) such as clonazepam (Klonopin) or lorazepam (Ativan). These additional drugs are used until the mania has been brought under control. Once the severe manic symptoms subside, the other drugs are discontinued and the patient continues taking the lithium to prevent future mood swings.

- Recurrent manic and depressive mood swings in individuals with bipolar manic-depressive illness. Lithium has significant preventative effects, so that the likelihood of future manic episodes is reduced.
- Single episodes of depression. Lithium is sometimes added in smaller doses to an antidepressant drug that is not working in order to try to improve its effectiveness. I will describe this and other augmentation strategies later in the chapter.
- Recurrent episodes of depression in patients without manic mood swings. Lithium maintenance may help to prevent recurrences of depression

following recovery. Some studies indicate that the preventative effects of long-term lithium treatment may be similar to the effects of long-term treatment with an antidepressant such as imipramine. However, this preventative effect on depression may not work for all patients. Lithium is probably more likely to prevent depressions in patients with a strong family history of bipolar (manic-depressive) illness.

- Individuals with episodic anger and irritability or outbursts of violent rage.
  - Individuals with schizophrenia. Lithium can be combined with an antipsychotic medication, and the combination may be more effective than the antipsychotic medication alone. The improvement seems to occur in schizophrenic patients who also experience mania or depression and in schizophrenic patients without any symptoms of mania or depression.

You should keep in mind that in all of these conditions, lithium is sometimes helpful but rarely ever curative. Like most medications, it is a valuable tool but not a panacea.

As noted above, manic-depressive illness is sometimes also called bipolar illness. “Bipolar” simply means “two poles.” Patients with bipolar illness experience uncontrollable euphoric mood swings that often alternate with severe depressions. The manic phase is characterized by an extremely ecstatic, euphoric mood, inappropriate degrees of self-confidence and grandiosity, constant talking, nonstop hyperactivity, increased sexual activity, a decreased need for sleep, heightened irritability and aggressiveness, and self-destructive impulsive behavior such as reckless spending binges. This extraordinary disease usually develops into a chronic pattern of uncontrollable highs and lows that can come on unexpectedly throughout your life, so your physician may recommend that you continue to take lithium (or another mood stabilizing drug) for the rest of your life.

If you have experienced abnormal mood elevations along with your depression, your physician will almost definitely prescribe lithium or another comparable mood-stabilizing drug. Some studies suggest that if you are depressed and have a definite family history of mania, you might benefit from lithium even if you have never been manic yourself. However, most physicians would first prescribe a standard antidepressant and observe you

carefully. Although antidepressants do not usually cause euphoria or mania in people with depression, they can occasionally have this effect in individuals with bipolar manic-depressive illness. The mania can begin as quickly as twenty-four to forty-eight hours after starting the antidepressant.

In my clinical practice, the development of a sudden and dangerous manic episode after starting an antidepressant has been quite rare, even in patients with bipolar illness. Nevertheless, if you have a personal or family history of mania, it is conceivable that you could experience this side effect. Be sure to tell your doctor about this so you can receive careful follow-up after starting an antidepressant. Your family, too, should be alerted to this possibility. Family members are often aware of the development of a manic episode before the patient realizes what is happening, and can alert the doctor that a problem has developed. This is because the distinction between normal happiness and the beginning of the mania may be unclear to the patient. Furthermore, mania feels so good at first that you may not recognize it as a dangerous side effect of the medication you are taking.

*Doses of Lithium.* As you will see in Table 20–1, lithium comes in 300-mg dosages, and normally three to six pills per day in divided doses are required. Your physician will guide you. Initially, you may take the lithium three or four times per day. Once you are stabilized on lithium, you may be able to take half your total daily dose in the morning and half before you go to bed. This twice-a-day schedule will be more convenient.

Sustained-release capsules containing 450 mg are also available. Because these drugs are released more slowly in the stomach and gastrointestinal tract, they may cause fewer side effects and they are more convenient because you don't have to take them so often. However, their increased cost, as compared with generic lithium, may not justify taking them. Furthermore, many patients have reported that the side effects of the inexpensive, generic brands of lithium are no different from the more expensive slow-release brands.

Like the other drugs used for treating mood disorders, lithium usually requires between two and three weeks to become effective. When taken for a prolonged period of time, its clinical effectiveness seems to increase. Thus, if you take it for a period of years, it may help you more and more.

Unfortunately, there appears to be a group of individuals who do well on lithium, stop taking it, become symptomatic again, and then find that the

lithium is less effective when they start taking it again. This is one reason why you should not stop taking lithium, or any other medication, without first consulting with your doctor.

*Lithium Blood Testing.* Too much lithium in your blood can cause dangerous side effects. In contrast, if your blood level is too low, the drug will not help you. Because there is a narrow “window” of effectiveness of lithium, blood-level testing is required to make sure that your dose is neither too high nor too low. Initially, your doctor will order more frequent blood tests so that she or he can determine what the proper dose should be. Later on, when your dose and symptoms have stabilized, you will not need the blood tests nearly as frequently.

If you are an outpatient and you are not experiencing severe mania, your doctor may order lithium blood tests once or twice a week for the first couple weeks, then once a month. Eventually, blood tests every three months may be sufficient.

If you are being treated for a more severe episode of mania, more frequent blood tests will be required. This is because higher blood levels of lithium are usually needed to control the severe symptoms. In addition, your body tends to get rid of lithium more rapidly during an episode of mania, so larger doses may be needed to maintain the proper blood level. As noted above, during a manic episode your doctor will almost definitely want to combine lithium with more potent drugs for the first few weeks until your symptoms have subsided.

Your blood must be drawn eight to twelve hours after your last lithium pill. The best time for a blood test is first thing in the morning. If you forget and take your lithium pill the morning of a blood test, *don't take the test!* Try again another day. Otherwise, the results will be misleading to your doctor.

Body size, kidney function, weather conditions, and other factors can influence your lithium dose requirement, so blood tests should be performed on a regular basis when you are on lithium maintenance. Your doctor will probably try to maintain your blood level at somewhere between 0.6 and 1.2 mg per cc, but this will vary with your symptom level. During an episode of acute mania, your doctor will probably want to keep your blood level closer to the top of the therapeutic range. Some doctors feel that levels as low as 0.4

to 0.6 mg per cc can be effective to help prevent an episode of depression or mania when you are feeling good.

Patients with chronic irritability and anger may also respond to lithium at these lower blood levels, even if they don't suffer from clear symptoms of manic-depressive illness. The advantage of these lower levels is that there are fewer side effects.

*Other Medical Tests.* Prior to treatment, the doctor will evaluate your medical condition and order a series of blood tests and a urinalysis. These blood tests will usually include a complete blood count, tests of thyroid and kidney function, electrolytes, and blood sugar. Your thyroid functioning should be tested at six-month or yearly intervals while you are taking lithium because some patients on lithium develop goiters (a swelling or lump on the thyroid gland) or underactive thyroid glands. Your kidney function must also be evaluated from time to time because of kidney abnormalities reported in some patients taking lithium. Your doctor may order an electrocardiogram (ECG) before you start taking the lithium, especially if you are over forty or if you have a history of heart problems. Your doctor will also need to know about any other drugs you may be taking, because some of them may cause elevations in your blood lithium level. These include certain diuretics as well as some anti-inflammatory drugs such as ibuprofen, naproxen, and indomethacin. You will learn below that some drugs can have the opposite effect of causing your lithium level to fall.

*Side Effects of Lithium.* The side effects of lithium are listed in Table 20–12 on pages 624–625 and compared with the side effects of two other mood stabilizers I will discuss below. As you can see, lithium tends to have many side effects. Most of them are mildly uncomfortable but not serious.

Starting with the effects on the muscles and nervous system first, you will see that lithium can cause a fine tremor of the hands and fingers in 30 percent to 50 percent of patients. This tremor will be present when your hands are resting and often worsens when you do something purposeful with your hands. For example, the tremor can make it more difficult to hold a cup of coffee or to write clearly. The severity of the tremor is related to the dose and may be more severe when lithium is prescribed along with one of the tricyclic antidepressants, which can also cause tremor.

This tremor is one of the major reasons that some patients stop taking their lithium. An antitremor drug called propranolol (Inderal) can be given if the tremor is especially severe and troublesome, but it is my policy to avoid prescribing an additional drug if possible. A reduction in dose can also help.

If your doctor does prescribe propranolol, the usual dose to reduce a lithium tremor is 20 to 160 mg per day, given in divided doses. It is best to start with small doses and increase gradually. The smallest effective dose is best. This is because propranolol can have other effects, including a slowing of the heart, a drop in blood pressure, weakness and fatigue, mental confusion, and upset stomach. Propranolol can also cause breathing difficulties and must not be given to patients with asthma. It is also contraindicated for patients with Raynaud's disease. Metoprolol (25 to 50 mg) or nadolol (20 to 40 mg), drugs similar to propranolol, have also been used to treat lithium tremor.

Lithium may cause tiredness and fatigue initially, but these effects will generally disappear with time. Some patients complain of mental slowing or forgetfulness, particularly younger individuals. The forgetfulness has been confirmed by memory testing. Other antidepressants that have anticholinergic properties, such as Elavil, can also cause forgetfulness. Complaints about these mental changes are very common and cause many patients to stop taking their lithium. Memory difficulties seem to be more pronounced at higher lithium blood levels, as might be expected, and often improve when the dose is reduced.

**Table 20–12.** Side Effects of the Mood Stabilizers<sup>a</sup>

Category	<i>lithium</i>	<i>valproic acid</i>	<i>carbamazepine</i>
<b>Muscles and Nervous System</b>	tremor problems with coordination tiredness mental slowing or dulling memory loss	tremor problems with coordination tiredness weakness	dizziness problems with coordination tiredness weakness
<b>Stomach and Gastrointestinal Tract</b>	upset stomach weight gain diarrhea	upset stomach weight gain abnormalities in liver function pancreatitis	upset stomach abnormalities in liver function dry mouth
<b>Kidneys</b>	nephrogenic diabetes insipidus (excessive urination and thirst) interstitial nephritis, leading to (usually mild) renal insufficiency		syndrome of inappropriate secretion of antidiuretic hormone (SIADH)

<b>Skin</b>	rash hair loss acne	rash hair loss	rash
<b>Heart</b>	ECG changes		abnormal heart rhythms
<b>Blood</b>	increased white blood cell count	decreased platelets with bleeding problems	decreased platelets with bleeding problems bone marrow failure (rare)
<b>Hormonal</b>	hypothyroidism	menstrual changes	decreased levels of thyroid hormones (T3 and T4)

<sup>a</sup>Information in this table was obtained in part from the *Manual of Clinical Psychopharmacology*<sup>1</sup> and *Psychotropic Drugs Fast Facts*.<sup>17</sup> These excellent references are highly recommended.

Along the same lines, some patients complain of substantial weakness and fatigue. These symptoms often indicate an excessive lithium level, and a dose reduction may be indicated. Extreme sleepiness with mental confusion, a loss of coordination, or slurred speech suggests a dangerously elevated lithium level. Discontinue the drug and seek immediate medical attention if such symptoms appear.

Some patients express the fear that they may lose their creativity when they start taking lithium. This is especially of concern for artists and writers who have used their highs and lows as a source of painful inspiration for creative expression. Indeed, many well-known painters and poets through the centuries suffered from manic-depressive illness, and their moods were clearly reflected in their work. However, three quarters of patients on lithium report that it does not seem to reduce their creativity, and in some cases their creativity increases.<sup>1</sup>

Turning next to the digestive system, lithium can cause an upset stomach or diarrhea that is most troublesome during the first few days of treatment. These side effects will usually disappear with time. It may help to take the lithium with food or to take it in three or four divided doses throughout the day, so that your stomach isn't hit with a large dose all at once. It can also help to increase the dose of lithium more slowly. In rare cases lithium can cause vomiting as well as diarrhea, and your body may become dehydrated because of all the fluid loss. This can make your blood levels of lithium higher, and so the drug becomes more toxic. This, in turn, can cause more nausea and diarrhea, creating a vicious cycle. Medical attention may be needed to make sure you are adequately hydrated until the episode has passed.

Unfortunately, many patients on lithium experience weight gain; this is another common reason patients stop taking the drug. Dr. Alan Schatzberg<sup>1</sup> has suggested that this problem will be greater if you are already overweight. The weight gain results from the stimulation of your appetite. This is often very difficult to control. Obviously, if you exercise more and eat less, the weight gain can be prevented or reversed, but this is often much easier said than done! If the weight gain is excessive or troublesome, switching to an alternative mood stabilizer, such as carba-mazepine, may be helpful.

Increased thirst and frequent urination can also occur when taking lithium. In some cases, patients develop intense thirst from urination that is so frequent and voluminous that the lithium must be stopped. This condition, known as nephrogenic diabetes insipidus (NDI), results from the effects of lithium on the kidneys. It is usually reversible when the lithium is stopped. In some cases, adding certain types of diuretics can also help. However, careful lithium monitoring must be performed, because these diuretics can cause increases in plasma lithium levels. Milder forms of increased urination probably occur in one half to three quarters of patients who take lithium.

Lithium can cause a form of kidney damage called "interstitial nephritis." This term simply means inflammation or irritation of the tissue. When first reported, psychiatrists were quite alarmed about this complication. Subsequent experience has indicated that although the problem may occur in 5 percent or more of patients who take lithium for many years, the degree of kidney impairment is usually mild. Your doctor will nevertheless want to monitor your kidney function periodically while you are on lithium. She or he will order two blood tests called the creatinine test and the blood urea nitrogen (BUN) test once or twice a year. These tests can be performed at the same time you are having your usual lithium blood test taken. If the tests indicate a change in kidney function, your doctor may request a consultation with a urologist and order a twenty-four hour creatinine clearance test. This is a more accurate test of kidney function and will involve saving all your urine for twenty-four hours in a special bottle that the clinical laboratory will give you. The results will help your doctor evaluate whether it will be safe for you to continue taking lithium.

An occasional patient will develop a rash, and patients with psoriasis who take lithium will often experience a flare-up of the condition. This may require consultation with a dermatologist, switching to another brand of

lithium, going off lithium temporarily, or switching to one of the other mood-stabilizing medications. Acne may also worsen during lithium treatment. This can be treated with antibiotics or retinoic acid, but in some cases the lithium may have to be stopped. Some patients complain of hair loss, but the hair usually grows back, whether or not the patient continues taking lithium. It is interesting to note that lithium-related hair loss occurs primarily in women, and hair can disappear from anywhere on the body. Hair loss is sometimes a sign of hypothyroidism (see below) and so your doctor may order a thyroid blood test if the problem persists.

Lithium can cause a variety of changes in the electrocardiogram (ECG), but these are usually not serious. Older patients, as well as those with heart disease, should have an ECG taken before they start on lithium, as noted above. The ECG can be repeated once you are stabilized on lithium to see if there are any changes in heart rhythm that might be a cause for concern.

You can see in Table 20–12 that lithium can also cause an increase in your levels of white blood cells. These are the cells that normally fight infection. A normal white blood cell count is in the range of 6,000 to 10,000. The white blood cell count in patients on lithium typically increases to the range of 12,000 to 15,000 per cc, elevations that are not considered dangerous. However, if you go to a physician because you are ill, make sure you remind him or her that you are taking lithium and that the lithium may cause a false elevation of your white blood cell count. Otherwise, your doctor may falsely conclude that you have a serious infection, even if you actually do not.

Finally, lithium can affect thyroid functioning in as many as 20 percent of patients. As noted above, one common effect is an increase in the size of the thyroid gland (called a “goiter”) without any changes in thyroid function. Other patients develop increases in the levels of thyroid stimulating hormone (TSH) in the blood. This indicates that the body is trying harder to stimulate the thyroid gland. As many as 5 percent of patients on lithium will develop hypothyroidism, and this may require treatment with thyroxine (0.05 to 0.2 mg per day), a thyroid hormone replacement. Hypothyroidism is more common in women than in men.

*Lithium Drug Interactions.* As you can see in Table 20–13 on pages 630–631, lithium interacts with many other drugs. Make sure you review this list

with your physician if you are taking other medications at the same time you are taking lithium.

The drugs near the top of the table may cause lithium levels in the blood to increase. This can lead to more side effects, including lithium toxicity. The dose of lithium may need to be reduced to maintain blood levels in the proper range. These drugs that cause increased lithium levels include several drugs commonly used in the treatment of high blood pressure, such as the so-called ACE inhibitors, the calcium channel blocking agents, and methyldopa (Aldomet). The calcium channel blocking agents in particular may lead to greater lithium toxicity, with symptoms such as tremor, loss of coordination, nausea and vomiting, diarrhea, and ringing in the ears. Caution is required if you combine lithium with any of these drugs.

Many common non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (Advil, Motrin, and other trade names) can also cause lithium levels to increase. Several antibiotics raise lithium levels, as does the common antifungal agent metronidazole (Flagyl), which is often used to treat vaginal infections. Several anticonvulsants are also listed in the top portion of Table 20–13. If you are taking any of these medications, you might need lower doses of lithium.

**Table 20–13.** Lithium Drug Interactions<sup>a</sup>

**Note:** This list is not exhaustive; new information about drug interactions comes out frequently. If you are taking lithium and any other medication, ask your doctor and pharmacist if there are any drug interactions.

Drugs Which Cause Blood Lithium Levels or Lithium Toxic Effects to Increase				
ACE (angiotensin-converting enzyme) inhibitors	alcohol antibiotics <ul style="list-style-type: none"><li>• ampicillin (Omnipen)</li><li>• spectinomycin (Trobicin)</li><li>• tetracycline (Achromycin)</li></ul>	antifungal agents <ul style="list-style-type: none"><li>• metronidazole (Flagyl)</li></ul> calcium channel blockers <ul style="list-style-type: none"><li>• diltiazem (Cardizem)</li><li>• nifedipine (Procardia)</li><li>• verapamil (Isoptin)</li></ul> anticonvulsants <ul style="list-style-type: none"><li>• carbamazepine (Tegretol)</li><li>• phenytoin (Dilantin)</li><li>• valproic acid (Depakene)</li></ul>	diuretics (thiazides) <ul style="list-style-type: none"><li>• chlorothiazide (Diuril)</li><li>• hydrochlorothiazide (Alosril)</li></ul> diuretics (potassium-saving type) <ul style="list-style-type: none"><li>• amiloride (Midamor)</li><li>• spironolactone (in Aldactazide)</li></ul> diuretics (loop type) <ul style="list-style-type: none"><li>• ethacrynic acid (Edecrin)</li><li>• furosemide (Lasix)</li></ul> ketamine low-salt diet	mazindol (Sanorex) methyldopa (Aldomet) non-steroidal anti-inflammatory drugs <ul style="list-style-type: none"><li>• diclofenac (Voltaren)</li><li>• ibuprofen (Advil)</li><li>• indomethacin (Indocin)</li><li>• ketoprofen (Orudis)</li><li>• piroxicam (Feldene)</li><li>• phenylbutazone (Butazolidin)</li></ul>
benazepril (Lotensin)				
catopril (Capoten)				
enalapril (Vasotec)				
fosinopril (Monopril)				
lisinopril (Prinivil, Vestri)				
quinapril (Accupril)				
ramipril (Altace)				

Drugs Which Cause Blood Lithium Levels or Lithium Toxic Effects to Decrease			
		Other Lithium Drug Interactions	
Drug	Effect	Drug	Effect
acetazolamide (Diamox) bronchodilators • albuterol (Proventil) • aminophylline (Mudrane) • theophylline (Bronkaid)	caffeine (in coffee, tea, soda, chocolate) corticosteroids • hydrocortisone (Cortef) • methylprednisolone (Medrol)	osmotic diuretics sodium bicarbonate salty foods urea	

<sup>a</sup>Some information in this table was obtained from *Psychotropic Drugs Fast Facts*, pp. 213–215.<sup>17</sup> This book is an excellent source of information on psychiatric medications.

If you have high blood pressure, you may also be treated with a diuretic (or water pill). Some diuretics cause lithium levels to increase. The loop diuretics and potassium-saving diuretics in Table 20–13 do not increase lithium levels as much as the thiazide diuretics that are listed there. Not all diuretics cause lithium levels to rise. For example, you can see in Table 20–13 that osmotic diuretics, which work a little differently from the others, can have the opposite effect of causing lithium levels to fall.

Your doctor may prescribe a low-salt diet if you have high blood pressure. However, a low-salt diet can cause lithium levels to rise. This is because your kidneys will excrete less salt in an attempt to preserve it. Since lithium is also a salt that is chemically very similar to table salt, your kidney will also excrete less lithium. By the same token, if you are sweating a great deal during the summer months, this can have the same effect of depleting your body of salt and causing your lithium levels to increase. Once again, your kidneys will try to preserve salt and lithium as well. Make sure you maintain an adequate intake of salt to compensate for the salt you will lose if you are sweating a great deal.

The opposite effect can also occur. You can also see in Table 20–13 that if you eat too much salt, it can cause lithium levels to fall. This is because your kidneys will sense that there is too much salt in your blood and will try to get rid of it. Your kidneys will excrete more lithium along with the extra salt.

In contrast, the drugs listed in the middle of Table 20–13 have the opposite effect of causing lithium levels in the blood to fall. As a result, lithium can

lose its effectiveness. You can see that several drugs used in the treatment of asthma reduce serum lithium levels. Caffeine also has the same effect, so if you are a heavy coffee drinker, you may need to cut down on coffee or take higher doses of lithium. Corticosteroids, which are used in many conditions including poison ivy, can also cause lithium levels to fall. The dose of lithium may need to be increased to maintain blood levels in the proper range if you are taking any of these drugs.

A number of other drug interactions are listed in Table 20–13. Psychiatrists used to think that the combination of lithium with certain antipsychotic medications (especially haloperidol) greatly increased the risk of a toxic effect called NMS (neuroleptic malignant syndrome). NMS consists of severe muscle rigidity and confusion along with elevated temperature, profuse sweating, increases in blood pressure, rapid heartbeat and breathing, trouble swallowing, abnormal kidney and liver function, and other symptoms. However, although any patient on antipsychotic drugs runs a small risk of developing NMS, recent clinical experience has indicated that the likelihood of NMS may be increased only slightly when antipsychotics are combined with lithium. Lithium is now often used in combination with antipsychotic drugs and may enhance their effects in the treatment of schizophrenia, as described above.

As with most psychiatric drugs, pregnant women should avoid lithium, if possible, because its use has been associated with birth defects involving the heart. This is not an all-or-nothing issue, and the potential benefits must be weighed against the potential hazards. The risk of a heart defect known as Ebstein's anomaly is twenty times greater than normal in mothers who take lithium, but the likelihood is still less than 1 percent. Other birth defects can also occur, especially when lithium is used during the first trimester of pregnancy. In addition, lithium (as well as some other psychiatric drugs) is secreted in human milk and should be avoided by nursing mothers. If lithium is needed, breastfeeding should be avoided.

If you or your doctor have any questions about lithium (as well as the other mood stabilizers described below), the lithium information center at the Madison Institute of Medicine, Madison, Wisconsin, can often help.<sup>22</sup>

### *Valproic Acid*

Valproic acid is usually used in the treatment of epilepsy but was recently granted FDA approval for the treatment of bipolar disorder, especially acute mania. You can see in Table 20–1 on page 522 that this drug is prescribed in one of two forms: valproic acid (Depakene) or the slightly more expensive divalproex sodium form (Depakote). The two forms are equally effective. Studies comparing valproic acid with lithium indicate that the two drugs are comparably effective and both appear to be twice as effective as a placebo. Valproic acid, like lithium, also appears to be effective in preventing or reducing future manic episodes. The drug may be especially effective in the treatment of the rapid-cycling form of bipolar disorder. It can help patients who experience mania and depression at the same time (so-called “mixed states”), as well as patients who experience the more common forms of bipolar disorder. It is probably less effective in the prevention and treatment of depression than in the prevention and treatment of mania.

*Doses for Valproic Acid.* It is best to start valproic acid gradually, in order to minimize the side effects. The dose on the first day might be 250 mg administered with a meal. During the first week, the dosage can be gradually raised up to 250 mg given three times a day. As with any medication, the dose you receive may be slightly different depending on your size, gender, and clinical symptoms. For example, a man who weighs 160 pounds might be started on 500 mg twice a day.

During the second and third weeks, the dose may be slowly increased further. Most patients end up with a total daily dose in the range of 1,200 to 1,500 mg, given in divided doses (for example, 400 mg three times per day). Individual doses can vary widely. Some patients respond to as little as 750 mg per day and others need as much as 3,000 mg per day. As with any drug, doses outside the normal range are occasionally needed.

Some improvement should be observed within two weeks of attaining a therapeutic blood level. If you respond to valproic acid, your doctor may suggest that you remain on it for an extended period of time, just like lithium.

*Blood Testing.* Your doctor will order blood tests to adjust your dose of valproic acid. Initially your doctor may order a blood test once a week until your dose and blood level are stabilized. After that you will need a blood test only every month or two.

The blood should be drawn approximately twelve hours after your last dose, just like the lithium blood test. Most patients take valproic acid in divided doses twice a day. If so, the blood can be drawn in the morning, before you take your first daily dose. Most physicians think that a blood level of 50 to 100 micrograms per ml is therapeutic, but others are comfortable with blood levels up to 125 mcg per ml, especially if the patient is acutely manic. Of course, more side effects are observed at the higher blood levels.

Prior to treatment, your doctor will probably order a blood test to check your liver enzymes, a bleeding test, and a complete blood count (which includes a platelet count). These additional blood tests are performed because in rare cases valproic acid can cause hepatitis (an inflammation of the liver) as well as bleeding problems. From time to time after you have been on valproic acid, your doctor will repeat these tests to make sure that no changes have occurred. Many physicians feel that it is probably necessary to check the blood count and liver enzymes only every six to twelve months, especially if the patient has been educated to report immediately any signs or symptoms that indicate a liver inflammation, as described below. You should also tell your doctor if you notice any excessive bleeding or easy bruising.

Temporary increases in liver enzymes have been reported in as many as 15 percent to 20 percent of patients during the first three months of treatment. In most cases, these elevations are not considered serious. Nevertheless, if your liver enzymes do change, your doctor will probably reduce the dose of valproic acid and continue to monitor the liver enzymes. Your doctor will also want you to be educated about the symptoms of hepatitis so you can contact him or her immediately if they develop. Jaundice is the classic symptom. Jaundice is a condition in which your urine becomes dark and your skin and eyes become yellow in color. In addition, your bowel movements become pale. When the liver becomes inflamed, the pigment that normally causes your bowel movements to become brown gets backed up in your blood, staining your eyes, skin, and urine. Other symptoms of hepatitis include fatigue, nausea, a loss of appetite, tiredness, and weakness. Fortunately, hepatitis only rarely complicates treatment with valproic acid and can usually be treated successfully, especially if you notify your physician right away.

Although the liver inflammation is nearly always mild, it is important to watch carefully for these symptoms because they could, in theory, progress to

fatal liver failure. This complication has been observed in infants and is rarely seen in adults. It usually occurs in individuals taking other anticonvulsants at the same time. In fact, some experts assert that it has not been seen in adults who take only one anticonvulsant.<sup>17</sup>

*Side Effects of Valproic Acid.* The side effects of valproic acid are listed in Table 20–12 on pages 624–625. On the average, valproic acid is usually better tolerated by patients than lithium because it has fewer side effects. Sleepiness is a common side effect. Taking more of your daily dose in the evening before you go to bed can often prevent the sleepiness from being problematic. Valproic acid can also cause stomach upset which can take the form of nausea, vomiting, cramping, or diarrhea. These effects on the gastrointestinal tract are less common and can often be helped by taking a drug like Pepcid twice a day. Drs. J. S. Maxmen and N. G. Ward indicate that the frequency of stomach upset is greater with valproic acid (15 percent to 20 percent) than with the enteric-coated divalproex sodium (10 percent) tablets, and so a switch to divalproex sodium may help if these symptoms are troublesome.<sup>17</sup>

You can see in Table 20–12 that valproic acid can also cause tremor. As with lithium, this effect can sometimes be helped by reducing the dose or by adding one of the beta-blocking drugs (see the discussion of lithium tremor above). Other uncommon side effects include a loss of coordination and weight gain.

Valproic acid can cause a rash in 5 percent of patients, much like the two other mood stabilizers listed in Table 20–12. Some patients have also reported hair loss, and if this develops you should discontinue the drug (after discussing this with your doctor, or course) because it can take several months for the hair to grow back. The hair loss is thought to be due to the fact that valproic acid can interfere with the metabolism of zinc and selenium. Vitamin supplements containing these two metals can be taken to try to prevent this. Dr. Alan Schatzberg and his colleagues recommend the vitamin supplement Centrum Silver for this purpose.<sup>1</sup>

As many as 20 percent of women have reported menstrual irregularities while on valproic acid. This may be due to the fact that valproic acid can cause blood levels of the relevant hormones to fall, resulting in impaired ovulation. Paradoxically, valproic acid can also cause certain oral

contraceptives to fail, so in theory you could become pregnant. Make sure you discuss this possibility with your doctor if you are taking oral contraceptives.

Valproic acid, like a number of other anticonvulsants, may lead to birth defects and should usually not be taken during pregnancy. The deformities include a cleft lip, clotting abnormalities, spina bifida, and others. During the latter phases of pregnancy (the third trimester) valproic acid can cause liver toxicity for the developing baby, especially when blood levels are greater than 60 mcg per ml. Make sure you inform your doctor if you think there is any chance you could become pregnant while taking this drug.

Special precautions are indicated for women under twenty who receive long-term treatment with valproic acid. Some studies have suggested that they may be more likely to develop polycystic ovaries and increased levels of male sex hormones, but the actual incidence of this complication is not known.<sup>17</sup>

*Drug Interactions for Valproic Acid.* Valproic acid does not seem to have as many drug interactions as lithium or carbamazepine. Because valproic acid can cause sleepiness, it can enhance the effects of other sedative drugs such as alcohol, major and minor tranquilizers, barbiturates, or sleeping pills. These combinations could be hazardous, especially when driving or operating dangerous machinery. In addition, valproic acid can cause substantial increases in blood levels of barbiturates, causing extreme sedation or intoxication. Valproic acid may also cause levels of diazepam (Valium) to rise. The resulting depression of the central nervous system can be serious, and so great caution must be exercised if these drugs are combined with valproic acid.

As noted above, valproic acid can interfere with bleeding and clotting, and so caution needs to be exercised if it is combined with other drugs that interfere with bleeding or clotting, such as warfarin (Coumadin) or aspirin. In addition, valproic acid can lead to increased blood levels of warfarin. This can also enhance the tendency to bleed.

Some caution should be exercised when valproic acid is combined with a tricyclic antidepressant (especially nortriptyline and amitriptyline) because the blood levels of the antidepressant may increase. Your doctor may want to

order a blood test to check the level of the antidepressant so the dose can be adjusted if necessary.

Several types of drugs can cause levels of valproic acid to increase. These include:

- antacids;
- non-steroidal anti-inflammatory drugs such as aspirin, ibuprofen (Advil, Motrin), and others;
- cimetidine (Tagamet);
- erythromycin (Erythrocin);
- felbamate (Felbatol), an anticonvulsant;
- lithium. Valproic acid also causes lithium levels to rise, and so the toxic effects of both drugs can increase;
  - some antipsychotic drugs, especially phenothiazines such as chlorpromazine (Thorazine);
  - SSRI antidepressants such as fluoxetine (Prozac) and fluvoxamine (Luvox).

If you are taking any of these drugs with valproic acid, your doctor may need to reduce your dose of valproic acid.

Some anticonvulsants, such as carbamazepine (Tegretol), ethosuximide (Zarontin), phenytoin (Dilantin) and possibly phenobarbital (Donnatal) can cause blood levels of valproic acid to fall, and so doses of valproic acid may need to be increased. At the same time, valproic acid can cause the levels of carbamazepine, phenytoin, phenobarbital, and primidone (Mysoline) to increase, and so the doses of these drugs may need to be reduced when they are combined with valproic acid. Patients with difficult cases of bipolar illness may be treated with more than one mood stabilizer, and some careful attention to these complex drug interactions will be needed.

Finally, the antibiotic rifampin (Rifadin) can cause blood levels of valproic acid to fall. This antibiotic is used in the treatment of tuberculosis, and it is also used as a two-to-four-day preventative treatment for individuals who have been exposed to patients with certain types of meningitis.

### *Carbamazepine*

Carbamazepine (Tegretol) was introduced in the 1960s as a treatment for a certain type of epilepsy that originates in the temporal lobes of the brain. In the 1970s, Japanese investigators discovered that carbamazepine was helpful in treating manic-depressive patients who did not respond to lithium. Although the FDA has not yet officially approved carbamazepine for the treatment of mania and depression, it appears to be helpful for 50 percent of bipolar (manic-depressive) patients who have failed to respond to lithium. Carbamazepine can be combined with lithium or with one of the major tranquilizers (also known as neuroleptics) in order to enhance the effects of these drugs in the treatment of mania.

Carbamazepine can also be helpful for some rapidly cycling manic-depressives. These individuals have more than four manic episodes per year and can sometimes be challenging to treat. Some studies have also suggested that carbamazepine may be helpful for manic-depressive patients who experience anger and paranoia during their “high” phases. Finally, some psychiatrists report that carbamazepine may be helpful in the treatment of patients with borderline personality disorder when severe anxiety, depression and anger coexist with impulsive, self-destructive behavior such as wrist-slashing. However, in one study the therapists but not the patients reported that the carbamazepine was helpful. It is difficult to know how to interpret such findings.

Many of the studies of carbamazepine have been conducted on patients who were also taking other drugs at the same time, such as lithium or a neuroleptic. These drugs can also have effects on mania. Dr. Alan Schatzberg and his colleagues have pointed out that this makes it difficult to tease out the true effects of the carbamazepine.<sup>1</sup> The limited data and patent issues may explain why the drug is not yet approved as a primary treatment for mania—because the safety and effectiveness of the drug in the treatment of mania have not yet been convincingly demonstrated through large, well-controlled studies.

*Doses for Carbamazepine.* The beginning dose of carbamazepine is 200 mg twice daily for two days. It may then be raised to 200 mg three times a day for five days. After this, the dose is gradually increased by 200 mg per day every five days up to a total daily maximum of 1,200 mg to 1,600 mg.

Carbamazepine usually takes at least one to two weeks to be effective, as do many psychiatric medications. If it is helpful, your doctor will probably suggest you stay on the drug for a longer period of time to prevent a relapse of the mania.

*Blood Testing.* Carbamazepine blood testing is required, just as it is for the two mood stabilizers discussed above (lithium and valproic acid). You will need a blood test every week for the first two months. After that, you will need a blood test every one or two months. The results will guide your doctor in the amount she or he prescribes. The usual effective blood level for carbamazepine is in the range of 6 mg to 12 mcg per ml, but some experts recommend blood levels in the range of 6 mg to 8 mcg per ml for most patients with depression or mania. Like any drug, there are fewer side effects at lower doses, but if the blood level gets too low, the drug will lose its effectiveness.

Levels of other drugs in your blood may fall if you are taking carbamazepine. This is because carbamazepine stimulates certain liver enzymes, and so your liver clears these drugs out of your system faster than usual. One of the drugs that is affected by carbamazepine is carbamazepine! In other words, after you have been on the drug for several weeks, you may find that you need a larger dose to maintain the same blood level. This is because your liver begins to metabolize the carbamazepine more rapidly, so it leaves your body faster.

Your doctor will probably want to check the blood levels of certain liver enzymes before you start the carbamazepine, and from time to time when you are on it. This is because carbamazepine may cause an elevation of liver enzymes in your blood, indicating possible liver inflammation or damage. Earlier you learned that valproic acid can have similar effects on the liver. Some elevation of liver enzymes occurs in most patients taking carbamazepine, but this is not usually a cause of concern. However, you will still want to watch out for any signs of hepatitis described in the previous section on valproic acid.

Your doctor will also order frequent complete blood counts while you are taking carbamazepine. This is because carbamazepine may cause a drop in your red blood cells, white blood cells, or platelets. These cells are all produced by your bone marrow, and carbamazepine can sometimes make the

bone marrow less active. Each type of blood cell serves a different function. The white cells help to fight infections. If you did not have enough white cells, you would be more vulnerable to infections. As noted above, a normal white blood cell count is in the range of 6,000 to 10,000. If your white cell count falls below 3,000, your physician will immediately consult with a hematologist (blood specialist). Roughly 10 percent of patients taking carbamazepine experience a drop in the white blood cell count, and levels below 3,500 are common. You should be reassured to know that a drop in the white blood cell count rarely develops into a serious problem. If carbamazepine is helping you, most doctors will continue prescribing it as long as your white cell counts are above 1,000. However, white cell counts below this level can be extremely dangerous, so your physician will monitor your blood count more frequently if your white cell count starts to drop.

Levels of red blood cells and blood platelets may also fall if you are taking carbamazepine. The red blood cells carry oxygen, and the platelets cause bleeding to stop. If your red blood cells fell to very low levels, you would experience anemia. You might appear pale and feel fatigued. If your platelets fell to low levels, you might experience an increased tendency to bleed. Dr. Alan Schatzberg and colleagues<sup>1</sup> state that these changes in the blood count are expected. They emphasize that good patient education and routine bloodcounts are the best ways to monitor them.<sup>1</sup> If you are taking carbamazepine, make sure you let your doctor know immediately if you develop any symptoms suggesting a change in your white cells, platelets, or red blood cells. These include fever, sore throat or sores in your mouth (indicating possible infection), bruising or bleeding (indicating a possible drop in the platelets in your blood), or fatigue along with pale lips and finger nails (suggesting anemia).

On extremely rare occasions, carbamazepine can cause a dangerous and potentially fatal failure of the bone marrow. In these cases, all your blood cells may drop to dangerously low levels. Recent estimates of severe and dangerous bone marrow failure range from approximately one patient in 10,000 to one in 125,000, so you can see that this complication is very rare.

When carbamazepine was first introduced, this possibility frightened many physicians, who were understandably reluctant to use the drug. Neurologists have been by far the largest group of doctors prescribing carbamazepine because it can be so valuable in the treatment of epilepsy as well as

trigeminal neuralgia (facial nerve pain). Neurologists have now had vast experience with this drug and are quite comfortable with its use. More psychiatrists are also starting to recognize that this medication can be used safely.

*Side Effects of Carbamazepine.* A number of common or significant side effects of carbamazepine are listed in Table 20–12 on pages 624–625. Tiredness is the most common side effect, especially at the start of treatment. A third of patients experience tiredness, and some (5 percent) also complain of weakness. Raising the dose more slowly can minimize these effects. Usually the drowsiness will wear off over time. The drowsiness is usually not due to anemia, but just to the sedative properties of the drug.

Approximately 10 percent of patients report dizziness, especially when standing. This is due to a temporary drop in blood pressure because blood tends to pool in your legs when you rise. As a result, there is not enough blood for your heart to pump to your brain, and you get dizzy. This can usually be minimized by standing more slowly and exercising your legs (such as walking in place) immediately when you stand up. This “squeezes” blood from your legs to your heart so your heart can pump the blood to your brain.

You will see that carbamazepine can sometimes cause problems with coordination. This has been reported in as many as 25 percent of patients. Patients may appear a bit intoxicated and tend to stagger when walking. This sometimes indicates that the dose is too high. Other symptoms of an excess dose include double vision, slurred speech, mental confusion, muscle twitches, tremor, restlessness, and nausea, along with slowed or irregular breathing, a rapid heartbeat and changes in blood pressure. Immediate medical attention is required if these symptoms occur, because in extreme cases overdoses can lead to stupor, coma, and death.

You may also experience some nausea and vomiting at first. These effects are usually temporary and can usually be managed by raising the dose more slowly and by taking the medication with food. These effects are probably less common than with valproic acid or lithium. Most patients who have been on carbamazepine for several weeks do not report these effects.

Like the tricyclic antidepressants, carbamazepine can sometimes cause dry mouth or blurred vision. This is because carbamazepine blocks the cholinergic receptors (also called muscarinic receptors) in the brain. These

anticholinergic effects are of special concern to patients with glaucoma, who have increased pressure in their eyes, because the carbamazepine may cause the glaucoma to worsen. If you have glaucoma you should have your intraocular pressures monitored closely while taking carbamazepine (or any drug with anticholinergic properties).

A side effect that involves the kidneys is called the syndrome of inappropriate secretion of antidiuretic hormone (SIADH), or water intoxication. Patients develop a great increase in thirst along with mental confusion and a fall in the levels of sodium in the blood. This side effect has been reported in as many as 5 percent of patients taking carbamazepine. If you develop excessive thirst, your doctor may order an electrolyte test to see if your sodium has dropped. She or he may want to reduce the dose, change to a different medication, or treat you with a drug called demeclo-cycline (Declomycin). This drug can often correct the problem of low sodium levels in your blood. Your doctor will probably monitor your kidney function from time to time by checking your levels of blood urea nitrogen (BUN) and creatinine.

Carbamazepine can have some adverse effects on the heart. If you are over fifty years of age you should have an ECG before starting the drug. The ECG should be repeated after you have been stabilized on the drug to make sure no changes of a serious nature have occurred. Carbamazepine often causes a slowing of the heart. These changes appear to be more common in older women. If you have a history of heart disease you may do better to take another mood-stabilizing drug with fewer effects on the heart, such as valproic acid.

As many as 5 percent to 10 percent of patients taking carbamazepine may develop a rash. You will see in Table 20–12 that any of the mood stabilizers (as well as many antidepressants) can cause a rash, but this is somewhat more common with carbamazepine. It can sometimes help to avoid direct sunlight (which may provoke the rash in some cases), to take an antihistamine, or to change to a different brand of carbamazepine. This is because you may be allergic to an ingredient in the pill other than the carbamazepine itself. On extremely rare occasions, two severe and potentially fatal skin rashes (called Lyell's syndrome and the Stevens-Johnson syndrome) have been reported in patients taking carbamazepine. Make sure you report any severe skin changes to your doctor immediately.

Like many other psychiatric drugs, carbamazepine can cause birth defects, especially spina bifida. A number of other fetal abnormalities have also been reported recently, especially when the drug is taken during the first trimester of pregnancy. Therefore, the potential benefit must clearly outweigh this risk if the drug is taken during pregnancy. The risk appears to be significantly higher when carbamazepine is combined with other anticonvulsants. If a pregnant woman definitely needs the drug, some experts recommend folic acid supplements that may reduce the likelihood of birth defects.

Carbamazepine is secreted in mother's milk. The concentration of carbamazepine in the milk is approximately 60 percent of the concentration in the mother's blood, and so the issue of nursing must be discussed with the pediatrician.

*Drug Interactions for Carbamazepine.* You can see in Table 20–14 on pages 648–650 that many drugs can influence the blood level of carbamazepine, and vice versa, so you and your physician will have to be very careful in this regard. At the top of the table, drugs are listed that cause carbamazepine level and toxicity to increase. If you are taking any of these drugs, your doctor may need to reduce the dose of carbamazepine. For example, many of the macrolide antibiotics (erythromycin is a common example) can double the blood level and toxicity of carbamazepine.

You can also see in Table 20–14 that some drugs, such as diuretics (water pills) and other anticonvulsant medications can cause the level of carbamazepine to fall. Your physician may have to give you a larger dose of carbamazepine to compensate for this.

Just as certain drugs can cause blood levels of carbamazepine to rise or fall, carbamazepine can change the levels of other drugs you are taking. Blood levels of the drugs that are listed next on the table may fall when combined with carbamazepine. This is because carbamazepine stimulates the liver enzymes that metabolize these drugs. As a result, the liver gets rid of these drugs more rapidly than usual. This would be equivalent to pulling out the plug while you are trying to fill the bath; the water may not rise to the proper level.

One important example would be birth control pills. The consequence of the decreased blood level is that the birth control pills may become ineffective, and you might become pregnant even though you are taking your

birth control pills consistently. Levels of other drugs listed in the table that may fall when combined with carbamazepine include some antidepressants, antipsychotic drugs, anticonvulsants, antibiotics, thyroid hormones, and others.

Sometimes the drug interactions work in both directions. A drug may cause the blood level of carbamazepine to fall, and carbamazepine may in turn cause the blood level of the other drug to fall. For example, if you are taking an antipsychotic medication like haloperidol (Haldol), which is often also given for mania, the haloperidol may cause the level of carbamazepine to fall. At the same time the carbamazepine may cause the blood level of haloperidol to drop substantially. As a result, it may seem that neither drug is working properly, and the mania may not be controlled adequately. Your physician may need to do blood tests to determine the levels of both drugs so that the doses can be adjusted properly. Carbamazepine probably has similar effects on other antipsychotic drugs as well.

Finally, several other potentially dangerous drug interactions with carbamazepine are listed at the bottom of the table. In particular, carbamazepine must not be combined with any of the MAOIs discussed on page 564 because of the risk of the potentially fatal serotonin syndrome.

**Table 20–14. Carbamazepine Drug Interactions<sup>a</sup>**

**Note:** This list is not exhaustive; new information about drug interactions comes out frequently. If you are taking lithium and any other medication, ask your doctor and pharmacist if there are any drug interactions.

Drugs Which Can Cause Carbamazepine Levels or Toxic Effects to Increase				
acetazolamide (Diamox)	antibiotics (other) • doxycycline (Vibramycin) • tetracycline (Achromycin) • azithromycin (Zithromax) • clarithromycin (Biaxin) • erythromycin (Pedialzole) • troleandomycin (Taoo) • other macrolides	antidepressants (SSRIs) • fluoxetine (Prozac) • fluvoxamine (Luvox) • sertraline (Zoloft) • others	calcium channel blockers • diltiazem (Cardizem) • verapamil (Calan) danazol (Danocrine)	lithium mexiletene (Mexitil) prednisolone (Delta- Cortef) propoxyphene (Darvon) terfenadine (Seldane) viloxazine
	anticonvulsants • valproic acid (Depakene, Depakote)	antidepressants (other) • nefazodone (Serzone)	dextropropoxyphene (Darvon)	
		cimetidine (Tagamet)	lipid lowering drugs • gemfibrozil (Lobid) • isonicotinic acid • niacinamide • nicotinamide	

Drugs Which Can Cause Carbamazepine Levels to Decrease	
anticonvulsants <ul style="list-style-type: none"> <li>• ethosuximide (Zarontin)</li> <li>• phenytoin (Dilantin)</li> <li>• primidone (Mysoline)</li> </ul> barbiturates <ul style="list-style-type: none"> <li>• phenobarbital</li> <li>• others</li> </ul>	diuretics <ul style="list-style-type: none"> <li>fentanyl (Duragesic)</li> <li>major tranquilizers (neuroleptics) <ul style="list-style-type: none"> <li>• haloperidol (Haldol)</li> </ul> </li> <li>methadone</li> </ul>

Blood Levels of the Following Drugs May Fall When Combined with Carbamazepine			
acetaminophen (Tylenol)	antidepressants <ul style="list-style-type: none"> <li>• bupropion (Wellbutrin)</li> <li>• imipramine (Tofranil)</li> <li>• others</li> </ul> antipsychotics (neuroleptics) <ul style="list-style-type: none"> <li>• haloperidol (Haldol)</li> <li>• others</li> </ul>	benzodiazepines (minor tranquilizers) <ul style="list-style-type: none"> <li>• alprazolam (Xanax)</li> <li>• clonazepam (Klonopin)</li> <li>• others</li> </ul> corticosteroids <ul style="list-style-type: none"> <li>• dexamethasone (Decadron)</li> <li>• methylprednisolone (Medrol)</li> <li>• prednisolone (Delta-Cortef)</li> </ul>	emergency intubation drugs <ul style="list-style-type: none"> <li>• pancuronium (Pavulon)</li> <li>• vecuronium (Norcuron)</li> </ul> fentanyl (Duragesic) mebendazole (Vermox) methadone (Dolophine) oral contraceptives theophylline (Theo-Dur) thyroid hormones warfarin (Coumadin)
antibiotics <ul style="list-style-type: none"> <li>• doxycycline (Vibramycin)</li> <li>• cyclosporine (Sandimmune, Neoral)</li> </ul> anticonvulsants <ul style="list-style-type: none"> <li>• phenobarbital</li> <li>• primidone (Mysoline)</li> <li>• phenytoin (Dilantin)</li> <li>• valproic acid (Depakene, Depakote)</li> </ul>			

Other Carbamazepine Drug Interactions	
Drug	Effect
clozapine (Clozaril) digitalis, digoxin (Lanoxin) MAOI antidepressants	increased possibility of bone marrow suppression levels rise, may cause toxicity including slowing of the heart serotonin syndrome (fever, seizures, coma)

<sup>a</sup>Some information in this table was obtained from *Psychotropic Drugs Fast Facts*, pp. 213–215.<sup>17</sup> This book is an excellent source of information on psychiatric medications.

Although Table 20–14 is lengthy, it is not comprehensive because new drugs and new information about drug interactions are constantly emerging. As noted previously, only a small percentage of the potential drug interactions have been studied, and our knowledge about them is rapidly expanding. Other drugs may have important interactions with carbamazepine, so make sure your physician knows of all the medications you are taking. Ask specifically if any of them interact with carbamazepine.

### *Other Mood Stabilizing Agents*

Until recently, lithium, valproic acid, and carbamazepine were the main drugs used for the treatment of bipolar illness. Recently, new drugs have been

synthesized which may soon be available to treat patients with this disorder. Many of these new drugs are actually anticonvulsants that were designed for the treatment of epilepsy. At least two of them are already being used in the treatment of bipolar (manic-depressive) illness, and many others will undoubtedly become available in the next several years. It seems likely that at least some of them will provide powerful new tools for treating bipolar illness and possibly other psychiatric disorders as well.

These new drugs (as well as the three mood stabilizers discussed previously) are quite different from the antidepressants because they do not significantly increase levels of serotonin, dopamine, and norepinephrine in the brain. Instead, they seem to stimulate a transmitter substance called GABA (gamma-amino butyric acid) or inhibit a transmitter substance known as glutamate. GABA and glutamate are used by a large percentage of the nerves in the brain. The anticonvulsants that stimulate GABA tend to cause sleepiness. Medications in this category include valproic acid, discussed above, as well as gabapentin (Neurontin), tiagabine (Gabitril), vigabatrin (Sabril), and several others. The anticonvulsants that inhibit glutamate tend to cause stimulation and anxiety. Medications in this category include felbamate (Felbatol), lamotrigine (Lamictal), topiramate (Topamax), and several others.

Although it is not known for certain why or how these drugs prevent epilepsy or stabilize manic-depressive illness, it is known that the GABA system and the glutamate system in the brain tend to compete with one another. This may be why drugs that stimulate GABA or inhibit glutamate are helpful for epilepsy and for bipolar illness.

Most anticonvulsant drugs also inhibit sodium transport across nerve membranes in the brain. Sodium, as you know, is present in table salt. It is known as an ion, because it carries a tiny positive electrical charge when it is dissolved in a fluid. The electrical impulses of nerves result when ion channels in the nerve membranes open up and positively charged ions like sodium and potassium suddenly rush across the membrane. These ion fluxes create the electrical impulses in the nerves. Because these drugs inhibit the sodium channels, they may stabilize nerve conduction in the brain by making nerves less excitable. Because nearly all anticonvulsants have this property, they are sometimes classified as "sodium blockers." The sodium-blocking effects may also explain why these new drugs can prevent seizures and stabilize manic-depressive illness.

Of course, all new drugs have unforeseen benefits and hazards, and the new anticonvulsant drugs are no exception. Quite a bit of testing will be necessary before we can identify which ones have most promise for patients with epilepsy and bipolar illness. There is considerable excitement about one of the new drugs, called gabapentin (Neurontin), because it seems to have very few side effects, an excellent safety record, and few if any toxic interactions with other drugs. In addition, it does not require blood testing like the three mood stabilizers discussed above.

So far, the FDA has approved gabapentin only for the treatment of epilepsy. Although it has not yet been officially approved for psychiatric disorders, many psychiatrists are beginning to prescribe gabapentin for patients with difficult bipolar illness who have not responded to other medications. Its eventual role will have to be determined by clinical experience and by controlled outcome studies.

At least eight studies of the use of gabapentin in mood disorders were published in 1997, and many more will undoubtedly be published in subsequent years. In these studies, gabapentin was reported to be effective for many patients with bipolar illness. Gabapentin also appeared to have antidepressant and antianxiety properties, and it may be useful in the treatment of chronic pain (including migraine headaches), as well as PMS (premenstrual syndrome), panic disorder, and social phobia.

*Doses for Gabapentin.* The current dose of gabapentin for epilepsy is 300 mg to 600 mg three times daily, for a total dose range of approximately 900 to 2000 mg per day. In studies of bipolar patients, the average dose was about 1700 mg per day, with some investigators giving doses as high as 3600 mg per day.

The absorption of gabapentin from the stomach and intestinal tract is not affected by food. However, the antacid Maalox can reduce the absorption of gabapentin from the stomach by about 20 percent. Therefore, you should wait at least two hours after taking Maalox before you take gabapentin.

About half of a dose of gabapentin disappears from the body within five to seven hours, so it must be taken several times per day rather than all at once. If you take a high dose of gabapentin on a single occasion, a smaller proportion of the dose will be absorbed from your stomach and intestinal tract into your blood. For example, only 75 percent of a single 400-mg dose

is absorbed, as compared with 100 percent of a 100-mg dose. From a practical point of view, this should not be a concern if you are taking gabapentin since you will be taking the medication several times per day in divided doses.

There is no evidence that men and women require different doses because of differences in metabolism, but individuals over seventy years of age may need only about half the doses used for younger people. This is because of changes in kidney function that occur with aging. Because the kidneys excrete gabapentin, individuals with impaired kidney function will require smaller doses.

Unlike lithium, carbamazepine, and valproic acid, blood testing does not appear necessary with gabapentin. This is another advantage of this medication.

*Side Effects of Gabapentin.* The main side effects are listed in Table 20–15 on pages 656–657. You can see that they include sleepiness, noted above, along with dizziness, tremor, problems with coordination, weight gain, and some visual side effects. All of these side effects will be more pronounced at higher doses and less noticeable at lower doses. Overall, the side effect profile of gabapentin is very favorable, especially when compared with the other currently available mood stabilizers.

In the studies cited in Table 20–15, gabapentin was given to patients with epilepsy who were already receiving one or more other anticonvulsants. Therefore, the side effects that were actually due to the gabapentin were lower. The best way to get a more realistic estimate of any side effect is to subtract the percentage seen in the placebo group from the percentage seen in the gabapentin group. For example, 11.0 percent of the gabapentin group experienced fatigue, whereas 5.0 percent of the placebo group experienced this side effect. The difference in these two numbers is 6.0 percent. This is a better estimate of the true incidence of fatigue that can be attributed to gabapentin.

Like nearly all psychiatric drugs, gabapentin should be used with great caution in pregnant women. Although there are no well-controlled studies of the effects of gabapentin on the developing fetus in pregnant women, fetal abnormalities have been observed when gabapentin was administered to pregnant mice and rabbits. Although animal studies do not always predict

human responses, gabapentin should be used in pregnancy only if the need is great and if the potential benefit outweighs the potential risk to the developing fetus. Although it is not yet known whether gabapentin is secreted into human milk, many drugs are secreted into human milk; consequently, gabapentin should probably not be used by mothers who are nursing. Certainly, you should discuss this risk with your physician.

*Drug Interactions for Gabapentin.* Gabapentin has one unusual and desirable property; it is not metabolized by the liver, but is excreted unchanged by the kidneys directly into the urine. For this reason, it does not seem to interact in adverse ways with other drugs. You will recall from previous discussions that all the antidepressants and mood stabilizers have fairly complicated interactions with lots of other drugs. This is because these drugs compete with each other for certain metabolic enzymes in the liver. With gabapentin, this is not a problem, so it is much safer to combine gabapentin with other medications. In fact, many experts believe that gabapentin has no metabolic interactions at all with other drugs. One benefit is that gabapentin can be combined with other mood stabilizers for patients with difficult cases of bipolar illness or epilepsy who have not responded to other medications.

The properties of gabapentin are certainly very appealing. Is there a downside? Sometimes problems with new medications surface after the medication has been in widespread use for a period of time and the initial excitement has worn off. Gabapentin may be no exception. One concern already voiced by some neurologists and psychiatrists is that the drug may not be particularly effective for either epilepsy or bipolar illness. This would be disappointing, since the drug has so few side effects or interactions with other drugs. A colleague with considerable experience with gabapentin told me she is using it primarily to help anxious patients with insomnia, because it has excellent sedative and relaxing properties and is not habit-forming. Unfortunately, she feels it may not be powerful enough to be a primary mood stabilizer for bipolar patients, but it may have value when it is used in combination with other medications.

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**Table 20–15.** Side Effects of Gabapentin (Neurontin)

**Note:** The information in this table was adapted from the 1998 *Physician's Desk Reference (PDR)*. In these studies, gabapentin or placebo was given to individuals with epilepsy who were already taking at least one other drug for epilepsy. The side effects in individuals not taking other drugs are likely to be less. Only the more common side effects are listed.

	Gabapentin (n = 543)	Placebo (n = 378)
<b>Digestive System</b>		
weight gain	2.9%	1.6%
dry mouth	1.7%	0.5%
upset stomach	2.2%	0.5%
<b>Energy</b>		
fatigue	11.0%	5.0%
sleepiness	19.3%	8.7%
<b>Nervous System</b>		
dizziness	17.1%	6.9%
trouble with coordination	12.5%	5.6%
tremor	6.8%	3.2%
slurred speech	2.4%	0.5%
memory problems	2.2%	0.0%
<b>Eyes</b>		
nystagmus (tremor of the eyes)	8.3%	4.0%
double vision	5.9%	1.9%
blurred vision	4.2%	1.1%

Another new anticonvulsant, lamotrigine (Lamictal) has also been approved by the FDA for the treatment of epilepsy. Like gabapentin,

lamotrigine has been used in the treatment of treatment-resistant bipolar illness. Dr. Alan F. Schatzberg and colleagues<sup>1</sup> point out that very few formal studies of lamotrigine have been conducted in psychiatric patients, and so the reports of its effectiveness are still mainly anecdotal. In addition, lamotrigine has some significant and troubling side effects. In particular, rashes and skin reactions occur in as many as 5 percent or more of the adults taking lamotrigine. While most of these rashes are not dangerous, lamotrigine can cause a severe and life-threatening skin reaction known as the Stevens-Johnson syndrome in 1 percent to 2 percent of cases. These skin reactions are more common in pediatric patients than in adults, and so lamotrigine should not be given to individuals under sixteen years of age. Taking lamotrigine at higher doses or in combination with other drugs, such as valproic acid, may make these feared skin reactions more likely. In premarketing trials, five patients taking lamotrigine died from liver failure or multiorgan failure.

Lamotrigine causes many other side effects such as headache and neck pain, nausea and vomiting, dizziness, loss of coordination, sleepiness, trouble sleeping, tremor, depression, anxiety, irritability, seizures, speech problems, memory difficulties, runny nose, rashes, itching, double vision, blurred vision, vaginal infections, and others. Lamotrigine also has a number of interactions with other drugs because it is metabolized by the liver. Because it has many side effects, including some dangerous ones, lamotrigine must be used with great caution. Until we learn more about it, it should probably be reserved for patients who have failed to respond to the better-established mood stabilizers discussed above.

## **What If My Antidepressant Does Not Work?**

As I have emphasized, I would recommend taking a mood test like the one in Chapter 2 to monitor your response to any treatment, including medications or psychotherapy. You can take the test once a week or even more frequently, and keep track of your scores. Your scores will show whether and to what extent the treatment is working. The goal of treatment is to get these scores reduced substantially. Ultimately, you want your scores to be in the range considered normal and ideally in the range considered happy.

If a drug doesn't help, or helps only somewhat, what should you do?

1. Make sure you have given the drug a fair trial. Ask yourself:
  - Is the dose adequate?
  - Have you taken the drug for an adequate period of time?
2. Make sure there are no drug interactions that are preventing the antidepressant from being effective. Remember that some other drugs can cause your blood level of an antidepressant to fall, even if you are taking the correct dose of the antidepressant. Inform your doctor about any other drugs you are taking.
3. You and your doctor may want to consider one of the augmentation strategies discussed below.
4. If these procedures are not successful, you and your doctor can discontinue the medication and try another type of antidepressant.
5. Psychotherapy along the lines described in this book, either alone or in combination with an antidepressant, can often be far more effective than treatment with drugs alone.

Let's examine each of these principles. First, you need to be certain the dose is sufficient. If for any reason your blood level of an antidepressant is too low, then the probability of a positive drug response will be diminished. However, a dose that is too high might also be less effective. This is because the side effects at excessively high doses may counteract the antidepressant effects. Concerns about the doses of antidepressant drugs are important because different people can metabolize these drugs quite differently. In other words, given a particular drug at a particular dose, different people can have dramatically different levels of the drug in their blood. In fact, the levels of a tricyclic antidepressant may differ by as much as thirty times in two different people who both receive comparable doses of the same drug. This can happen even if the two people are the same sex, height, and weight.

These differences in blood levels can result from differences in the ways people absorb a drug from their gastrointestinal tracts and from differences in how fast people get rid of a drug from their blood. Genetics can play a role. For example, approximately 5 percent to 10 percent of the Caucasian population in western Europe and the United States lack the liver enzyme called CYP2D6 (in the P450 family), and 20 percent of the Asian population lack the enzyme called CYP2C19.<sup>23</sup> These enzymes help to metabolize a

wide variety of drugs including many antidepressants. Individuals who lack either of these enzymes may develop dramatically higher blood levels of certain antidepressants because their liver enzymes cannot get rid of these drugs nearly as rapidly as the average individual.

Medical conditions such as liver, kidney, or heart disease can have an impact on the blood level of antidepressants. Age can also be important. On the average, children and elderly individuals require lower doses of most medications including antidepressants. You may recall, for example, that individuals over sixty-five may develop blood levels of several SSRIs, citalopram (Celexa), fluoxetine (Prozac) and paroxetine (Paxil), that are approximately 100 percent greater than the blood levels of younger individuals taking identical doses. Sometimes gender can play a role as well. As noted previously, men may develop blood levels of fluoxetine (Prozac) or sertraline (Zoloft) that are 30 percent to 50 percent lower than women taking similar doses of these medications.

Weather, your personal habits, or other medications you are taking can sometimes influence blood levels of antidepressants or mood stabilizers. For example, if you are sweating a great deal during the summer, your blood level of lithium may rise, so your doctor may need to reduce the dose. If you are a smoker, your body will break down tricyclic antidepressants more rapidly because of the effects of the nicotine. Consequently, you may need a higher dose of these antidepressants. Many other drugs that can also cause a rapid breakdown of tricyclic antidepressants are listed in Table 20–5. In contrast, some drugs on this table can slow the metabolism of tricyclic antidepressant drugs by the liver, leading to excessively high blood levels of the antidepressants. Remember that these drug interactions can work both ways: an antidepressant or mood stabilizer may affect the level or activity of other drugs you are taking, and vice versa.

Before you and your doctor decide that a particular drug is not working, make sure that you review the dose with him or her. Ask about the possibility of drug interactions if you are taking more than one drug. Your doctor may want to order a blood test to ensure that the level in your blood is adequate. Blood-level testing is more commonly done for the mood stabilizers and for the tricyclic and tetracyclic drugs than for other types of antidepressants listed in Table 20–1.

If the blood level is adequate and you have been taking the medication for a sufficient period of time but your antidepressant is still not working, your doctor may try switching you to a different type of antidepressant or may try an augmentation strategy. This involves adding a small dose of a different drug to try to boost the effect of the antidepressant. Several kinds of augmentation strategies currently in vogue are listed in Table 20–16 on pages 664–669. A complete discussion is beyond the scope of this book; I will describe just a couple of them to give you a feel for this approach. Interested readers may want to consult the excellent reference by Schatzberg and his colleagues.<sup>1</sup>

Two drugs commonly used for antidepressant augmentation are lithium, a drug you've learned about in this chapter, and a thyroid hormone called liothyronine (also known as Cytomel, or T<sub>3</sub>). Your doctor may add 600 mg to 1,200 mg per day of lithium carbonate or 25 to 50 micrograms per day of liothyronine to your antidepressant for several weeks if the antidepressant has not been working adequately. As noted above, lithium is usually used to treat bipolar (manic-depressive) illness, and liothyronine is used to treat people with underactive thyroid glands. However, in this case, the goal is different—the purpose of adding a small dose of lithium or liothyronine is to make the antidepressant more effective. It is not clear why lithium and liothyronine sometimes have this effect of boosting the effectiveness of antidepressants.

A liothyronine trial will usually last for one to four weeks. If you respond positively, your physician may continue the liothyronine for two more months. Then she or he will probably taper you off the augmentation medication over one to two weeks.

The dose of lithium used for augmentation will be adjusted with a blood test so that your blood level will remain in the range of around 0.5 to 0.8 mEq per L. These levels are a little lower than the levels used to treat patients who are experiencing mania. The lower levels have the advantage of having fewer side effects. The lithium augmentation trial will generally last for two weeks. Positive results have been reported when lithium was combined with tricyclics, SSRIs, and MAOIs. Research studies suggest that as many as 50 to 70 percent of patients who do not respond to an antidepressant will respond more favorably when lithium is added. If there is no improvement in your depression, your doctor will probably discontinue the lithium as well as the antidepressant and try another medication.

Some doctors use antidepressant combination therapy for patients with difficult depressions. For example, one new approach is to add an SSRI when a tricyclic does not work, or to add a tricyclic when an SSRI does not work. This combination can cause large increases in the blood level of the tricyclic medication, and so your doctor may decrease the tricyclic first and then check your tricyclic level with a blood test after you start the SSRI. Your doctor may also order an ECG to make sure there are no adverse effects on your heart.

An MAOI might also be combined with a tricyclic antidepressant as a combination antidepressant strategy. This is an advanced form of treatment for the specialist and requires careful teamwork between you and your doctor. You will recall that dangerous reactions can result from combining MAOIs with other antidepressant drugs or with lithium. Although the *Physician's Desk Reference* advises against such drug combinations, Schatzberg and colleagues report that the combination can be safe and helpful to some patients who fail to respond to single medications.<sup>1</sup> To maximize safety, these investigators recommend: (1) the MAOI and tricyclic should be started at the same time; (2) clomipramine should be avoided; (3) the safest tricyclics to use in combination with MAOIs appear to be amitriptyline (Elavil) and trimipramine (Surmontil); (4) among the two commonly prescribed MAOIs, phenelzine (Nardil) appears to be safer than tranylcypromine (Parnate) to use in combination with a tricyclic.

**Table 20–16.** Antidepressant Augmentation Chart.

Note: The first and second columns list several types of drugs that have been added in small doses to antidepressants in attempts to make the antidepressants more effective. The next three columns list three major classes of antidepressants. A check mark (✓) indicates that at least some favorable research regarding this augmentation strategy has been published in psychiatric journals. Some combinations are dangerous and best administered by experts in research settings. Information in this table was obtained in part from the *Manual of Clinical Psychopharmacology*.<sup>1</sup>

Augmentation Drug	Augmentation Dose	Type of Antidepressant			Comments
		TCAs	SSRIs	MAOIs	
Amino acids					
inositol	6 gm twice daily	see comment	see comment	see comment	Inositol is the precursor of the phosphatidylinositol (PI) system in the brain. There are no reports yet using inositol as an augmentation drug, but it appears to have antidepressant properties and will probably soon be used for augmentation. <sup>21</sup>
L-tryptophan	2-6 gm per day	✓		✓	Tryptophan is the precursor of serotonin in the brain. L-tryptophan plus MAOIs or SSRIs could cause the serotonin syndrome.
Phenylalanine	500 mg-5 gm per day	✓			Phenylalanine is the precursor of dopamine and norepinephrine in the brain. At least one authority has not been impressed with the effects of this drug in augmenting antidepressants. <sup>1</sup>
Antidepressants					
bupropion (Wellbutrin)	low doses usually, but doses up to 300 mg per day have been used. <sup>1</sup>		✓		Bupropion may be used in an attempt to combat the sexual side effects of SSRIs. There are anecdotal reports it may enhance the SSRIs, but no controlled studies. <sup>1</sup> There is at least one documented case of seizures from bupropion plus fluoxetine (Prozac).
buspirone (BuSpar)	15 mg-45 mg per day		✓		Buspirone (BuSpar) has been shown to enhance the effects of fluoxetine (Prozac) in an open trial. <sup>26</sup> However, double-blind studies have not confirmed this. <sup>1</sup> Buspirone may also be used in an attempt to combat the sexual side effects of SSRIs.
MAOIs	15 mg (or more) of phenelzine (Nardil) daily and 150 mg (or more) of amitriptyline (Elavil)	✓			The <i>PDR</i> states that the combination of an MAOI and a tricyclic is prohibited, but the combination can be relatively safe in the hands of experts. Double-blind studies have not documented the effectiveness of this combination. Both drugs should be started at the same time. Amitriptyline (Elavil) and trimipramine (Surmontil) appear to be the safest TCAs to combine with MAOIs, and phenelzine (Nardil) and isocarboxazid (Marplan) appear to be the safest MAOIs. <sup>1</sup>

Augmentation Drug	Augmentation Dose	Type of Antidepressant			Comments
		TCAs	SSRIs	MAOIs	
Antidepressants cont.					
SSRIs	First ↓ dose of TCA; 30 mg per day of nortriptyline or 50–75 mg of imipramine recommended <sup>1</sup>	✓			See comments on TCAs below
TCAs	when adding a TCA and patient is on an SSRI, start with 25 mg nortriptyline or 50 mg of imipramine; increase by 25 mg after 3 days <sup>1</sup>		✓	✓	See note on MAOI and TCA combinations above. Several reports suggest that desipramine (Norpramin) will enhance the effects of SSRIs. <sup>27,28</sup> TCA blood level testing must be done because the SSRI may cause a large ↑ in desipramine levels, side effects, and toxicity. ECGs must be monitored closely during TCA and SSRI combinations.
trazodone (Desyrel)	25 mg–300 mg per day		✓		Trazodone (100 mg HS) is often added to fluoxetine (Prozac) or bupropion (Wellbutrin) to help with sleep, since these two drugs may cause insomnia. However, trazodone (Desyrel) may also enhance the effects of SSRIs. <sup>129</sup>
Appetite Suppressants					
fenfluramine (Pondimin)	20 mg–40 mg per day <sup>1</sup>		✓		This is an amphetamine-like drug that may enhance serotonin release in the brain. Some patients become overly stimulated.
Hormones					
estrogen					Estrogen has been used for years, alone or in combination with other antidepressants, to treat depressed women. The evidence for effectiveness is shaky at best, and the combination is unwarranted. <sup>1</sup>
liothyronine (Cytomel; T3)	12.5 mg–25 mg per day; slowly ↑ to 50 mg per day	✓	✓	✓	Some studies have reported positive results with TCAs <sup>30</sup> but other studies have reported negative results. <sup>1</sup> May be more effective for women than men. Case reports also suggest augmentation of SSRIs and MAOIs. <sup>1</sup> Responses should be seen within one to four weeks. If the response is positive, you can continue for two more months. Should be used with caution in patients with heart disease or high blood pressure.

Augmentation Drug	Augmentation Dose	Type of Antidepressant			Comments
		TCAs	SSRIs	MAOIs	
<b>Mood Stabilizers</b>					
lithium	600 mg–1,200 mg per day in divided doses	✓	✓	✓	Several open studies and double-blind studies suggest that lithium in small doses may enhance the effects of antidepressants about 50% of the time. The trial will last about two or three weeks, but the combination may be continued if effective. The combination may also help prevent relapses. Lithium may also be combined with either carbamazepine (Tegretol) or valproic acid (Depakene) in patients with difficult cases of bipolar manic-depressive illness, especially those with "rapid cycling" (many episodes per year).
<b>Stimulants</b>					
amphetamine (Dexedrine)	start at 5 mg per day			✓	In one study, amphetamine or pemoline (see below) was added to an MAOI in patients with severe, treatment-refractory depressions. <sup>31</sup> Some patients responded, but 1 in 5 developed symptoms of mania (abnormal euphoria). Such combinations are potentially dangerous and could trigger hypertensive crises. Also see comment on methamphetamine.
methamphetamine (Desoxyn)	start at 5 mg per day	✓			Any stimulant can be addictive. This drug is intensely addictive and potentially dangerous in combination with antidepressants. Its use in any other psychiatric disorders, alone or in combination with other drugs, is controversial. Large doses over prolonged periods can produce rage and a psychosis resembling paranoid schizophrenia.
methylphenidate (Ritalin)	start at 5 mg per day	✓			This combination causes an ↑ in TCA blood levels, so blood level testing should be done. Also see comment on methamphetamine.
pemoline (Cylert)	start at 37.5 mg per day or at 18.75 mg per day			✓	See comment on methamphetamine.
<b>Beta-Blockers</b>					
pindolol (Visken)	2.5 mg twice daily for 1 week; then ↑ to 5 mg twice daily; continue for 3 weeks <sup>1</sup>		✓		Pindolol blocks beta receptors and stimulates 5-HT <sub>1A</sub> receptors. It is used to treat hypertension, so blood pressure should be monitored. Side effects include dizziness, fatigue, and activation, with anxiety, irritability, and insomnia.

You will see quite a number of additional augmentation strategies listed in Table 20–16. My experience with these antidepressant combination and augmentation strategies has been limited, but I have not been impressed with the results. I have tried lithium or thyroid augmentation with a number of patients but none of them seemed to improve. I was not encouraged to continue with this approach. However, if a depressed patient has failed to respond to an adequate trial of several antidepressants, one at a time, from different chemical classes, then a combination of antidepressants or an augmentation strategy might be worth a try.

If you have received an adequate dose of an antidepressant for an appropriate period of time and you are not responding, what antidepressant should you try next? Many physicians will switch you to an antidepressant of a completely different class to maximize the chance of a positive response. This idea makes good sense, since the different antidepressants have slightly different effects on the brain. If you have failed to respond to an SSRI such as fluoxetine (Prozac), your doctor may want to try a tricyclic such as imipramine (Tofranil), for example. Prozac selectively activates the serotonin systems in the brain, whereas imipramine has effects on many different systems.

If you switch to another drug, you will usually need to taper off your current drug slowly so as to prevent any withdrawal effects. Antidepressants are not addictive and they do not cause craving when you stop taking them. However, they need to be discontinued slowly to prevent uncomfortable withdrawal reactions. For example, the tricyclics can cause insomnia and upset stomach if you go off them abruptly, as noted previously.

Further, as noted above, there may be a mandatory waiting period when you are switching from one drug to another. This is because the two drugs might be dangerous if mixed together, and the effects of the first drug may persist for a while after you have stopped taking it. The classic example would be switching from an SSRI, such as fluoxetine (Prozac), to an MAOI, such as tranylcypromine (Parnate). The combination of these two drugs can cause the previously described serotonin syndrome, which is occasionally fatal. In addition, both types of drugs clear out of the body slowly, and so a drug-free period is necessary before switching from one to the other. When switching from Prozac, an SSRI, to Parnate, an MAOI, this waiting period may be five weeks or more. When switching from Parnate to Prozac, the waiting period will be at least two weeks. With some combinations of drugs, however, a waiting period is not necessary. Check with your doctor about this.

Suppose that all these strategies fail to bring about an optimal antidepressant response. What then? In my experience this is not unusual. I have seen lots of patients who were treated for years with all kinds of medications and yet they were still severely depressed. Early in my career, I realized that drugs did not provide the answer for many people. That is why I devoted so much of my career to the development of new psychotherapeutic

techniques, such as those described in this book. I wanted to have more tools available than just drugs.

In my experience, the idea that a pill alone will solve your problems and bring you joy is not productive. In contrast, the willingness to use these cognitive therapy tools, often in combination with a compassionate, persistent, and creative therapist will often lead to substantial improvement.

## **Other Drugs Your Doctor May Prescribe**

The various types of antidepressants I have described are the ones that in my opinion have a clear-cut indication in the treatment of depression. I will describe several types of drugs that you might want to avoid, although there are exceptions to this rule.

*Minor Tranquilizers (Benzodiazepines).* Some doctors use minor tranquilizers (called benzodiazepines) or sedatives to treat nervousness and anxiety. The benzodiazepines include many familiar drugs such as alprazolam (Xanax), chlordiazepoxide (Librium), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), oxazepam (Serax) and prazepam (Centrax). Minor tranquilizers may be added to the mix of drugs your doctor prescribes if you are depressed. Because most depressed patients also experience anxiety, this practice is unfortunately quite common.

I usually do not recommend minor tranquilizers because they can be addictive, and the sedation they produce might make your depression worse. In my experience, anxiety can nearly always be treated successfully without using these drugs. Two highly esteemed colleagues from Canada, Dr. Henny A. Westra from the Queen Elizabeth II Health Sciences Center, and Dr. Sherry H. Stewart from Dalhousie University, recently reviewed the world literature on the treatment of anxiety disorders with cognitive behavioral therapy versus medications. Based on their careful review of many clinical outcome studies, the authors recommended treatment of anxiety disorders with cognitive behavior therapy instead of medications.<sup>1</sup> The authors concluded that cognitive behavioral therapy without drugs is a highly effective and long lasting treatment for anxiety. In comparison, they emphasize that benzodiazepines may give some limited relief but only for a

short period of time, tend to lose their effectiveness over time, and are very difficult to discontinue. If you have a serious interest in this topic, the scholarly article by Drs. Westra and Stewart would be worth reading.

Although the benzodiazepines such as Ativan, Librium, Ritrovil (available in Canada), Valium, Xanax, and others can have wonderfully calming effects almost immediately after you take them, the main problem is that these relaxing effects do not last. As soon as the drug leaves your body a few hours later, there is a high likelihood you will feel nervous again. In addition, if you take these drugs daily for more than a few weeks, you may experience withdrawal effects when you try to go off them. The most common withdrawal symptoms are anxiety, nervousness and trouble sleeping. Ironically, these are the exact reasons you started taking the drug in the first place. These withdrawal symptoms trick you into thinking you still need the drug, and so you start taking it again. This is how the pattern of drug dependency develops. Fortunately, antidepressants are also effective in treating anxiety, as are the cognitive and behavioral therapy techniques described in this book, and these treatments are not addictive. This is why I avoid the benzodiazepines in the treatment of depressed or anxious individuals.

There are other reasons to avoid minor tranquilizers in the treatment of anxiety. One of the cardinal treatment principles is that anxious individuals must face their fears and surrender to their fears in order to overcome them. For example, if you have a fear of heights, you may have to climb to the top of a ladder and stand there until the anxiety goes away. I could give you dozens of examples of patients who have experienced dramatic improvements or even complete recoveries when they faced their fears in this way. Anxious individuals who face their fears often feel tremendous relief because they discover their fears were not realistic in the first place. This realization may not occur if you are simply taking tranquilizers and not facing your fears. Even if you do manage to face your fears with the help of tranquilizers, the medication will tend to reduce the effectiveness of your efforts. In fact, when doctors prescribe tranquilizers for anxious patients, there is the danger that this will reinforce the idea that the fears really are dangerous and must be avoided and that the uncomfortable symptoms must be suppressed. These messages are the very antithesis of the newer exposure therapies that have shown so much promise in the treatment of anxiety.

If your doctor has been prescribing a benzodiazepine, or suggests this type of medication, a discussion of the pros and cons would be indicated. Remember that you are the consumer, and your doctor is working for you. You have every right to discuss your treatment in a frank and respectful way. This sense of teamwork and collaboration is quite important.

*Sedatives.* Many prescription sleeping pills can also be addictive and are easily abused: They can lose their effectiveness after only a few days of regular use. Then greater and greater doses may be required to put you to sleep. This can lead to a pattern of drug tolerance and dependency. If you take them daily, these pills can disrupt your normal sleep pattern. Severe insomnia is a withdrawal symptom from sleeping pills, and so every time you try to stop taking the pills you will falsely conclude that you need them even more. Thus they can greatly worsen your sleeping difficulties.

In contrast, there are several sedative medications that enhance sleep without requiring increased doses. In my opinion, these drugs represent a superior approach to treating insomnia in depressed individuals. Three that are often prescribed for this purpose are 25 to 100 mg of trazodone (Desyrel) or doxepin (Sinequan) or 25 to 50 mg of diphenhydramine (Benadryl). The first two are antidepressants that require a prescription. Benadryl is an antiallergy medication that is now sold without a prescription. Make sure that you consult with your doctor before taking any medication, even one that is sold over the counter, to make sure there are no dangerous drug interactions with other medications you are taking. Remember that many over-the-counter drugs, like Benadryl, were once available only on prescription, so they can be just as dangerous as prescription drugs. The new anticonvulsant, gabapentin, also has sedative and antianxiety effects without being habit-forming, and some doctors are prescribing it for this purpose.

If you are having trouble sleeping, you may have personal problems that make it hard to get to sleep. It could be anything—a problem at school or work, or a conflict with a family member or friend. Some people sweep these problems under the carpet so they won't have to deal with them. Then they develop a variety of symptoms instead. Some people become anxious, others have trouble sleeping, and some develop aches and pains that have no organic causes.

I have always felt it is better to try to identify and solve the problem rather than masking it with tranquilizers or sleeping pills. In our culture, the idea of a quick cure is tremendously appealing to patients and physicians alike. It is easy to prescribe a drug that will make the problem go away. This contributes greatly to the enormous popularity of sleeping pills and minor tranquilizers.

*Stimulants.* How about the “pep pills” (stimulants) such as methylphenidate (Ritalin) and the amphetamines that used to be so commonly prescribed for weight loss? It is true that these drugs can produce a temporary stimulation or elation (much like cocaine), but they can also be dangerously habit-forming. When you come down from the temporary high state, you may tend to crash and experience an even more profound sense of despair. When given chronically, these drugs can sometimes produce an aggressive, violent, paranoid reaction resembling schizophrenia.

I have not prescribed stimulants for depressed patients (or for any other problem) because of my concerns about these drugs, but this is clearly an area of controversy. Some psychiatrists do prescribe stimulants for elderly depressed patients under certain circumstances, and they are quite popular for treating hyperactive children and adolescents. If your doctor recommends taking such pills, you should certainly discuss the pros and cons. You might also want to obtain a second opinion if you feel uncomfortable about the treatment.

There are exceptions to this rule, like any. Because of its energizing properties, some doctors add methylphenidate (Ritalin) to a tricyclic antidepressant. This combination may be helpful for some patients who are very sluggish and unmotivated. However, methylphenidate also inhibits the breakdown of most tricyclic antidepressants by the liver, and so the blood level of these other antidepressants will increase. This may lead to greater side effects and may require a reduction in the dose of the antidepressant.

*Antipsychotic Medications (Neuroleptics).* What about the antipsychotic medications (also called neuroleptics or “major tranquilizers”)? Some of the older drugs in this category include chlorpromazine (Thorazine), chlorprothixene (Taractan), haloperidol (Haldol), fluphenazine (Prolixin), loxapine (Loxitane), mesoridazine (Serentil), molindone (Moban), perphenazine (Trilafon), pimozide (Orap), thiothixene (Navane), thioridazine (Mellaril), and trifluoperazine (Stelazine). Some of the newer drugs include

clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), sertindole (Serlect), and ziprasidone (trade name not yet available). These agents are usually reserved for patients with schizophrenia, mania, or other psychotic disorders. They do not play a major role in the treatment of most depressed or anxious patients. Pills that combined an antidepressant with an antipsychotic medication were marketed and promoted in the past, but most clinical studies have not documented any superior efficacy of such preparations in the treatment of depression.

Only a minority of depressed individuals benefit from antipsychotic agents. These include depressed patients who are delusional—that is, patients who draw false and highly unrealistic conclusions about external reality. For example, a depressed patient might have the delusion that there are worms in his or her body or that there is a conspiracy against him or her. Elderly depressed patients seem more likely to develop paranoid delusions. Depressed patients who are extremely agitated and cannot stop pacing sometimes benefit from the antipsychotic agents as well. However, the major tranquilizers may also cause a worsening of the depression because of their tendency to cause sleepiness and fatigue.

In addition, unlike most antidepressants, many of the antipsychotic medications carry the risk of an irreversible side effect called tardive dyskinesia. Tardive dyskinesia is an abnormality of the face, lips, and tongue; it involves repetitious, involuntary movements, such as smacking the lips over and over or grimacing. The abnormal movements can also sometimes include the arms, legs, and torso. The major tranquilizers can also cause a number of other alarming but reversible side effects. Therefore, these drugs should be used only when they are clearly needed so that their potential benefit outweighs the potential risk.

## Polypharmacy

Polypharmacy refers to the practice of prescribing more than one psychiatric drug at a time to a particular patient. The idea is that if one drug is good, two, three, or more will be even better. Doctors may combine antidepressant drugs with other types of antidepressants as well as with other types of drugs, such as minor and major tranquilizers. The patient ends up taking a cocktail of many different types of drugs.

Polypharmacy used to be frowned upon. Now the practice has become more accepted, and many psychiatrists routinely prescribe two or more drugs for many of their psychiatric patients. In contrast, if a family physician is treating your depression, then it is much less likely that she or he will prescribe more than one psychiatric medication at a time. This is because a family doctor is usually more concerned with your medical problems and much less aggressive in the treatment of emotional problems.

In some instances, polypharmacy can be helpful in the treatment of mood disorders. For example, I have described several augmentation strategies that might boost the effectiveness of an antidepressant. I have also described how the occasional use of a second medication can combat a drug side effect. Rational polypharmacy might also be helpful when a patient has separate disorders that both require treatment. For example, a patient with schizophrenia may also be depressed and may benefit from a combination of an antipsychotic medication along with an antidepressant. A bipolar (manic-depressive) patient may receive an antidepressant in addition to the lithium during an episode of depression. During an episode of mania, the doctor may prescribe a neuroleptic or a benzodiazepine in addition to lithium to combat the acute symptoms, as described previously.

Although there are specific instances like these when combinations of drugs are indicated, I am usually not in favor of polypharmacy in the treatment of depression or anxiety because of the increase in side effects, drug interactions, and costs. In addition, polypharmacy has the tendency to convey the message that all the patient's problems can be dealt with by drugs. The patient may take one or two drugs for depression, one or two additional drugs to treat the side effects of the antidepressants, one more drug to treat anxiety, and so on. And if the patient is angry, she or he may get yet another drug, such as a mood stabilizer, to treat the anger.

The patient may end up in a rather passive role as a kind of human test tube. You may think I am exaggerating, but I have seen numerous patients who were in just this position. They were taking lots of drugs with lots of side effects but were receiving very little benefit from any of them. I have treated many of these patients successfully with cognitive therapy and no drugs or cognitive therapy and only one antidepressant

I believe that some psychiatrists rely too much on drugs. Why is this? One problem is that most psychiatric training programs strongly emphasize

biological theories about depression and stress the importance of drug treatments for depression and other disorders. In addition, a great many of the continuing education programs for psychiatrists in practice are sponsored by drug companies, and the focus of these conferences is nearly always on medications. The psychiatric journals, too, are filled with expensive drug company advertisements promoting the benefits of the latest medications for depression or anxiety, but I have never seen an ad promoting the latest psychotherapy technique. This is because there is simply no money to pay for such an ad! Drug companies also fund a great deal of the research on medications that appears in psychiatric journals, and concerns have been voiced about the potential conflict of interest inherent in such arrangements.

I do not mean to sound like a rabble-rouser! This is not a black-or-white issue. Clearly, the excellent research conducted by the pharmaceutical industry has been an enormous boon to the psychiatric profession and to individuals suffering from psychiatric disorders. My concern is that the emphasis on drugs sometimes seems excessive. Unfortunately, some psychiatrists do not have good training in the newer forms of psychotherapy, including cognitive behavioral therapy, which can be so helpful for individuals suffering from depression and anxiety. When a patient does not respond to medications, the main response of the psychiatrist may be to increase the dose or add another medication because this is what the psychiatrist has been trained to do. And when a patient complains of an adverse side effect, the psychiatrist may decide to add some other additional drug as an antidote—because that is what she or he has been trained to do. The result in some cases is that patients end up taking more and more drugs in larger and larger doses—without any real benefits. This is when polypharmacy can get out of hand.

When I was a psychiatric resident, I used to have the idea that if only I could find the right “magic bullet” (in other words, the right pill), I could help every patient. In those days, we treated our patients with pill after pill after pill but very little psychotherapy. My clinical experience taught me over and over again that this model was not sufficient—too many of my patients simply did not recover, no matter how many drugs I used, singly or in combinations.

To make things worse, most psychiatrists do not require patients to take mood tests, like the one in Chapter 2, between therapy sessions to track

progress. As a result, the psychiatrist may conclude that the patient is being “helped” by a drug when the patient has not really improved substantially. To my way of thinking, treating patients without session-by-session assessments is anti-scientific and represents a barrier to good treatment and progress in the field.

Some psychiatrists and many patients are almost exclusively committed to these biological theories and treatments for depression. They may discount the value of other approaches, sometimes with a religious fervor. A number of well-known psychiatrists are quite outspoken in this regard. The intensity of these debates about psychotherapy versus drug therapy is sometimes more reminiscent of a power struggle for turf than an intellectual search for the truth. Fortunately, there is a growing and healthy trend to recognize that all of our current psychiatric drugs are limited in their effectiveness. In addition, there is an increasing recognition that a combination of medication with the newer forms of psychotherapy (including cognitive behavioral therapy and others) usually provides a more satisfactory outcome than does treatment with drugs alone.

It is clear that antidepressant drugs can help some individuals, but it is also clear that many patients do not respond adequately. When patients do not respond, I would prefer to switch into a different gear and use cognitive therapy or a combination of cognitive therapy and one antidepressant medication at a time. Most depressed people have real problems in their lives, and nearly all of us need a compassionate, healing relationship with another human being to talk things out at times. The idea that drugs alone should work to cure depression and anxiety may be appealing, but this approach is often ineffective.

To be fair, an exclusive focus on psychotherapy alone can be just as biased. I have seen patients who did not respond to many psychotherapeutic interventions that I personally administered—week after week their depression scores on the test in Chapter 2 did not change. Sometimes I prescribed an antidepressant while we continued working with a variety of psychotherapeutic strategies. Within several weeks, the depression and anxiety often began to improve, and the psychotherapy suddenly began to work better. In these cases, I was glad to have the medications available.

A final problem contributing to polypharmacy is that many patients are unassertive. Even though they feel uncomfortable about all the drugs they are

taking, they may sometimes assume that “the doctor knows best.” This is understandable. The doctor does have a great deal of training, and the patient’s knowledge is usually limited. In addition, the patient often admires the doctor and respects his or her advice. But in psychiatry and psychology, treatment approaches are far more subjective and varied than in internal medicine, where the treatments are far more precise and uniform. Your feelings about the treatment are important, and you have every right to share these feelings with your doctor.

This review of drug-prescribing practices obviously represents my own approach. Your physician’s ideas might differ. Psychiatry is still a blend of art and science. Perhaps some day the “art” will no longer be such a prominent ingredient. If you feel uncertain about your treatment, ask your physician questions. State your concerns and urge your doctor to explain the treatment in simple terms you understand. After all, it’s your brain and body that are at risk, not the doctor’s. The sense of teamwork and collaboration are important to successful treatment. As long as the two of you agree to a rational, understandable, and mutually acceptable strategy for your therapy, you will have an excellent chance of benefiting from your doctor’s efforts to help you.

## **Suggested Resources**

### **Other Books by Dr. Burns**

*The Feeling Good Handbook* (New York: Plume, 1990). Dr. Burns shows how you can use cognitive therapy to overcome a wide variety of mood problems such as depression, frustration, panic, chronic worry and phobias, as well as personal relationship problems such as marital conflict or difficulties at work.

*Intimate Connections* (New York: Signet, 1985). Dr. Burns shows you how to flirt, how to handle people who give you the run-a-round, and how to get people of the opposite sex (or the same sex, if that is your preference) to pursue you.

*Ten Days to Self-Esteem* and *Ten Days to Self-Esteem: The Leader's Manual* (New York: Quill, 1993). In this ten-step program, Dr. Burns provides a practical, workable blueprint for breaking out of the bad moods that rob us of self-esteem. He provides you with clear, easy-to-understand instructions and specific tools gleaned from twenty years of systematic research and psychiatric practice. The *Leader's Manual* shows you how to develop this program in hospitals, clinics, schools, and other institutional settings.

### **Workshops and Lectures by Dr. Burns**

Dr. Burns offers workshops and lectures for mental health professionals and for general public audiences as well. For a list of dates and locations, you are invited to visit Dr. Burns' Web site at [www.FeelingGood.com](http://www.FeelingGood.com)

### **Audiotapes for the General Public**

Burns, *The Perfectionist's Script for Self-Defeat*.

Dr. Burns helps you identify perfectionistic tendencies and explains how they work against you. He shows you how to stop setting unrealistically high standards and increase productivity, creativity, and self-satisfaction.

### *Burns, Feeling Good.*

Dr. Burns describes ten common self-defeating thinking patterns that lead to depression, anxiety, frustration, and anger. He explains how to replace them with more positive and realistic attitudes so you can break out of bad moods and enjoy greater self-esteem now and in the future.

## **Audiotapes for Mental Health Professionals**

### *Strategies for Therapeutic Success: My Twenty Most Effective Techniques—Volumes I and II. 8 Cassettes*

In this two-day intensive workshop, Dr. Burns illustrates the most valuable therapy techniques he has developed during two decades of clinical practice, training, and research.

### *Feeling Good: Fast & Effective Treatments for Depression, Anxiety, and Therapeutic Resistance. 4 Cassettes*

Dr. Burns describes the basic principles of CBT and illustrates state-of-the-art treatment methods for depression and anxiety disorders. He also illustrates how to deal with difficult, angry patients who seem to sabotage the treatment because they feel mistrustful and unmotivated.

### *Feeling Good Together: Cognitive Interpersonal Therapy 4 Cassettes*

In this workshop, Dr. Burns shows how to modify the attitudes that sabotage intimacy and lead to anger and mistrust. He also explains how to deal with patients who blame others for their personal relationship problems.

### *Rapid, Cost-Effective Treatments for Anxiety Disorders 4 Cassettes*

In this workshop, Dr. David Burns shows you how to integrate three powerful models in the treatment of the entire spectrum of anxiety disorders, including generalized anxiety, panic disorder (with or without agoraphobia), phobias, social anxiety, obsessive-compulsive disorder, and

post-traumatic stress disorder (including victims of childhood sexual abuse).

You may order the audiotapes for professionals or for the general public by visiting Dr. Burns' Web page at [www.FeelingGood.com](http://www.FeelingGood.com)

## **Treatment and Assessment Tools for Mental Health Professionals**

### *Therapist's Toolkit 2000*

Includes hundreds of pages of state-of-the-art assessment and treatment tools for the mental health professional. Purchase includes licensure for unlimited reproduction in your clinical practice. Site licenses are available.

## **Feeling Good Web Site**

You are invited to visit Dr. Burns' Web site at [www.FeelingGood.com](http://www.FeelingGood.com). This Web site contains information about:

- dates and locations for upcoming lectures and workshops by Dr. Burns
- audiotapes for the general public
- training tapes for mental health professionals (including CE credits)
- links for referrals to cognitive therapists around the country
- description of Dr. Burns' new *Therapist's Toolkit*
- links to other interesting sites
  - new information of potential interest to patients, therapists, and researchers
- Ask The Guru. You can submit questions about any mental health topic. Answers to selected questions are posted in a column format.

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The development of cognitive therapy has been a team effort involving many talented individuals. In the 1930s, Dr. Abraham Lowe, a physician, began a free-of-charge self-help movement for individuals with emotional difficulties, called “Recovery Incorporated,” which is still in existence today. Dr. Lowe was one of the first health professionals to emphasize the important role of our thoughts and attitudes on our feelings and behavior. Although many people are not aware of his work, Dr. Lowe deserves a great deal of credit for pioneering many of the ideas that are still in vogue today.

In the 1950s, the noted New York psychologist, Dr. Albert Ellis, refined these concepts and created a new form of psychotherapy called Rational Emotive Therapy. Dr. Ellis published over fifty books that emphasize the role of negative self-talk (such as “shoulds” and “oughts”) and irrational beliefs (such as “I must be perfect”) in a wide variety of emotional problems. Like Dr. Lowe, his brilliant contributions are sometimes not sufficiently acknowledged by academic researchers and scholars. In fact, when I wrote the first edition of *Feeling Good*, I was not especially familiar with the work of Dr. Ellis and did not really appreciate the importance and magnitude of his contributions. I want to set the record straight here!

Finally, in the 1960s, my colleague at the University of Pennsylvania School of Medicine, Dr. Aaron Beck, adapted these ideas and treatment techniques to the problem of clinical depression. He described the depressed patient’s negative view of the self, the world, and the future, and proposed a new form of “thinking therapy” for depression, which he called “cognitive therapy.” The focus of cognitive therapy was helping the depressed patient change these negative thinking patterns. Dr. Beck’s contributions, like those of Drs. Lowe and Ellis, have been substantial. His

Beck Depression Inventory, published in 1964, allowed clinicians and researchers to measure depression for the first time. The idea that we could measure how severe a patient's depression was, and track changes in response to treatment, was revolutionary. Dr. Beck also emphasized the importance of systematic, quantitative research so we could get objective information on how well the different kinds of psychotherapy actually worked, and how effective they are in comparison to antidepressant drug therapy.

Since the time of those three early pioneers, many hundreds of gifted researchers and clinicians throughout the world have contributed to this new approach. In fact, there has probably been more published research on cognitive therapy than on any other form of psychotherapy ever developed, with the possible exception of behavior therapy. Clearly, I cannot mention all the individuals who have made important contributions to the development of cognitive therapy. In the early days of cognitive therapy, during the 1970s, I worked with several colleagues at the University of Pennsylvania School of Medicine who helped to create many of the treatment techniques still in use today. They included Drs. John Rush, Maria Kovacs, Brian Shaw, Gary Emery, Steve Hollon, Rich Bedrosian, Ruth Greenberg, Ira Herman, Jeff Young, Art Freeman, Ron Coleman, Jackie Persons, and Robert Leahy.

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## **About the Author**

**DAVID D. BURNS, M.D.**, is an adjunct clinical professor of psychiatry and behavioral sciences at the Stanford University School of Medicine and has served as Visiting Scholar at Harvard Medical School. His bestselling book, *Feeling Good: The New Mood Therapy*, has sold more than four million copies worldwide and is the book most often recommended by mental health professionals to patients suffering from anxiety and depression.

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## About the Book

In a national survey of more than 1,000 self-help books, Dr. David Burns's *Feeling Good* was rated as the most helpful book on depression—the most frequently recommended by American mental health professionals. Five controlled outcome studies published in scientific journals indicated that 70 percent of depressed individuals who read *Feeling Good* improved within four weeks, without receiving other treatment—and maintained their improvement during follow-up periods of up to three years.

**The antidepressant effects of *Feeling Good* appear to be as strong as antidepressant medications or individual psychotherapy for patients suffering from episodes of major depression!**

Although Dr. Burns does not recommend any self-help book as a substitute for professional therapy, *Feeling Good* should prove immensely illuminating to anyone suffering from depression or anxiety.

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“I would personally evaluate David Burns’s *Feeling Good* as one of the most significant books to come out of the last third of the Twentieth Century.” Dr. David F. Maas, Professor of English, Ambassador University

## **Notes and References (Chapters 17 to 20)**

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2. Some psychologists are lobbying for the right to prescribe drugs, and some psychologists in the armed services have already been licensed to prescribe drugs. There is intense controversy about the merits of this proposal. Some psychologists argue that the right to prescribe drugs is desirable because it will put them on an even footing to compete with psychiatrists for patients. Other psychologists argue that drug prescribing requires extensive medical training and that the profession will lose an important part of its identity if psychologists win the right to prescribe drugs. They also point out that the role of the psychiatrist, particularly in managed care situations, has become quite unappealing. Many psychiatrists who work for HMOs are now forced to see huge numbers of patients for extremely brief visits consisting only of discussions about medications without any time to do psychotherapy or to learn about the problems in their patients' lives.
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18. You will notice that the percentages of patients reporting stomach upset in Table 20–5 are a little lower than 20 percent to 30 percent on the average. This is because the percentages in the table represent the differences between the rates for the actual drug minus the rates for patients taking placebo medications.
19. You will learn below that the MAOIs can cause dangerous blood pressure elevations, but this is only if you take one of the forbidden foods or medications. Usually, the MAOIs can cause a mild drop in blood pressure.
20. A patient with a “difficult” or “resistant” depression is simply one who does not readily respond to the usual treatments. If your doctor tries many antidepressant drugs and you do not improve, your doctor will naturally conclude that your depression is more difficult than usual to treat. However, you may respond nicely to another type of treatment. I have treated large numbers of patients who had years and years of unsuccessful treatment with a wide variety of drugs prior to seeing me. Many of these “difficult” patients recovered when I used cognitive therapy techniques like those described in this book.

No single treatment is a panacea for everyone. That's why it is important to have lots of approaches available, including many different kinds of medicines and many different kinds of

psychotherapeutic methods as well. The term, “different strokes for different folks” is right on target in the context of depression treatment!

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## **Other Books**

### **Books by David D. Burns, M.D.**

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\*No current treatment is a panacea, including cognitive therapy. Another new short-term therapy, called interpersonal therapy, has also shown some promise for patients with eating disorders. In the future, studies like those conducted by Dr. Agras and his colleagues will undoubtedly lead to more powerful and specific treatments for eating disorders.

\*The idea that your thinking patterns can profoundly influence your moods has been described by a number of philosophers in the past 2500 years. More recently, the cognitive view of emotional disturbances has been explored in the writings of many psychiatrists and psychologists including Alfred Adler, Albeit Ellis, Karen Homey, and Arnold Lazarus, to name just a few. A history of this movement has been described in Ellis, A., *Reason and Emotion in Psychotherapy*. New York: Lyle Stuart, 1962.

\*Table 1–1 was adapted from Rush, A. J., Beck, A. T., Kovacs, M., and Hollon, S. “Comparative Efficacy of Cognitive Therapy and Pharmacotherapy in the Treatment of Depressed Outpatients.” *Cognitive Therapy and Research*, Vol. 1, No. I, March 1977, pp. 17–38.

\*Blackburn, I. M., Bishop, S, Glen, A. I. M., Whalley, L. J. and Christie, J. E. “The Efficacy of Cognitive Therapy in Depression. A Treatment Trial Using Cognitive Therapy and Pharmacotherapy, Each Alone and in Combination.” *British Journal of Psychiatry*, Vol. 139, January 1981, pp. 181–189.

\*Some readers may recall that I included the Beck Depression Inventory (BDI) in the 1980 edition of *Feeling Good*. The BDI is a time-honored instrument that has been used in hundreds of research studies on depression. Dr. Aaron Beck, the creator of this test, deserves a great deal of credit for creating the BDI during the early 1960s. It was one of the first instruments for measuring depression in clinical and research settings, and I was grateful for his permission to reproduce it in the earlier edition of *Feeling Good*.

\*Mental health professionals may be interested to learn that the psychometric properties of the BDC are excellent. The reliability of the twenty-five-item BDC has been assessed in a group of ninety depressed outpatients seeking treatment at the Center for Cognitive Therapy in Oakland, California, and in a group of 145 outpatients seeking treatment at a Kaiser facility in Atlanta, Georgia. The reliability was extremely high and identical in both groups (Cronbach’s coefficient alpha = 95%). The high

correlation between the BDC and the BDI  $r(68) = .88$ ,  $p < .01$  in the Oakland group indicates that these two scales assess a similar if not identical construct. When both instruments were purged of errors of measurement using structural equation modeling techniques, the correlation between the scales was not significantly different from 1.0. The BDC was also normed against the widely used depression subscale of the Hopkins Symptom Checklist-90 in the Atlanta, Georgia, sample. The extremely high correlation between the two measures  $r(131) = .90$ ,  $p < .01$  further confirmed the validity of the BDC.

Extensive clinical experience with the BDC in a variety of treatment settings indicates it is well accepted by patients. Many have commented that the test is easy to complete and score and helpful for tracking changes in symptoms over time. A brief, five-item BDC with outstanding psychometric properties has also been developed. The brief BDC is ideal for testing patients on a session-by-session basis because patients can complete it in less than one minute. It has performed well with adults and adolescents in a variety of psychiatric and medical settings, including recently arrested juveniles in the California judicial system. Mental health professionals who are interesting in learning more about these and many other assessment instruments that can be used in clinical or research settings (including an electronic patient testing module) are cordially invited to visit my Web site at [www.FeelingGood.com](http://www.FeelingGood.com)

\*Beck, Aaron T. *Depression: Clinical, Experimental, & Theoretical Aspects*. New York: Hoeber, 1967. (Republished as *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania Press, 1972, pp. 17–23.)

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\* Dr. Wayne W. Dyer, *Your Erroneous Zones* (New York: Avon Books, 1977), p. 173.

\*\* *Ibid.*, pp. 218-220.

\* Adaptive means useful and self-enhancing; maladaptive means useless and self-destructive.

\*Copyright 1978, Arlene Weissman.

\* This is a purely imaginary dialogue having no bearing on the real Helen Gurley Brown.

\* Beck, Aaron T. *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania Press, 1972, pp. 30–31.

\* Some of the newer forms of psychiatric treatment, such as cognitive therapy, allow for a natural fifty-fifty dialogue between the client and therapist, who work together as equal members of a team.

\*I would like to thank Joe Bellenoff, M.D., a psychopharmacology fellow at Stanford University Medical School, and Greg Tarasoff, M.D., a senior psychiatric resident at Stanford, for helpful suggestions during the revision of this chapter. In addition, much useful information was obtained from the excellent *Manual of Clinical Psychopharmacology*, Third Edition, by Alan F Schatzberg, M.D., Jonathan Cole, M.D., and Charles DeBattista, D.M.H., M.D. (Washington: American Psychiatric Press, 1997). This scholarly but highly readable book is an invaluable reference. I highly recommend it for individuals who would like more information on the medications currently used in the treatment of emotional problems.