SECOND EDITION

Cognitive Therapy Techniques

A Practitioner's Guide

ROBERT L. LEAHY

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Preface

The first edition of *Cognitive Therapy Techniques* provided clinicians with a wide range of cognitive-behavioral techniques that could be used to expand the arsenal of interventions that one could use in clinical practice. When I originally considered what I wanted to cover in that book, I thought of what I would want to know if I were learning cognitive-behavioral therapy (CBT), or what I would want to know if I hadn't been at this for so many years. Many of us can find ourselves getting "stuck" with—or accustomed to—a few simple techniques. For example, one might just find oneself using techniques such as identifying the automatic thought, examining the costs and benefits of that thought, looking at the evidence, and coming up with another more adaptive thought. That's fine—up to a point. Or one might think, "I will use some behavioral activation techniques"—and those might work, too. Or mindfulness—that can help. What I have learned, though, is that patients present with a wide range of problems, a wide range of beliefs about change, reasons not to change, and impediments to improvement. So, I guess I turned my own frustration as a clinician into writing a book, one that might be helpful if you want to move beyond your habitual techniques to see if there are some other things you can do.

I have been fortunate to have wonderful and creative colleagues at the American Institute for Cognitive Therapy in New York City (*www.CognitiveTherapyNYC.com*). Rather than churning out "mini-me's" of me, I have encouraged our staff members to be the best that they can be at being themselves—whether it's cognitive therapy, behavioral therapy, acceptance and commitment therapy, dialectical behavior therapy, mindfulness, or whatever it is that they do. This experience has been immensely enriching for me because I learn so much from them. So, the current volume reflects a lot of integration of CBT techniques from a wide range of approaches. And, of course, I have learned from the many patients who have trusted me with their care, who have taught me about how things make sense when you are depressed and anxious, and who have sometimes come up with their own ideas of change. I don't think I am alone as a therapist in having experienced a patient saying something that he or she thinks is helpful, and thinking, "Gee, maybe I should try that in *my* life."

I have organized this book around certain categories of interventions or techniques, beginning with many of the traditional techniques for identifying and evaluating thoughts and assumptions. Chapters 2–5—"Eliciting Thoughts," "Evaluating and Testing Thoughts," "Evaluating Assumptions

and Rules," and "Examining Information-Processing and Logical Errors"—provide a number of techniques that target the cognitive content of often biased and unhelpful thinking. Chapter 6, "Modifying Decision Making," examines the typical assumptions and biases—or heuristics—that affect difficulty or problems in making decisions. Decision making has been an interest of mine for years, and so this chapter brings into focus issues such as sunk-cost effects, risk aversion, basing decisions on limited information, overfocus on immediate consequences, and other factors. Many depressed and anxious people have great difficulty in making decisions and often get stuck with situations that they have trouble changing. Chapter 7, "Responding to and Evaluating Intrusive Thoughts," owes a great debt to the metacognitive model advanced by Adrian Wells, which is one of the truly innovative models of the past decade. Again, intrusive thoughts often lead to an overvaluation of the content of that thought, the tendency to take a thought personally, beliefs that thoughts that are unpleasant or unwanted have to be eliminated, or that these thoughts are out of control. I hope this chapter provides the clinician with some techniques that will innovate change.

For those familiar with my writing, it will come as no surprise that I've included a chapter on "Modifying Worry and Rumination" (Chapter 8), which provides a great number of techniques that can be combined with the many techniques on coping with intrusive thoughts. This material will be relevant to helping people with worry, rumination, and intrusive thoughts in posttraumatic stress disorder and in other disorders. In Chapter 9, "Putting Things in Perspective," I provide numerous techniques that can be helpful in supporting patients in reducing their tendency to overreact to events and to assist in accepting the inevitable difficulties in life. Chapter 10, "Identifying and Modifying Schemas," illustrates a wide range of techniques that one can use to address long-standing schematic issues, often associated with personality disorders or "personality styles." Clinicians working with patients who experience recurrent problems in relationships, with self-identity, and at work, and who often benefit from longer-term CBT, may find these techniques helpful. Chapter 11, "Emotion Regulation Techniques," also reflects some of the work by many other clinicians, my colleagues, and me on helping patients utilize coping skills to live with turbulent emotions. Indeed, it may be that some patients will need emotion regulation work before they can even use the other techniques in this book.

The last section of the book includes a brief chapter (Chapter 12) with examples of how to address each of the cognitive distortions mentioned earlier. Then I provide three short chapters that address techniques for common problems, such as "need for approval" (Chapter 13), "self-criticism" (Chapter 14), and "anger" (Chapter 15). We could cover many other problems, but I hope these examples will serve as a guide to how clinicians can actually use a wide range of techniques for other common and not-so-common problems.

My hope is that clinicians will be able to integrate additional techniques and strategies to overcome impasses that inevitably occur, and provide patients with new skills to use in handling the difficulties that they face. No technique is a panacea, and no model is perfect. Given the world of limitations in which we live, having additional coping skills can make the difference between getting stuck and making the change that really matters. It's part of the flexibility that we should all embrace.

Acknowledgments

One of the pleasures in writing a book is to acknowledge the influence and support that I have received over the years. First, I want to thank Jim Nageotte, who has been a wonderful editor since working on my first book with The Guilford Press. Also, Jane Keislar and Jeannie Tang from Guilford and copyeditor Margaret Ryan have been remarkably conscientious in making much of this into a reality.

There have been so many people whose work has influenced me, beginning with Aaron T. Beck, the founder of cognitive therapy. I also wish to acknowledge the important influence of the following people: Jill Abramson, Lauren Alloy, Arnoud Arntz, David Barlow, Judith Beck, David Burns, David A. Clark, David M. Clark, Frank Dattilio, Keith Dobson, Michel Dugas, Edna Foa, Paul Gilbert, Allison Harvey, Steve Hayes, Stefan Hofmann, Emily Holmes, Sheri Johnson, Marsha M. Linehan, Doug Mennin, Cory Newman, Christine Purdon, Stanley J. Rachman, John Riskind, Paul Salkovskis, Debbie Sookman, John Teasdale, Dennis Tirch, Adrian Wells, Mark Williams, Jeffrey Young, and Zindel V. Segal. I am also indebted to my colleagues at the American Institute for Cognitive Therapy, who over these many years have probably heard some version of almost everything that I have published. In particular, I wish to thank Melissa Horowitz, Laura Oliff, Susan Paula, Mia Sage, Scott Woodruff, Maren Westphal, and Peggilee Wupperman. Of special note, I wish to thank my editorial assistant Sindhu Shivaji, who has worked tirelessly, beyond the call of duty, in every phase of the editorial and research process. I would also like to thank my friend and colleague Philip Tata, from the British Association for Behavioural and Cognitive Psychotherapies, who has been a wonderful guide and support to me for many years.

And, of course, where would I be without my lovely, thoughtful, wise wife, Helen, who continues to provide the humor and support that have made all of these endeavors possible? It is to her that this book is dedicated.

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PART I

Beginning Cognitive Therapy

CHAPTER 1

Introduction

This second edition of *Cognitive Therapy Techniques* provides the clinician with a wide range of cognitive and behavioral interventions that can be used to address depression, anxiety, anger problems, relationship problems, and many other forms of psychopathology. Although the orientation is primarily cognitive in the sense of focusing on the content, function, and form of thinking, I have included techniques that reflect contributions from metacognitive, acceptance, dialectical behavioral therapy, behavior activation, and compassion-focused therapy.

The cognitive model has expanded since its early formulation by Beck and Ellis. In the early cognitive model emphasis was placed on the specific content of thinking, such as the typical categories of distortion of automatic thoughts, underlying assumptions, and core schemas or beliefs. The cognitive model emphasizes the need to determine the role of schemas in affecting attention and memory and in the maintenance of problematic beliefs. Thus, the cognitive model would identify the role of confirmation bias and schematic processing in maintaining the negative beliefs of the depressed individual, even in the presence of positive information that might presumably contradict these beliefs.

This cognitive architecture is preserved in the current formulation as well as expanded to include a recognition that personality disorders are characterized by persistent schemas about self and others, and styles of compensation, avoidance, or schema maintenance. In addition, the concept of modes introduces systemic and coordinated patterns of response that organize cognition, motivation behavior, interpersonal functioning, and emotional responses around consistent and self-maintaining systems such as anger, mania, or depression (Beck & Haigh, 2014). The mode is a superordinate construct that represents the coordination of these various components and serves to maintain and expand the mode to new areas of life.

While recognizing the significant contribution of the cognitive model, other models have contributed to the range of formulations, strategies, and techniques available to the therapist. In particular, this new edition recognizes the important contributions of the metacognitive model advanced by Wells (2007, 2008, 2011); the behavioral activation model advanced by Martell, Dimidjian, and Herman-Dunn (2010); acceptance and commitment therapy (ACT) advanced by Hayes, Strosahl, and Wilson (2003); dialectical behavior therapy (DBT) advanced by Linehan (2015); compassion-focused therapy (Gilbert, 2009); and other approaches. In addition, I have also included ideas from

the cognitive science of decision making (Kahneman, 2011), mindfulness (Teasdale et al., 2012), and my work on emotional schemas (Leahy, 2015).

As will become clear in the first few chapters, the cognitive model proposes that depression, anxiety, anger, and other problems are maintained, activated, or exacerbated by biases in thinking. In particular, at the center of these biases are schemas that are consistent patterns of organizing information around a preexisting concept. The concept of schema is an old one in psychology, dating back to Bartlett and Piaget. In the 1970s, the fields of cognitive science and social cognition placed a great deal of emphasis on the role of schemas in determining selective attention, memory, and the interpretation of information. Thus, the cognitive model is partly derived from the information-processing revolution in the psychology of that era. Although both the Beck model and the Young model of schemas place an emphasis on the early development of these schemas in childhood, the research on schematic processing indicates that schemas can be formed at any time and that the formation of these schemas is outside immediate awareness (Bargh & Morsella, 2008; Andersen, Saribay, & Przybylinski, 2012; Fiske & Macrae, 2012). Although these schemas operate with automaticity, the cognitive model proposes that they can be accessed into conscious awareness through a variety of techniques. Thus, the goal is partly to make the implicit explicit.

The cognitive model of therapy places an emphasis on psychoeducation of the patient regarding his or her fundamental assumptions and the approach to be utilized in therapy. Thus, the therapist may indicate to the patient in the first session of therapy that they are going to focus on what the patient is consciously thinking and doing currently, how he or she can look at things differently and behave differently, and how self-help homework between sessions will allow the generalization of the gains in the session. In addition, bibliotherapy is a frequent component of cognitive therapy, with therapists providing information sheets on various problems or recommendations of books to read to help guide the patient through the process.

The cognitive approach stresses the importance of testing the patient's construction of reality against the facts as they become available. Thus, the therapy attempts to uncover, through questioning and behavioral experiments, what the patient believes to be true and the habitual patterns of thinking underlying his or her problems. For example, the depressed individual often reveals a negative view of self, life in general, and the future and, as a result, may be reluctant to attempt new behavior that might fail and lead to further demoralization and regret. Therapy attempts to encourage a greater awareness of the thoughts that may be shaping and fueling this negativity and introduce fundamental doubts about the infallibility of this way of thinking. The therapist encourages skepticism toward any thoughts that disable a patient and points out that thoughts have consequences and need to be evaluated as to whether they are pragmatic and whether they conform to the facts. In short, this approach emphasizes an empirical approach to reality: "What are the consequences of thinking this?," "What would be the consequence of an alternative view?," or "Let's test your thought against reality."

Moreover, cognitive therapists examine the meaning, or the lack of meaning, in the salient concepts with which depressed or anxious individuals berate themselves. These might include concepts that have no empirical referent, such as "worthless person" or "loser." I have found it immensely helpful to encourage patients to avoid general labels of fixed qualities (e.g., "I'm a *failure*") and to consider more specific, behavioral descriptions (e.g., "I did not achieve my goal *on this task at that time*"). By specifying and limiting descriptions to behaviors, situations, and time, the therapist and patient can introduce the understanding that performances vary depending on the context, beliefs held, motivation to engage, and the behavior enacted. This more nuanced perspective allows the patient to move from fixed to flexible thinking and to consider an experimental approach to testing his or her negative thoughts—for example, I might say, "Let's try a different way of approaching this

and see what happens." Behaviors can be changed, but traits give us the illusion of permanence and a subsequent belief in the hopelessness of ever changing.

In the cognitive model, "reality" is an *open system*. Thus the cognitive model is constructivist to the extent that the "knower"—here, the therapist and the patient—will never have all of the facts. There is no exhaustive test of information. Decisions in the real world are made with incomplete information, in real time, always under conditions of uncertainty. This view of an open system is an important recognition in the decision-making process, which I discuss in some detail in Chapter 6. *Knowing* in the empirical world is a statement more of probabilities than of certainties. Predictions are based on incomplete information—always. The recognition that inferential thinking is always incomplete, indeterminate, and probabilistic is an essential component of the cognitive therapist's perspective. Thus, when the patient demands certainty—"Yes, but I could be the one whose plane crashes!"—the cognitive therapist should recognize that existential possibilities do exist and cannot be eliminated. The real question for the patient demanding certainty is, "Why is it difficult to accept uncertainty?" This kind of questioning leads to a new approach to the patient's "knowledge needs": that is, the need to predict with certainty. Often examining this need reveals that the patient views "certainty" as part of a desire for absolute control—without which disasters will occur. We will see how uncertainty training is an important antidote to worry and rumination whereby the "thinker" attempts to exhaust all possibilities of outcomes and solutions in an attempt to gain certainty. Patients need to recognize that we all make decisions in an uncertain world, and there is no certainty in an uncertain world. Life occurs in real time under conditions of limited information and control.

Cognitive therapy does not proffer the power of positive thinking. The therapist is not a cheerleader for optimism. The therapist asks the patient to look at the evidence for and against his or her beliefs and to consider the pragmatic implications of various ways of viewing things. It is important to recognize that a single examination of a thought is not a final verdict. New information is always coming available. Reality is a fluid system. This perspective allows the patient to recognize that beliefs can be revised, behavior can be modified, new decisions can be made, new strategies can be considered. Thus, the search for solutions is organic, constantly evolving through an ongoing dynamic system of mutual feedback—that is, feedback among thoughts, behavior, and outcomes. Indeed, if one were to imagine an epistemological antidote to helplessness and hopelessness, it is this organic, open, and dynamic system of viewing thoughts, behavior, and new strategies. There is always another possibility, always another way to look at things, and always something new to try.

Cognitive therapy necessarily involves behavioral techniques such as activity scheduling, practicing exposure, providing self-rewards, constructing reward menus, practicing assertiveness, and other valuable techniques. These behavioral techniques are then evaluated by obtaining initial predictions ("What do you predict will happen if you do this exposure? How long will your anxiety last? How intense will it be? What will you not be able to do if you experience anxiety?"), collecting the evidence ("Exactly what happened?"), and comparing this information with the initial predictions. An important component of behavioral techniques is to modify the beliefs and therefore the future expectations and willingness to engage in behavioral strategies. Behavior affects cognition, and cognition affects the willingness to engage in behavior as well as what is learned from the behavioral experiments. We like to view these as behavioral experiments because they not only enhance the repertoire for the patient but they also modify the beliefs that have maintained the problem for so long. The therapist might invite the patient to test the belief that the consequences of not getting approval will be disastrous. This testing would involve behavioral experiments such as assertiveness exercises, through which the patient learns that experiencing disapproval (or giving disapproval) often results in no change in real life. By changing the beliefs associated with inactivity, the therapist can assist the patient in developing a new perspective about taking action. These behavioral tests

are also important in treating panic disorder; the therapist encourages the patient to intentionally induce the feared sensations to see what will happen and in exposure to induce feared thoughts by using thought flooding. The key point here is to articulate what has been learned. Behavior is followed by reflection.

Although the traditional cognitive model emphasizes the content of a thought (e.g., "I'm a loser"), newer models in cognitive-behavioral therapy (CBT) propose that it is the patient's response to the thought that may be more significant. In this volume I have included techniques from mindfulness approaches, metacognitive therapy, acceptance models, and an integrative cognitive model that recognizes that patients often respond to intrusive thoughts with rumination and worry. Patients often get "hijacked" by the thought and view the occurrence of the thought as an unacceptable mental experience. The various approaches described above help the therapist address the following: the interpretation of the thought as dangerous, personally significant, and out of control; the ability to "decenter" or gain distance from the thought; the willingness to take action despite the background noise of the occurrence of the thought; and placing the thought in the context of other transitory mental experiences. A wide range of techniques is discussed that the therapist can use to address these concerns.

Therapy often involves discomfort. In fact, it can be an important component in using ACT, mindfulness, behavior therapy, DBT, and emotional schema therapy. Topics arise that may be unpleasant, memories are activated that bring sadness and anxiety, new behavior is enacted that leads to an escalation of discomfort. Discomfort may be unpleasant but it may also be inevitable, and when experienced in pursuit of valued action, the discomfort may be a useful experience. The patient can learn that he or she can tolerate discomfort if the task is worth pursuing. In the current volume I review a wide range of approaches relevant to emotion regulation—and to tolerating difficult feelings. For example, my emotional schema therapy can help patients recognize and modify their beliefs that their emotions will last for an indefinite period of time and will escalate and need to be suppressed or controlled. These problematic beliefs about emotion will lead to more avoidance and passivity. The question for them is, "Are these beliefs about your emotions valid?" Thus, the therapist can use a wide range of techniques from different approaches to address these problematic beliefs about emotion in order to facilitate not only behavioral change but to deepen therapy and enhance the meaning of therapy. If therapy is to avoid being superficial, it will sometimes be unpleasant, even painful.

The use of techniques should also include a case conceptualization. Now there is no one case conceptualization, and therapists from different orientations will have different ways of going about it. The cognitive therapist will often place an emphasis on the levels of cognition—automatic thoughts, underlying assumptions, and schemas about self and others—and relating these schemas and coping strategies to childhood experiences, significant life events (current and past), and the outcome of these coping strategies. I have found that the case conceptualization evolves over the course of therapy, as the therapist learns more about the patient's problematic metacognitive strategies (e.g., worry and rumination) and his or her tendencies toward behavioral avoidance, inertia, dysfunctional patterns of decision making, poor choice of partners or friends, and other important components that may maintain a long pattern of problems. The therapist can deepen the meaning and significance of what is uncovered in therapy by periodically asking, "How does this fit together with other things we know?" Thus, techniques may help the patient overcome obstacles and change thinking, but the evolving case conceptualization may broaden the picture and help the patient recognize future vulnerabilities not only in what triggers problems but also which thoughts, behaviors, and choices make matters worse. Indeed, the goal of therapy should not be simply "feeling better"; it should help the patient develop a wide range of effective techniques that can enable him or her to cope with future problems. Thus, techniques along with conceptualization can empower the patient.

The cognitive therapist recognizes that rational analysis and descriptions of thought processes may not be sufficient to effect change. Evocation of emotion, development of motivation, and experiential techniques that activate new phenomenological experiences and feelings also may be essential. The patient may need to confront reality with new thoughts and behaviors in order to experience, on an emotional level, the existential importance of a "rational" response or simply a new way of thinking. Cognitive therapists help clients put thoughts into action by engaging in behavioral experiments that translate insight into practice.

Some critics of cognitive therapy argue that it is too rational and too simplistic, more an exercise of words than an exercise of emotion. I have included a chapter on the experiential techniques of emotion-focused therapy as well as other models, including some of my work on emotional processing. It is essential to balance the techniques of cognitive therapy with empathy, validation, and motivational interviewing—styles of conducting therapy that assist the patient in viewing cognitive interventions as emotionally relevant. I often wonder, though, how such critics can account for the dramatic changes in emotion that cognitive therapy facilitates in individuals who are depressed and anxious. After all, if cognitive therapy helps people become less depressed and anxious, it *is* addressing emotion in the most important way—by changing negative feelings.

Therapists who practice cognitive therapy often seem to have their "favorite techniques." Some rely heavily on activity scheduling, examining the evidence and daily records of dysfunctional thoughts, whereas others may rely more on the techniques of rational role play, double standard, and testing predictions. The problem with this circumscribed repertoire is that different techniques work for different clients and problems. Some patients respond well to cognitive restructuring, others to behavioral activation, others to metacognitive techniques, and others to acceptance. The clinician should not feel limited to a particular school of therapy. After all, patients are coming to us to get the best tools that we have and, as in pharmacotherapy, no one approach works for everyone. It is important to fit the treatment to the patient, not the patient to the treatment.

A number of years ago I recall a trainee asking, "But how do you know which question to ask?" I assumed that he was referring to "which technique" to use. Initially I thought it was not a very good question—probably because I did not have a ready answer—but I realized it was an excellent question (and I regretted not asking it myself). Years later, I still do not have the answer, but I do have a lot of techniques. Interested readers may find numerous techniques they have never used (or even heard of). But most likely, readers will find this compendium of techniques a valuable "refresher"—that is, something that will jog their memory and help them recognize that the, say, five techniques they are using on their current patient can be augmented by 50 other techniques that they have not used in recent months (or years). In using this book, I imagine that clinicians will refer to it on a regular basis—especially in planning sessions, but also in addressing the roadblocks we will inevitably experience. Having the flexibility to ask oneself "What else can I try?" can lead to significant changes.

The current volume describes a wide range of techniques that can be used for almost any psychiatric disorder. In this sense, it is *transdiagnostic*. For example, although schizophrenia and generalized anxiety differ considerably, they both involve intrusive thoughts and problematic strategies and interpretations that can be modified.

Although this volume is not a step-by-step approach to CBT, it is essential that the therapist assist the patient in understanding the nature of the therapy. Gaining this understanding is an ongoing process, of course, with the therapist introducing the idea that one's thoughts and feelings about something and the reality of that something may be quite different, and that one of the goals of therapy is to examine how habits of thinking may negatively affect the patient's life. Many patients come to therapy with assumptions that may not be helpful—for example, that therapy involves simple ventilation, that reviewing the past is the essential issue, or that all psychological problems can be

reduced to biological causes and treated with medication. Although these ideas share some validity, the cognitive-behavioral approach is action-oriented, focused on the current problems, involves self-help, and engages the patient in a collaborative relationship with the therapist.

For example, in the first session with a patient with a history of a suicide attempts and a recent serious plan that was almost carried out, I asked her what she hoped to gain out of therapy. She said, "I want to understand why I'm so negative."

I responded, "Understanding can be interesting and at times useful, but this therapy is about *change*. So, I'm interested in what you want to change. Your thinking, your behavior, your passivity, your way of relating, your tendency to ruminate, and your hopelessness—those are things that we might try to change. Understanding might give us a theory that could be intriguing, but I think we could get a lot further if we focused on change."

She returned the next session, saying, "I have been in therapy for many years, and this is the first time that I thought about it this way—'What do I want to change'?"

The emphasis on identifying problematic ways of thinking and coping and then suggesting that there might be an alternative is the central tenet of all of the CBT approaches. It is about change. So, if we were to think about the initial "first technique," it is—"What do you want to change?" I often introduce this idea by what I have come to call the "magic wand technique": "If I had a magic wand—which I don't have—and I could wave it, what would have to change so that you would feel better?" Emphasizing change—engaging the patient in looking for alternatives—is a key antidote to helplessness and hopelessness.

The first four chapters—"Eliciting Thoughts," "Evaluating and Testing Thoughts," "Evaluating Assumptions and Rules," and "Examining Information-Processing and Logical Errors"—provide an overview of the basic techniques used in cognitive therapy. These chapters should be read in sequence. Chapter 2 reviews a number of techniques that can help the patient understand the difference between thoughts, feelings, and reality and how to recognize automatic thoughts that may determine their mood and behavior. For example, a thought can be a description of reality and the description can be either consistent or inconsistent with the facts of reality. These thoughts or interpretations of reality lead to specific feelings. The goal in therapy is to evaluate the correspondence between thoughts and the reality to which they refer. Chapter 3 provides a range of techniques to evaluate and test these thoughts against the facts and develop more adaptive and flexible ways of viewing experience. Chapter 4 addresses the conditional rules ("should" statements, "if–then" statements, and "rules about what you must do") that often lead to faulty inferences, problematic coping, and the maintenance of negative schemas. Chapter 5 examines the typical information-processing and logic errors that lead to confirmation bias and maintenance of more general negative beliefs. Recognizing these errors and correcting them is an essential component of effective cognitive therapy. Chapter 6, "Modifying Decision Making," reviews a number of issues that underlie problematic approaches to decision making and provides the therapist with conceptualizations, strategies, and techniques to improve decision making. Many people are depressed and anxious because of the problematic decisions that they have made or their tendency to ruminate and procrastinate rather than to accept reasonable risk. Change is about decisions, after all. In Chapter 7, I review techniques from a range of theoretical models that address how one experiences, evaluates, and responds to unwanted intrusive thoughts. Drawing on metacognitive, acceptance, mindfulness, and other approaches, the therapist can acquire useful strategies for addressing these frequent roadblocks. In Chapter 8, I review a wide range of techniques to address worry (or rumination) that can provide the clinician with a detailed approach to this vulnerability. Again, techniques are drawn from cognitive models and models of emotional avoidance, uncertainty training, metacognitive theory, acceptance, and other approaches. My observation in treating worry over many years is that having a wide range

of techniques can be helpful, since some patients benefit from some approaches, but not others. The reader will need to experiment with these techniques to determine which ones fit and which do not for a particular patient. In Chapter 9, I address a frequent problem in anxiety, depression, and anger: *putting things in perspective*. Indeed, one needs to remind oneself that the word "rational" is derived from the Greek word "ratio," which is precisely about putting things in perspective. Chapter 10 addresses schema therapy approaches; I review some of the issues involved in eliciting and identifying schemas; tracing their developmental origin; reviewing patterns of schema avoidance, compensation, and maintenance; and reversing the rigidity and pervasiveness of these schemas using a wide range of techniques. In Chapter 11, I review emotion regulation using techniques drawn from DBT, emotional schema therapy, mindfulness and acceptance approaches, as well as other approaches. In some cases, clinicians may find that emotion regulation may be the first order of business if the patient's emotional dysregulation is so severe that cognitive reflection, behavioral activation, and exposure are difficult to do and when the patient's safety, or that of others, is an issue.

In Part III on specific applications, I include four chapters. In Chapter 12, I offer a list of specific techniques for each of the cognitive distortions. For example, there are 10–15 techniques with brief examples for examining, challenging, and changing mind reading, personalizing, labeling, and other categories of distorted thoughts. (Some therapists may object to the use of the term "distorted," but I have kept this term because I believe much of depression, anxiety, and anger can be due to distortions in thinking. The reader can replace "distortions in" with "biased," "unhelpful," or "problematic," if this seems less pejorative or more useful.) This chapter may be a handy reference guide for therapists looking for a way of structuring a session—or series of sessions—and therapists are encouraged to add other techniques to the list for each cognitive distortion. In Chapter 13, I provide a case example along with dialogues of how one may modify the need for approval. Again, there is no set way to approach any session, but the reader can get some idea of what a session might sound like and what one can say. In Chapter 14, I provide a similar example of how one can modify self-critical thinking. Again the reader will see what a dialogue sounds like and consider how his or her own style might be different.

I always found it helpful to observe experienced clinicians actually doing therapy. But how you will do therapy will reflect your own style and the techniques that you personally find helpful. In Chapter 15, I describe the treatment of a man with anger management issues and the threat of divorce hanging over his head. Many patients with anger problems have mixed motives—some want to change, whereas others want to continue blaming others and minimizing their problem. The dialogues described here provide an example of how to approach anger management with one particular individual. Specific intervention strategies for disorders—such as panic, social phobia, and obsessive–compulsive disorder—are not covered here but may be referenced in Leahy, Holland, and McGinn (2012). A detailed description of a specific case, utilizing many cognitive therapy techniques, is available in Judith Beck's (2011) excellent *Cognitive Behavior Therapy: Basics and Beyond, Second Edition*.

Critics may be eager to point out that cognitive therapy is already too technique-oriented and too formulaic. I agree that cognitive therapy can become mechanical, invalidating, nonconceptual, shallow, and just plain boring. That is why I wrote a book on resistance in cognitive therapy, emphasizing validation concerns, risk aversion, victim roles, schematic processing, self-limitation, and self-consistency (Leahy, 2001b), and why I have written about the importance of emotion in CBT and how to address this (Leahy, Tirch, & Napolitano, 2011; Leahy, 2015). There are excellent books that describe case conceptualization in CBT (Persons & Tompkins, 1997; Beck, 2005; Kuyken, Padesky, & Dudley, 2009). Countertransference issues can be conceptualized and addressed within a cognitive therapy framework and may assist the therapist in utilizing his or her countertransference

response to understand the patient's interpersonal world and interpersonal strategies (Leahy, 2001b; Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). But we should keep in mind that there is something essential in the utilization of techniques that elicit, examine, test, challenge, and modify thoughts and behaviors. Cognitive therapy is based on these established—and proven—approaches.

Many therapists prefer to practice their own style of therapy and their own integration of models. Independence and innovation are laudable, but they should take second place to starting the patient with empirically supported treatments. For example, it might make sense to postpone the schema work until the treatment modules for depression and anxiety disorders—interventions that have proven effective—have been given a vigorous trial. Don't we owe it to our patients to employ, as our first line of treatment, those techniques we know actually work (based on outcome literature)? I recall how one of our trainees, who was quite intelligent but thought she could do cognitive therapy "her way," had a significantly high premature termination rate with her patients. To her credit, she modified her eclectic style (which did not include homework assignments) to utilize a more basic cognitive therapy model focused on techniques, structure, and homework assignments. Her effectiveness and premature termination rate improved dramatically. Essentially, I recommend that therapists first master the techniques and treatment approaches that have been shown to be effective. Before developing a grand theoretical scheme about how cognitive therapy needs to be modified for a particular patient, it would be valuable to utilize the interventions that have already been shown to be empirically valid.

In conducting cognitive therapy, I often utilize several techniques with a patient—even after the patient has seemed to change a negative thought. I believe in *overpractice* or *overlearning*—especially when it comes to modifying habits of thinking that have persisted for years. An advantage of utilizing a variety of techniques to test or challenge a single negative thought is that the patient has alternative techniques for future use, should his or her initial challenge not work. This approach was impressed on me years ago when I was learning cognitive therapy in individual supervision with the master of technique, David Burns. I would present a problem with a patient, let's say, a hard-wired negative thought, and David would say, "Tell me 10 techniques that you could use." In actual practice, I found this reliance on a multiplicity of techniques to serve as a powerful way of structuring sessions that had an enormous impact on patients. They were getting a lot of ideas about how to cope with their negative thoughts!

I have found it is essential to elicit ongoing feedback from patients. In addition, it is useful for the patient and therapist to intermittently summarize the techniques they have used, write them down, and examine which were useful, which were not, and why. For example, it is always helpful to examine why weighing the evidence for an automatic thought does *not* work. Perhaps there is a more fundamental belief, conditional rule, or demand for absolute certainty that needs to be explored. When techniques fail, the failure allows us to discover something even more fundamental, such as schemas or absolute rules. In fact, the ambitious and curious clinician should look forward to the failure of techniques, because failure (and resistance) in therapy can serve as windows into more fundamental problems, which in turn provide excellent opportunities to develop case conceptualizations and then bring to bear more techniques to examine patients' core beliefs.

I think behavioral techniques are essential, and I have included a list of these in Appendix A of *Treatment Plans and Interventions for Depression and Anxiety Disorders* (Leahy, Holland, et al., 2012). Readers interested in a comprehensive review of behavior therapy can consult *Contemporary Behavior Therapy, Sixth Edition*, edited by Michael D. Spiegler (2016). As a cognitive therapist (or cognitive-behavioral therapist), I view the behavioral techniques as serving the purpose of testing out negative thoughts. For example, activity scheduling, graded task assignments, and pleasure predicting are behavioral interventions that allow the patient to test out negative beliefs, such as "I don't

enjoy anything" or "I'm always depressed." Assertiveness training is used to test out the thoughts "No one likes me" and "I'm just shy." Attentional distraction is used to test out the idea that "I have no control over my thoughts" or "I just worry all the time." Exposure hierarchies can modify the belief that a specific stimulus is dangerous and cannot be tolerated. Imaginal exposure challenges the idea that even thinking about something is unbearable. Relaxation training can accomplish several goals: (1) It can test the thought that, for example, "I'm always nervous"; (2) it can help the patient induce more calming thoughts or moods that can be used to challenge the negative thoughts; and (3) it can reduce overall level of arousal, thereby reducing the likelihood of emotional priming for negative thoughts. Finally, self-reward and self-contingency management can be helpful in modifying negative beliefs about competence. In each case when using behavioral techniques, it is helpful to have the patient identify the automatic negative thoughts and to use behavioral tests as a challenge to these thoughts.

I include examples of therapist–patient dialogues for each technique. I always find it helpful to see how a therapist actually talks with a patient—for me it provides a good role model of what to do. Although I hope this volume will prove to be helpful, it cannot substitute for direct training and supervision. Fortunately, there are excellent opportunities for continuing education through webinars, conferences sponsored by the Association for Behavioral and Cognitive Therapies, the British Association for Behavioural and Cognitive Psychotherapies, the Anxiety and Depression Association of America, as well as local and regional workshops and conferences. The Academy of Cognitive Therapy is a credentialing and membership organization with worldwide participation and offers unprecedented opportunities for discussions about therapeutic issues. And, of course, the best source of knowledge is to listen to our patients—to listen carefully—as to what works and why other things do not work. In a sense, if we listen and learn from those we help, we will have a therapy that makes more sense to other patients in need. Therapy is not an abstract, theoretical endeavor. It is experienced in real time with real people coping with real problems.

This is a book about techniques, but the most valuable technique and the most meaningful intervention is whatever you do to help someone feel cared about and heard. I recall when I closed my practice in Philadelphia to move to New York City many years ago, I asked my patients what they liked and did not like about the treatment that I had provided. Much to my surprise almost no one said it was too structured and rational. One woman captured the sentiment: "I knew that you really cared. I knew you would always be there if I needed you." And, what did you not like? "You would not let me hug you."

In using this book, please keep in mind that behind every technique should be a genuine person who cares, who has compassion for those who are suffering. Perhaps that is the best technique. We can call it *compassion*.

PART II

Techniques

CHAPTER 2

Eliciting Thoughts

A number of cognitive models of stress, anxiety, and psychopathology emphasize the role of appraisal, attribution of cause, and interpretation of events in the elicitation and maintenance of problematic coping. Ellis's rational–emotive behavior therapy (REBT) proposes that "distortions" or "biases" such as "awfulizing" ("It's terrible that I got a low grade"), "demandingness" or "musts" ("I must be perfect" or "You should meet my needs"), "global thinking" ("It's always happening to me"), and "low frustration tolerance" ("I can't stand it when I have to wait so long") are often at the root of psychological difficulties (Ellis & Harper, 1975; Ellis, 2001). For example, the student who believes it is awful that she got a "C" on her paper thinks that she must be perfect in all her work and cannot "stand" the idea that she is not living up to her expectations. Because she thinks that she is a complete failure, she will likely become depressed and anxious.

In a similar vein, Beck's cognitive model of psychopathology stresses the central role of thinking in the elicitation and maintenance of depression, anxiety, and anger (Beck, 1967, 1976; Beck, 2011; Beck, Emery, & Greenberg, 1985; Beck, 1979). Cognitive biases impute vulnerability to negative life events, such that a loss or impediment will more likely be interpreted in an exaggerated, personalized, and negative fashion (Beck & Alford, 2009). Beck's cognitive model suggests that there are several levels of cognitive assessment (Beck, 2011). At the most immediate level are the automatic thoughts that come spontaneously, appear valid, and are associated with problematic behavior or disturbing emotions. These automatic thoughts can be classified according to their specific biases or distortions—for example, mind reading, personalizing, labeling, fortune telling, catastrophizing, or dichotomous (all-or-nothing) thinking (see Beck, 1976; Beck, Emery, & Greenberg, 1985; Beck, 1995, 2011). Automatic thoughts can be true or false; for example, the automatic thought "She doesn't like me" may be based on mind reading (i.e., I lack sufficient evidence to derive this belief), but nonetheless it may prove to be true. The emotional vulnerability to this thought will result from the underlying assumptions, conditional beliefs or rules (e.g., "I must get the approval of everyone to be worthwhile"), and the underlying personal schemas (e.g., "I'm unlovable" or "I'm worthless") held by the individual. Underlying maladaptive assumptions or rules are typically rigid, overinclusive, impossible to attain, and confer vulnerability to future depressive episodes or to anxiety states (see Dozois & Dobson, 2001; Dykman, Abramson, Alloy, & Hartlage, 1989; Halberstadt et al., 2007; Ingram, Miranda, & Segal, 1998; Persons & Miranda, 1992; Everaert, Koster, & Derakshan, 2012).

In particular, suicidal individuals are characterized by negative cognitive biases (Pinto & Whisman, 1996). Personal schemas are more general beliefs about unlovableness, helplessness, special status, and other personal traits of the self and beliefs that others are judgmental, controlling, irresponsible, and other qualities. We discuss schemas in more detail in the chapter on schema-focused approaches (Chapter 10), but individuals who have the personal schema that they are incompetent will often predict that they will fail (fortune telling) and conclude that failing at something is terrible (catastrophizing) and indicative of their general incompetence (schema). Similarly, individuals who believe that they must gain the approval of everyone are more vulnerable to depression and anxiety because they inevitably will fail to live up to these standards. Their mind reading and personalizing will make them more likely to perceive rejection when it is not there.

Incoming information is channeled through these automatic thoughts (e.g., "Did she reject me?") and then evaluated according to the underlying assumptions (e.g., "If I don't get approval, then I'm worthless"). The underlying assumptions are linked to the personal schema (e.g., "I'm unlovable"), further reinforcing the negative personal belief and adding confirmation to the distrust and fear of others. These negative personal schemas ("I'm unlovable," "worthless," "defective") create selective attention and memory—that is, these individuals will be more likely to detect or interpret and recall information consistent with the schema, thereby further strengthening the schema. Thus depressive and anxious styles of thinking are "theory-driven" and "research-based," in that they are continually "looking for information" to confirm the schema—that is, "confirmation bias." For example, depressed individuals are more likely to recall negative experiences and are more overgeneralized in their memory of events (Kircanski, Joormann, & Gotlib, 2012; Rude, Wenzlaff, Gibbs, Vane, & Whitney, 2002; Williams et al., 2007), whereas anxious individuals are more attentive to threatening information but no more likely than nonanxious individuals to recall threat-relevant information (Coles & Heimberg, 2002; Mogg, Bradley, Williams, & Mathews, 1993). The cognitive model identifies specific cognitive biases and coping strategies for each of the psychological disorders, allowing for more detailed case conceptualization (Beck & Haigh, 2014).

The current cognitive model, advanced by Beck and his colleagues, stresses the aspect of scientific thinking that seeks "disconfirmation" or "falsification" of a belief—that is, examining how a belief could be proven wrong or inadequate, rather than simply seeking out confirmatory evidence (see Popper, 1959). The depressed individual may focus selectively on information consistent with the negative state of feeling depressed, ignoring the relevance of disconfirming evidence. The cognitive model seeks to examine both kinds of evidence.

Although I emphasize the Beckian model of cognitive therapy in this book, I also recognize the substantial contribution made by Albert Ellis and his colleagues (see Dryden & DiGiuseppe, 1990; Ellis, 1994; Tafrate, Kassinove, & Dunedin, 2002). Ellis's system, developed contemporaneously with Beck's model, provides a more general approach to psychopathology by emphasizing a set of common cognitive vulnerabilities. These include low frustration tolerance, "shoulds," and other demanding and irrational cognitive distortions (David, Lynn, & Ellis, 2010). The current approach does not conflict with the REBT model advocated by Ellis and may be usefully integrated with it.

Automatic thought biases and maladaptive assumptions are part of each of the mood and anxiety disorders. For example, the individual with social anxiety disorder engages in mind reading ("She can see my anxiety—I'm sweating") and catastrophizing ("It's awful that people see that I'm anxious). The individual with obsessive–compulsive disorder engages in fortune telling ("I'll get contaminated if I touch this!") and catastrophic thinking ("I'll get Ebola!"). The patient with panic disorder also engages in fortune telling ("I'll lose control") and catastrophic thinking ("I'll have a heart attack if my anxiety gets worse"). And the depressed patient engages in a wide range of cognitive biases—discounting the positive ("Anyone can graduate from college"), labeling ("I'm a failure"), and fortune telling ("I'll never be happy again") (Beck & Haigh, 2014).

Throughout this chapter (and the book), I examine how therapists can assist patients in identifying and evaluating thoughts of various kinds (see Leahy, 2011a). The cognitive model of psychopathology recognizes commonalities in thinking distortions and biases across diagnostic categories (e.g., automatic thought distortions), but also recognizes that there are specific conceptualizations for each diagnostic grouping. The goal here is to help patients adapt a cognitive approach to their problem by stressing the importance of identifying patterns of thinking to change unhelpful thoughts.

TECHNIQUE: Distinguishing between Events, Thoughts, and Feelings

Description

An "event" may be a specific situation ("I got a C on the exam") that can occur in the past, present, or future ("I might get a C"). It can also be a sensation ("I'm feeling my heart beat rapidly") and can be factual or anticipated. (In Chapter 11 I describe how an "emotion" can be "an event," in that the individual is aware that he or she "feels anxious," and then have a range of interpretations of that anxiety—for example, "I'll always be anxious" or "My anxiety is a sign of my weakness.") Often depressed, anxious, or angry individuals may claim that the "reason" they behaved a specific way or felt a specific way is that an event occurred: "I felt hopeless because I lost my job" or "I'm anxious because I have an exam coming up." The implicit implication is that an event necessarily leads to a feeling. Similarly, the individual may attribute the cause of her behavior to the event: "I left the party because I didn't know anyone there." These explanations may seem plausible and are quite common, but the cognitive therapist will want to examine further how the interpretation of the event led to the behavior or the emotion. For example, it is possible not to feel hopeless after losing a job or not choose to leave a party if you do not know anyone. The key element is the thought about the event and which emotions and behaviors are evoked by these thoughts.

Questions to Pose/Intervention

The therapist can help the patient distinguish between events, thoughts, feelings, and behavior by saying the following: "We are interested in how you think and feel about events in your life. Let's say that you experience the following event or situation. Your boss tells you that your work is late and that it needs to get done by this afternoon. In this case, the 'event' is your boss talking to you and what she says. Now, you might say, 'That would make me anxious,' which is not an unusual way for people to feel. But it may be that people have different thoughts and feelings about the event. Some people may not feel anxious—they may feel motivated to work hard and get focused. They may think, 'I have to really focus on this now and get it done, so I can't let anything distract me.' But another person might feel anxious because he thinks, 'I'll never get this done, and then my boss will be really angry and I night get fired.' So, we have the same event, different thoughts, and different feelings."

Example

THERAPIST: Can you tell me a little bit about why you were feeling anxious at work?

PATIENT: Well, my boss made some corrections on my work and told me to get back to her when it is finished.

THERAPIST: So, you felt anxious because your boss gave you corrections?

PATIENT: Right. That's why I had a lousy day yesterday. It's like that all the time. She just doesn't like me. I know it.

THERAPIST: OK, it sounds like there is a lot going on in this. In our work we will make a distinction between an event—like your boss giving you feedback—and your thoughts and feelings. In this case, your feelings were anxiety and maybe some resentment, and your thought was that she doesn't like you.

PATIENT: Well, she just criticizes my work.

THERAPIST: OK, so the event—or the situation—is *she gave you feedback*. Can you imagine someone else being asked to make changes in her work, but then not becoming so anxious?

PATIENT: I guess so.

THERAPIST: So, in this case, you might be thinking about it in a particular way—that this is personal to you, you are guessing at what she thinks, and then you are worried that this is happening all the time. Those are your thoughts, but the event is simply your boss giving you some feedback. Now, your thoughts might be correct or they might be extreme or there may be other thoughts that come up, but the same event can lead to different feelings because we have different thoughts.

Homework

The patient can utilize Form 2.1 to record events, thoughts, and feelings.* The therapist can indicate that the goal is to identify the kinds of thoughts and feelings that arise when different events occur and to see what the relationship is between thoughts and feelings.

Possible Problems

Some patients insist that a situation or event is a sufficient explanation for their feelings, thoughts, or behavior. For example, the patient might say, "Anyone would feel anxious if they got corrections from their boss" or "Of course, I felt anxious, that's what happened."

Indeed, in everyday discourse we often treat an event as a sufficient explanation for a thought or feeling: "Of course, she felt hopeless. She's out of work." An essential component of cognitive therapy is to help the patient recognize that the same events can lead to different thoughts, feelings, and behaviors. For example, a man who was laid off from his job explained, "I feel pretty hopeless right now. I just lost my job 2 weeks ago." The therapist said, "It's hard to lose a job, but people can have different ways of thinking about it and reacting to the situation, as difficult as it may be. If you thought you had to feel hopeless because you lost your job, you might isolate yourself, give up trying, and feel sad. But if you thought there were productive things you could do while you are in between this job and the next, you might be more energized, more challenged, and you might become more active. Are there people you know who have lost jobs that took action, got interviews, used the time in between jobs in productive ways?" The important point here is to help the patient consider the possibility that events do not necessarily lead to one response, but that one can be flexible, curious, imaginative, and adaptive in considering a range of alternative thoughts and behaviors.

Cross-Reference to Other Techniques

Distinguishing events, thoughts, and feelings is often the first step in utilizing a wide range of other techniques, such as explaining how thoughts create feelings, distinguishing thoughts from facts, and looking for variation in the degree of belief in thoughts. In addition, all of the techniques related to alternative interpretations, problem solving, and acceptance are relevant.

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* All forms are at the ends of the chapters.

Form

Form 2.1 (Distinguishing Events, Thoughts, and Feelings).

TECHNIQUE: Explaining How Thoughts Create Feelings

Description

The fundamental assumption guiding cognitive therapy is that the individual's interpretation of an event determines how he or she feels and behaves. Many people, in fact, are surprised to learn that their feelings are the result of how they think about an event and that by modifying their interpretation of an event, they can have very different feelings. In this chapter, I review a variety of techniques that are useful in helping patients learn how to recognize the ways in which their thoughts and feelings interact. After all, people seek therapy not because they think they are irrational but because their feelings, behavior, and relationships are problematic. Two fundamental points are worth considering:

1. *Thoughts* and *feelings* are distinct phenomena.
2. Thoughts lead to feelings (and behavior).

Thoughts are not the same thing as feelings (although we can have thoughts about our feelings). Feelings are internal experiences of emotions; for example, I may feel anxious, depressed, angry, afraid, hopeless, happy, exhilarated, indifferent, curious, helpless, regretful, or self-critical. To say I have a particular feeling or emotion is similar to saying, "This hot iron hurts" or "This scone tastes good to me." We do not challenge feelings—it would not make sense to say to a patient, "You're not really anxious." To do so would be equivalent to saying, in essence, that the hot iron did not really hurt the patient when he or she said, *Ouch.* "Ouch" is a report of a sensation—just as the words "I'm happy" or "I'm sad" are reports of feelings. We do not dispute feelings. We evaluate the thoughts that give rise to those feelings. Thoughts can be tested against the facts.

Therapists can explain to patients how their thoughts may create their feelings or may increase or decrease a feeling. Consider, for example, the different feelings these two statements engender: "I think I'm unlovable, and therefore I feel hopeless"; or "I think I'm better off without him, and therefore I feel hopeful and relieved." Figure 2.1 provides additional explanatory examples.

Thought: I think . . .	**Feeling:** Therefore, I feel . . .
I'm going to fail.	Anxious, frustrated
I failed.	Sad
He thinks I'm boring.	Anxious, sad
He is insulting me.	Angry, anxious

FIGURE 2.1. How thoughts create feelings.

Questions to Pose/Intervention

Therapists can use the following wording as a model for explaining these ideas to patients in straightforward, jargon-free language: "Before you can evaluate and change thoughts, you have to understand how thoughts affect your feelings. When you are feeling down or anxious, you may have certain thoughts. For example, imagine you are walking down the street in a strange part of town late at night and you hear someone walking behind you. Glancing over your shoulder, you see that it's two large men. Your thought might be, 'They're going to rob me.' How would you feel? Afraid? But what if you thought, 'They're my friends from work'? How would you feel? Relieved? When you are feeling down or anxious in your day-to-day life, you have different thoughts. So, let me ask you, when you were sitting in your apartment and you noticed that you felt anxious, what were you thinking?"

Example

As indicated in Figure 2.1, thoughts can create both positive and negative feelings. Sometimes the patient may get so focused on what he or she is feeling that he or she does not recognize that it is a particular thought that creates the feeling. Consider the following dialogue:

THERAPIST: What seems to be bothering you?

PATIENT: I just feel sad.

THERAPIST: Can you tell me why you feel sad?

PATIENT: I just feel awful, like a sense of doom. I cry a lot.

THERAPIST: OK. Maybe you can help me understand what you are saying to yourself that's making you feel sad. Complete this sentence: "I feel sad because I think. . . ."

PATIENT: I'm unhappy.

THERAPIST: *Unhappy* is a feeling. But what are you saying to yourself that makes you feel sad? For example, are you saying anything about yourself as a person, about the future, or about this experience?

PATIENT: I guess I'm saying I think I'll never be happy.

In this example, the therapist was able to elicit the hopeless prediction, "I'll never be happy." This prediction can be evaluated by using the following techniques: cost–benefit analysis, examining the evidence for and against the validity of the prediction, examining logical errors (e.g., "I feel sad now, therefore I'll always feel sad"). All of these techniques are discussed in the pages to follow.

Homework

Patients are asked to keep track of their feelings and how these feelings are related to their thoughts. The therapist could say: "I want you to keep a record of your negative feelings over the next week, using Form 2.2. When you notice you are having a feeling or an emotion, write down what that feeling is in the right-hand column. Examples of feelings are *sad*, *anxious*, *afraid*, *hopeless*, *angry*, and *confused*. Now, in the left-hand column, write down the thought that goes with that feeling. For example, the feeling might be 'anxious' and the thought might be 'I'm afraid I'll do badly at work.' So the entire thought is, 'I feel anxious because I am afraid I'll do badly at work.'"

Possible Problems

Patients commonly confuse thoughts with feelings. It is useful to anticipate this problem by offering an example: "Sometimes people confuse a thought with a feeling. For example, someone might say, 'I feel anxious because I'm nervous.' This is really a report of two feelings or emotions—that is, *anxious* and *nervous*. 'I feel anxious' is a feeling, and 'I'm nervous' is another feeling. The thought might be 'I think I won't do well' or 'I think I'll always be anxious.'" In addition, some patients equate a thought with a feeling by reporting two thoughts: "I feel I won't ever be happy again because I will never find someone like her." These are two thoughts—a prediction about happiness and a prediction about finding a partner. The therapist might point out that a prediction might be related to specific feelings such as sadness, loneliness, hopelessness, and anxiety. Again, the important point to make is that thoughts can be examined for their truth value: for example, "Let's see if your mood changes over the next week to see if it is possible to be happy or not miserable." In contrast, statements about feelings are considered valid (unless the person is lying): "I feel hopeless about the future" is not a statement that we challenge—but we might examine the rationale for thinking that things are hopeless.

Another common problem initially is that patients are unable to identify the thoughts associated with their feelings.

Cross-Reference to Other Techniques

As indicated, we can utilize other techniques in this chapter, such as "guessing the thought," or we can use imagery induction techniques. Many patients receive assistance in identifying automatic thoughts from reading books on cognitive therapy, such as my books *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005); *Beat the Blues: How to Overcome Depression* (Leahy, 2010); *Anxiety Free: Unravel Your Fears Before They Unravel You* (Leahy, 2009). In addition, providing patients with a list of common cognitive distortions (Form 2.7) is quite helpful.

Form

Form 2.2 (How Thoughts Create Feelings).

TECHNIQUE: Distinguishing Thoughts from Facts

Description

When we are angry or depressed, we often treat our thoughts as if they were facts. I might say, "He thinks he can take advantage of me," and I might think I'm absolutely right—but I could also be wrong. When I am anxious, I might think, "I know I'll do poorly in this presentation"—but I could be either right or wrong. I can believe or think that I am a giraffe, but it does not mean that I am a giraffe. Just because I believe something is true does not mean that it *is* true. Thoughts are interpretations, descriptions, perspectives, and even guesses. They can prove to be either true or false. Or they can be partly true. Patients need to learn how to identify their thoughts and then examine the facts. In order to distinguish thoughts, feelings, and facts, therapists can use the A-B-C technique in which patients have an opportunity to recognize how the same *a*ctivating event can lead to different *b*eliefs (thoughts) and *c*onsequences (feelings and behavior). If I believe I can never do well on the exam (my thought), I might feel hopeless and behave accordingly—for example, by not bothering to study. On the other hand, if I believe I have a good chance of doing well on the exam, I might feel hopeful and therefore study for it.

What is interesting about this example is that my initial thought—"I won't do well on the exam"—leads to the maladaptive behavior of not preparing for the exam, which then leads to the self-fulfilling prophecy of doing poorly on the exam.

Many people who are depressed, anxious, or angry treat their thoughts as if they were facts—that is, "It's *true* that I won't do well on the exam" or "I *know* she'll reject me." Figure 2.2 contains a number of examples of the same activating event leading to different thoughts, feelings, and behaviors. The importance of distinguishing a negative thought from possible facts is illustrated in Figure 2.3. Here the patient is asked to imagine that he or she is having a negative thought, such as "I'm not prepared for my exam." The right-hand column prompts the patient to consider any facts that might be relevant to a valid evaluation of his or her preparedness. The initial thought is a belief; the possible facts can *become* beliefs, once they are considered. The patient can be asked, "Is it possible that your thoughts are not the only things to consider? Wouldn't you want to look at other possible facts?" Thoughts and facts are not equivalent. Another way to illustrate the relationship between thoughts and facts is to ask the following questions:

Have your thoughts about situations ever proved to be wrong?
Did you ever predict that something would happen, but it did not happen?

A = activating event	B = belief (thought)	C = consequence: feelings	C = consequence: behaviors
I hear the window rattling.	Someone is breaking into my house.	Anxious	Lock the door, call police.
I hear the window rattling.	It's windy outside and the window is old and loose.	Slightly irritated	Try to tighten the window, go back to sleep.
A man is approaching me on a dark, empty street.	I'm going to get mugged.	Terrified	Run.
A man is approaching me on a dark, empty street.	I wonder if that's my old friend Steve.	Curious, pleased	Call out Steve's name.
My husband is sitting reading the newspaper.	He doesn't care about my feelings.	Angry, resentful	Tell him he's self-centered.
My husband is sitting reading the newspaper.	He's withdrawing from me because he's angry with me.	Upset, guilty	Avoid interacting with him.
I feel my heart beating rapidly.	I'm having a heart attack.	Anxiety, panic	Go to emergency room.
I feel my heart beating rapidly.	I've had too much coffee.	A little regretful	Try to cut back on caffeine.

FIGURE 2.2. The A-B-C technique. The same event gives rise to different thoughts that lead to different feelings and behaviors. You determine if your thought is true by examining the facts.

Negative thought	Possible positive facts
It's raining outside and I'll never get home on time.	Maybe it stopped raining since I came in an hour ago. I can go outside to check out the facts.
I'm not prepared for my exam.	I've read the material, gone to class, and done some work.
I'll always be alone.	I don't have all of the facts, since I don't know what is in the future. I have friends. I have a lot of qualities that people like.

FIGURE 2.3. Thoughts versus possible facts.

Have you noticed that other people sometimes have different interpretations than you do about the situation?

Is it possible that you are looking at only some facts right now, but that other facts might become apparent with time?

Do people ever disagree about the facts?

Questions to Pose/Intervention

"Thoughts and facts are not the same. Just because you think something is true does not necessarily mean that it is true. I can think that I am a zebra—but my thought does not mean I am a zebra. We have to check out the thought against the facts."

Example

THERAPIST: Can you tell me what you're thinking about that's making you so anxious?

PATIENT: I think I'm going to get fired.

THERAPIST: How do you know you will get fired?

PATIENT: I just know it. I can see it coming.

THERAPIST: You may believe or think you'll get fired, but isn't it possible that you could be wrong about this?

PATIENT: I feel pretty strongly about this. I just know it's going to happen.

THERAPIST: Although it could be true—it could happen that you might be fired—it may also be possible that it won't happen. There's a difference between a *belief* and a *fact*. Believing it's true doesn't make it true. Would you consider the possibility of examining the reasons why you might get fired and the reasons why you might *not* get fired?

PATIENT: But, I don't know, I *really, really* think this will happen. I'm really anxious about it.

THERAPIST: Sometimes we think the more intense our anxiety, the truer our belief is. It's like we are reasoning from the starting point of our emotion: "I feel anxious, therefore something bad will happen." But does that make sense? I can feel very anxious and really strongly believe I will fail, but that doesn't mean I will. It's simply what I feel and think at this moment in time.

PATIENT: I guess I do that a lot—using my anxiety as a basis for what I think will happen.

THERAPIST: The interesting thing about checking out the facts is that we often find that our anxiety has been a poor guide to the truth. I call this "emotional reasoning"—using my emotions as evidence of the facts. Even strongly held beliefs often don't survive the test of reality. But we will have to see, I guess.

In this example, the therapist acknowledges the patient's strong belief and explains that *belief* does not equal *truth*. The therapist then invites the patient to examine the evidence and the reasoning that leads to the belief about getting fired. The recognition that thoughts are not facts is the starting point in helping the patient to construct alternative interpretations of events.

Homework

The therapist can ask the patient to keep track of activating or preceding events that lead to specific beliefs and feelings by using Form 2.3. Of particular interest is to note if there is a pattern to the events that trigger problematic feelings and thoughts. Is the patient more likely to feel anxious when approaching a new behavior, interacting with people, when alone, or when facing a novel and challenging task? Is the patient more anxious when he or she is around people or in places that remind him or her of past experiences that are still upsetting? In addition, the patient can use Form 2.4 to examine how a particular thought does not always take into account all of the possible facts. For example, the thought "I'm not prepared for the exam" does not include the possible facts that I'm intelligent, I have attended class, and I have read the assignments. The therapist can suggest, "When in doubt, collect more facts." This directive reinforces the distinction between a thought and a fact.

Possible Problems

Some people believe that their thoughts are the last word on the truth. Indeed, sometimes the negative thoughts *are* true. We do not want patients to get the impression that we believe everything that they believe is false. Nor do we want to convey the idea that therapy is about positive thinking. It is about *realistic* thinking. This distinction can be made in the following way: "Sometimes your thoughts will accurately describe the facts, and sometimes your thoughts will not accurately reflect all of the facts. Wouldn't it be a good idea to use a general rule of checking out your negative thoughts against all of the relevant facts?" Or, the thought that the patient has may only describe "part" of the reality—for example, "I got a C on that paper, but I got B's and A's on other papers and exams." Indeed, if we consider one's performance at work or school, there may be thousands of "facts" that are possible candidates for examination, but the patient may selectively focus on a few that confirm his or her negative beliefs.

Some patients respond by saying that examining the facts seems invalidating and critical of their feelings or their position. I have described this problem in *Overcoming Resistance in Cognitive Therapy* (Leahy, 2001b). The feeling of invalidation can be explored directly by asking the patient if these questions about the facts seem like "putdowns" or "rejections." In addition, the therapist can suggest that whenever the patient feels invalidated, it offers an excellent opportunity to share these feelings with the therapist. It may be helpful to indicate to the patient that some of the techniques might very well seem invalidating, but it is not that the therapist does not respect or care about the patient's feelings. It is more that the therapist and patient are working together to help the patient feel better. Imagine going to your doctor believing you have a heart condition, and the doctor does a thorough examination but cannot find any signs of a heart condition. Would you consider this invalidating? Again, the important point to make is that examining the facts does not necessarily mean the

patient is incorrect. Of course, if the patient is correct ("I will do poorly on the exam"), the therapist can examine what has led to this outcome (e.g., choosing a course that one is not prepared for, poor study habits, lack of resources, not attending class) and how any problems could be addressed in a practical manner. True facts that prove negative may lead to positive change through the use of problem-solving strategies.

Cross-Reference to Other Techniques

Other relevant techniques include looking at the evidence for and against the validity of a thought, distinguishing thoughts from feelings, categorizing cognitive distortions, and looking at variations in believing a thought. For example, the patient who has variation in a thought such as "I'm a failure" can be asked if his or her belief in the thought depends on the facts to which he or she is attending.

Forms

Form 2.3 (The A-B-C Technique); Form 2.4 (Other Possible Facts).

TECHNIQUE: Rating the Degree of Emotion and Degree of Belief in the Thought

Description

We may have many different emotions and beliefs about a single event. What is really important is how strongly we *feel* something and how strongly we hold a *belief*. Emotions obviously vary in degree. I can feel slightly sad, somewhat sad, very sad, extremely sad, or overwhelmingly sad. Since many people who are sad, anxious, or angry are often undifferentiated in their thinking or in their observations of their own emotions, it is useful to teach them how to distinguish the various degrees of their emotions. Furthermore, given that change in therapy is often gradual, it is important that patients be able to detect various degrees of change in their feelings or emotions. For example, a patient whose feelings change from overwhelmingly sad to somewhat sad might realistically conclude that good progress has been achieved. Rather than view "reality" as black and white ("I'm either sad or not sad"), the therapist can encourage the patient to view greater degrees of intensity and differentiation—"I'm 60% sad, and I believe I won't succeed on this even at 50%." Further, the therapist can help the patient expand the range of facts that might be relevant, examining information that is negative, neutral, and positive and, in addition, examining how the facts change across time and situations. This "fluidity," "flexibility," and "differentiation" provide the patient with opportunities to view events in greater perspective and to consider how change might be possible.

Questions to Pose/Intervention

"How much do you feel upset, and how strongly do you hold your belief? Rate your feeling [emotion] from 0% to 100%, where 0% corresponds to having none of that feeling and 100% corresponds to the most intense experience of that feeling. The same with your beliefs: 0% corresponds to not holding that belief at all, and 100% corresponds to believing your thought 100%. To what degree do your feelings and thoughts change? What could be some reasons why you feel better at certain times rather than other times? Are you doing different things when you are feeling down? Or up? Are you thinking differently when you are down? Or up?"

Example

THERAPIST: You said you are feeling sad since you and John broke up. Can you describe this sadness for me?

PATIENT: Oh, I feel very sad. Sometimes I cry when I think of how he left me.

THERAPIST: Your feelings are important, so I want to be able to really understand how you feel when you're thinking about the breakup. If you were to rate your sadness from 0% to 100%, where 0% represents absolutely no sad feelings and 100% represents the greatest sadness imaginable, how would you rate your sadness?

PATIENT: I guess I've never thought about how I would rate my feelings. I'd say about 90% sadness.

Similarly, the patient may hold an absolute belief—for example, "I can never be happy without John"—but the patient's degree of belief (i.e., the credibility or strength of the belief) might be less than 100%. This recognition that beliefs vary in strength is a very important beginning in gaining distance from distressing beliefs. If I can hold a belief in which I invest less than 100% veracity, then it means I already have some doubt about that belief. It also means that the degree to which I believe this belief could vary—it could weaken. Consequently, I could then imagine changing this belief even more vividly. In a sense, cognitive therapy is a therapy about the "power of doubt"—if I can doubt a negative belief, then I'm taking the first step in changing it.

THERAPIST: You said you feel very sad when you think about John leaving you. Can you complete this sentence with the first thoughts that come to your mind? "I feel very sad when I think of John leaving me because I think. . . ."

PATIENT: I can never be happy without him.

THERAPIST: OK. The automatic thought is "I can never be happy without him." Why don't you write that down? [The therapist has given the patient a clipboard with paper and pen to take notes during the session.] Now let's see how much you believe that thought: "I can never be happy without him." If you were to rate that thought from 0% to 100%, where 0% represents the complete absence of that belief and 100% represents your absolute certainty that this belief is true, how would you rate it?

PATIENT: I guess I'd have to say it's a pretty high rating. I really believe this—most of the time. I'd give it about 90%.

Some people have a hard time using this kind of scale. The idea of rating emotions and beliefs is foreign to their thinking. The therapist may need to provide visual aids.

THERAPIST: You said you felt sad, but it's hard for you to use the scale. Let's define what this scale is. (*Draws the scale shown in Figure 2.4.*) Let's say that 0% represents absolutely no sadness, and that 100% represents the most sadness that anyone could imagine—you are absolutely

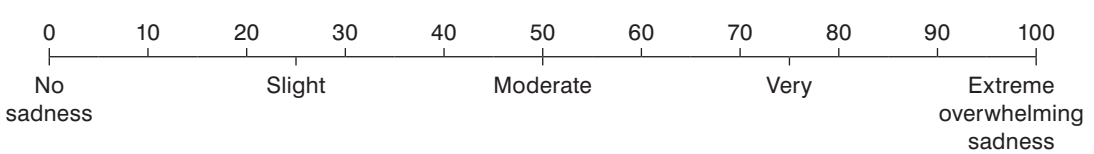


FIGURE 2.4. Rating emotions on a scale from 0% to 100%.

overwhelmed with sadness, so that you can't think of anything else. Fifty percent represents a moderate amount of sadness, whereas 90% represents an extreme amount of sadness—a very disturbing amount—but you are still able to function, to a large degree. Now, when you think about John leaving you, where would you place your sadness on this scale?

PATIENT: I'd say at about 90%. I'm extremely sad, but I'm still able to function, to some degree.

Homework

The therapist can ask patients to keep track of how their degree of belief in their thoughts changes during the course of the next week. Patients are asked to use Form 2.5 for rating emotions and beliefs, noting what events preceded the thoughts and feelings and rating the degree of belief and the degree of emotion associated with each event. After this exercise has been completed, it can be suggested that patients reflect on what could account for the variation in the negative thoughts and feelings they experience.

Possible Problems

Problems that typically occur with this exercise include a lack of motivation to write down the same belief more than once during the week. Patients may think, "I've already done this." However, the purpose of the exercise is to examine carefully the variation in the belief and the feeling and what accounts for this change. This differentiation also helps us identify possible "trouble times" for patients—that is, times when they are more likely to feel depressed or anxious. This knowledge can assist the therapist in focusing treatment around these problematic times.

Cross-Reference to Other Techniques

Other relevant techniques include examining how thoughts lead to feelings, distinguishing thoughts from facts, the vertical descent technique, categorizing negative thoughts, and looking for variations in a particular thought.

Form

Form 2.5 (Rating Emotions and Beliefs).

TECHNIQUE: Looking for Variations in a Specific Belief

Description

Thoughts, feelings, behavior, and facts are fluid and constantly open to change. The depressed or anxious individual often is fused or fixated on a particular thought or feeling at the present moment, not realizing how variable these experiences are over time. And, as indicated above, facts change as we get more information—either contradicting initial thoughts (or facts) or adding to the mitigating context in which one experiences them. In order to gain distance from a belief, it is often useful to recognize that even in the present circumstances, our beliefs may change in strength or credibility. Consequently, the therapist directly assesses variability of belief. This technique is closely related to the technique of rating degree of emotion and degree of belief in the thought described above. The emphasis here is on a specific belief and its variation across time and situations.

Questions to Pose/Intervention

"Are there times you believe this thought with less conviction? What is going on when you believe this negative thought less? If your thought were entirely true, then how could you believe it to be less true at certain times?"

Example

THERAPIST: You said you believe that you can never be happy without John, and you give this belief a 90% rating.

PATIENT: That's right. I really believe this. That's why I'm so unhappy.

THERAPIST: Now during the course of the day, I imagine your moods change—sometimes you're unhappier than at other times?

PATIENT: Yes. I'm not always crying or even thinking about John.

THERAPIST: What are you thinking about when you're not thinking of John?

PATIENT: I'm thinking about changing the apartment—maybe getting some new furniture. Or I'm thinking of having lunch with my friends. Other things.

THERAPIST: Obviously, when you're not thinking about John, the strength of the belief is 0%—since at that very moment, you're not feeling unhappy, even though John is not with you.

PATIENT: Well, that's a novel way of thinking about it. But I guess you're right.

THERAPIST: Are there times during the day when you think of John but you are not 90% unhappy?

PATIENT: Yes. Sometimes I think "Maybe I'm better off without him."

THERAPIST: So, if I were to jump into your head at that moment and ask you, "Tell me—right now—how much do you believe 'I can never be happy without John?,' how would you answer?"

PATIENT: Oh, well, at those times, my belief would be very low, maybe even 10%.

THERAPIST: So this belief that you have right now *can* change—even in the course of a few hours. What do you make of that?

PATIENT: I guess that my thoughts about the breakup might change.

THERAPIST: When people go through breakups, they often have very strong, negative, powerful beliefs. I'm sure you have friends who have gone through this experience.

PATIENT: Yes, my friend Alice got divorced 5 years ago.

THERAPIST: Perhaps she had the exact same belief that you have right now. Have her beliefs changed over the years?

PATIENT: You're right, they have! Now she can't even imagine being in the same room with her ex-husband.

THERAPIST: Well, let's keep this in mind—how your beliefs change and the beliefs of other people change.

Homework

Using Form 2.6, the patient can be given the homework assignment of tracking the degree of belief in a specific thought for several days. Presumably, the patient's focus and concern about a belief will vary with time of day, events, and other thoughts. This variation further reinforces the idea that a

strongly held belief can be changed. Furthermore, the patient's strongly held belief may vary during the session. Periodically during the session, as the patient and therapist focus on challenging beliefs and planning behavior, the therapist can ask the patient how strong the belief is at those different points. It is not uncommon for a patient to begin the session with a belief held at 90% and end the session with the belief held at 40%.

This change in belief is then linked to the change in emotion—for example, sadness has decreased as the strength in the belief has diminished—further reinforcing the assumptions of cognitive therapy and providing hope to the patient that strongly held beliefs and unpleasant emotions can be modified. The therapist can ask, "If your degree of belief can change in 20 minutes in our session, imagine how much it can change in the future."

THERAPIST: Your belief has changed from 90% to 40% in 30 minutes, and your sadness has greatly decreased. What do you make of that?

PATIENT: I guess my thoughts and feelings can change in this kind of therapy.

THERAPIST: If we were able to change your thoughts and feelings in just 30 minutes, what do you think would happen if you were able to use these techniques on your own?

PATIENT: Well, I guess I'd feel better.

THERAPIST: Why don't we see what happens, then?

Possible Problems

As with the foregoing techniques in this chapter, a patient may be less motivated to write down a negative belief when he or she is feeling better. The therapist needs to make clear that there is a lot of useful information contained within feeling better. For example, if the patient believes "I have nothing to offer because I'm a loser" but notices that his or her degree of belief in this thought is 0% when talking with friends, the patient has gained useful information that can lead to the following intervention and question: "If your belief changes, then assign yourself tasks that are associated with more positive beliefs. If your belief changes, then it may not be accurate. What information are you considering when you are feeling less negative?"

Cross-Reference to Other Techniques

As suggested above, other relevant techniques include graded task assignment, examining all of the information or facts, challenging beliefs by examining the evidence for and against their validity, distinguishing a fact from a thought, and distinguishing a thought from a feeling.

Form

Form 2.6 (Tracking Degree of Belief in a Thought).

TECHNIQUE: Categorizing the Distortion in Thinking

Description

Continually distorting thoughts in the same manner—for example, by jumping to conclusions, personalizing bad events, or labeling oneself as a failure—are common patterns in people who are

depressed or anxious. The cognitive model proposes that unpleasant emotions are often associated with these biases or distortions in thinking. Automatic thoughts (i.e., thoughts that come spontaneously) are associated with negative affect or dysfunctional behavior and seem plausible to the individual. Examples of automatic thoughts are "I'll never be happy," "I'm stupid," "No one likes me," "It's all my fault," and "She thinks I'm boring." Automatic thoughts can be true, false, or have varying degrees of validity. The same thought may contain more than one distortion—for example, "When I go to the party, she'll think I'm boring." This thought reflects both fortune telling and mind reading. Beck (1976; Beck et al., 1979) and others (Leahy et al., 2012) have identified various automatic thought distortions. Form 2.7 provides common thought distortions that are associated with depression, anxiety, and anger.

Questions to Pose/Intervention

"Are you continually distorting your thinking in the same way? Look at the checklist of cognitive distortions. Are there certain kinds of distortions that you are using? What are they?"

Example

The therapist elicits the patient's automatic thoughts by asking, "What were you thinking when you felt sad?" or by supplying a sentence stem for the patient to complete, such as, "I felt anxious because I thought. . . ." The automatic thoughts are then categorized. The therapist explains: "Write down your negative or upsetting thought in the left-hand column and categorize the distortion in the right-hand column." See Figure 2.5 for an example.

Homework

The patient can be given the assignment of monitoring any negative automatic thoughts over the following week and categorizing them, using Forms 2.7 and 2.8. The value of this exercise is that patients see how they repeat the same categories of automatic thoughts—for example, fortune telling: "I'll never be happy," "Nothing will work out," "No one will ever want me," "I'll always be alone." If there is a clear repetition of a specific category of negative thoughts, then the therapist and patient can develop a specific set of challenges that can be used repeatedly to decrease the power of the thoughts. For example, the patient who continually engages in mind reading (e.g., "He thinks I'm

Automatic thought	Distortion
I'm a failure.	Mislabeling
She thinks I'm unattractive.	Mind reading
Nothing I do works out.	All-or-nothing thinking
Anyone can do this job—it doesn't mean anything.	Discounting positives

FIGURE 2.5. Examples of automatic thought distortions.

a loser," "They don't like me," "I must look pathetic") might be instructed to compose a list of challenges to these repetitive thoughts. These challenges could include the following: "I don't have any evidence," "I'm jumping to conclusions," "Why should they dislike me if they don't even know me?," "I'm just as good as anyone here," "I don't need their approval," "I don't need to impress everyone," or "Maybe they're thinking about whether *I* like *them*."

Possible Problems

As indicated above, some patients believe that categorizing their thoughts as distortions implies that they are stupid or crazy. It is important to clarify that some negative thoughts are true. For example, the thought might be, "She doesn't like me." We can categorize this thought as mind reading, but it could also be true. Perhaps she doesn't like me. I indicate to patients that we use the form for "cognitive distortions" because it is a handy way of categorizing thoughts—but that many negative thoughts have a degree of truth to them. Once we are able to find a pattern to the thoughts—let's say, mind reading—that is associated with feeling down, then we can develop some specific interventions for that pattern. Categorizing thoughts should not be equated with refuting or negating thoughts. We have to examine the facts. In some cases, the therapist may wish to refer to these as "cognitive habits" or "biases" or "patterns" rather than as "distortions," since some patients may feel that "distortions" sounds overly critical.

Cross-Reference to Other Techniques

Other relevant techniques include the thought monitoring described above, whereby the patient keeps track of thoughts, facts, feelings, and variations in the degree of belief in a thought. In addition, Form 2.7, Checklist of Cognitive Distortions, can assist the therapist in planning interventions or questions, such as using vertical descent, identifying underlying assumptions and schemas, evaluating feared fantasy, looking at the costs and benefits, and considering the evidence for and against the validity of certain thoughts.

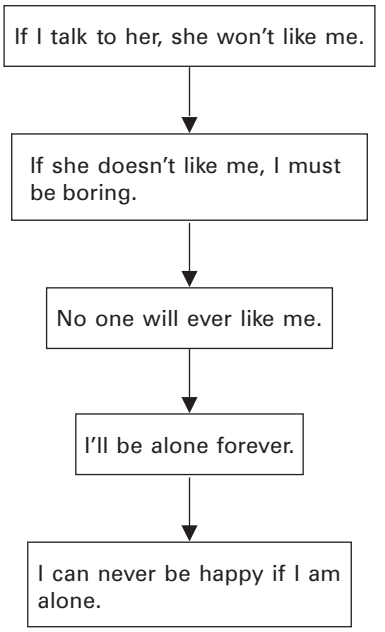
Forms

Form 2.7 (Checklist of Cognitive Distortions); Form 2.8 (Categorizing Your Thought Distortions).

TECHNIQUE: Vertical Descent

Description

Sometimes negative thoughts turn out to be true. Let's say a male patient predicts he will be ignored or rebuffed at a party. This is fortune telling, but it may prove accurate. Exploring the beliefs underlying the fear of that outcome helps to reduce the impact of the thought. With this technique, the therapist continues to ask about that thought or event: "What would then happen if that were true?" or "What would that mean to you if that happened?" We refer to this process as *vertical descent* because we are attempting to burrow down to the bottom-most belief. Accordingly, the therapist writes the patient's thought on the top of a page and then draws a downward arrow to the series of thoughts or events that is implied by the thought (see Figure 2.6).



Event and thought	Implication
Event: Considering going to a party. **Thought:** "I feel anxious approaching that woman at the party."	
What do you think will happen?	*I'll get rejected.*
If that happens, then it means . . .	*I must be a loser.*
If I'm a loser, then it means . . .	*I'll never find anyone for a relationship.*
If I never find anyone, then . . .	*I'll always be alone.*
If I'm always alone, then that would bother me because . . .	*I can't be happy if I'm alone—I'd always be miserable.*
What is my underlying assumption?	*I need other people to feel happy.*

FIGURE 2.6. Taking the vertical descent to the implication of a thought.

Questions to Pose/Intervention

"If your thought is true, why would it bother you? What would it make you think? What would happen next?" The therapist continues digging deeper for thoughts or events that would follow if the preceding thought were true or the preceding event occurred. The goal is to uncover the ultimate implication of the negative thought or event.

Example

Vertical descent is a useful way of getting at the underlying fears of which patients are unaware. I use this technique frequently, because I have found I can never really tell what the patient's underlying

beliefs and fears might be. For example, most of us have a fear of dying—but what is it that each of us really fears? Consider these two patients, each of whom had a fear of dying.

THERAPIST: You said that you sometimes fear you might have cancer. Even though the doctor has reassured you that you are OK, what would it mean to you if you did have cancer?

PATIENT: I'd be afraid that I might die.

THERAPIST: Almost everyone has a fear of that, of course, but let me ask you about your own fears of dying. Complete this sentence: "I'd be afraid of dying because. . . ."

PATIENT: I'd be afraid I wasn't really dead—that I was only in a coma—and that I would wake from the coma in my grave, buried alive.

This patient's fears of being buried alive are quite symbolic (to use a noncognitive term). Many of her problems revolved around the issue of constraints on her behavior, such as food restrictions, limits set on her by her boss, and the limits of her finances. It is useful to write out on a sheet of paper or a blackboard in the office the string of thoughts showing the downward progression to the core fear. The example of the first patient, with the fear of being buried alive, is shown in Figure 2.7.

Another patient, whom I would describe as a compulsive caretaker who tries to take care of everyone's needs, also had a fear of dying. His fear focused on the well-being of his wife and daughter, were he to die.

THERAPIST: What about dying would bother you the most?

PATIENT: It's not the physical pain. I don't really worry about that. And I've already done enough for five lifetimes. It's that if I died, I would be worried that I didn't take care of everyone.

THERAPIST: Who is it that you would have to take care of?

PATIENT: My wife and my daughter. I could die if I knew they'd be alright.

THERAPIST: So you're saying that you can accept death if you know that the people you love are taken care of?

PATIENT: That's right.

THERAPIST: Are you assuming that they are helpless without you?

PATIENT: I guess I am.

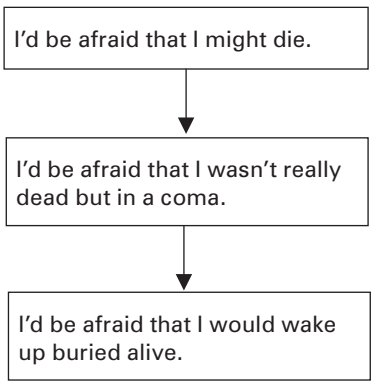


FIGURE 2.7. Taking the vertical descent to the implication of a thought.

The therapist can ask any number of questions about an event or thought. For example:

> "Why would that be a problem for you?"
> "What would happen?"
> "Why would that bother you?"
> "Then what?"
> "What would that mean to you?"
> "What would you think?"
> "What is the worst thing that you can imagine happening—if that happened?"

Homework

The patient is asked to draw out the implication of negative thoughts by using the vertical descent form (Form 2.9). This form asks the patient to identify a string of implications. The therapist might say to the patient: "Your negative thoughts are connected with other negative thoughts. We are interested in how you think and what each negative thought means to you. For example, someone might have the negative thought 'I'm not prepared for the exam,' which then leads to the thought 'I'll fail the exam,' which tumbles into the thought 'I'll have to drop out of school.' Try to identify some of your negative thoughts and then examine the string of thoughts that follows. Keep asking yourself, 'And if that were true, it would bother me because it would mean. . . .'"

Possible Problems

Some patients stop identifying their negative thoughts in the middle of the sequence. For example, the patient might stop with the thought "I'll flunk the exam" and not go any further in the vertical descent. The patient might say, "Flunking seems bad enough" or "I don't really believe I would flunk the exam." It is helpful to ask the patient to keep pushing for even "deeper" or "worse" thoughts that would follow from the first few thoughts. Often we find that the patient's thoughts about having any failure or rejection are associated with fantasies of awful or catastrophic consequences. These underlying "worst fears" fuel the anxiety about the initial thoughts.

Cross-Reference to Other Techniques

Techniques related to the vertical descent include identifying thoughts and feelings, examining the evidence for and against the thought, examining the costs and benefits of the validity of the thought, evaluating the leaps in logic underlying the thought, calculating sequential probabilities, and challenging the thought.

Form

Form 2.9 (Using the Vertical Descent).

TECHNIQUE: Assigning Probabilities in the Sequence

Description

People who are prone to depression and anxiety often think in dichotomous (all-or-nothing) ways and often are overgeneralized and vague in their thinking. These styles of thinking often lead the individual to state a thought—for example, "It won't work out"—without specifying precisely what will happen. Moreover, by being overly generalized and vague, it is difficult to determine the likelihood of an event—and to instill "doubt." Estimating probabilities is an excellent technique for considering the possibility that the feared event will not occur and for determining the patient's exaggeration of risk.

Using the vertical descent procedure described above, the patient can now estimate the probability of each event occurring in the sequence, given that the preceding event is true. We are interested not only in the thoughts that are implied in the vertical descent but also in the subjective estimates of probabilities. These subjective estimates are usually far beyond what we would expect to be true, given our knowledge of baseline information in the general population.

Questions to Pose/Intervention

"What is the probability that *X* would happen? What is the likelihood, from 0% to 100%?"

Example

The therapist might introduce the idea of probability in the following way.

THERAPIST: The likelihood that something will happen is called *probability.* Probabilities can vary between 0% and 100%—there are probably very few things that have a 0% or 100% probability. For example, the probability of getting heads when I flip a coin is 50%. The question that I will ask you is, "What is the probability of each of your thoughts being true?" Let's take the first thought, "I'm not prepared for the exam." What is the probability that this thought is true?

PATIENT: I'd say about 90%.

THERAPIST: Your next thought was that you would fail the exam. What's the probability that you would fail the exam, given that you are not prepared?

PATIENT: Oh, I'd say about 30%. I actually know some of the things that will be on the test.

THERAPIST: OK. But if you *did* fail the exam, what is the probability that you would flunk out of school?

PATIENT: Probably 2%. I have already taken a lot of courses and passed them.

THERAPIST: OK, but if you *did* flunk out of school, what is the probability that you would never get a job?

PATIENT: Less than 1%.

THERAPIST: So, we would be looking at a sequence of increasingly less likely events—failing the exam is 30%, flunking out is 2%, never getting a job is 1%. And each would have to occur—one after another.

PATIENT: That seems like an unlikely event.

Homework

The therapist can ask the patient to use Form 2.10 to keep track of the estimated probabilities of various events that are of concern. The goal here is to identify the kinds of probabilities that patients might assign for negative events. In some cases it might be useful instead to have the patient rate the probabilities of positive events.

Possible Problems

As with the previous vertical descent exercise, the patient may stop prematurely in the sequence, claiming that he or she really doesn't believe the next thought in the sequence. Or the patient may claim that the initial thoughts would be bad enough. Again, the therapist should emphasize that even if the other thoughts don't seem credible or likely, they still should be identified because they might illustrate underlying fears that need to be examined. Another type of problem arises when the patient claims, in essence, "Well, I know that it is unlikely, but what if *I'm* the one to whom this happens? You can't show me that it is impossible." Patients who demand "certainty" can be asked, "What are the costs and benefits of demanding certainty?" "Are there any things in your life for which you don't have certainty?" "Why do you tolerate that uncertainty?"

In addition, people are often prone to "loss aversion"—that is, they fear losses—and when events are "framed" as losses, people tend to be more risk averse or negative (Kahneman, 1979, 2011). Thus, one alternative to asking for sequential probabilities of negative events is to frame the question as sequential probabilities of positive events. In the foregoing example, the therapist can ask, "What is the probability that you will pass the exam?," "What is the probability that you will graduate from college?," and "What is the probability that you will get a job?" By framing these questions in terms of positive outcomes, the patient is more likely to view the situation as having more positive implications.

Cross-Reference to Other Techniques

Other relevant techniques include all of the techniques identified in Chapter 8 on modifying worry and rumination.

Form

Form 2.10 (Looking at Probabilities in a Sequence).

TECHNIQUE: Guessing the Thought

Description

It is not always possible for the patient to identify the negative thought; sometimes the intensity of the emotion is so great that the patient finds it difficult to reflect on the thoughts that go with the feelings. Beck (1995) recommends that the therapist suggest some possible thoughts to the patient to determine if any of them seem consistent with how he or she is thinking and feeling. The therapist must be careful not to suggest that the patient has an "unconscious" belief that only the therapist can identify. Both therapist and patient can attempt to speculate as to the nature of the underlying thought.

Questions to Pose/Intervention

"You can't say exactly what your thought is. What kinds of thoughts would go with these negative feelings? Is it possible that you are saying these things to yourself?" (The therapist suggests some possible thoughts.)

Example

The patient feels overwhelmed with sadness and hopelessness after the breakup of her engagement. She focuses on her physical complaints: "I can't eat, and I feel so tired." She repeats to the therapist, "I feel so awful since we broke up. I just can't think straight." The therapist tries to elicit specific negative thoughts.

THERAPIST: You said that you felt awful since the breakup. Could you tell me what kinds of thoughts you're having?

PATIENT: I just feel terrible. I can't sleep.

THERAPIST: Yes, those are feelings that you are describing right now. But could you complete the sentence "I feel awful since the breakup because I think. . . ."

PATIENT: I don't think anything. I just feel like dying.

THERAPIST: Can you identify any thoughts that go with that feeling of hopelessness?

PATIENT: No, the feeling is too intense.

THERAPIST: I wonder if we could try to guess at what those negative thoughts might be. I don't know what they are, so I'll just make some suggestions and you tell me if any of these ring a bell for you.

PATIENT: OK.

THERAPIST: Could you be saying to yourself, "I'll never be happy again"?

PATIENT: Yeah. That makes sense. That's what I'm thinking.

THERAPIST: Are you saying, then, "I can never be happy unless I have [Roger] in my life"?

PATIENT: Definitely. That's what I'm feeling.

Homework

The therapist can request that the patient list any unpleasant moods and either identify or "guess" the underlying thought.

Possible Problems

The therapist could have tried to get the patient to review the differences between a thought and a feeling, but sometimes the patient is unable to gain enough emotional distance to identify the thought. Once the negative thoughts are identified, the therapist can continue with the vertical descent procedure: "I could never be happy without Roger because . . . Roger was unique. . . . I could never love anyone like I loved him. . . . I can never be happy unless I have a man in my life." Sometimes the patient insists that there are no thoughts, just feelings. The therapist can ask the patient to close (in this case) her eyes and attempt to induce the negative feeling as intensely as she can. The

therapist can instruct the patient to imagine the situation that has elicited this feeling—for example, "sitting at home alone thinking of [Roger]." The therapist can guide the patient toward identifying the negative thoughts while the feeling or emotion is intensely felt: "While you are feeling really sad, can you imagine what you are thinking? Could it be that you are thinking 'I can never be happy without Roger'?"

Form 2.11 allows the patient and therapist to write down their "guesses" about these possible negative thoughts. These guesses need to be examined quite carefully, since many patients may believe that everything is driven by mysterious unconscious thoughts and motivations. The therapist will want to examine, with the patient, the plausibility that these are the real thoughts underlying the feeling. Furthermore, patients can verify the guesses by staying on the lookout for the problematic thoughts the next time they feel sad or hopeless.

Cross-Reference to Other Techniques

Techniques related to this one include the use of vertical descent; monitoring emotions, thoughts, and situations; reviewing the list of cognitive distortions to determine if there are any suggestions that remind the patient of the underlying thought; imagery techniques; emotional evocation; point–counterpoint; challenging the thought; and role playing negative and positive thoughts with the therapist.

Form

Form 2.11 (Guessing at the Negative Thought).

FORM 2.1

Distinguishing Events, Thoughts, and Feelings

Examples of events, thoughts, and feelings are listed in the form below. See if you can correctly identify each statement in the left column as an event, a thought, or a feeling. Place an "X" in the appropriate box. For example, "My boss criticized my work" is an event.

	Event	Thought	Feeling
My boss criticized my work.			
I'll lose my job.			
I'm anxious.			
I never get a break.			
I'm sad.			
I'm stuck in traffic.			
It's raining.			
I think that she doesn't like me.			
I feel embarrassed.			

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FORM 2.2

How Thoughts Create Feelings

Our thoughts are often related to how we feel. For example, the thought "I will do poorly on the exam" may lead to the feelings of anxiety and sadness. Alternatively, the thought "I will do well on the exam" may lead to the feelings of calmness and confidence. In the form below, please identify your thoughts in the left column and the feelings that these thoughts give rise to in the right column.

Thought: I think . . .	**Feeling:** Therefore, I feel . . .

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FORM 2.3

The A-B-C Technique

"Activating event" refers to an event that precedes your thought or belief. For example, it is helpful to recognize that "The exam is tomorrow" is the activating event that precedes the thought "I'm not prepared," which might lead to the "consequence: feeling" of anxiety and worry and to the "consequence: behavior" of studying hard for the exam.

The same activating event might lead to different thoughts, feelings, and behaviors. Let's say your boss says something critical of your work (activating event). In one situation you might think "She is having a rough day and this has happened with everyone here." So, you might feel a bit frustrated (feeling) but not particularly anxious, and you might just continue with your work (behavior). Alternatively, you might think "She's going to fire me!" This thought might lead to intense anxiety (feelings) and to your deciding to stay home the next day because you are so upset (behavior). Thus, the same activating event can lead to different thoughts, feelings, and behaviors.

In Column A, write down an event that happened recently that provoked strong feelings in you. In Column B, briefly state the belief or thought that arose when the event occurred. In the third column, note down the feelings you had as a result of that thought or belief, and in the last column indicate what behavior you engaged in as a result of these thoughts and feelings.

A = activating event	**B = belief (thought)**	**C = consequence: feelings**	**C = consequence: behaviors**

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FORM 2.4

Other Possible Facts

Sometimes we have a negative thought, but we don't consider other possible effects. For example, you might think you are not prepared for an exam, but there might be other possible facts that could be positive—such as, you are intelligent, you have done some of the reading, and you have studied some of the material. In the form below, you can identify your negative thoughts in the left column and in the right column write down other possible facts that could be positive.

Negative thought	Possible positive facts

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FORM 2.5

Rating Emotions and Beliefs

The degree that you believe in your negative thoughts may change with different events and at different times. Write down the event or situation that you are in when you have a negative thought. For example, repeated events and situations might include "sitting alone" or "thinking of going to a party" or "trying to get some work done." Then write down your negative thoughts, how much you believe them, your emotions, and the degree of your emotions.

Event/situation	**Negative thought and degree of belief (0–100%)**	**Emotion and degree of emotion (0–100%)**

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FORM 2.6

Tracking Degree of Belief in a Thought

The degree to which you agree with your specific negative belief may change during the course of the day. For example, the belief "I can't do anything" may be very strong when you are lying in bed in the morning. You may believe it 95%. But when you are at work, you may believe this thought only 10%. Keep track of a negative belief for a couple of days and try to note if there is any change or variation in the degree to which you agree with your belief. What are you doing when that variation occurs? Are you with anyone? Does the strength of the belief vary with the time of day?

Negative belief:			
Time/activity	**% Belief**	**Time/activity**	**% Belief**
6 A.M.		4 P.M.	
7		5	
8		6	
9		7	
10		8	
11		9	
12 NOON		10	
1 P.M.		11	
2		12	
3		1 A.M.	

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FORM 2.7

Checklist of Cognitive Distortions

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. For example: "He thinks I'm a loser."
2. **Fortune telling:** You predict the future—that things will get worse or that there is danger ahead. For example: "I'll fail that exam" or "I won't get the job."
3. **Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. For example: "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. For example: "I'm undesirable" or "He's a rotten person."
5. **Discounting positives:** You claim that the positive accomplishments you or others attain are trivial. For example: "That's what wives are supposed to do—so it doesn't count when she's nice to me" or "Those successes were easy, so they don't matter."
6. **Negative filter:** You focus almost exclusively on the negatives and seldom notice the positives. For example: "Look at all of the people who don't like me."
7. **Overgeneralizing:** You perceive a global pattern of negatives on the basis of a single incident. For example: "This generally happens to me. I seem to fail at a lot of things."
8. **Dichotomous thinking:** You view events, or people, in all-or-nothing terms. For example: "I get rejected by everyone" or "It was a waste of time."
9. **"Shoulds":** You interpret events in terms of how things should be rather than simply focusing on what is. For example: "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame for negative events to yourself and fail to see that certain events are also caused by others. For example: "My marriage ended because I failed."
11. **Blaming:** You focus on the other person as the source of your negative feelings and you refuse to take responsibility for changing yourself. For example: "She's to blame for the way I feel now" or "My parents caused all my problems."
12. **Unfair comparisons:** You interpret events in terms of standards that are unrealistic by focusing primarily on others who do better than you and then judging yourself inferior in the comparison. For example: "She's more successful than I am" or "Others did better than I did on the test."
13. **Regret orientation:** You focus on the idea that you could have done better in the past, rather than on what you could do better now. For example: "I could have had a better job if I had tried" or "I shouldn't have said that."
14. **What if?:** You ask a series of questions about "what if" something happens, and you are never satisfied with any of the answers. For example: "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"
15. **Emotional reasoning:** You let your feelings guide your interpretation of reality. For example, "I feel depressed; therefore, my marriage is not working out."
16. **Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as irrelevant any evidence that people like you. Consequently, your thought cannot be refuted. Another example: "That's not the real issue. There are deeper problems. There are other factors."
17. **Judgment focus:** You view yourself, others, and events in terms of black-or-white white evaluations (good–bad or superior–inferior), rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. For example: "I didn't perform well in college" or "If I take up tennis, I won't do well" or "Look how successful she is. I'm not successful."

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FORM 2.8

Categorizing Your Thought Distortions

In the left-hand column, write down an automatic thought you have. Then in the right-hand column, identify the category (or categories) of thought distortion this thought falls into. Use these categories of thought distortions: mind reading, fortune telling, catastrophizing, labeling, discounting positives, negative filter, overgeneralizing, dichotomous thinking, "shoulds," personalizing, blaming, unfair comparisons, regret orientation, what-if thinking, emotional reasoning, inability to disconfirm, judgment focus.

Automatic thought	**Distortion**

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FORM 2.9

Using the Vertical Descent (Why Would It Bother Me If My Thought Were True?)

One way of evaluating what an event means to us is to look at the string of thoughts that we have about that event. For example, the event might be that I am alone. The first thought might be "I will never be with anyone." If that thought were true, I might conclude ". . . because I'm not lovable"; and if that thought were true, I might think "I can't be happy without someone." We call this "vertical descent" because we look at the thoughts that lie behind each thought. In the form below, identify the event and the string of thoughts that follow from the event and each thought along the way.

Event: _____

Thought

It would bother me because it would make me think . . .

Thought

This would mean

This would mean

This would mean

This would mean

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FORM 2.10

Looking at Probabilities in a Sequence

We often get upset about a string of events where each event in the sequence has an increasingly lower probability of occurring. For example, someone might think "My boss is displeased" and give that a probability of 50%. Then the person might think "If she is displeased, I might get fired," and give that a probability of 10%.

Event: _____

It would bother me because it would make me think . . .

Thought

This would mean

Probability

This would mean

Probability

This would mean

Probability

This would mean

Probability

Comment: What could be some reasons why each of these events would not occur?

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FORM 2.11

Guessing at the Negative Thought

"Emotions" refer to feelings such as sad, anxious, angry, helpless, or hopeless. In the middle column, "Possible negative thoughts" refer to thoughts that you believe may go with these feelings. In the right-hand column, rate the degree of belief that you have in each negative thought, using a scale ranging from 0% to 100%.

Emotions	Possible negative thoughts	Belief (0–100%)

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CHAPTER 3

Evaluating and Testing Thoughts

After the patient and therapist have identified and categorized the various negative thoughts and examined how they are related to depression, anxiety, and anger, the stage is set for evaluating, testing, and challenging these thoughts. Cognitive therapy involves both the identification of thoughts associated with depression, anxiety, and anger and evaluating the validity of these thoughts in terms of a realistic or balanced depiction of reality. It is not enough simply to recognize that one is having negative thoughts. One can focus on the credibility of these thoughts by examining whether they are based on fact, whether they are useful, if they are based on logic, and if they are thoughts that one would apply universally—or only to oneself. Thus, in cognitive therapy the examination of the thoughts associated with dysphoric mood is based on the assumption that the credibility or perceived validity of these thoughts is what maintains the patient's difficulties.

The therapist works with the patient to elicit and identify problematic thoughts, but also focuses on evaluating the credibility or impact of these thoughts on the patient. For example, it is possible to have the thought "I'm a loser" but assign very little credibility to it because you believe the evidence overwhelmingly disputes this label. Moreover, the cognitive-behavioral therapist can help the patient test out the belief that the occurrence of negative thoughts necessarily implies that one must act in ways consistent with those negative thoughts. For example, if one believes that one is boring, it does not logically follow that one should never express an opinion. One can act in opposition to the thought—as if one did not believe the thought. I examine this decoupling of thoughts from action when I describe behavioral experiments and techniques, and in outlining how metacognitive therapy can assist the patient in recognizing that the occurrence of a thought—and even its current credibility—need not govern behavioral choices.

A central assumption of the cognitive model is that doubt and skepticism can be empowering. Indeed, the patient who begins therapy with articulating his or her doubts—for example, "I don't know if this is going to help me"—can be encouraged to develop respect for healthy skepticism. The therapist can *join with the doubt*: "We find that honest skepticism can be one of the most powerful tools to use in this kind of therapy. I would encourage you to apply this power of doubt to both the work we do and the negative thoughts you have. The more doubt, the greater the honesty you can apply to the evaluation of the thoughts and actions that you take. Doubt allows us to freely examine what we are doing and thinking. You don't want to be limited by old habits or even by the way you

might feel. You can take any thought and say 'Let me see what would happen if I questioned it, if I had some doubt about it.' And we can go even further and suggest, 'Maybe it is possible to take action even if I have doubts.' For example, you might have the doubt 'I don't think I will have a good time if I go out with my friends,' but you can choose to act in spite of the doubt—you can *separate the doubt from the choice to take action*."

One can have a negative thought but not believe in the thought. This "credibility" issue is a central part of the emphasis on examining, testing, and challenging thoughts in the cognitive model. One can have any thought without believing it fully and without allowing the thought to control one's choices. Cognitive therapy is not a therapy about the suppression of thoughts.

In this chapter we consider a variety of techniques that are used to test the validity of negative thoughts, keeping in mind that negative thoughts are true sometimes. Cognitive therapy does not advocate the "power of positive thinking" but rather the power of identifying *whatever* is being thought and examining its validity. Some individuals underestimate the negative implications of their behaviors—for example, individuals who are abusing alcohol or drugs or individuals with manic tendencies (Leahy, 1999, 2002a, 2002b). Technically, cognitive therapists evaluate or test thoughts, examining their implications, looking at the evidence, and considering alternative interpretations. At times, however, the therapist may ask the patient to mount a more vigorous challenge, in the hope of activating new and more adaptive interpretations through active disputation. In a sense, these challenges or disputations are a way of testing the validity of a negative thought. If the negative thought is valid, it should be able to withstand vigorous challenge. However, the therapist should recognize that overly disputatious debating with the patient might result in the patient feeling invalidated, dominated, humiliated, or misunderstood. With these caveats in mind, let us turn to a sampling of techniques that can help patients examine the validity of the thoughts under consideration.

TECHNIQUE: Defining the Terms

Description

The therapist might explain this next stage to patients in this way: "In order for us to examine and challenge your thoughts, we have to know what you are talking about. If you label yourself as a 'failure,' we need to know what *failure* means to you. How would you define a *failure*? Are you using terms and concepts that you have never defined for yourself or others? This technique—*defining the terms*—is known as the 'semantic technique' because it asks you to define the meaning of the terms you are using. Imagine that you are a scientist (or a psychologist) doing research. Someone says, 'Bill is a failure,' and you want to determine if this statement reflects an accurate perception of Bill. The first thing we need to do is define *failure.* For example, you might define failure as:

- 'Having no success'
- 'Being unable to achieve rewards'
- 'Being inferior to almost everyone on everything'

"Or, if you are prone to self-criticism and depression, you might have a rather unique way of defining failure for yourself. You might define failure in a way that almost no one but you would agree constitutes a failure. For example, you might define yourself as a failure by the following criteria:

- 'Not doing as well as I'd like'
- 'Giving less than 100% of myself'

- 'Not doing as well as someone else'
- 'Doing poorly at a single task'

"So today we are going to discover your definition of failure."

Questions to Pose/Intervention

"How would you define the things that are bothering you? For example, how would we know if someone is worthless, successful, a failure, and so on? How would we know if someone is not some of these things? Give a detailed definition. What could we observe in reality that would be an example of what you are talking about? If you were teaching someone how to see what you see, what would you point to as an example? Would that person be able to agree immediately with your definition? Why or why not?"

Example

THERAPIST: You said you feel like a failure since Bill left you. How would you define *failure*?

PATIENT: Well, the marriage didn't work out.

THERAPIST: So you believe the marriage didn't work out because you, as a person, are a failure?

PATIENT: If I had been successful, then he would still be with me.

THERAPIST: So could we conclude that people whose marriages don't work out are all failures?

PATIENT: No, I guess I wouldn't go that far.

THERAPIST: Why not? Should we have one definition of failure for you and another for everyone else?

In this example, the therapist helped the patient identify how he was using the term "failure" and then identified an implication of generalizing this definition to others. A key element of a definition is that it should be universal in its application. Definitions need to be clear, universal, and internally consistent—for example, we cannot logically say that I am a failure if my relationship does not work out, but that this would not apply to anyone else. One is not "allowed" to use a "private language" that only applies to oneself. Individuals who define failure as less than "extraordinarily successful" can see that their definition is a polarized one that uses all-or-nothing terms—that is, "complete success" versus "complete failure." Would you apply it to everyone? A variation on the semantic technique is to ask patients how others would define "success" or "failure." My preference is to focus patients on the positive end of the continuum by asking them to define terms such as "success" or "worthwhile." By also including the positive end of the spectrum, patients can examine evidence that they have positive traits, not simply the opposite of an extreme negative quality.

THERAPIST: You can see that your definition of failure is quite different from the way other people might see it. Few people would say a person who is divorced is a failure. Let's focus on the positive end right now. How would most people define success in relation to a person?

PATIENT: Well, they might say people are successful when they accomplish some of their goals.

THERAPIST: OK. So could we say that if a person accomplishes some goals, he or she is successful?

PATIENT: Right.

THERAPIST: Could we also say people have different degrees of success? Some people accomplish more goals than others?

PATIENT: That sounds right.

THERAPIST: So, if we applied these ideas to you, could we say you have accomplished some of your goals in life?

PATIENT: Yes, I did graduate from college, and I have been working for the past 6 years. I've been busy raising Ted, and he had some medical problems a couple of years ago, but I got the right doctors for him.

THERAPIST: So could we call these successful behaviors on your part?

PATIENT: Right. I've had some successes.

THERAPIST: Is there a contradiction, then, in your thinking—calling yourself a failure but saying that you have had several successes?

PATIENT: Yes, that doesn't make sense, does it?

Homework

Using Form 3.1, patients can practice defining the terms of their negative thoughts. Figure 3.1 is an example of a male patient articulating his definitions in order to test out the possibility that his thinking is idiosyncratic. The patient can be asked to give the best definition of the terms that he or she is using.

Possible Problems

For some patients the feeling *is* the definition—"I feel like I'm a failure." This "emotional reasoning" is the evidence the patient summons to support his or her notion of being a failure. I suggest to patients that they examine the way the dictionary arrives at definitions. The dictionary examines the common use of a word is—that is, how do most people go about defining *failure*? I suggest that

Negative thought: "None of my relationships work out."

Terms	Definitions	Problems with my definitions
None	Not a single one	All-or-nothing thinking. I have many different kinds of relationships, with various degrees of positives and negatives.
Relationships	Romantic relationships	I have many kinds of friendships, romantic relationships, and shorter-term relationships.
Work out	End up in a permanent, blissful marriage	"Working out" doesn't have to mean "permanent, blissful marriage." Things can be relatively more positive than negative for various degrees of time.

FIGURE 3.1. Example of defining the terms.

we are trying to come up with definitions that we could use in a scientific study—that is, definitions other people could use that would allow them to look at the same facts and come up with the same conclusions. For example, if I define "cold" as "less than 30 degrees Fahrenheit," then people can determine easily whether it is cold outside. If I define successful behavior as making progress toward a goal, then I can evaluate whether someone is making progress toward his or her goal and thereby determine if he or she is achieving some success as a result of that behavior.

Other problems that often occur with patients' definitions are that they are too global, vague, idiosyncratic, and/or inconsistent. The definitions may change with changes in moods. It is helpful to point out to patients that the definition may not be clear and precise enough. One way to convey this point is to ask, "If others used your definition of 'loser,' would they be able to go out and determine the people who are losers?" It is worth stressing that patients' definitions can be so idiosyncratic that they bear little resemblance to how others define the same terms. The therapist should ask, "Is this how most people would define this term?" or "How do others use this term?" Humor can be introduced: "Could your doctor perform an examination and locate the failure in you?" or "Is there a test for failure that we can give everyone?"

In addition, the term may be so value-laden and subjectively determined that it is not really amenable to definition. For example, for our purposes the term "worthwhile person" is meaningless, since there is no way we can go out and determine who is a worthwhile person and who is not. We might be able to grapple with the term "worthwhile actions"—that is, actions that have value for self and others—but even here we are skating on thin ice since it may be worthwhile only for this individual in this context at this time. Another challenge to the definition offered is to ask if there is a simpler way of describing what has happened—without using the negative evaluation term. For example, "Would it be more accurate to say, 'This behavior did not work out for me this time'?" By replacing a global and idiosyncratic term with a neutral descriptive term—a term that is more specific about what actually happened—the negative impact is lessened. I return to this issue of vagueness, overgeneralized thinking, and negative evaluation throughout our discussion of other techniques. It is common for individuals to find that they are upset over these kinds of meaningless terms such as "worthwhile person," "loser," or "total failure." Helping patients focus on behaviors that are more or less desirable for them sets the stage for evaluating how these behaviors could be increased or decreased in frequency. Indeed, we might say that definitions that are most helpful are those that are publicly verifiable, clear, replicable, and that provide opportunities for flexibility and freedom of action.

Cross-Reference to Other Techniques

Techniques related to this one include eliciting automatic thoughts, categorizing thoughts into cognitive distortions, looking at the evidence for and against the validity of the thoughts, and examining the quality of the evidence.

Form

Form 3.1 (Defining the Terms).

TECHNIQUE: Making Definitions Clear and Fair

Description

As just noted, it is not unusual for people to define terms that lead to depression, anxiety, and anger in a manner that is vague and prejudicial to their interest. When we conduct research or engage in

an intelligent discussion, we want to agree on the terms we are using so we can proceed on common ground. Many people who are prone to depression use overgeneralized language so that the specific details are often left unclear (Williams, Teasdale, Segal, & Soulsby, 2000). For example, the individual who claims "failure" is defined as "things not being quite right" is being guided by a vague, overgeneralized, and difficult-to-evaluate statement. How do we evaluate—how can we falsify—"things not being quite right"? Moreover, some definitions or terms are remarkably unfair to the individual—for example, claiming "failure" is equivalent to "not making things work out the way you want them to work out." This idiosyncratic definition is prejudicial against the individual, since almost everyone could say at some time that things aren't working out exactly the way he or she wanted. We would view a definition as "unfair" if it is biased toward a negative outcome for most people using that definition. The technique to use is to evaluate the clarity and fairness of a definition.

Questions to Pose/Intervention

"You have suggested a definition, but what I want to evaluate first is whether this definition of the term that you are using is completely clear. For example, would anyone listening to this be able to understand exactly what you mean? How would they know if what they are observing is what you mean? An example of a definition that is clear and easy to see in real life is to say that 'a chair is a piece of furniture that has legs and on which there is a seat on which you can sit.' People would not confuse a chair with a dog. They could easily see the difference. But perhaps the way you define things may be vague or unclear. For example, if you define 'failure' as not getting what you want, would everyone hearing that definition know exactly what that means?" In addition, the therapist can inquire as to the "fairness" of the definition. For example: "If we define 'failure' as not getting what you want, then is everyone who doesn't get what he or she wants a 'failure'? If not, then the definition that you are using can be viewed as unfair to you. Our goal is to have terms and definitions that are clear and fair."

Example

THERAPIST: It's important when you are using terms that upset you to be clear about what you are thinking. A thought is, in some ways, like a tool and a target. It's a tool in that it makes things happen. For example, the thought "I'm a failure" is a tool with which I criticize myself. It is also a target for our evaluation: We can start focusing on that thought to see if the terms that you are using make sense. Are they clear? Are they fair?

PATIENT: I'm not sure what you mean by "clear."

THERAPIST: Well, that's exactly the point. How can we evaluate ideas if they are so unclear that one or both of us doesn't know what we are talking about? So let's take the thought "I'm a failure" that you have defined as "Not getting what I want." How would someone looking at your behavior be able to tell that you are "not getting what you want"? If the person observed you from the time you get up in the morning to the time you go to bed, would it be clear to him or her?

PATIENT: (*pausing*) I never thought of it that way. It's just how I feel when I think I'm a failure.

THERAPIST: That's an interesting observation—"how I feel." It's almost as if your thought "I'm a failure" is a feeling—it's emotional rather than truly factual. We often find that very emotional thoughts are quite vague. The thought "This is a chair" is clear; we can agree—or disagree—that this is a chair. But "I'm a failure" doesn't have that kind of clarity, does it?

PATIENT: No, it feels powerful, but it's hard to pin it down.

THERAPIST: So think about the irony of that. If I can't really pin it down, if other people don't know what that means, then am I feeling bad about something that is so vague, so hard to point to, that I am punishing myself with vagueness and inaccuracy?

PATIENT: I guess that's true.

THERAPIST: And if it is so vague, then it makes it hard for you to find out if you are right or wrong, and that may make you feel helpless and hopeless.

PATIENT: That's how I feel.

THERAPIST: So part of what we need to do is to get clearer, get more precise about the terms that we are using, so that we can find out eventually if the truth is really what we think it is. One way of being clear is to use terms that you define by behaviors or things that we can all observe. For example, we can all observe that that is a chair and that is a clock. We can all observe that I just raised my right arm and then lowered it. Good definitions lend themselves to easy observations on which we can agree. Do you think everyone could observe your behavior and conclude that you are a failure?

PATIENT: No, they don't feel the same way as I feel about myself.

THERAPIST: So, what if we were to start thinking about behaviors and observable things rather than these vague terms like "failure" or "worthwhile"? Imagine you are teaching someone to understand exactly what you mean by "failure." And imagine if that person would wonder if you were using the term the same way everyone else would use the term.

Homework

The therapist can ask the patient to list a number of terms that he or she uses when feeling down—for example, "failure," "loser," or "boring." The patient can then define what he or she means by these terms. In addition, the patient can ask him- or herself these questions: (1) "Is this definition so clear that everyone would know exactly what I'm talking about?," (2) "If I applied this definition to everyone else, would they think it is fair?," and (3) "What would be some examples of behaviors that represent the general term that I'm using?" For example, if the patient defines failure as "not getting what I want," then it might be that other people would have little ability to observe that in others. In addition, if this definition were applied to other people, then we would conclude that everyone is a failure, which makes the term meaningless. And, finally, we might observe that specific behaviors did not lead to preferred outcomes—and we could list these behaviors. These would be examples of behaviors that did not pay off in "this situation" and could be used to replace the more general and vague term, "failure." The patient can use Form 3.2 to explore his or her definitions; see Figure 3.2 for an example of how one patient used this form.

Term I use when I'm upset	How I define this term	Would other people know what I'm talking about? Is it vague, idiosyncratic, hard to determine? Why?
Nothing I do ever works out.	*"Nothing"—not a single thing.*	*People would think this is vague and overgeneralized and would think I'm not seeing things rationally.*

FIGURE 3.2. Making definitions clear.

Possible Problems

Getting patients to narrow and clarify their definitions is often a difficult task because many people are so accustomed to their "private language" of terms that they cannot imagine that others would have difficulty understanding them. But shifting from vague, unobservable, and unverifiable terms to clear, specific, behavioral, and observable terms can be "revolutionary." The patient who insists "But I *feel* like a failure" is confusing a statement about an emotion (e.g., feeling helpless, demoralized, defeated) with a statement about a public reality, such as, "He is a failure, and everyone would agree on that." The therapist can ask the patient to experiment with replacing vague and overly general terms with specific behaviors: "What would change for you if you gave up these vague and general terms and started using simple behaviors to describe things? For example, what would change if you replaced the self-critical term "failure" with the more precise statement "In this particular situation, this behavior didn't pay off"? Often patients can recognize that specific behavioral terms are less vilifying and easier to tolerate. Indeed, behavioral terms are generally easily observed and used for self and others without a great deal of emotional baggage. And, behavioral terms lend themselves to behavioral change.

Cross-Reference to Other Techniques

Other relevant techniques include the semantic technique, examining the evidence for and against, the double-standard technique, and examining cognitive distortions such as emotional reasoning, overgeneralization, and dichotomous thinking.

Form

Form 3.2 (Making Definitions Clear).

TECHNIQUE: Cost–Benefit Analysis of a Thought

Description

Once the patient has identified a thought that leads to disturbing feelings, the question is, "Are you motivated to change your thought?" We are interested in directing the patient to examine the consequences—both positive and negative—of holding a particular belief. Once the consequences are clear, the patient can choose either to maintain the belief or replace it with a different one. In focusing on the costs and benefits of a thought or behavior, the therapist can help the patient examine if the costs and benefits to the patient are long-term or short-term and whether the thoughts or behavior are consistent with longer-term goals or values. For example, a student might think that studying tonight, rather than going out with his or her friends, would have a higher cost tonight and that the immediate benefit would be to go to a party. But the longer-term goals and values of being a good student and getting into graduate school mean that it would be wiser to take a short-term loss to pursue longer-term gains. Costs and benefits need to be examined in terms of the values and goals that are most important to the patient.

Questions to Pose/Intervention

"What are the costs and benefits of your belief? What are the advantages and disadvantages of your thought? List them. What would change if you believed this less? If you believed this more? If you had to apportion 100% between the costs and benefits, would it be an even 50/50 split? Perhaps

60/40? or 40/60? How would you apportion the 100% between those costs and benefits? Alternatively, look at a thought that is more positive or less critical. What are the costs and benefits of that thought? How does this cost–benefit analysis compare with the analysis of your original thought?" Figure 3.3 represents a cost–benefit analysis for a patient who considers sitting at home rather than going to a party. The therapist can ask the patient to use Form 3.3 to record costs and benefits of the belief and then weigh those costs and benefits.

Example

THERAPIST: Let's examine your thought "I'll get rejected if I go to that party." I'd like you to write that thought down and put a line down the middle of the page. On the left side at the top, write "Advantages" and on the right side, "Disadvantages" [as in Figure 3.3]. Now let's examine all the advantages of believing that you would be rejected at the party.

PATIENT: I can't think of any advantages.

THERAPIST: There are always reasons or advantages that people have for believing something. Is there any way that this thought protects you?

PATIENT: Well, I guess if I believe that I'll get rejected, I won't be surprised—I'll be prepared for it.

THERAPIST: OK. Any other advantages?

PATIENT: I might be able to avoid rejection by avoiding the party. (*The therapist and patient then examine the disadvantages.*) If I think I'll be rejected, it makes me anxious and lowers my self-esteem. It makes me avoid people. (*The therapist and patient continue to examine if there are any other advantages or disadvantages, and fill in Form 3.3. They then divide up 100 points between the advantages and disadvantages.*) The disadvantages outweigh the advantages. If I were to divide up 100 points, I'd say it's 10% for the advantages and 90% for the disadvantages.

THERAPIST: So the disadvantages outweigh the advantages by 80 points.

The therapist is not finished with this patient. An alternative assumption or thought is examined: "I should care less about what people think of me." The therapist and patient construct a cost–benefit analysis for this new thought and weigh the tradeoffs (using Form 3.3). The patient concludes that the advantages are 90% and the disadvantages are 5%—a resultant of 90% in favor of the advantages. Clearly, the patient is better off believing that she should care less about what people think of her.

Negative thought: "I should sit at home rather than go to the party."

Advantages and disadvantages of the thought: "I'll get rejected if I go to that party."

Advantages	Disadvantages
I won't be surprised. I avoid rejection.	I'm anxious. My self-esteem sinks. I avoid people. I'm less assertive. I don't get what I want—settle for less. I feel inferior to others. I don't meet people I'd like to know.

FIGURE 3.3. Examining advantages and disadvantages.

What if the patient finds that the advantages of a maladaptive assumption outweigh the disadvantages? Then what? As an example, consider the following. Bill believes "I should always meet the expectations of my boss, no matter how unreasonable they may be." Bill claims that the advantages of this belief are that it prompts him to work harder and to get himself "psyched up," and that "everyone on the job is like that" and he can't be different. The disadvantages include anxiety, self-criticalness, overwork, and subservience to his boss's irrational demands. When he weighs the advantages, he gives them 70%; the disadvantages are given 30%. Consequently, he believes that the advantages outweigh the disadvantages—that is, on balance, this thought "works" for him. Even when the therapist examines the evidence that he must believe he has to meet *all* of his boss's irrational expectations to motivate himself, he still concludes that he needs this thought in order to be productive on the job.

THERAPIST: You have concluded that this thought works for you?

BILL: Yes. If I didn't think this way, I couldn't work there.

THERAPIST: OK. Well, you're entitled to believe anything that you wish. If you are committed to this thought and choose to believe it, then I assume that you are willing to absorb the costs of this thought.

BILL: What do you mean?

THERAPIST: I assume that you are willing to pay the costs of anxiety, overwork, self-criticism, and having your moods depend on the whims of your boss.

BILL: I don't *want* to feel anxious and self-critical.

THERAPIST: Yes, I know you don't like the costs of this assumption. But if that is the thought you believe you need, there is no way of getting around the costs. *Those are the costs of that thought.*

This excerpt illustrates how patients must confront their choices—either a problematic thought must be modified, or they will have to pay the costs. For this particular session, Bill decided to maintain his belief. This technique frees patients to examine the consequences of their beliefs—they can choose to hold any belief as long as they recognize the cost of the belief.

The therapist can acknowledge that the patient's tradeoffs might make sense in the short-term, but that longer-term goals are sacrificed. For example, the patient who wants to lose 20 pounds may be "correct" that this morning it makes more sense to loaf around than to exercise, since the benefits of exercising today are minimal. The therapist might then ask, "Are you focusing primarily on short-term gain rather than longer-term goals? What are the costs and benefits of this way of thinking?"

Homework

The cost–benefit analysis is useful in confronting patients' procrastination, avoidance, or underlying assumptions. Consider the example of a patient who is considering joining a health club. He is asked to list the costs and benefits of sitting at home watching television versus the costs and benefits of going to the health club (using Form 3.3). Similarly, the patient and the therapist may have identified an underlying belief that "I must be certain before I do anything." This belief can be submitted to a cost–benefit analysis and contrasted with another thought: "I can take reasonable risks." The purpose of the cost–benefit analysis is to confront patients with the issue of choosing among alternatives and to focus on the motivation to change.

Homework can consist of utilizing Form 3.3, in which the patient and therapist identify thoughts or choices confronting the patient and weigh their tradeoffs. The therapist can say, "We

have identified several thoughts [or behaviors] that are problematic for you. I'd like you to list these and then write out the costs and benefits of each one and look at how they weigh out for you."

Possible Problems

A common problem is denial that there is any benefit to a negative thought: "Oh, I know that it is irrational. There are no benefits. I don't know why I keep doing it." Here the therapist should insist on examining the possible "silent" benefits for the patient: "There are very few things that we do for which we see no benefit. For example, even though people may claim that cigarette smoking has very high costs and no real benefits, people who smoke actually get some short-term benefit from smoking. It helps them feel better, and it staves off the craving for a smoke." The therapist can ask the patient to try *not* to be rational: "Try to be neurotic when you think about the possible benefit of your negative thought." Possible benefits for negative thoughts include avoiding frustration, hopeless behavior, failure, risk, and discomfort. Possible benefits for worry include being prepared, avoiding surprises, and motivating oneself. Sometimes it is useful to ask patients to close their eyes, imagine confronting the choice (e.g., going to the health club vs. watching TV), and thinking of all the reasons and feelings that get in the way.

Another problem is that some of the benefits of a negative thought or behavior, though short-lived, confer highly reinforcing effects in their immediacy and saliency. For example, smoking, drinking, overeating, and passive behavior may confer immediate benefits of high intensity. Thus patients need to examine the longer-term negative consequences of these thoughts and behaviors. The costs of changing are "front-loaded" or up-front—using an investment analogy might be helpful—with payoffs accumulating over time (see Leahy, 2001a). Thus, the advantages of adaptive behavior may take time to accumulate—just as it may take time to see positive effects from working out.

Cross-Reference to Other Techniques

Related techniques include eliciting automatic thoughts, vertical descent, role playing against the thought, and guessing at the thought. Imagery techniques can be helpful in eliciting reasons for not engaging in positive behavior or thoughts.

Form

Form 3.3 (Cost–Benefit Analysis of a Thought).

TECHNIQUE: Examining the Validity of Short-Term and Long-Term Costs and Benefits

Description

The individual who predicts that the costs of doing something or thinking something will be excessively high is making a prediction about what will actually happen and how he or she will feel about it. For example, the thought "I'll feel exhausted and have aches and pains if I go for a long walk" is a prediction about a cost (how the person will feel). Similarly, thinking "I won't feel much pleasure or pride if I exercise" is another prediction about how the person will feel. Yet, the research indicates that predictions about how one will feel in the future are notoriously poor in accuracy (Wilson & Gilbert, 2003, 2005). People tend to believe that the occurrence of a negative event will lead

to long-lasting and rather extreme negative feelings, underestimating the balancing or mitigating effects of other positive events. Depressed and anxious people are often more extreme about the negativity of the consequences of their choices and underestimate the positive aspects of what might happen. Thus, anticipated costs and benefits may be exaggerated in the negative.

In addition to this hedonic affect forecasting bias, many benefits are cumulative and take some time in building up and acquiring a positive impact. For example, exercising in order to lose weight may be a long-term process, often requiring months to achieve a desired goal. The therapist can help the patient evaluate if the only benefit that the patient counts is the "final goal," and to consider the possibility of "making progress" or "engaging in self-help" as a positive, intermediate (and daily) goal. The "sample" of "allowable benefits" may often be limited in the patient's mind, thus making the costs seem so much more salient.

Finally, many depressed and anxious individuals have a limited search for costs and benefits, and if they quickly come up with a cost of doing something, they "stop out" or quit. I examine this behavior later (see Chapter 5); for now it is important to keep in mind that generating more points on the motivational grid of tradeoffs can help patients become more flexible in pursuing adaptive behavior.

Questions to Pose/Intervention

"You have identified the costs and benefits of your thought, but I wonder if you might be focusing on the short-term benefits and costs rather than considering the long-term tradeoffs. If you were to think about the longer term, what might the tradeoffs be? Sometimes the benefit of doing something requires repetition until those benefits accumulate. It's not an all-or-nothing or immediate thing. If you engaged in [the positive behavior] over and over for some time, do you think that the benefits would change?

"Also, we often find that we are not so good at predicting how we will feel down the road. I'm wondering, when you predict the costs and benefits, if you have noticed that in the past you often predict that something will be negative but it turns out to be neutral or positive. Is it possible that you have a negative bias about your future feelings?"

Example

THERAPIST: When you described the costs and benefits of getting together with your friends, you seemed to focus a lot on the discomfort that you might feel thinking about seeing them and the idea that you would be uncomfortable while you are with them. So you are inclined not to see them. But I'm wondering if you're focusing a lot on the immediate costs and benefits and not thinking of the longer-term tradeoffs. For example, if you got more active—seeing friends, exercising, getting out and doing things—the benefits might accumulate over time.

PATIENT: Well, I guess I think I would feel awkward seeing my friends when I feel so depressed.

THERAPIST: Yes, I can see that this might feel uncomfortable. But sometime when we think about the costs of something, we focus on the immediate experience. For example, have you ever thought, "If I work out at the gym, I'll feel exhausted," but then you go anyway and find out that as you work out, you feel better?

PATIENT: Yes, that does happen. I have a hard time getting motivated.

THERAPIST: Perhaps when you think about the costs of doing something, you first think about the negatives, you find one, you think it will be the only thing that matters, and then you decide

not to do it. The cost in seeing your friends might be the initial feeling of awkwardness, but the benefit—if it happens—might come later. Is that something that you have observed?

PATIENT: You might have a point. I don't know. I guess once my friends and I get talking about things, it takes my mind off my depression.

THERAPIST: So, the benefits might come with time. Let's take the idea of losing weight. If someone exercised just once, it might not help, but if he or she exercised five times a week for a year, that person is likely to show some significant benefit. Maybe benefits are cumulative?

PATIENT: Yeah, I know. I did make a commitment to exercise at the gym 2 years ago and I did lose a lot of weight—but it took a long time.

THERAPIST: What got you to discipline yourself?

PATIENT: I thought I wanted to have a better social life, and I thought I would have to just commit to it. And I felt good every time I went to the gym because I was taking care of myself.

THERAPIST: Perhaps thinking of the benefits as cumulative, thinking of taking pride in making progress, and giving yourself credit for acting in your longer-term interests is powerful.

PATIENT: I guess I've been too narrow in thinking primarily about how I'll feel bad in the short term.

THERAPIST: It's important to expand your awareness of costs and benefits—make them longer-term, cumulative, less focused on immediate discomfort, and taking pride in doing the best you can to move forward. Sometimes we just give up because we predict that nothing good will come of our efforts or that the costs and discomfort will be too great, but sometimes our predictions about how we feel can be off the mark.

Homework

The therapist can ask the patient to think about current predictions and thoughts and consider the range of possibilities of what might occur: positive, negative, and neutral. Then, looking back at past predictions, the therapist can ask one or more questions: "Have there been any that have not come true?" "Is there a tendency to make predictions that are extremely negative or to think that the way one feels at the current moment will be the way one always feel?" "What is the consequence of these biases in prediction? Do they add to feelings of helplessness, hopelessness, depression and anxiety?" The therapist can focus the patient on examining the short-term and long-term costs and benefits of a thought or a behavior. Using Form 3.4, the patient can evaluate if he or she is continuing to make short-term decisions that sacrifice more beneficial long-term gains. Figure 3.4 provides an example of how one patient used this form.

Thought	Short-term costs and benefits	Long-term costs and benefits
I'll get rejected by everyone if I go out to dinner with my friends.	**Costs:** *isolation, self-criticism, loneliness, depression, dwelling on the negative, worrying about things.* **Benefits:** *I'll avoid rejection.*	**Costs:** *more depression and isolation and feeling less effective in my life and nothing good happening.* **Benefits:** *none.*

FIGURE 3.4. Examining the validity of costs and benefits, short-term and long-term.

Possible Problems

Many patients who make negative predictions may experience any questioning of the validity of those predictions as dismissive, condescending, and/or invalidating. The therapist can acknowledge that examining thoughts can seem invalidating to the person holding the thought, but that a valid thought should be able to tolerate some questions, and there is little harm in examining alternative interpretations or predictions. Some patients will say that they know for sure how things will turn out—and these certainties can then be examined in terms of the evidence that can be forthcoming. The therapist can say, "It sounds like this is a strong belief, so perhaps we can note it and write it down and collect some facts going forward to see how things turn out."

Cross-Reference to Other Techniques

Other relevant techniques include examining the evidence, looking at past predictions, setting up behavioral experiments, examining the "heuristics" or "rules of thumb" that the patient uses, and point–counterpoint.

Form

Form 3.4 (Examining the Validity of Costs and Benefits, Short-Term and Long-Term).

TECHNIQUE: Examining the Evidence

Description

In describing this technique of examining the evidence, the therapist might say the following: "Now that you have defined your terms and indicated what would be a test of your thought, including what predictions you might make from your thought, you should examine the evidence both *for and against* the validity of your negative beliefs. Let's take the negative thought 'I'm a failure.' You have defined failure as 'not achieving goals' and success as 'achieving goals.' Placing a line down the center of the page, with 'I'm a failure' written at the top of the page, list all the evidence in the left-hand column that is consistent with your belief and all the evidence in the right-hand column that contradicts your belief (see Figure 3.5).

"In addition to counting the items for and against the validity of your thought, it is important to weigh them psychologically—that is, how much does this evidence convince you one way or the other? In weighing the evidence, you will notice that there is almost always some evidence to support any belief; the important point is to examine all evidence on *both* sides of the ledger.

"When testing a belief, it is essential to put the belief into the form of a proposition about facts—that is, a statement about what you believe is the truth. Avoid any statements that simply refer to feelings—such as, 'I feel sad, depressed, angry, etc.'—because these are not thoughts or beliefs that we can test. It would make no sense to argue that you do not feel sad if you say that you do feel sad. Similarly, we need to avoid examining rhetorical statements, such as 'Isn't life awful?' or 'I can't believe that this is happening.' Again, these are not testable thoughts. You can rephrase them as propositions—that is, statements about facts, such as 'Life is awful' or 'It's terrible that this is happening,' so that we could then collect evidence for and against the validity of these thoughts.

"Examine statements that you are testing to see if they are meaningless because they are true for almost everyone: For example, 'It is *possible* that I could have a panic attack' is meaningless because it is true for everyone. What you are really worried about—and which we *can* test against

Negative thought: "I'm a failure."

Evidence for . . .	**Evidence against . . .**
I'm single. I don't make a lot of money. I'm not as well liked as some other people. I feel depressed.	I have friends. I'm a good person—I have good values. I'm doing a decent job at work. I'm kind and considerate to my family.
Most important evidence in favor of thought: I don't make a lot of money.	*Most important evidence against the thought:* I'm a good person.
% evidence in favor of thought: 10	*% evidence against thought:* 90
Evidence in favor – evidence against = −80	
Conclusion: A lot of good people get depressed, and making a lot of money doesn't make anyone better or worse than anyone else. Everyone is single at some point. I need to stop putting myself down and stop using words like "failure."	

FIGURE 3.5. Examining the evidence.

the facts—are the implied beliefs, such as 'I probably will have a panic attack' or 'It would be terrible if I had a panic attack' or 'I'll go crazy if I have a panic attack.' Finally, we cannot collect evidence on 'what-if' statements, because these are not clear statements about reality. Consequently, you need to transpose your 'what if' statements into propositions—predictions and statements about facts. For example, 'What if I have a panic attack' might become 'I'm going to have a panic attack' or 'It would be terrible to have a panic attack' or 'I will die if I have a panic attack.'"

Questions to Pose/Intervention

"Weigh the evidence for and against your thought. Is it 50/50? 60/40? 40/60? If you subtracted the costs from the benefits, what would the result be? In addition, you might consider an alternative, more positive thought. Conduct a similar cost–benefit analysis and compare the results. What are the most important costs? What are the most important benefits? Why are these the most important costs or benefits?"

Example

THERAPIST: You said that you are a "loser" because you and Roger got divorced. We already defined what it is to be a loser—someone who does not achieve anything.

PATIENT: Right. That sounds really extreme.

THERAPIST: OK. Let's look at the evidence for and against the validity of this thought that you have not achieved anything. Draw a line down the center of the page. On the top I'd like you to write, "I have achieved some goals."

PATIENT: (*Draws line and writes statement.*)

THERAPIST: What is the evidence that you have achieved some goals?

PATIENT: I graduated from college, I raised my son, I worked at the office, I have some friends, and I exercise. I'm a good person—I am reliable, and I care about my friends.

THERAPIST: OK. Let's write all of that down in the left-hand column. Now in the right-hand column let's write down evidence against the validity of the thought that you have achieved some goals.

PATIENT: Well, maybe it's irrational, but I would have to write down that I got divorced.

THERAPIST: OK. Now, in looking at the evidence for and against the validity of your thought that you have achieved some goals, how do you weigh it out? 50/50? Some other ratio?

PATIENT: I'd have to say it's 95% in favor of the positive thought.

THERAPIST: So how much do you believe now that you have achieved some goals?

PATIENT: 100%.

THERAPIST: And how much do you believe that you are a failure because you got divorced?

PATIENT: Maybe *I'm* not a failure, but the marriage failed. I'd give myself about 10%.

Homework

Give the patient Form 3.5 and ask him or her to write down a negative thought each day (or to write down negative thoughts identified in the session) and to weigh the evidence for and against the validity of the negative thoughts. I tend to prefer having the patient also weigh the evidence for and against the validity of a positive thought, since this is more likely to lift his or her mood.

Possible Problems

As with other cognitive challenges to negative thoughts, the patient may say, "I know it's irrational, but I feel that it's true." As noted, this category of response is called "emotional reasoning" and can be addressed through a variety of techniques, including double standard, cost–benefit analysis, point–counterpoint, imagery induction, imagery restructuring, feared fantasy, and role playing. Other patients may view these evaluations of negative thoughts as invalidating, dismissive, critical, or minimizing. The therapist can explain that the purpose of the exercise is simply to examine the evidence, as the patient sees it, in regard to his or her thoughts. Indeed, some negative thoughts are true, and this validity can readily lead to an examination of underlying assumptions that fuel the emotional impact of the thought, or to problem-solving endeavors that can change the external reality to which the patient responds problematically.

Cross-Reference to Other Techniques

Related techniques include eliciting and identifying automatic thoughts, cost–benefit analysis, categorizing cognitive distortions, defining the terms, double-standard technique, examining limited information searches, and examining schemas.

Form

Form 3.5 (Examining the Evidence).

TECHNIQUE: Examining the Quality of the Evidence

Description

In describing this technique of examining the quality of the evidence, the therapist might say: "You have now listed the evidence for and against the validity of your negative belief—a belief with which you may be prosecuting and punishing yourself. You may have already established that you would be better off without this belief, but as you examine the evidence that supports your belief, you find that you have many reasons for holding on to your negative thought. The question you can ask yourself then is, 'How good is this evidence?' To put it in very direct terms, would you be able to convince other people of your negative belief? Would a jury accept your evidence as valid? For example, take the negative belief 'I'm a failure.' You may have offered the following evidence in support of your belief:

"I feel like a failure."
"Dan thinks I'm not as good as he is."
"I didn't do well on the exam."
"I lost the game in tennis."

"Imagine that you are presenting these items to a jury as evidence of the case you make against yourself. You say to the jury, 'I feel like a failure—so that proves I'm a failure.' Do juries accept feelings as evidence of someone's worth? No.

"Or how about saying to the jury, 'I'm a failure because Dan thinks I'm not that great'? Would the jury accept hearsay about Dan's evaluation of you as evidence? Again, no. If you pointed out that you did not do well on the exam, would the jury conclude that you are a failure as a person? Again, definitely not. Your feelings, your need for approval, or your poor exam results would not be regarded as quality evidence of your failings as a person.

"The important point to make is that you may be using information as evidence that is emotional, personal, debatable, and irrelevant. Just because you have come up with a lot of reasons to support your negative belief does not imply that the evidence is conclusive or even relevant. For example, you may be concluding that you are a failure because you are using emotional reasoning, personalizing an event, overgeneralizing, using perfectionistic standards, discounting your positives, filtering out your negatives, mind reading, jumping to conclusions about the future, referring to irrelevant material, or drawing illogical conclusions."

Questions to Pose/Intervention

"How good is the evidence supporting and refuting your belief? Do you think other people would consider your evidence convincing? Irrational? Extreme? Would other people think you could convince a jury that your statement is true? Or would they think it is too extreme? Why? What are some of the errors in your thinking?"

Example

THERAPIST: You said your evidence of being unattractive is that you feel ugly and that Roger broke up with you.

PATIENT: I just don't feel attractive.

THERAPIST: Right. You also said the women in the magazines are more attractive than you are.

PATIENT: That's right. They look like they're perfect.

THERAPIST: What do you think about the quality of your evidence in relation to the thought "I'm ugly"? Would you be able to convince a jury that someone *is* ugly because they *feel ugly*?

PATIENT: No. I guess they would require some kind of other information.

THERAPIST: You mean, some kind of independent information—something other than the way you feel?

PATIENT: Yeah, like what other people think of that person.

THERAPIST: Are there some men who think you're attractive?

PATIENT: Well, there have been a number of men who find me attractive. But I'm not interested in them.

THERAPIST: As evidence that you are not attractive, you cite the fact that Roger broke up with you. What were the reasons for the breakup?

PATIENT: We weren't getting along. He just can't commit to anyone. And he lies.

THERAPIST: So you personalized *his* shortcomings and concluded that *you* are not attractive?

PATIENT: That's true.

THERAPIST: I wonder if we could look at the evidence that you use to support your negative beliefs and see if the evidence is relevant and convincing or if it is characterized by these kinds of distortions.

Using Form 3.6, the patient can list the evidence supporting the negative beliefs and evaluate its quality by ferreting out any distortions. Many patients find it helpful to recognize that their beliefs are supported by evidence that is not convincing or that is irrelevant.

Homework

The patient can keep track of several thoughts during the week, identifying each negative thought and the evidence for and against the validity of that negative thought. Or the patient can review previous homework or notes from therapy sessions, wherein he or she has listed evidence for his or her negative thoughts. The assignment is to examine the possible problems with the evidence, focusing on whether there are cognitive distortions, biases, or illogical reasoning. The therapist might say: "After you have listed the evidence in favor of your negative thoughts, go back and use the form [Form 3.6] for examining the quality of your evidence. Now ask yourself if your evidence has any distortions in it. You can even grade each piece of evidence for its quality as A, B, C, D, or F. You can also grade the quality of evidence against the validity of your negative thoughts."

Possible Problems

As noted previously, many patients adhere to their feelings as evidence: "I feel it's true, even though I know it's not rational. I know the evidence doesn't support this view." Several questions can be raised for this kind of response. First, the therapist can utilize the point–counterpoint technique, described later in this book. Second, the therapist can point out that feelings are important, though they are not evidence, and we need to distinguish between feelings and facts. Third, the therapist

can explain that *feeling* the validity or invalidity of a belief is a different level of experience from *mental* or *cognitive* knowledge. When patients really *feel* that a particular belief is truly invalid, their maladaptive belief will have changed even more. Moreover, the therapist can note that feeling an old, habitual belief is truly *not* true may come later, after examining the facts and the logic of their thinking a number of times.

Cross-Reference to Other Techniques

As indicated, it is helpful to utilize the point–counterpoint technique, the double-standard technique, role plays, vertical descent, and examining cognitive distortions and the logic or inferences drawn.

Form

Form 3.6 (Examining the Quality of the Evidence).

TECHNIQUE: Defense Attorney

Description

In describing this technique of the defense attorney, the therapist might say: "In challenging your thoughts, you can imagine yourself brought into a trial where the prosecution (played by your automatic thoughts) has been attacking you for the last several days, labeling you as a lazy loser, an incompetent, and a generally guilty person. You are now given the task of playing the role of the defense attorney who must attack the evidence, the credibility of the witnesses against you (the defendant), and the logic of the prosecution's case. After suffering through several days of prosecution, you would not expect the defense to get up and simply say 'My client is innocent,' and then sit down and rest the case. You would expect a vigorous defense, one in which you would present evidence and witnesses on your own behalf. As the attorney, you do not have to believe in the innocence of your client (that is, yourself). You only have to take the job seriously." (For this analogy, see Freeman, Pretzer, Fleming, & Simon, 1990; Reinecke, Dattilio, & Freeman, 1996; de Oliveira, 2014.)

Questions to Pose/Intervention

"If you were trying to act as your own attorney whose job was to defend yourself, what would you say in your own defense? Try to be the best lawyer possible in defending yourself. Think about the errors in logic that the negative thought represents. Is it personalizing, labeling, blaming, discounting positives, overgeneralizing, using demanding 'should' statements, focusing only on the negative, or catastrophizing? Would the negative thoughts be fair in a system of justice and decency? Would we apply these to everyone?"

Example

THERAPIST: You've been criticizing yourself for much of your adult life, calling yourself a loser, a worthless person, lazy. Now I want you to imagine that you have been hired as "Tom's lawyer," and you have to defend Tom against these slanderous attacks. It's not necessary that you believe

in Tom's innocence or even that you like Tom. I just want you to be a competent lawyer in your defense of Tom. I'll play the part of the prosecutor and tell you how bad Tom is. You defend Tom.

PATIENT: OK.

THERAPIST: [as prosecutor] Tom is a lazy loser who has never accomplished anything.

PATIENT: [as defense attorney] That's not true. He has graduated from college. He has a good job, he supports his family, and his boss thinks he's doing well.

THERAPIST: [as prosecutor] Well, Tom just feels like a loser to me.

PATIENT: [as defense attorney] Feelings don't count as evidence in court. The facts don't support the idea that he's a loser.

THERAPIST: [as prosecutor] Well, he's not perfect, so he's a loser.

PATIENT: [as defense attorney] If that were true, then *everyone* would be a loser.

The advantage of this defense attorney exercise is that many people find it easier to imagine being a lawyer defending someone else than imagining themselves defending themselves. By taking on the "professional role" of lawyer, patients can place themselves in a role of demanding proof, questioning evidence, challenging the prosecutor—that is, all the things we expect from lawyers.

Homework

The therapist can instruct the patient to imagine acting as his or her own defense attorney by posing the questions to consider listed on Form 3.7 (see the example of a filled-in form in Figure 3.6).

Possible Problems

As with many techniques that actively challenge negative thoughts, patients may view this exercise as a naïve attempt to lie to themselves so that they feel better. In some cases, patients may believe that they deserve to criticize themselves and should not defend themselves, because they are really beneath contempt. These sabotaging thoughts should be elicited: "Can you tell me if you have any difficulty with the idea of acting as your own defense attorney?" Some patients believe that they cannot argue against the negative thoughts unless they totally believe the positive side. The therapist can point out that the role of a good lawyer is to take both sides, which allows the jury the opportunity to consider all points of view.

Cross-Reference to Other Techniques

Other relevant techniques include examining the evidence, the point–counterpoint technique, evaluating logical inferences, role playing, and categorizing cognitive distortions.

Form

Form 3.7 (Playing the Role of Your Own Defense Attorney).

What "law" was broken? With what offense are you charging yourself? Is there overwhelming evidence? *I'm depressed and I shouldn't be depressed because I have a good job and a good relationship with my partner.*
What crime is the defendant charged with? *I'm depressed for no reason.*
Is there overwhelming evidence against the defendant? *There is strong evidence that I am depressed. I have had problems with depression in the past.*
Are there other explanations for the defendant's behavior? *It seems that depression runs in my family. My mother was depressed and often was very critical of me.*
Did the defendant act maliciously? *No, it just seems to happen to me.*
Was the defendant acting in a way that a reasonable person might act? *I don't know how to answer that. I guess if you're depressed, you act like someone who is depressed.*
Is someone else guilty—or share part of the responsibility? *I guess I would say that my genetics and my experience growing up with a depressed, critical mother and distant father have caused this.*
Given what the prosecutor is able to actually prove, does it follow that the defendant is guilty of something terrible? *No, it's more reasonable to say that I am an innocent victim.*
Would we apply these rules to everyone? *I don't think we should blame people for being depressed.*
Would the jury convict? *No.*
How would you defend yourself? *I didn't choose to be depressed. I'm unlucky.*
Are there other explanations for your behavior? *Simply being depressed. Genetics, problematic child rearing. Things not working out at times, overreacting because I'm depressed.*
Did you act with malice or cruelty? *No.*
How would a responsible person act? *A responsible person would seek out treatment, which is what I'm trying to do.*
What is the quality of the case for and against you? *The quality of the evidence against me is not good. We don't blame people for depression, we help them. The evidence on my behalf is good.*
How would a jury evaluate this evidence? *The jurors would have sympathy for me. They would reject the evidence.*
Would a jury punish you as severely as you punish yourself? *Never.*

FIGURE 3.6. Playing the role of your own defense attorney.

TECHNIQUE: Is the Rational Response Relevant to the Automatic Thought?

Description

Many times the patient may list "rational responses" to challenge a negative thought, but the rational thought is simply a positive affirmation (e.g., "I'm a good person") rather than an argument or evidence that contradicts or challenges the negative thought. As a result of this "irrelevance" of the rational response, the patient concludes that the techniques do not work since he or she still strongly believes the negative thought. A typical example of this is when the patient uses a double- or triple-column form, listing the automatic thoughts and rational responses, with the list in the left-hand column recording a stream of negative thoughts and in the right-hand column, the "rational column," a string of positive thoughts. The key point is to focus on the most significant automatic thought and then use the cognitive therapy techniques to test, examine, and challenge that thought. Simply listing positive affirmations will not "put the lie" to the thought. Finding the logical holes in the thought, the lack of evidence, the internal contradictions, and the unfairness of the thought will be far more effective than simply listing positive attributes or accomplishments about the self. The patient's rational response should be relevant to challenging, defeating, and depotentiating the force of the negative thoughts.

Questions to Pose/Intervention

"Many times when people challenge or examine their negative thoughts, they simply list positive statements. Sometimes those positive statements will help you feel better, but they really may not be relevant to the exact thoughts that are upsetting you. For example, the thought 'I'm a failure' may lead you to write out 'challenges' such as 'My wife likes me,' but the fact that your wife likes you may not be a relevant challenge to the thought that you are a failure. Or, your thought 'I'll fail in school' may lead you to counter with 'I'm trying hard to do a good job,' which is helpful but does not really challenge the thought that you will fail in school. So we want to see if your rational responses are really relevant to the automatic thoughts that are bothering you."

Example

THERAPIST: An important part of challenging your negative thoughts is to focus on one thought at a time and then direct your argument or evidence to that one thought. In other words, we want to know which thought you are examining at any given time and what your arguments are against that thought. For example, let's take your thought "I'm a failure." Now that's a very negative, very general thought, and it must be difficult to have that thought and believe it. I see on your homework record that you listed a number of negative thoughts in the left-hand column and then some positive thoughts in the right-hand column. But it's not clear which positive thought is really directed at which negative thought. For example, the thought "I'm a failure" is in the left-hand column and then in the right-hand column you have "I go to work" and "I'm trying to do the best I can." But I wonder if those positive thoughts are really doing the job on the negative thought.

PATIENT: Well, I'm trying to think positively. Isn't that what this therapy is about?

THERAPIST: I can see that it's easy to get that impression, but cognitive therapy is not about positive thinking; it's about realistic and rational and helpful thinking. So looking at the thought "I'm a failure" makes me think we need to come up with some relevant arguments to dispute that thought. What would be relevant evidence that might challenge the idea that you are a failure?

PATIENT: OK, I see where you are going with this. Yes, making my positive thoughts relevant. I never thought of it that way.

THERAPIST: That's not unusual, you know, because the automatic thoughts are so emotional that they don't always lead to thinking logically and factually. But cognitive therapy is about reality. So, what is some evidence you can think of that you are not a failure?

PATIENT: Well, I have a job, I have friends, I graduated from college, and I have paid off a lot of my student loans.

THERAPIST: Now we are really moving forward, I think, with relevant evidence against that thought. Anything else you can think of that is relevant to the idea that you're a failure?

PATIENT: Well, I guess I think the term "failure," as you pointed out, is so vague and general, and it seems unfair to call an entire person a failure.

THERAPIST: So, one relevant argument is that it isn't logical or fair or accurate to label an entire person based on a couple of negative behaviors.

PATIENT: Yeah. That makes more sense.

THERAPIST: And, so, thinking about the logic and evidence that is relevant, can this help you feel more confident in challenging that negative thought that you're a failure?

PATIENT: Yes, it seems more focused to me now.

Homework

The therapist can ask the patient to write down some typical automatic thoughts over the next week, write out the rational responses to those thoughts, and then describe how each rational response is relevant to disproving or refuting the automatic thought (use Form 3.8). Quite often a patient will write down a "negative thought" (e.g., "I'm a failure") and then write down a "positive thought" (e.g., "I have some friends") without identifying how the rational or positive thought is relevant to the negative or automatic thought. Irrelevant rational responses will not effectively diminish the credibility of an automatic thought.

Possible Problems

In some cases, the patient may claim that the rational or helpful responses make him or her feel better, so there is no need to examine the relevance or logic. "Why bother, if I feel better?" This may sound plausible—even useful—but the therapist can suggest that proving that the negative thought is not based on facts, or is illogical or unfair, will be more powerful in the long run. The therapist can indicate that it is not enough to feel better right now; it is more important to take the wind out of the sails of the negative thought for the longer term. The most effective way to do that is to prove it is unreasonable and untrue. "Imagine a child who believed in ghosts, so I distracted her with ice cream, and she said, 'I feel better right now. I'm not scared. You're with me and I have my ice cream.' Would this be enough for her to give up her fear of ghosts? Or would it be more effective in the long run for her to understand that ghosts are simply part of the imagination and have no basis in reality?"

Cross-Reference to Other Techniques

Techniques related to this one include identifying the costs and benefits of a thought, examining the evidence, examining the quality of the evidence, role playing against the thought, and using the defense attorney technique.

Form

Form 3.8 (Are My Challenges Relevant to My Negative Thoughts?).

TECHNIQUE: Role Playing Both Sides of the Thought

Description

In order to modify the negative thought, the patient and therapist can alternate between both sides of the thought. For example, the therapist initially can take the positive or rational position while the patient takes the negative position. After they have role played these positions, they can switch sides, with the therapist supporting the negative thought and the patient, the positive thought. One advantage of these role reversals is that the patient can observe some highly useful challenges, as presented by the therapist, and the therapist can determine which rational responses work for the patient and which automatic thoughts are difficult for the patient. These role reversals can continue for several rounds with patient and therapist reversing their roles.

Questions to Pose/Intervention

"Let's take your negative thought and do a role play. I'll play you in the role of the positive thought—that is, I'll respond in a positive and rational manner. You play the role of the negative thought—you try to convince me that your negative thoughts are really true." While doing the role play, the therapist can ask which rational responses worked well, which did not, and which negative thoughts were the most difficult to handle. In addition, the therapist can inquire if there are additional negative thoughts that were not mentioned.

Example

THERAPIST: Let's do a role play. You can play the role of the negative thoughts of you as a failure, and I'll play you being rational and positive.

PATIENT: [as negative] You and Jane broke up, so you're a failure.

THERAPIST: [as positive] Well, that's all-or-nothing thinking. Are you saying every single thing about me is a failure?

PATIENT: [as negative] No, but you failed.

THERAPIST: [as positive] You mean, one of my behaviors didn't work out?

PATIENT: [as negative] No, I'm saying *you* are a failure as a person.

THERAPIST: [as positive] I'm not sure what it means to be a failure as a person. How could we observe me, in action, as "a failure as a person"?

PATIENT: [as negative] We'd look at how you messed up in the relationship.

THERAPIST: [as positive] You mean, you would look at some of my behaviors?

PATIENT: [as negative] Yeah, OK.

THERAPIST: [as positive] Which specific behavior would you cite?

PATIENT: [as negative] Well, you were critical of her.

THERAPIST: [as positive] OK, so you think that behavior didn't work? Were some of my behaviors positive or neutral?

PATIENT: [as negative] You did do some things that were positive. You were generous to her. You bought her gifts, you made dinner for her.

THERAPIST: [as positive] So some of my behaviors were positive, and some were negative? How could I be a failure as a person if I did some positive things, too?

PATIENT: [as negative] I guess there are negatives *and* positives about you.

THERAPIST: [as positive] You mean, just like every other human being?

PATIENT: [as negative] I guess so.

After the patient and therapist conduct this role play, the therapist can ask the patient which rational response didn't work well with which automatic thought. In the above example, the patient indicated that he'd had a hard time accepting that he had been critical of his girlfriend. He believed he should never be critical, never make mistakes. This exchange led to an examination of his perfectionism and self-criticism, and then to an alternative assumption, "I can learn from my mistakes and try to correct them."

Homework

Using Form 3.9, the therapist can ask the patient to write out positive or rational arguments in answer to his or her negative thoughts and then write out a series of negative responses to these rational arguments. In addition, the patient is asked to indicate which automatic thoughts are still hard to handle and which rational responses do not work well. In the next session these can be examined for their underlying assumptions, such as "I should always be perfect" or "I should never make a mistake."

Possible Problems

Some patients agree with the negative thought and have a hard time arguing against something they believe. The instruction should be to present the kinds of arguments a therapist or friend might make—for example: "You don't have to believe anything right now; we are just trying to get an idea of different ways of thinking." Similarly, patients may say that they have different negative thoughts from those presented by the therapist. The therapist can respond: "You may not have these thoughts right now, but I'd like to see how you would handle them if you did have them." Another problem with role playing is that some patients may think that the therapist is ridiculing or making fun of them. The therapist can answer: "I'm not trying to make fun of you. If anything, I want to help you find some new ways of thinking and feeling. Sometimes the role playing can be annoying; just let me know when you feel that way and we can stop and consider other things to do."

Cross-Reference to Other Techniques

Other relevant techniques include categorizing the cognitive distortions, examining the costs and benefits, examining the evidence, the semantic technique, the double-standard technique, and the point–counterpoint technique.

Form

Form 3.9 (Role Playing Both Sides of the Thought).

TECHNIQUE: Distinguishing Behaviors from Persons

Description

One of the common errors in thinking is to equate a single behavior with the entire person. Thus, if I fail at one behavior, then I'm a complete failure. This technique helps patients isolate mistakes or errors and separate these from a global judgment of themselves. In addition, it facilitates patients' abilities to modify particular categories of cognitive distortions: in particular, labeling, personalizing, all-or-nothing thinking, and overgeneralization. By distinguishing behaviors from persons, the patient can identify *behaviors* that can be changed. It is difficult to imagine changing "persons."

Questions to Pose/Intervention

"It's important to distinguish between a behavior and an entire person. Sometimes we might say 'I'm a failure,' but the truth is closer 'I didn't do well on that test' or 'I got fired.' Let's look at some of your self-critical thoughts and examine if what you really should be talking about is some of your behaviors rather than labeling yourself in such global terms. If you view a particular behavior as a problem, perhaps you can imagine ways of changing that behavior to make things better."

Example

THERAPIST: You said that after the exam, you thought you were a failure. I wonder if we can tell the difference between failing some questions on an exam and being a failure as a person.

PATIENT: But I feel like I'm a failure.

THERAPIST: Well, that's emotional reasoning, isn't it? You're saying that your emotions are evidence of your failure as a person?

PATIENT: I know it's not rational.

THERAPIST: OK, but let's look at this idea that "I'm a failure." Are there some things that you have done well in your life?

PATIENT: I've taken a lot of courses and passed every one of them. I have friends. I have a boyfriend.

THERAPIST: OK, so those are some successful behaviors. Even on this exam of 40 questions, do you think you got some of them right?

PATIENT: Probably most of them. But I really blew it on about five of them.

THERAPIST: Would it be fairer to say that you did well on most of them but didn't do well on a few of them?

PATIENT: Yes, that's more accurate.

THERAPIST: So is this appraisal of not doing well on a *few* of the test questions consistent with thinking that you're a failure as a person, or that you have made some mistakes?

PATIENT: That I've made some mistakes.

Homework

The homework is focused on distinguishing between global labels and specific behaviors. Patients are encouraged to use Form 3.10, on which they list negative personal labels—for example, "loser," "failure," "worthless"—rate the degree of their belief in the labels, and then list the negative

behaviors that are evidence of the negative trait and the positive behaviors that suggest that they are not always this negative. Also, patients are asked to list the negative and positive behaviors they can predict occurring in the future—thereby helping them challenge the global labeling—and to articulate their conclusions and re-rate their belief in the negative label after looking at the evidence. Is there a more balanced way of looking at themselves and the situation?

Possible Problems

Some individuals are prone to affixing moral judgments on many of their own or others' behaviors. They may think that these judgments are conscientious, ethical, or moral. I have referred to this pattern as "moral resistance" and outlined a number of questions to pose by way of challenging this kind of thinking (Leahy, 2001b). For example, if the patient says "Well, if I did this bad thing, then it means I'm bad," we can ask him or her if this rule is applicable to everyone—that is, anyone who ever does anything bad is a bad person. We can ask if this rule promotes human dignity—a question posed by the philosopher Immanuel Kant. Another typical problem patients demonstrate is making categorical errors in claiming, for example, that "bad people do bad things." Indeed, we can argue that all people do bad things, good people do good things, and bad people do good things. Finally, we also can suggest that terms such as "good person" or "worthless" are not particularly meaningful. We might want to replace these global, value-laden labels with more empirically grounded thinking patterns, such as, "What can I predict about this person's behavior?" For example, the employee who labels her boss a "bastard" may assume that everything he does will be negative. However, by replacing the global label with pragmatic, empirically grounded predictions, she will see that her "bastard" boss actually does a lot of positive things—an important realization. The patient can then be asked how she can take advantage of the positives and avoid the negatives.

Cross-Reference to Other Techniques

Other relevant techniques include categorizing negative thoughts, downward arrow technique, examining costs and benefits, and examining the evidence.

Form

Form 3.10 (Evaluating Negative Labels).

TECHNIQUE: Examining Variations in Behavior in Different Situations

Description

A frequent error in thinking is to focus on a single instance of a behavior and then generalize it to the entire person. Many of our common language descriptors imply dispositions, traits, or temperaments. For example, we say, "He was hostile," rather than stipulating: "I have observed him in 50 different situations, and in this one situation he was 20% hostile, as indicated by his use of critical language." Moreover, when we say, "He was hostile," we are attributing the quality of the behavior to the person rather than to factors in the situation. By refocusing on situational factors—such as what led up to his behavior (or what provoked it), what happened after, or the history of his relationship with the other person—we are able to understand his behavior in context. Diffusing our focus

beyond the single given moment in time allows us to see variability in the frequency and intensity of the behavior as well as in the situations in which it occurs. This wide-angle focus decreases the likelihood of labeling the person in one-dimensional terms and increases the ability to understand factors—such as provocation or potential consequences—that might support or mitigate the behavior under question.

Questions to Pose/Intervention

"When we label someone, we are often thinking in all-or-nothing terms. If you label yourself as a 'failure' or 'stupid' (or any negative tag), you are probably ignoring a lot of evidence. Consider the negative label you are using against yourself (or someone else). Now let's think about how much your behavior changes in different situations. Look for various degrees of your behavior. For example, if you label yourself as 'lazy,' try to rate your behavior at different times in terms of *how* lazy you are, from 0% to 100%. Are there some situations in which you are less lazy? Are there some situations in which you are energetic? What accounts for this variability in your behavior? How is this variation inconsistent with thinking of yourself only in terms of the label *lazy*?"

Example

THERAPIST: You said the reason that you don't exercise is that you are "lazy." How lazy do you think you are, from 0% to 100%, where 100% represents total immobility?

PATIENT: I guess when it comes to exercise, I'd give myself a 95%.

THERAPIST: Are there times when you have exercised?

PATIENT: Yeah, I went to the health club last week, but I hadn't gone for 2 weeks.

THERAPIST: So how lazy were you when you went to the health club?

PATIENT: I guess 0%.

THERAPIST: OK. You work full-time as an executive. What time do you start work, and what time do you finish?

PATIENT: I'm at work at 8 A.M., I finish at about 6 P.M. and then I drive home, which takes about an hour—and, of course, it took an hour's drive in the morning, too.

THERAPIST: So how lazy are you when you are fulfilling this schedule?

PATIENT: Not at all lazy. I'm working all the time.

THERAPIST: And you help out with the kids. You took your son to baseball practice. How lazy were you when you did that?

PATIENT: Not at all.

THERAPIST: So, if you're not lazy in a lot of those areas, then what does it mean to say that the reason you didn't exercise is because you're lazy?

PATIENT: Maybe I was just tired.

THERAPIST: How is that different from saying that you're lazy?

PATIENT: It's not as self-critical.

Homework

Using Form 3.11, patients are asked to list one negative label each day that they apply to themselves or to someone else. Then they should examine how this behavior or quality varies at different times and in different situations. They are asked to examine why their behavior varies in different situations and what this variation says about labeling themselves in these all-or-nothing terms. Is it more accurate to say that people are flexible and variable? If their behavior can change depending on the situation, what does this say about using global labels?

Possible Problems

Some individuals cling to their negative labels because they believe criticizing themselves is both realistic and motivating. They often believe they need to tell themselves how stupid or inferior they are so that they will not become complacent. The therapist can ask such patients to examine the costs and benefits of the labeling and criticism and to consider the value of increasing self-reward for positive behaviors. Some patients believe that this exercise will "let them off the hook," whereas they would not let themselves go that easily. It is useful for the therapist to point out that patients' variations in behavior may tell them something about what factors encourage positive behavior so that *this* behavior can be increased in frequency. A behavioral experiment could be constructed to help patients examine the advantages and disadvantages of self-reward, over a 2-week period, to see if the negative qualities increase. This exercise is especially useful with couples that believe that holding onto negative labels about their partner motivates the partner to comply.

Cross-Reference to Other Techniques

Relevant additional techniques include categorizing cognitive distortions, the continuum technique, the double-standard technique, vertical descent, cost–benefit analysis, and examining the evidence.

Form

Form 3.11 (Looking for Variations).

TECHNIQUE: Using Behavior to Address the Negative Thought

Description

Many times the automatic thought is true and the patient is not distorting reality. Thus challenges to the thought may be insufficient in helping the patient feel more hopeful. However, a nondistorted automatic thought actually can make things more hopeful and the patient less helpless, because the focus then shifts to one of problem solving or problem acceptance. This shift allows the patient to use action to initiate change by acquiring the needed skills, be they social, communicative, work-related, or whatever. If there is a negative behavior, then the patient can focus on changing that behavior.

Questions to Pose/Intervention

"Ask yourself, 'If [the negative thought] is true, then what can I do to make things better? What are some ways that I can improve my skills, solve the problem, or change the situation?' "

Example

THERAPIST: You sounded pretty discouraged about your job interview.

PATIENT: Yeah. I keep telling you that no one wants to hire me. I just blow the interviews.

THERAPIST: OK, well let's try to role play a scenario. I'll play the role of the person interviewing you, and you can play yourself at the interview. (*Patient and therapist interact, and the patient demonstrates that he acts in a grandiose fashion and blames previous employers.*)

PATIENT: So, how did I do?

THERAPIST: You're right. It turns out your thought that you blow the interviews is correct. You were really not that good at the interview.

PATIENT: Oh, great. Now I'm *really* hopeless.

THERAPIST: No. Not really. Actually, this is very good information. Now we have to shift to training you in interview skills. Let's start with examining what this person is looking for in hiring someone.

PATIENT: So, you're saying my negative thoughts are true?

THERAPIST: In this case, it's great to find out that we can narrow things down to this problem. You can learn better interviewing skills. Let's imagine you were playing tennis and your coach noticed that the reason you kept hitting the ball into the net was that you held the racket the wrong way. Now the coach shows you how to hold it the correct way. So your thought, "I hit the ball into the net," is true, but now you can change your behavior and become a better tennis player.

The patient and therapist worked on improving his interviewing skills, making a list of *do's* and *don'ts* on interviews, and tape-recording the role plays done in therapy. The patient subsequently received a job offer.

Homework

The therapist can explain: "Sometimes our negative thoughts are true. Sometimes someone doesn't like us or something doesn't work out. However, that reality then leads to another set of more positive questions: 'What can I do to solve the problem?' or 'What alternatives are available to me?' If your negative thought is true, then you can ask, 'How can I change my behavior to improve?'

"Use Form 3.12 to make a list of several things that are bothering you, and then make a list of a number of things that you could do to make matters better for yourself."

Possible Problems

Some patients believe that if their automatic thoughts are true, then things are really hopeless. Consequently, it is essential to point out that cognitive therapy is a form of reality testing or reality therapy in that we examine or evaluate negative thoughts. Thus we remain open to negative thoughts being true. Some patients believe that if the therapist recognizes a negative thought is true, then the therapist is criticizing them. On the contrary, the therapist can explain that recognizing the truth of a negative thought empowers patients to find ways of making needed changes. However, patients may be so self-critical that they believe they cannot make these changes. These negative self-statements can be tested out with behavioral assignments: "Let's make a list of simple positive

behaviors, and you tell me which of these you think you can do and which you cannot do. Let's look at the costs and benefits of doing each one of these."

Cross-Reference to Other Techniques

Other relevant techniques include graded task assignment, assertiveness training, problem solving, vertical descent, cost–benefit analysis, and examining the evidence.

Form

Form 3.12 (Changing Negative Thoughts by Changing Behavior)

FORM 3.1

Defining the Terms

Sometimes we use terms that are quite vague. Perhaps other people would not know what we are referring to, or perhaps they would use the terms in a different way. In the form below, identify the negative thought that is bothering you at the top of the table. In the left-hand column, list each term you are using. In the middle column, write down how you would define each term. In the right-hand column, identify the kinds of problems with these terms and how you define them.

Negative thought: _____

Terms	Definitions	Problems with my definitions

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FORM 3.2

Making Definitions Clear

A good definition of a quality would be one that almost everyone would agree on and would be able to easily determine is true. For example, most people could agree on whether it is raining outside, but not everyone would know what it means when we say, "This is terrible" or "He's an idiot." Are the terms or language you are using clear and precise? If they are not clear, then are you making yourself upset about things that are vague, hard to determine, or even meaningless? In the form below, in the left-hand column, write down a term or expression you use to describe something you're upset about. In the middle column, write down how you currently define this term. In the right-hand column, note how you suppose others would interpret this expression, and whether you expect it would be easy for them to understand.

Term I use when I am upset	How I define this term	Would other people know what I am talking about? Is it vague, idiosyncratic, or hard to determine? Why?

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FORM 3.3

Cost–Benefit Analysis of a Thought

Sometimes we have thoughts that make us feel worse, but we may also believe that these negative thoughts are helpful. We may believe a thought will motivate us, or that we are simply being realistic. Write down a negative thought that bothers you and then write out the costs (left-hand column) and the benefits (right-hand column) of holding this thought.

Examining Advantages and Disadvantages

Negative thought: _____

Advantages	**Disadvantages**

After listing the costs and benefits of your belief, circle the most significant ones. Why are these costs or benefits important? Could you challenge your view that these costs and benefits are important? What is an alternative belief—one that is more adaptive? How would you do a cost–benefit analysis on that belief?

Belief: _____

Costs	**Benefits**
Result: Costs =	**Benefits** =
	Costs – Benefits =

Conclusions:

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FORM 3.4

Examining the Validity of Costs and Benefits, Short-Term and Long-Term

Often we have thoughts and predictions that seem very real—almost certain—for us, but our thoughts and predictions may prove to be extreme and inaccurate as we examine the evidence. It is important to think about what the short-term and long-term tradeoffs are for us. For example, you might think over the next few hours that there is little benefit in exercising, but if you thought about the long-term—and the possibility of exercising regularly—there might be long-term benefits. Look at some of your thoughts, decisions, and predictions and examine the short-term and long-term tradeoffs.

Thought	Short-term costs and benefits	Long-term costs and benefits
	Costs: Benefits:	Costs: Benefits:
	Costs: Benefits:	Costs: Benefits:
	Costs: Benefits:	Costs: Benefits:
	Costs: Benefits:	Costs: Benefits:

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FORM 3.5

Examining the Evidence

We often have negative thoughts for which we may have only limited evidence. In the form below you can examine the evidence for and against your negative thoughts. Answer the questions at the end to evaluate if the evidence really strongly supports your thought.

Negative thought: _____

Evidence for . . .	**Evidence against . . .**
Most important evidence in favor of thought:	*Most important evidence against the thought:*
% evidence in favor of thought:	*% evidence against thought:*
Evidence in favor – evidence against =	
Conclusion:	

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FORM 3.6

Examining the Quality of the Evidence

Identify an automatic thought you wish to evaluate. Then list evidence that supports that thought. Last, evaluate each piece of evidence for signs of cognitive distortions, such as emotional reasoning, personalizing an event, overgeneralizing, using perfectionistic standards, discounting your positives, filtering out information, mind reading, jumping to conclusions about the future, referring to irrelevant material, or drawing illogical conclusions. Finally, grade the evidence, giving the strongest evidence an "A" grade and the weakest an "F." Finally, write down any conclusions you come to, based on this analysis.

Evidence	**Possible problems with its quality or relevance**	**Grade the evidence**
Conclusions:		

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FORM 3.7

Playing the Role of Your Own Defense Attorney

Many times we criticize ourselves but don't take the time to defend ourselves against our negative thoughts. In this exercise you play the role of a lawyer defending yourself against the negative "charges" or criticisms being made against you. Answer each of the questions in this form and examine whether you are being too harsh on yourself.

What "law" was broken? With what offense are you charging yourself? Is there overwhelming evidence?
What crime is the defendant charged with?
Is there overwhelming evidence against the defendant?
Are there other explanations for the defendant's behavior?
Did the defendant act maliciously?
Was the defendant acting in a way that a reasonable person might act?
Is someone else guilty—or does someone else share part of the responsibility?
Given what the prosecutor is able to actually prove, does it follow that the defendant is guilty of something terrible?

(continued)

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Playing the Role of Your Own Defense Attorney *(page 2 of 2)*

Would we apply these rules to everyone?
Would the jury convict?
How would you defend yourself?
Are there other explanations for your behavior?
Did you act with malice or cruelty?
How would a responsible person act?
What is the quality of the case for and against you?
How would a jury evaluate this evidence?
Would a jury punish you as severely as you punish yourself?

FORM 3.8

Are My Challenges Relevant to My Negative Thoughts?

Many times we can identify a negative thought that is bothering us, and then we might come up with a positive thought that could make us feel better temporarily. However, what we will find more helpful is coming up with alternative thoughts that disprove our negative thought or put things in a more realistic perspective. Write down your negative thoughts in the left-hand column, your helpful thoughts in the middle column, and then describe how your helpful thoughts are relevant to your negative thoughts in the right-hand column. You want to make arguments or look at evidence that is relevant to showing that your negative thoughts are unrealistic, illogical, or not based on facts.

Automatic thought	**Alternative helpful thought**	**How is this relevant or not relevant to the automatic thought?**

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FORM 3.9

Role Playing Both Sides of the Thought

Use *both parts* of this form. With the first part, you start as the negative thought and argue back with positives. With the second part, you start as the positive thought and argue back with the negatives. Review your answers and then circle those you think are not that helpful to you and the negative thoughts that are still strong.

Negative	**Positive**

(continued)

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Role Playing Both Sides of the Thought *(page 2 of 2)*

Positive	**Negative**

Which responses are useful?
Why?
Which responses are not useful?
Why?

FORM 3.10

Evaluating Negative Labels

We often use very general terms about ourselves or others. For example, if we are negative, we might label ourselves as a failure, loser, unattractive, or boring. These negative labels make us feel discouraged and lead us to ignore how we may be capable of lots of different behaviors. In the top left portion of the form write down a negative label of yourself (or someone else) and rate the degree to which you believe this label to be true. Then write out the negative behaviors that are evidence of this negative trait and the positive behaviors that suggest that you or the person is not always this negative. In addition, list the negative and positive behaviors that you can predict in the future. What conclusions would you draw from this information? Do you still believe that this negative label is as true as you first thought?

Negative label: _____

Belief (%): _____

Relevant negative behaviors	Relevant positive behaviors
What are some negative behaviors I can predict in the future?	What are some positive behaviors I can predict in the future?
Conclusion:	

Rerate the negative label (%): _____

(continued)

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Evaluating Negative Labels *(page 2 of 2)*

What could be some reasons why my behavior or that of someone else might be different at different times?

Negative	**Positive**

Role playing both sides of the thought

Positive	**Negative**

Which responses are useful?
Why?
Which responses are not useful?
Why?

FORM 3.11

Looking for Variations

Sometimes we label ourselves or other people with all-or-nothing terms, such as lazy, boring, cruel, etc. It's as if we are thinking that this is the way the person always is. Write down the negative label you are applying to yourself or another person. Now think about what label you would use to describe the most negative end of that scale—for example, "cruel"—and then think about the most positive end of the scale—for example, "kind." Write these ends of the scale in the top right-hand corner of the table. Now write down variations in that kind of behavior in the left-hand column. In the right-hand column, describe the situations in which these different behaviors occur. For example, let's say that you label yourself as "lazy." The other end of the scale is "motivated" or "energetic." Write out examples of various degrees of "lazy" and "motivated or energetic" in your behavior. Describe the situations. What conclusions would you draw?

<table>
<tr><td rowspan="2">Negative label:</td><td>Negative end of scale:</td></tr>
<tr><td>Positive end of scale:</td></tr>
<tr><td>Examples of positive behavior:</td><td>Describe the situation:</td></tr>
<tr><td>Examples of negative behavior:</td><td>Describe the situation:</td></tr>
<tr><td colspan="2">What are some reasons why your behavior changes with these situations?</td></tr>
<tr><td rowspan="2">Conclusion:</td><td>What situations are the most positive?</td></tr>
<tr><td>Most negative?</td></tr>
</table>

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FORM 3.12

Changing Negative Thoughts by Changing Behavior

Many times our negative thoughts are true—or, at least, have some degree of truth. When this occurs, it's a great opportunity to think of how you can change your behavior to make things better, or figure out some alternatives that might be better for you. For example, the man who thinks he's not good at job interviews might find out that this negative thought is true. The changes in behavior he could try could include learning better job interview skills. The woman who laments "I'm all alone" may be correct a lot of the time. She can learn how to be more assertive, join activities, and also do more rewarding things when she is alone. In this form, list some of your negative thoughts in the left-hand column, and then list some behaviors or activities that you could carry out to help make things better for yourself.

Negative thought	Possible changes in behavior or ways to solve the problem

Conclusion:

To do list:

Behaviors	When will I do them?

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CHAPTER 4

Evaluating Assumptions and Rules

Sometimes negative automatic thoughts are true. For example, the patient may be engaged in mind reading and think, "Susan doesn't like me," and it may actually be true that Susan doesn't like him or her. Or the patient may engage in fortune telling and predict, "I'll fail the exam," and in fact—he or she does fail the exam. It is important to realize that cognitive therapy is not equivalent to the "power of positive thinking" or simply "optimistic thinking." Rather, it is the power of *realistic thinking,* which includes the recognition that negative things do happen, people make mistakes, problems can be put in perspective, and sometimes solutions can be found.

Even if automatic thoughts are true, at times a useful question can then be raised: "Why would that be such a problem?" Using the vertical descent exercise, I examined the implications of rejection for a patient by asking, "Why would it bother you if someone did not like you?" and the patient answered, "Because it means that I'm worthless." Thus, the single negative thought may be linked to a more general, pervasive, and rigid rule: "If you fail at something, then you are worthless."

Recurrent problems of depression, anxiety, and marital conflict often are the result of rigid rules, assumptions, "shoulds," imperatives, and "if–then" beliefs. Research on vulnerability to depressive relapse indicates that underlying assumptions about the importance of perfectionism and the need for approval are activated in negative mood states and by negative life events (Dozois & Beck, 2008; Miranda & Persons, 1988; Miranda, Persons, & Byers, 1990; Segal & Ingram, 1994) and that negative attributional style and dysfunctional attitudes on the Dysfunctional Attitude Scale (DAS) contribute to vulnerability to depression (Haeffel et al., 2005).

These underlying assumptions may not seem problematic when things are going well—for example, the man who believes he is lovable when he has a partner may feel fine when he is in a relationship. However, the threat or actual termination of a relationship may precipitate a major depressive episode, because the underlying assumption (e.g., "I can't be happy if I'm alone") and the negative personal schema ("I'm unlovable") are activated.

During relatively stable periods, these underlying assumptions may not be apparent. The therapist can examine past episodes of depression or conflict (e.g., "Tell me about a time when you felt really bad—what led up to it?"). This may reveal that an unpleasant event (e.g., receiving criticism, ending of a relationship, or failing at a task) elicited negative automatic thoughts (e.g., "I'm always failing") that then led to a more general maladaptive assumption (e.g., "If you fail at something, then you're a failure").

Alternatively, the therapist can ask patients to imagine what could possibly happen that would upset them (e.g., the patient answers, "If I did poorly on an exam"). What negative thoughts and assumptions would be activated? These might include, using the examples above: "When we broke up, it made me think that I can never be happy because I'll be alone"; or "If I did poorly on the exam, it would mean that I didn't do my best, which would mean that I'm a failure." In this chapter, we examine how the therapist can assist patients in identifying and testing the underlying assumptions and rules that may persist even when they are feeling well.

TECHNIQUE: Identifying the Underlying Assumption or Rule

Description

The vertical descent procedure usually leads to the underlying assumptions. These underlying assumptions are the "if–then" statements, rules, "shoulds," "musts," or "have-to's" that are rigid, imperative, and associated with vulnerability to depression, anger, and anxiety. For example, the vertical descent can lead to the following assumptions and rules (or standards):

"If I'm alone, I must be unhappy [or undesirable]."
Or "If I'm alone, then I'll always be alone."
Or "People who are single are losers."
Or "I must have a partner to be happy."
Or "I can't make myself happy—happiness is only derived from other people."
"If I don't do well at something, then I must be a failure."
Or "I should always do well at everything."
Or "I should do better than everyone."
Or "It's awful to fail at something."
Or "If I make a mistake, then I should criticize myself."

Depression, anxiety, and anger are associated with a variety of assumptions and rules; the same individual may have several such beliefs activated by a single event. Consider the individual whose supervisor dislikes her, even though she has been an effective employee for years. It is clear from the therapist's perspective that this situation is the result of a personality clash. The patient is terminated from employment but is able to obtain productive work elsewhere. However, this single event leads to the activation of several assumptions:

"If I got fired, it means I failed."
↓
"If I failed at this job, then I'm a failure as a person."

Or

"If I got fired from a job once, then no one will want to hire me [preceding her first interview following her termination]."
↓
"If my boss didn't like me, then I must be alienating everyone."
"If people don't like me, then I must be worthless."
"If I'm worthless, then I can't be happy."
"If I'm worthless, then life is not worth living."

In reality, the event of being terminated may often lead to generous severance packages, the opportunity to get away from a stressful work environment, and the chance to pursue new work or training elsewhere. Of course, it may also lead to loss of income, the increased stress of uncertainty in finding a new job, and loss of rewards in the workplace. However, the individual's assumptions, as indicated above, place her at greater risk for depression because they are absolute, rigid, and self-condemning. There is little that is proactive or practical in these assumptions.

Questions to Pose/Intervention

"Let's take some of the assumptions and rules that you have just identified. A lot of times we have rules for ourselves or for other people. These rules are often along the lines of 'I should succeed' or 'I must get the approval of other people.' Sometimes we make assumptions that 'If [such and such] happens, then [such and such] else is true.' For example, we might make the assumption 'If I don't succeed, then I am not that worthwhile' or 'If someone doesn't like me, then I must be unlovable.'"

The therapist may wish to use the short form of the DAS to assess these underlying assumptions (Beevers, Wells, & Miller, 2007). The more comprehensive DAS developed by Weissman and Beck (1978), which yields scores on a number of dimensions of interest, can also be administered. The therapist and patient then can examine any extreme responses on the DAS to determine vulnerability to future depression, anxiety, or anger.

Example

THERAPIST: You said you're upset because you lost your job. I wonder what your thoughts were. Please try to complete the following sentence: "Losing my job bothers me because. . . ."

PATIENT: I'll look like a failure.

THERAPIST: And, if I look like a failure, then that would mean . . .

PATIENT: Then I *am* a failure.

With another patient who experienced a breakup with his partner, the therapist inquired as to the meaning of this event for him.

THERAPIST: I know that you're upset because you and Ellen broke up. But let's look at what you're thinking that may add to this distress. Complete this sentence: "When I think about the fact that Ellen and I broke up, it bothers me because it means. . . ."

PATIENT: I'll never find anyone.

THERAPIST: And if I don't have someone, it would mean. . . .

PATIENT: I'll be miserable.

THERAPIST: It sounds like you think that you have to be in a committed relationship to be happy.

PATIENT: That's what I think, I guess.

Homework

Specific "shoulds" or "rules" that the patient holds can also be identified and monitored using Form 4.1. The therapist might say, "See if you can identify and keep track of the rules and assumptions

underneath those thoughts over the next week." The therapist can indicate that "rules" often have an "if–then" quality or "should" quality, such as, "If I get rejected by someone, then I must be a loser" or "I should succeed at everything I try." Figure 4.1 provides an example of how one patient used Form 4.1.

Possible Problems

I've noticed that some therapists will treat a negative automatic thought as a sufficient reason to be depressed or anxious. For example, they may tacitly agree with the patient that "it's terrible to get rejected," often attempting to convince the patient that he or she will not get rejected. The therapeutic value of focusing on the more general maladaptive assumption is that in real-life, people do indeed fail, get rejected, and are treated unfairly. Thus, it is much more valuable to go beyond the automatic thoughts to get at the underlying beliefs that add more pervasive negativity. One can get rejected, fail, or get fired without developing a major depression.

Some patients believe that their rules, expectations, assumptions, and judgments are simply facts—that is, they believe, for example, "If you don't make a lot of money, then you're a failure," or "If you're not attractive, then you're ugly." Such patients treat their personal expectations, rules, and values as if they were scientific or objective data. When these rules or expectations are culturally shared—such as the widely held expectations that one should get married or one should be successful—the attachment to them as so-called facts is especially strong. At this stage of identifying the rules and assumptions, the therapist can make clear that the point is not to dispute them but simply to *record* them.

Cross-Reference to Other Techniques

Other techniques of relevance include identifying automatic thoughts, vertical descent, imagery techniques, rational role playing, and examining the costs and benefits.

Form

Form 4.1 (Monitoring Your Assumptions, Rules, and Standards).

Examples of my typical assumptions, rules, and standards:	**Endorsement of belief (0–100%)**
If I don't do a perfect job, then I have failed.	90%
I must always do the best that I can do.	90%
People will think less of me unless I am outstanding in my work.	85%
I should criticize myself for my failures.	80%
Problems with my assumptions:	
These beliefs add to my anxiety and stress and make it difficult for me to enjoy anything. I worry about failing and I don't give myself credit for the work that I do. I can't relax. These ideas make it hard for me to take on new work. I'm afraid of taking risks.	

FIGURE 4.1. Monitoring your assumptions, rules, and standards.

TECHNIQUE: Challenging the "Should" Statement

Description

Many global rules or standards are experienced as moral imperatives, such as, "I should always be perfect" or "I should always be successful." Because these are stated as moral imperatives, they often imply a judgment about the worth or value of self or other. For example, "I should always be perfect" might imply the opposite—"I'm worthless" or "I'm inferior" and "I don't deserve to be happy" if the rule or standard is not achieved. Self-criticism, guilt, and shame are common side effects of these moralistic "should" statements. Ellis (1994) noted that many of these "should" statements are comprised of illogical, overgeneralized, and dysfunctional ideas. Numerous challenges can be lodged against the logic of "should" statements, such as:

"What is the rationale, logic, or evidence that one should do *X*?"
"What is the origin of this rule?"
"Would this rule be applicable to everyone?"
"Could this rule really be a *preference* rather than a tenet?"

Cognitive therapy and rational–emotive therapy attempt to deconstruct many of these "should" statements to reveal their illogical, unfair, and pejorative nature.

Questions to Pose/Intervention

As indicated above, the therapist might pose a number of cognitive challenges. For example, consider the "should" statement "I should be perfect." Questions to pose might include:

"What is the evidence that you should be perfect [and what is the evidence that you cannot be perfect]?"
"Where did this rule come from? Who or what authority ordained that you should be perfect?"
"Should *everyone* be perfect? Why would you have a different standard for others than you do for yourself?"
"Would it be more realistic to say that you would prefer to do a better job, rather than insisting on a futile need to be perfect?"
"When you use 'should' statements you are treating everyday events as moral issues. Is there some moral issue involved in what you are considering? Is it unethical? Or is it simply a statement of a preference?"
"If you view everyday events as moral issues—as 'shoulds' and 'musts'—then you set yourself up for self-criticism and self-condemnation. Does this really help you?"

Example

THERAPIST: You said that you should have done better on the exam. Why?

PATIENT: Because I'm smart, and I should do the best that I can do.

THERAPIST: What is the best that you can do?

PATIENT: I could get straight A's if I really applied myself.

THERAPIST: But since you're not always getting straight A's, it seems that you're not perfect. Should you be doing things that you might not be capable of?

PATIENT: Maybe if I tried harder, I'd get straight A's.

THERAPIST: What are the costs and benefits of demanding perfection?

PATIENT: The costs are that I feel pressured and disappointed. The benefits—maybe I'll try harder.

THERAPIST: So, how is it working?

PATIENT: I'm miserable.

THERAPIST: What if you had a standard that said "I'll try to do a good job." What would be the benefit of that notion compared to demanding perfection?

PATIENT: Maybe I wouldn't feel overwhelmed.

THERAPIST: Do all your friends get perfect grades?

PATIENT: No. Some of them are barely getting average grades, and some get good grades. No one I know is getting straight A's.

THERAPIST: What do you think of them?

PATIENT: They're doing OK. Maybe I'm tougher on myself.

THERAPIST: What if you applied the same expectations to yourself?

PATIENT: I'd be a lot better off.

Homework

"Select one of your 'should' statements. Write it down on Form 4.2. Note the degree to which you believe it, the emotion it triggers and the degree to which it occupies you, the costs and benefits, and then challenge the statement by answering the questions." Figure 4.2 offers an example of how one patient filled out this form.

Possible Problems

Some people believe challenging their "should" statements will leave them irresponsible or immoral (see Leahy, 2001b) in their behavior. I have distinguished between good and bad "should" statements. Good "should" statements are rules we would apply to everyone—for example, "You should not rape someone." However, most of the "should" statements that rule patients are not valid moral statements since we would not apply them to everyone. Patients who object to challenging "should" statements can consider what constitutes a reasonable moral rule; for example, a reasonable moral rule is one we would apply to everyone and that would enhance human dignity (see Leahy, 2001b). Saying that someone should be perfect in order to be worthwhile implies that everyone is not worthwhile, since no one is perfect. Most people would reject such an absolute and pejorative rule.

Some patients believe that their "should" statements lead them to try harder and to get things done. The therapist can inquire if these rigid rules have led to procrastination, avoidance, inefficiency, distraction, and inability to concentrate. In fact, since these rules are associated with anxiety and depression, they often lead to a decrement in performance.

Furthermore, the idea that irresponsible behavior would be the outcome of discarding arbitrary and extreme "shoulds" can be challenged with the evidence: "Do you have perfectionistic

"Should" statement: *I should always do an excellent job.*

Degree of belief (0–100%) *90%*

Emotion (and degree 0–100%) *anxiety 90%; frustration 90%; anger 80%*

Costs and benefits: Costs: *I'm under constant stress. I can't relax. I worry about how I will do. I don't give myself credit unless it's perfect and it never is. I criticize myself.*

Benefits: *Maybe I'll be motivated and try harder.*

Who established this rule? *This is my rule. My father had a lot of demands on me.*

Do you apply this rule to everyone? Why not? *Not really. I tend to be more tolerant of other people than I am of myself. Sometimes, though, I can get frustrated with other people, especially if they're holding me up in my work.*

Restate this rule as a preference rather than a "should." *I would prefer to do an excellent job, but it's not necessary.*

What would be a more reasonable expectation? *It would be more reasonable for me to try to do an excellent job but to accept as OK doing a very good job or a good job.*

Re-rate belief and emotion: Belief: *60%*

Emotion: *anxiety 60%; frustration 60%; anger 40%*

FIGURE 4.2. Examining and challenging "should" statements.

standards for everything and always think in the most extreme terms?" Since it is unlikely that anyone is a perfectionist in everything, the evidence will indicate that the individual has not become irresponsible when more reasonable expectations are employed. The double standard is also useful: "If other people are not perfectionistic, then what accounts for the fact that they have not become irresponsible?"

Cross-Reference to Other Techniques

Many techniques are applicable to challenging "should" statements. As indicated, we use the cost–benefit analysis, the double-standard technique, and examine the logic and the evidence. In addition, the therapist might use the techniques of vertical descent, examining rules on a continuum, role plays, and acting against the belief.

Form

Form 4.2 (Examining and Challenging "Should" Statements).

TECHNIQUE: Identifying Conditional Rules

Description

Let's assume that the patient's underlying assumption is, "If someone doesn't like me, then that means I'm worthless." In order to prevent rejection or negative appraisal by others, the patient may develop "conditional rules"—guidelines and strategies—that will serve to protect him or her from rejection. These might include rules such as, "If I give everyone I meet what they want, they won't reject me," or "If I sacrifice my needs to meet others' needs, then I won't be rejected." Conditional rules around the theme of perfectionism might include "If I work all the time, I might do a perfect job" or "If I try something difficult, I'll probably fail—so I should avoid any challenges." Conditional rules allow the patient to cope with inadequacies and fears either by compensation—that is, trying to overcome feelings of inferiority by exerting extra effort—or by avoidance of situations that may carry the risk of rejection or failure—that is, avoiding people in order to avoid the possibility of rejection, or avoiding challenges in order to avoid defeat and failure. These ideas were originally developed by Alfred Adler (1964a, 1964b) and later applied to the cognitive model by Guidano and Liotti (1983) and Beck, Davis, and Freeman (2014).

Two problems arise in relying on these conditional rules: First, these rules are almost impossible to live up to, and, second, they do not lead to disconfirmation of the underlying assumption. For example, the rule, "If I defer to others, I will be liked, and then I won't be worthless," does not allow the person to test out and challenge the deeper assumption or core belief that "I'm worthless if someone doesn't like me." For example, the alcoholic patient may believe "I can't survive unless I drink," but he or she does not test out this assumption because he or she does not stop drinking.

Questions to Pose/Intervention

"Sometimes we try to avoid worse things that might happen by living in accordance with certain rules. We've already identified your assumption or core belief—'If someone rejects me, then I'm worthless.' Now the question we can consider is what guideline or rule do you use to avoid getting rejected? For example, 'In order not to get rejected, I tend to do. . . .' (Alternatively: 'If I do [such and such], then I won't get rejected,' or 'If I do [such and such], then I won't fail.')

"Similarly, sometimes we have rules about what we should avoid, so that bad things won't happen. For example, given your core belief of being worthless, if someone rejects you, you might have certain rules or strategies about how you can avoid any rejection. How would you complete the following statement: 'In order to avoid getting rejected, I tend to avoid (what sorts of things or what sorts of people).' (Alternatively: 'In order to avoid failure, I tend to avoid [what sorts of behaviors or tasks].')"

Example

In this case, the patient was a highly intelligent woman with perfectionistic standards who felt stuck working in a city government job, rather than working in the private sector where there would be more demands and more risks of failure.

THERAPIST: You complain about your current job, but you're reluctant to look for a different job either in the private sector or in the city government. You're reluctant to look for something more challenging. What about challenge makes you uncomfortable?

PATIENT: I'm afraid I might fail.

THERAPIST: And what would that mean to you?

PATIENT: That I'm stupid.

THERAPIST: Are there other things you've avoided doing or trying because you're afraid you might fail?

PATIENT: Yeah. I didn't go to law school—even though I got accepted.

THERAPIST: So your rule is to avoid doing things that you could fail in?

PATIENT: Right. I guess that's true. I don't want to find out I'm stupid.

THERAPIST: I wonder if there's another way of testing whether you're stupid. For example, how did you do on the SATs?

PATIENT: I did OK. I got in the 95th percentile.

THERAPIST: How did you do in college?

PATIENT: OK. But not as well as I'd like. I wasn't a straight-A student.

THERAPIST: What kind of grades did you get?

PATIENT: Mostly A's, but I got some B's too.

THERAPIST: If you consider the evidence, does it indicate that you are stupid or not stupid?

PATIENT: Well, I'm not stupid. But I'm not the smartest either.

THERAPIST: Is your assumption that you need to be the smartest in order not to be stupid?

PATIENT: Could be.

THERAPIST: I wonder what the consequence is of that belief?

Homework

The therapist might explain this basic idea and assign related homework in the following manner: "A lot of times we rely on certain rules in the hopes of preventing something bad from happening. For example, some people hold the belief or rule that 'If I worry, then I won't be caught by surprise.' We call this a 'conditional belief'—which is a belief that we think protects or prepares us. Other common conditional beliefs include 'If I get 100%, then I won't be a failure,' or 'If I impress everyone, then I'll be accepted.' Let's get an idea of these types of coping beliefs. Use Form 4.3 to help you identify the conditional beliefs you employ on a regular basis."

Possible Problems

As occurs with the underlying assumptions (discussed above), some patients believe their conditional beliefs are objective and useful. We emphasize at this point that we are simply collecting information. Later we can evaluate the utility of these conditional beliefs.

Cross-Reference to Other Techniques

Other relevant techniques include identifying assumptions, vertical descent, cost–benefit analysis, examining the evidence, and the double-standard technique.

Form

Form 4.3 (Identifying Conditional Beliefs).

TECHNIQUE: Evaluating Second-Level Assumptions

Description

In most cases patients have a second-level set of assumptions that adds even greater vulnerability to their risk for depression and anxiety. The first level maladaptive assumption might be something like the following: "If I fail at something, then I must be a failure." Thus, one goes from a behavior to a label about the entire person. However, the second-level assumption addresses how the person should respond to the conclusion of the first assumption. Here are some examples:

"If I'm a failure, then I should criticize myself."
"If I'm a failure, then I don't deserve to have any pleasure or happiness."
"If I'm boring, then I can't have a relationship."
"If I make a mistake, I should give up."

These second-level assumptions lead to self-criticism, avoidance, and pervasive self-condemnation. In evaluating these second-level assumptions, we can point out to patients that even if they conclude that they are "a failure," they can still respond to that belief with thoughts and behaviors that are not self-condemning. For example, "Even if I think I'm a failure, I can still find happiness and love." Or "Even if I think I'm boring, I can still find people who will enjoy my company." Or "Even if I think I'm a failure, I can still feel compassion and kindness for myself."

Questions to Pose/Intervention

"It may be that you have a set of beliefs that follow after your maladaptive assumptions. For example, let's take your automatic thought—'I'll fail the exam'—and then look at your assumption, 'If I fail the exam, then I'm a failure.' But now you may have another set of beliefs. 'If I'm a failure, I should criticize myself.' Or 'I should never be happy—I don't deserve it.' Perhaps we can look at these 'second-level assumptions'—that is, what you think you should do once you judge yourself with global, negative statements."

Example

THERAPIST: So, you say, "I'll fail at the exam," and then your assumption pops up, "If I fail at the exam, then I'm a failure." So let's say this assumption that you're a failure if you fail the exam, which is so strong it's a belief, is the first level of your maladaptive assumption. But then, try to answer the following question: "If I'm a failure, then what should I think or do?"

PATIENT: (*pausing*) Um. I guess I should feel bad—probably because I'll be criticizing myself.

THERAPIST: So the belief is that if you're a failure, you should be depressed and self-critical?

PATIENT: Yeah.

THERAPIST: OK, let's look at that. What is the advantage of criticizing yourself if you are a failure?

PATIENT: I don't know . . . maybe I'll try harder next time.

THERAPIST: Is that what you do after you get depressed from criticizing yourself? You try harder?

PATIENT: No, I give up and isolate myself. I just do nothing, really.

THERAPIST: So, can you imagine how you would feel if you held a different assumption? How about, "If I think I'm a failure, I can try to direct compassion toward myself"?

PATIENT: I can't imagine doing that.

THERAPIST: Well, let's imagine there was someone in your life who you really loved and cared for. Someone special. And that person failed and thought that he or she was a failure. Would you offer some compassion to them?

PATIENT: I guess I would, of course, yes.

THERAPIST: What if you were able to do that for yourself?

PATIENT: I might feel a lot better.

Homework

The patient can identify a number of should statements and maladaptive assumptions. Then, after listing these, he or she can then identify the second-level assumptions—"If the first statement is true, then what do you think you should think or do?" The patient can use Form 4.4 to evaluate these second-level assumptions.

Figure 4.3 provides an example of how one patient filled out that form. Once patients have identified the second-level assumptions, they can then submit these to a cost–benefit analysis. In addition, what if they considered doing the opposite of the second-level assumption? For example, what if they stated "If I think I must be a failure, then rather than criticize myself I can direct compassion and acceptance toward myself." What are the costs and benefits of this?

Possible Problems

Some patients believe their second-level assumption "logically" or "necessarily" follows from the first assumption. Thus, "People who fail should criticize themselves" or "Boring people can never have relationships." Empirical analysis can lead one to ask, "Are there people who have failed a lot or who are often boring to you who aren't particularly self-critical or who have friends? Are they ever happy? Do they ever smile?" Some patients also believe "That's just the way I think—I can't change." This stance can be addressed by having the patient try doing the opposite toward him- or herself to see how it feels: "How do you feel when you direct compassion toward yourself?" The therapist can engage in a role play in which the therapist plays a person saying "I'm a failure" and the patient expresses compassion and kindness for him or her.

If this happens	Then I think I should	And if that is true, then I should
I don't do as well as I would like.	Worry about it	Criticize myself
Someone doesn't seem to like me.	Feel like I've done something wrong	Worry about what other people will think of me
I don't know everything before the exam and I'm not totally prepared.	Worry about failing the exam	Keep worrying about it so that I'll be motivated to study

FIGURE 4.3. Evaluating second-level assumptions.

Cross-Reference to Other Techniques

Other relevant techniques include vertical descent, looking at probabilities in a sequence, irrelevance technique, and indifference technique.

Form

Form 4.4 (Evaluating Second-Level Assumptions).

TECHNIQUE: Examining the Value System

Description

Many assumptions concern one dimension of the individual—for example, an assumption about the necessity of success at work may include only achievement in financial gain. When the patient becomes anxious or depressed about this one dimension, other values are eclipsed. Examining and clarifying the value system can be helpful in placing certain self-deprecatory judgments in the perspective of other superseding values. For example, the patient who focuses excessively on self-worth, as measured by achievement, can be asked to consider additional values such as love, forgiveness, kindness, curiosity, personal growth, fun, and leisure. Forced choices can then be introduced: "If you had to choose between achieving more and giving more love, which would you choose?" The first task is to develop a list of life values, such as the ones just mentioned. Other values a patient may articulate, such as physical well-being, friendship, and religious values, also can be introduced. The patient can then compare the choices and determine which values are higher and which lower in his or her hierarchy. An alternative is to ask the patient to articulate which values he or she would like his or her child or partner to pursue (a variation of a double-standard technique), or which values he or she would like to see adopted by the general public.

Questions to Pose/Intervention

"Let's examine a set of different values you might hold as important. Consider the following values: love, forgiveness, kindness, curiosity, personal growth, fun, leisure, self-esteem, religion, cultural/financial/work achievement, physical attractiveness, and approval by others. Let's take the issue you are upset about right now: achieving more at work. If you had to choose between achieving more at work and receiving and giving more love [alternatively, forgiveness, kindness, curiosity, personal growth, etc.], which would you choose?"

Example

THERAPIST: You said it was important to do really well on this project and that now you are criticizing yourself for your performance, which you deem inadequate. Sometimes we place a great deal of value on something—here, you are valuing work achievement. But there may be other things that you value as well. For example, consider love, forgiveness, kindness, curiosity, personal growth, fun, leisure, self-esteem, religion, cultural/financial/achievement, physical attractiveness, and approval by others. (*Writes these down.*) If you had to choose between work achievement and these other values, would any of these other values be more important to you?

PATIENT: Almost all of them. Maybe not leisure—although I really do need to take some time off.

THERAPIST: OK. So all of these other areas are actually more important to you? How about trying love, kindness, and forgiveness on yourself right now?

PATIENT: How?

THERAPIST: By being kind, loving, and forgiving toward yourself for not doing as well as you would have liked to do.

PATIENT: I guess if I did that, I'd feel a lot better.

THERAPIST: Didn't you just say that these are your more important values?

Homework

Patients can be given Form 4.5, upon which they identify the value they are upset about—for example, work achievement—and then consider and rank 16 other values. This form allows patients to identify the relative importance of different values and to identify specific actions that can be pursued in relation to these values.

Possible Problems

Sometimes what the patient is upset about is the most important value to him or her—for example, work achievement. The therapist can address this circumstance by asking the following questions:

"If you pursue all of these other values, or any of them, isn't that of some value?"
"Would you apply the same value system to someone you love? Why not?"
"What would most people think of as a more desirable value system?"
"Why would their ranking of values be different from yours?"

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, the double-standard technique, and vertical descent.

Form

Form 4.5 (Values Clarification).

TECHNIQUE: Distinguishing Progress from Perfection

Description

Perfectionism can be adaptive or maladaptive. Having healthy high standards can be useful if these standards provide direction and enhance motivation without the debilitating effects of self-criticism. In contrast, maladaptive perfectionism is characterized by standards that continue to get more demanding even when one achieves the stated goal, and failure to achieve the highest standards results in self-criticalness and possibly depression and/or anxiety (Egan, Wade, Shafran, & Antony, 2014; Di Schiena, Luminet, Philippot, & Douilliez, 2012; Cox, Enns, & Clara, 2002).

One characteristic of maladaptive perfectionism is the continued escalation of a standard: that is, the "receding reference point." No matter how well the individual does, it is not good enough

because "I can always do better." The perfectionist does not take any pleasure from what is achieved or the progress that he or she makes. The therapist can direct the patient to consider if his or her standards of performance keep changing to become more demanding; if the failure to meet a demanding standard leads to self-criticism; if the patient discounts any progress toward a goal as "not good enough"; and if these standards of perfection are self-enhancing or self-defeating. The patient can complete the Perfectionism Inventory (Hill et al., 2004), which has eight subscales: Concern Over Mistakes, High Standards for Others, Need for Approval, Organization, Parental Pressure, Planfulness, Rumination, and Striving for Excellence (see Form 4.6). By applying the technique of aiming for progress rather than perfection, patients can focus on how to improve some aspect of a past performance, rather than struggling to attain an impossible standard.

Progress can be assessed in numerous ways. For example, a patient who scored 36 on her first Beck Depression Inventory (BDI) complained that therapy wasn't working when her BDI score was 22 after 6 weeks—and she was still depressed. Rather than evaluating treatment in terms of the total absence of depressive symptoms, I suggested that she acknowledge the progress she had made, as evidenced by the 14-point decrease in her BDI score. I suggested that we examine what led to this progress so that we could continue building on it and making more progress.

Questions to Pose/Intervention

"Examine the advantages of trying to *improve* rather than trying to be *perfect.* If you try to be perfect, you will inevitably be frustrated. In contrast, if you try to make progress, you may feel more in control and hopeful. Are there some areas in which you have made progress? Do you give yourself credit for the progress or only for the perfection? What would be the consequence of giving yourself credit for progress rather than waiting for perfection?"

Example

THERAPIST: You're upset right now because you got a lower grade than you expected in the exam. What was your grade?

PATIENT: I got a C. I didn't expect to do well, because I didn't study much. But this grade is a disappointment.

THERAPIST: What thoughts are you having?

PATIENT: I'm a real loser. I probably won't do well in the "real" world.

THERAPIST: Do you think that you could do better on your next test?

PATIENT: I can't imagine doing worse!

THERAPIST: What did you learn about the importance of preparing for the exam?

PATIENT: I guess that I have to study. I guess I'll do better next time.

THERAPIST: So, if you focused on progress and learning, then this might be something to learn from?

PATIENT: Yeah.

THERAPIST: This experience might be an inexpensive lesson in something really important—such as the importance of studying and preparing and not taking your performance for granted. Is this a lesson that could be useful to you throughout your life?

PATIENT: I guess it could.

THERAPIST: So let's focus on what you've learned and how this temporary downturn can motivate you to make progress in the future. It's better than thinking that you're a loser because you're not perfect.

PATIENT: That would be a better way of looking at it.

Homework

The therapist can give patients Form 4.6, which assesses perfectionism in different areas of life. The scoring criteria are also provided. In addition, the patient can complete Form 4.7A to explore the costs and benefits of perfectionism versus progress, and Form 4.7B, on which he or she lists different areas that trigger self-criticalness—for example, work or school performance, relationships, health, finances, etc.—and then notes the various ways in which he or she could make progress in these areas—for example, work hard, study more, communicate better, exercise and diet, and save money. Figure 4.4 provides an example of how one patient filled out Forms 4.7A and 4.7B.

Possible Problems

Some people believe self-criticism motivates them to work harder. In cognitive therapy we try to focus on problem solving rather than self-criticism, and we point out to patients that diagnosing a

Behavior I demand perfection in: *How I come across with people I meet the first time*

	Accepting progress	**Demanding perfection**
Costs:	*Maybe I'll let my guard down and seem stupid. Maybe I won't try as hard.*	*I feel anxious. I won't approach people. I will constantly be self-conscious. I will worry. I will look back and regret things.*
Benefits:	*I can feel more relaxed. I can be more myself. I'll worry less about what people think.*	*Maybe I can try my best and this will motivate me.*
Conclusions: *I'm much better off aiming for progress rather than for perfection. I can still try hard and make a good impression without having to be perfect. No one is perfect. I don't expect other people to be perfect with me.*		

What I criticize myself about:	**How I can make progress:**
How I come across when I meet new people	*I can focus more on getting to know them. I can let the conversation flow more naturally. I don't have to try to impress them all the time.*
Why would progress be better than pursuing perfection? *I don't have to be so self-conscious. I can always aim for improving and getting better and still give myself credit for trying. I will never be perfect but I can do things to get better.*	

FIGURE 4.4. Costs and benefits of progress and perfection.

problem is not the same thing as solving it. For example, diagnosing myself as 10 pounds overweight is not the same thing as solving the problem by exercising and dieting.

Cross-Reference to Other Techniques

Other relevant techniques include identifying assumptions, behavioral assignments such as graded task assignment and activity scheduling, problem solving, and cost–benefit analysis.

Forms

Form 4.6 (Perfectionism Inventory); Form 4.7A (Costs and Benefits of Progress and Perfection); Form 4.7B (Making Progress Rather Than Trying for Perfection).

TECHNIQUE: Using Relapse for Relearning

Description

One way to challenge perfectionistic assumptions is to reframe relapse as a learning experiment. The patient with all-or-nothing assumptions about failure and acceptance (or any other standard or value) will view the relapse of a problem as an indication of how hopeless things are. For example, a patient who had decreased her consumption of alcohol to one drink per night had a relapse in which she consumed five drinks. She was highly self-critical and began to think that she was hopeless. However, I proposed that we consider viewing this as a learning experiment—or as a "natural experiment"—in which she could consider how she felt when she did not follow the self-help guidelines (Leahy & Beck, 1988). What she learned from this relapse was that our analysis was correct: (1) She felt worse the next day after a drinking binge; (2) trying to please her drinking friends by drinking with them was not in her best interest; and (3) all in all, drinking more than one alcoholic beverage a night was not worth doing. Another way of viewing relapse is to reframe it as a helpful type of pain: "Make pain your friend by recognizing that pain is an essential aspect of learning, at times, and that it is trying to help you recognize what does not work for you."

Questions to Pose/Intervention

"Although you are feeling badly that you have had a relapse of your problem, it may be helpful to use this setback as an important learning experience. First, it's important to keep in mind that a relapse means that you have improved. You might think of it as two steps forward and one step backward. We can also learn about what leads to a relapse so that we can be prepared in the future and use some techniques and skills. What have you learned about yourself? What have you learned about what works, and does not work, for you? How could you use the pain and disappointment to guide you in the future?" The therapist can use a "chain analysis" by identifying the details of the thoughts, emotions, and sensations in the situation that preceded the relapse.

Example

A patient who had improved in avoiding binge eating reported that she had engaged in a binge the night before her therapy session. She indicated that she was very self-critical now and thought she was hopeless.

THERAPIST: So I can see you are really discouraged by the bingeing you did. You said this makes you feel like giving up.

PATIENT: Yeah, nothing works.

THERAPIST: That's a strong statement that I'm sure makes you feel even worse. But let's keep in mind that you couldn't have had a relapse unless you had already improved. If you traveled 10 miles but then got detoured, you could still see that you've made progress. What progress have you made in the last 3 months?

PATIENT: Well, I guess I have been bingeing a lot less, and I now understand that there are some skills I can use to handle my emotions so I don't have to binge.

THERAPIST: So you have made progress in different ways, but it's not perfect, and the relapse leads you to discount everything that you've accomplished with your hard work.

PATIENT: That's how I am at times. I get overwhelmed when things don't work and then give up.

THERAPIST: That must be hard for you—not taking credit for progress. OK, so let's look at what you were thinking and feeling right before the binge.

PATIENT: I was home alone and I felt empty and sad and I felt like, "I'll never find anyone," and I just got overwhelmed with these sad feelings, and then I got more anxious and I said to myself, "Why not?" and then I just binged on ice cream. And then I kind of spaced out a little.

THERAPIST: So if we look at this, you might think of each step along the way as a learning opportunity. For example, the thought that you will always be alone. How could you challenge that thought?

PATIENT: I have friends, and I know that I have had relationships before. And I can't really predict the future, but I do have something to offer.

THERAPIST: OK, so that is something to keep in mind the next time you feel this way. You can challenge the thoughts. How about the use of mindfulness? How could you use that the next time?

PATIENT: I could stand back and observe the thoughts and the feelings and accept them as something that I have right at this moment and that this moment will pass.

THERAPIST: Yes, moments come and go. And so mindfulness is a tool to use in the future. How about improving the moment? How could you use this the next time?

PATIENT: I could have taken a nice bath and put some candles out and listened to some music. And I could have just relaxed and, you know, I could have done some yoga, too.

THERAPIST: So this relapse is a great opportunity to think about what tools to use next time that you feel the urges and the sadness.

PATIENT: Yeah. I could learn something.

THERAPIST: Learning something is different from giving up and criticizing yourself.

PATIENT: Yes, I know. I know.

Possible Problems

"When we relapse from the progress we've made, it is a good opportunity to learn something. For example, if you are on a diet and then you overeat and feel bloated, you might start to criticize yourself. But the really valuable point from the experience is to learn what works and does not work for *you*. Using this table [Form 4.8; see Figure 4.5 as an example of how one patient filled out this form],

The behavior I am concerned about is: *drinking too much—had six drinks*

What was working before	What I learned to make things better in the future	What made me lapse
Counting my drinks and limiting myself to two drinks	*I was feeling anxious and wanted to fit in with my friends who were drinking a lot*	*I feel worse when I drink too much. I've said stupid things in the past when I've been high.*
What are the advantages of using lapses or mistakes as learning experiences? *I can always use mistakes as learning experiences. With my recent experience, I can realize that trying to fit in with other people wasn't worth it. I don't need the hangover.*		
What are the disadvantages? *To be honest, I would like to be able to drink as much as I want. So I have to face the fact that giving up doing something I like to do isn't worth it in the long run. I don't want to face that. I don't want to give it up.*		

FIGURE 4.5. Learning from lapses.

think about some area that was working for you—for example, diet, exercise, communicating better, self-discipline—and then think about how 'you fell off the wagon.' Rather than criticize yourself, try to identify what worked and what did not work for you."

Possible Problems

Relapse can activate feelings of hopelessness and self-criticism. Common thoughts include "It didn't work, so I may as well give up" and "I'm a failure." These critical responses are especially likely for people who have substance disorders, such as drinking, smoking, and binge eating. It is helpful to point out that we can't have a relapse unless we have made improvement in an area. Perfectionistic assumptions about performance often lead to discounting the positive and overgeneralizing the relapse. Useful interventions include viewing the relapse in a temporal context, perhaps using a visual aid such as a sketch of a continuum or a pie diagram, by asking, "For how much of the past month have things been better?" or "Where would you put your overall performance for the past month compared to a year ago?"

Cross-Reference to Other Techniques

Relevant techniques include identifying cognitive distortions (e.g., all-or-nothing thinking, fortune telling, discounting positives, overgeneralizing, and negative labeling), looking at progress rather than perfection, identifying the costs and benefits of modifying assumptions, the double standard, setting a zero point as a comparison, and rational role playing.

Form

Form 4.8 (Learning from Lapses).

TECHNIQUE: Using Case Conceptualization

Description

Identifying patients' underlying assumptions and conditional rules is helpful in developing a case formulation or conceptualization (see Beck, 1995; Kuyken et al., 2009; Needleman, 1999; Persons & Miranda, 1992; Tompkins, 1996) wherein we link the current cognitive assessment of automatic thoughts, core beliefs, conditional beliefs, and personal schemas to developmental issues and current and past coping styles. For example, the individual who has a personal schema that he is unlovable and that others will criticize and reject him may have the following automatic thoughts:

"She thinks I'm a loser."
"I'm a loser."
"When I ask her out, she'll say no."
"It's awful to be rejected."
"Nothing ever works out."
"I'll end up alone."

In addition, he may hold the following maladaptive assumptions:

"You should never let anyone know what you really think."
"If you count on people, they will abandon you."
"If people really knew what I was like, they wouldn't like me."
"You need others' approval to be happy."

Conditional beliefs might include:

"If I'm very pleasing and give in, then people will like me."
"If I meet everyone's needs, then nobody will leave me."

This individual may attempt to cope with fear of rejection either by avoidance (e.g., not approaching people, not disclosing, not asking someone out) or by compensation (e.g., smiling at everything someone else says, engaging in deferring and self-sacrificing behavior). The core belief he holds about himself is that he is defective and unlovable. Reviewing his earlier developmental history might reveal that he was regularly criticized by his father and that his mother threatened to leave the family. In addition, his peers teased him for being smaller than they were. The case conceptualization could be diagrammed as in Form 4.9.

Questions to Pose/Intervention

The therapist provides case conceptualization in the session, explaining: "It is useful to identify how your thoughts and assumptions are related to each other. I will help you diagram a conceptualization of how your thoughts, feelings, and behavior are related."

Example

THERAPIST: You said that you thought you were a loser because the woman at the party didn't seem interested in you. That's the automatic thought: "I'm a loser." Then you also said that you

thought you'd never meet anyone because you don't have much to offer. Let's diagram some of this [using the schematic in Figure 4.6].

PATIENT: Yeah, that seems to be what I'm saying.

THERAPIST: OK. It goes further, though. Your thought that "she didn't like me" then means what to you?

PATIENT: I guess that I'm not lovable.

THERAPIST: Have you had other thoughts like that before? Would it be helpful to ask yourself, "If I allow people to get to know me, what do I fear?"

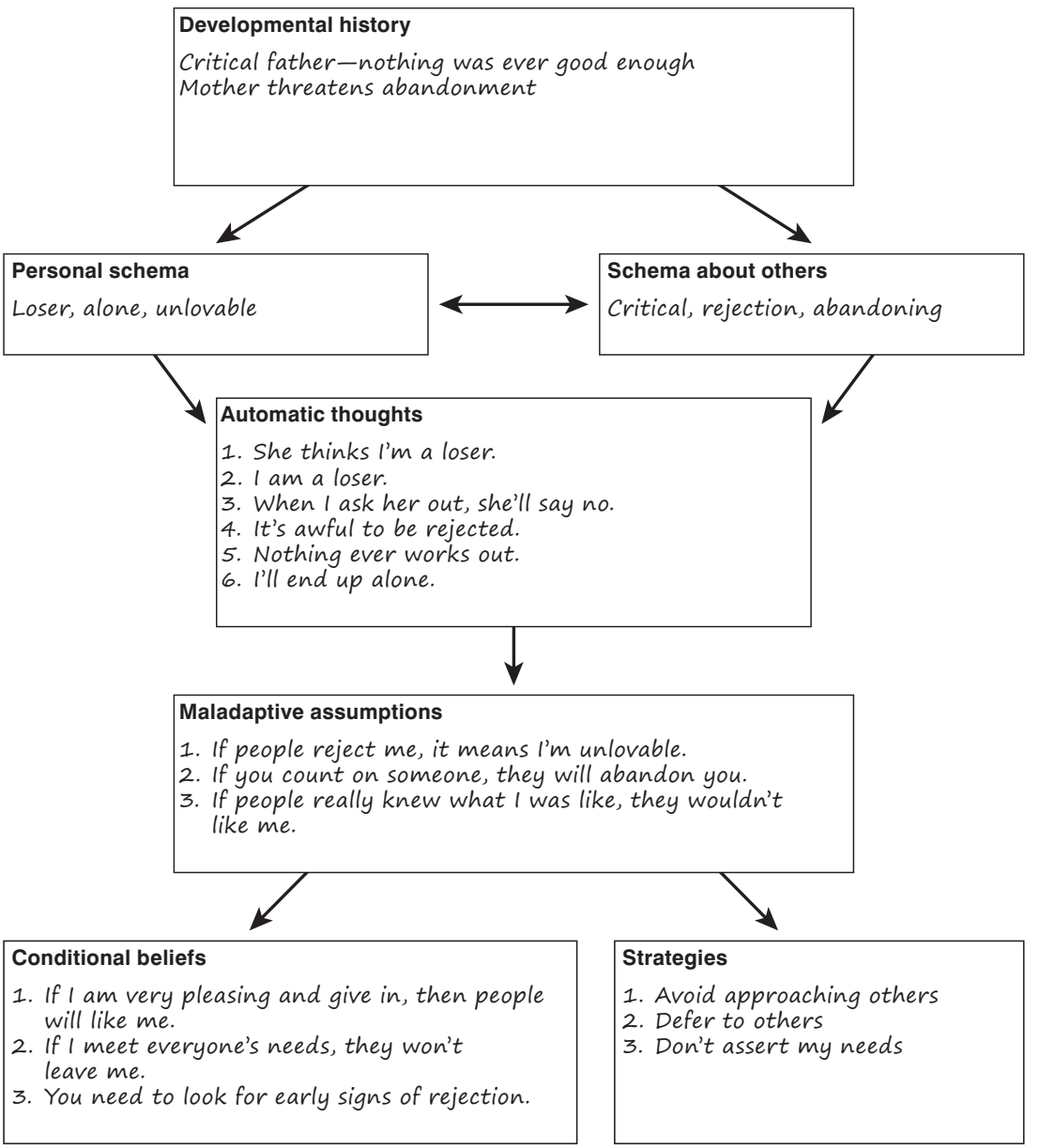

FIGURE 4.6. Case conceptualization diagram.

PATIENT: Oh, the more they know me, the less they will like me. Then they'll leave. They'll find out who the real me is.

THERAPIST: So you seem to feel that people are automatically critical and will reject and abandon you.

PATIENT: Right.

THERAPIST: OK. Let's put that into our chart here. Do you try to do things so that people won't criticize you?

PATIENT: Yeah, I generally don't disagree with people. I try to meet everyone's needs before my own.

THERAPIST: Do you avoid anything?

PATIENT: Oh, yeah. I avoid approaching new people and starting conversations. I avoid letting people know much about me.

THERAPIST: Now, these ideas that you are unlovable and that people will criticize you, where do you think they come from?

PATIENT: My father was really critical and cold.

THERAPIST: OK. Let's put that in the box for "developmental history." How about your mother, what was she like?

PATIENT: She used to tell Dad that she wished she had never married him. She said, "I wish that I could just go away and leave all of you to deal with things. Then you would appreciate me."

THERAPIST: OK. So Mom would threaten abandonment. How about the other kids in school?

PATIENT: They'd criticize me because I wasn't as big as they were. I guess they also liked seeing me getting upset. I'd get really upset.

THERAPIST: OK. So if we look at the diagram about your schema, you can see that you had a critical father, a mother who threatened you with abandonment, and you interacted with kids who teased you. This treatment made you think that you were a loser, all alone, and that you might not be lovable. That fed into having automatic thoughts about being a loser, getting rejected, and ending up alone. Your assumption is that if people reject you, then you are unlovable. You tried to compensate by either trying to please everyone or by avoiding people if you thought you would be rejected.

PATIENT: That seems to describe who I am.

Homework

The therapist can give patients the case conceptualization developed in the session and ask them to write out thoughts and feelings about it. These might include additional memories or examples or emotional responses to the conceptualization. On Form 4.9, patients can add to the case conceptualization any thoughts, feelings, coping styles, assumptions, strategies, or information about childhood experiences that is relevant. Each "box" in the case conceptualization form can be utilized for strategies and interventions. Thus, the therapist can later examine effects of developmental history, schemas, assumptions, and beliefs. See the discussion on schema-focused therapy in Chapter 10, "Modifying Schemas."

Possible Problems

Although the case conceptualization is often a powerful intervention that helps patients make sense of current problems, it may raise concern for some. For example, some patients may believe they are

hopeless cases because they were "ruined" by their childhood experiences. These concerns about "fundamental" defects can be challenged by asking patients to consider if they have ever had any beliefs they subsequently changed or if they have ever learned any new behaviors. Since we are learning and changing daily, knowing that old habits and beliefs were established earlier on may be the first step in changing them now. A good question to ask is, "Since some of the beliefs that bother you now were established when you were 6 years old, would you want to continue believing things you learned as a child?" Another point to add: "When you learned this belief as a child, you did not have the ability to think as an adult. Now you can challenge those ideas with all the benefits of being older and wiser."

Cross-Reference to Other Techniques

All of the techniques described in this book can be helpful in this endeavor. I begin to formulate the case conceptualization from the intake and continue to elaborate on it, with the patient, throughout treatment. This procedure takes the mystery out of therapy and helps patients understand that their problems are comprehensible and potentially manageable.

Form

Form 4.9 (Case Conceptualization Diagram).

TECHNIQUE: Examining the Implication of Perfectionism

Description

Many people who endorse perfectionism as rigid rule for themselves assume that achieving perfection will have lasting and beneficial consequences. We have discussed the vertical descent technique that examines the implications of not achieving a goal—for example, "If I'm not perfect, then I'm a failure. If I'm a failure, then life is not worth living." However, we can also examine the implications of achieving the goal of perfection—or of achieving any goal (e.g., getting everyone's approval).

Questions to Pose/Intervention

"You seem to believe it is important to achieve perfection [or to get the approval of everyone, or to get certainty, etc.]. But let's think this through and examine what it would mean to achieve the goal. Please complete the following sentence: 'If I achieve perfection, then it means that . . .' or 'Once I achieve perfection, then the following will happen. . . .'"

Example

THERAPIST: You have been focused on your fear of failing at your work, and we have examined some of the negative implications for you of failing. It seems you think if you fail at something, then you are a failure; in turn, if you are a failure, then you cannot be happy—indeed, the very opposite: You would be miserable for your entire life. But let's look at what it would mean if you succeeded and achieved this perfection you so desire. Complete the following sentence: "If I succeed and finally achieve perfection, then. . . ."

PATIENT: But it's not really possible to be perfect.

THERAPIST: That may be, but let's think it through. What if you did achieve perfection?

PATIENT: I guess I would be happy.

THERAPIST: OK, now let's imagine it's the day after you achieved perfection, then what?

PATIENT: I guess I would be worried about slipping back.

THERAPIST: So how long would your happiness last once you'd achieved perfection?

PATIENT: I never thought it through. I don't know.

THERAPIST: Would you then be happy with everything in your life once you got that perfection?

PATIENT: It's hard to imagine that. Life is so complicated.

THERAPIST: So with a complicated life, achieving perfection might give you momentary pleasure, but this would go away. Now, think of the most successful people you can recall and ponder whether they are completely happy and contented.

PATIENT: No, life is hard for everyone at times. The contentment only lasts a short time.

THERAPIST: So aiming for something that lasts a short time—perfection—something you would then worry about losing and something that would not affect other areas of your life: That sounds like aiming for something that comes and goes and is gone.

PATIENT: I never thought of it that way.

Possible Problems

The patient can use Form 4.10 to examine the implications of achieving the rigid and demanding goals that concern him or her. For example, "Once I get everyone's approval—what will happen?," "Once I achieve perfection—what will happen?," or "Once I have certainty—what will happen?" The patient can consider how long the pleasure or satisfaction will last. Will it affect every aspect of his or her life, or will its impact be short-lived, confined to a particular issue, and pass away? The therapist may ask, "Is it worth sacrificing your happiness to achieve something that is so short-lived?" Figure 4.7 shows how one patient filled out this form.

Possible Problems

Some patients may believe that giving up on perfectionism will lead to loss of motivation, lower standards for themselves, mediocrity, and finally, failure. They may believe that their ideal of perfectionism keeps them on their toes, that they need it to scare themselves into their optimal performance. The therapist can acknowledge that having healthy high standards may be helpful but that perfectionism can lead to procrastination and helplessness, since it is impossible to achieve. The therapist can ask if there were any achievements that the patient could take pride in that were less than perfect. Also, what is the evidence that achieving the highest standard on a performance leads to lasting satisfaction?

Cross-Reference to Other Techniques

Additional relevant techniques include vertical descent, costs and benefits, examining the evidence, opposite action, acceptance, compassion-focused approaches, and the universal application of a rule.

Form

Form 4.10 (Examining the Implications of Perfectionism).

If I achieve perfection in this activity	Then the following will be true
Getting a perfect grade on the exam	I'll get an A in the course. My grade point average will go up. I'll get into a great law school. I'll get a terrific job and make a lot of money. I'll be a success in life.
How likely is it that seeking perfection will lead to the outcomes that you desire? Describe the problems with this approach. It's just one of many exams in many courses. I have an up and down record. Who knows what law school I'll get into? And I can't know how my life will end up based on this one exam.	
How often have you actually achieved perfection? Why has it been so difficult? I have never achieved perfection. So it's not likely that I will this time. It's an illusion. It's impossible to be perfect.	

FIGURE 4.7. Examining the implications of perfectionism.

TECHNIQUE: Enhancing Curiosity, a Positive Experience of Challenge, and Growth in Patients Rather Than Ideals of Perfection

Description

Many assumptions are overly demanding and uncompromising in their positions. The individual believes he or she should be accepted and liked by everyone or excel at every task. As a result, when events are less than perfect, the individual may feel hopeless or self-critical. Dweck and her associates (Dweck, Davidson, Nelson, & Enna, 1978; Dweck, 2000, 2006) have found that people can persist more effectively when confronted with challenging tasks if they view the task as a learning experience or if they develop curiosity, in contrast to viewing the task as an evaluation or test. Indeed, Dweck indicates that individuals differ in their theory of ability and mind, with some individuals believing that abilities are fixed whereas others believe they can be changed. This difference between fixed versus growth mindsets reflects the difference between individuals who give up in the face of frustration (the fixed mindset) compared with those who try harder and persist (the growth mindset). Perfectionistic expectations can undermine persistence, since the individual may become discouraged at the first experience of "failure" or "frustration" and view failure and inability as unchangeable.

Questions to Pose/Intervention

The therapist can ask any of the following questions: "What did you learn?," "What could be interesting about this experience?," "How is this experience a challenge?," and "How would you feel if you did better the next time?" More specifically: "If you do poorly on an exam, rather than focus on your score as a final measure of your worth, consider how you could develop curiosity about the subject matter or feel challenged to do better in the future"; "What would be the advantage of thinking that

this is a chance to try harder, put more effort into it? What if you thought of your ability as something that grows with experience and learning?"; "Do you think of your abilities as something that can change and grow? Or do you think of your abilities as fixed and unchangeable? Which skills and abilities do you have that you have grown in? How did that happen? What have you learned from setbacks, mistakes, and failures?"

Example

THERAPIST: It sounds like you felt discouraged because you did not do as well on the exam as you expected.

PATIENT: Yeah, I was hoping I'd get an A, but I got a B–.

THERAPIST: Which parts of the history test did you do well on, and which parts did you not do well on?

PATIENT: I did well on the essay part—I'm pretty good at pulling things together. But the part on the dates and names—I just didn't know them.

THERAPIST: OK. Let's try to develop some curiosity about why dates might be important in history.

PATIENT: I never thought of it that way. Obviously, you have to know what happens after what.

THERAPIST: How could you develop this task of remembering dates and names into a challenge for yourself?

PATIENT: Maybe I could make up some flash cards and see if I can start learning some of this.

THERAPIST: How would you feel if you did better on this stuff next time?

PATIENT: Like I learned something that I should learn.

THERAPIST: Let's think of that as the next step in your challenge to do better and to learn from this experience.

Moreover, the therapist can ask patients the following: "What is your goal in the situation? Is your goal to succeed at everything? To be accepted by everyone? Could you modify your goal to 'learn how well I can do' or 'meet some new people'?" Often patients' goals revolve around unrealistic standards. By considering new goals, patients are freed to consider more than one way to approach a challenge.

The therapist can use the "Turning Work into Play" form (Form 4.11) to turn critical thoughts into thoughts about challenge and curiosity.

Possible Problems

The therapist can ask patients to use Form 4.11 to consider experiences with which they are frustrated or have felt were failures. Short narratives can be written down, describing what events occurred and what negative thoughts or behaviors resulted. Then patients write down what they learned, what could be done differently in the future, and how they could develop curiosity about the problems to be faced. See Figure 4.8 for an example of how one patient used this form.

Behavior I think of in terms of evaluation: *Doing well on the exam coming up*

Critical thoughts	Thoughts of curiosity and challenge
There will be questions that I won't be able to answer. Other people are better prepared. I will not do well. I was stupid for not studying earlier. My mind will go blank.	*I'm actually interested in the topic. Psychology is my major, so studying means that I'll be learning about things that are interesting to me. If I want to be a psychologist, these things might be helpful to me someday. I can grow and be challenged in learning new things. It's fun to learn new things.*
What would be the advantage of having thoughts about curiosity and challenge? *I would be much better off because curiosity is a positive feeling and it means that new material is interesting and exciting. I'm much better at learning when I get interested in the material. I'm less likely to criticize myself. Curiosity can motivate me.*	

FIGURE 4.8. Turning work into play: Changing criticism and disappointment into curiosity.

Possible Problems

As with the technique of focusing on making progress rather than seeking perfection, patients sometimes believe that demanding standards and self-criticism are essential to achieving their goals. The therapist can identify this perfectionistic assumption as in need of evaluation. For example, the therapist might ask, "What are the costs and benefits of an attitude of perfectionism versus one of curiosity and challenge?" and "Have you developed a curiosity about other behaviors?" If the patient looks at past experiences of success, were they partly the result of persisting, trying harder, and developing a sense of challenge?

What evidence is there, for and against, that the experience of curiosity can motivate a person to action? Patients also can be asked to identify behaviors in which they engage simply because they enjoy them and are interested in them. Patients' curiosity can be diminished by excessive self-criticalness, so that they regard the task simply as an obligation or requirement— for example, "I'm not interested in history—I'm taking it only because it's required." The therapist could enhance curiosity in such a patient by asking him or her to speculate about why other people would be interested in history—that is, what makes it interesting to them? Or the patient could be asked if there are any behaviors that were once intrinsically interesting but which have become uninteresting because they were subjected to critical evaluations.

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, examining the evidence, double-standard technique, vertical descent, examining the negative filter, and role play.

Form

Form 4.11 (Turning Work into Play: Changing Criticism and Disappointment into Curiosity).

TECHNIQUE: Developing New Adaptive Rules, Standards, and Assumptions

Description

We are often reluctant to abandon one belief unless we can come up with an alternative belief that works better for us. Having challenged and rejected maladaptive standards, values, or assumptions, the therapist can assist patients in developing new, more flexible and realistic ones. Often these new statements are expressed as preferences rather than as hard and fast rules. For example, the patient might replace "I should do a perfect job at everything," with a more adaptive standard such as, "It's good to have high standards, but it's also good to be able to accept myself no matter how I perform." Or "I'd like to excel, but that's not always possible, so I find satisfaction in what I do achieve." The maladaptive standards usually involve all-or-nothing implications—for example, "I should always succeed"—and are followed by self-criticism or judgment of others. (The words *always* and *never* are easy cues of these types of statements.) New rule/standards, values, and assumptions can be flexible, differentiated, and action-oriented, emphasizing learning, growth, and acceptance rather than judgment, rejection, and quitting; for example, "When I encounter an obstacle, I can engage in productive behaviors to overcome it." These new beliefs can be examined in terms of their costs and benefits, the evidence supporting their helpfulness, and their applicability to others (e.g., "How would you feel if we applied this rule [in contrast to the old rigid assumptions]) to others?"

Questions to Pose/Intervention

"A lot of the time we hold assumptions and make rules that we just can't live up to—rules such as 'I should always succeed' or 'I should get the approval of everyone.' We have examined how these rigid rules make life difficult for you. Now let's develop some new rules and assumptions that might be more realistic, more flexible, and more growth oriented. Let's take your old rules and assumptions and come up with some new ones. For example, let's take your rule 'I should always do extremely well' and replace it with a new standard or value such as this one: 'I like doing well, but I can also learn from my mistakes, and I can take credit for what I do accomplish rather than measure myself against unrealistic standards.' "

Example

THERAPIST: You felt really bad after the history exam because you didn't get a good grade. Your rule was that "I must get high grades all the time." Let's find a new rule that can empower you by enhancing your curiosity and sense of growth and acceptance.

PATIENT: I guess I could say I can learn from my mistakes. I could also give myself credit for the parts that I did well on.

THERAPIST: OK. What are the costs and benefits of learning from your mistakes?

PATIENT: The costs are that I might become complacent; I might get lazy and not even try for high grades. And the benefits would be that I stay motivated even when things don't go well. I wouldn't be as self-critical.

THERAPIST: How does that sound to you?

PATIENT: Like I'm better off learning from my mistakes and being challenged.

THERAPIST: What concrete behavior follows from this new formulation? What could you do over the next week to put this new value or standard to work?

PATIENT: I could look at what I did well on and what I still need to work on and I could plan to study. I could set it up as a challenge to memorize some of those dates and names.

THERAPIST: So you could set about making progress rather than demanding perfection?

PATIENT: Right.

In working with another patient, who was overly focused on getting approval from everyone, the therapist asked him to weigh out the costs and benefits of a new assumption. He made the following list:

New assumption: "I'm worthwhile regardless of what others think of me."
Costs: Getting conceited and alienating people.
Benefits: Self-confidence, can take risks, not shy, not dependent on others, more assertive.
Costs: 5% *Benefits*: 95% *Costs–Benefits* = –90%
Conclusion: This assumption is better than the assumption that I have to get other people to like me in order to like myself.

Another point to raise when evaluating assumptions is to ask patients to consider the following: "Rather than get trapped by your way of reacting, try to identify someone whom you think is highly adaptive. How would this person think and act if this event happened to him or her?" Often other people can serve as role models for adaptive thinking. For example, a single man was concerned about getting rejected if he approached a woman for a date. The therapist asked him to identify someone he thought was confident with woman and to consider how his friend would think of the situation. He was able to identify his friend's adaptive assumption that "It's better to take chances then to play it safe."

Finally, patients can consider the benefits of developing adaptive flexibility: "Examine the benefits of being flexible in your standards and behaviors. What would happen if you allowed yourself some room for error or mistakes?"

Possible Problems

Instruct patients to identify any maladaptive rules and assumptions and then come up with alternatives that are more reasonable (use Form 4.12). The guidelines for the new formulations are the following: "The new rule or assumption should be more adaptive, more flexible, fairer, more realistic, and more positive. It should focus on fairness, growth, acceptance, and positive goals. It should be the kind of rule you would use for someone you love and care about." Furthermore, patients should be asked to evaluate the new rule or assumption and propose behaviors that would follow from it. See Figure 4.9 for an example of how one patient filled out part of this form.

Possible Problems

As with any challenge to perfectionism, patients may believe that more reasonable rules are too lenient and that they would run the risk of becoming lax, lazy, and irresponsible. These perfectionistic ideas can be challenged, as indicated above, by looking at the evidence for and against, using the double standard, or carrying out an experiment with the new rules.

Criteria	Old assumption	Rate criteria	New adaptive assumption	Rate criteria
Flexible	I should do everything by the book and stay completely focused all the time.	Never being distracted—0. Always doing extremely well—2. Not tolerating mistakes—1.	I should give myself some room to breathe and accept that I can't know everything.	Try to focus but realize that it is human to get distracted—8. Notice my distraction but then get back onto the task at hand—7.
Fair	The world should be fair and people should recognize how good my work is.	People giving me praise for everything that I do—5. Everyone being fair and kind and reasonable with me—5.	People are not always fair and I'm not always fair. I would be better off accepting variation in how people respond. The world is not set up to treat me fairly.	Accepting some unfairness—8. Accepting that people don't notice my work at times—7. Learning how to strategize to deal with people in my life—6.

Evaluating and Acting on More Adaptive Rule/Assumption

New rule or assumption: Accepting some unfairness as part of human nature.

Costs	Benefits	Behaviors to do
I'll have to put up with things that I don't like. It's like saying it's OK to treat me badly.	This is far more reasonable and realistic. I won't be resentful. I won't take things personally.	Try to do the best I can while accepting the fact that not everything is noticed and not everything is rewarded. Don't take things personally. I'm not the center of the universe.
What would I be more likely to do if I believed this new assumption? I would be more likely to get along with my colleagues. I would be less resistant to feedback.		
What would I be less likely to do if I believed this new assumption? Less likely to get into arguments. Less likely to dwell on unfairness.		

FIGURE 4.9. Changing old rules/assumptions into new rules/assumptions.

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, vertical descent, evaluating pro and con evidence, the double standard, and the behavioral experiment.

Form

Form 4.12 (Changing Old Rules/Assumptions into New Rules/Assumptions).

TECHNIQUE: Bill of Rights

Description

Patients can be urged to read the Declaration of Independence, focusing especially on the section pertaining to the right to life, liberty, and the pursuit of happiness. All new and old assumptions can be evaluated against these basic rights. The idea is that our rights come from an assumption that a good rule is one that enhances human dignity. Human dignity is defined as the qualities that would reflect respect, compassion, and caring for human beings and would recognize a responsibility to care for those who are not advantaged. Human dignity can be operationalized in terms of the rules or behaviors that one would direct with compassion and respect toward someone you love.

The therapist might then explain: "Develop a list of your rights as a person and how you could exercise them. New more adaptive rules and assumptions can be derived from an overarching humane sense of personal rights. These rights could include the following: the right to be free of depression, anxiety, and anger; the right to accept yourself; the right to experience growth, curiosity, and challenge; the right to learn from your mistakes; and the right to accept that some people won't like you."

Questions to Pose/Intervention

"As a human being, you would agree you have certain rights. As the Declaration of Independence states, these include the right to life, liberty, and the pursuit of happiness. Let's come up with your own Bill of Rights. Let's imagine that we would apply these rights not only to you but to each new baby born this year. These would be *human* rights."

Example

THERAPIST: You have been upset because your husband has been drinking, as usual, and criticizing you and telling you that you are stupid. How does this make you feel?

PATIENT: I feel trapped, like I'm ready to explode.

THERAPIST: What if we were to come up with your personal Bill of Rights? Let's imagine that we would apply these rights not only to you but to each new baby born this year. These would be *human* rights. What rights would you give yourself?

PATIENT: I'd start with the right not to be battered, not to be criticized, not to have to live with an alcoholic. I have the right to be happy.

THERAPIST: And if it got really, really bad and you couldn't stand it any longer?

PATIENT: The right to leave.

THERAPIST: You have a 2-year-old niece. Would you want her to have these rights?

PATIENT: Absolutely.

Possible Problems

Patients can examine some of the problems, rules, or assumptions that have been causing stress and then consider a list of their basic rights. It is useful to have patients use the sentence stem "I have the right to . . ." for each right they identify (see Form 4.13). The emphasis should be on rights that extend from the assumption of human dignity and that patients would wish to apply to someone they love and respect. For example: "You would want to direct compassion, acceptance, generosity, and kindness toward someone you love, whereas you would not want to direct criticism, exclusion, deprivation, and hatred toward someone you love." Figure 4.10 provides an example of how a patient might complete Form 4.13.

Possible Problems

People with high, demanding standards or self-sacrificing schemas may believe that they must endure hardship in order to be moral. It is helpful to call attention to the double standard they likely apply by examining the implications of a newborn baby living in a world with these demanding or self-sacrificing rules. Patients also can examine the consequences that have ensued because they have not demanded, or acted upon, their rights.

Cross-Reference to Other Techniques

Other relevant techniques include the double standard, asking others about their ideas regarding human rights (surveying opinions), cost–benefit analysis, vertical descent, and rational role plays.

Form

Form 4.13 (My New Bill of Rights).

I have a right to . . .	**Therefore I can . . .**
be human and make mistakes	*do a job that is less than perfect and feel satisfied with it. I can give myself credit for making progress. I can free myself from self-criticism.*
How would you be better off with this new bill of rights? *Less self-criticism, less worry, less dissatisfaction, less stress*	
If you had a son or daughter, what bill of rights would you like him or her to have for him- or herself? Why? *I would want my daughter to have less stress and to accept herself as human being who doesn't have to be perfect. I would want her to feel loved no matter what she achieved.*	

FIGURE 4.10. My new Bill of Rights.

FORM 4.1

Monitoring Your Assumptions, Rules, and Standards

It would be useful to examine your typical assumptions, rules, and standards. As you keep track of your negative thoughts over the next few weeks, see if you can identify any "should" statements, "if–then" statements, "musts," or rules. Write them in the form below, along with a figure representing how much you believe each of them (with 100% meaning you believe it fully). What is your underlying "should" statement? Do you have an underlying assumption such as "If this happens, then something else must be true"? At the bottom of the page, see if you can list any possible problems with these assumptions.

Examples of typical assumptions	**Endorsement of belief (0–100%)**
I must be perfect in everything that I do.	55%
If I fail at something, then I'm a failure.	75%
Failure is intolerable.	90%
To like myself, I must receive approval from everyone.	40%
My typical assumptions, rules, and standards:	**Endorsement of belief (0–100%)**
Problems with my assumptions:	

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FORM 4.2

Examining and Challenging "Should" Statements

Think about one of your typical "should" statements—such as, "I should have done better" or "I should be perfect" or "I should be beautiful." Answer each of the questions in this form. Think about how you could change your "should" statement into a preference—for example, "I would *prefer* to do better" rather than "I *should* do better."

"Should" statement:

Degree of belief (0–100%)

Emotion (and degree 0–100%)

Costs and benefits: Costs:

Benefits:

Who established this rule?

Do you apply this rule to everyone? Why not?

Restate this rule as a preference rather than a "should."

What would be a more reasonable expectation?

Re-rate belief and emotion: Belief:

Emotion:

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FORM 4.3

Identifying Conditional Beliefs

Area of concern	How much of a concern is this to you? (0–100%)	How I try to cope . . .
Example: Am I smart? (Intelligence)	95%	In order to be competent, I need to do better than everyone. Or If I avoid really challenging tasks, I won't fail.
Intelligence		
Attractiveness		
Closeness with others		
Trust in self or others		
Laziness in self or others		
Rejection by others		
Being controlled by others		
Being humiliated		
Knowing things for sure		
Being interesting		
Being alone		
Others:		

Examples of conditional or coping beliefs:

In order to be competent, I need to do better than everyone.

In order to be attractive, I need to be perfect in my appearance.

I need to keep control of all my emotions, or I will lose control completely.

If I'm cautious, I can avoid rejection.

If I give in to others, then they will like me.

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FORM 4.4

Evaluating Second-Level Assumptions

Sometimes we have a belief or assumption that we then follow up with another assumption. For example, some people think, "I shouldn't make a mistake," and then follow with, "And if I do make a mistake, then I should criticize myself." Or, "If something bad could happen, then I should worry about it ahead of time," and then follow up with, "I should keep thinking about it and not let my guard down." Use the form below to see if you can identify assumptions or rules that follow after other assumptions or rules.

If this happens	Then I think I should	And if that is true, then I should

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FORM 4.5

Values Clarification

Consider a current value that seems to be bothering you—for example, being financially successful. Contrast this value with each of the values in the left-hand column. Rank all of these values, from 1 to 17, with 1 for the most important, in the middle column. Use a different number for each value. In the right-hand column, list some ways that you could pursue these other values.

Current value I am upset about: _____

Value	**Rank (1–17)**	**How I can pursue this value:**
Love		
Forgiveness		
Family/intimate relationship		
Work achievement		
Friendship		
Financial success		
Self-esteem		
Personal growth		
Physical beauty or attractiveness		
Physical health		
Approval by others		
Kindness		
Fun		
Learning		
Religion		
Cultural endeavors		
Personal freedom		
Others:		

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FORM 4.6

Perfectionism Inventory

Please use the following options to rate how much you generally agree with each statement.

1	2	3	4	5
Strongly disagree	Disagree somewhat	Neither agree nor disagree	Agree somewhat	Strongly agree

1. My work needs to be perfect in order for me to be satisfied. (se1) _____
2. I am oversensitive to the comments of others. (na1) _____
3. I usually let people know when their work isn't up to my standards. (hso1) _____
4. I am well organized. (o1) _____
5. I think through my options carefully before making a decision. (p1) _____
6. If I make mistakes, people might think less of me. (cm1) _____
7. I've always felt pressure from my parent(s) to be the best. (pp1) _____
8. If I do something less than perfectly, I have a hard time getting over it. (r1) _____
9. All my energy is put into achieving a flawless result. (se2) _____
10. I compare my work to others and often feel inadequate. (na2) _____
11. I get upset when other people don't maintain the same standards I do. (hso2) _____
12. I think things should be put away in their place. (o2) _____
13. I find myself planning many of my decisions. (p2) _____
14. I am particularly embarrassed by failure. (cm2) _____
15. My parents hold me to high standards. (pp2) _____
16. I spend a lot of time worrying about things I've done, or things I need to do. (r2) _____
17. I can't stand to do something halfway. (se3) _____
18. I am sensitive to how others respond to my work. (na3) _____
19. I'm not very patient with people's excuses for poor work. (hso3) _____
20. I would characterize myself as an orderly person. (o3) _____
21. Most of my decisions are made after I have had time to think about them. (p3) _____
22. I overreact to making mistakes. (cm3) _____
23. My parent(s) are difficult to please. (pp3) _____
24. If I make a mistake, my whole day is ruined. (r3) _____
25. I have to be the best in every assignment I do. (se4) _____

(continued)

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26. I'm concerned with whether or not other people approve of my actions. (na4) _____
27. I'm often critical of others. (hso4) _____
28. I like to always be organized and disciplined. (o4) _____
29. I usually need to think things through before I know what I want. (p4) _____
30. If someone points out a mistake I've made, I feel like I've lost that person's respect in some way. (cm4) _____
31. My parent(s) have high expectations for achievement. (pp4) _____
32. If I say or do something dumb I tend to think about it for the rest of the day. (r4) _____
33. I drive myself rigorously to achieve high standards. (se5) _____
34. I often don't say anything, because I'm scared I might say the wrong thing. (na5) _____
35. I'm frequently aggravated by the lazy or sloppy work of others. (hso5) _____
36. I clean my home often. (o5) _____
37. I need time to think up a plan before I take action. (p5) _____
38. If I mess up on one thing, people might start questioning everything I do. (cm5) _____
39. Growing up, I felt a lot of pressure to do everything right. (pp5) _____
40. When I make an error, I generally can't stop thinking about it. (r5) _____
41. I must achieve excellence in everything I do. (se6) _____
42. I'm self-conscious about what others think of me. (na6) _____
43. I have little tolerance for other people's careless mistakes. (hso6) _____
44. I make sure to put things away as soon as I'm done using them. (o6) _____
45. I tend to deliberate before making up my mind. (p6) _____
46. To me, a mistake equals failure. (cm6) _____
47. My parent(s) put a lot of pressure on me to succeed. (pp6) _____
48. I often obsess over some of the things I have done. (r6) _____
49. I'm often concerned that people will take what I say the wrong way. (na7) _____
50. I often get frustrated over other people's mistakes. (hso7) _____
51. My closet is neat and organized. (o7) _____
52. I usually don't make decisions on the spot. (p7) _____
53. Making mistakes is a sign of stupidity. (cm7) _____
54. I always felt that my parent(s) wanted me to be perfect. (pp7) _____
55. After I turn a project in, I can't stop thinking of how it could have been better. (r7) _____
56. My workspace is generally organized. (o8) _____
57. If I make a serious mistake, I feel like I'm less of a person. (cm8) _____
58. My parent(s) have expected nothing but my best. (pp8) _____
59. I spend a great deal of time worrying about other people's opinion of me. (na8) _____

(continued)

Scoring Directions for the Perfectionism Inventory

1. Concern Over Mistakes (8 items) AVE Items: 6 14 22 30 38 46 53 57
2. High Standards for Others (7) AVE Items: 3 11 19 27 35 43 50
3. Need for Approval (8) AVE Items: 2 10 18 26 34 42 49 59
4. Organization (8) AVE Items: 4 12 20 28 36 44 51 56
5. Perceived Parental Pressure (8) AVE Items: 7 15 23 31 39 47 54 58
6. Planfulness (7) AVE Items: 5 13 21 29 37 45 52
7. Rumination (7) AVE Items: 8 16 24 32 40 48 55
8. Striving for Excellence (6) AVE Items: 1 9 17 25 33 41

---

9. Conscientious Perfectionism Sum Scales: HSO, O, P, SE
10. Self-Evaluative Perfectionism Sum Scales: CM, NA, PP, R
11. PI Composite: Sum of all 8 PI scales

Interpretation: Normative data described at *www1.appstate.edu/~hillrw/Perfection.Inventory.JPA.pdf.* Generally, scores 1 *SD* above the mean would represent Higher scores, while 1 *SD* below the mean would reflect Lower scores. PI Scale means, undergraduate sample (N = 366):

Scale	Items	Mean	*SD*
Concern Over Mistakes	8	2.46	.75
High Standards for Others	7	2.83	.78
Need for Approval	8	3.22	.77
Organization	8	3.5	.86
Perceived Parental Pressure	8	3.17	.89
Planfulness	7	3.4	.76
Rumination	7	2.83	.82
Striving for Excellence	6	3.1	.80
Conscientious Perfectionism		12.83	2.41
Self-Evaluative Perfectionism		11.68	2.61
PI Composite	59	24.51	4.40

(continued)

Perfectionism Inventory Scales, Construct Definitions, Sample Items, and Expected Relationships with MPS Scales

Perfectionism Indicator Scale	*Construct Definition*	*Sample Item*
Concern Over Mistakes	Tendency to experience distress or anxiety over a mistake	"I am particularly embarrassed by failure"
High Standards for Others	Tendency to hold others to one's own perfectionist ideals	"I get upset when other people do not maintain the same standards I do"
Need for Approval	Tendency to seek validation from others and to be sensitive to criticism	"I compare my work to others' and often feel inadequate"
Organization	Tendency to be neat and orderly	"I always like to be organized and disciplined"
Perceived Parental Pressure	Tendency to feel the need to perform perfectly to obtain parental approval	"My parents hold me to high standards"
Planfulness	Tendency to plan ahead and to deliberate over decisions	"I tend to deliberate before making up my mind"
Rumination	Tendency to worry about past errors, less than perfect performance, or future mistakes	"I spend a lot of time worrying about things I've done, or things I need to do"
Striving for Excellence	Tendency to pursue perfect results and high standards	"I drive myself rigorously to achieve high standards"

FORM 4.7A

Costs and Benefits of Progress and Perfection

Sometimes we make life difficult because we demand perfectionism of ourselves or others. Consider something you seem perfectionistic about, and then contrast the costs and benefits to you of accepting progress versus demanding perfection.

Behavior I demand perfection in: _____

	Accepting progress	**Demanding perfection**
Costs:		
Benefits:		
Conclusions:		

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FORM 4.7B

Making Progress Rather Than Trying for Perfection

Identify some areas in your life that you criticize yourself about—for example, your performance in school or work. Then list some actions you could take to make improvements in this area—for example, study harder, prepare, work more, learn some skills. List a number of areas of self-criticism and a number of specific actions you could take to improve those areas.

What I criticize myself about	How I can make progress

Why would progress be better than pursuing perfection?

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FORM 4.8

Learning from Lapses

Consider a behavior that you have been making progress on—for example, exercise, diet, drinking less, smoking less, etc. Write it down in the first column (e.g., "Exercising three times per week"). In the middle column, write down what made you lapse from your desired behavior (e.g., "I was too tired to exercise"). In the right-hand column, write down what you learned to make things better (e.g., "I can exercise even if I am tired" or "I can pick up my exercise routine tomorrow"). Lapses or relapses are learning experiences.

The behavior I am concerned about is: _____

What was working before	What made me lapse	What I learned to make things better in the future
What are the advantages of using lapses or mistakes as learning experiences?		
What are the disadvantages?		

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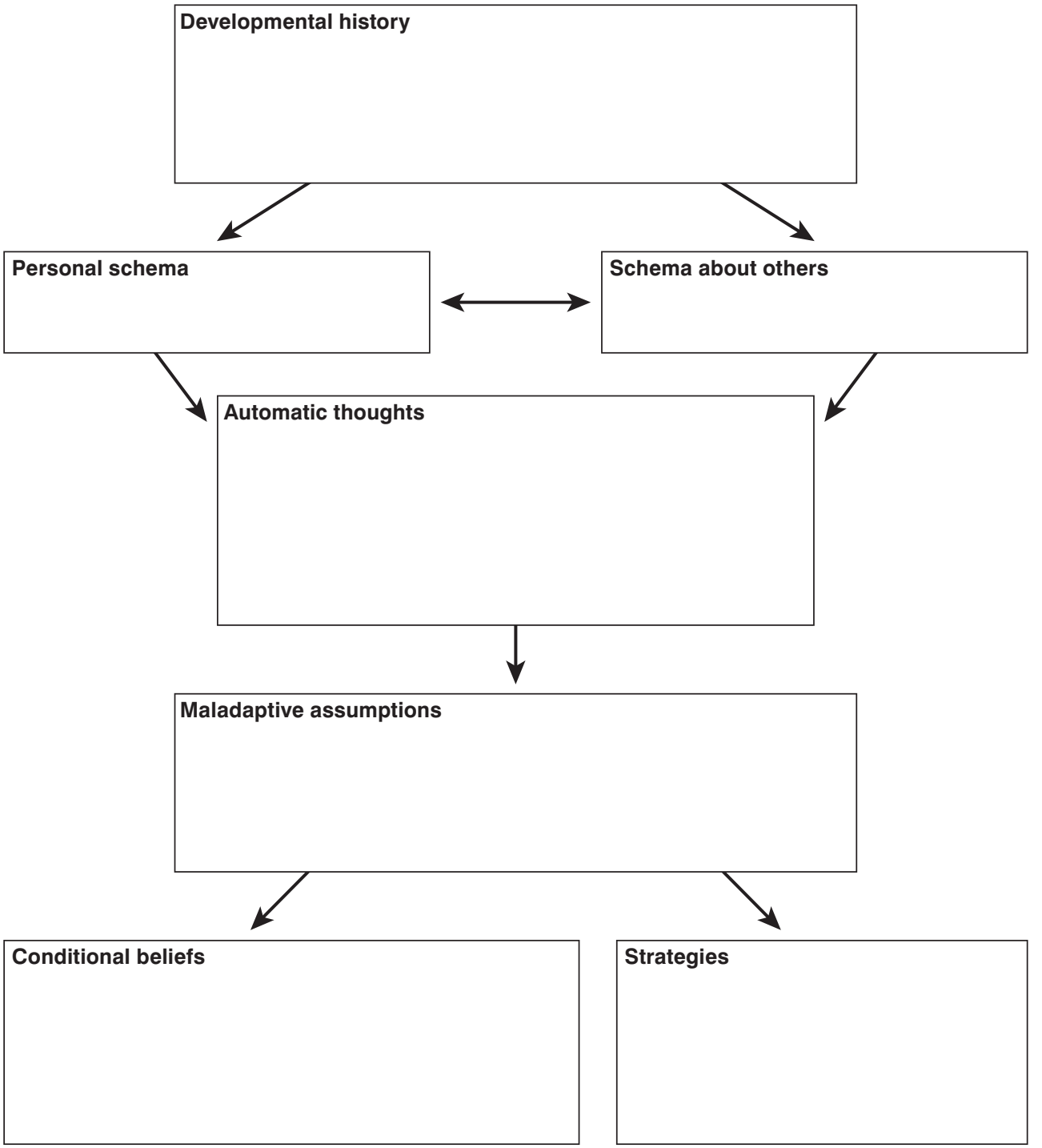
FORM 4.9

Case Conceptualization Diagram



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FORM 4.10

Examining the Implications of Perfectionism

Sometimes we believe that if we achieve perfectionism at something, then certain beneficial things will follow. We may believe that we will be admired or loved, feel satisfied, gain high self-esteem, or feel secure. Let's look at what achieving perfection or demanding standards will mean for you.

If I achieve perfection in this activity	**Then the following will be true**
How likely is it that seeking perfection will lead to the outcomes that you desire? Describe the problems with this approach.	
How often have you actually achieved perfection? Why has it been so difficult?	

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FORM 4.11

Turning Work into Play: Changing Criticism and Disappointment into Curiosity

In the left-hand column, write down some examples of negative judgments and criticisms you make about yourself or other people. In the right-hand column, write down some ways you could develop curiosity about the issues in the other column. For example, "My boss is cruel. She doesn't seem friendly at all" is a judgmental thought. Thoughts reflecting curiosity might be "I wonder why that bothers me?" and "I wonder if there are times when she is friendlier? If so, why would that be?"

Behavior that I think of in terms of evaluation: _____

Critical thoughts	**Thoughts of curiosity and challenge**
What would be the advantage of having thoughts about curiosity and challenge?	

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FORM 4.12

Changing Old Rules/Assumptions into New Rules/Assumptions

Sometimes the rules we have for ourselves are inflexible, unfair, unrealistic, and difficult to live by. In the form below, look at the criteria for evaluating one of your rules. For example, is it flexible? Is it fair? Now in the second column list some of your old assumptions. Rate each assumption on the criteria from 0 to 10, where 10 represents the best possible rating. Write out a new assumption in the fourth column and rate it from 0 to 10, as you just did for the old assumption. When you're finished, consider this question: What would change for you if you had this new adaptive assumption?

Criteria	Old assumption	Rate criteria	New adaptive assumption	Rate criteria
Flexible				
Fair				
Realistic				

(continued)

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Changing Old Rules/Assumptions into New Rules/Assumptions *(page 2 of 3)*

Criteria	**Old assumption**	**Rate criteria**	**New adaptive assumption**	**Rate criteria**
Positive				
Growth-oriented				
Help achieve positive goals				
Enhance self-esteem				
Rule I would apply to everyone				

(continued)

Evaluating and Acting on More Adaptive Rule/Assumption

New Rule or Assumption: _____

Costs	Benefits	Behaviors to do
What would I be more likely to do if I believed this new assumption?		
What would I be less likely to do if I believed this new assumption?		

FORM 4.13

My New Bill of Rights

It is important to know and exercise your rights. In the left-hand column, list the rights you believe you should have. In the right-hand column, list the ways you can pursue these rights. Think of "action plans" for yourself—actions you could take in the future to make sure that your rights and needs are met.

I have a right to . . .	**Therefore I can . . .**
How would you be better off with this new bill of rights?	
If you had a son or daughter, what bill of rights would you like him or her to have for him- or herself? Why?	

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CHAPTER 5

Examining Information-Processing and Logical Errors

Cognitive theory proposes that anxiety and depression are maintained and augmented by biases and distortions in information processing. As I discuss in Chapter 10 on identifying and modifying schemas, the cognitive model suggests that individuals selectively attend to and recall information consistent with preexisting beliefs. In this chapter, I focus on errors in information processing that result in a selective confirmation of negative beliefs, and I examine typical logical errors that lead individuals to go beyond the current information to draw negative conclusions.

TECHNIQUE: Confirmation Bias

Description

The nature of schematic processing is that we tend to seek out information that is consistent with our belief or schema. Thus, if I think I'm a loser, I will automatically attend to, focus on, and value information that is consistent with that belief. This is not an intentional process or even a process of which one is conscious, but rather an automatic process that occurs rapidly and serves to strengthen the preexisting belief (Gotlib & Neubauer, 2000; Bargh & Morsella, 2008; Beck & Haigh, 2014). The confirmation bias may affect attention, amount of time focused on information, memory, the degree to which the information is heavily "weighted" in forming an impression, and the centrality of the information in forming concepts of traits or general characteristics. This ongoing bias in attention and memory continues "in the background," below one's conscious awareness of the bias, only to magnify the preexisting belief. Cognitive psychologists refer to this particular pattern as "confirmation bias." In lay terms, it is looking only for information that is consistent with our beliefs. Thus, if we believe that people with blue eyes are nasty people, we will notice any information that confirms the belief and then stop looking. In the search process, we may ignore any information that is inconsistent with that belief (see Simon, 1983).

Questions to Pose/Intervention

"We often have preexisting beliefs that are negative when we are depressed or anxious. For example, you might have the belief, 'I'm a failure.' Because you have this underlying belief, you might be biased toward paying attention to or recalling information that is consistent with that belief. You might find it easier to remember past mistakes that you made, or you might find yourself primarily focusing now on things that are not working out or even predicting that the future will be bad. This tendency to be biased in the way we focus is known as 'confirmation bias' or 'negative bias.' It is sometimes called 'My-side Bias' because we automatically focus on information consistent with 'My View.' It's not that you are doing this intentionally and it's not that you want to feel badly; it's simply an automatic and very immediate way of thinking. We can examine if you seem to be primarily focused on one thing—that is, something negative—and whether this might continue to reinforce your preexisting beliefs. After all, if you only focus on the negative, you will only notice the negative. But maybe there are other things going on."

Example

THERAPIST: Sometimes people have a habitually negative way of looking at things, and they may find themselves remembering negatives and paying attention to negatives in their current life. It's kind of a habit of thinking. Does this ever characterize your thinking?

PATIENT: Yeah, my wife says I tend to be really negative a lot of the time.

THERAPIST: Well, it's kind of a negative filter where you are looking at the world through tinted glasses—in this case, the glasses may be very dark and you might find yourself immediately remembering negative things and seeing negative things today. In fact, because of that filter, you might even predict negatives. Does that seem to be what might be going on?

PATIENT: It seems like a relentless string of negatives for me at times.

THERAPIST: And, so, if you had this preexisting belief that you come back to, "I'm a failure," and your filter is only negative, it will just keep confirming that negative belief and make it even stronger, won't it?

PATIENT: Yes, that seems like what is happening. But these things really are true. I didn't do well on that project. I'm not just making it up, you know.

THERAPIST: No, it's not that you're making up anything. These memories may very well have some accuracy to them, but it may be that you are primarily looking at the negatives to the exclusion of other things. And this confirms your more general belief that you are a failure. We call this tendency a "confirmation bias" because you are selectively focused on confirming your negative beliefs. It's not conscious or intentional—it's just simply an automatic bias or habit.

PATIENT: I'm not trying to make myself feel bad, am I?

THERAPIST: No, not at all, it's just a habit of thinking that some people have. So what we have to find out if this is something that might be going on and, if it is, then we might see if there are some ways of making your thinking more accurate and balanced.

PATIENT: You're not telling me just to think positively, are you?

THERAPIST: No, I can see how people might think that. No, I'm suggesting that we try to see if you are looking at only one side of things to the exclusion of other things that might be going on. In a sense, I'm suggesting that if you have that habit of thinking and focusing on the negative, then

it might not be the most realistic way of thinking. So, you might say, I'm suggesting that, rather than think positively, we want to see if there is a more *realistic* and *balanced* way of thinking.

PATIENT: I guess that makes sense. Maybe I have been focusing on the negative too much.

Homework

The therapist can suggest that the patient keep track of times during the week when he or she felt sad, anxious, or angry and to write out what he or she was thinking at the time. Then the patient can examine if these emotions were related to a string of negative thoughts. In addition, the therapist can ask the patient to describe the first thoughts or images that come to mind in thinking about the him- or herself, whether in terms of current experience or the future. Is it easier to come up with negative thoughts than positive or even neutral thoughts? The patient can list the advantages and disadvantages of having a negative bias. Form 5.1 can be used to track the confirmation bias toward the negative.

Possible Problems

As mentioned above, some patients may claim that their thinking is realistic, because they may actually be recalling real events. Perhaps the patient did fail an exam or did get rejected by someone. The therapist can suggest that real events can, of course, be negative, but that it also may be that negative experiences are what the patient primarily remembers and focuses on, perhaps to the exclusion of other neutral or even positive events. One way to illustrate this point is to ask if the patient finds that other people view the events/experiences that have occurred in less negative ways, or if other people attempt to bolster the patient's mood by pointing out positives. If they do, then perhaps others are looking at the events in a more balanced manner because they do not have the negative schemas and confirmation bias that may be making things difficult for the patient.

Cross-Reference to Other Techniques

Other relevant techniques include categorizing automatic thoughts, examining the evidence for and against, role playing against the thought, creating positive narratives about positive outcomes, seeing the perceived negative event/experience from another person's perspective, and mood induction to change the mood affecting the bias.

Form

Form 5.1 (Examining Confirmation Bias).

TECHNIQUE: Limited Search

Description

When people are depressed or anxious, they are likely to automatically search for evidence that is negative, and once they have confirmed their negative belief, they discontinue looking for additional information. Similar to the confirmation bias described above, this limited search habit precludes the possibility of finding evidence that would disconfirm the original negative belief.

The therapist might explain this concept as follows: "We are going to explore something called 'limited search,' which is a quality of information processing that limits your awareness and focus to proving that your depressive or anxious thought is true. For example, let's suppose that your negative thought is 'I'm a failure.' In order to confirm that thought, you might focus only on information that shows your failures. Once you get a hold of evidence that you have failed, *you stop looking* for any other information—especially information that shows that you have succeeded. Consequently, you say to yourself 'See, I've failed'—as if you have proven, beyond any doubt, that you are a failure. As I described before, this is what is called 'confirmation bias.' But, just as important as your bias in focusing on the negative is that you give up looking for information that might prove that your belief is false or at least imbalanced. You just don't look at all the information that might be available.

"Compare this highly selective process to the search function on your computer. What if I asked my search function to find any mention of the word 'failure'? It would then find countless places in the millions of sites where the word 'failure' appears. If I possess a limited search schema, I might conclude that all I'm writing about is failure. [In fact, as I am writing this material, there are 10,095 words in the chapter, but the word 'failure' is mentioned only 24 times, meaning that 10,070 words are different from that word.]

"Depressive and anxious thinking, driven by biased information processing, is almost always characterized by limited search. When you are anxious, you might wonder, 'Is it possible that I could make a mistake?' Since it is always *possible* to make a mistake, the answer would be, 'Yes,' which would lead you to stop looking for more information and quit now! Limited search leads to limited behavior. Confirmation bias leads you to focus on information consistent with the negative belief, and limited search leads you to give up looking for information that goes against your belief. It's not that you want to be depressed or anxious, it's just an automatic 'rule' that you have—'Once I find the negative, stop looking for any other information.'"

I use the following explanation for professionals: "Consider the following example, taken from an elementary course in statistics in which we examine chi square. Let's say you notice that there are 15 examples of blondes who are intelligent and then conclude that blondes are intelligent. However, you might want to ask other questions: 'Are there blondes who are not intelligent? Are there brunettes who are intelligent? Are there brunettes who are not intelligent? How about other people?' You then come up with the following table:

	Blondes	Brunettes	Bald
Intelligent	15	30	10
Not intelligent	15	30	2

"Much to your surprise, you learn that, in this sample, half of the blondes are intelligent, as are half of the brunettes. In fact, there are twice as many brunettes who are intelligent, but only because there are two times more brunettes than blondes in the sample. Most interesting to those who are not bald, an overwhelming number of bald individuals are intelligent, even though they are the fewest in the sample.

"Most people do not examine all the possibilities of the chi square or of sampling bias. For example, if you are depressed, you might emphasize the fact that you failed at something and conclude that you are a failure, even though it would be useful to look at the following table, which argues against your conclusion:

	Self	Others
Tasks failed	3	30
Tasks succeeded	57	70
Total tasks	60	100

"In examining the table, you might observe that you did fail at 3/60 tasks (5%), whereas others failed at 30/100 tasks (30%). The search for information may be so limited that you see only the cell in which you have three failures and conclude that you are a failure. However, a more complete and accurate search might lead you to examine the possibility that you also succeeded on 60 tasks and that the 'norm' is 30% failure (much higher than your 5% failure rate). Let's imagine that you had the belief that all swans are white and you go out to the park and notice five white swans. You swiftly conclude, 'See, all swans are white.' But this single and very limited experience does not prove that you are correct. There may be black swans, and if you kept looking elsewhere, you would find them.

"Consider the following example, imagining it occurring in your own practice. Let's say that you have just heard that a patient is terminating therapy. Your first thought is, 'I didn't help that patient.' You then feel awful. However, what if you looked at your entire caseload for the past year and found that 80% of your patients do not terminate prematurely. You would feel better. And what if you find out that for other therapists, only 40% do not terminate prematurely. You would feel compassion for your colleagues but better for yourself. (Of course, the numbers could work against you if the outcome were different.)"

The key elements in recognizing this limited search habit are the following: (1) You may be giving up searching for information once you have 'confirmed' the negative; (2) the result of this is that you reduce the opportunity to weigh and consider all the information; (3) you inadvertently reinforce the negative belief; and (4) you reduce the chance of disconfirming the belief. In fact, good science looks for opportunities to prove that a statement is *false*—it attempts to falsify a statement by setting up an experiment to attempt to prove that the statement is not true (Popper, 1959).

Questions to Pose/Intervention

"To determine if you are engaging in a pattern of limited search, you might ask yourself the following questions: 'How would I go about looking for information that is inconsistent with my negative belief? What information is inconsistent with my negative view?' In addition, consider the costs and benefits to you of limiting your search to the negative. Lastly, given that you are predicting a negative outcome, what positive or neutral outcomes could you also predict?"

Example

THERAPIST: You said that you are feeling really bad right now because you did poorly on the chemistry exam. What did you get?

PATIENT: I got 75%. That's failing for me. And I also got a 70% on the other quiz in the course.

THERAPIST: What do you conclude from these grades?

PATIENT: I'm really an idiot.

THERAPIST: What is your average grade so far?

PATIENT: I'm averaging about an A– in about 25 courses.

THERAPIST: So you were focusing only on the grades from these two tests?

PATIENT: Yeah.

THERAPIST: What's the average grade in your school?

PATIENT: About B-level work. I'm doing better than average.

THERAPIST: When you do a very limited search and focus only on these two tests you didn't do well on, you ignore all the other information. Are you aware of this?

PATIENT: I was just looking at these tests.

THERAPIST: What if you looked at all the tests that you and your classmates take. What would you conclude?

PATIENT: I'm doing fairly well.

THERAPIST: Sometimes, when we are depressed, our thinking is so biased that we focus only on the negative, and we don't look for any positive information. Perhaps the glass is both half empty *and* half full.

Homework

Since patients may be limiting their search for information to the negative pole, the goal in the homework is to see if they can find evidence that balances or "falsifies" the negative. The therapist can ask patients to examine the possible advantages and disadvantages of expanding the search to include more information that might contradict the negative belief. The therapist can ask patients to list disappointments and negative thoughts about their performance on some task or problem. Then they are instructed to look for additional evidence that refutes those thoughts, and evidence for and against the idea that others do well or poorly on these tasks. Additionally, the therapist can ask for other negative thoughts about the self, about past or current experience, and then generate possible positive or neutral information to counterbalance the negative. Patients can use Form 5.2 to examine alternative positive information and to evaluate whether they are prone to a limited search of information that is consistent only with a negative thought. Figure 5.1 offers an example of how one patient used that form.

Possible Problems

Some patients argue that this more exhaustive search for information is just rationalization about negative behavior that is real, say, for example, "After all, it is a fact that I didn't do well." The therapist can indicate that it is also a fact that other facts exist—and that a more accurate picture can be drawn only if all the information is used. Perfectionistic patients may protest that their "failure" on

Negative belief or prediction	Examples in favor of belief	Examples against belief
I'll never get this work done.	I haven't finished it yet and it's due tomorrow afternoon. I feel confused and I don't think I'll be able to concentrate.	I usually get things done at the last minute. I've had this kind of project before and I've done OK.

FIGURE 5.1. Using all the information.

a single task is intolerable. In response, challenges to perfectionism can be utilized, such as "Exactly what will happen as a result of not doing well?" and "What will remain the same?"

Cross-Reference to Other Techniques

Other useful interventions include challenging dichotomous thinking, thinking along a continuum, the double-standard pie, and the semantic technique.

Forms

Form 5.2 (Using All the Information).

TECHNIQUE: Ignoring Base Rates

Description

To determine the risk in any given action, we generally ask ourselves, "What are the chances that this might not work out?" But how do we get the information to assess the odds? Kahneman (1995) and Tversky and Kahneman (1974, 1979) have indicated that most of us place undue emphasis on information that is recent, salient, and personally relevant. We ignore abstract information about "base rates"—that is, the frequency distribution of events in the entire sample under consideration. For example, in considering how dangerous it is to fly, anxious travelers, hearing of a plane crash that day on the news and watching the burning wreck of the airplane, immediately conclude that the airplane they are due to board the next day is likely to crash. They have ignored the base rate—that is, that air travel is considerably safer than any other means of traveling the same distance. Because the information on the news is recent, salient (burning wreckage), and personally relevant (flying tomorrow), its impact is greater than the abstract information conveyed in statistical tables.

We ignore base rates all the time. For example, American women are likely to overestimate their weight compared to others, and almost all Americans believe they are middle class, regardless of their economic position. Tversky and Kahneman (1974) found that most people use irrelevant information to "improve" their estimates of the likelihood of an event. Similarly, anxious travelers will place great emphasis on any noises onboard the airplane when estimating the perceived danger posed.

Many people who are depressed or anxious believe that their psychiatric problems are unusual, even though national surveys reveal that half the population has experienced a psychiatric condition. In evaluating an individual's ability to assess performance or judge the risk posed by certain behaviors, it is useful to examine first which base rates the individual is employing—knowingly or unknowingly.

Questions to Pose/Intervention

"When something unpleasant happens, we often focus only on the negative in the moment, and we ignore how often something like this happens, in general, to everyone else. For example, a person might fear that a current headache means that she or he has a brain tumor—but we would want to know what percentage of people, in general, who have headaches also have brain tumors. We call this information 'base rates.' It tells us how often something is generally true. Let's take the area

you are worried about. Consider how base rates are relevant to your fear of flying. How often do airplanes crash? What percent of the time is a crash occurring in the real world?"

Example

PATIENT: I'm really afraid of flying next week. I just saw that there was a near-miss at the airport.

THERAPIST: Near-misses are scary, but what did that lead you to believe?

PATIENT: Flying is dangerous. There was that airplane that blew up last year over Long Island.

THERAPIST: It sounds like you are focusing on two very newsworthy stories. Are you concluding that these events indicate that flying is now dangerous?

PATIENT: I guess I am.

THERAPIST: If we wanted to know if flying were dangerous, shouldn't we examine the number of people killed per miles traveled? Or, perhaps we could examine the number of flights that take off that end in a crash.

PATIENT: I guess that would be the logical thing to do.

THERAPIST: Well, first, we know that flying is far safer, per mile traveled, than all other means of transportation.

PATIENT: Yeah, I've heard that. But it's still frightening to me.

THERAPIST: Did you know that 65 million passengers flew in and out of O'Hare Airport in Chicago last year and no one was killed?

PATIENT: That's interesting.

THERAPIST: Or that you could fly, round-trip every day, for 45,000 years on a commercial airline before your "number" came up?

PATIENT: It sounds safer than I thought. But how about that crash off Long Island?

THERAPIST: What makes it newsworthy is that an airplane crashed. Do you think they'd want to interview the 65 million passengers who landed safely at O'Hare and ask them how they felt about nothing happening?

Homework

The therapist can elicit patients' estimates of base rates by asking "What percent of the time does *X* occur?" or "What percent of the population has *X*?" These figures can be extrapolated into conclusions that the patient may find difficult to defend. For example, the patient mentioned above claimed that the chances were 1% of any plane crashing. Since several hundred planes would be arriving or leaving New York every day, we would then conclude, given her "guesstimated" base rate, that several planes would crash every day in New York. This percentage was untenable to her.

Patients can use Form 5.3 to examine estimates and base rates. (See Figure 5.2 for an illustrative example.) Patients write down their prediction—for example, "The plane will crash"—and then their estimate of the percentage of times their feared outcome occurs, in general—for example, 1%. Similarly, the form can be used to make a needed comparison. For example, the patient who believes that he is poor writes that statement in the left-hand column (i.e., "I'm poor"), and in the right-hand column notes his estimate of the average income in the population. The therapist can use a normal distribution curve to illustrate where patients believe they place in comparison to others.

Prediction or negative belief	What is the likelihood that this is true in the population? (0–100%)
The plane will crash.	20%

What sources of information can you use to find out the likelihood of something being true? I can look up the number of planes that have crashed in the past year and the number of flights.
Are you overestimating the likelihood of something being true or coming true? Yes. There are tens of thousands of flights and no commercial fatalities in the United States this past year.
What if you were to look at events in terms of the probabilities that actually exist? I would feel a lot less anxious. I guess I was getting anxious about the Russian plane that was blown up in Egypt.

FIGURE 5.2. Estimates of the likelihood of events.

Possible Problems

Problems include the demand for certainty—"I could be the one!" This kind of demand directs the therapist to examine the costs and benefits of demanding certainty versus the value of acceptance and to practice flooding. Another problem involves patients' impression that this intervention is invalidating. The therapist can explain that the purpose of this exercise is to examine all the information in order to achieve a valid interpretation of events.

Cross-Reference to Other Techniques

Other relevant techniques include examining costs and benefits, evidence, overgeneralization, catastrophizing, double standard, and conducting an exhaustive search.

Form

Form 5.3 (Estimates of the Likelihood of Events).

TECHNIQUE: Examining the Logic

Description

Much of depressive and anxious thinking is characterized by illogical conclusions. Consider the following:

> "I'm single, therefore I'm unlovable."
> "I failed at the test, therefore I'm a failure."
> "Since bad things *can* happen, they *will* happen."

"If Bill doesn't like me, then I'm worthless."
"If good things happen to me, then something bad is likely to follow."

Illogical conclusions often are prefaced by "because" or "therefore." Much of depressive thinking begins with an observation of a fact and then draws a negative conclusion that does not logically follow from the fact. Logical errors include:

Extrapolating from a single instance to a universal generalization.
Identifying a single behavior with the entire person.
Confusing possibility with necessity or probability.
Believing that all events are interdependent with one another (i.e., a good event must be compensated by a bad event).

Examples of challenging illogical thinking include:

Examine internal contradictions: "Do you hold two thoughts that are self-contradictory? For example, 'I should be perfect, but I don't want to criticize myself' or 'I'd like to meet as many people as possible, but I never want to be rejected.'"
Reductio ad absurdum: "Look at the logical implication of your beliefs—is it absurd? For example, 'If I'm single, then I'm unlovable.' Implication: 'All people who are married were once single; therefore, all married people are unlovable.'"
Challenge recursive self-criticism: "Examine whether you are locked in an inescapable loop of criticizing yourself for being self-critical. For example, 'I think I'm a loser because I'm depressed, and I'm depressed because I think I'm a loser.'"

Questions to Pose/Intervention

The therapist can ask patients the following questions:

"Given these facts, what conclusion are you drawing?"
"Are any other conclusions possible? Is it at all possible to imagine another outcome?"
"Could someone else imagine another outcome different from your prediction/conclusion?"
"Are you confusing a possibility with a necessary outcome? With a probability?"
"Has what you thought could never happen, ever actually happened?"
"When you predict that one event will cause another event, how does it actually cause the other event? Is there a physical force involved? Is there any communication between events?"
"Would you apply your conclusion to everyone [every situation]?"

Example

THERAPIST: You said that you think you are worthless because you are single. Would you agree that everyone who is married was once single?

PATIENT: Yes. Of course.

THERAPIST: So, from your logic—that is, if you are single, then you are worthless—it follows that everyone who is married got married to a worthless person, and they were both worthless until they got married.

Or, consider the following:

THERAPIST: You said that since it is possible the elevator could crash, then it probably will crash.

PATIENT: I know it sounds foolish, but that's how I think.

THERAPIST: Is it possible that an extraterrestrial could land on your head?

PATIENT: I guess it's possible, but I've never seen one.

THERAPIST: You've never seen an elevator crash either. But both events are possible. The question is, "How *probable* are these events?"

PATIENT: I don't know. With the extraterrestrial, very improbable. I don't know about the elevator crashing.

THERAPIST: Well, how often have you heard of an elevator crashing?

PATIENT: I've never heard of it.

THERAPIST: Would it be reasonable to think that it is improbable—very improbable?

PATIENT: Yeah, I guess so.

THERAPIST: What would happen if you thought that everything that was possible was probable?

PATIENT: I'd worry all the time.

Homework

The therapist can use Form 5.4 to help patients assess common distortions in conclusions. This form can be explained as follows: "We all make common mistakes in how we reason or how we draw conclusions. I'd like you to examine some of the negative thinking you have and identify some problems with this thinking. For example, imagine that you go to a party and someone is not friendly to you. If you are really negative, you might conclude, 'No one likes me.' The error in your thinking is that you are drawing a conclusion about everyone from an experience with a single person."

Possible Problems

Some patients claim that their negative conclusions are really accurate. The homework exercise is aimed at examining the logic of such inferences or conclusions. We also can examine the empirical validity of these thoughts by considering the evidence for and against the thought or by examining the underlying assumption (e.g., "I should get the approval of everyone").

Cross-Reference to Other Techniques

Other relevant interventions include identifying the underlying assumption, double-standard technique, examining the conditional rules, and evaluating the evidence for and against the validity of a thought.

Form

Form 5.4 (Examining Logical Errors).

TECHNIQUE: Linking Unrelated Events and Seeing Patterns That Are Not There

Description

Almost all of us have, at some time, linked two events that are actually unrelated to one another and concluded that one is a cause of another. Whether we call this magical thinking, superstitious thinking, or simply human nature, we are generally searching to identify causes of events that may or may not be within our control. The tendency to see patterns that are not there is part of schematic processing and helps reduce the information overload that affects all of us. Moreover, as noted, many individuals are driven toward confirmation bias in their thinking, looking for evidence that will confirm their negative views. Illusory correlations, categorical statements, and the perception of patterns and trends that are not there may contribute to feelings of anxiety and depression—even when there is ample evidence, potentially available, that is countervailing. The therapist's task is to dispute these illusory correlations and false patterns.

Often we believe that two events are related to each other simply because we have observed that Event 1 occurs with Event 2 some of the time. For example, we may be anticipating taking a plane to Florida, leaving New York next Saturday. We hear on the radio that an airplane has crashed at Kennedy Airport. We recall that an airplane was hijacked from Indonesia 12 months ago. The conclusion that we draw is that there is a high probability that another plane will crash or be somehow be waylaid near Kennedy Airport. This is the illusion of correlation—we attribute a significant predictable relationship between two events when, in fact, there may be no predictability.

People who are anxious are prone to this illusion of correlation, often resulting in magical thinking: "I wore that red tie when Susan broke up with me. It must be bad luck to wear that tie." Or the individual might think: "When I'm in an elevator, I need to check for sounds that signify danger. I've been doing that for years now and no elevator I've been in has ever crashed."

The problem with illusory correlation is that the pattern of relationship in which we established a belief may not exist. For example, if we are trying to predict whether the elevator will crash, then we would want to know how likely is it that the elevator will crash when we are not checking for odd sounds. Thus, the obsessive "checker" might conclude, "The elevator didn't crash because I was checking." If we want to know how dangerous it is to fly from JFK Airport, we need to know how many planes took off and landed safely. In other words, we need to look at the probability of an event in the presence and absence of another event.

Questions to Pose/Intervention

"You are concluding that because two events occur in time, one is a cause of the other. Imagine if you went into a house and noticed that there were ashtrays everywhere. Would you conclude that ashtrays cause people to smoke? Or suppose you recognized that Mary wore a red dress on Mondays. Would you conclude that wearing a red dress caused the work week to begin? Think of some of the things you are linking together as a cause of each other. For example, you said, 'I noticed that a plane crashed; therefore planes must be crashing a lot now.' In order to test whether one thing is a cause of another, we have to examine the many times in which one thing does not occur while another thing does. For example, if you had a fear of flying, you might think flying was dangerous because you read a recent story about a plane crash. However, how would you account for the millions of times people fly when planes do not crash?"

Another way to word this explanation: "You seem to think that these two events are related to one another. For example, you think that generally when *X* happens, *Y* will follow. Perhaps you even

think that one is a cause of another. However, in order to test out this possible correlation, we need to know how likely is *Y* to happen when *X* does not happen."

Example

The patient was a professional investor who worried about the volatility of his stocks.

THERAPIST: You are concerned about your compulsion to watch the screen several hours a day, to see if your stocks have gone up or down. Let's explore why you do that.

PATIENT: I guess my thought is that I can catch something earlier.

THERAPIST: Is there a risk of trading too frequently in your stocks because you are anxious?

PATIENT: Definitely. I've lost a lot of money that way.

THERAPIST: What happens with your stocks when you are away from the desk?

PATIENT: They do whatever they will do. I'm no worse off. I remember worrying about going away on vacation, and when I returned, my stocks were actually up.

THERAPIST: So you have the illusion that watching stocks keeps them from going down and that you can catch something early?

PATIENT: Yeah.

THERAPIST: Would you be willing to limit the time that you screen-watch? Let's see, over the next month, if your stocks go up or down when you are watching versus not watching.

PATIENT: OK.

This patient decreased his screen-watching time, which he spent looking for illusory correlations and patterns that were not there. Needless to say, his decreased viewing had no effect on the direction of his stocks, but it did help decrease his panic-driven trading practices. Another example of illusory correlation or false pattern recognition is the following:

THERAPIST: You seem to think that there is a lot of danger in flying. You just heard on the news that a plane crashed at JFK Airport.

PATIENT: Yes, I can remember back in September when those planes were hijacked.

THERAPIST: That's true. That was a terrible tragedy. Are you thinking it's dangerous to fly?

PATIENT: Yeah. The planes are being blown up or crashing. It seems to be happening a lot now.

THERAPIST: What do you base that conclusion on?

PATIENT: Well, the plane crashed recently, and then the two planes were hijacked in September.

THERAPIST: Do you think the recent crash was related to the hijacking?

PATIENT: No, they said it was some kind of technical problem. Something about weakness in the structure of the plane.

THERAPIST: So these events are unrelated?

PATIENT: Yeah.

THERAPIST: How many planes take off and land at JFK in a month?

PATIENT: Thousands.

THERAPIST: How about in a year?

PATIENT: Tens of thousands, I'd guess.

THERAPIST: How do you explain that all the other planes landed safely? Is there a pattern there?

PATIENT: Oh—you just have to be on the wrong plane.

THERAPIST: That would be unlucky. But is there really a pattern of crashes, if these two events are unrelated and almost all of the other planes landed and took off safely?

PATIENT: I guess there really isn't a *pattern,* per se.

THERAPIST: And what do you make of seeing a pattern to crashes that are not related to each other? You were linking the terrorism with the mechanical failure.

PATIENT: Yeah. I guess they really aren't related.

THERAPIST: It's kind of like a coincidence?

PATIENT: That's right.

Homework

The therapist can have patients record examples of patterns or correlations that they perceive may be contributing to their worry or depression. For example: "I get worried because I think [*X* pattern] is occurring," or "I feel worried because I think *A* will cause *B*." Behaviors such as checking, monitoring, avoiding, or exertion of effort to forestall a perceived calamity can be monitored. Using Form 5.5, the therapist can ask patients to consider counterexamples to these patterns or correlations: "Are there exceptions to these rules or patterns? Are there times this does not occur?" The goal with the homework is to facilitate a more differentiated perspective, so that patients begin to acknowledge, "Sometimes this is not true." Figure 5.3 provides an example of how one patient used this form.

Possible Problems

There may be some patterns that *are* correlated and need to be addressed. For example, the patient may notice that her new boyfriend is drinking more on the weekends and that when she asserts herself, he is cruel and condescending. It is important to view the intervention as a means whereby we collect information. Patients often come up with examples to support their unfounded correlation: "I know a man who . . ." or "I saw several examples of . . . ." These confirmation-biased examples often contribute to strengthening the belief.

Cross-Reference to Other Techniques

Other relevant techniques include evaluation of the evidence, examining probabilities, semantic technique, examining the quality of the evidence, behavioral experiments, and evaluating rules for disconfirmation.

Form

Form 5.5 (Seeing Patterns That May Not Be There).

Pattern that I see	Evidence against this pattern
A plane blew up in Egypt, and there was a terrorist attack in Paris. Therefore, it is unsafe and it is likely that I could be killed by a terrorist.	There are 325 million people in the United States, and there have been very few fatalities due to terrorism. I'm more likely to die from skin cancer than terrorism.

Rather than see it as a pattern, could there be other reasons for these events? The only pattern is that there is terrorism in different parts of the world at different times. This does not mean that it is probable. Flying in a commercial plane is one of the safest ways to travel.
Could they be unrelated to one another? Acts of terrorism probably are related to one another, but they are not really relevant to flying from New York to Chicago. If there is a pattern, it's that planes are landing safely.
What do you make of these events? The events in Egypt and Paris are not really relevant to flying from New York. I need to focus on the actual probabilities based on past flights—which are safe.
Does everyone see the pattern? Why not? Some people might be scared because it's in the news. But people are still flying and traveling—millions of people. People get on with their lives, which is what I need to do.

FIGURE 5.3. Seeing patterns that may not be there.

TECHNIQUE: Creating False Dichotomies

Description

Typical of much depressive thinking is the view that only two choices exist for the person, neither of which is attractive, resulting in the feeling of being trapped and helpless. For example, a woman who was unhappily married and engaged in an affair with a married man believed she had to choose between these two unappealing relationship alternatives. It did not occur to her that there might be numerous other alternatives—other than these two men—that could be more attractive (e.g., more suitable men, friends, spending time alone).

The key to the effective negotiation of problems is the creative exploration of a third, fourth, even fifth alternative. Rather than getting stuck in one position—for example, "Either we do exactly what you want or we do exactly what I want"—we might examine several other alternatives that meet both our needs. For example, a manager at a company was upset that she was passed over for a promotion. She indicated that she was so angry that she wanted to go into her boss's office, tell him he was a jerk, and quit on the spot. We examined the costs and benefits to her of this course of action and then explored what her long-term goals might be at the company. She readily identified these goals as increased responsibility, respect, and financial reward. First we identified her false dichotomy: "Either I tell him off or I'm a doormat." Then we created an alternative: "Let me explain to him how I can be helpful in making this company grow." After rehearsing her plan to present her boss with this third alternative—how she could be helpful—she met with him, impressed him

with her business acumen and diplomatic skill, and secured a promotion for her in another part of the company. Several years have passed since that experience. She still works at this company, has substantial financial rewards, and feels secure in her position. By sidestepping a false dichotomy—either clobbering the person or passively acquiescing—she was able to construct a better option for herself.

Other examples of false dichotomies include:

"I'm a winner or loser, a failure or a great success, poor or rich."
"I've got to choose between these two jobs . . . lovers . . . places to live."
"I've got to do it now or never."
"I've got to keep this job because I'll never get another one."
"It's either John or Bill—and I don't like either one that much."

Questions to Pose/Intervention

"You may be viewing things in all-or-nothing terms. We call this 'dichotomous (all-or-nothing/black-and-white) thinking.' For example, you might say, 'I'm always failing' or 'I'm always getting rejected.' The important point is to look at all the shades of gray and all of the evidence that suggests that things change and things vary. Try to look for evidence that goes against the all-or-nothing thinking. Look for examples of when things are going a bit better for you."

Example

THERAPIST: You said that you are a complete failure and that you are always messing up. I guess that a complete failure is someone who never gets anything done?

PATIENT: Right. I'm a loser.

THERAPIST: OK. This sounds like all-or-nothing thinking—black and white. Let's see if there are any shades of gray. Are there any things you have done right in the past year?

PATIENT: Yeah. I took a class on accounting and did OK in it. And I lost 10 pounds. That was good.

THERAPIST: Do your friends like you?

PATIENT: Yeah, they think I'm a pretty good friend. I listen and I can be fun. I have a sense of humor when I'm not depressed.

THERAPIST: OK. So this all-or-nothing thought, "I'm a complete failure," doesn't seem to hold up to the facts?

PATIENT: Yeah. But I got a B on an exam and I was hoping for an A.

THERAPIST: So you discount the B? Is your all-or-nothing thought "If I don't get an A, then I'm a complete failure"?

PATIENT: I guess. I know it sounds irrational.

THERAPIST: Why?

PATIENT: Because I get different grades. I do very well on some things and sort of well on others.

THERAPIST: Maybe that's the way to think about things . . . shades of gray, variation.

PATIENT: I'd feel better if I did.

Homework

The homework is focused on identifying all-or-nothing thinking. Examples include thoughts that use the following language: *all, total, complete, always, never,* and *the most.* The patient should record examples of all-or-nothing thinking on Form 5.6, note examples of when the thinking is not true, and lastly, rewrite the all-or-nothing statements beginning with the sentence stem, "Sometimes I. . . ." The goal is to move toward more qualified, conditional, flexible thinking.

Possible Problems

Some patients contend that the evidence of their worthlessness, or that nothing works out, is overwhelming. They will challenge this exercise as a mere rationalization. The response to this position acknowledges that there may be a lot of evidence to support the negative but points out how important it is to examine evidence of when things *are* better—". . . so that we can figure out why things work when they do." For example, a patient complained that her relationships with men "never work out." When we examined the evidence of better relationships she'd had with men, we noticed that these relationships involved single men who were not depressed. This insight was useful in helping her avoid future no-win relationships.

Cross-Reference to Other Techniques

Other relevant techniques include looking for variations in a belief, examining the evidence, role-playing both sides of the thought, distinguishing behaviors from persons, and distinguishing progress from perfection.

Form

Form 5.6 (Challenging False Dichotomies).

TECHNIQUE: *Reductio ad Absurdum*

Description

A common technique that is used to challenge an argument is to carry the logic of the argument to an absurd conclusion. Doing so can take several entertaining forms. One form is to take the structure of the argument and examine how a parallel argument would be absurd. For example, consider the following:

1. Some people who make mistakes are stupid.
2. I made a mistake.
3. Therefore, I'm stupid.

A parallel form of argument would be:

1. Some animals have four legs.
2. I'm an animal.
3. Therefore, I have four legs.

Or:

1. Some horses have brown eyes.
2. I have brown eyes.
3. Therefore, I'm a horse.

Another way of reducing an argument to absurdity is to look at the illogical implications of the statements. For example, many single people believe, "If I'm single, then I'm unlovable." To reduce this thinking to an absurdity, consider the following: "All people who are married were once single. Therefore, all married people are unlovable." Consider the following thinking:

1. I haven't finished yet.
2. Therefore, I will never finish.

The absurd implication of this is:

1. Everyone who has finished once had not finished at a prior time.
2. Therefore, everyone who has finished will never finish.

Questions to Pose/Intervention

"We can examine the logical implications of your thoughts. Let's see if your reasoning leads to reasonable ways of viewing things. Let's write down your different thoughts and the reasons that you give for them, and see what this would lead us to if we carried your thinking forward. Consider the following thought: 'If I'm single, then I'm unlovable.' This belief leads to the following implication 'All people who are married were once single' and the conclusion 'All people who got married were unlovable.' Maybe you have some illogical thoughts that we can examine."

Example

THERAPIST: You said that you're worthless and that's why you want to die.

PATIENT: I seem to fail at everything.

THERAPIST: What do you mean by *worthless*?

PATIENT: Someone who hasn't achieved a lot.

THERAPIST: What is *a lot*?

PATIENT: Someone who isn't very successful or rich.

THERAPIST: So are you saying people who are not successful and rich are worthless?

PATIENT: I guess so. It sounds so judgmental.

THERAPIST: If we carried your reasoning forward, we might say people who are worthless don't deserve to live.

PATIENT: Well, that sounds very elitist.

THERAPIST: And then we could conclude that we should kill anyone who is not successful and rich?

PATIENT: Oh, I wouldn't go that far.

THERAPIST: Why not? The Nazis did. They murdered old people, handicapped people, and retarded people. You see, if we carry this judgment to its logical conclusion, then we should get rid of all people who aren't successful and rich.

PATIENT: That would be inhuman.

THERAPIST: How could you be more humane toward yourself?

Homework

Using Form 5.7, the therapist can ask the patient to identify several negative thoughts and the underlying implications of these thoughts, if carried to the extreme. For example, the patient who says, "I've failed and I don't deserve to live" can be asked what the implications would be if we used this reasoning for everyone—that is, everyone who fails at something should die.

Possible Problems

Some patients believe that their irrational conclusions are valid. The exercise does not address the validity of the thought but rather its implications were it generalized. Thus the issue is not whether the thought is "true" or "logical" but what the implications of this thought would be as a general principle or process of reasoning. The therapist can explain: "We are not examining whether or not your thought is true or false. We are only examining what it would look like if we applied this reasoning to everyone else."

Cross-Reference to Other Techniques

Other relevant techniques include challenging "should" statements, examining costs and benefits, examining the value system, and developing new adaptive assumptions.

Forms

Form 5.7 (Reducing Thoughts to Absurdity).

TECHNIQUE: Emotional Heuristics

Description

A common feature of anxious and depressive thinking is to base estimates of reality on one's current emotional state. For example, Finucane, Alhakami, Slovic, and Johnson (2000) have found that inducing anxious arousal leads individuals to increase their estimates of risk and danger for unrelated events. This outcome suggests the underlying emotional reasoning of "I feel anxious, therefore, there is danger" (Keller, Siegrist, & Gutscher, 2006). Emotions are not a good indicator of external events. In examining emotional heuristics, we ask patients to consider how emotions might affect thoughts—a causal direction (emotions → thoughts) that might seem odd to some cognitivists. Mood induction techniques, in which patients learn how to create a specific mood, can be used to modify the emotional heuristic. For example, if the patient is utilizing emotional reasoning or if his or her thoughts are emanating from a negative mood, the mood can be modified by inducing a positive

mood. Using the Velten technique, for example, patients either repeat positive words or recall positive imagery until a positive mood is experienced, and then they examine the current problem in the new mood state (Snyder & White, 1982; Velten, 1968).

Questions to Pose/Intervention

Emotional Reasoning

"When we are worried or anxious or depressed, we often use our emotions to guide us. So you might think 'Things are really bad' because you are feeling sad or anxious. This is called 'emotional reasoning.' Examine what you are worried about and ask yourself if you are using your emotions to guide your thinking. Is there an alternative way of viewing things?"

Emotional Heuristics

"Sometimes your mood directly affects how you think. For example, you might feel sad, and this sadness produces a lot of negative thoughts. Your experience of the world is colored by your sad mood. In order to examine this pattern, we ask you to do three things. First, write down your current negative mood and any negative thoughts you are having. Second, repeat positive words for 10 minutes, until you begin feeling better. Third, now try to think of the current situation from the vantage point of your new, more positive mood. Write down these new thoughts, especially any positive or constructive thoughts that you might have."

Example

Emotional Reasoning

THERAPIST: You said that you are feeling really upset about flying next week. How would you describe this feeling of "being upset"?

PATIENT: I'm really jittery. I can't get my mind off of the fact that I'll be flying, and the plane might crash. I feel really tense. I can't sleep.

THERAPIST: So that's how you know you're upset: You feel jittery and tense and can't sleep. When you think about flying, how do you relate your fear of flying to feeling jittery?

PATIENT: I feel really tense, afraid, so I think, "It's going to be really dangerous."

THERAPIST: It sounds like you are using your fear and your tension as evidence that the flight will be dangerous.

PATIENT: Yeah, whenever I feel really tense, I think that something bad is going to happen.

THERAPIST: But are your tension and anxiety really evidence that something bad is going to happen?

PATIENT: No, they're just my feelings.

THERAPIST: What if you ignored the way you were feeling and asked yourself, "Is there any really strong evidence that this flight will be dangerous?"

PATIENT: I don't have any evidence that it will be dangerous.

Emotional Heuristics

THERAPIST: You've been feeling really down recently, and now that you and Nancy have broken up, you are flooded with negative thoughts and feelings. Sometimes when we feel really down, our negative mood just triggers lots of negative thoughts.

PATIENT: Yeah, I've been thinking I'll never meet anyone quite like her. Never be happy again.

THERAPIST: OK. Let's try an experiment. I'd like you to close your eyes and try to relax. We're going to work at creating a positive feeling. I want you to open your eyes and read these words. Try to concentrate on the positive feelings these words evoke. (*Gives patient the Velten cards.*) How are you feeling?

PATIENT: Better. A lot less sad than before.

THERAPIST: Let's look at how you think about this breakup with Nancy. Any positive or neutral thoughts?

PATIENT: Well, maybe it's for the best. We tried, but we're just very different from each other.

THERAPIST: Can anything good come from this breakup?

PATIENT: Maybe I can meet someone who is more my type.

THERAPIST: How does that thought feel?

PATIENT: Better. Like there's some hope.

THERAPIST: Does this shift tell you anything about how changing your mood changes your thinking?

PATIENT: Yeah. I feel less sad reading these words, and now I'm thinking . . . in a way, I'm thinking about things in a more positive light.

THERAPIST: So, what we learned is that our feelings can affect how we think about things.

Homework

Using Form 5.8, the therapist can ask patients to (1) examine some of the negative beliefs they are holding at the present time (e.g., "No one likes me," "I'll always be alone," "I can never do anything right") and (2) consider the emotions associated with those beliefs (e.g., anxiety, depression, sadness, anger, loneliness). Lastly, the therapist can ask patients to examine how they would view the current situation if they were feeling "especially good" or "especially optimistic."

Possible Problems

Some individuals may have a difficult time imagining feeling differently from the way they currently feel. Highly anxious or sad patients may be enveloped by their negative mood. The therapist can help patients induce a positive mood by use of relaxation exercises and positive imagery. This imagery can be used to guide patients to a more positive set of memories of past happiness or calmness. This induced positive or relaxed emotion then can be utilized to challenge the emotional heuristic characterizing the current situation.

Cross-Reference to Other Techniques

It is often useful to utilize distancing techniques such as the double standard, placing things in perspective, or looking at the current situation from "the balcony." In addition, the time machine

technique, examining the costs and benefits, and examining the evidence for and against the validity of the belief are useful.

Form

Form 5.8 (Mood Induction and Alternative Thoughts).

TECHNIQUE: Recency Effects

Description

A common "rule of thumb" (or heuristic) is to place greater emphasis on recent information than on averaging information over a longer period of time. Recent events are often viewed as more representative than baseline or repeated events. For example, the individual who hears about a recent plane crash may conclude that planes are now very dangerous; an individual whose relationship has ended may feel rejected and conclude that this recent "rejection" is likely representative of all relationship outcomes in the future.

Questions to Pose/Intervention

"You seem to be placing a lot of emphasis on what has been happening recently. For example, you noticed that [*X*] happened recently, and now you're thinking that [*X*] is going to continue to happen. Let's step outside of the current situation and take a longer-term view of things. How many times in the past [year] has [*X*] *not* happened? How many times has [*X*] actually happened?"

Example

THERAPIST: You are afraid to fly next week because, you said, there was a plane crash last week.

PATIENT: Yeah, I think flying is dangerous.

THERAPIST: Do you think that flying feels more dangerous to you this week than it did 2 weeks ago—before that crash?

PATIENT: Yeah, of course!

THERAPIST: It seems you think the recent crash reflects how dangerous flying is. But how many planes have taken off in the past year and arrived safely at their destination?

PATIENT: Thousands, I guess.

THERAPIST: So if one plane out of thousands crashes, what is the likelihood of the next plane crashing?

PATIENT: Very small.

THERAPIST: Sometimes we emphasize recent events more than makes sense. In order to figure out how dangerous flying is, you need to look at *all* the flights over a long period of time. Imagine that you're playing roulette, and you play 100 times and lose each time. But now, on the next throw, you win. Would you conclude that you're having a winning streak?

PATIENT: No.

THERAPIST: You would guess that the next game of roulette is more likely to be similar to the first 100 games—each of which you have lost.

PATIENT: That makes sense.

THERAPIST: So the recent event is not the only one to consider; instead, you need to consider all of the prior events.

Homework

Homework is focused on contrasting recent events that are perceived negatively with earlier events that may contradict the recent ones in their outcomes. The therapist asks patients to list the recent events or experiences that are troubling, then to list as many prior events—especially events in the distant past—that are not consistent with the current events or experiences. (Form 5.9 can be used.) Alternative, more positive thoughts are thereby elicited. To counter recency effects on the estimates of current danger (e.g., the patient who believes that airplanes are unsafe because there was a recent plane crash), valid base-rate information can be obtained. For example, the patient who has a fear of flying can consult the Internet at *www.airsafe.com* to learn how many millions of passengers fly on each airline safely.

Possible Problems

Due to the recency effect, patients may recall more negative events that are consistent with their negative automatic thoughts than positive ones. For example, a patient who did poorly on an exam recalled prior experiences of not achieving his goals and of being rejected as a failure. The therapist can ask such patients if there were any times in the past when they passed the exam, accomplished a goal, or achieved anything that was at all pleasurable. At times it is helpful to have patients bring in their curriculum vitae or résumé.

Cross-Reference to Other Techniques

Other relevant techniques include examining the evidence, reviewing the quality of the evidence, viewing probabilities in a sequence, and examining the costs and benefits of worrying. In addition, uncertainty training, such as exposure to uncertainty thoughts, can be helpful.

Form

Form 5.9 (Examining the Recency Effect).

TECHNIQUE: Arguments Based on Logical Fallacies

Description

Aristotle identified a number of common fallacies in arguments or logical deduction. Many people use authoritative hearsay as proof of truth, claiming that something is true because someone in authority says it is true. For example, it is common to hear statements beginning with "My father always said . . ." or "My boss says . . ." or "My therapist says. . . ." Another example of a fallacy in arguing is to refer to convention—that is, "Everyone does this"—as proof or evidence. Related to

this fallacy is the argument based on prior examples—for example, "This is how it was always done." These arguments do not prove that something is currently correct, logical, practical, desirable, or moral. Lots of authorities have claimed very incorrect things—such as claiming the earth is the center of the solar system. Similarly, the fact that someone else does something a certain way does not mean it will be useful for you to do it that way. Indeed, there may be a variety of ways of doing something, and one should consider tradeoffs, preferences, and the opportunities currently available. Another fallacious argument is the "ad hominem" (i.e., against the person) argument: "The only reason he believes [such and such] is because he is a terrible person." These ad hominem arguments attack the character of the person rather than establish the validity of the argument. For excellent discussions of logical fallacies, see Halpern (2002), *Thought and Knowledge: An Introduction to Critical Thinking,* and Cohen and Nagel (1993), *An Introduction to Logic.*

Questions to Pose/Intervention

"A lot of times we hold negative beliefs because we are responding to ideas or arguments that are not valid, though they carry the weight of authority or convention. For example, someone powerful or deemed 'expert' asserts that something is true. Or, the argument is based on the assertion, which is really an unsubstantiated assumption, 'That's what everyone does.' Similarly, arguments may be based on prior behavior—for example, 'That's what was done in the past,' or the argument is no more than an attack—for example, 'Only an idiot would do this.' Think about why you believe some of the negative things you believe. Then ask yourself if you are basing your judgment on authority, convention, approval, fear of personal attack, or simply that things were done a certain way before."

Example

THERAPIST: You said that you feel ashamed that you are gay. Why is that?

PATIENT: Other people look down on gay people.

THERAPIST: Everyone?

PATIENT: Well, not everyone. But my father always criticized gays, and the Bible condemns them.

THERAPIST: It seems you're basing your shame on a need for approval, on authority, and on convention. Did you ever hear about Galileo?

PATIENT: He was an astronomer.

THERAPIST: Right, and the Catholic Church condemned him because he claimed the earth was not the center of the solar system. He claimed that the earth turns. But the church authorities—and almost everyone else—criticized him. Were they right or was Galileo right?

PATIENT: Well, Galileo was right.

THERAPIST: OK. So think about the fact that you are gay, and that you feel ashamed because of the authority and disapproval of your father. Is he really knowledgeable about these areas?

PATIENT: No.

THERAPIST: And when you say that being gay isn't what everyone is, does that mean it's wrong? Not everyone is left-handed. Not everyone likes chocolate.

PATIENT: No. It's a personal thing. It's something you're born with.

THERAPIST: So if we reject arguments based on authority or winning approval or what some other people want, then we are left with your personal orientation.

Homework

Using Form 5.10, the therapist can ask patients to list all of the arguments that fuel their self-criticism or negative beliefs. For example, if the patient has negative beliefs about being gay, resulting in shame, these negative beliefs should be listed. Similarly, if the patient has demanding expectations of self—for example, "I should succeed at everything I try"—then the negative beliefs underlying these expectations are listed. Then patients list as many arguments as they can think of that support their negative beliefs. For example, arguments that "support" the negative beliefs that one should not be gay might include arguments based on conventional perspectives (e.g., "Most other people are not gay"), authority (e.g., "My father thinks it's bad"), ad hominem (e.g., "People who are gay are defective"), emotion, ridicule, popularity, etc. Then patients list why these arguments are illogical. For example, the argument that convention determines right and wrong is illogical, since conventions are always changing and there is a wide range of behavior in global society. Ad hominem arguments are invalid because denigrating a person's character does not invalidate the point of view with which you disagree.

Possible Problems

Some individuals have a difficult time analyzing the errors in logical thinking in these fallacious arguments. For example, long-held beliefs in convention ("Most people think that people who do *X* are *Y*") are difficult to dislodge. The therapist can help patients analyze the logical errors in these arguments by examining how such arguments would apply in different circumstances. For example, arguments based on convention are dislodged by illustrating the prior conventions of slavery and anti-Semitism. Ad hominem arguments are dislodged by pointing out all the famous people who were vilified (Jesus, Moses, Buddha, Lincoln, etc.).

Cross-Reference to Other Techniques

Related techniques include cost–benefit analysis, double standard, rational role play, and *reductio ad absurdum*.

Form

Form 5.10 (Fallacies in Arguments: Analyzing Negative Beliefs).

FORM 5.1

Examining Confirmation Bias

Sometimes we find ourselves automatically focusing on something that is negative. It's almost as if we have dark glasses on, and we conclude it's dark outside. Let's say that you start with a negative thought, and then you notice you are seeing negatives everywhere. We call this pattern "confirmation bias"—you are drawn toward the negative. This is not because you want to be negative, it's because you simply have a habit of thinking a particular way and you pay attention to negatives, remember negatives, or interpret events in a negative way. In the table below notice any negative mood you're feeling (anxious, sad, angry, frustrated). List your negative mood in the first column, what is going on (what happened) in the second column, and in the third column list your interpretation of what happened. In the fourth column, describe how someone with a positive bias might interpret what happened. Is there a pattern to your view of things?

Negative mood	**What actually happened**	**Negative interpretation**	**How someone who is positive might view it**

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FORM 5.2

Using All the Information

When we are feeling anxious or down, we tend to limit our search for information. When we come up with an example of a negative, we think we have proved that things are very negative. The question is whether we have simply engaged in a limited search for information and have discontinued looking for information against our negative belief. It is important to use as much information as possible. Write down your negative belief in the left-hand column, and then over the next week collect examples of information (from the past or present) that are consistent with the negative belief (middle column) and examples of information that are inconsistent with the negative belief (right-hand column). What do you notice?

Negative belief or prediction	Examples in favor of belief	Examples against belief

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FORM 5.3

Estimates of the Likelihood of Events

Write down a worry or negative prediction you have in mind, or a negative belief you hold. In the right-hand column, indicate the likelihood this is true or going to come true (with 100% being total certainty). Then answer the questions at the bottom of the form.

Prediction or negative belief	**What is the likelihood that this is true in the population? (0–100%)**

What sources of information can you use to find out the likelihood of something being true?
Are you overestimating the likelihood of something being true or coming true?
What if you were to look at events in terms of the probabilities that actually exist?

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FORM 5.4

Examining Logical Errors

Examples of logical errors: Drawing conclusions that do not follow, confusing possibility with probability, confusing a behavior with a person, linking two independent events, making self-contradictory statements (e.g., "I have a lot of success, but I'm a failure"), basing self-worth on what someone thinks.

Negative thoughts	Errors in my thought

What would be a more rational, factual, or logical way to view things?

How would you feel if you thought differently about these things?

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FORM 5.5

Seeing Patterns That May Not Be There

Many of us see patterns in events that may not be completely accurate. For example, someone might say, "Everything is going badly for me," not recognizing that there are many things that have been going well. Or someone might think one event or action is a cause of another; for example, "Every time I try to have a conversation with anyone, it ends up badly." It is important for us to examine whether these patterns exist in reality or mostly in our minds. Try to come up with examples that disprove your thought that there is a pattern or that one thing is always a cause of another thing.

Pattern that I see	**Evidence against this pattern**

Rather than see them as a pattern, could there be other reasons for these events?
Could these events be unrelated to one another?
Are there events that don't fit this pattern?
What do you make of these events?
Does everyone see the pattern? Why not?

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FORM 5.6.

Challenging False Dichotomies

Sometimes we use all-or-nothing thinking that creates false dichotomies. Examples of this type of thinking are, "I'm either a winner or a loser," or "I always get rejected." In the left-hand column below, write down some examples of your all-or-nothing thinking (your false dichotomies). In the middle column, write down examples of when this thinking is not true. In the right-hand column, rewrite your negative black-and-white statement by saying something positive as well as negative—for example, "Sometimes I do well and sometimes I don't do well." If your negative thinking concerns a choice ("It's either *A* or *B*"), then come up with at least one alternative.

Example of all-or-nothing thinking (false dichotomy)	**Examples of when this thinking is not true**	**"Sometimes I . . ."**

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FORM 5.7

Reducing Thoughts to Absurdity

Look at the logical implication of your belief—is it absurd? For example, the implication of the thought "If I'm single, then I'm unlovable" is "All people who are married were once single. Therefore, all married people were unlovable." Take any one of your most negative thoughts and carry it to the most extreme level of absurdity. What thoughts do you have about these absurd thoughts?

Current negative thought	**Why it would be absurd to think this way**
Everyone who is single is not married. Therefore, everyone who is single is a loser. Therefore, people always marry losers because they have to marry single people. Therefore, everyone who is married is a loser, too. Therefore, everyone is a loser.	Being single or married has nothing to do with personal deficiencies. The logic of the idea that "I'm single, therefore I'm a loser" is that everyone is a loser, which is absurd.

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FORM 5.8

Mood Induction and Alternative Thoughts

In the left-hand column, write down your current negative thoughts; in the middle column, list your current negative feelings or emotions. Then try this mood induction experience:

Mood Induction: Close your eyes and try to form an image of a positive and relaxing scene. Relax all of your muscles and breathe slowly. When you have a positive scene in mind, try to think of some positive words. These words might include *relax*, *calm*, *warm*, *kind*, *safe*, etc. After you have formed this positive image and feel calm and relaxed, try to think of the current situation in the most positive light—think of it from the point of view of your positive feelings. Then open your eyes and write down your positive thoughts in the right-hand column while in this positive mood.

Current negative thoughts	**Current negative feelings**	**Alternative positive thoughts while in positive mood**

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FORM 5.9

Examining the Recency Effect

In the left-hand column, list any recent events that have triggered your negative thoughts (e.g., poor performances, accidents, rejections, disappointments). In the right-hand column, list events that are not recent but that contradict these current experiences. For example, the person who says, "I just did poorly on the exam—I'm really dumb," may be basing this negative thought solely on a recent experience and would therefore list all the examples in the past of positive performances on exams.

Recent event or experience from which I may be overgeneralizing	**Prior events that contradict this**
What is the consequence of placing greater emphasis on recent information rather than all the information?	
What if I based my judgments on the likelihood of an event in the general population, rather than on the recency of an event?	

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FORM 5.10

Fallacies in Arguments: Analyzing Negative Beliefs

Look at these examples of mistakes and errors (fallacies) in thinking. All of us engage in these fallacies at some point. Now examine some of your current negative thoughts and see if any of them fit any of these fallacies in reasoning. Can you think of how you might correct these fallacies? What is wrong with your reasoning?

Logical fallacies	Examples of fallacies in negative beliefs	Examples of my use of this fallacy	What is wrong with this thinking?
Attacking the person	He's wrong because he's a bad person.		
Appeals to authority	My father thinks it's wrong.		
Convention	That's the way it's always been done.		
Emotion	I feel upset when I think that, therefore it's wrong.		
Fear	Terrible things will happen if you believe that.		
Pity	You shouldn't do that because it will make someone else unhappy.		
Fear of ridicule	If you do that, everyone will think you're a loser.		
Popularity	It's what everyone does.		
Begging the question	You shouldn't do something other people don't like. Therefore, it's wrong to do it.		
Post hoc	I must have been an idiot—it didn't work out.		

(continued)

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Fallacies in Arguments: Analyzing Negative Beliefs *(page 2 of 2)*

Logical fallacies	**Examples of fallacies in negative beliefs**	**Examples of my use of this fallacy**	**What is wrong with this thinking?**
Gambler's fallacy	I must have a string of good luck. [Alternative: My luck will turn because I just lost a lot.]		
Guilt by association	She must be a bad person since she hangs out with that guy.		
Lack of imagination	I can't think of any reasons that he did that—he must be crazy.		
"No true Scotsman"	No real man would do that—he did that, so he's not a real man.		
Relativistic fallacy	Everything is relative. Anyone can have a point of view. There is no reality.		
Slippery slope	If you make a mistake, everything will fall apart.		
Correlation means causation	I noticed that a lot of people who do *X* are like that. She did *X*, therefore she is like that.		
Small sample	My two friends had a bad experience with Internet dating; therefore it's a bad idea.		
False forced choice	I've got to choose between Susan and Carol.		
Confusing a preference with a necessity	I'd like to be rich, therefore I should be rich.		

CHAPTER 6

Modifying Decision Making

Decision making is a key to almost every aspect of life: choosing what to eat, whether to exercise, what to buy, which relationship to pursue, where to live, what to say, which career to pursue, and whether you should reverse your decision and get out of that job or relationship. Depression is often characterized by indecisiveness; individuals may often procrastinate on important behavior because they cannot decide what to do, and they fear a flood of self-critical thoughts should they make the wrong decision. Anxiety often involves decisions to avoid situations that arouse discomfort, fearing that one will have a panic attack, become contaminated, look foolish, or face a life-threatening situation. It is not uncommon to exaggerate the intensity and duration of an anticipated outcome, only to learn later that things turned out better than expected. Individuals with substance abuse problems confront decisions about choosing to have another drink or to use an illegal drug, often focusing on their short-term feelings and sensations rather than on the longer-term consequences.

In this chapter I examine a number of problems in decision making and review techniques and strategies to help patients make more adaptive decisions. Classic models of decision making have focused on "utility"—that is, the benefits (or losses) that are associated with specific alternatives. These models of utility are often based on assumptions about the decision maker that may prove to be incorrect. These include the assumption that decision makers have all the relevant information, that they weigh information rationally, that they do not give preference to recent or salient information over other sources of information, that they ignore past decisions and focus on future utility, that they do not use their emotions to guide their decisions, and that they are consistent in their preferences. However, research on decision making has demonstrated that each of these assumptions is false. As a result, decisions can often lead one in the wrong direction, further contributing to depression and anxiety.

Contrary to the "normative model" that decision makers utilize rationality, weigh costs and benefits, and utilize only relevant information, there is now considerable evidence that individuals utilize shorthand "rules of thumb" or heuristics to reach decisions. These heuristics allow one to make quick decisions without considering base rates or engaging in pairwise comparisons. One heuristic is the "satisfying" rule: that is, "I will search until I find an alternative that simply satisfies my desire, without trying to maximize the outcome or reach the best decision." For example, I go to a diner for lunch but am pressed for time because I must return to my office shortly for an

appointment. The menu arrives, presenting me with the opportunity to examine the possible pairwise comparisons of 100 entrees, appetizers, and salads. What decision strategy do I utilize? One rule of thumb might be, "Choose something that I'm familiar with that is 'good enough to eat.'" Along with this "satisfaction" rule might be the "first one" rule—that is, "The first dish that meets this criterion is good enough." An alternative rule of thumb (which is not a shortcut) would be to ask the waiter for the pros and cons of every dish and to ask for comparisons between these dishes. Since time is of the essence, I utilize the first one that *satisfies* (Simon, 1979). Now, it might be that there is a much better alternative on the menu—if only I had continued to search—but it might also be that time is of value, so I stop my search when I come to a choice that satisfies. Continued searching has "search costs"—that is, I will have less time to eat, I might be frustrated, and I don't like doing pairwise comparisons of salads and stroganoff. However, a corollary of this is that I might also have a confirmation bias—only looking for an alternative that confirms my original belief. For example, I might believe that I'm a loser and I search for evidence until I find the first example of failure and then conclude that this is enough for me to hold my belief.

Another heuristic is "loss aversion"—that is, I may suffer my losses more than I enjoy my gains. Thus, a loss of $1,000 is experienced as more important than a gain of $1,000. Kahneman and Tversky's (1979) *prospect theory* proposes that the way in which alternatives are framed or considered—for example, as *losses* or *gains*—may lead to violations of expected utility theory—that is, to irrational decisions. For example, when considering the following alternatives—"50% chance of losing $1,000 versus a sure loss of $500"—individuals choose the "riskier" 50% chance of losing, even though the expected utility of both alternatives is equivalent ($500). Related to loss aversion is the "endowment effect," which reflects the tendency to attach a higher value to what one has already paid for and possesses—that is, "I place a higher value on what I possess simply because I possess it." Thus investors who own a stock will require a higher payment for the stock than they would pay to buy the stock themselves if they had never owned it (Thaler, 1992). Because of the endowment effect, people are reluctant to give up what they have or make a change—a characteristic of depressive indecisiveness. The endowment effect is conceptually related to the concept of "sunk costs" that I describe later in this chapter (and elsewhere; see Leahy, 2000). Because people overvalue the possessions (or decisions) to which they have committed themselves, they are more likely to "ride a loser"—whether it is a stock investment, a relationship, or an opinion.

We often place greater emphasis on information that is recent and salient in our estimation of risk. For example, if we hear of a recent plane crash—which is salient since it is on the news and the opening page of a new website—we overestimate the likelihood that there will be another accident. We often ignore the abstract baseline information—that is, the percent of planes that take off and arrive safely—placing greater emphasis on information that activates intense visual images, seems concrete, and is easily accessible to our consciousness (Kahneman, 1995; Tversky & Kahneman, 1974, 1979). This finding has implications for individuals with generalized anxiety disorder (GAD) who worry excessively when they hear of a recent and widely publicized accident ("I don't think flying an airplane is safe, because there was an accident yesterday"). When an individual with hypochondriasis scans the Internet and reviews information about all the "symptoms" of cancer, this information and the disease are more accessible than the abstract and rather unconvincing base rates, which this person seldom examines. Finally, emotional arousal affects the perception of risk, such that increasing anxiety (by mood induction) can increase the estimates of risks in other areas of life (Finucane et al., 2000; Slovic, 2000). Once the anxiety is activated, it serves as a priming catalyst for perceptions of possible danger. Cognitive therapists (who would consider this an example of "emotional reasoning") are correct in noting that one can use one's own emotions to estimate the external threat. This emotional heuristic—and the consequent perception of risk or

scarcity of resources—is a major component of decision making and the perception of alternatives in depression and the various anxiety disorders. Risk is everywhere in the eyes of a depressed or anxious individual.

I have advanced a model of risk assessment in decision making based on the proposal that individuals differ in their tolerance of risk and that these differences are based on beliefs about a number of factors that may influence exposure, likelihood, recoverability, and management of risk (Leahy, 1997, 1999, 2001a, 2003). In particular, individuals who are prone to depression and anxiety are risk averse because they have the following beliefs: They have few current or future resources, their time horizon (or expectation of positive gain) is short, they do not believe that they can repeat or replicate behavior toward a goal (Hawley, Ho, Zuroff, & Blatt, 2006), they do not enjoy their gains, they suffer their losses, they are highly oriented toward regret, and they do not trust their judgment. As a result of the depressive evaluation of risk, these individuals are inclined to "manage risk" by requiring extensive information, seeking reassurance, quitting early (stopping out), discounting gains as aberrations, waiting a long time to decide, and looking for signs of danger or risk (Leahy, 1997, 1999, 2001a, 2003). For example, the depressed individual who is considering "taking the risk" of going to a party to meet new people may believe that he has little to offer in a relationship, that rejection would be highly costly, that he would strongly regret it if he did get rejected, that it would take a long time to recover from the rejection, and that if he doesn't succeed here he may as well give up. He may seek reassurance, requiring certainty, before actually deciding to go. He is risk averse. In contrast, a more confident individual may believe that she has a lot going for her, that she has many opportunities for future interactions with rewarding people, and that "rejection" would not be a significant problem because in her view, some rejection is normal when socializing. In short, she is less likely to focus on regret and more likely to focus on opportunity. These two individuals reflect pessimistic and optimistic risk strategies based on different assessments and assumptions.

The evidence supports the general view that individuals higher on levels of depression and/or anxiety have more risk-averse beliefs. Thus, in considering decision making in cognitive therapy, it is helpful to evaluate the individual's beliefs about his or her ability to produce positives, recover from negative events, diversify sources or reward and behavior, and his or her tendency to overemphasize regret, downplay positive outcomes, and require considerable information to make a decision. These factors are central elements in avoidance, lack of perseverance, regret, and threat detection as problematic risk management strategies (Leahy, 1997, 1999, 2001a, 2003). According to this model, individuals consider a number of factors both in contemplating a decision and in taking a risk. These factors include the following: perception of current resources, anticipation of future earnings or gains (independent of the current decision), ability to predict and control outcomes, generalizability of negative and positive outcomes, criteria for defining a gain or a loss, disposition to blame self or other, tendency to take credit for gains, acceleration of loss or gain, replication of "investment" or behavior directed toward a goal, time horizon, need for information, and risk aversion or toleration. I develop these themes in the following section when discussing pessimistic and optimistic models of decision making.

Related to the issue of decision making, as outlined above, is the research and theory on "affect forecasting." This term refers to the process by which people predict how they will feel in the future, given certain events. Research indicates that people often overestimate the degree to which their emotions will change given an event—a form of "impact bias." Thus, if one anticipates receiving tenure or getting married, there is a tendency to overpredict the emotional impact—that one will feel wonderful. This is true for both positive and negative effects. A form of impact bias is the "durability" effect, which refers to the belief that emotions will last a long time. You will feel wonderful—*forever.* In anticipating the emotional impact of decisions and events, people often focus on one single element to the exclusion of other relevant elements. For example, in moving from one

place to another, one might focus on the pleasant climate in the new location, overlooking the importance of other factors that might affect mood, such as relationships, jobs, and recreational outlets. This process is known as "focalism." Relatedly, in the event of a negative experience (e.g., divorce), individuals often underestimate their ability to cope effectively in the future, often overlooking new opportunities and new relationships that might ensue. This is known as "immune neglect," reflecting the lack of recognition that one might be immune to these anticipated durable negative events. I describe brief interventions to address a number of affect forecasting errors later in this chapter.

TECHNIQUE: Identifying Short-Term and Long-Term Goals

Description

Decision makers often get overly focused on their short-term objectives—especially, how they predict they will feel. For example, when considering exercising, the person might focus on the anticipated discomfort, the inconvenience of going to the health club, the time that will be taken up, and the less "arduous" forgone activities in that time period. These decision makers are focused on the short term; we might say that they are myopic or near-sighted because they only consider the immediate consequences and fail to recognize the importance of longer- term gains. In contrast, the decision maker who focuses on longer-term gains will recognize that short-term discomfort may be the price to pay for getting into shape and losing weight and that these behaviors need to be replicated over a long period of time to realize the desired payoff. Another aspect of short-term thinking is that the advantage of the longer-term gain is "discounted"—that is, one is willing to accept a lower reward immediately rather than wait for a larger reward later. The classic example of the "marshmallow" experiments by Mischel exemplify this unwillingness to delay gratification—I will take two marshmallows now rather than wait for four later (Mischel, Cantor, & Feldman, 1996). Mischel's research demonstrates that this inability to delay gratification has long-term implications for academic performance and success in one's occupation.

Questions to Pose/Intervention

"We often make decisions based on our short-term or longer-term goals. For example, I can decide to spend some money now because I might enjoy buying this meal or this piece of clothing, or I can save the money and invest it and hope to buy something bigger later—like a car. Think of your long-term goals—things that you feel are important to you in your life. They could be goals related to your health, your training, your financial well-being, your career, or your personal relationships. Now, think of some shorter-term goals that keep you focused on immediate gratification—such as comfort, tempting foods and drinks, hanging around enjoying leisure time, excitement, or other things that appeal to you in the short term. How do you think you make decisions in your life? Are you often focused on the short-term gratification, not thinking about the longer-term consequences of goals? What are the consequences of being focused on the short term rather than the longer term?"

Example

THERAPIST: I understand that you're frustrated with your weight and your social life, including your friendships. Are losing weight and having a better social life long-term goals for you?

PATIENT: Yeah, I need to lose about 20 pounds. And I just don't feel like going out with my friends when I'm feeling down, so I sit at home eating ice cream and watching television.

THERAPIST: Sounds like eating ice cream and avoiding the discomfort of exercise and going out are important short-term goals for you. How do you think you might go about losing weight in the long term?

PATIENT: I know what I have to do—diet and exercise—but it's too hard.

THERAPIST: It is frustrating and discouraging at times, I know. But what would happen if you decreased your calorie intake and exercised every day for a year? What would the consequence be?

PATIENT: I'm sure I would lose weight and feel better.

THERAPIST: Have you ever made a decision about the long term and just stuck with your plan on a regular basis until you achieved your long-term goal?

PATIENT: (*thinking*) Hmm, come to think of it, that's how I got into the college I wanted to go to. I decided to study almost every night and focus on my grades, and I got in. It took a long time.

THERAPIST: And is that something that you took pride in?

PATIENT: Yes, I looked back and thought, "I did it."

THERAPIST: So, maybe you could take pride in behavior like dieting and exercising that have short-term costs but long-term gains.

PATIENT: I guess that's the only way to make progress, but it's hard to do.

THERAPIST: Yeah, it's hard to do until it becomes a habit, and then it becomes automatic—probably like a lot of good habits that you have, or have had, which just became so automatic that you just did them no matter what.

Homework

The therapist can ask the patient to identify some long-term goals, especially goals that reflect "quality of life," such as better physical condition, better intimate or personal relationships, more effective at work, etc. These are the longer-term goals that the patient can keep in mind. Then the therapist can ask the patient to identify some behaviors each day for the coming week that might move him or her closer toward realizing those goals. Next, the therapist can ask the patient to consider the following: (1) the costs and benefits of these behaviors in both the short term and the long term and (2) the costs and benefits of persisting in the assigned behaviors. The patient can use Form 6.1 to identify these different temporal components of goals. Is the patient primarily shortsighted? In addition, the patient can use Form 6.2 to assess the behaviors and implications of decisions for the longer term. Examples of responses to these two forms are provided in Figures 6.1 and 6.2, respectively.

Problematic behavior	Short-term benefits	Longer-term costs
Lying around doing nothing. Not exercising.	Can just relax. Don't have to go to the health club and feel like I'm out of shape. It's comfortable and cozy here.	Will continue to gain weight, feel out of shape, won't be comfortable dating. Will feel like I'm making no progress.

FIGURE 6.1. Problematic behavior of focusing on short-term goals.

Longer-term goal	What I have to do now	How I would feel in the future if I did what I need to do now
Lose weight and get into better shape.	Exercise four times every week. Walk to work. Eat fewer calories.	I would feel less tired, have more energy, more pride, and feel more comfortable dating.

FIGURE 6.2. Focusing on longer-term goals.

Possible Problems

Many people who focus on short-term gains have difficulty with emotion regulation and with looking beyond the immediate moment. For example, the patient might say, "But it's so tempting to eat that ice cream," predicting that the benefits of that short-term gratification will be quite significant. The therapist can ask, "How much pleasure, on a scale from 0 to 10, do you think you will get from that [ice cream]? How long will that pleasure last? How will you feel later about giving into that immediate pleasure?" Alternatively, the therapist can ask, "If you did not give in to immediate gratification and actually did the more difficult thing [exercise, forgo dessert, study], how much of a sense of mastery of yourself would you experience? Would you have any sense of making progress? Would that be important to you?"

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, pleasure predicting, activity scheduling, testing predictions, and examining past examples of adaptive behavior.

Forms

Forms 6.1 (Focusing on Short-Term Goals); Form 6.2 (Focusing on Longer-Term Goals).

TECHNIQUE: Precommitment Strategies

Description

Many people recognize that they will have difficulty making a decision in "real time" if there is a temptation to act otherwise. For example, many people will have money deducted monthly from their salaries for a savings plan or retirement plan, since they realize they can't trust themselves not to spend the money (Thaler & Shefrin, 1981; Thaler, 1992). The recognition that one cannot rely on spontaneous self-control allows the individual to plan self-control in advance of confronting the temptation. These "precommitment" strategies include automatic payment of bills, automatic deductions for savings, purchasing a membership that "obligates" one to go to the health club, hiring a trainer who is going to show up no matter how unmotivated you feel, and setting up reminders that automatically go off. In addition, precommitment may also involve making a commitment to another person to hold oneself accountable—for example, reporting to a friend what one has done regarding self-help. Another form of precommitment is a planner that outlines behaviors in which one will engage—such as which foods to eat, which exercise to engage in, what study behaviors

to do. Precommitment can also involve rewards and penalties for compliance and noncompliance, respectively; for example, "I'll send a check for $10 to an organization I don't like if I fail to engage in the promised behavior."

Questions to Pose/Intervention

"Many of us realize that temptation is often *too* tempting, and that if we wait until the last minute we probably won't do what is in our long-term interest. So we use work-arounds, like using automatic payment of bills and automatic savings withdrawal from our salaries for a retirement plan, making a commitment to someone in advance that we'll engage in self-help, or planning exactly what we're going to eat or do for the next 2 days. This is what is called 'precommitment': We are making the decision before we get into the situation. The advantage of precommitment is that we are emotionally calmer before the event and can make decisions that are really in our long-term interests."

Example

THERAPIST: You tell me that you want to get into better shape, but then find the ice cream is too tempting when you're feeling lonely at night. One way of thinking about this is that we can be smart enough to realize that our self-control is not what we want it to be, and thus to make a decision when we are calm, when there is no temptation, and we are focusing on our longer term goals, not on our immediate pleasure. For example, you might realize that you're more likely to spend your salary if you get it all at the end of the month, so you make a commitment—a decision—to have some money automatically deducted for savings.

PATIENT: Yeah. I realize it's hard not to spend it when I have it.

THERAPIST: This is what we call a "precommitment" strategy—you make a decision to commit to something before you are confronted with it in reality. For example, with the ice cream—it's so tempting and delicious—a precommitment might be to decide not to buy any for your refrigerator. And you can commit to sending yourself and me an e-mail if you do buy it, so that you automatically hold yourself accountable.

PATIENT: If it's in the refrigerator, I'm going to eat it.

THERAPIST: Another precommitment strategy is to write a check for $10 that you give me in advance and, if you eat a certain amount of junk food, I would send it to a charity that you don't like.

PATIENT: That would motivate me. It's like realizing that I have already set up the penalty for breaking my promise to myself.

THERAPIST: That's a good way to view it.

Homework

The therapist can indicate something like the following: "We often realize that we are not very skilled in resisting temptation if the tempting stimulus or object is in front of us. We may know that we give in to temptation and later regret it. Sometimes we can anticipate this and plan ahead. One example would be if we realized that we cannot resist ice cream if it is in front of us. So we can commit beforehand not to buy ice cream and bring it home. We are committed to an action before we go into the store. We can think of this as a 'precommitment' strategy whereby we know we want to be sure we don't give in, so we either remove the temptation or set up a consequence. An example of

a precommitment strategy is having an automatic deduction for your savings or retirement account so that you do not have to make a decision that might lead you to overspend. You can think of consequences you might not like and commit to penalize yourself if you break your rule. Or you can think of an automatic deduction that would occur if you broke your rule. Another way of thinking about precommitment is to buy a membership in a class or health club that commits some resources toward your learning or exercising." The therapist can also ask, "Is there some behavior you want to decrease or increase for which we could set up these consequences?" Homework can also include committing beforehand to send a text message to someone (including the therapist) in the event that one is tempted to act out. The patient can use Form 6.3 to strengthen his or her precommitment strategies. An example of a precommitment approach for a patient is given in Figure 6.3.

Possible Problems

In some cases, patients may be reluctant to establish a "response cost" for their undesirable behavior. The patient may argue, "Why should I punish myself if I'm trying?" The therapist can indicate that making decisions to change might often involve making decisions to experience consequences, even if they are undesirable. Having a small negative consequence may help the individual become more motivated to make the desired change. In some cases, the patient may overestimate his or her ability to exercise self-control: "I don't need artificial constraints to do the right thing for myself." This is a common misperception of self-control. The therapist can suggest that the patient set up an experiment for a couple of weeks without any precommitment strategies to see if things work out well. In addition, the therapist can inquire if there have been other times that the patient believed that he or she could exercise self-control but was unable to follow through. What are the costs and benefits of knowing your limits and planning ahead?

Cross-Reference to Other Techniques

Other relevant techniques include activity scheduling, pleasure prediction, cost–benefit analysis, making decisions for a future self, and examining affect forecasting.

Form

Form 6.3 (Committing to the Future by Deciding Now).

Behavior I want to change	Advantages of changing this	What I am willing to commit to do (penalty, send message, tell friend, etc.)
Exercise four times every week	*Lose weight, have more energy, feel better about my appearance, get into better shape, feel like I am taking care of myself*	*I will keep track of every day that I exercise. I will use the app on my phone to remind me to do this. I will report to my friend, Karen, what I have actually done.*

FIGURE 6.3. Committing to the future by deciding now.

TECHNIQUE: Overcoming Sunk Costs

Description

Rational decision making focuses on future cost–benefit ratios—that is, on future utility: "What will I gain if I do this and at what cost?" One cost of a decision is the loss of other options—for example, if I travel to Boston to see a friend, I will sacrifice the opportunity to go the beach closer to home. This loss of an option is an "opportunity cost." However, many people will focus on a cost they have already incurred for a behavior or prior commitment (a "sunk cost") rather than on future utility, while also ignoring opportunity costs. We can think of sunk costs as focusing on the past cost rather than the future utility: You are concerned with what you "paid" for something rather than what you will get out of it in the future. Sunk costs are *backward-looking decisions*. Humans are the only animals who honor sunk costs (Arkes & Ayton, 1999). Laboratory rats may show a burst of activity as they face extinction trials when reinforcements have been eliminated, but they quickly learn to look somewhere else for rewards. Why are rats "smarter" than humans? Or are we too smart for our own good? Unlike the "rational" rat, humans appear condemned to continually reflect on their past decisions, attempting to make "sense" of them and to justify their future decisions by reference to the past. Honoring sunk costs can be explained by loss aversion—we don't like the idea or feeling of losing (Wilson, Arvai, & Arkes, 2008); commitment theory—we get stuck in a commitment, no matter the cost (Kiesler, Nisbett, & Zanna, 1969); cognitive dissonance theory—we try to make sense or justify a cost by exaggerating the benefits (Festinger, 1957, 1961); prospect theory and loss frames—we frame change as loss rather than gain (Kahneman & Tversky, 1979); fear of wasting—we want to prove that it was not a waste so we stay in whatever the project is, hoping that things will improve (Arkes, 1996; Arkes & Blumer, 1985); and inaction inertia—it's easier not to change than to initiate change, partly because of fear of immediate regret (Gilovich & Medvec, 1994; Gilovich, Medvec, & Chen, 1995). In each case it is the absence of reward that makes this puzzling until we recognize that it is the interpretation of change and the "need to explain" the past that keeps us trapped.

Let's take a closer look at why we get stuck in sunk costs—or why we "honor" a sunk cost. There are several reasons. First, we have a fear of wasting. We don't want to think that we wasted all that time or effort. Consider the following example: I hold up a $100 bill and tell you that I'm going to burn it rather than give it to someone or spend it. Your immediate response is outrage. Why? You can't stand the idea of wasting—even if you are no worse off observing my wasting the money. And this fear of wasting is even more pronounced when we think that we have wasted money on that suit or wasted time majoring in art history or wasted 2 years in a dead-end relationship. Second, we may think that we need to prove that we are right about making our decisions and that giving up a sunk cost will prove that we made a mistake. We fear regret, so we ride a loser in the hope that things will improve. Third, we may be concerned with how bad we will feel in giving up the sunk cost. We may think that our unhappiness will be so intense that we won't be able to stand it. Fourth, we may not anticipate the positive opportunities that might follow once we have abandoned a sunk cost. We don't recognize that new possibilities may open up once we lift the anchor and sail away. And, fifth, we may be overly concerned with how others will view us if we give up a sunk cost, anticipating that they will criticize us, blame us for not giving up sooner, or view us as a quitter.

Smart people often get stuck with poor decisions that they keep holding onto, hoping that they will prove worthwhile in the long term. I'm not suggesting that patients whimsically abandon marriages, careers, jobs, or even that suit/dress in the closet, only that they take a few minutes to examine their commitment to a past decision that seems no longer to be rewarding and that might help them make a better decision now. I point out that good decisions should point to future benefits. They should not be overly concerned in justifying the past when they can benefit more by moving forward.

Questions to Pose/Intervention

The therapist can ask the patient to consider the following:

"What are the current costs and benefits of continuing in the present situation?"
"What are the long-term costs and benefits of continuing in the present situation?"
"If you were deciding again to make that purchase [get into that relationship, etc.], would you make the same decision? Why not?"
"If you lost that suit or dress [or current situation], would you go out and buy the same one again? Why not?"
"Are you sacrificing other opportunities because you are stuck with this sunk cost? For example, are you giving up the possibility of other relationships or work or studies by sticking with something that is leading nowhere? What is the opportunity cost of your commitment to a past decision?"
"Could it be that the benefits of your choice decreased over time while the costs increased? If so, has the tradeoff—that is the costs versus the benefits—changed?"
"Did you not have all the information when you made the initial decision but now—with new information—it is clear that this is not what you expected?"
"Are you trying to prove that you are right, even if it keeps you committed to the wrong decision? Is it more important to be right than to be happy?"
"If you were observing someone else in the same predicament, would you recommend that he or she stay with the sunk costs or get out? We are usually much better at advising someone else to give up sunk costs because we are not trying to justify our own behavior. We are talking about someone else."
"Could abandoning a sunk cost be the sign of *good decision making* rather than bad decision making? All of us have made decisions that don't work out—but a key element in good decision making is knowing when to quit."
"Do you admire a good decision maker who has given up on a bad investment? Knowing when to fold is the sign of good poker."
"Are you overestimating the importance of short-term discomfort in giving up the sunk cost? Is it possible the initial discomfort will give way to relief?"
"Have you given up on sunk costs in the past? Are you glad that you got out while you could? Did anything positive follow from giving up?"

Example

THERAPIST: I know you have been involved with Ron for 4 years now and you keep pointing out how unhappy you are. How long do you think you have been unhappy in this relationship?

PATIENT: If I'm honest with myself, I would say about 3 years. The first year was pretty good, but he has just been irritable and unavailable emotionally for a long time. I've been really unhappy. I keep thinking I should leave, but I've been with him for 4 years.

THERAPIST: What do you see as the long-term costs and benefits of staying with him?

PATIENT: Well, maybe things will work out in the long term. Maybe we can make it work. But I know that the long-term costs will probably be a lot more of the same: just not feeling connected, not really happy. And I guess I'm not getting any younger. So maybe it's a waste of time.

THERAPIST: How about the short-term costs and benefits?

PATIENT: Well, the short-term cost of staying is I'm unhappy. But a benefit is that I don't have to face the pain of breaking up and feeling lonely and maybe regretting things.

THERAPIST: What advice would you give a friend?

PATIENT: I'd tell her to get out. It's not worth it. You're just kidding yourself.

THERAPIST: Have you ever had the experience of buying something—maybe a dress—for which you paid good money, and after taking it home, hanging it in the closet, and look at it again, you realize it's not really you? And even though you can't return the dress, because it was in a closeout sale, and you know you won't wear the dress, you're still unwilling to donate it because you paid good money for it? That's known as a "sunk cost." You can't accept that it's not useful to you now, but you keep it because you already invested in it.

PATIENT: Yeah. That really is me—hoarding things and not throwing them out.

THERAPIST: I wonder if the relationship with Ron is like that. Is it a sunk cost?

Homework

The therapist can ask the patient to consider how he or she would handle problems that might arise in the short term and long term if the patient decided to make a change. Form 6.4 can help the patient identify the problems and errors underlying the need to honor sunk costs. An example of a sunk-cost response for a patient considering breaking up with a married man is shown in Figure 6.4.

Possible Problems

Patients typically have many objections to abandoning a sunk cost. These include the belief that giving up now means that they have wasted all that time, that they are poor decision makers, that others will ridicule them and say, "I told you so," and that they could not stand admitting and accepting the loss. The therapist can point out that although the benefits outweighed the costs earlier on, these tradeoffs have changed and that continuing in the sunk cost is a waste of time. Also, even if they have wasted time, that is no justification for continuing along a losing course. Since everyone wastes time at some point, the issue is when does the patient make a decision to pursue other opportunities? Further, good decision making involves recognizing a sunk cost and giving up on it, so *giving up* would actually be a sign that the person is moving toward better decision making. The objection that others will ridicule the person can be addressed by pointing out that true friends will be happy that he or she has finally given up on something that is without benefit. Finally, although there may be an initial sadness about admitting and accepting the loss, letting it go is likely to open up the freedom to pursue achievable goals.

Cross-Reference to Other Techniques

Additional relevant techniques include cost–benefit analysis, making decisions for a future self, and examining affect forecasting.

Form

Form 6.4 (Examining Sunk Costs).

Problematic behavior: *Dating a married man*

- **What are the current costs and benefits of continuing in the present situation?**
  Costs: Feel second best, angry, and resentful on the weekends; feel trapped; feel embarrassed telling my friends.
  Benefits: Enjoy spending time with him, good sex, don't have to go through the pain of a breakup now.
- **What are the long-term costs and benefits of continuing in the present situation?**
  Costs: Won't find a suitable partner. Will regret this even more. Will feel more depressed and more trapped.
  Benefits: Can continue to hope that he will breakup with his wife.
- **If you were deciding again to make that purchase or get into that relationship, would you make the same decision? Why not?**
  No, I would not pursue this relationship if I knew how this would end up for me. It's not going to go anywhere, and I will feel more and more trapped and resentful.
- **If you lost that suit or dress (or current situation), would you go out and buy the same one again? Why not?**
  I will never get involved with a married man again. It's foolish.
- **Are you sacrificing other opportunities because you are stuck with the sunk cost? For example, are you giving up the possibility of other relationships or work or studies by sticking with something that is leading nowhere? What is the opportunity cost of your commitment to a past decision?**
  Yes, there are other men out there whom I could pursue, but this relationship keeps me from being truly open to them.
- **Could it be that the benefits of your choice decreased over time while the costs increased? If so, has the tradeoff (costs–benefits) changed?**
  That's true, it was more enjoyable at first when I fooled myself into thinking I could handle it. But I have become more resentful and depressed over time.
- **Did you not have all the information when you made the initial decision, but now—with new information—it's become clear that this is not what you expected?**
  In some ways, no, because he kept telling me how bad his marriage was and I had hopes that he would separate from his wife. He did lead me on.
- **Are you trying to prove that you're right, even if it keeps you committed to the wrong decision? Is it more important to be right than to be happy?**
  I know it sounds stupid, but I guess I try to prove that I am right because I get defensive when I talk to my friends.
- **If you were observing someone else in the same predicament, would you recommend that he or she stay with the sunk costs or get out?**
  This is a good point. I have told other friends in similar situations that they are getting stuck in relationships where they are second best and that they would have better alternatives elsewhere.

(continued)

FIGURE 6.4. Example of examining sunk costs in a relationship.

• **Could abandoning a sunk cost be the sign of *good decision making* rather than bad decision making?** *I've been making a bad decision for over a year now—staying in this relationship. It's time for me to make a good decision and start getting out.*
• **Do you admire a good decision maker who has given up on a bad investment?** *I do. I can see that I have admired my friend who got out of a bad marriage.*
• **Are you overestimating the importance of short-term discomfort in giving up the sunk cost? Is it possible that the initial discomfort will give way to relief?** *I am, because I think that I'll be devastated. I know I'll feel bad for a while, but I'll probably feel relieved after a few months.*
• **Have you given up on sunk costs in the past? Are you glad you got out while you could? Did anything positive follow from giving up?** *Yes, I've gotten out of dead-end relationships before and, looking back, have never regretted getting out. I only regretted staying in so long.*

FIGURE 6.4. *(continued)*

TECHNIQUE: Modifying Emotional Reasoning in Decision Making

Description

A key element in problematic decision making is relying on emotions to determine risks, outcomes, and alternatives—reflected in the terms "affect heuristics" or "risk as feelings" (Lowenstein, Weber, Hsee, & Welch, 2001). When people are anxious or depressed, they often use their emotions to predict the outcome. For example, the individual anticipating taking a flight might think, "I'm so anxious, so this must be really dangerous." When someone asks, "How do you know it's dangerous?" the individual might respond, "I don't know, I just feel that way." This "emotional heuristic" is a common factor in decision making and may lead to avoiding reasonable risks or to taking unnecessary risks (Finucane et al., 2000; Slovic, Finucane, Peters, & MacGregor, 2004). For example, the individual might find the activity especially pleasurable—for example, drinking, using drugs, having unprotected sex, driving without a seatbelt—and may then anticipate that the risks are minimal (Alhakami & Slovic, 1994). "If it's pleasurable, it must be safe" is often an *implicit* belief. Decision making may be more deliberative or more automatic (the "fast vs. slow" processes described by Kahneman [2011]), and slowing down the decision process may decrease the impact of effect on estimation of risk. In addition, Peters and Slovic (1996) have found that the emotional response to choice is affected by the perception that the approaching threat is unknown, invisible, or hard to determine. For example, a fear of radiation or poison would evoke more of an emotional response than the threat of a car accident.

Mere exposure to a stimulus leads to an increase of positive feelings, even in the absence of any positive contingencies (Zajonc, 1982). Individuals are more likely to estimate increased risk or probability of harm if they consider something they dread (e.g., cancer) than in considering other harmful consequences (e.g., accidents) (Slovic, Finucane, Peters, & MacGregor, 2007).

Questions to Pose/Intervention

"Sometimes we make decisions based on our current emotion. For example, if we're sad or anxious, we may be reluctant to take any risks and want to avoid situations that might seem challenging. In contrast, if we're feeling happy and confident, we are more likely to face a challenge and less likely to avoid things. Now consider how you currently feel and ask yourself if your negative mood is affecting your decision making. Are you more pessimistic, less willing to try things, and more hesitant to face challenges? If you were feeling really happy, what would you be inclined to do? Think back to some happier moments; picture some images and memories in your mind. Imagine yourself feeling confident, strong, and happy. What would you be inclined to think or do?"

Example

PATIENT: I'm so worried about my son. He's been having such a hard time this past week.

THERAPIST: Yes, I know. It sounds like you are really upset. Can you tell me what is especially upsetting?

PATIENT: I know he's been up and down for the past few months, but I am feeling really anxious and I think something might happen.

THERAPIST: What are you afraid will happen?

PATIENT: I don't really know. I just feel anxious.

THERAPIST: What does that make you want to do?

PATIENT: I guess I want to go check on him at his apartment, but I know that will get him angry. He doesn't want me interfering with his life.

THERAPIST: Yeah, that must be frustrating for you. But what is the reason you think there is something really bad happening?

PATIENT: I can't think of anything except that I'm anxious.

THERAPIST: Could it be that you think, "Because I am anxious, something bad is happening?" Like you are using your emotion as evidence about reality?

PATIENT: I do that a lot, I guess.

THERAPIST: And what happens when you do that?

PATIENT: I get more anxious. And then I think it's really terrible.

THERAPIST: A lot of times we can make decisions based on our emotions. Sometimes that's OK. But it might not be the best guide to what is really going on. Is there any evidence that things for your son could be getting better?

PATIENT: I guess. He's started with a new therapist.

Homework

The patient can consider current or past decisions that have been troubling, identify the unpleasant emotion (e.g., anxiety, sadness, anger), and identify the decision most likely to follow from the negative or unpleasant emotion. Then the patient can imagine what would have happened if he or she felt very happy and optimistic, inducing this mood by recalling positive images of experiences from the past. Once the positive mood has been induced, the patient can consider how he or she might go

Decision I would consider	How I would think of this if I were in a negative mood	How I would think of this if I were in a positive mood
Breaking up with Mark, who is married to someone else	I'll never be happy without him. He is the only person who can make me happy. I'll never find anyone to love.	I would think of myself as having better options with single men who are available and who are honest. I would recognize that I have a lot of things going on in my life that don't include him.

FIGURE 6.5. Considering of the effects of mood on decision making.

about making the decision based on this positive mood. What information seemed to have different importance once the positive mood was induced? What information was less important? Why? The patient can use Form 6.5 to evaluate the potential impact of negative moods (e.g., sadness, anger, anxiety) on decision making and the alternatives that would be more likely to be pursued in positive moods. One patient's response to this issue is shown in Figure 6.5.

Possible Problems

Some patients believe that their emotions are based on reality and that "making believe" they feel differently is unrealistic. The therapist can indicate that this is an experiment in thinking differently; it's a way of opening up their imagination to new ways of approaching things. They can always evaluate the options at a later time, or they can test things out by trying new behaviors. In addition, the therapist can inquire about past pessimistic and anxious predictions for which the patient used emotions as a guide. Were these predictions ever wrong? If someone was observing the current situation and did not have the emotions that the patient is experiencing, how would he or she see it differently?

Cross-Reference to Other Techniques

Other relevant techniques include activity scheduling, pleasure predicting, examining costs and benefits of emotional reasoning, and examining past predictions and outcomes.

Form

Form 6.5 (Mood and Decision Making).

TECHNIQUE: Reframing Change as Gain Rather Than Loss

Description

A common error in decision making is to view a change primarily as a loss of something rather than a gain. Individuals are generally averse to loss and will often be reluctant to make a change because they frame the decision in terms of what is lost rather than what is gained. This is known

as "prospect theory," which suggests that the framing of a decision may be more important than the actual tradeoffs. For example, the individual described in the example of sunk costs (see previous technique) may view getting out of the relationship as a loss rather than as gaining new opportunities or experiencing the relief from helplessness in the current situation. (Kahneman & Tversky, 1979; Thaler, 1992). The consequence of focusing on the perception of loss rather than the perception of gain is that one may take the riskier alternative of maintaining a relatively worse outcome. Staying in a bad relationship or maintaining a bad habit is riskier in the long term.

Questions to Pose/Intervention

"We often may think about change as a loss rather than a gain. Of course, it often involves tradeoffs, such that something might be lost while something is gained, or we may have to risk some downside in order to gain some upside. Is it possible that when you think about making a decision, you primarily focus on the downside or the loss part of it while overlooking, to some extent, what might be gained?"

Example

THERAPIST: Now when you are thinking of this breakup with Brian, you seem to focus a lot on how bad you will feel initially and what you will miss. That seems pretty normal to me, since the relationship has meant a lot to you. But I'm wondering if there might be some positives that might also follow from the breakup. For example, were there some unpleasant and painful experiences in the relationship that might no longer be there?

PATIENT: Yeah. I don't have to worry about whether he is cheating. I mean, he would disappear for days sometimes, after a fight, and never tell me where he was. And then I found his phone and saw that he had been in contact with his ex-girlfriend. So I won't deal with that.

THERAPIST: So one thing to be gained from the change is not dealing with cheating and disappearing. Anything else?

PATIENT: Yeah, he was always—well, maybe not always—but often arguing about things with me, and we just had a really hard time getting along. And, you know, there was no intimacy for the last few months. Nothing.

THERAPIST: So you gain getting rid of that?

PATIENT: I guess so, but I'll miss him.

THERAPIST: That's pretty normal to miss someone you have been involved with. How long do you think that will last?

PATIENT: I don't know. I guess I will get over it.

THERAPIST: Any new opportunities that might happen after the breakup?

PATIENT: Maybe I can meet someone I can trust, someone who treats me well.

THERAPIST: So, if you look at the gains and compare them to the losses, there seem to be a lot of potential positives.

PATIENT: I guess so, yeah.

THERAPIST: Do you think that you tend to think of change primarily in terms of loss and not gains?

PATIENT: That's why I get stuck.

Homework

The patient can review the current and past decisions that seemed problematic in terms of whether the focus was primarily on the potential loss rather than the potential gain. To what did this loss focus lead? If the patient had focused also on balancing the view with considering potential gains, what alternatives would have been pursued? Since both losses and gains are objective possibilities, what would be the consequence of considering both and making an argument for both losses and gains? The patient can use Form 6.6. One patient's response to these questions is shown in Figure 6.6.

Possible Problems

Some patients have a hard time seeing a potential gain as a plausible alternative. They may claim, "Oh, this is simply trying to fool myself by thinking positively." The therapist can validate that urging a person to think only positively would be unrealistic, but indicate that the goal here is to think about alternatives and to consider the possibility that *all* decisions involve tradeoffs—costs and benefits—and that looking at changes as potential gains rather than losses may open up new possibilities for reward and action. For example, a patient who was viewing divorce as a total loss was able to eventually see some potential gains as a result of terminating the relationship, including reduced daily conflict and the possibility in the future of a better relationship with someone else. This did not deny the reality of the loss of the relationship or the decreased time with his children, but it did frame the positives as part of the decision-making process.

Cross-Reference to Other Techniques

Other relevant techniques include examining costs and benefits, setting up predictions and testing them, examining evidence from past decisions, role playing against negative thought, and taking someone else's perspective on decision.

Forms

Form 6.6 (Viewing Losses and Gains as a Focus in Making Decisions).

Possible decisions	What happens when I focus primarily on loss?	What happens if I focus primarily on gains?
Breaking up with a married man	I focus only on how bad I'll feel, how lonely I'll be, how much I'll miss him.	I can focus on new opportunities with new men. I can focus on getting out of a no-win situation. I would feel better about myself, and I would feel that I could now pursue positive goals that might actually work out.

FIGURE 6.6. Viewing losses versus gains as a focus in making decisions.

TECHNIQUE: Overcoming Regret Avoidance

Description

A key factor in either indecisiveness about new behavior or consideration about making a change in old behavior is the perception that regret will be severe, long-lasting, and demoralizing. "Regret theory" holds that decision makers may base their decisions on how to minimize future regret and thereby overlook more objective information that could be more relevant (Zeelenberg, van Dijk, Manstead, & van der Pligt, 2000). For example, investors might make the more "conventional" or "popular" decision—going along with a popular stock or a safe bet—rather than consider the merits of alternatives that are more promising. Following the crowd is a regret strategy, since one can always say, "I wasn't the only one doing it." Or requiring more information, waiting, seeking reassurance, or even deferring the decision to others might be used as ways of mitigating potential regret. Thus, one might make decisions by placing more emphasis on reducing potential regret than on maximizing potential gain. As indicated above in the discussion on depressive decision making, regret may be viewed as an ongoing source of self-critical rumination and thus might be a high cost for "failed" decisions.

Questions to Pose/Intervention

"We often stay in a bad situation or don't take action because we believe that we might regret it. As a result, we often avoid change and then feel stuck. Are you making decisions or not making decisions because you fear regretting things in the future? Have you ever looked back and regretted that you did not do something? Sometimes we regret what we did not do rather than what we did do. Is it really possible to live a life without making decisions that don't work out?"

Example

THERAPIST: You sound like you are ambivalent about making this decision about changing jobs. The job offer sounded pretty good to you when we first discussed it, but now you seem reluctant. Why is that?

PATIENT: Well, I can see some uncertainties with this new job and I don't know how it's going to work out. And if I take the job and it doesn't work out, then I would be stuck and I would regret it.

THERAPIST: So, you want to make sure, you're saying, that you can never regret anything? What do you think about the fact that you have felt disappointed with your current job for the past 2 years?

PATIENT: I guess I know it's not right for me, but I could make a decision that doesn't work out.

THERAPIST: That's always true, I guess, but making decisions involves not knowing for sure how they will turn out. But you know what you have and you don't like it. If you stayed where you are for another year, might you regret that decision?

PATIENT: I know I would.

THERAPIST: Sometimes people decide to stay in something that's not so good because they think making a change will be a bigger regret. But you could regret both staying and leaving. The question is not whether there is a possibility of regret, but rather what are the tradeoffs in staying or leaving?

PATIENT: I'm always afraid to make a change because I don't want to regret what I do.

THERAPIST: And, ironically, that's led you to have a lot of regrets about not making a change.

Homework

The therapist can ask the patient to consider how important avoiding regrets may be in making decisions. Listing past decisions that were difficult to make—or, in hindsight, seem now less than optimal—the therapist can inquire how much the patient was thinking about possible regrets in making a decision. Did he or she stay in problematic situations due to worry over possibly regretting the outcome of making a change? Does he or she focus more on short-term or long-term regrets? Looking back over the last several years, does he or she regret the choices to make a change or the choices to stay in the same situation? The patient can use Form 6.7 to identify problematic decision making motivated by a strong desire to avoid regret. An example of one patient using this form is shown in Figure 6.7.

Possible Problems

Some patients may argue that they will regret making a decision to make a change, pointing out past regrets. The therapist can indicate that decisions are often made under conditions of uncertainty,

Decision I am considering or had considered *Changing jobs*

	Examples
Waited a long time	*I've been thinking about this for months—almost a year now.*
Did what other people told me to do	*Actually, no one is telling me to do anything. Some people I talk with don't realize how unpleasant this job is for me.*
Focused on reasons not to change	*Yes. I can always think of reasons not to do something—always keeping myself stuck.*
Sought out lots of reassurance	*I do this a lot and it annoys my friends.*
Let someone else make the decision	*I keep thinking that one of my friends will make the decision for me. But that hasn't happened. And that wouldn't be such a good idea either.*
Tried not to think about it	*I sometimes space out and overeat and drink too much wine at night so I don't have to face things.*
Other	*I miss work a lot. Just don't want to face things. Want to escape.*

FIGURE 6.7. Trying to avoid regrets.

with limited information, and that a decision not to change carries risks as does a decision to make a change. It is risk versus risk. Decision making involves comparing tradeoffs in real time at the point of making a decision. Thus, one cannot guarantee an outcome. Good decision making is not measured against any single outcome; it can only be evaluated at the point that one is making a decision. Regret avoidance may result in an inability to make decisions at all. The therapist can ask if the patient has regretted *not* making changes. Moreover, regrets do not have to lead to rumination—that is, one can say "I regret I chose this" without ruminating for long periods of time. In addition, regret does not necessarily involve self-criticism. I can say that I regret I took this route without criticizing myself.

Cross-Reference to Other Techniques

Additional relevant techniques include examining evidence from past decisions to avoid change; costs and benefits; distinguishing between regret, rumination, and self-criticism; examining the ability to cope with past, present, and future outcomes; and risk versus risk consideration.

Form

Form 6.7 (Regret Avoidance).

TECHNIQUE: Decision for a Future Self

Description

A frequent problem in decision making is to give greater preference to a short-term, smaller reward while forgoing a longer-term reward. Consider this issue in terms of a model of investment. One can invest in exercise on a regular basis for 1 year in order to achieve the longer-term goal of better health, physical fitness, and looking better. However, one can also choose to focus on the shorter-term goal of eating junk food, drinking several drinks, and loafing around the house. We have reviewed some of these issues above in discussing preferences for myopic shorter-term rewards over longer-term greater benefits—a form of "time discounting"—that is, the value of a future goal is discounted simply because you have to wait for it. It's as if one were saying, "I'll take $10 now rather than $20 in 1 year—"paying" an interest rate of 100% to get that $10. (Consider whether you would take a loan with a 100% interest rate; Ersner-Hershfield, Garton, Ballard, Samanez-Larkin, & Knutson, 2009; Hershfield, Goldstein, Sharpe, & Fox, 2011). One way of thinking of time discounting is the tendency we have of placing a greater value on the present "self" versus the "future self." The technique of "decision for a future self" reverses that focus.

Questions to Pose/Intervention

"We often make a decision based on how we feel about getting something immediately—we are impatient, we want it now, we can't wait for it later. So, in your case, think about how you are talking to yourself right now—or for the next 20 minutes—not thinking of how you might think and feel in the future. But let's imagine your 'future self'—a self that might talk to you a year from now or 10 years from now. If that future self were telling you what to do right now, what would he [or she] tell you? If you did all the things that you believe are really in your longer-term interest, and your future self were talking to you, what would he [or she] say?"

Example

THERAPIST: Let's imagine there are two "Yous"—the You who is here right now and for the next 10 minutes, and the You that is to come in a month or a year. The current You makes a decision to lie on the couch, eat ice cream, and watch television because your current You is deciding what it will feel like in the next 10 minutes—it will feel relaxing and the ice cream is delicious. But let's think about a different You—the You that looks back a month or a year from now and is talking to you about the kinds of decisions it wants you to make so that you get from "here" to "there"—that is, from where you are sitting right now to where your future self wants to be a month or a year from now. What would that future You say?

PATIENT: It would tell me to get off my butt and do something and stop complaining.

THERAPIST: Sounds pretty demanding, that future You. Let's do a role play and I'll play you right now trying to decide to have that ice cream and you play the future You.

PATIENT: OK.

THERAPIST: [as current you] I just want to lie here and eat ice cream and just relax.

PATIENT: [as future you] Hey, listen, I need you to get off your butt and exercise. I want to get into shape. You aren't doing your part.

THERAPIST: [as current you] But exercise is so hard and I don't want to do it.

PATIENT: [as future you] It's not as hard as you think it is, and being depressed and out of shape is harder. I need you to do your part and help me get to where I want to be.

THERAPIST: [as current you] You're running a guilt trip on me.

PATIENT: [as future you] No, I'm telling you that you can do it, and I want you to do it. I need you now.

THERAPIST: How does it feel to be the future You?

PATIENT: I never really think this way. It really makes me aware of how I want to be, and I feel like I am letting myself down—that is, my future self.

THERAPIST: We often forget that what we are doing now will determine who that future self could be, and it could be something you desire or something you don't, but it is up to the You in the present to make decisions. Keep in mind the future You that will someday actually look back and evaluate what you did today.

Homework

The patient is asked to consider current and past decisions in terms of how he or she would look at the issues in relation to a future self—1 year and 10 years from now—and how he or she would consider the self making the decision from the point of view of 1 minute from now. Thus, there are three selves—now, 1 year from now, and 10 years from now. Ask the patient: "What would be the important factors if you considered the decision in terms of how you will feel in 1 minute? What is less important? Alternatively, what would be important to consider from the point of view of the future self 1 year and 10 years from now? What would be different if you had made past decisions by considering how your future self would think and feel?" Form 6.8 can help clarify the differences between current and future selves in directing present-moment decisions. An example of a patient using this form to decide to break up with a married man is shown in Figure 6.8.

Current decision I am considering	What seems important right now	Future self: 1 year from now	Future self: 10 years from now
Breaking up with Mark	Having him in my life to do things with. Feeling close to him when I see him.	My future self tells me that this is a bad idea and that I will regret this even more if I stay longer.	I can't imagine being stuck like this for 10 years. It would make me think that life is not worth living.

FIGURE 6.8. Making decisions from the perspectives of current and future selves.

Possible Problems

Some patients claim they cannot imagine a future self that is positive. They view themselves as stuck in a negative pattern that will continue unabated forever. The therapist can inquire if the patient ever had long-term plans that worked out. For example, these might have included simple shorter-term plans as intermediary steps (e.g., planning a trip or a vacation) or longer-term plans (e.g., getting into college or preparing for a career). In the event that the patient claims it is hard to imagine a future self, the therapist can use this belief as an opportunity for change: "Perhaps it is precisely this difficulty in imagining your future self that has kept you from staying with a course of action that might be more productive. Sometimes good decisions are based on imagining the future and how we would want to feel later, rather than making decisions based on the present moment and our level of anxiety or intolerance of discomfort."

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, viewing losses and gains as a focus in making decisions, loss aversion, and precommitment strategies.

Form

Form 6.8 (Decisions by Current and Future Selves).

TECHNIQUE: Diversifying Sources of Reward

Description

A key factor in making decisions is to recognize that there are a variety of sources of reward or potentially positive behaviors. One of the predictors of individuals' willingness to take risks is their perception that they have the ability to engage in a wide range of positive activities and that they are competent to create new opportunities (Leahy, 1997; Leahy, Tirch, & Melwani, 2012). For example, individuals may be more willing to risk approaching others at a social event if they believe that they have a wide range of support in their social life already—they are less "desperate," less in need. They can risk something not working out. Sometimes patients may say, "If it doesn't work out here, I'll have nothing," or "It will never work out." In contrast, if individuals believe that they are "diversified," with many sources of reward and the potential to create new sources of reward, then they are less likely to be demoralized by a setback on one area since they have other potential sources of reward available.

The therapist might explain this idea in the following way: "Imagine that you have all of your life savings invested in one stock, and that stock is volatile with the price going up and down. You would feel immensely anxious. In contrast, imagine that your savings are diversified across 10 different stocks and also included other investments such as real estate and bonds. A decrease in one investment would not imply a decrease in other investments. This 'diversification' provides a sense of security to take some risk in one area." As applied to decision making, individuals can be encouraged to take some risks involving change if they realize that they have a wide range of sources of reward currently and in the future.

Questions to Pose/Intervention

"Sometimes when we think about making a decision, we don't realize that we may have many sources of pleasure, reward, and meaning that would still be available if one thing did not work out. We often may focus on one thing without realizing that there are many rewards we could pursue even if this one thing did not work out. Imagine if you were at a buffet and your favorite dish had run out. Now, you could focus on that one dish and feel badly or you could consider a wide range of alternatives that are still available. In a sense, we can do that in our lives by considering the wide range of rewarding activities that are available to us."

Example

THERAPIST: You seem to focus a lot on the fact that you think that breaking up with Brian would leave you with nothing in your life. Can you tell me more about that?

PATIENT: Well, it seems that we have been together for a couple of years and I just wouldn't know what to do. I would be alone, and I don't know what to do with myself. It's so depressing.

THERAPIST: Yes, it's hard, but I wonder about this idea that you would have nothing. What does that mean?

PATIENT: I don't know what I would do all alone—there's nothing to do.

THERAPIST: Before you met Brian, were there any things that you liked doing?

PATIENT: (*pausing*) Yeah, I had a lot of friends, I worked every day, I traveled, I took yoga, and I used to work out more.

THERAPIST: Could some of those things be available now if you were on your own and free to do whatever you wanted to do?

PATIENT: I guess I would have a lot more time for my friends. I guess I got isolated in the past year. You know, I used to like going to art museums and movies, but he just didn't like those things so I haven't been doing that.

THERAPIST: How about work? Is that rewarding at times?

PATIENT: I've been feeling so depressed about Brian that I have lost interest in work. But before I got depressed, I used to like going to work, and I was doing well.

THERAPIST: So, if you were to think you have lots of areas of your life that have been rewarding and could be rewarding and that didn't require Brian, how would you feel about making a change?

PATIENT: I guess I would be more decisive and let it go.

THERAPIST: You may find yourself focusing on one thing—Brian—to the exclusion of all of those

other great sources of reward and experience and growth that are available. Perhaps we can even begin with setting up some categories of rewarding and meaningful activities. For example, what comes to mind right now is friends, work, exercise, yoga, classes, travel, movies, and reading—just to get things started. And then you can add to these categories of rewarding activities and keep track of what you do each day to see if there is a wide range of possible rewarding experiences for you.

Homework

The therapist can ask the patient to consider a wide range of possible current and future rewarding and meaningful activities. "What activities were rewarding in the past? Could these be similar possibilities now or in the future? How could you go about planning some of these activities? How do you think you would feel if you actually did some of these things?" The patient can list possible rewarding activities from the past, present, and anticipated future, using Form 6.9. In Figure 6.9, a patient reviews her decision to break up in terms of a range of positive available behaviors.

Possible Problems

Some patients have difficulty imagining possible rewarding activities, claiming that their depression or anxiety precludes reward. The therapist can address this by having the patient keep an activity schedule, rating each activity during the week for pleasure and mastery. In addition, the therapist can use pleasure predicting to assess how accurate the patient is in anticipating pleasure. Further, reward menus can be used to sample behaviors that are possibly rewarding. Finally, the therapist can ask what rewarding behavior the patient has experienced in the past independent of this current decision. Decision hesitancy is often due to the belief that it is essential that this decision work out because there are no other rewards available.

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, making decisions for a future self, precommitment, activity scheduling, and reward menus.

Things I did in the past	Things I could do now	Things I could do in the future
Saw my friends Exercised Went to the movies and to theatre Read Traveled Dated different people Played with my dog Took long walks in the city Worked Saw my family	I can do everything in the left-hand column now.	I could do everything in the left-hand column. Date new people Travel more Take courses See more of my friends

FIGURE 6.9. Listing past, current, and future rewarding activities.

Form

Form 6.9 (Past, Current, and Future Rewarding Activities).

TECHNIQUE: Comparing Risk versus Risk

Description

Many people are hesitant to make decisions because they believe there is a risk involved and that not making a decision will avoid the risk. For example, the young woman who thinks of approaching someone at a party may think it is risky for her since she might get rejected and feel humiliated. She focuses on the risk of taking action rather than the possible risk of not taking action. In order to bolster her strategy of avoiding risk, she may wait a long time to "feel comfortable," look for the right moment, search for signs that the other person is interested, or wait to feel confident. As she waits, however, the opportunity may pass and she may lose the chance to meet an interesting person. In making decisions, the rational view would be to weigh the risk of deciding versus the risk of not deciding. There is no risk-free alternative, so the individual may need to weigh the cost of lost opportunities in not deciding.

Questions to Pose/Intervention

"You seem to wait a long time to make a decision and hope to find a point when there is no risk in either moving forward or not. It is as if you are looking for a risk-free choice. But, like a lot of things in life, there are costs in waiting: the costs of lost opportunities. We call this 'opportunity' cost. So making a decision involves weighing one risk and cost against another."

Example

THERAPIST: You and Carol have been together for about 18 months, and it sounds like you are having a hard time deciding whether to get married or to move out and move on. Is there some additional information you need to help you make a decision one way or another?

PATIENT: I guess it's easier for me to coast along and do nothing, but Carol is putting pressure on me to decide to get engaged, and I just don't want to. I just don't see this as a lifelong relationship.

THERAPIST: What would be the possible downside of getting married to Carol?

PATIENT: Well, I find her boring a lot of the time, like we have nothing in common. And I guess nothing has really changed in the past 18 months. She's nice, she really is devoted to me, but I just don't have fun. I don't miss her, and I kind of like being away on business. I'm just not sure if I should break up, but I don't want to have that conversation with her—it's hard to imagine.

THERAPIST: So, what would be the risk if you broke up—what would be the potential downside for you?

PATIENT: I would have to tell her, and it would really upset her. I mean, she's put in a lot of time. And I guess I would be afraid of having to date again—it's not the easiest thing for me.

THERAPIST: Yes, you do care about her feelings and she seems like a good person. So, the downside of leaving is it would upset her, and you would have to date again—and that's uncomfortable for her and for you. So those are the risks of leaving. What is the potential downside of staying?

PATIENT: I would have to deal with the possibility of being bored with my wife if we got married, and then I might come across someone else and find that she might be a better partner for me, but I couldn't pursue her because I would be married. And probably have kids and it would be hard to get out of it.

THERAPIST: So, this is really risk versus risk—the risk of leaving and the risk of staying. We have to keep in mind that not to decide is to decide. There is no risk-free alternative, is there?

PATIENT: I think that's true. I guess I just focus on the risk of leaving, thinking about upsetting her and thinking about how difficult it would be to date again.

THERAPIST: One way of thinking about making a decision is to think of the opportunities that you might lose if you stayed or left.

PATIENT: If I stayed with her, I would lose the opportunity of finding someone I really enjoyed—someone in whom I might actually be interested.

Homework

The patient can consider alternatives that are currently under consideration. The therapist can reiterate: "There are no risk-free choices—everything has a potential cost and a potential upside. Doing nothing has its costs and its benefits, and doing something else also has its tradeoffs. You might be looking for a risk-free alternative, but they don't exist." The therapist can ask the patient to consider the relative risks of doing nothing different versus doing something different. Also, the therapist can ask, "What is the consequence of looking for a choice that has no risk?"

Possible Problems

Some patients believe if they think hard enough and collect enough facts and reassurance, they will be able to avoid risk. As a result they wait an excessive period of time and often miss out on opportunities. The therapist can indicate that there are "search costs" involved in waiting and collecting information. The longer one searches, the higher the loss of opportunities. For example, a young man felt trapped in a relationship that he believed was leading nowhere, but persisted in ruminating about it, seeking reassurance, and trying to look for new information. The therapist indicated that although there were some good things that he found in the relationship, he was trying to make a risk-free decision, which was an impossibility because there was the risk of leaving and the risk of staying. The question was, which risk was likely to produce the better outcome? The patient can use Form 6.10, which provides the space and format to compare alternatives as tradeoffs of risks, to sort through his or her comparative risks.

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, testing predictions about behavior, examining short-term versus long-term consequences.

Form

Form 6.10 (Risk versus Risk Choices).

FORM 6.1

Focusing on Short-Term Goals

Many times we focus on how we want to feel immediately rather than what we want to accomplish over the long term. For example, you might want to lose weight, but you focus on eating that delicious cake that is right in front of you. Think about some decisions or behavior you think could be a problem for you and list that behavior in the left-hand column. In the middle column, list the short-term benefits of that behavior. In the right-hand column, list the longer-term costs.

Problematic behavior	Short-term benefits	Longer-term costs

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FORM 6.2

Focusing on Longer-Term Goals

In order to make improvement in our lives, we need to think about our longer-term goals. For example, if you wanted to get into better physical shape, you might have to exercise even when you don't want to do so. In the left-hand column, list some of your longer-term goals. In the middle column, list some of the behaviors you would need to engage in to accomplish this goal. In the right-hand column, list the way you would feel in the future (months from now) if you consistently did the behavior in the middle column.

Longer-term goal	**What I have to do now**	**How I would feel in the future if I did what I need to do now**

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FORM 6.3

Committing to the Future by Deciding Now

We are often quite good at coming up with goals and affirmations about what we want to accomplish, but we don't follow through. But one way of increasing your likelihood of following through is to make a specific plan and commitment before you are in that situation. For example, this might include "paying a small penalty" or "sending a text message or e-mail" before you do the behavior you want to stop doing. In the left-hand column, list the behavior you want to stop or start doing. Then in the middle column, list the advantages of doing or not doing this behavior. In the right-hand column, list some actions (e.g., paying a penalty, sending a text message, telling a friend) that you would be willing to do.

Behavior I want to change	**Advantages of changing this**	**What I am willing to commit to do (penalty, send message, tell friend, etc.)**

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FORM 6.4

Examining Sunk Costs

Many times we continue to do something because we don't want to admit that it will not work out, and we tend to justify continuing in this course of action because we think we can't just walk away from it. For example, imagine you bought a jacket but seldom wore it, and it hangs in your closet for 10 years. Your partner says, "Why don't you throw it out or give it away?" and you say, "I can't do that, I spent good money on it." Even though it is no longer useful, you feel you can't let it go. We often continue in a course of action simply because we need to justify having been on that course for a long time. This is called "sunk costs" or "throwing good money after bad money." Look at the questions below and write out your answers to each one.

• What are the current costs and benefits of continuing in the present situation?
• What are the long-term costs and benefits of continuing in the present situation?
• If you were deciding again to make that purchase or get into that relationship, would you make the same decision? Why not?

(continued)

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- If you lost that suit or dress (or current situation), would you go out and buy the same one again? Why not?

- Are you sacrificing other opportunities because you are stuck with the sunk cost? For example, are you giving up the possibility of other relationships or work or studies by sticking with something that is leading nowhere? What is the opportunity cost of your commitment to a past decision?

- Could it be that the benefits of your choice decreased over time while the costs increased? If so, has the tradeoff (costs–benefits) changed?

- Did you not have all the information when you made the initial decision but now—with new information—it is clear that this is not what you expected?

- Are you trying to prove that you are right, even if it keeps you committed to the wrong decision? Is it more important to be right than to be happy?

(continued)

- If you were observing someone else in the same predicament, would you recommend that he or she stay with the sunk costs or get out?

- Could abandoning a sunk cost be the sign of *good decision making* rather than bad decision making?

- Do you admire a good decision maker who has given up on a bad investment?

- Are you overestimating the importance of short-term discomfort in giving up the sunk cost? Is it possible that the initial discomfort will give way to relief?

- Have you given up on sunk costs in the past? Are you glad that you got out while you could? Did anything positive follow from giving up?

FORM 6.5

Mood and Decision Making

Sometimes when we make decisions, we base our thinking on our mood or emotions at the time. For example, when we are sad or anxious, we might make decisions based on a pessimistic view. When we are feeling secure and happy, we might make decisions based on our positive mood. In the left-hand column, write down some current or past decisions that you have considered. In the middle column, write out how you would approach this decision if you were feeling down or anxious. Then, in the right-hand column, write how you might think about this if you were feeling happy or secure. What differences do you notice?

Decision I would consider	How I would think of this if I were in a negative mood	How I would think of this if I were in a positive mood

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FORM 6.6

Viewing Losses and Gains as a Focus in Making Decisions

We often make decisions while being biased toward looking at losses rather than gains. For example, we might view a change that we could consider or a new behavior we might try in terms of what is to be lost. Or we might think about a decision in terms of what might be gained. If you look at current or past decisions, were you primarily deciding on the basis of what might be lost or on the basis of what might be gained? What would be a more balanced way of making a decision?

Possible decisions	What happens when I focus primarily on loss?	What happens if I focus primarily on gains?

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FORM 6.7

Regret Avoidance

Often when we are considering alternatives, we focus on the possibility that we might regret our decision in the future. As a result, we may be reluctant to make a change or we might choose a less "risky" alternative at the moment. Some people try to avoid regret by choosing the "popular" alternative, getting reassurance from others, asking others to make the decision, waiting a long time, collecting more and more information, or trying not to think about the decision. Look at some of the decisions you have made or are considering, and write down one of them below. Then consider some of the strategies you might have used to avoid regret and give examples in the right-hand column. What do you think about this approach to decision making?

Decisions I am considering or had considered: _____

	Examples
Waited a long time	
Did what other people told me to do	
Focused on reasons not to change	
Sought out lots of reassurance	
Let someone else make the decision	
Tried not to think about it	
Other	

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FORM 6.8

Decisions by Current and Future Selves

Often when we make decisions, we focus on how we will feel immediately or soon after: We focus on short-term issues. But what if you looked at decisions in terms of how you might feel a year or 10 years from now—your "future self"? Perhaps some issues might be more important to you for the future. This might affect how you think about things now. On this form write down a current decision you are considering, and then write down some of the issues that are important for the next 1 minutes in making that decision. Now get into a time machine and write down what would be important 1 year from now and 10 years from now. What do you observe? Try this with some past decisions.

Current decision I am considering	What seems important right now	Future self: 1 year from now	Future self: 10 years from now

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FORM 6.9

Past, Current, and Future Rewarding Activities

One of the best ways to feel better is to engage in rewarding and meaningful activities. The more sources of reward and pleasure, the better you are likely to feel. In the left-hand column in this form, jot down activities that you've enjoyed in the past—they can be quite simple activities. In the middle column, list some current rewarding activities, and in the right-hand column, some future activities. How do you think you might feel if you did a lot of these activities?

Things I did in the past	Things I could do now	Things I could do in the future

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FORM 6.10

Risk versus Risk Choices

We often try to minimize our risks by doing nothing or by trying to play it safe, but every decision is really a matter of *risk versus risk*. There are no risk-free decisions. Consider a current and a past decision and list them as Alternative 1 and 2, respectively. Now list the risks or downside of doing or not doing whatever is involved in the decision. What are the consequences for you in trying to avoid all risk?

Decision I am considering	**Risk of doing it**	**Risk of not doing it**
Alternative 1		
Alternative 2		

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CHAPTER 7

Responding to and Evaluating Intrusive Thoughts

Intrusive thoughts, images, and urges are core features of a variety of disorders (obsessive–compulsive disorder [OCD], GAD, PTSD, social anxiety disorder, panic disorder, health anxiety, schizophrenia, and body dysmorphic disorder) and underlie depressive rumination and chronic worry. These are thoughts or images that occur spontaneously, have some plausibility from the perspective of the individual, and are experienced as unwanted. In OCD, the individual experiences intrusive thoughts, such as fears of contamination or beliefs about making mistakes; these thoughts are viewed as intolerable, as a signal that something bad will happen and that the thought must be neutralized through actions such as washing or checking. People with OCD often endorse a belief that a thought and an action (or a thought and "reality") are equivalent—that is, "If I have the thought that I might stab someone, then it will become a reality unless I neutralize the thought or avoid the feared target." This "thought–action fusion" underpins a considerable range of OCD beliefs and behaviors, such as the belief that thoughts are dangerous, need to be controlled, and cannot be tolerated. Moreover, the individual will continue to neutralize until there is a sense that "It is enough" (a felt sense)—that is, he or she judges whether the neutralization effort is "sufficient" by the observation that the thought or urge has subsided.

In GAD, intrusive thoughts are experienced as worries that are repetitive negative thoughts about the future. Worriers live in a future that may never occur, overpredicting negative outcomes, demanding certainty, discounting positive outcomes, and underestimating their ability to cope with real problems if they should occur. In PTSD, intrusive thoughts are experienced as images, sensations, memories, thoughts, or urges that are reminiscent of an original traumatic event. For example, an individual who has been brutally assaulted in the past may lie awake in bed with a dread that another attack will occur if he lets his guard down. He is easily startled, for example, by the sound of the wind against the window, experiencing the sound as the recurrence of someone breaking in. With PTSD the images and sensations may be triggered by any stimuli that bears similarity to the original traumatic event, and these intrusive images, thoughts, and sensations are experienced with a sense of "newness"—"It's happening NOW!" As a result of the fear of these intrusions, individuals with PTSD often utilize alcohol and drugs to suppress arousal and to dull their senses, and they avoid situations that are likely to remind them of the feared traumatic memory. Similarly, panic disorder is often characterized by the evaluation that physical sensations (rapid heartbeat, dizziness)

are signs of catastrophic events that are unraveling—such as a heart attack, collapse, or loss of control. In this case, the sensations are the "intrusions" and the individual equates them with the occurrence of a catastrophe unless safety can be established. Thus, individuals with panic disorder may utilize safety behaviors (e.g., have someone accompany them when walking down the street), check their heart rates to determine if they are losing control, avoid any behaviors where the sensations might arise (e.g., swimming), seek reassurance from physicians, or take medications (e.g., selective serotonin reuptake inhibitors [SSRIs], beta-blockers) that may suppress these sensations. In health anxiety the individual's intrusive thoughts follow hypervigilant observation of "symptoms," which are any physical sensations or imperfections that are then interpreted as the manifestation of a threatening disease. Thus, a mole is equated immediately with skin cancer or indigestion is equated with stomach cancer. Intrusions are subsumed under a "disease model of the self," such that the individual believes the occurrence of the thought of a disease is equivalent to a high risk that a disease is present or unfolding and that some imminent action must be taken.

In schizophrenia, delusional thoughts and hallucinations are experienced as intrusive thoughts that have validity. The delusion of being watched by nefarious characters is not interpreted as a thought to be resisted or suppressed, but rather as a thought that is a realistic portrayal of the dangers that are present. The intrusion may take the form of a warning or a sign that one must become hypervigilant. Similar to the intrusions for the individual with OCD—"thought–action fusion"—the paranoid individual may treat his or her delusion of persecution as conferring a benefit, in that it may protect him or her from further harm. Finally, in the case of body dysmorphic disorder, slight imperfections in the body or face are interpreted as ugliness, fat, or deformity, leading either to further self-examination (self-monitoring) through mirror checking or to avoidance of observing the specific body feature. For example, individuals who believe they are too fat (and who, objectively, are not overweight, let alone obese) may observe their stomachs in the mirror, use magnifying mirrors to enlarge the image, pinch their stomachs, ask for reassurance, exercise excessively, eat a very low-calorie diet, purge, or avoid exposing themselves to avoid public humiliation.

A wide range of cognitive-behavioral approaches have been advanced to account for the occurrence, evaluation, and response that individuals have toward intrusive and thoughts or images. For example, individuals with OCD often experience their intrusive thoughts, images, and urges as unwanted, personally relevant, dangerous, conferring responsibility to do something, and as requiring suppression or elimination (Purdon, 1999; Purdon & Clark, 1999; Salkovskis, Forrester, & Richards, 1998). Thus, the occurrence of an intrusive thought—for example, "My hands are contaminated with germs"—is evaluated as indicating that there is something personally relevant ("I must be having this thought because there is something wrong"), requiring an action ("I must wash my hands"), conferring responsibility ("If I don't wash my hands and I get sick, it's all my fault"), and as requiring elimination of further intrusive thoughts ("I must do something until this thought disappears"). These appraisals and control strategies then lead to self-monitoring of the thought, evaluating the occurrence of the thought as a predictor of danger, and activating a variety of control and avoidance strategies such as neutralization, magical safety behaviors, or avoidance of situations where these thoughts might occur.

In this chapter, we review a variety of techniques to address intrusive or unwanted thoughts. Many of these techniques are consistent with metacognitive therapy and with acceptance and commitment therapy and with the integrative CBT models for addressing intrusive thoughts in OCD. These techniques can be used for a variety of problems ranging from all of the anxiety disorders, trauma, depression, and even intrusive thoughts that characterize psychotic delusions. In Chapter 8, I review a wide variety of techniques that can be employed for worry and rumination while recognizing that all of the techniques in this current chapter on intrusive thoughts are also relevant for those problems.

TECHNIQUE: Mindful Detachment

Description

The occurrence of an intrusive thought or worry does not necessitate active engagement or disputation of the thought. Wells and his colleagues have developed a sophisticated and effective "metacognitive therapy" that addresses the individual's response to intrusive thoughts by suggesting that the content of the thought is less important than the *engagement* with the thought. According to Wells, the cognitive attentional syndrome (CAS) is activated when an individual focuses excessively on an intrusive thought (Wells, 2005, 2008). This engagement precipitates worry and rumination and continues unabated, leading to generalized anxiety and the prolongation of depression. Mindful detachment is a technique that allows one to stand back, observing, while not engaging in any control, suppression, or judgment about the validity or importance of a thought. This can involve noticing that a thought occurs, imagining the thought as a cloud that passes, viewing the thought as a telemarketing call to which one does not respond, or imagining the thought as a series of trains coming into and departing the station, as one merely watches them pass. This may appear similar to the use of mindfulness as suggested by Roemer and Orsillo (2002), although the metacognitive model uses mindful detachment as an illustration that the most valuable approach to a thought is often to do nothing. In the metacognitive model, mindful detachment is used as a technique to demonstrate that one need not engage in any control of a thought and that the thought will lose its significance on its own.

Questions to Pose/Intervention

"You may often notice you have an unwanted thought that occurs in your mind. You focus on that thought, interpret the thought, try to get rid of the thought, try to answer the thought, or try to do something to respond to the thought. It's as if the thought has hijacked your attention, and you can't seem to get away from it. We are going to try a different technique here that will allow you to notice the thought and simply observe that it occurs without really doing anything. It's a technique that we call 'mindful detachment,' and it simply allows you to notice that a thought occurs and allows you to step back and just let it be without really doing anything. We can use a number of metaphors to illustrate this."

Example

THERAPIST: So you were telling me that you've been having these thoughts recently about the idea that you will die someday, and this makes you anxious because you wonder what life means and what will happen to your wife and kids once you're gone. But you are 36 years old and healthy, so you don't really think you're going to die anytime soon.

PATIENT: I know it's irrational to be thinking about this, but these thoughts come to my mind and I can't get rid of them.

THERAPIST: When you try to get rid of a thought, it just rebounds. Imagine if I asked you to try not to think of white bears. How long would it be until you thought of a white bear?

PATIENT: I just thought of one.

THERAPIST: So suppressing thoughts doesn't work. You seem to think you have to get an answer to the question—what does life mean—whenever you have a thought like that. It's as if the thought is ordering you around.

PATIENT: Yes, I can't get it out of my head.

THERAPIST: Maybe the goal can shift to observing that the thought is there and that you are going to do nothing about it.

PATIENT: How can I possibly do that?

THERAPIST: Well, imagine if you could just observe it was there and not really engage in it. Sort of like listening to the noise from the street outside and just treating it like background noise.

PATIENT: That would allow me some freedom, I guess. I wouldn't be so obsessed.

THERAPIST: Yeah. It's almost like the thought appears and you are off and running, chasing after the thought, trying to get rid of it.

PATIENT: It's driving me crazy.

THERAPIST: OK. So let's imagine the following. When you get a telemarketing call, do you spend a lot of time talking to them on the phone?

PATIENT: No, I just tell them I'm not interested.

THERAPIST: What if you treated your intrusive thoughts like a telemarketing call?

PATIENT: (*laughs*) That's kind of what they are, really.

THERAPIST: You just notice it and hang up. Or, just notice the caller ID and don't take the call. Consider this example: You're at the train station waiting for the train to Boston and a train comes in marked for Newark, New Jersey. Do you get on?

PATIENT: No, it's not my train.

THERAPIST: OK, the same is true for an intrusive thought. You noticed the train, it's not relevant, so you don't get on.

PATIENT: That would be great if I could do it.

THERAPIST: Or imagine you are watching the clouds in the sky; they are drifting, and you are just observing them.

PATIENT: That could be relaxing.

THERAPIST: So the intrusive thought might be the telemarketing call, the train you don't take, or the clouds that drift by.

PATIENT: That would be really cool if I could do it.

THERAPIST: Do you spend a lot of time reading the messages in your spam filter?

PATIENT: No.

THERAPIST: Then the goal is to recognize that the most important thing to do is to do nothing.

Homework

The patient is told that the goal is to observe a thought without doing anything to suppress it, engage it, refute it, or judge it. A thought is "just a thought." Observing in a detached manner can include imagining the intrusive thought as a telemarketing call that is not answered, as a message in the spam filter, as a cloud passing in the sky, or as a train that one does not board (Wells, 2000a, 2008). The patient can use Form 7.1 to stand back and simply observe a thought, and Form 7.2 to practice acknowledging and letting go of an intrusive thought. In Figure 7.1, we can see one patient's response to these mindfulness instructions.

Distractions I noticed in trying to stand back and observe	Advantages of simply observing and letting go	Disadvantages of observing and letting go
My mind kept focusing on what I need to do—like I need to get the answer. Then I began thinking about whether this is really going to help. I noticed the sound of traffic in the street. I was also noticing I felt edgy, like it was hard sitting still.	I guess if I can just observe the thought and not get caught up in it, I can relax more. I seem to get caught up with the idea that I need an answer every time these thoughts come into my head.	I guess I'm afraid I'll ignore something important and not do what I need to do. But I can't really think of what I'm going to do that will make anything better.

FIGURE 7.1. Practicing detached mindfulness.

Possible Problems

Some patients say it's impossible for them to just stand back and observe a thought and let it go. They believe that a thought has a magnetic pull for them. This idea that one is inevitably hijacked by a thought can be addressed by asking the following: "Imagine your boss comes into your office and says, 'I have something urgent to discuss.' Would you say that you couldn't talk right now because you're wrapped up in your thoughts?" Or the therapist can ask the patient to notice an intrusive thought that bothers him or her. Then the therapist can ask the patient to describe all the green and blue shapes and objects in the room in as much detail as possible. After the patient has engaged in this distraction exercise, the therapist can ask what happened to the intrusive thought. The point is that paying attention to the thought and engaging it is a matter of choice, and that one can hear the phone call or watch the trains coming in and out without getting hijacked.

Cross-Reference to Other Techniques

Other relevant techniques include acceptance, scheduling worry time, observing from a balcony, doing a mindful breathing exercise.

Forms

Form 7.1 (Detached Mindfulness); Form 7.2 (Imagining the Thought as Something Else: Don't Take the Call).

TECHNIQUE: Thought Balloon

Description

Related to the idea of detached mindfulness is the technique that suggests we can imagine our thoughts or impulses or emotions as "thought balloons" that float around in the air. The patient can imagine the balloon has a string that allows him or her to dance the balloon around, swing it in the air, and watch it bob up and down. In addition, the patient can imagine letting the balloon go and watching it drift around in the air, float away, and eventually disappear. This technique addresses the patient's belief that he or she is "fused" or "identified" with a thought—"I am my thoughts"—and replaces this belief with "My thoughts can be out there and can float away."

Questions to Pose/Intervention

"Imagine your intrusive (bothersome) thought is a thought balloon—sort of like a little balloon that contains whatever thoughts, emotions, and impulses with which you are struggling. Imagine the balloon as a little party balloon. Perhaps it is red, and perhaps it has a little smiling clown face on it. You hold the string of the balloon, wave it around, and watch the balloon going up and down. There is a little breeze, so you let go of the string and it floats away. It gently floats up in the air, it pauses, and then it drifts into the distance."

Example

THERAPIST: Sometimes we think our thoughts are really powerful, and that they can overwhelm us and dominate us. It's like a thought intrudes on your mind and takes over. We call these kinds of thoughts "intrusive thoughts" because they often bother us, as if they were invading and controlling us. Does that ring a bell for you?

PATIENT: Yeah, I get caught up in these thoughts that I will always be alone.

THERAPIST: So the thought enters into your mind and you get carried away. I think of this as being hijacked by your thoughts.

PATIENT: It feels like the thought just won't let up.

THERAPIST: You get pulled away by the thought and can't let go. But let's imagine something different. Let's take your thought that you will always be alone and imagine that this thought is now inside a balloon. I will call this your "thought balloon." Imagine that it is a red balloon, the kind that a kid would have at a birthday party. And you are holding the string and bobbing the balloon up and down. Can you picture that image?

PATIENT: OK, I see a red balloon. OK.

THERAPIST: Now let's imagine that you are going for a walk and you have the balloon above you, and there is a little breeze and you watch the balloon moving in the breeze, but you are still holding the string.

PATIENT: Yeah, that feels good, actually.

THERAPIST: Now imagine that you decide to let go of the string. The balloon drifts away a little, hangs there in the breeze, then drifts some more.

PATIENT: I can see that.

THERAPIST: And now the balloon is drifting up and you see it. It's still there. And you watch it. You wonder where it will go. It stays there for a while, and then it drifts away.

PATIENT: I like this. (*laughing*)

THERAPIST: So, with the thought balloon, you are not the thought because it's in the balloon. You are not trying to smother the thought. Imagine if the balloon had been really, really big, like one of the floats in the Macy's Thanksgiving Parade. Larger than you. And you were trying to grab the balloon with your arms and hold it, and it began to rise and take you away. That's the kind of experience in which the balloon is larger than you and hijacks you.

PATIENT: Ugh.

THERAPIST: But in this thought balloon example, this is a small balloon, a party balloon, and it has a little clown face on it, and it's drifting around and you are watching it. And then you let it go.

Thoughts/feelings about intrusive thought	Thoughts/feelings about letting the balloon go
This idea that I'll always be alone really plagues me. I can't get it out of my head at times. I keep having images of lying in bed in my apartment feeling lonely and sad and hopeless.	This makes me feel like I can just let it go for a few minutes. Watch it drift away into the sky. I like the image of a clown face on the balloon. Like it's something I don't need to take seriously. I can see my hand letting the string go. It floats away.

FIGURE 7.2. Letting go of thoughts using the thought balloon.

Homework

The patient is instructed to observe if any troubling thoughts occur and to imagine a troubling thought as a balloon (see Form 7.3). The patient can give the balloon a color, imagine a silly face on the balloon, and even imagine a set of balloons floating around, each balloon with a different thought, feeling, or impulse. Imagining the balloon as part of a party for intrusive thoughts, the patient is waving the balloon by a string. And then the patient can imagine letting it go, watching it drift away. One patient's response to using the thought balloon technique is shown in Figure 7.2.

Possible Problems

In some cases the intrusive thought is frightening, and it may be difficult at first for the patient to imagine the playful image of the balloon. In this case, the patient can imagine the intrusive thought as a very large balloon, much larger than him- or herself. Using imagery restructuring, the patient can now imagine taking the air out of the balloon by pressing an imaginary valve and listening to the squeak and squeal of the air leaving the balloon. Now that the balloon is much smaller, the patient can imagine walking along in the park, holding the string to this smaller balloon as it drifts along and is eventually released.

Cross-Reference to Other Techniques

Other relevant techniques include mindful detachment and imagining the thought as something else (trains in station, clouds, telemarketing call).

Form

Form 7.3 (Thought Balloon).

TECHNIQUE: Examining Thought–Action Fusion

Description

Many people who have difficulty with intrusive thoughts equate the occurrence of a thought with an increased risk that unwanted actions will occur. This is known as "thought–action fusion," and it underlies all of the anxiety disorders in which unwanted intrusive thoughts are a problem for patients (Rachman & Shafran, 1999; Rachman, 2003). For example, individuals who have the thought that they have contaminated themselves will believe they are contaminated; individuals who believe

they might do something violent also believe that they must get rid of this thought lest they act out; and individuals who believe they might go insane also believe that the occurrence of the thought will lead to insanity. Thus, thoughts are monitored and feared, and the underlying belief is that a thought is the same thing as reality. By examining and disputing this belief, patients can learn that the occurrence of a thought is not the same as an action or reality.

Questions to Pose/Intervention

"You may believe the occurrence of a thought is the same thing as reality. Thus, if you have the thought that you are contaminated [going insane, at risk of acting violently, acting out sexually, etc.], you may believe the thought predicts this as a reality [behavior]. The thought becomes reality or the thought becomes action. This is what we call 'thought–action fusion,' and it is an important component of your anxiety. You may notice that you have a lot of thoughts during the day and that some 'stand out' to you because you believe that they are dangerous or that they predict something. For example, imagine if I asked you to write down the name of someone you love and then write 'I want [name] to get into a car accident.' Would you have a difficult time doing that? Most people would. It's because many of us will treat writing out an unwanted thought as actually a dangerous thing to do. Of course, if you think about it logically, writing down anything does not mean that it will happen. Accidents don't occur because someone wrote something on a piece of paper. I only mention this to illustrate that all of us are susceptible to thought–action fusion.

"But let's look at how you are responding to having a thought. Do you believe that the occurrence of a thought will lead to action? Does a thought mean the same thing as reality? How are thoughts and reality different? If you went to the doctor and told her [him] that you thought you had pneumonia, would the doctor examine your thoughts or would she take your temperature, listen to your lungs, and take an x-ray? How are thoughts and reality different? How often have you had a thought about an action but did not take that action? Why not?"

Example

THERAPIST: Sometimes we treat our thoughts as if they are the same thing as reality. For example, you believe that the thought "I'm contaminated" means that you are indeed contaminated. So you then wash your hands or you do everything you can to avoid touching things that might lead to that thought.

PATIENT: I know, but it seems so real to me.

THERAPIST: Of course it does, which is why it's so hard for you. Every time you have that thought, to you it means that you *are* contaminated, and that really is upsetting. But I wonder if we might look at that more closely. Is the thought "I'm contaminated" the same thing as being contaminated?

PATIENT: I don't understand.

THERAPIST: Well, imagine you had the thought that you had pneumonia and you saw your doctor. Would she examine your thoughts or would she examine your body?

PATIENT: My body, of course.

THERAPIST: But if your thoughts were the same thing as a disease, then your thoughts would be as relevant as a chest x-ray.

PATIENT: I know. It sounds absurd.

THERAPIST: It's almost as if you have to wash yourself because you are contaminated by the thought that you are contaminated.

PATIENT: That's how it feels. When I have the thought, it just makes me feel like I need to wash.

THERAPIST: Yeah, I know. That's what we call thought–action fusion, whereby a thought and reality are considered to be the same thing. But thoughts are simply chemical and electrical events in your brain. Let's try this thought: "There's a zebra over there." Just repeat that 10 times.

PATIENT: (Repeats "There's a zebra over there.")

THERAPIST: Any zebras?

PATIENT: No. (*laughing*)

THERAPIST: OK, let's try the thought "I'm contaminated." Let's repeat that thought.

PATIENT: (Repeats "I'm contaminated.")

THERAPIST: How do you feel?

PATIENT: I feel contaminated.

THERAPIST: So the thought becomes reality—thought–action or thought–reality fusion. The thought "I'm contaminated" becomes the contamination. What if you treated the thought like background noise that is irrelevant and insignificant?

PATIENT: That would be a relief.

THERAPIST: OK, close your eyes and just listen to the sounds you hear.

PATIENT: (*Closes his eyes.*)

THERAPIST: What did you hear?

PATIENT: I heard the traffic from the street and the sound from the air conditioner.

THERAPIST: OK, but you didn't notice that before I asked you to close your eyes and listen. So you treated that as background noise. You can do the same with your thoughts.

Homework

The patient can list the thoughts (or images) that are disturbing and then indicate why they are disturbing. For example, does the thought imply that something is really happening or about to happen? The patient can indicate how a thought is different from action or from reality. How many times has the patient had the thought and nothing bad happened? Why? The patient can use Form 7.4. The patient who feared being contaminated used the form in Figure 7.3.

Possible Problems

Some patients argue that their thoughts are real to them. For example, a patient may say, "But I'm not making this up. These are the thoughts that I have." This is a legitimate observation, but the patient may be confusing the fact that having a mental event (a thought) is not the same thing as observing something outside the self. The thought–action fusion illusion can be illustrated by asking the patient to close his or her eyes and imagine a zebra, visualizing the striped animal, watching it walking, petting it, and imagining the zebra saying, "Thank you." Then the therapist says, "Now open your eyes and see what is in front of you. Having a vivid imagination is not the same thing as depicting reality." Further, the therapist can demonstrate the illusion of the thought–action fusion by

Thought that bothers me	What I think it means—what will happen if I have the thought?	How is this thought different from reality?
I'm contaminated from touching the seat where someone else just sat down.	I think that this means that I'll get more and more anxious unless I clean my hands right now.	Just because I have a thought about being contaminated doesn't mean I am contaminated. We touch a lot of things every day and that doesn't mean we'll get sick. If touching something meant you would get sick, then everyone would be sick all the time. My thoughts are not the same thing as reality.

FIGURE 7.3. Examining thoughts versus reality.

asking the patient to levitate the chair. "Try really hard to make the chair rise." Nothing happens. In addition, the therapist can ask the patient how many times in the past have these intrusive thoughts been wrong. If thoughts and reality were the same, what accounts for these wrong outcomes?

Cross-Reference to Other Techniques

Additional relevant techniques include distinguishing thoughts from reality, linking thoughts to feelings, mindful detachment, thought balloon, and acceptance.

Form

Form 7.4 (Thoughts versus Reality).

TECHNIQUE: Asking If the Thought Is Relevant

Description

A key element in many of the anxiety disorders and in rumination is the belief that a specific intrusive thought is personally relevant to the individual. For example, the individual with OCD believes that an intrusive thought about contamination implies that there *is* some contamination that needs to be addressed (Clark, 2005; Purdon, 2009). Similarly, the individual with GAD believes that an intrusive worry about possibly doing poorly on an exam requires that he or she *do* something. In the case of OCD, the individual may believe that a "bizarre" or "inappropriate" thought reflects some nefarious quality about him or her, even though a vast majority of the nonclinical population will have similar thoughts but consider them irrelevant. Thus, it is not the occurrence of a negative thought, per se, that is the problem, but rather the initial evaluation of the thought as personally relevant and, in some cases, reprehensible, dangerous, or predictive of a negative event. The clinician can examine the patient's belief that a thought is personally relevant—that it is saying something about the thinker.

Questions to Pose/Intervention

"Many times when we have a thought, we may believe it is saying something about us. We may believe that having a thought about violence, sex, sacrilegious content, or other unwanted content is personally relevant to us. For example, you might believe that having a thought about violence means that you will do something violent. Or you might think that if you have a thought about being contaminated, it means that you are contaminated. So we might want to look at whether simply having a thought really means it is relevant to something about you."

Example

PATIENT: I had this thought that I might go crazy and I began to worry.

THERAPIST: What did you worry about?

PATIENT: That this might be a sign that I am going crazy.

THERAPIST: So having a thought that you might go crazy seems very relevant to you. It's like believing, "If I have this thought, it must mean I'll go insane." Is it possible that this thought is only a random thought signifying nothing?

PATIENT: Why would I have this kind of thought?

THERAPIST: Well, people have thousands of thoughts that come and go every day, and they don't make anything of them. You seem to believe that this one thought means something about you. So do you focus on the thought?

PATIENT: Yes, I get anxious when I have that thought.

THERAPIST: So, because you think there is something bad about having this thought, it leads you to watch for it and then you find it and think, "I'm having that thought over and over again. There must be something wrong!"

PATIENT: It's a vicious circle.

THERAPIST: So, if you have this thought a lot, then why haven't you gone crazy?

PATIENT: I don't know. Maybe I will.

THERAPIST: So, if you had the thought that you were going to win the lottery, do you think that this would increase your chances of winning?

PATIENT: No, of course not.

THERAPIST: So thoughts may have nothing to do with reality, they may just be random mental events.

Homework

The patient can identify the thoughts that bother him or her, why the occurrence of that thought is bothersome, and why it seems relevant to him or her. For example, "Am I having this thought because I'm disturbed, losing control, or that something bad will happen? What kind of person has these kinds of thoughts?" Then the patient can indicate why the thought may not be relevant to anything important about him or her. For example, is it possible for someone to have sexual or violent fantasies without running the risk of acting on them? What would be the advantages and disadvantages of considering the thought as irrelevant to something about them? The patient can use Form 7.5. One patient with the thought that he might go crazy if he felt anxious used this form as shown in Figure 7.4.

Intrusive thought or image that bothers me	Why it is irrelevant to who I am	How I would be better off treating these thoughts as irrelevant
I think that when I feel anxious, I'll lose control and go insane. I'll fall apart.	Simply because I have a crazy thought doesn't mean I'm going crazy. I have a lot of thoughts every day, but that doesn't mean that simply because I have a thought, something bad will happen. I have had these thoughts on and off for months and nothing bad has really happened.	This would be great because I can just imagine the thought as background noise that I don't pay attention to. I can focus on enjoying my life. I can concentrate on my work.

FIGURE 7.4. Are these thoughts really relevant?

Possible Problems

Some patients argue, "It must be relevant because I'm the one having the thought." The therapist can suggest that we often get concerned about intrusive thoughts because they actually represent the fact that we do not want to do the feared behavior. For example, a patient who is bothered about sexual or violent thoughts and fears these thoughts is actually demonstrating that the only "relevance" is that he or she is the kind of person who is the least likely to act on those thoughts.

Cross-Reference to Other Techniques

Other relevant techniques include examining logical distortions, arguing back at the thought, thought balloon, and mindful detachment.

Form

Form 7.5 (Are These Thoughts Really Relevant?).

TECHNIQUE: Welcoming the Visitor

Description

In many cases of intrusive thoughts, the patient pushes away from the thought, attempts to suppress or neutralize it, or tries to avoid the thought at all costs. The assumption is that the occurrence of the thought is a terrible thing that might lead to worse consequences or that one must defeat the thought and get rid of it. More attempts to suppress and struggle with the thought lead to more frustration, which further reinforces the view that the thought is dangerous or problematic. In the technique of "welcoming the visitor," the patient is asked to imagine the thought as a visitor that was unexpected. Rather than throw the visitor out or yell at him or her, the patient is asked to imagine welcoming in the visitor, treating the visitor with kindness, and making room for the visitor. A humorous anecdote is provided about an intrusive thought "who" shows up for an appointment with the therapist.

Question to Pose/Intervention

"Many times we fear that if we allow a particular thought to stay with us, something bad will happen. We think we have to get rid of the thought. But there is another way of relating to this thought and that is by treating it like a visitor that you welcome. Maybe it is even someone for whom you might feel sorry. Let's read this little story [see Form 7.6] and imagine yourself welcoming the visitor."

Example

THERAPIST: Sometimes we think that a bothersome thought is something that we need to get rid of. We try to suppress the thought and we get more anxious—even angry—that the thought keeps coming back. But let's imagine that you were to think of the thought as a visitor that you welcome.

PATIENT: A visitor? What do you mean?

THERAPIST: Let's imagine that you think of the thought as a visitor, like an aunt who is a little odd, but you are polite and respectful toward her, and you just act like you are glad to see her. You know she is a bit odd, and maybe she has ideas you don't like, but you have learned to accept that and just welcome her to visit.

PATIENT: OK.

THERAPIST: Now, I'm going to give you a little story about a visitor who shows up unexpectedly. (*Gives the patient the story.*)

After reading this story, can you imagine if you were to treat your intrusive thoughts like this visitor? Just be kind to them, humor them, let them be who they are.

PATIENT: I've never thought of it this way. It's kind of funny—the thought showing up and wanting to talk to a therapist.

THERAPIST: Yeah, and the therapist is just sort of kind to the thought and accepts him and lets him be who he is. In fact, the therapist recognizes that the thought is really lonely, just wants attention, a kind of a lonely thought that nobody cares about.

PATIENT: (*laughing*) It's a funny story.

THERAPIST: Over the next week, try to imagine this story. Read it a few times and then let me know what you think.

Homework

The therapist has the patient read the story "On My Mind" and imagine what it would be like to simply accept a thought as a visitor. Act politely toward the thought, say "I hear you and understand how you feel," and think of the thought as a sad, lonely thought that simply wants someone to talk to.

Possible Problems

Some patients may view this technique as ridiculing the significance of their thought and experience this exercise as invalidating. Although I have seldom found this to be the case, it is a possibility with some patients. It is important to indicate that the exercise and the story is used as an illustration of how we can take thoughts too seriously and that standing back and thinking about a thought as a visitor who simply wants attention allows us to accept a thought without struggling to suppress it.

Cross-Reference to Other Techniques

Other relevant techniques include thought clown, thought balloon, acceptance, and distinguishing a thought from reality.

Form

Form 7.6 (The Thought Visitor).

TECHNIQUE: The Thought Clown

Description

One of the problems that people have with intrusive thoughts is that they view them as unfriendly, dangerous, problematic, and as something that must be resisted and eliminated. The technique of the "thought clown" allows patients to imagine the thought as a funny and silly clown that is jumping around with silly antics, babbling nonsense. By externalizing the thought as a humorous visual image, the patient can let the thought go, observe it, let go of fear and resistance, and simply accept the thought as background noise that is not taken seriously.

Questions to Pose/Intervention

"One of the problems that we often have when we have a thought that bothers us is that we take the thought too seriously. We think we have to do something about the thought because the thought says something bad about us, the thought could be dangerous, and we just can't stand the thought. But another way that we can think about a thought that bothers us is to make-believe that it is a silly clown that is dancing around, making noise, and simply entertaining us. Imagine the clown with a high-pitched voice, dancing with big clown shoes, and big gloves on his or her hands. What would it be like if you just thought of this clown as someone in the background, someone you accept, someone you don't take seriously?"

Example

THERAPIST: It seems that you take your negative thoughts really seriously, almost as if an expert in anxiety is telling you that you will have a panic attack. So, when you have the thought that you will have a panic attack it sounds like the world's authority is talking to you and it is serious and you get anxious.

PATIENT: It scares me when I have those thoughts.

THERAPIST: What if you were to think of these thoughts as coming from a very silly-looking clown. Imagine a clown with big floppy feet, squeaky voice, and weird looking hair. He or she is saying in a squeaky voice (using a squeaky voice), "You're going to have a panic attack." And this clown is jumping around, dancing, singing, "You're going to have a panic attack!"

PATIENT: That's a funny image, a clown. You do a good job with that voice, Doctor.

THERAPIST: I know, I practice. (*Both laughing*)

So, let's do a role play. I will be the wacko clown trying to convince you that you will go crazy, and you argue against me or treat me like a clown. Whatever.

[as clown] (using a squeaky voice) Listen to me! You are going to go crazy and have a panic attack!

PATIENT: You're just a clown. Go away!

THERAPIST: I won't go away. I live here, in your head. I am an expert on panic attacks.

PATIENT: You are a clown. I don't have to take you seriously.

THERAPIST: You certainly do. Do I look like the kind of person who would kid you?

PATIENT: (*laughing*) You're just a circus clown. You're always dancing around saying silly things.

THERAPIST: [outside of role] So, let's say that the next time you have the thought that you are going to have a panic attack, you think, "It's just that clown."

PATIENT: I guess that would be funny. I won't take it seriously.

Homework

The therapist can ask the patient to imagine again that the intrusive thoughts are a thought clown that is dancing around. The goal is not to get rid of the thoughts and not to get rid of the clown, but to allow the thoughts to dance around with the clown, making all kinds of anxious predictions. The patient is instructed to notice the clown and the thoughts, but to consider the source (see Form 7.7). A patient who was a lawyer used the thought clown technique in considering his thought that his anxiety meant that he would start shouting in court (see Figure 7.5).

Possible Problems

Some patients claim that they cannot ignore the thoughts, and they interpret the clown exercise as a technique to fool them into ignoring the thoughts. The therapist can indicate that the clown is not to be ignored but rather observed as an external event involving someone who is quite silly and looks absurd is dancing around singing the thoughts. This visualization allows patients to have distance from the thoughts while still allowing them to be heard but not take seriously.

What the clown looks like	The silly things that clown is saying	How I might think about the clown as background noise that is silly
The clown looks really silly with a big grinning face, floppy feet, and big gloves on his hands. I can even imagine that he has a little horn that he blows, and he dances around.	I imagine him saying that I'll lose control in court and start screaming at the judge.	Well, if I think about it, it's really silly because I have never lost control. It can simply be a joke that my sick creative mind is playing on me. Sometimes I can stand back and think about my client or a witness as a bit of a silly person saying things that don't make sense. It's all part of the game. So I can imagine that this is just more noise.

FIGURE 7.5. Using the thought clown to depotentiate unwanted thoughts.

Cross-Reference to Other Techniques

Other relevant techniques include the thought as visitor, the thought as something else, and thought balloon.

Form

Form 7.7 (The Thought Clown).

TECHNIQUE: Relinquishing Control of Thoughts

Description

Related to thought–action fusion is the belief that one must control or suppress thoughts in order to prevent them from going out of control and leading to unwanted action. Thus the individual who has the thought "Maybe I'll start screaming on the plane" notices the thought, attempts to suppress it, tells him- or herself "I must not scream," and makes every effort to eliminate the thought. The belief is that the uncontrolled thought will lead to uncontrolled action. Relatedly, the belief that a thought will lead to some change in reality (even when unrelated to one's action) is another example of the fusion of thoughts with reality. With this technique of relinquishing control, the patient is instructed to examine his or her beliefs that thoughts are dangerous and need to be suppressed. Next, the individual is instructed to allow the unwanted thoughts to simply occur. Finally, the individual is asked to repeat, "I want this [event] to happen." The question is, "Does letting go of control and repeating the feared thought lead to a negative outcome?"

Questions to Pose/Intervention

"When we have an intrusive thought, we often think that we need to get control of it or things will unravel. We try to suppress the thought or reassure ourselves that we will be OK. We may ask for reassurance from others, only to reject this because the thought comes back. We might dwell on the thought, trying to figure out what it means and what we need to do. When we try to suppress a thought or control it, the thought seems to have a mind of its own. Have your attempts to suppress or control your thoughts really worked? Have they made you more concerned because you cannot control the thoughts? What if you simply allowed each thought to exist—as background noise—while you pursued productive behavior?"

Example

PATIENT: I keep having this thought that I might go crazy. It really bothers me.

THERAPIST: What about having this thought bothers you so much?

PATIENT: Well, I think that it might lead me to go crazy.

THERAPIST: So, what do you do next when you have this thought?

PATIENT: I try to tell myself that I won't go crazy, but that doesn't work—the thought comes back. And then I try to get rid of it—I try to tell myself "stop thinking this."

THERAPIST: That doesn't work, does it?

PATIENT: No.

THERAPIST: You seem to think that you have to control the thought or it will go out of control and you will go insane. It's like you're constantly watching yourself to keep yourself from going insane.

PATIENT: Yeah. It's exhausting.

THERAPIST: I imagine it would be. When something catches your attention and distracts you, and you're not trying to suppress the thought, why don't you go insane?

PATIENT: I don't know. It doesn't bother me then.

THERAPIST: Or when you go to sleep and let your guard down, why don't you go insane?

PATIENT: I never thought of it that way. I don't know.

THERAPIST: So, it would stand to reason, given your theory about needing to control a thought, that repeating it over and over would be very difficult and you might go insane.

PATIENT: I guess I would fear that.

THERAPIST: Now, if you had a fear of elevators and I asked you to get on an elevator and we rode up and down a thousand times, what do you think would happen to your fear of elevators?

PATIENT: I guess it would go away.

THERAPIST: So, let's try that with your feared thought. Repeat after me, "I might go insane." (*Therapist and patient repeat the thought for 5 minutes.*)

I noticed that you began to look tired, like you might nod off.

PATIENT: Yeah, it so boring. It was hard to focus after a couple of minutes.

THERAPIST: So if repeating a feared thought makes you bored, then there is no need to suppress it.

PATIENT: That seems so different from anything I ever thought. Just repeating it. Like it goes away on its own. It becomes boring.

Homework

The patient is instructed to notice that he or she attempts to get rid of unwanted thoughts through neutralization, suppression, or other means and that this further confirms the belief that these thoughts are relevant and dangerous. The patient can consider the many other "irrelevant thoughts" that he or she has during the course of the day and the fact that these thoughts are not treated as important. In addition, the patient is instructed to simply notice the thought and allow it to occur. Then the patient is instructed to repeat the thought slowly over the course of a 10-minute period. The patient can use Form 7.8 to indicate his or her problematic responses to their intrusive thoughts and Form 7.9 to practice the boredom technique (also see Figures 7.6 and 7.7 for responses to repeated exposure of a thought).

Possible Problems

Some patients believe that it is impossible to relinquish control of thoughts, even if it is viewed as desirable to do so. They may say, "I can't ignore the thought if I'm having the thought." The therapist can ask if their boss came into their office while they were ruminating or worrying if they would say, "I can't talk with you right now because I am dealing with an intrusive thought." In addition, the

Thoughts that bother me	Attempts to control or suppress	Outcome
I'll lose control and go insane.	I try to reassure myself that I'm OK.	I feel better for just a few minutes before the thought comes back.

Repeat the thought over and over: "I'll lose control and go insane."	Rate your level of anxiety from 0 to 10 (10 is the highest level of anxiety) Before repeating the thought: 8 After 1 minute: 8 After 5 minutes: 5 After 10 minutes: 2 After 15 minutes: 1
Conclusion: The more I repeat the thought, the more boring it is. It seems that just allowing myself to have the thought won't make me crazy.	

FIGURE 7.6. Problematic responses to an unwanted thought.

Disturbing thought	Initial discomfort	After 3 minutes	After 6 minutes	After 10 minutes
I'll lose my job.	9	4	3	1
My boss will yell at me.	8	3	2	2

FIGURE 7.7. Using the boredom technique to depotentiate unwanted thoughts.

therapist can ask these patients to describe everything in the room that is blue or green and then ask if they ignored their intrusive thought during this exercise.

Cross-Reference to Other Techniques

Other relevant techniques include thought balloon, thought visitor, thought clown, and mindful detachment.

Forms

Form 7.8 (Problematic Responses to an Unwanted Thought); Form 7.9 (The Boredom Technique).

FORM 7.1

Detached Mindfulness

Sometimes a thought occurs in our mind and we have a hard time letting it go. We get hijacked by the thought, dwell on it, and think it is important. The detached mindfulness technique allows you to stand back and observe the thought as if you were watching a movie or watching clouds pass in the sky. Try this for 10 minutes each day; simply observe your thought without doing anything. Doing nothing is the goal. Observe and let it go. After you have practiced this detached mindful awareness, fill out the form below. In the left-hand column, write down what distracted you from simply observing that you were having a thought. Did you think of other things? Were you distracted? In the middle column, write down the advantages of simply observing a thought rather than engaging it, responding to it, or obeying it. In the right-hand column, write down the disadvantages of simply observing and letting go of these intrusive thoughts.

Distractions I noticed in trying to stand back and observe	**Advantages of simply observing and letting go**	**Disadvantages of observing and letting go**

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FORM 7.2

Imagining the Thought as Something Else: Don't Take the Call

In this exercise, imagine a thought you are having as something other than a thought. Imagine the thought as a telemarketing call that you don't answer, or trains coming in and out of a station. You don't have to answer the call or get on the train. Keep track of how you feel later by allowing yourself to detach and let the thought go.

Imagining the thought as a telemarketing call I don't answer or as trains coming in and out of the station	**How I felt later about not taking the call or just observing the passing of the trains**	**What would be the advantages of being able to do this with my intrusive thoughts?**

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FORM 7.3

Thought Balloon

Imagine your intrusive thought or uncomfortable feeling is now a small balloon. Imagine it has a little string and you are holding the string and waving the balloon in the air. And now you let the string go, and the balloon floats in the air and then gently drifts away. Try this exercise every day when you have a thought that bothers you. Write down your thoughts about these thoughts before you try the thought balloon. Why does the thought bother you? Then, after you have let the balloon go, write down your thoughts about letting it go.

Thoughts/feelings about intrusive thought	Thoughts/feelings about letting the balloon go

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FORM 7.4

Thoughts versus Reality

Sometimes we believe that a thought or an image means that something will happen. We might believe the occurrence of the thought means we will lose control or that something bad will happen to ourselves or other people. This is known as "thought–action fusion." But thoughts are different from reality. A thought is simply an occurrence in your brain. In the left-hand column, list some thoughts that bother you. In the middle column, list the concerns that you have about having the thought. Do those concerns imply that something will happen or that you will do something that disturbs you? In the right-hand column, give some reasons why a thought is different from an action or different from reality.

Thought that bothers me	What I think it means—what will happen if I have the thought?	How is this thought different from reality?

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FORM 7.5

Are These Thoughts Really Relevant?

We often have random thoughts and images that we mistakenly think are quite relevant to us. For example, someone may have a sexual fantasy and conclude that there must be something wrong with his or her marriage, or someone might have thought that he or she has some dreaded disease and conclude that this must mean impending death. But perhaps many of the thoughts, images, impulses, and fantasies that we have are not relevant to who we are. They may be random firings in our imagination. In the left-hand column, write down the thoughts or images that concern you. In the middle column, write down some reasons why this thought or image is not relevant to your daily life. In the right-hand column, note how you might be better off if you treated a lot of your intrusive thoughts as irrelevant.

Intrusive thought or image that bothers me	**Why it is irrelevant to who I am**	**How I would be better off treating these thoughts as irrelevant**

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FORM 7.6

The Thought Visitor

Let's imagine that a thought is a visitor that is unexpected, but you welcome him and let him speak his mind. Read the following story and write out how this might be helpful to you if you simply accepted the thought and allowed it to be who it is.

On My Mind

I was sitting in my office, worrying about my taxes, when I heard yelling coming from the waiting room. This surprised me, because no one had an appointment. I opened the door and there was a very short man, with a wrinkled and torn suit, his hair rising wildly in the air.

"I've got to see you. Right now. It's an emergency."

"But you don't have an appointment and . . . "

"I don't need an appointment, do I? If I'm here, why can't I see you right now?"

Filled with doubt and without any ready-made answers to this plausible question—and even more curious than I was disturbed—I said, "What's on your mind?"

"That's exactly it. Exactly! I knew you were the right person for me. I knew you'd understand."

"Understand what?"

"Whatever absolutely needs to be done—and done *soon*. I can't wait anymore."

"Done about what?"

"What's on my mind."

I thought, *Is one of my friends playing a joke on me? Is this "Who's on First?"*

"Who are you?" I gently and cautiously inquired.

"Why? Don't you recognize me? No—how could you? I'm in deep trouble."

"Have I met you before?"

"Perhaps yes, perhaps no. Maybe a thousand times or a thousand, thousand times."

"I don't recognize you."

"Ah. That's exactly the problem. OK—I may as well tell you. I'm an intrusive thought. Yes, I know it sounds incredible. You're probably thinking, *I must be crazy to be talking with him*. But yes, I'm REAL. And I'M HERE!" For a moment he seemed happier, but then looked down forlornly.

"You 'think' you're an intrusive thought. But you look like someone I might see walking around outside."

"Think? Of course I think! I think, *therefore I am.*" He began laughing. And then he began to cough. Louder, gasping for air. "I don't have much time left. Look," he went on, wheezing. He sat down on the chair, his short legs dangling over the sides. "I used to be someone *important*. People would pay attention to me. They would analyze me. If I went off on a wild tirade, people would *interpret* me. Like I was the sphinx. I love it. 'What does it really *mean*?' Hours lying on the couch trying to understand me. Writing me down, tracing my history. 'Do you remember the first time you had this thought?' Ah, those were the days. Real class. Real sophistication. *Interpretations*. 'What does this remind you of?' I loved it."

(continued)

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"It sounds like those were wonderful times for you." I tried to empathize.

"Yes, people took me *seriously*. I was always busy. No one could get an appointment. I mean, I could be *anywhere*—New York, Vienna, Beverly Hills—and I would pop up and people—I mean *educated people*—people with *real* medical degrees—would stand up and say, "There he is! Again!"

"Did it go to your head?" I gritted my teeth after saying this. So insensitive.

"What do you think?" he said, somewhat contemptuously, but sadly too. Like he was lost in a reverie of a better time—one gone forever.

"I traveled in the best of circles. I didn't get any sleep—which, when you come to think about it, is the point. Yes, always on, 24/7."

"Then what happened?"

"Well, at first—back in the old days when I was cooking—at first someone thought, 'Let's get rid of him *completely*.' I loved that. What an *invitation*. To try to get rid of me completely." He began laughing and his cough got worse. There were tears in his eyes as he recalled those days. "Get rid of me. Hah! They began shouting at me. STOP. STOP THINKING! It never worked, so they shouted more. All day shouting at me. It's the most attention I ever got."

"Then what happened?"

"Well, after a long time people began realizing that the shouting was making things worse. After all, you had to pay attention to me—and take me seriously—to shout at me. I never went away. I kept popping up. Then one day someone approached me—totally cool, level-headed—and said, 'Why should I take you seriously?' This guy with a bowtie—he took out a pad of paper and said, 'Let's test you out.' All day—every day—it seemed I was being tested. They barraged me with logic, asking me, 'What's the evidence?' They told me to go out and test my predictions. It was exhausting."

"Then what happened?"

"Well, it was like being humiliated every day. None of my predictions held up. And, can you imagine, telling me, an intrusive thought, 'You're not really rational'! Well, you can imagine how the *other thoughts* felt about me."

"How did they feel?"

He looked down, a bit ashamed. "They wouldn't have anything to do with me."

And he looked at me, almost looking for reassurance that I wouldn't judge him. "That's when I began drinking."

"I imagine this must have been hard for you. At one time people were interpreting you, writing books about your *secret message*. And now you were feeling humiliated. How terrible."

"Oh, it gets worse."

"How?"

"Well, one day someone just said, 'OK. Let him hang out. But we'll get on anyway.' That's the day I saw this psychologist *just walk past me*. He said, 'If you want to go along, that's cool. But I'm getting on with things with or without you.' "

"I can't imagine anything more humiliating for you."

"Oh, no. It gets even worse. Then one guy said, 'So you think you're so powerful. Let's see you do this. Stand in front of the mirror and just keep repeating yourself.' "

"What happened when you did that?"

"I began to disappear. I was simply an empty voice. I finally checked myself into a rehab center for intrusive thoughts."

"Wow. What an experience."

(continued)

"But can you help me?"

I wasn't sure what he wanted. In fact, the longer I spent with him the more I doubted that this was real. But I thought, 'It's a nice sunny day in New York. He's a tourist—I don't know how long he's going to be in town.' "Let's take a cab to the Empire State Building."

He brightened up. His feet began kicking. "I've never seen it. OK!"

We went downstairs and caught a cab downtown. He began fidgeting, "Watch the traffic. It's dangerous. I'm scared." A smile came over his face when he saw I was getting nervous, clutching the door in the cab. When we got to the Empire State Building I took him inside, paid the fee to go to the observation tower, and we got in the elevator. There was a family from Pittsburgh in the elevator. He looked at them and said loudly, "Are you sure this elevator is safe?" His energy was growing. This is what he needed. We got to the roof and I walked out to the deck with him.

We were standing there and I looked at him and said, "Close your eyes." He closed them. I could see this made him nervous. Must be his lack of control. I looked out at the sky over Manhattan. The clouds were drifting in the sunlight. "Open your eyes." I pointed toward the western sky. "Isn't this magnificent?" I said.

I heard him grown and then he gave a deep sigh that grew more feint. He coughed. "I can't take it any . . . longer." His voice became softer. I looked around, but the deck was empty. I thought I saw a shadow, very small, creeping away. In the smallest voice, below even a whisper, I heard him sadly say, "Thanks for everything."

He was gone. I felt sad. He was simply a prankster. And no one cared anymore. I looked over the buildings and saw the clouds reflected in the windows. I felt lost in the sky and the reflections. And for a moment, I felt, I was at peace.

FORM 7.7

The Thought Clown

We often think of our thoughts as negative and dangerous and that we must take them seriously. But imagine the thought as a silly clown who makes a lot of noise and is trying to get a lot of attention. Imagine what its voice sounds like—maybe it's squeaky. In the form below, describe your visual image of the silly thought clown. In the middle column, write down some silly things that the clown might say—like, "Something bad is going to happen"—and then imagine the clown blowing a horn and dancing around. In the right-hand column, note your thoughts about treating your thoughts as a clown dancing in the background rather than as someone or something that you take seriously.

What the clown looks like	The silly things that the clown is saying	How I might think about the clown as silly background noise

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FORM 7.8

Problematic Responses to an Unwanted Thought

We often notice that we have thoughts that we do not want to have and we try to do something to get rid of them or suppress them. This might include telling ourselves to stop thinking that way, seeking reassurance, saying the opposite of the thought, avoiding situations where we might have the thought, etc. In the left-hand column, list some of the unwanted thoughts that you have. In the middle column, list some things that you have done to try to control or get rid of the thought. In the right-hand column, describe what the outcome was. Did it really work in the long run?

Thoughts that bother me	Attempts to control or suppress	Outcome

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FORM 7.9

The Boredom Technique

Many times we believe we need to get rid of an intrusive or bothersome thought so we argue with ourselves, we reassure ourselves, we seek out reassurance. But many times these efforts do not work. This is because we are trying to control or suppress a thought. In this exercise we are going to try the opposite: We are going to *practice* the unpleasant thought over and over to see what happens. Will things get worse? Will you get bored?

In the first column, write down the thought that bothers you. In the second column, write the level of anxiety or discomfort (from 0 to 10, where 10 is the most discomfort) when writing it down. Then repeat the thought silently to yourself for 10 minutes, recording the level of discomfort or anxiety at the intervals noted in the third, fourth, and fifth columns. Do you become bored? Why is that?

Disturbing thought	Initial discomfort	After 3 minutes	After 6 minutes	After 10 minutes

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CHAPTER 8

Modifying Worry and Rumination

Worry is often a chronic condition that persists for years. Many patients with GAD say that they have been worried all their lives. Chronic worry often precedes the onset of depression or dysthymia, wherein the worrier continually focuses on the negative, avoids situations he or she believes might be problematic, and fails to enjoy the present moment. Worry is not limited to GAD: Worries and fears are also characteristic of patients suffering from OCD, social phobia, panic disorder, PTSD, and/or depression. Patients who worry are often told to stop worrying, to believe in themselves, to stop punishing themselves, to try to think of something positive, or to get their minds off of it. None of these well-intentioned suggestions works, and often they further demoralize the worrier because they only reinforce the belief that there is no effective help. The often used technique of "thought stopping," in which the therapist tells the patient to yell "Stop!" (silently, if necessary) whenever a worry or obsession occurs, is not effective. In fact, attempts to suppress the worry only lead to the rebound of the worry because the patient has to "look for the worry" in order to suppress it. This rebound reinforces the idea that the worry is so powerful and out of control that it cannot be suppressed, requiring even further efforts to suppress.

The cognitive-behavioral models of worry have been elaborated in recent years. These models suggest that worry is related to beliefs about the uncontrollability of worry, about the need to attend and suppress worry, the intolerance of uncertainty, perceived limitations in problem-solving ability, exaggerated base rates, perceived need for future threat detection, emotional avoidance, emotional dysregulation, and base-rate neuroticism (Borkovec & Hu, 1990; Borkovec & Inz, 1990; Dugas, Buhr, & Ladouceur, 2004; Freeston, Rhéaume, Letarte, Dugas, & Ladouceur, 1994; Mennin, Turk, Heimberg, & Carmin, 2004; Wells, 2000a, 2002). Wells has advanced a model of worry that proposes that concerned individuals automatically activate the cognitive attentional syndrome (CAS), which is characterized by threat monitoring, repetitive thinking, perceived limitation in cognitive resources, unhelpful control strategies, and continued focus on the content of thinking (Wells, 2000a, 2002; Wells & Carter, 2006; Wells & Matthews, 1994). The subscales of the Metacognitions Questionnaire (MCQ) assess the various functions characterizing worry: specifically, Positive View of Worry, Uncontrollability and Danger, Cognitive Confidence, Negative Beliefs about Worry, and Cognitive Self-Consciousness (Wells, 2004). An alternative model of worry—the avoidance theory—proposes that worry is reinforced by the temporary decrease in arousal during the activation of "cognitive" or abstract worry (Borkovec, Alcaine, & Behar, 2004; Borkovec & Inz, 1990).

Intriguing empirical findings suggest that worry actually inhibits the physiological arousal of unpleasant feelings, resulting in both the incubation of worrisome thoughts that rebound later and the apparent short-term reinforcement of worry as a means of emotional suppression (Wells & Papageorgiou, 1995; York, Borkovec, Vasey, & Stern, 1987). Worry is generally experienced in abstract or linguistic form, further "neutralizing" emotional content and inhibiting habituation, since the emotional or arousal component of "worry schemas" is not activated during the process of worrying (Borkovec & Inz, 1990; Wells & Papageorgiou, 1995). Moreover, worriers believe that worry protects against, prepares them for, and prevents negatives, on one hand, while, on the other hand, also believing that worry will result in negative consequences, such as illness or insanity, and that worrying must be controlled or eliminated (Wells, 2000a, 2002).

In this chapter, I examine a variety of techniques that are helpful in reducing the amount of worry and its negative impact. All of these techniques are applicable to rumination as well. More detailed descriptions of cognitive-behavioral interventions for GAD (the disorder most characterized by worry) can be found in Dugas and Ladouceur (1998), Wells (2000a, 2009, 2011), Portman (2009), Leahy, Holland, and McGinn (2012), or by reading *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2006).

TECHNIQUE: Identifying Worries

Description

We can view worry as repetitive negative thoughts or images about the future. Thus, the single negative thought "I might fail," if quickly disregarded, would not qualify as a worry. The thought must be repetitive, unwanted, negative, and recurrent over time. That is, it must be something that happens on more than one occasion and the individual on each occasion gets stuck in a repetitive loop or focus on the thought. Some of these worries may be experienced as thoughts, such as "I worry that I'll end up all alone," whereas others may be experienced as images, such as "I see myself in an empty apartment crying." In addition to identifying the content and occurrence of worries, it is important to identify the stimuli or situations that trigger the worry. For example, sitting at home alone might trigger the thought "I'll always be alone," or getting an unexpected bill might trigger the fear "I'll go bankrupt."

Questions to Pose/Intervention

"We can think of worry as any thought or image that you might have that makes you anxious about the future. For example, someone might have the thought 'I will fail,' and this thought may bother him or her. This is an example of a worry. These worries are often repetitive. Sometimes we might have a visual image of something bad happening, such as an image of ourselves as alone and feeling lonely or feeling lost. These are worry images.

"Can you tell me what you're thinking when you feel anxious? When you feel worried? Do you ever have visual images or pictures in your mind when you're anxious? Are you making predictions that bother you? Are you thinking that some bad things might happen? What situations trigger your worry? What is happening right before you start to worry?"

Example

THERAPIST: You said you felt really anxious when you were on your way to the party. Can you tell me what was going through your mind?

PATIENT: I thought "I won't have anything to say—I'll look like a fool."

THERAPIST: Did you have any kind of visual image of what that would be like at the party?

PATIENT: Yeah, I could imagine people laughing at me. I could see them laughing, and I turn away from them, humiliated.

Alternatively, the therapist can inquire:

THERAPIST: Can you tell me what you were worried would happen if you started to talk to someone?

PATIENT: I was worried I would begin to fumble for words and make no sense.

THERAPIST: Then what would happen?

PATIENT: I'd look like a fool.

Homework

The therapist can ask the patient to write down examples of worries that arise during the coming week, using Form 8.1. This Worry Log allows the patient to review the pattern of worries, what triggers the worries, what the outcome is, and how these worries may dissipate on their own. The therapist can identify examples of these worries that have already occurred during therapy: "We've already identified some examples of your worries. For example, you've told me you have thought 'What if I fail the exam?' and 'What if I don't pass the course?' You've had worries about meeting new people. Your worries are 'I won't have anything to say' and 'I'll make a fool out of myself.'" Patients begin to realize that there are a limited number of themes and predictions, thereby narrowing the scope of their problem.

Possible Problems

Problems that typically occur include not being able to identify thoughts or worries, confusing worries with feelings or emotions, and not complying with the homework, fearing that writing down worries will make them more "real" and will only increase the intensity of the worrying. The therapist can clarify that a worry is a prediction about the future, whereas anxiety is a feeling that one is having now. Worries, as predictions, can be tested against reality, whereas feelings are true for the individual, by their very nature. Often chronically worried individuals believe that they should "stop thinking" about their concerns or "stop worrying" and that keeping a Worry Log will increase their worries. As noted, thought stopping is not a useful technique for affecting the habit of worrying. The therapist can say: "Some people believe writing down their concerns will make them more worried and the thoughts stronger. You might recall that we have been writing down your thoughts in our sessions in therapy. Do you think this activity has made you feel worse, or does it help you get more distance from the thoughts?"

Cross-Reference to Other Techniques

Techniques related to self-monitoring include eliciting, identifying, and categorizing automatic thoughts; mood monitoring, vertical descent; and imagery techniques focused on eliciting automatic thoughts.

Form

Form 8.1 (Self-Monitoring of Worries).

TECHNIQUE: Examining Costs and Benefits of Worry

Description

Many people have a positive view of worry as a form of problem solving, preparation, protection against possible calamities, motivation, or even as a personal responsibility (see Papageorgiou & Wells, 2000; Wells, 2011). Wells views this belief that worry helps as a Type 1 worry. A Type 2 worry in the metacognitive model is worry that is out of control, dangerous, interferes with daily functioning, and has other negative consequences. The individual is locked in a self-conflicted battle with worry, believing that he or she needs to worry as well as to suppress that worry.

Indeed, worry *can* be helpful in motivating people to get things done; for example, the worry prior to an examination may be helpful in motivating the student to study for the exam. But in many cases the worry can be so intense and continuous that there is decreased ability to concentrate, solve problems, and recall information. Worry often leads to avoidance and procrastination. The patient's underlying theory of worry can be explored by evaluating the costs and benefits of worrying.

Questions to Pose/Intervention

"What are the costs and benefits to you of worrying? [Alternative: "What are the advantages and disadvantages of worrying?"] If you worried less, what do you predict would happen? What would get better if you worried less?"

Example

THERAPIST: Let's examine the costs and benefits to you of worrying about taking the exam.

PATIENT: OK. The costs are that I'm anxious all the time, I can't relax, I feel terrible. I hate exams. The benefits are that I'll be motivated to study.

THERAPIST: If you had to divide 100% between the costs and benefits of worrying, what would it be? 50/50 for costs and benefits? 60/40? 40/60?

PATIENT: I'd say the costs of worrying are a lot more than the benefits. I would give it 75% for the costs and 25% for the benefits.

THERAPIST: So you think you'd be better off if you worried less? What if you worried 50% less? What do you think would happen?

PATIENT: I don't know. I guess I'd worry that I'm not worrying enough!

THERAPIST: Then what would happen?

PATIENT: Maybe I wouldn't do well on the exam.

Homework

Patients can be assigned the task of writing out the costs and benefits of a specific worry, each time they begin to worry, using Form 8.2.

Possible Problems

Possible problems patients encounter when evaluating the costs and benefits include claiming that there are no benefits to worrying; that they do not consider worrying a "choice," and therefore examining the costs and benefits is not relevant; or that reducing worry might make them irresponsible or

careless. We address these issues by asking the following: "Even though you say there are no benefits in worrying, people seldom do anything unless they believe—on some level—that it can be helpful. Try not to be rational when you consider this question." The therapist can suggest some possible benefits to worrying: "Is it possible that worrying motivates you, prepares you, or protects you?" We find it helpful to administer the Metacognitions Questionnaire (MCQ), developed by Adrian Wells (2000a), to assess different beliefs about worry. In regard to the issue of whether worry is a choice, we tell patients to forgo deciding the answer to that question for the immediate moment and to focus instead on becoming more mindful or aware of worrying as a mental activity. Becoming more aware of something—for example, overeating—can be helpful in gaining control and finally experiencing a sense of choice.

Cross-Reference to Other Techniques

Other techniques that are helpful in identifying the costs and benefits of worrying include identifying automatic thoughts, using vertical descent, self-monitoring of worries, examining the behavioral consequences of worrying, and identifying underlying assumptions.

Form

Form 8.2 (Costs–Benefits of Worry).

TECHNIQUE: Turning Worries into Predictions

Description

As noted, many worries are expressed in vague or "what if" terms; it is difficult to test out worries that are really rhetorical questions or statements. Consequently, we encourage patients to restate their worries as specific predictions about events in the real world.

Questions to Pose/Intervention

"Specifically, what are you predicting will happen? When will it happen? Try to specify exactly what will happen so that we will know whether your predictions are accurate or inaccurate. How bad would it be? What would be the long-term consequences of what you are predicting? Are there some positive things that you will no longer be able to do if your worry comes true? How certain are you of these predictions?"

Example

A college student complained of worries about her exams that were coming up in 2 weeks. Her worries were: "I'm not prepared for the exam. There are things we covered that I don't know. I won't do well on the exam."

THERAPIST: You have a lot of worries about the exam. Let's see if you can rephrase your worries as specific predictions. For example, you said, "I'm not prepared for the exam." Exactly what are you predicting will happen?

PATIENT: I won't do well on the exam.

THERAPIST: The exam is in 2 weeks. What do you predict your score will be on the exam?

PATIENT: I don't know. I just won't do well.

THERAPIST: What's an example of a score that reflects "not doing well"?

PATIENT: I guess around 70%.

Homework

Patients can use Form 8.3 to write down worries as they occur, even if they are "what if" worries. Then they should turn them into specific predictions. The therapist may explain: "After you write down your worry in the first column, I'd like you to write down the specific prediction you are making in the second column. For example, if you worry that you are not prepared for the exam, write down that general worry, and then note a specific prediction—for example, as you just said, you'll get around 70% on the exam." One patient's response to this form is shown in Figure 8.1.

Possible Problems

As in the worry monitoring described earlier in this chapter, patients may confuse a worry with a feeling. This confusion can be clarified, as it was earlier. Another more likely problem is that patients will make a vague rather than specific prediction—for example, "I won't do well on the exam" or "I'll choke on the exam." We urge patients to "act like a good journalist" by asking themselves the "W" questions: what, where, and when. "Exactly *what* will happen, *where* will it happen, and *when* will it happen?" Another problem is that patients may not think past the initial worry—for example, "I'm not prepared"—but focus on how they can solve the problem before it arises—for example, "I need to work really hard." This confusion can be addressed in the session by identifying the string of worries and predictions that follow from the initial thoughts.

Cross-Reference to Other Techniques

The most relevant additional techniques include identifying and categorizing automatic thoughts, relating a thought to a feeling, and the use of vertical descent.

In the first column write down your worry as a prediction—for example, "I will fail the exam."

I predict:	Confidence (0–100)	Actual outcome	Conclusions
I'll fail the exam.	80%	I got 85% on the exam, so I did fairly well.	My prediction was way off.
My mind will go blank and I won't remember anything on the exam.	75%	I did get anxious and stopped a couple of times, but then I got back on track and finished the exam.	I was only partly right and only for a few minutes. The bigger picture is that I did OK.

FIGURE 8.1. Testing negative predictions.

Form

Form 8.3 (Turning Worries into Predictions).

TECHNIQUE: Examining If the Prediction Is Testable

Description

Many people label themselves or make predictions that are based on thoughts or statements that can never be proven false. For example, terms such as "worthless person" or "good for nothing" are not even definable: We don't really know what we are talking about when we use those terms. Ironically, we can get ourselves upset over something that is meaningless.

Patients should look at their thoughts as hypotheses or statements about what they think the facts are. Consider the follow statements asserted as "facts":

"Bill is six feet tall."
"I will fail the test."
"It's going to rain tomorrow."
"She won't talk to me."
"No one likes me."

We can "test" the truth of each of these statements by collecting information—by making observations about what is true or false. We can measure Bill's height, we can see how I do on the test, we can look outside tomorrow to see if it rains, we can observe whether she talks to me, and we can collect information about whether people like me. These are *testable thoughts that can be either true or false.*

Some thoughts stated as facts, however, are not testable. We say that they are not open to disconfirmation; they are not "falsifiable" (Popper, 1959). If there is no possible way to disprove a statement, then the statement is meaningless. Here are some examples of statements that are not open to disconfirmation:

1. "No matter what I do, I'm worthless."
2. "Angels exist."
3. "There are spirits that control us."
4. "It's possible that I could go crazy."
5. "I need to know for sure."

Consider how each of these statements could be disproved—or not.

1. If "no matter what I do, I'm worthless," then how can I disprove this? Since you discount all evidence of behavior as indicating you're worthwhile, then you are stating *as an axiom*—as a statement that cannot be challenged—"I'm worthless." You are simply saying, "I'm worthless and there's nothing you can say that can change that belief."
2. The statement "angels exist" also is not open to disconfirmation. We could confirm it only by observing angels, but since angels are generally unobservable, the fact that we don't observe them proves nothing. We can't possibly disconfirm the idea that "angels exist."
3. The same thing is true about unobservable "spirits" that control us. We can't observe them, so we can't disprove any possible influence over us.

4. The statement "It's possible that I could go crazy" also cannot be disproved, since the possibility exists for everyone.
5. We all do many things—for example, drive to work, eat lunch, start conversations—about which we don't know for sure what's going to happen next. Still, we do them. But the belief of needing to know something *for sure* cannot be disproved. It's a preference, an emotion, a "need," or a "want," and there is nothing to prove or disprove.

The criterion of "falsifiability" is important because it allows us to test out the truth of statements. Science is based on taking statements and testing them against the facts. If thoughts cannot be tested, then the thinker can never find out what is true and what is false. From the scientific point of view, such thoughts are meaningless because they cannot be tested.

Questions to Pose/Intervention

"Is there any way that your worry could be tested? Is it at all possible to disprove your worry? When you make a prediction that something bad will happen, how will we know if you are right or wrong?"

Example

THERAPIST: You're saying that you are worried you won't do well at the party.

PATIENT: Yeah, I think I'll screw up.

THERAPIST: When we are worried and we make predictions and what's going to happen, we often find ourselves expecting that something will not work out. How will you know if there are some things that *do* work out? What could count as some positive outcomes?

PATIENT: I guess if people talk to me and smile at me?

THERAPIST: OK. That would be one way of showing that your negative prediction might be inaccurate. How else?

PATIENT: If I had a good time.

THERAPIST: How would we know if you had a good time?

PATIENT: If I met some people, had some conversations, and didn't freak out.

THERAPIST: OK. So let's write those down as possible outcomes to see if your prediction is wrong.

Homework

The therapist can explain the assignment as follows: "Using this form [Form 8.4], consider the thoughts that bother you—'I'm a loser' and 'I'll fail'—and indicate how you could test out their truth or falsity. What would you need to observe or know to conclude that you are indeed a loser or that you have clearly failed? Conversely, how would you know that you were not a loser and had not failed?"

Possible Problems

Some worriers predict their own worry and emotions—for example, "I'll go to the party and worry and feel nervous." This kind of prediction becomes circular: "I'll worry because I'm anxious." The

therapist should ask the patient to predict positive events involving behaviors displayed by self and others—for example, "I'll talk and smile at someone" or "Someone will initiate a conversation with me." In other cases, worriers may discount the positive outcomes, pointing out that this is no guarantee of future positive outcomes. In this case, the demand for certainty can be addressed though "uncertainty training," as described later in this chapter.

Cross-Reference to Other Techniques

Relevant alternatives include distinguishing thoughts from facts, testing predictions, the semantic (definition) technique, and examining the evidence.

Form

Form 8.4 (Making Thoughts and Predictions Testable).

TECHNIQUE: Testing Negative Predictions

Description

In describing this exercise to patients, the therapist might say: "Let's go back over examining your thoughts and predictions. Let's say you have the thought 'I'm a loser.' What does this thought predict about the future? If it predicts nothing, you would probably agree that it's fairly meaningless. But you're upset with the thought because you think it means something about what's going to happen. For example, you might think 'I'm a loser' and therefore:

'I'll never be happy.'
'Judy won't talk to me at the party.'
'I'll never get another date.'
'I'll get fired.'

"Of course, you could be right. But now we have clear predictions that we can test out and see if you are right about being a loser. If your predictions do not come true, you will have to reexamine your negative thought."

However, many times people who have negative thoughts make predictions that are true for everyone. For example, consider the following predictions:

"I'll be unhappy."
"Someone won't like me."
"I'll be alone on a Saturday night."
"I'll have problems at work."

Each of these events is true for almost everyone in the world. To say these events prove "I'm a loser" would mean that everyone is a loser. It is important to examine whether the predictions are good *tests* of the idea that is bothering the patient. To be good at testing a belief, the prediction has to differentiate the patient from most other people; it cannot lead to predictions that are true for almost everyone.

Another important aspect of a workable, useful prediction is that it should give us a reasonable time period. For example, the prediction "I'll get fired" should be expanded to specify the date by which this event will happen. Since it is plausible that most people might lose a job sometime during their lifetime, it would be hard to say that losing a job 10 years from now would make the person unique.

Finally, just as we ask patients to predict what will happen, we also ask them to predict what will *not* happen. Examples of predictions of things that will not happen are the following:

"I won't get a date in the next 3 months."
"I won't get a raise during the next year."
"I won't be able to start a conversation with a stranger."
"I won't be able to finish the project."
"I won't be able to pay my bills this month."

Using Form 8.5, patients can test out their negative beliefs about themselves or the future by listing the events they predict will come true, those they predict will not happen, and then the actual outcomes.

Questions to Pose/Intervention

"Make a list of specific predictions for the next week and keep track of the outcomes. For example, predict the amount of stress you will experience for specific activities and then chart the actual outcome."

Example

For example, a woman is sitting in her apartment feeling lonesome, thinking, "I can't believe I'm alone again! I feel so rotten." These worries or ruminations were addressed in the following manner:

THERAPIST: When you were sitting there thinking about how bad you felt, what were you thinking would happen?

PATIENT: I thought I'd always be alone.

THERAPIST: How could you test that prediction?

PATIENT: By seeing if I could develop a relationship?

THERAPIST: OK. That would be one way. Could you also keep an activity schedule for a week and see if you spend all your time alone, or if you spend some time with other people?

PATIENT: I already know what I'll find. I spend every day with people at work, and I see my friends at least a couple of times a week.

THERAPIST: So the prediction that you'll always be alone isn't true for most days of the week.

PATIENT: But I don't have anyone *special* right now.

THERAPIST: Are you predicting that you never will?

PATIENT: I guess I am.

THERAPIST: OK. We can keep this prediction in mind and test it out in the future. But let's look at the reasons why you think you would never have a relationship. . . .

Homework

Homework involves collecting information about specific predictions during the current time frame and testing the predictions against reality. Patients are asked to write down predictions for the coming week about a variety of negative thoughts and worries—for example, "I won't be able to concentrate" or "I'll have nothing to say" or "I won't be able to get any sleep." Then the data are collected and tested against the outcome.

Possible Problems

Testing the predictions derived from worries requires a way to disconfirm the predictions. If patients phrase the worry in terms of possibilities—for example, "It's possible I could have cancer"—then there is no way to prove it is impossible. Another problem: predictions regarding a distant or vague future—for example, "I might go bankrupt someday." In order to set up behavioral experiments to test predictions, it is necessary to position them in the current time frame. Furthermore, some predictions may turn out to be partly true—for example, the outcome of the prediction "I won't be able to sleep" may be "I got 5 hours of sleep."

Cross-Reference to Other Techniques

Other relevant techniques include identifying automatic thoughts, turning worries into predictions, vertical descent, and mood monitoring.

Form

Form 8.5 (Testing Negative Predictions).

TECHNIQUE: Examining Past Thoughts and Predictions

Description

Worriers often become engulfed in their present anxious state of mind, forgetting that many of their past worries never came true. Indeed, even when one calls attention to this fact, the worrier might say, "Yes, but it might happen this time." In examining past predictions, the therapist can suggest that worries may often be proven false, but we tend to forget that and then start worrying again. The therapist can indicate, "You may get caught up in the here and now of how you're thinking and feeling. You may think *now* 'I'll always be alone' or 'I'll always feel depressed.' But if you were to look back on your negative thoughts in the past, you might find that there is a pattern: You often predict that negative events or feelings will continue indefinitely. By examining the past negative predictions that you've made, you may learn that your pessimism is seldom accurate. Thus *making* a prediction is a lot different from *having a prediction come true*." If patients can learn that they are actually poor prognosticators, this may reduce the credibility of the current worries.

Questions to Pose/Intervention

"Have you made negative predictions in the past? Have they come true or have they proven to be false? Have you had past negative thoughts about yourself, others, and experiences that have not

come true? You were worried about events in the past that you no longer even think about. List as many of these past worries and ask yourself why these are no longer important to you. What does this tell you about your tendency to make false alarms? Could your current worry be another false alarm?"

Example

Consider the following: Judy recently separated from her husband because she felt she did not love him anymore. Even though it was her choice to separate, actually experiencing the separation triggered thoughts about loneliness that led her to feel depressed. She then predicted that she would never find anyone else to care about and that she would always be depressed.

THERAPIST: You told me this is your second marriage, and that you also have had a couple of significant relationships besides the two marriages.

PATIENT: Yes. Before Bill there was my marriage to Ted, and I had relationships with Dave and Ed—Ed was before Ted, and Dave was the one I had the affair with last year.

THERAPIST: What was it like for you in the past when relationships ended?

PATIENT: Oh, I always get depressed and feel hopeless. It's just like it is now.

THERAPIST: So could we predict that when relationships end, you'll think, "I'll never love anyone again," and "I'll always be depressed"?

PATIENT: Yeah. I keep doing that. Just like now.

THERAPIST: But you did love again, didn't you? After Ted there was Ed, and then there was Bill, and then there was Dave.

PATIENT: I guess it's true. I tend to make these predictions, but then I always have another relationship.

THERAPIST: So what could we predict about your loving again and always feeling depressed?

PATIENT: Well, the pattern is, I will love again, and I will get over my depression.

In addition, it was important for us to examine Judy's belief that the only way she could be happy was by being involved with a man. But helping the patient step back from her current predictions and feelings to realize that she has a recurrent pattern of negative predictions that do not come true was quite helpful.

Another application of this technique is with anxious patients who continually predict that they will have a heart attack or lose control. These people suffer from *panic disorder*—they are afraid of having panic attacks. For example, for 4 years Betsy predicted she would lose control and pass out on the subway.

THERAPIST: How many times in the past year have you taken the subway or bus?

PATIENT: I try to avoid them, but I'd say about 25 times.

THERAPIST: How about over the last 4 years?

PATIENT: I used to take public transportation more often, so I'd say about 150 times.

THERAPIST: And what percentage of the time did you predict that you would keel over in a faint?

PATIENT: Close to 100%!

THERAPIST: How many times have you passed out?

PATIENT: Never.

THERAPIST: So your predictions have been wrong roughly 150 times—100% of the time?

PATIENT: I guess these predictions aren't coming out true.

Homework

The therapist can explain this next assignment in the following way: "Review some negative events in your life, or events that you thought were negative at the time. List your thoughts and predictions and then list the actual outcomes. For example, a past event might be 'giving a talk,' with the negative prediction or thought 'I'll look like an idiot' or 'I'll freeze up,' and with the actual outcome of 'The talk went, OK, although I was nervous.' You also might have made negative predictions that came true. Make a list of the different negative predictions that you have made in the past, going back as far as you can, then examine the actual outcomes." Patients can use Form 8.6.

Possible Problems

Some patients believe that their negative predictions were not really predictions because they were stated as possibilities, such as "I *might* fail." Review how a worry can be turned into a specific prediction: "Were you really thinking 'I'm going to fail'?" Past worries, even when qualified, should be turned into predictions.

Another problem: The past worry continues—for example, "I might get cancer." This possibility still exists—but it cannot be addressed in that form. These kinds of worries can be restated as "My worry or prediction did not come true this week." Yet another problem: Some patients would rather forget their past events that caused them to worry, believing that to recall them would only make them feel worse. The therapist can point out that examining how past worries about specific events have not come true will add to their new belief that current worries may constitute another set of false predictions.

Cross-Reference to Other Techniques

Related techniques include eliciting, identifying, and categorizing automatic thoughts; mood and thought monitoring; and imagery techniques. In addition, it is helpful to review turning worries into predictions with these patients.

Form

Form 8.6 (Examining Past Negative Predictions).

TECHNIQUE: Imagining Better Outcomes

Description

The worrier is so focused on the possibility of the worst possible outcome that better possible outcomes are ignored. This selective bias only fuels more worry. The patient can offset this bias by considering a fantasy of better outcomes that might possibly be true. For example, the therapist can

suggest that the patient consider describing the worst possible outcome, the best possible outcome, and the most likely outcome. Then the patient can elaborate the best possible outcome or a good outcome, describing what might have to happen for this outcome to come true.

Questions to Pose/Intervention

"When we worry, we often focus on the worst outcomes that we can imagine and then we dwell on those. Of course, anything is possible, including good outcomes or neutral outcomes. What could be the best outcome, the worst outcome, and the most likely outcome? Can you describe some neutral or good outcomes and what would have to happen to make those come true?"

Example

THERAPIST: You've been focusing on the possibility that your boss might be angry with you and then you jump to the idea that you will get fired. I wonder if there are other possible outcomes?

PATIENT: I guess I could imagine that nothing will happen. That would be a neutral outcome, I guess. But she *is* annoyed.

THERAPIST: Ok, so we'll call nothing happening the neutral outcome. What would be the worst possible outcome?

PATIENT: I guess it would be that I get fired and I don't get another job.

THERAPIST: OK, so you would be unemployed forever?

PATIENT: Yeah. I know that sounds crazy. I'd get a job.

THERAPIST: Why do you believe that you would get a job?

PATIENT: I have skills that people need. I would get a job.

THERAPIST: OK, so what would be the best possibility?

PATIENT: I don't know . . . my boss promotes me? That's not going to happen.

THERAPIST: What would be the most likely outcome?

PATIENT: It could be that she just wanted to give me feedback. So I use her feedback and do better and things are fine.

THERAPIST: Tell me some details about that possibility.

PATIENT: I would have to use her criticism in a constructive way, and try to do what she wants and get back to her.

THERAPIST: Is that something that might happen?

PATIENT: I guess so.

THERAPIST: Now let's imagine that you focus on this outcome. This might be the "use the feedback" goal. Now you have things to do and you can start today. How would that be?

PATIENT: A lot better than worrying about it.

Homework

The patient can identify the following: the worst possible outcome, the best possible outcome, a neutral outcome, and the most likely outcome. In addition, the patient can then describe in some detail

what would have to happen for the best, neutral, and most likely outcomes to occur (see Form 8.7). Finally, the patient can describe possible outcomes and what would have to happen—and what he or she would need to do—to bring about those better outcomes (see Form 8.8).

Possible Problems

Some patients focus on the idea that "It's possible that the worst outcome can happen" and "If it's possible, then I should worry about it." The therapist can ask the patient to consider the implications of focusing almost exclusively on the worst possible outcome. What are the costs and benefits? What would be the advantage of focusing on the most *probable* outcome?

Cross-Reference to Other Techniques

Other techniques that might be used include testing predictions, examining past predictions, how the patient handled past negative outcomes, and making predictions and terms clearly testable.

Forms

Form 8.7 (Possible Outcomes); Form 8.8 (Stories about Outcomes).

TECHNIQUE: Avoiding Rejection of Imperfect Solutions

Description

Some people who worry look for solutions that are perfect and that completely eliminate any downside. They think about what the problem might be, generate possible solutions, test the solutions against a standard of perfection, and then reject the solution. They promptly return to worrying and generating more problems, then more solutions, in an endless quest for perfection. The therapist can ask the patient to consider the possibility that there may not be perfect solutions in an imperfect world, and that accepting probable and pragmatic solutions that are less than perfect might be a better alternative. The therapist can suggest that one can make progress by practicing "successful imperfection"—that is, by taking small and imperfect steps in the right direction so that success accumulates over time.

Questions to Pose/Intervention

"Sometimes when we worry we think about solutions that we could pursue, but then we reject them because they are not perfect solutions. We might think, 'It won't be the best solution' or 'I'm not sure it would work' or 'It might be unpleasant.' Our demands for perfection might not allow us to be practical. In an imperfect world, imperfect solutions might be the only ones available. What would be some examples of your demand for a perfect solution? What could be some imperfect solutions that you might consider? What are the costs and benefits of accepting an imperfect solution?"

Example

THERAPIST: You worry that you might lose your job, and then you think about things that you can do—like get feedback from your boss, improve your performance, look for other jobs, and

acquire new skills—but then you reject each solution. It seems that when you worry, you generate problems and then reject the solutions that you come up with.

PATIENT: I'm just trying to be realistic.

THERAPIST: It's important to be realistic. Yes, of course. But if you reject solutions, is that realistic or pessimistic?

PATIENT: Maybe it's both.

THERAPIST: Could be. But one way of thinking about possible solutions is to view solutions as having both pros and cons. Every solution has tradeoffs. So if you focus on your work and try to get along, there are tradeoffs. Maybe you have to do things that you don't want to do. That might be the case. Or if you consider other jobs, there are tradeoffs. Are there any solutions for anything where there are not tradeoffs?

PATIENT: I guess not. But some are better than others.

THERAPIST: That's for sure. Yes, some are better than others. But none of them is perfect. What are the costs and benefits of looking for a perfect solution?

PATIENT: I guess the cost is that I will never find one. That is frustrating. It just makes me more anxious.

THERAPIST: Yeah. Any benefits of looking for the perfect solution?

PATIENT: Maybe I will find something really great. Maybe it will work out.

THERAPIST: How is it working out for you, looking for that perfect solution?

PATIENT: Not well, I guess.

THERAPIST: How about looking for reasonable alternatives, something that might be practical but not perfect?

PATIENT: I guess that's what I will have to do eventually, won't I?

THERAPIST: Maybe focusing on and accepting imperfect solutions in an imperfect world would help with your worries.

PATIENT: Maybe. Maybe it would.

Homework

The patient can consider if the solutions that he or she comes up with are rejected because they are not perfect. Are they rejected because there is no guarantee that they will solve the problem, there is uncertain information, they would seem unpleasant or unfair, or other negatives that lead to rejection? What would be the costs and benefits of accepting imperfect solutions? What would be some productive action that one could take toward using an imperfect solution?

Possible Problems

Some patients object that pursuing or considering an imperfect solution either is too risky or is settling for less. In the case of risk assessment, the therapist can suggest that there are two sets of risk: the first is the risk of continuing to worry and becoming more depressed, and the second is the risk of pursuing a solution that may be less than optimal. In regard to the risk of continued worry, the therapist can indicate that there is the "opportunity cost" of worry, which involves the "search

cost" of spending more time and energy generating problems and solutions and the cost of forgoing enjoyment of life because the worry will interfere with daily functioning. The objection that one is "settling for less" may be reframed in this way: "You are choosing among imperfect alternatives, and the task is to find the better of the alternatives." The therapist can also suggest setting a time limit for searching for solutions—at least for the present time that the person is engaged in worry. For example, the time limit might be 15 minutes and then the patient can consider, for the present time, ranking the better of the solutions as the one that will be accepted for the time being. This approach allows the individual to reevaluate solutions as new information becomes available.

Cross-Reference to Other Techniques

Related techniques include examining the costs and benefits of perfectionism, examining alternatives and solutions, acceptance, and problem-solving strategies.

Form

Form 8.9 (Examples of Imperfect Solutions).

TECHNIQUE: Reviewing How You Coped with Past Negative Events

Description

People who worry may be good at solving real problems that occur, but not particularly good at solving problems that they make up in their minds. Worriers believe they are actually not good at coping with real problems, but they may be as competent as anyone else. Moreover, worriers may believe that worrying is a form of problem solving in that they generate a worry, think about it as a problem for which they need to generate solutions, test the solutions against a standard of perfection, reject the solutions, and continue to worry (Leahy, 2006).

Patients can review past problems that actually occurred and how they resolved them. In describing this exercise to patients, the therapist might say: "Many anxious and depressed people predict that outcomes will be negative, and many times they are wrong. But sometimes they are right. Bad things do happen to people. Sometimes they happen even if you do not predict them. The real question is, 'Have you ever been able to handle negative events?' The research on worriers shows that when a negative outcome occurs, worriers actually handle it much better than they thought they would. This is an important finding, for it suggests that part of worrying is underestimating one's ability to cope with negative outcomes. If the worrier believes that he or she can handle negative outcomes, then there will be less provocation to worry."

I often use the following story to drive this point home: "Henry is a business consultant working for a medium-sized company. He and his boss have had a number of conflicts in the past month, resulting in Henry's fear that he will lose his job. Henry obsessed about the idea that he might get fired. We examined his ability to earn a living independently of the company, which was somewhat helpful, but his anxiety still remained. Then we decided to look at his history of handling negative events.

"It turned out that Henry was fairly skilled in handling negative events in the past, such as difficulties he had in college, finding his first job, dealing with his son's behavioral problems, and building up business leads in a company that was not doing well.

"I told Henry a story I had heard about another psychologist. The psychologist had a patient who obsessed about getting a sexually transmitted disease. Nothing seemed to help the patient. The therapist and patient reviewed all the things that he could do if he did get a disease, but the patient remained anxious. Then one day the patient came to the office and announced that, indeed, he had contracted syphilis. Much to the patient's and therapist's surprise, the patient responded with excellent adaptive skills to the situation. He obtained the proper medical treatment and quickly recovered.

"A month after I told Henry this story he called me and said, 'Bob, I got syphilis.' At first I had no idea what he was talking about, until he reminded me of the story I had told him. Henry had gotten fired—and now, he said, he felt energized! He had called all of his clients, and most of them were coming away with him into his new consulting company. Just like in the past, he was a survivor.

"In order to examine how you have done in handling negative events in the past, you might list past negative events and ways that you handled them. If you had problems handling negative events in the past, you will benefit from this and other exercises we will explore.

"If you know that you have handled past negative events well, you might want to examine what skills, resources, problem-solving abilities, and other capabilities you brought to bear on these problems or adversities. For example, another patient, whom I'll call Kathy, often worried about negative things happening in the future, leading her to believe that she needed to rely on her husband to solve every problem. We examined the problems that she had already faced in her life and resolved—depression, breast cancer, asserting herself with her mother, learning how to drive, overcoming her fear of flying, and negotiating her contract at work. Indeed, as I reviewed with her how resourceful, assertive, and intelligent she was, I realized that she was the kind of person *I* might call in crisis!"

Questions to Pose/Intervention

"Have you made negative predictions in the past that have come true? Have you been able to handle the outcome? Have you faced negative events before? Do you tend to underestimate your ability to handle negative outcomes?"

Example

PATIENT: I just don't know what's going to happen with Ted and me.

THERAPIST: You're worried that your relationship with Ted might end?

PATIENT: Yeah. We're always fighting, and we haven't been intimate in 2 months now.

THERAPIST: You've had some negative things happen to you in the past, haven't you?

PATIENT: Yes. I lost my job 3 years ago, and my mother died last year. I just don't seem to have any luck.

THERAPIST: Have you ever gone through a breakup before?

PATIENT: Oh, yeah. When I was in college, Ed and I broke up. Then 2 years ago I was going out with Glen, and we broke up. It was very upsetting.

THERAPIST: It was upsetting, yes, but you were able to recover from that breakup. What helped you recover?

PATIENT: Well, I relied a lot on my friends, and then I began to focus a lot more on my work. My friends were terrific.

THERAPIST: If you remember from our talk a few weeks ago, you told me that when you and Glen broke up, you thought you wouldn't meet anyone else.

PATIENT: Yeah, but I did. I met a number of people—some I liked, some I didn't.

THERAPIST: It seems that you were able to recover from the breakup. Maybe you won't break up with Ted, but if you did—perhaps you could think about how you handled some of these other relational situations in the past and harness those skills and resources.

Homework

The homework assignment can be proposed in this light: "If you have been able to handle problems in the past, then you may be able to handle new problems that might arise. I'd like you to spend some time over the next week listing some problems that you have had in the past related to school, work, family, relationships, finances, health, relocating, making new friends—whatever category is applicable. Use this form (Form 8.10). Write out the kinds of things you did that were helpful in resolving these problems as well as the kinds of things that were not helpful." An example of one patient's response to this form is shown in Figure 8.2.

Past negative event	**How I coped**	**Unhelpful ways of coping**
Breakup with girlfriend	*I reached out to friends for support.* *I went online to start dating again.* *I began to work out at the health club.*	*I sat around and isolated myself for a while.* *I ruminated about the past.* *I complained to people about my ex.*
Current problem that I worry about	**How I could cope effectively**	**Unhelpful ways of coping**
Will I lose my job? They are downsizing.	*Try to do the best job that I can* *Network with friends who might know about other job opportunities* *Examine what my skills are and how to find the right match for myself*	*Complaining at work* *Withdrawing and isolating myself* *Drinking to calm my nerves*

FIGURE 8.2. Reviewing how I handled past negative events.

Possible Problems

Many worriers maintain impossible standards of perfectionism. They believe that they should be able to handle negative outcomes at an exceptional level, thus resulting in their observation that when the negative event occurred, they could have done better to cope with it. Because perfectionistic beliefs are a central component of depression, anxiety, and anger, the therapist should examine patients' standards. The cost–benefit analysis and the double-standard technique, as well as examining the evidence as to how self and others compare in coping with negative events, are useful tools for this purpose. Moreover, certain types of negative events may be far more problematic than others. For example, the patient may feel particularly undermined by negative events in relationships but cope better with work problems. The therapist can examine the schemas and assumptions activated in these different categories and can ask the patient to apply skills in one area to the more problematic area (e.g., problem solving, behavioral activation, and communication skills).

Cross-Reference to Other Techniques

Relevant techniques include activity scheduling, problem solving, pleasure predicting, examining the evidence, double standard, vertical descent, and setting up behavioral experiments.

Form

Form 8.10 (Reviewing How I Handled Past Negative Events).

TECHNIQUE: Examining Outcomes and Using Point–Counterpoint

Description

Some people are able to review their past negative predictions and recognize that they are almost always too negative. For example, "Laura" had a fear that she would have a panic attack crossing bridges. When she examined her past predictions that she would lose control and crash, she realized it had never happened. However, rather than learning she was inaccurate in making predictions, she discounted the past information and said "*But it could always happen!*"

Many anxious people discount the validity of past information because it cannot give them the guarantee about the future on which they insist. They want to rule out both *probability* and *possibility.* The past may be a good indicator of probability, but it says nothing about possibility. Consequently, it is considered irrelevant to the issue of demanding certainty about the future. After all, it is possible that Laura could lose control and crash in her car.

A second reason people fail to learn that their negative predictions do not come true is that they are so relieved when things turn out well that they do not want to reexamine the distortion in their thinking. It is part of the nature of memory processing that we recall events that *do occur* rather than events that *do not occur.* For example, try to recall all the events that *did not occur* yesterday. The instruction sounds ludicrous—but, in some ways, it is relevant to the pattern of making a lot of negative predictions that do not come true but failing to note the absence of these unwanted occurrences.

A third reason people fail to learn from past experience is that they develop *exceptions to the rule,* which we refer to as *discounting.* For example, "Gary" predicted that "Paula" would reject him

at the party. However, when he spoke with her, she was quite friendly. Gary discounted this unexpected reception by saying "She was just *acting* friendly. She's a phony." Thus Gary could not learn from the experience because he would not allow his belief to be disconfirmed.

A fourth reason that people might not learn from past experience is that they are heavily invested in their negative belief. Perhaps they think that their negative belief protects them in some way, or they just have a hard time acknowledging that they are wrong. In some cases, patients get into power struggles with the therapist—or with other people—and believe that they will "lose face" if they admit that they are wrong.

Questions to Pose/Intervention

"Are you able to learn from your past negative predictions? Think back about your negative predictions from the past. Did some of them *not* come true? When you think back about the fact that some of them did not come true, what do you make of it? Do you discount this evidence of incorrect predictions? Do you think that somehow your new negative predictions must be valid?"

The therapist can examine, with patients, their tendency to discount past experience by asking them to list evidence from the past that seems to contradict the negative thoughts in the present and to consider the following points:

1. They need guarantees that are not feasible in the "real" world.
2. They do not reexamine occurrences that contradict their belief.
3. They discount the evidence of incorrect predictions.
4. They demonstrate a need to maintain their belief and to be right.

Example

THERAPIST: You're thinking now that the discoloration on your face is a sign of skin cancer. Have you made these kinds of predictions before?

PATIENT: Yeah. It's always something. Last year I thought I had AIDS. A couple of months ago I thought I had a brain tumor.

THERAPIST: So you've made a lot of predictions that haven't come true. What is the evidence that this discoloration is not skin cancer?

PATIENT: The doctor looked at it and said it's nothing to worry about. I've had this on my face a lot of other times.

THERAPIST: So what do you make of the doctor's verdict?

PATIENT: She could always be wrong.

THERAPIST: That's true. And if she could be wrong . . . ?

PATIENT: Then I shouldn't accept what she says—what *any* doctor says—unless I can be certain.

THERAPIST: And if you accepted what your doctor said but you did not feel certain?

PATIENT: I would always regret it, if it turned out to be skin cancer.

THERAPIST: Is your thought "I should continue worrying and checking until I can be certain"?

PATIENT: That's it.

Homework

The patient can list some past negative predictions that did not come true and then list the reasons why he or she did not use this as information to change the pattern of negative predictions. Form 8.11 can be used for this purpose. Examples of why the past does not lead to correction of current negativity can include thoughts such as "I won't settle for anything but a guarantee," "I don't look at evidence that I could be wrong about my current predictions," or "I don't look at the evidence of incorrect past predictions." The patient is encouraged to come up with his or her own reasons for discounting these predictions. In addition, the patient can engage in an argument, back and forth, with him- or herself that involves challenging each point in the argument, while the patient shifts sides, pro and con. The patient is asked to engage in a point–counterpoint. This exercise involves giving a rational response to the current negative thought (e.g., "I might have AIDS"), then challenging the rational response, and again challenging the negative thought. The patient can use Form 8.12 to debate, back and forth, from automatic thought to rational response in this point–counterpoint exercise.

Possible Problems

One problem is that patients may claim that they cannot think of any challenges to the rational response. They may agree with the therapist. In this case, the therapist should attempt to modify the task into a role play, in which the therapist plays the negative counter to the rational response. This addition may reveal automatic thoughts and assumptions that patients cannot challenge adequately.

Cross-Reference to Other Techniques

Related techniques include examining the costs and benefits, role playing both sides of the thought, examining the evidence, examining the logic, and using the double standard.

Forms

Form 8.11 (Why I Don't Learn from Past Predictions); Form 8.12 (Point–Counterpoint).

TECHNIQUE: Distinguishing between Productive and Unproductive Worry

Description

Many people who worry will resist considering—let alone accepting—the idea that worrying is useless. Indeed, worrying *can* be a helpful catalyst for preparation and a deterrent to negative outcomes. The goal of therapy is not for patients to eliminate all worrying but rather to learn to distinguish useful from useless worrying and how to turn worries into solutions. The therapist might use the following explanation.

"Let's imagine that you are beginning a 700-mile drive. You might begin the journey with productive worries such as 'Do I have enough gas? Have I checked the oil and coolant? Do I know the way? Have I given myself enough time to get there?' These are useful worries because they are prudent; they are focused on events or problems that have a reasonable probability of being relevant to your trip, could reasonably cause you a problem if left unexamined, and, most importantly, *lead you to solving a problem.* In contrast, suppose your train of thought went in the following direction:

'What if I have a heart attack while I'm driving? What if the tires explode on the highway? What if I get kidnapped? What if I leave for the day and my wife runs off with someone?' Each of these worries describes something that is *possible* but *highly improbable,* is stated in catastrophic terms, and describes something over which you have very little control.

"I distinguish between productive and unproductive worries as the difference between a 'to do' list and a 'what if' list. A 'to do' list leads to a set of reasonable actions that I can take. For example, I can check the gas, oil, and coolant; get a map. This is a list of prudent actions. In contrast, worries about heart attacks, exploding tires, kidnapping, and infidelity do not lead to a 'to do' list. Thinking about these 'what ifs' only leads to a sense of doom and helplessness. These are unproductive worries.

"Not all 'what ifs' are unproductive, however. Some 'what ifs' can be translated into a 'to do' list. For example, 'What if my computer crashes and wipes out the CPU? My document would be lost!' This worry could be translated into a problem-solving question: 'What could I do to secure my files on the computer?' 'I can back up my files in a cloud.' The 'to do' list mentality leads to the productive action of backing up the files."

Unproductive worries are typically phrased in nonconfirmable ways, such as "I can't believe that this is happening" or "I feel so lousy I can't stand it." These ruminations lead to, deepen, and maintain depression (Nolen-Hoeksema, 2000). They can be rephrased by raising the following questions: "Can I change my statement to a prediction?" "What is the problem that needs to be solved?" and "What would be a possible solution to the problem?"

Questions to Pose/Intervention

"Some worries are productive, and other worries are not productive. A productive worry is a concern about something that is plausible—something that a reasonable person might think about. For example, if you were driving from New York City to Washington, DC, it would be productive to ask yourself 'Do I have enough gas?' and 'Can I GPS my map?' Productive worry leads to a 'to do' list of actions that I can take. In contrast, unproductive or useless worries are about very unlikely events—things that a reasonable person would not worry about. A lot of times, these worries don't lead to anything that you can do. Worries that are unproductive include, for example, 'What if I get a flat and my car spins out of control?' or 'What if my engine blows up?' or 'What if someone runs into me?' "

Example

THERAPIST: You said you are worried about the exam. We went over some of these worries—for example, the worry that if you blow the exam, then you won't get into law school and you won't be able to get a job. Those worries led to worries about not making a living and then being a failure.

PATIENT: Yeah, I have a whole string of worries.

THERAPIST: Some of these worries are what we would call "unproductive worries." They are worries that aren't plausible right now and that you can't really do much about. For example, the worry that you might end up as a failure, without any job, is not something you can do anything about today. You can't go out and get a job today because you're in school.

PATIENT: I have a lot of worries like that—like "What if my boyfriend leaves me?" or "What if I get sick?"

THERAPIST: Do any of these worries—about doing poorly on the exam, not getting into law school, ending up with no job, and failing in life—lead to a "to do" list for today and this week?

PATIENT: I guess the only thing is preparing for the exam.

THERAPIST: OK. Let's make a list of things to do to prepare for the exam. When you have the other unproductive worries, you can write them down in your "list of unproductive worries" and put them in a drawer.

PATIENT: What you're saying is that I should only focus on things that I can do something about?

THERAPIST: That's right. We'll narrow ourselves to the productive worry and turn it into a "to do" list.

PATIENT: That sounds more manageable.

Homework

Patients can be asked to monitor their worries and then check off whether each is productive or unproductive. Productive worry is worry that others would find plausible or reasonable and that leads to a specific action. A more detailed form (Form 8.13) is provided that requests patients to ask themselves a series of questions about their worry, such as "Is this worry something with a very low probability of occurring? What prediction am I making? What is the problem that needs to be solved? What specific actions can I take? Is there a "to do" list for me today? Is there something I can do today that will move things forward? Do these actions seem reasonable? Am I worrying about things over which I have little or no control? And is this a productive or unproductive worry?

Possible Problems

Some patients respond that they know that all of their worries are irrational. However, not all worries are entirely irrational or without benefit—for example, worrying about an upcoming annual medical examination or bills due and then making sure that you have the exam or you pay the bills on time is preferable to ignoring such tasks. We wish to indicate to patients that some worries can quickly be turned into a useful "to do" list. Other patients may confuse "possible" worries with "plausible" ones. For example, it is possible that a tire will blow out on the highway and the car spin out of control. However, the only "to do" list for this worry is to make sure the tires are inflated and that normal speed limits are observed. Individuals who claim they need certainty to feel safe can examine the costs and benefits of demanding certainty and consider why they are willing to tolerate many uncertainties on a daily basis but demand certainty for the current situation.

Cross-Reference to Other Techniques

Other relevant techniques include identifying automatic thoughts, vertical descent, mood monitoring associated with thoughts, and cost–benefit analysis.

Form

Form 8.13 (Productive and Unproductive Worries).

TECHNIQUE: Assigning Worry Time

Description

Worries seem to preoccupy an inordinate amount of time for some people, leading them to worry at work, at home, and when they are trying to fall asleep. One technique that is useful in addressing chronic worrying is to establish "stimulus control" over worries—that is, to restrict worrying to a specific time and place (i.e., stimuli), thereby decreasing the association of work, home, and bed with worrying. Furthermore, creating this specific "worry time" helps worriers recognize that they can exercise some control over worrying, even if it only means delaying it a couple of hours. Finally, by assigning a specific time for worrying, worriers come to recognize the limited and finite nature of the content of their worries—that is, they generally worry about the same types of things. This recognition helps reduce the overwhelming sense that they are worrying about *everything*.

The therapist explains that a specific time and place should be chosen for worrying, and that the patient should limit the time during which the worrying occurs, but worry intensely during this time. If worries occur earlier or later during the day, the worrier should jot them down on a piece of paper and save them for "worry time." No other activity should be engaged in during worry time, and the patient should be encouraged to write out the worries, making no attempt at this point to challenge or resolve them. A specific duration should be set—for example, 30 minutes—and worrying should cease at the time limit, but not before.

Questions to Pose/Intervention

"Sometimes people feel their worrying is out of control and that they are worrying all of the time. I'd like you to plan to set aside 30 minutes each day to engage in your worry. Write down all of your worries. If you have a worry during another time during the day, just write it down on a piece of paper and set it aside until your worry time."

Example

THERAPIST: Sometimes people feel they are worrying all of the time. They feel they have little control over when, or how much, they worry. Is that how you feel?

PATIENT: Yes. I just can't get these worries out of my head. I'll find myself worrying when I'm on the bus or sitting at home alone.

THERAPIST: How does all that worrying make you feel?

PATIENT: Like I have no control over my worries. Then I try to tell myself to stop worrying, but that doesn't do any good.

THERAPIST: I'm going to suggest something that might sound a little odd to you. It's called "worry time." I suggest that you set aside some time every day to focus on nothing else but your worries. If you have a worry earlier in the day, just write it down and assign it to yourself during the worry time.

PATIENT: Won't this make me worry more?

THERAPIST: Almost everyone thinks that. But we find that you end up limiting most of your worrying to the worry time and end up worrying *less*.

PATIENT: It seems odd that assigning myself worry time would make me worry less. I thought I was trying to get *rid* of my worries.

THERAPIST: Well, we're not really trying to get rid of your worries. We're trying to get more control over the worries.

PATIENT: When should I do this?

THERAPIST: Plan a regular time every day—a long time before you go to bed. Don't do the worry time when you're in bed. Just write out the worries during that time.

PATIENT: OK. I'll try doing it at 5:30, when I get home from work.

Homework

The therapist can explain the assignment as follows: "Assign 30 minutes each day during which to worry intensely. Write down all of your worries, noting how anxious you are before you start the worry time and how anxious you are after the 30 minutes. Please set aside a time period long before you go to bed. Sit down at a table—not on your bed—and write out all of the worries that come to mind. If you have any worries earlier in the day, write them on a piece of paper and put them off until the worry time. When you have done this exercise for a week, look back at your worries and see if there are some common themes that keep repeating themselves. Form 8.14 can be used to track worries for worry time. A patient's response to this form is shown in Figure 8.3.

Possible Problems

Sometimes worriers find that they cannot fill their designated time period with worries. This "problem" suggests that the worrying is limited—as does the recognition that the worries are similar in content. Intensive worry time serves the purpose of providing stimulus exposure unmediated by neutralization (i.e., by trying to resolve the worries—similar to the type of exposure used when treating people with obsessions and compulsions). Presumably, worriers try to neutralize their feared images by trying to find solutions. In contrast, worry time compels them to focus on their worries without neutralization, thereby leading to habituation of the worry pattern.

Cross-Reference to Other Techniques

Worry time involves identifying automatic thoughts. Other techniques that may be related include monitoring thoughts and feelings, vertical descent, imagery techniques, and categorizing automatic thought distortions.

Form

Form 8.14 (Keeping Track of Worries for Worry Time).

TECHNIQUE: Self-Fulfilling Prophecies

Description

When we try to explain why negative events occur, we may often overlook our own role in their existence. Avoidance, procrastination, and coercion are three types of behavior that foster self-fulfilling prophecies. The avoider eschews interactions with people and explains her lack of relationships by claiming there are few good people available. The procrastinator claims that it will make him anxious

Situation that triggered this worry	My specific worry	Have I had this worry before?
Thinking about this weekend	I'll be depressed and lonely.	Yes, before weekends after the breakup.
Planning on seeing my friend for dinner	When I see my friends, they will think I am boring.	Sometimes—it depends on how I am feeling at the time.
Sitting at home by myself	I'll always be alone and miserable.	Regularly since the breakup. Also, after other breakups.

Worry Time

Time/Date: September 12	**Duration (minutes):** 20
Place: In my apartment, alone	
Anxiety at start of Worry Time (0–100%): 60	**Anxiety at end of Worry Time (0–100%):** 20
Worries: I'll always be alone. I'll never be happy. I'll die alone.	
Common themes in my worrying: Loneliness and depression and isolation	
What are the costs and benefits of worrying about this? Costs: Makes me anxious and miserable and I can't enjoy life. Benefits: Maybe I'll motivate myself by worrying. Maybe I'll find a solution.	
Is this a productive or unproductive worry? The worry is unproductive. Just makes me unhappy.	
Is there any productive action I can take today that will help solve this problem? I can contact my friends, see a film, make plans to go out, go to the gym, read a book, do some yoga.	
Would I be better off if I accepted my limitation at the current time—that I might not know, there is nothing I can do, or there is always some uncertainty? I guess I would be. I don't really have a choice. There is always uncertainty no matter how much I worry.	

FIGURE 8.3. Keeping track of worries for worry time.

to work on the project, not realizing that the reason that he is generally so anxious when working on these projects is because he's put them off until the last minute. The coercive or punitive spouse complains about his wife's coldness, not recognizing that his criticisms have led her to withdraw.

Questions to Pose/Intervention

"Are your problems the result of how you yourself make your predictions come true? Have you behaved as if your thoughts were true and therefore not had the opportunity to find out that you are wrong? For example, you have assumed no one would like you, so you don't interact with people or you leave as soon as you feel uncomfortable. As a result, you have few opportunities to challenge your negative thoughts."

Example

Consider a young woman who claims it is difficult to meet a man. She says she goes to parties, but men do not seem to pursue her.

THERAPIST: What are your thoughts before you go to the party?

PATIENT: I think "I'll never meet a man."

THERAPIST: If a woman were going to show an interest in meeting a man, how would she show that interest?

PATIENT: I don't understand.

THERAPIST: Would she look at the man, look in his eyes when she meets him, smile at him, compliment him, ask him questions?

PATIENT: Well, I can't do that!

THERAPIST: You mean "I don't do that." If you did that, rather than looking down and withdrawing the second you feel the man is not interested—if you stuck with it—what would happen?

PATIENT: I'd get rejected.

THERAPIST: Could it also be that the man might respond positively, smile back, ask you about yourself, maybe even ask you out?

At this point, the patient recognized that her shyness and avoidance might actually be the reason men were not pursuing her. I told her to monitor the number of times men smiled and looked at her and to look back, smile, and ask them about themselves. The outcome for her over the next 2 months was an increase in the interest directed toward her by the men she met.

Now consider a man who procrastinated on his taxes until the week before they were due, resulting in excessive pressure to get the information to his accountant. His thought was, "Every time I think of doing my taxes, I get anxious because I think it'll be so unpleasant." Consequently, he delayed until the last minute. The therapist asked: "Is doing your taxes the event that is unpleasant? Or is doing your taxes *at the last minute* the unpleasant event?" Since he had never tried doing his taxes early, he could not distinguish between the two and had concluded that delaying an unpleasant task would be the better option. This was a self-fulfilling prophecy.

The question such patients need to ask is, "Could my behavior [or lack of a certain behavior] be the cause of what I'm complaining about?"

Depressed individuals often complain to their friends and focus excessively on the negative. Then they complain that people do not like them. If the belief is "I have no friends" or "People do not like me," the question could be: "Am I doing something that could be alienating to people?" Some patients see this question as a criticism. The therapist can explain that the question and answer could empower them by directing them to focus on the behavior that needs to be changed—such as, decrease the complaining and the negative focus.

Homework

The purpose of the homework assignment is to help the patient recognize that negative predictions often lead to negative outcomes. These are "self-fulfilling prophecies." The therapist can ask the patient to list a number of negative predictions from the past or from current experience. The therapist can then ask the patient to identify what is likely to make these negative predictions come true. For example, how will the patient's procrastination, avoidance, lack of trying, giving up, or even hostile and aggressive behavior lead to confirming these negative predictions. The form for examining self-fulfilling prophecies (Form 8.15) can be used as a homework assignment to help the patient recognize how he or she engages in self-fulfilling prophecies.

Possible Problems

Self-critical patients often view the fact that they have a role in their own problems as further evidence of their failure. They may believe that the therapist is blaming the patient. The therapist should validate these concerns and focus on "fixing the problem rather than fixing the blame." Examining the costs and benefits of recognizing one's role in the problem and examining alternative ways to behaving—for example, acting against one's negative predictions—may be helpful.

Cross-Reference to Other Techniques

Other techniques that are useful include graded task assignments, activity schedules, examining alternatives, problem solving, double-standard technique, and rational role plays.

Form

Form 8.15 (Making Negative Predictions Come True: Self-Fulfilling Prophecies).

TECHNIQUE: Flooding Uncertainty

Description

Worriers often complain about the *possibility* of the dreaded event—for example, "Well, it's possible the plane *could* crash . . . I *could* get AIDS at the dentist's office . . . I *could* go crazy . . . I *could* lose all my money." It is *not* possible to eliminate possibility—although many worriers certainly try to do so. The therapist should focus on how the patient can estimate *probability,* given the information available and given what we know about the base rates of various human experiential categories in the real world. Thus it is possible that one could get AIDS from a dentist, but the probability is so low that it approaches 0%. It is also possible that a plane taking off from Chicago could crash, but, again, this probability is remote.

Questions to Pose/Intervention

"A lot of time we worry about things that are possible but are not really that probable. For example, it is possible to have a heart attack when anxious, but what is the probability? If we worried about everything that is possible, then we would worry about *everything*. For example, it's possible you could walk out on the street and someone could think you are Satan and attack and kill you. But what is the probability of such an event happening? We get information about probability by looking at how often something generally happens in the real world. Sometimes we refer to information about probability as the 'base rate.' For example, what base rate (or percentage) of people who have headaches also have brain tumors? We would talk to all the people who have headaches—which is just about everyone—and ask how many of these people also have brain tumors. The answer would amount to a very small base rate or percentage."

Example

The patient reported that he had a headache and was worried that a brain tumor was the cause. He had recently heard of someone in the news who had a brain tumor.

THERAPIST: What is the evidence that you have a brain tumor?

PATIENT: I have a headache. Isn't that one of the signs of a brain tumor?

THERAPIST: How long have you had a headache?

PATIENT: For a couple of hours.

THERAPIST: What makes you think this is a brain tumor?

PATIENT: I heard about this guy who died from a brain tumor—they said he had headaches.

THERAPIST: How many people in New York City have headaches in any given year?

PATIENT: I'd imagine over half.

THERAPIST: How many of those headaches are caused by brain tumors?

PATIENT: Almost none.

THERAPIST: So, if you were to estimate the probability that someone who has a headache also has a brain tumor, what would it be?

PATIENT: It's possible, though, isn't it? Even if it's a very low probability? I could be that unlucky one in a million.

THERAPIST: Are you trying to rule out all probability and have absolute certainty?

PATIENT: I know, it's impossible. But I wish I had certainty.

THERAPIST: What are the costs and benefits of demanding certainty?

PATIENT: The cost is that I'm anxious a lot. And the benefit—I don't know, maybe that I can catch something wrong sooner.

THERAPIST: But you live with uncertainty every moment of the day. How do you manage that?

PATIENT: I just accept a lot of things that are beyond my control.

THERAPIST: What if you accepted this headache in that way?

PATIENT: I might be better off, but I also might overlook a symptom of a serious condition.

THERAPIST: What's the probability that you have a brain tumor?

PATIENT: Almost 0%.

THERAPIST: If you want to eliminate possibility, then you might spend all your time worrying. What if you simply focused on things that seem plausible or that have some probability? For example, what is the probability that if you don't pay your credit card bill on time, you will get penalized?

PATIENT: 100%.

THERAPIST: That's a probability that makes sense. There is no certainty in an uncertain world. What would be the advantages and disadvantages of accepting that you can never know a whole lot of things for certain and to accept uncertainty as a human condition?

PATIENT: I'd be better off. I keep driving myself crazy by demanding certainty. I guess I think that if I try to achieve certainty, then I'd be less anxious—but it only makes me more anxious.

THERAPIST: Exactly.

After the patient established that certainty is impossible, the therapist asked him to repeat this sentence for 10 minutes: "No matter what I do, I can never achieve certainty." After an initial increase, his level of anxious arousal decreased.

Homework

Patients are asked to write down examples of worries that involve a demand for certainty—for example, worries about health, finances, relationships, or work. Each worry is recast as "I'm not sure if *X* will happen"—for example, "I'm not sure if I have cancer." Then patients are asked to write down the costs and benefits of demanding certainty in order to resolve or depotentiate this particular worry. Finally, patients are asked to repeat the worry that has been restated in terms of "I'm not sure . . ." for 15 minutes each day. The goal is to become bored with uncertainty. Form 8.16 can be used to keep track of this flooding process, whose goal is to habituate the patient to uncertainty.

Possible Problems

Some patients fear that repeating their worry as a statement of uncertainty will make them more anxious. This thought flooding should be done within the session the first time to demonstrate that the anxiety will decrease. Some patients may need more than 15 minutes; they should be instructed to continue repeating their thought until the arousal has decreased by half. Patients may interrupt the effect of flooding by repeating the thought in a rote or mechanical way or by distracting themselves with other behavior or stimuli. Doing so may interfere with the habituation process. These "safety behaviors" should be eliminated.

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, acceptance training, double-standard technique, and vertical descent.

Form

Form 8.16 (Flooding Yourself with Uncertainty).

TECHNIQUE: Taking Yourself Out of It/Disappear

Description

Most of our worries are about something that might happen to us or something that we think we need to do: for example, "I won't pass the exam" or "That person thinks I'm boring" or "I need to convince them." We tend to see the world as if we are the center of things and that control, approval, and outcomes are all up to us. The technique of "Take Yourself Out of It" allows patients to imagine that they have temporarily disappeared and that what is going on, or could go, on does not involve them. This technique allows individuals to imagine the possibility that they do not have to control things and that the world is not personally relevant to them at times.

Questions to Pose/Intervention

"We often worry about something that we must do or about something that might happen to us. This puts us at the center of what people think or do or what might happen. We then think we need to know, we need to do something, and we need to control outcomes. But let's try to imagine that you disappeared for a while and that what is happening is not about you. You are not part of the picture."

Example

THERAPIST: I know you are worried about what people will think about you at this party. You tell me that they might think you are not attractive or interesting, so you worry about this. It's as if all eyes are on you.

PATIENT: Yeah, I think I kind of look like a nerd.

THERAPIST: So it's about *you* and how you look and what people think about you. That must be a hard burden to bear to think that all eyes are on you. But what if you were to imagine going to the party but being *invisible* at the party, and you are simply observing other people interacting with one another.

PATIENT: But I'm not invisible.

THERAPIST: Of course, you're not. But let's imagine that no one could see you and you were simply observing and describing what other people are doing—as if you were reporting on a film you are watching.

PATIENT: I'd be a lot less anxious.

THERAPIST: So, let's imagine that. You go into the party, you do say, "Hello," but then you stand back and simply observe people interacting. What are they wearing, who is smiling, who is talking, what are they saying?

PATIENT: It's a lot less anxious for me this way. It's not like I have to do anything.

THERAPIST: Yes, you could choose to say something if you wish, but imagine just observing and describing. You are standing there and they are talking to one another.

PATIENT: OK.

THERAPIST: Now, here's another way of taking yourself out of it. Imagine you are talking with your friend Linda, and you don't like her political views, but you don't want to get involved in an argument. Rather than get angry at her or argue with her, you just stand back and observe and make-believe this has nothing to do with you. You have momentarily disappeared. She would

be saying the same thing about politics even if you were not there. So, imagine not being there. You disappeared.

PATIENT: That would be great. Sometimes I want to disappear.

THERAPIST: But you can for a moment. Because you can imagine that you are not participating, you are not doing anything. You are there but not taking part, like watching a film of Linda while she babbles on.

Homework

The patient can imagine that he or she has disappeared, is invisible, or actually does not exist. While invisible, the patient can imagine observing what is going on not as a participant or as someone who has to *do* something, but as an observer who sees what is happening and does not need to do anything. "Imagine that these things would happen even if you did not exist for the moment." Form 8.17 can be used to examine what it would be like to be invisible, to disappear. Figure 8.4 demonstrates the use of this technique by a young man thinking of going to a party and feeling self-conscious.

Possible Problems

Some patients argue that they cannot imagine that they do not exist or that they are invisible. The therapist can suggest that they think about all the things that are happening right now that don't involve them as a way to recognize the experience of invisibility. For example, "Think about someone you are concerned about. Is it possible that he or she is not thinking about you right now?" In addition, the therapist can suggest, "Think about this situation. Is it possible that it would have happened even if you did not exist?" Finally, the therapist can indicate, "The exercise of disappearing for a moment does not mean that you do not exist. It simply means *you can imagine not being here*." It is momentary. The goal is to imagine being an observer, not a participant or a target.

Cross-Reference to Other Techniques

Related techniques include acceptance, thought balloon, looking at it from the balcony, examining how I will feel in the future.

Form

Form 8.17 (Take Yourself Out of It/Disappear).

Situation that bothers me	What I worry about	When I disappear, what do I observe?
Going to a party where there are women I don't know.	*I'll sound stupid. I won't have anything to say. People will look at me and think I am a dork.*	*I observe a lot of people standing around talking about nothing in particular. Just making small talk, and there is nothing really exciting or important that is being said by anyone. And I feel more relaxed just observing this.*

FIGURE 8.4. Take yourself out of it/disappear.

TECHNIQUE: Becoming a Grain of Sand

Description

So many worries are about us and what we must do and how people view us. In our worries we are very large, central to everything, and the things that are happening around us seem so relevant. The grain of sand technique allows the patient to imagine being so small—really, infinitesimal—that he or she is simply an element in an infinite universe. By imagining him- or herself as a grain of sand on an endless beach with billions of other grains of sand, the patient can take the perspective that what happens is not up to him or her. Relinquishing the self as the center of things frees me from worrying about what can happen to me, what do people think of me, or what do I have to do.

Questions to Pose/Intervention

"We often think of ourselves as the center of things when we worry—like, 'What are people thinking of me?' or 'What do I have to do?' It's almost as if the seven billion people in the world are relevant to me. It's a burden to be this large and central self. But we can try something different from being the large, central self. Imagine that you are a grain of sand on an endless beach. You are like all other grains of sand: the wind blows you this way and that way, the tide pulls you in and out, and you are so small and indistinguishable that you have momentarily disappeared. Try to imagine this grain of sand as a way of experiencing things at times, so that you become so small that the world is beyond your control."

Example

THERAPIST: You are so worried about what your coworkers think of you, it's like the world and others in it are focused on you. I think we all do this at times. We see things only from our perspective and we conclude that we are the center of things. Then we worry about what people think and what we must do. It's all about us.

PATIENT: I know, when I walk into the office I'm on alert. I worry about what Jan is thinking or what I might have done wrong.

THERAPIST: Yeah, we all do that, don't we? But imagine yourself for a moment each day as a grain of sand on an endless beach with billions of other grains of sand. Each looks exactly the same. The wind blows the sand around. The waves come in and out. As a grain of sand there is no self and everyone around you is also a grain of sand.

PATIENT: At first it felt a little scary when you mentioned this. But as I imagine it longer, it seems relaxing.

THERAPIST: Could it be relaxing because we don't expect a grain of sand to do very much? And you can give up that concern about what people think of you. By becoming nothing, becoming so small that there is nothing there but a grain of sand, you are liberated. You are free not to care.

Homework

The patient can imagine him- or herself not as a "self" but as a grain of sand on an endless beach. Each grain of sand looks the same as all other grains of sand. Each grain of sand is blown along with the wind and shifts on the beach as the tide comes in and out. Form 8.18 can be used to imagine becoming a grain of sand to gain perspective and relinquish control. Figure 8.5 demonstrates the use of this technique with someone with anxiety over a family dinner.

What concerns me	Thoughts and feelings as a grain of sand	How would I be better off if I could imagine myself as a grain of sand
People will say stupid things that annoy me.	I can sit back and watch this and realize that this is not about me. This has nothing to do with me. I can just let go.	I don't have to do anything and I don't have to care what people say or think. It's a relief.
People will argue with me.		

FIGURE 8.5. Imagining oneself as a grain of sand.

Possible Problems

Some patients may view this exercise as a denial of reality, as a facile exercise that is all about make-believe. This is not an unusual response. But the therapist can illustrate that there are currently over seven billion people in the world, and each one of them, at any given moment, thinks that he or she is the center of things. If we could momentarily relinquish the burden of the self, give up the idea that we need to do something, or that we need to get something—such as approval—we could then allow ourselves to simply observe rather than worry. Doing nothing can be liberating.

Cross-Reference to Other Techniques

Related techniques include looking at it from a balcony, disappearing, acceptance, and seeing it from another perspective.

Form

Form 8.18 (Grain of Sand).

TECHNIQUE: Looking Down from the Balcony

Description

As indicated above, worry often involves the sense that we must do something, that something is happening to us, people are thinking about us, and we are the center of something important. As we see the world from the perspective of a participant who is seeing others looking at us, talking to us, doing things to us, we often respond that this "self" must *do* something. We must say something, do something, impress someone, control something. The technique looking down at things from the balcony allows us to step away from the current interaction or situation and to imagine ourselves as standing above it, watching it. Thus, it is not "you" and "me" but rather now viewed as "those two down there." This is a metacognitive perspective in that it allows one to stand back from the self (and other) and take a perspective that is above and beyond the egocentric self.

Questions to Pose/Intervention

"When we are worried, we often see things only from our own perspective and cannot imagine that we are not the center of things. We worry about what someone is thinking about us, what is happening to us, what we must do. We are standing there and we see the person in front of us—or the challenge in front of us. But imagine, for a moment, if you decided to step away, go up to a balcony far above, and observe what is happening from the perspective of a neutral observer—someone who doesn't care that much, someone who is watching the people below. And you are one of the many people below who is being observed. You are out there, down below, while you—as an observer—are up here, far away."

Example

THERAPIST: When you are interacting at the party, it seems that you are thinking a lot about what someone is thinking of you or how you look or if you're boring and anxious. It's a constant focus on yourself.

PATIENT: I know, I can't get my mind off of this. The minute I start interacting with someone, I think I must sound boring.

THERAPIST: So, when you walk into the room, it's like everyone is thinking about you. Or when you are having a conversation, you are focused on yourself and your thoughts.

PATIENT: Yeah, it drives me crazy.

THERAPIST: Ok, so let's imagine that there is a balcony above you—maybe 50 feet up in the air—five stories up. And you are looking down on people and you notice yourself and Jane down there and you observe them. What do you see?

PATIENT: If I imagine it, I can see two figures, very small from up here, and lots of other people milling around.

THERAPIST: And as you watch the scene from up here, you are small and just one among many down there. You are separate, up here on the balcony.

PATIENT: OK, I can imagine that.

THERAPIST: How does that feel to you being up here, watching it?

PATIENT: Less worried.

THERAPIST: Perhaps you are less worried because you are not participating for a moment, but just watching. And you stand apart from it.

PATIENT: It does free you up.

Homework

Patients can imagine themselves as rising up to a balcony far above the current situation and describe what they see below. If they are worried about an exam, they can imagine describing a person who looks like them sitting down below studying. What do they see? Or if they are worried about what people think about them, they can imagine seeing the two people—self and other—from a balcony far above. The goal is for patients to separate themselves from their role as a participant and become an observer. Patients can use Form 8.19 to imagine themselves taking the perspective from the balcony, rather than being down in the mix, as participants. Figure 8.6 demonstrates the use of this technique by someone who is concerned about conflicts at work.

How I think and feel when I'm worried	What I see below me from the balcony	How I think and feel standing on the balcony
I think people at work don't value what I do, and they are talking about me and think I'm not really important.	I see my colleagues talking about work and talking about small talk and this is part of everyday life.	I guess I'm not the center of the universe. This is a relief. Things go on that have nothing to do with me. Work is work.

FIGURE 8.6. Seeing it from the balcony.

Possible Problems

Some patients object that they cannot imagine standing apart from the immediate situation. They think, "This *is* happening," or "I have to *do* something." The therapist can acknowledge that these thought—that something is happening and that one has to do something—are very powerful, but then suggest that standing back and observing from far above does not negate them. It only allows us to stand back for a while and see the situation from a different perspective. Indeed, we often do this when we remember things that happened in the past. We do not have that sense of having to do something since it is now in the past. And that may be why are less concerned.

Cross-Reference to Other Techniques

Related techniques include taking someone else's perspective, imagining oneself as grain of sand, disappearing in order to see reality, and taking a future time perspective.

Form

Form 8.19 (Seeing It from the Balcony).

TECHNIQUE: Time Machine (Self)

Description

Often we believe that what is happening to us now will continue to disturb us forever. We get engulfed in the field, caught up in the moment, and find it difficult to escape our emotions and our current perspective. At times, we focus entirely on what is directly in front of us in that moment, failing to realize that our thoughts and feelings will change. When we are caught up in the moment, we cannot imagine variations in how we will feel at another time and in a different situation. Decentering would involve stepping back and observing how feelings and experiences change.

The purpose of the time machine technique is to foster perspective on a current problem. Patients can use this exercise either to go back into time or to go forward in time. The therapist asks patients to imagine that they are placed in a time machine that will take them back to the past or into the future of their own lives.

Questions to Pose/Intervention

"Go back in time and recall very pleasant experiences. Notice how your mood changes when you think of past positive experiences.

"You are very worried about this right now, but I wonder how you will feel about this a week from now, a month from now, a year from now, 5 years from now. What would be some reasons why you would be less upset about this in the future? You may feel engulfed in the moment right now. What other events [unrelated to this event] will transpire over the next day, week, month, and year that will lead you to disregard this event?"

Example

THERAPIST: You are very upset about not doing well on your job. You told me that your boss criticized your performance on the job last Tuesday. Let's go into the time machine and go back to a time when you were feeling happy. Perhaps it was a time during your childhood.

PATIENT: I can picture myself sitting on the porch with my parents. It's summer and we're drinking lemonade. It's warm outside, but we're sitting in the shade and it's cool.

THERAPIST: How are you feeling in this memory?

PATIENT: I feel relaxed. I have a feeling of well-being.

Going back in time to a pleasant memory is helpful in getting patients to recognize that they can escape from this one moment that bothers them and experience pleasurable and peaceful feelings. The next step is to place patients into a time machine that goes forward into the future to a time when they will no longer care about what is happening now.

THERAPIST: Now, I want you to imagine that you are going forward in the time machine into the future. Let's imagine that it's a month from now. How do you think you'll feel about your boss's criticism of your work last Tuesday?

PATIENT: I can't imagine I'd care that much. But I'd still think of it.

THERAPIST: How about 6 months from now? How would you feel?

PATIENT: I probably wouldn't care.

THERAPIST: How about a year from now?

PATIENT: I'd probably have forgotten about it.

THERAPIST: Now, that's interesting. I wonder how many things have bothered you in your life—things that you felt were devastating at the time—which you don't care about now, and can't even recall them.

PATIENT: Probably almost every one of them.

This exercise is helpful in getting patients to understand that the immediate reaction to a situation may be the most disturbing, but that its negativity wears off with time.

Homework

The therapist can explain this assignment as follows: "One way of changing your worries is to put them in perspective—that is, to imagine how you would feel about these concerns in the future. We can call this the 'time machine' method, since you will imagine yourself going backward or forward in a time machine. Ask yourself how you would feel about this concern at different times in the future. What would be some reasons you would feel less bothered by this worry? Would you have found that other things valuable to you—and things that you simply enjoy—would overshadow

these things that you are worried about? Use Form 8.20 to write down your different worries and then indicate how you would feel about these things at different times in the future."

Possible Problems

Some patients who feel hopeless may believe they will feel worse in the future. For example, the patient going through a breakup may believe he or she will feel increasingly lonely in the future. The therapist should inquire as to what positive actions could be taken to handle loneliness—for example, activity scheduling, becoming proactive in pursuing contact with people, engaging in challenging and interesting behavior, such as taking a class or joining a hiking group. Alternatively, the therapist can ask the patient if he or she had experienced losses before and how was he or she able to make progress in regaining a satisfying social life. Often, the worried patient may underestimate his or her ability to handle problems that arise but may be able to recall coping competently in the past.

Cross-Reference to Other Techniques

Other relevant techniques include the double-standard technique, problem-solving techniques, rational role plays, vertical descent, and examining the evidence.

Form

Form 8.20 (Time Machine).

TECHNIQUE: Time Machine (Others)

Description

Just as gaining distance in time can help us feel better about what is currently happening, we can imagine that others also will care less about what is happening as time passes. For example, the socially anxious patient believes people will notice his or her anxiety and remember it, resulting in the impression that he or she is weak and inadequate. In fact, of course, people seldom remember other people's anxiety (since it is usually irrelevant to what is important to other people).

Questions to Pose/Intervention

"You are worried what other people are thinking about you, but people often stop thinking about things after a short period of time. Can you imagine yourself in a time machine that goes forward a week, a month, a year in time, and now you are learning what people are thinking about? If you are concerned with how others think of you, put them in our time machine and ask yourself how they will feel about your concern 1 week, 1 month, 1 year from now. Are they thinking about you and your performance? Or are they thinking about something else?"

Example

This exercise was used with a young executive who feared people would notice his anxiety at a meeting, and would form a lasting, negative impression of him. His automatic thoughts were, "They'll see I'm anxious, think I'm weak, and word will get back to my boss. It could have terrible consequences." Simply eliciting these automatic thoughts reduced his anxiety slightly, since he realized

the unlikelihood of this sequence of events. However, we continued to examine his mind-reading assumptions that people were thinking about his anxiety by using the following version of the time machine:

THERAPIST: OK. Let's imagine you're at that meeting. Who will be there?

PATIENT: Probably six executives from the other companies. I'm the only one representing my company.

THERAPIST: Now let's imagine that someone named John is at this meeting. He's from Company *X*. He sees that your face is flushed and thinks "That guy is anxious!" How would that make you feel?

PATIENT: More anxious!

THERAPIST: All right. Now, one of your assumptions is that people are thinking about your anxiety a lot. Let's see if that makes sense. I want you to describe to me, hour by hour, what John might be doing after the meeting ends.

PATIENT: Well, I don't really know, but I would imagine the meeting will end at about 11 A.M., and he'll probably call his office, then go to lunch.

THERAPIST: Is he thinking about your anxiety at lunch?

PATIENT: I can't imagine he would.

THERAPIST: Then what happens?

PATIENT: He finishes lunch and drives back to the airport, where he waits for his plane. Then he gets on the plane.

THERAPIST: Is he thinking about your anxiety?

PATIENT: No.

THERAPIST: Then what happens?

PATIENT: He's probably doing work on the plane. Maybe having a drink. Then, after a couple of hours, the plane lands and he gets his car and goes home. Then he sees his family . . .

THERAPIST: Are there things that John might be worried about or thinking about during the day?

PATIENT: He might be thinking about whether the meeting went well for him or whether he has any problems on his job. He might wonder about his marriage or his health. There could be a million things.

THERAPIST: Does it seem likely that he's thinking about your anxiety?

PATIENT: No, he has other things on his mind. It's funny. It seems kind of conceited of me to think he'd think about my anxiety.

THERAPIST: Well, it's probably not conceited, because it actually makes you feel badly when you think these things. But imagine if your automatic thoughts were true. Here's what it might look like. John is at the meeting, noticing your anxiety. He gets lost going back to the airport because all he can think about is your anxiety. He can't get any work done, because he's thinking about your anxiety. His wife feels he's ignoring her because when he gets home he just thinks about your anxiety. Far-fetched, isn't it?

PATIENT: I can't imagine that would ever happen.

THERAPIST: So, if he noticed that you were anxious, how long would he think about it?

PATIENT: Possibly 10 seconds.

My negative behavior	Other things the person will do or think about that have nothing to do with me
I lost my train of thought while I was drunk at the party. Maybe I said something stupid.	They will think about how they enjoyed the party or did not enjoy the party. They'll think about their friends, their relationships, the exams coming up, the sports teams that they follow.

FIGURE 8.7. Why others won't care later about my "negative" behavior.

Homework

The therapist can explain the assignment as follows: "Using this form [Form 8.21], write out the kinds of things that you are worried about—especially how you think you appear to others and what they might be thinking of you. Then ask yourself, if you were in a time machine, what would they think about this in the future at the various times that are listed. What things—other than your behavior—would they think about? In Figure 8.7, a man thinks about how others will think of him after a party."

Possible Problems

Patients may think people form rigid negative beliefs about them, based on their current behavior or performance. For example, a man feared that if he lost his erection with a woman, she would form a long-lasting negative belief about him. This fear was examined in several ways: "Predict how she will feel about this lost erection 1 week, 1 month, and 1 year from now. If you continued to see her, would there be other times when you would have rewarding sex with her? Are there other things that she would learn about you? Even if she did form a negative view of you—and she held this view a year from now and you no longer saw her—how would this be a problem for you?"

Cross-Reference to Other Techniques

Relevant techniques include turning worries into predictions, identifying and monitoring automatic thoughts, and vertical descent.

Form

Form 8.21 (Why Others Won't Care Later about My "Negative" Behavior).

TECHNIQUE: Negation of Problems

Description

Therapy often seems to serve the function of raising problems, with each session focusing on "what's gone wrong." Of course, we want to help people solve their problems, but it also may be useful to place events in perspective by recognizing that some problems that seem insurmountable are really minor inconveniences or, in fact, not problems at all. This exercise, "negation of problems,"

is (obviously) not meant to serve the purpose of denial or repression; rather, it is used with other cognitive therapy techniques to help patients understand that their problems are not necessarily roadblocks that prevent progress. By examining how something is "not really a problem," patients put things in perspective. This focus also draws patients' attention to how problems can be solved and reduces rumination on the problem.

Questions to Pose/Intervention

"You're worried that something might go wrong. Let's see if you can come up with some reasons why this is not a problem. Imagine this thing happens—whatever it is. Can you think of some reasons why this might *not* be a problem—even if it did happen? You might want to think about how you could solve the problem, put it in perspective, or even ignore it."

Example

In this technique, patients are asked to restate each "problem" using this sentence stem: "This is not a problem because. . . ."

THERAPIST: Right now, you've been feeling pretty low because you're out of work and you're looking for a job. You've had some hopeless thoughts that we've gone over, and it seems you're now able to see some possible solutions. Let's try this: I'll start by restating the problems that have bothered you, and you respond, "This is not a problem because . . ."—and then you tell me what the solution is. For example, if I say, "You think it's a problem because it's raining outside," you might respond with "That's not a problem because I have an umbrella." OK. Let's start with "You don't have a job right now . . ."

PATIENT: This is not a problem because I know I can get a job.

THERAPIST: Yeah, but there are a lot of people looking for jobs.

PATIENT: That's not a problem because I have an excellent résumé. I have a lot of experience.

THERAPIST: You have no structure to your day.

PATIENT: That's not a problem because I can spend my day on my job search, and I can exercise and see friends.

THERAPIST: But some people might think less of you because you don't have a job right now.

PATIENT: That's not a problem because my friends and family are supportive, and I don't have to care about what other people may or may not think.

The value of negating problems is that it mobilizes patients to minimize the negativity in the semantic structure of their responses. They immediately respond with the idea that it is not a problem and then provide a more positive perspective or a solution.

Homework

The therapist can ask patients to list some things that they are worried about and then come up with as many reasons as possible why these worries are not really problems. Negation of the problem can include listing solutions, placing it in perspective, arguing that it does not interfere with other valued goals, or other logical and empirical challenges. Form 8.22 can be used to expedite this exercise. In Figure 8.8, a young man reflects on why it's not really a problem that he said something stupid at a party.

Problem	Why it's not a problem
I got drunk and said something stupid	I can still see my friends, study, work out, go to other parties, spend time with my family on vacations, get a summer job, and meet other women. There's nothing I can't do as a result of doing something stupid the other night.

FIGURE 8.8. Negation of "problems."

Possible Problems

As with any technique that attempts to minimize a problem, patients may experience it as invalidating and dismissive. The therapist can inquire as to these feelings and suggest to patients that this is an experiment in thinking, rather than a final description of facts. Double-standard techniques and rational role plays can be utilized to help patients put things in perspective. Listing all of the behaviors that are still available—even if this "problem" exists—can help put it in perspective.

Cross-Reference to Other Techniques

Other relevant interventions include problem-solving techniques, use of the continuum, rational role play, use of the time machine, double-standard techniques, and examining alternative assumptions that are more adaptive.

Form

Form 8.22 (Negation of "Problems").

TECHNIQUE: Feared Fantasy Worry

Description

People often worry because they are trying to avoid having an image or thought that is very upsetting to them (Borkovec & Hu, 1990; Borkovec et al., 2004). For example, an individual may worry that he is spending too much money or that he is not earning enough. He thinks of all of the ways that he could tighten his budget. But if we utilize the vertical descent technique, we will learn that he has an ultimate fear of becoming destitute and ending up as a street person. All of his cognitive energy is deployed in trying to prevent this terrifying thought from occurring. Similarly, an individual may lie in bed worrying that she will not get enough sleep, focusing all of her mental energy on her physical and cognitive arousal, further disrupting her sleep patterns (Harvey, 2002). But what if these patients *practiced* their feared fantasy worry? What if they practiced holding the image for long periods of time, of ending up on the street impoverished or not getting enough sleep ever again? This paradoxical flooding of the feared fantasy should result in habituation to the worst fear, thereby short-circuiting the worries that precede it.

Questions to Pose/Intervention

"A lot of the time we worry because we are afraid that something even worse might happen. For example, you might be worried that you will not get to sleep in the next hour. But if we dig deeper

we might find the worry that you will get absolutely no sleep and will feel exhausted tomorrow. I'm going to ask you to try to identify that 'worst fear'—the worry that you fear most. Then I want you to practice repeating this worry, over and over, until you become bored with it."

Example

THERAPIST: You're worried that you will lose more money. Try to tell me what this would mean to you. "If I lose more money, then . . ."

PATIENT: I will go broke.

THERAPIST: OK. So your real fear is not just losing money but going broke. We find that a lot of the time, people worry about things and they come up with all kinds of ways of avoiding that image or that thought.

PATIENT: Well, I try to get reassurance from people. I ask my wife what she thinks, and she tells me that things will work out.

THERAPIST: But the real problem is being able to accept going broke. It's hard to live with having that thought. That's what you have to practice—the thought of actually going broke.

PATIENT: It's too upsetting.

THERAPIST: Let's see. What are some reasons why you *won't* go broke?

PATIENT: I have lots of other investments, and I have a job and my wife has a job. I won't go broke.

THERAPIST: But let's practice the image and the thought of going broke. What image or picture comes to mind of you going broke?

PATIENT: I see myself as homeless, with no money.

THERAPIST: OK. Close your eyes and get this image really clear in your head. Now repeat "I will go broke and end up homeless."

PATIENT: "I will go broke and end up homeless."

THERAPIST: How anxious do you feel, from 0% to 100%?

PATIENT: About 80%.

THERAPIST: Keep repeating this . . .

PATIENT: (*Repeats the thought and the image for 10 minutes, and his anxiety drops to 5%.*) I'm feeling bored with this.

THERAPIST: That's because you can tolerate having the thought that you will go broke.

Homework

The therapist asks patients to use vertical descent ("What would happen next that would bother you?") until the worst fears are identified. These are then listed and their costs and benefits estimated. Patients can use Form 8.23 to identify the series of events or implications that might arise from each step in their process of thinking. This helps patients focus on "Why this would bother me," rather than simply on the single event that they imagine. Next, patients form a visual image of the worst fear and the statement that goes with it (e.g., "I will die from cancer"). Patients then focus on the image and repeat the statement for 15 minutes. This process allows patients to practice exposure to their feared fantasy and experience habituation to the image. One patient's response to her feared fantasy is shown in Figure 8.9.

Identify your worst fears behind your current worry	Cost of worrying about these fears	Benefit of worrying about these fears
I'll be alone and won't have anyone to talk to. I see myself sitting alone.	Anxious, depressed, hopeless	Maybe I can prevent it. Maybe I will be motivated.

Repeat the feared image and the statement that goes with it, rate anxiety from 0 to 100%:

	Anxiety (0–100%)
1 min	80%
5 min	70%
10 min	50%
15 min	20%
20 min	10%

FIGURE 8.9. Feared fantasy worry.

Possible Problems

Some patients believe that repeating a feared fantasy will make them feel worse. This exercise can be set up as an experiment within the session: "Let's see how your anxiety changes the longer you hold the image in your mind." Many worried patients find this process to be counterintuitive, because all their effort has been focused on escaping their negative images through worry and reassurance seeking. Another problem can be patients' belief that the worst fantasy is a plausible reality—for example, some people *do* go bankrupt. In this case, the worried patient can be assigned the homework of collecting information on how people cope with negative life events—for example, how do people cope with bankruptcy, divorce, or cancer? Coping models are helpful in reducing the anxiety about worst possible outcomes.

Cross-Reference to Other Techniques

The therapist can ask patients to examine past worries and outcomes; the costs and benefits of worrying about the worst possible outcome; the evidence for and against these worries; the ability to solve problems, should they arise; and the double-standard technique.

Form

Form 8.23 (Feared Fantasy Worry).

TECHNIQUE: Acceptance of Thought

Description

In presenting this exercise, the therapist can say: "Rather than trying to control and change everything, perhaps there are some things you can learn to accept and make the best of. For example, perhaps you won't be perfect in your job, but you could learn to appreciate what you can do. Rather

than criticizing yourself for having a problem or catastrophizing the problem, start with 'I accept that I have a problem with [name the problem], and now I will try to find a solution to that problem.'"

Questions to Pose/Intervention

"We learn to accept a lot of things in life. If you live in Vermont in the winter, you learn to accept the cold. If you live in Miami in August, you learn to accept the heat. Think about practicing a detached acceptance of what is going on. Act as an observer—someone who does not necessarily need to act. How would you describe what is going on without passing a judgment on it or recommending an action? Are there any advantages you might experience as a detached observer? What would happen if you decided to be a detached observer and watch these events just go by?"

Example

THERAPIST: Many times we worry about things we feel we need to control. But what if we were to aim for accepting and observing instead of worrying? When we accept and observe, we do not judge, we do not control. For example, if it is cold outside in January, we can observe it and accept it. No doubt we would wear warm clothing, but it is a reality with which we live. What if you were to aim for accepting the things that you currently worry about?

PATIENT: I don't understand.

THERAPIST: Well, let's take your worry that your aches and pains are a sign of terminal cancer. Even though your doctor tells you that all you need is exercise, you still worry that you might die. Accepting your aches and pains means to observe them but not judge them. It means to simply describe. It means not interpreting, just recording. How would you describe your legs?

PATIENT: I feel a little tension in my left leg. A small pain. Sort of like a little needle, but then it goes away at times.

THERAPIST: How does your foot feel?

PATIENT: I noticed it doesn't feel unusual. I can feel my toes more in my shoe. I can feel a little warmth on the bottom of my foot.

THERAPIST: How about accepting eventually dying? What would that look like?

PATIENT: I can see myself as a dead body. I can see that I'm not moving. I'm not breathing. I stand back and see myself.

THERAPIST: How does that feel to stand back and observe?

PATIENT: I feel a little nervous at first, but there's a sense of calm as well.

Homework

The therapist can explain this assignment as follows: "We worry about many things in life that we really cannot control ultimately. One technique that is useful, if we are uneasy in these ways, is to practice acceptance. You already practice this acceptance in many areas on a day-to-day basis. You accept the fact that you are hungry, need to sleep, have to pay your bills, go to work, get stuck in traffic, or that it is hot or cold. You don't protest or worry about these things. Acceptance can involve becoming an observer who does not judge or interpret or control. The observer sees and accepts. Let's look at some of the things that you worry about and see how you could learn to accept them. Use this form (Form 8.24) to indicate what you are worried about—for example, "I will fail the exam." and write down a description of what has actually happened—just the "bare bones" of it.

Avoid making any predictions, interpretations, judgments, or solutions. Simply describe the event or situation. For example, let's say you lost money in your investments. Write down exactly what happened. Then estimate the costs and benefits of simply *accepting* this loss. Try to be passive, to feel no protest, just acceptance." One patient's response to this form is shown in Figure 8.10.

Possible Problems

Many worriers pride themselves on preventing bad things from happening. Acceptance is the ability to accept what *may* happen. The therapist can help patients examine the costs and benefits of *solving* versus *accepting*. It is often helpful to have patients examine all the things they accept on a daily basis.

Cross-Reference to Other Techniques

Other relevant techniques include uncertainty training, double standard, rational role play, vertical descent, and identifying automatic thoughts.

Form

Form 8.24 (Practicing Acceptance).

The thing I'm worried about is: I'll never find anyone to love.

Costs and benefits of acceptance:	Costs:	It will make me depressed. It's giving up. I need to get rid of this thought.
	Benefits:	I can simply accept the thought as something I experience. It doesn't necessarily predict anything.
Things I accept daily that could bother me if I let them:		Traffic, noise, rude people, crowded subways, being delayed, things not going my way at work at times, friends not responding quickly.
Why I accept these things:		I can't control everything so I just accept them and move on. I don't really have a choice.
Describe, in some detail, what is actually happening that is causing the worry (do not judge, interpret, or predict):		**Detached observer:** I'm sitting alone in my apartment and the television is on, and I just checked my e-mails and I'm eating a slice of pizza.
Conclusion:		If I accept the thoughts as just something that happens now and then and don't struggle, I can get on with these other things. It's helpful for me to think about some thoughts as noise.

FIGURE 8.10. Practicing acceptance.

FORM 8.1

Self-Monitoring of Worries

Write down the date and time of each of your worries, noting the situation that gives rise to each worry, your emotion or feeling (e.g., anxious, sad, helpless, self-conscious), and the specific content of your worry (e.g., "I'll get into an argument" or "I won't know what to do"). A sample entry is provided for illustration.

Date/time	Describe situation	Emotion or feeling	Specific worry
6/14	Thinking about going to the party tonight.	Anxious	I won't know what to say. I'll sound like an idiot. There will be a lull in the conversation and she'll think I'm clumsy and stupid. I'll get so anxious, I'll have to leave.

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FORM 8.2

Costs–Benefits of Worry

Write down your specific worries, and for each, see if you can identify the costs you incur for having that worry, as well as the benefits you derive from it. Rate the costs and benefits, each on a scale from 0 to 100, and then calculate the net cost or benefit to you of holding this worry. A sample entry is provided for illustration.

Specific worry	Costs	Rate costs	Benefits	Rate benefits	Costs–benefits
I'll sound stupid	Makes me anxious. Can't enjoy myself. I want to avoid the party.	80	Maybe I can reassure myself. Maybe I can think of something to say.	20	−60

Can you point to any specific examples where worry made things more difficult for you?
If you worried somewhat less, what would improve in your life?

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FORM 8.3

Turning Worries into Predictions

In the first column, write down your worry as a prediction—for example, "I will fail the exam," and in the second column, record the degree of confidence (0–100, where 100 = absolute certainty) you have that your prediction will come true. In the third column, write what actually happened, and in the fourth column, describe your conclusions.

I predict:	Confidence (0–100)	Actual outcome	Conclusions

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FORM 8.4

Making Thoughts and Predictions Testable

We often have thoughts that are quite vague, so we might not be able to test whether they are true or false. For example, the thought "Life will be empty" is hard to test because it's hard to know what "empty" means. On the other hand, we can test the thought "I won't experience any pleasure" by keeping track of pleasure that we do experience. Sometimes we have thoughts that are quite unrealistic. For example, we might have the thought "I'm a failure," and we might think that the test of that thought is whether we have any failures or disappointments in life. Since all of us have some failures and disappointments, most people might not agree with the idea that "being a failure" is the same thing as failing on a test or getting rejected. List some of your troublesome thoughts below and then answer each of the questions.

Thought	**How could I test it? What can I observe that would prove this is correct?**	**Would other people agree with my test for this thought?**	**Would other people see things differently?**	**Are my thoughts vague and general?**

Double-check: Is there anything wrong with how your thoughts are stated? Are they really testable? Could we really collect information that could weigh against your thought?

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FORM 8.5

Testing Negative Predictions

For the coming week, write down predictions about your negative thoughts and worries—for example, "I won't be able to concentrate" or "I'll have nothing to say" or "I won't be able to get any sleep." Then at the end of the week, record what actually happened.

I predict . . . will happen.	I predict . . . will not happen.	Actual outcome

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FORM 8.6

Examining Past Negative Predictions

It is useful to look back at your negative predictions in the past to see if you have a bias toward negative fortune telling. Think back about situations (i.e., activating events) when you made negative predictions. For example, you might have gone through a breakup and predicted "I'll never have another relationship" or "I'll never feel happy." In the left-hand column, write down the activating event; in the middle column, write down your prediction; and note what actually happened in the right-hand column. One entry is provided as an illustration.

Past activating event	Prediction/thought	Actual outcome
I broke up with a man.	I'll always be alone. I'll never be happy again. I'll have a nervous breakdown.	I met someone 6 months later. I felt happy the next day seeing friends. I did get depressed for a while, but I got over it.

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FORM 8.7

Possible Outcomes

We often focus on the worst outcomes when we are anxious. In the form below, list the worst possible outcome, the best possible outcome, a neutral outcome, and the most probable outcome. What probabilities would you give for each outcome?

Worst (%)	Best (%)	Neutral (%)	Most likely (%)

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FORM 8.8

Stories about Outcomes

One way of thinking about alternatives is to come up with stories about what would have to happen for that outcome to occur. In the form below, list the most probable outcome, the best outcome, and a neutral outcome. Then describe in detail what would have to happen for these outcomes to occur. What specific action could you take?

Type of outcome	What would have to happen? What would I have to do?
Most probable outcome	
Best possible outcome	
Neutral outcome	

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FORM 8.9

Examples of Imperfect Solutions

Sometimes we can only make progress by doing things imperfectly. We call this "successful imperfection." For example, it might be ideal if you could exercise 45 minutes five times per week, but you just might not be able to do that. But you can make progress "doing things imperfectly"—like walking more or exercising for 20 minutes three times per week. Getting started often means taking *imperfect steps forward*. In the form below, list some possible "imperfect solutions" that you can take (e.g., "Exercise more than I'm doing now") and list the costs and benefits of doing these things imperfectly. Then list the specific actions that you could take (e.g., "Walk 30 minutes each day").

Possible imperfect solutions	**Costs**	**Benefits**

What action can you take using this imperfect solution?

Action:

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FORM 8.10

Reviewing How I Handled Past Negative Events

All of us deal with negative events from time to time. Perhaps you do not think you can handle negative situations that well. Think back about negative experiences you have had and identify ways in which you were able to cope. What did you eventually do to make things better? Also, identify some problematic or unhelpful ways of coping—for example, drinking, isolating yourself, pursuing no-win relationships, procrastinating, or just complaining. Finally, examine your current problem and identify some possible effective ways of coping and some ineffective ways of coping.

Past negative events	**How I coped**	**Unhelpful ways of coping**
Current problem that I worry about	**How I could cope effectively**	**Unhelpful ways of coping**

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FORM 8.11

Why I Don't Learn from Past Predictions

Sometimes we realize that our past predictions don't come true, but we don't see our current predictions as part of this string of false alarms. Perhaps you have some reasons to think this way. In the form below, list all of the reasons you can think of why the past false alarms are less important to you than your current worry.

Reasons why I don't use the past false alarms as evidence that I'm just a pessimist	**Consequence of this belief**
1. I won't settle for anything but a guarantee.	
2. I don't look at evidence that I could be wrong about my current predictions	
3. I don't look at the evidence of incorrect past predictions.	
4. This time it could happen, so I should worry about it.	
5. Other reasons (specify)	

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FORM 8.12

Point–Counterpoint

Start with the automatic thought and then challenge it with a rational response. In turn, challenge the rational response. Keep going back and forth—challenging your previous response.

Automatic thoughts	Rational responses

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FORM 8.13

Productive and Unproductive Worries

We all worry about something some of the time. The question here is whether your current worry is productive or unproductive. Productive worry is worry that leads to concrete, specific action. It is worry about something that is plausible or has a reasonable probability of occurring. Unproductive worry is simply worrying about what is possible—what could happen—but about things that are very, very unlikely.

My current worry: _____

Question	Answer
Is this worry something with a very low probability of occurring?	
What prediction am I making?	
What is the problem that needs to be solved?	
What specific actions can I take?	
Is there a "to do" list for me today? Is there something I can do today that will move things forward?	
Do these actions seem reasonable?	
Am I worrying about things over which I have little or no control?	
Is this a productive or unproductive worry?	
Why or why not?	

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FORM 8.14

Keeping Track of Worries for Worry Time

In the form below you can keep track of the worries you have at different times of the day or night. Set aside 30 minutes each day when you will focus on your worries. At all other times, write down the worries using the form below.

Situation that triggered this worry	My specific worry	Have I had this worry before?

Worry Time

Write out your worries using the following form. After the 30 minutes of worry time, answer each of the questions.

Time/date:	Duration (minutes):
Place:	
Anxiety at start of worry time (0–100%):	Anxiety at end of worry time (0–100%):

(continued)

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Keeping Track of Worries for Worry Time *(page 2 of 2)*

Worries:
Common themes in my worrying:
What are the costs and benefits of worrying about this? Costs: Benefits:
Is this a productive or unproductive worry?
Is there any productive action I can take today that will help solve this problem?
Would I be better off if I accepted my limitation at the current time—that I might not know, there is nothing I can do, or there is always some uncertainty?

FORM 8.15

Making Negative Predictions Come True: Self-Fulfilling Prophecies

In the left-hand column, list your negative predictions (e.g., "No one will talk to me at the party"). In the middle column, list all the things you do that make your prediction "come true" (e.g., "I don't talk to people" or "I act like I'm afraid"). In the right-hand column, list things you could do to act against your negative prediction—for example, what you would do if you believed the opposite of your negative prediction (e.g., "I'd introduce myself to people" or "I'd ask people about themselves").

My negative predictions	How I make these predictions come true	Alternatives that can disprove my negative predictions

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FORM 8.16

Flooding Yourself with Uncertainty

In the left-hand column, write down the thought that you will repeat to yourself—for example, "It's always possible that [something terrible] could happen to me." In the middle column, note that you have repeated the thought in 3-minute intervals. In the right-hand column, note your anxiety level, from 0 to 100%. Keep repeating the statement over and over, until your anxiety has been reduced by half. Thus, if your highest level is 80%, then repeat the thought until the anxiety is less than 40%. Keep repeating the thought for at least 15 minutes, regardless of your anxiety level.

Thought to be repeated	**Time: Exposure**	**Anxiety (0–100%)**

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FORM 8.17

Take Yourself Out of It/Disappear

When we worry about things, we often view ourselves as the center of things. Or we think that it is "about us" or that "we must do something." As an alternative, we can imagine that we temporarily disappeared. We are invisible. It's not about us, because we are not here. We are just watching what happens. We are describing it. We don't have to do anything. By disappearing, we observe. In the left-hand column below, describe a situation that may bother you—something you might be worried about. In the middle column, note the thoughts you have that make you worried. Then imagine that you are invisible or temporarily don't exist; you are simply observing what is happening outside of you. Now, in the right-hand column, describe what you observe.

Situation that bothers me	**What I worry about**	**When I disappear, what do I observe?**

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FORM 8.18

Grain of Sand

We often think of ourselves as the center of something when we worry. We think it's about what people think about us, what can happen to us, what we must do. In this worried mind, we are very large, very important. But imagine, for a moment, that you are simply a grain of sand on an endless beach, with billions of other grains of sand. They all look alike. The wind blows them around.

In the form below, think about something that concerns you—something you worry about—and write it down in the left-hand column. In the middle column, imagine you are a grain of sand among billions of grains of sand. Imagine drifting, losing yourself for a moment, letting go. Hold this image in your mind. What new thoughts and feelings do you have as a grain of sand? In the right-hand column, describe how you might be better off if you could let go and allow yourself to imagine being a grain of sand.

What concerns me	**Thoughts and feelings as a grain of sand**	**How I would be better off if I could imagine myself as a grain of sand**

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FORM 8.19

Seeing It from the Balcony

We often get caught up in things when we worry. It's all about us and what people think of us, what is happening to us, what we must do. Instead, imagine yourself rising above the current situation and observing it from a balcony far above. You are now just observing what you see below. By taking yourself out of it for a moment, you can let go of having to make something happen or let go of your concern about what is going to happen to you. In the left-hand column, describe how you think and feel when you are worried. In the middle column imagine yourself describing what you see below from the balcony far above. In the right-hand column, note how you think and feel standing on the balcony.

How I think and feel when I am worried	What I see below me from the balcony	How I think and feel standing on the balcony

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FORM 8.20

Time Machine

When we worry, we focus on one thing happening and we may not realize at that moment that a lot of other things could happen that might make us feel better. Imagine you are worried about something right now, but then you get into a time machine that takes you to a week from now, a month from now, a year from now, maybe even 5 years from now. How would your thoughts and feelings change? What are some possible good things that might help you cope?

How I'll feel about what's bothering me now in . . .	**Why I would not feel as bad about this**
1 week	
1 month	
6 months	
1 year	
5 years	

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FORM 8.21

Why Others Won't Care Later about My "Negative" Behavior

Sometimes we worry what people might think about something that happened that involves us. But people forget. They think about other things in their lives, and we may not be the focus on their attention or interest at other times. Imagine getting into a time machine and going to the future. How would other people think about the thing you are worried about at different times in the future?

My negative behavior	Other things the person will do or think about that have nothing to do with me

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FORM 8.22

Negation of "Problems"

Many times we worry about something because we think it is a problem or could become a problem. But there is another way to look at it. Maybe it would not be such a problem because you could cope with it or there are other sources of reward or meaning.

Problem	Why it's not a problem

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FORM 8.23

Feared Fantasy Worry

First, identify your worst fears behind your current worry and estimate the costs and benefits of those worst fears. Next, focus on the image of the very worst fear and repeat to yourself the statement that goes with it for 15 minutes. At 3-minute intervals, rate and record your level of anxiety.

Identify your worst fears behind your current worry	Cost of worrying about these fears	Benefit of worrying about these fears

Repeat the feared image and the statement that goes with it, rate anxiety from 0 to 100%:

	Anxiety (0–100%)
1 min	
5 min	
10 min	
15 min	
20 min	

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FORM 8.24

Practicing Acceptance

When you notice a bothersome thought, you may often think that you need to get rid of it immediately. But imagine if you were to accept the thought as "background noise"—like accepting that there is noise from street traffic. Imagine just allowing the thought "to be" without doing anything about it. You can get on with other activities, the thought remains in the background. In the form below, write down the thought that worries you and then note the costs and benefits of simply accepting the thought. Next, identify other things that you accept and why you are able to accept them. Finally, imagine yourself as the detached observer and describe—without judging, interpreting, or predicting—what is causing you to worry, along with your conclusion at the end of this exercise.

The thing I'm worried about is: _____

Costs and benefits of acceptance:	Costs:	
	Benefits:	
Things I accept daily that could bother me if I let them:		
Why I accept these things:		
Describe, in some detail, what is actually happening that is causing the worry (do not judge, interpret, or predict):	**Detached observer:**	
Conclusion:		

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CHAPTER 9

Putting Things in Perspective

The cognitive-behavioral approach recognizes that negative thoughts may sometimes be true or partly true. However, the problem is often the extremity, the seriousness, and the pervasiveness of a negative thought. It is not unusual for a patient to say, "I can't stand it," "It's terrible," "This is just too difficult," or "It's awful." Or for the individual to claim, "It's all my fault," or "I really screwed up." Indeed, the word "rational" is derived from the Greek word for "ratio"—to see things in proportion or perspective. The clinician should consider that the individual might be viewing things out of proportion whenever the level of anxiety, sadness, or anger is extreme. Moreover, as this chapter emphasizes, events that seem terribly difficult in the present moment may lose their emotional impact over time.

Negative thoughts may be partly true. For example, it may be true that the person made mistakes, did not do as well as others on the test, or that money was lost in the stock market. The problem with dealing with these negative events arises when they are viewed in the most extreme way imaginable. For example, the individual who loses 30% of his portfolio in the stock market may view this as signifying that he has no money left or that he will not be able to live the life he wants to live. In this chapter we review a number of techniques that can help patients put things in perspective.

TECHNIQUE: Pie Chart

Description

A patient may say, "It's all my fault," and then fall into a period of intense self-criticism. When a bad event happens, we may believe we are 100% to blame. The woman going through a divorce blames herself entirely for the end of the relationship, and the woman seeking a job blames herself 100% for not getting the job offer. The individual personalizes the entire problem, and causality is assigned in all-or-nothing terms. In the case of a negative outcome, the individual may focus on one cause to the exclusion of all other causes. For example, the woman who blames herself for the divorce may overlook other factors that may have caused the breakup, including her husband's anger problems,

his lack of commitment, the impact of his job loss on the relationship, and the stress of having to take care of the children without his support.

There is often a tendency to view an event in terms of "single causality"—blaming only ourselves or blaming only someone else—rather than recognizing a variety of possible causes.

One intervention that is useful in challenging all-or-nothing thinking is the use of the pie chart, in which the individual is asked to consider a pie with different-size pieces in it that represent different degrees of responsibility for an event. The patient then indicates all of the possible causes for the event and how large a piece of pie should be ascribed to each cause. He or she then considers the remaining cause—self—and ponders how this "slice of the pie" reflects his or her degree of responsibility.

Questions to Pose/Intervention

"Let's consider a pie sliced into pieces. (*Therapist draws a circle with different-sized segments.*) Now I want you to consider all of the different causes for this event [the event that bothers the patient and for which he or she blames him- or herself]. Each piece of the pie represents a possible cause of the event. How big a piece of pie is represented by each of these causes? How much of the pie is due to you?"

Example

For example, a woman working in an office where excessive demands are placed on her to get the job done criticized her own work performance, labeling herself a "failure." Her assumption was "I should get the entire job done, and if I don't, it's entirely my fault." We decided to list possible contributing factors to the job problems, assigning various percentages of causality to each, with the condition that the total must be equal to, or less than, 100%:

Limitations in computer software	10%
Staff does not provide me with enough information	10%
Unreasonable expectations of senior staff	30%
Lack of technical and personnel support	45%
Lack of my effort	0%
Lack of my ability	5%

We then converted these ratios into a pie chart (Figure 9.1). Form 9.1 is a pie chart that patients can use.

Homework

The therapist asks patients to think about the bad event or outcome for which they are blaming themselves (or someone else). The therapist can explain: "I want you to consider all of the possible reasons why this [bad event] happened, including your role and the role of other people or the importance of the situation. Also consider the role of 'bad luck.' In addition, consider the possibility that there are causes that may be unknown. Now look at this copy of the pie chart [Form 9.1] and divide up the pie into the different causes or elements. How much of the pie is left over for self-criticism?"

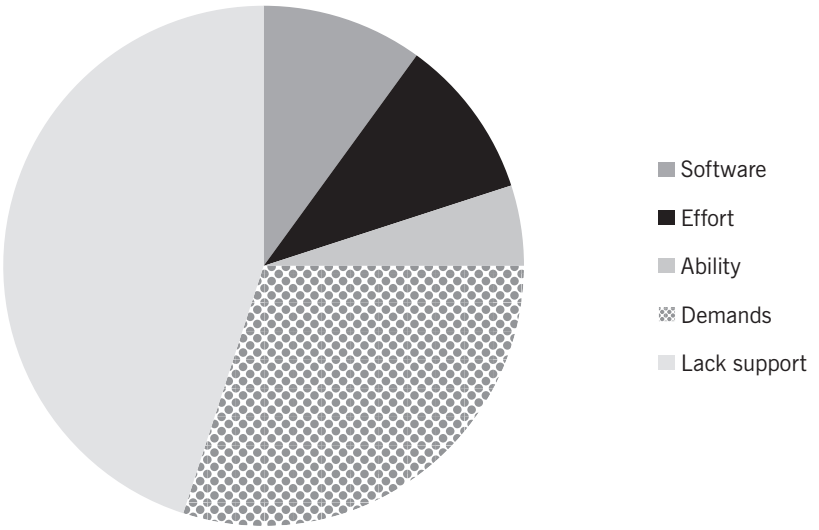


FIGURE 9.1. A pie chart.

(A variation of this exercise can be used to challenge labeling. For example, patients can be asked to list the negative label for self such as "I'm stupid" and then list all of their other qualities and behaviors. A pie chart can be used to divide up the various components of patients' self-concept.)

Possible Problems

Patients may have difficulty identifying other possible causes of the event, especially if they are blaming themselves exclusively. The therapist can ask patients to consider taking the role of their own defense attorney, who is required to come up with new ways of viewing the situation so that they are not blamed entirely. What would the defense attorney say? The therapist can also offer suggestions of possible causes—for example, the other people involved may have engaged in certain negligent behaviors, it was a bad choice, the patient had bad luck, the patient did not try as hard as he or she could, etc. In addition, the therapist can suggest that causes can include task difficulty, bad luck, lack of effort, and lack of ability. Some patients believe that this reattribution is just another set of excuses for themselves—that is, they believe they are "morally obligated" to blame themselves entirely. The therapist can examine the rationality of viewing the gathering of information about actual or possible causes as different from coming up with excuses. If causes are true facts, then they are not the same as excuses to avoid responsibility. In addition, the therapist can use the double-standard technique to examine the severity of the judgment.

Cross-Reference to Other Techniques

Other relevant techniques include point–counterpoint, examining the evidence, cost–benefit analysis, use of the continuum, looking at the issue from the balcony, and rational role play.

Form

Form 9.1 (Pie Chart Exercise).

TECHNIQUE: CONTINUUM

Description

Much of depressive thinking is dichotomous (all-or-nothing) thinking: "I'm either a loser or a winner"; "I'm either brilliant or stupid." Or outcomes are viewed as either catastrophic or neutral: "My friend was rude to me—I can't stand it" becomes "It's awful that this happened." This kind of dichotomous thinking lacks qualifiers such as "slightly," "somewhat," and "sometimes," resulting in black-and-white thinking. Rather than saying, "Sometimes I don't do well on a test," the individual might say, "I'm always doing poorly." Similarly, the individual may view outcomes as either all good or all bad.

This black-and-white thinking can be examined using the continuum technique. The purpose of this technique is to help the patient think in terms of degrees or variations rather than all-good or all-bad. Often the depressed, anxious, or angry individual responds to events as if they were catastrophic. Rather than view an event as an inconvenience or a frustration, the individual thinks that the world is coming to an end and that things cannot be tolerated as they are. Thus, the individual believes that he or she "can't handle it," even though the outcome the person experiences or anticipates might pose no more than a temporary inconvenience.

The continuum technique asks the individual to view the event along a scale from 0% to 100%, where 0% corresponds to the absence of anything negative and 100% corresponds to the worst possible outcome imaginable—for example, the Holocaust or having one's skin burned off slowly. Patients are asked to consider how bad they feel about the current event, place this evaluation along a 100-point scale of possible bad outcomes, and then consider other points on the scale. By filling in the "intermediate" points on the scale, patients are required to view events along a continuum. Each point along the continuum, in 10-point increments, is identified, and a corresponding event is associated with that point. Typically, patients have difficulty identifying events or outcomes that are lower in the scale of negative outcomes, especially points along the scale below 75%, illustrating the tendency to view things in all-or-nothing terms. This is an important recognition, since looking at these shades of gray will be important in putting things in perspective. Patients are then asked to reevaluate the outcome, assigning a new point value and indicating why it is not as bad as it seems.

Questions to Pose/Intervention

"You said this event was pretty bad. Just how bad do you feel, from 0% to 100%, where 100% represents the worst feeling you can imagine—something like the Holocaust—and 0% represents the absence of anything negative? [Using Form 9.2] I'm going to draw a line with markers for each 10-point increment.

"You have assigned the current event a 90% bad rating. Now let's look at some of the other points on the scale. Let's take 95%. What would be something that could happen to someone that would be 95%? 80%? 70? 60? 50? 40? 30? 20? 10? Are there some points that are hard to fill? Why would it be hard to fill out points below 60%? Are you looking at what is happening right now in extreme terms? Would you think of changing where you place this event on the scale? What are some reasons why it is not as bad as you thought it was?"

Example

THERAPIST: You said that you're upset because Roger never called you back. You went out with Roger twice. You seem very upset right now. I wonder, from 0% to 100%, where 100% represents the most upset you've ever been, how upset you are, right now, thinking about this?

PATIENT: I'd say about 95%. I'm really angry and hurt.

THERAPIST: OK. That's pretty bad. Now let's imagine that Roger never calls back. Where would you put that possibility in terms of bad things that could happen—from 0% to 100%, where 100% represents the Holocaust?

PATIENT: I'd give it about 75%. I'm always getting rejected.

THERAPIST: OK. Let's draw out a scale from 0% to 100%—we call this a "continuum." Now, 100% represents the Holocaust, and 75% represents Roger not calling you. Let's see, what would you put at 90%?

PATIENT: I guess being physically assaulted.

THERAPIST: OK, what would you put at 85%?

PATIENT: Getting injured but recovering.

THERAPIST: 60%?

PATIENT: I don't know. Losing my job.

THERAPIST: 50%?

PATIENT: My friend getting angry at me over nothing at all.

THERAPIST: 40%?

PATIENT: This is getting kind of monotonous. I don't know. Feeling overweight—like I've gained 5 pounds.

THERAPIST: Do you have a hard time filling in points below 50%? I wonder why.

PATIENT: I guess most things aren't too bad. Most things are under 50%.

THERAPIST: Do you really believe that Roger not calling you is 75% as bad as the Holocaust? Or almost as bad as being assaulted?

PATIENT: Probably not. It just feels that way.

THERAPIST: Your feelings are really important, but it might be important to look at this event in perspective. For example, why is this not really as bad as losing your job?

PATIENT: I need my job to pay my bills. I don't need Roger.

Homework

The therapist asks patients to consider examining some of their negative labeling, catastrophic thinking, and all-or-nothing judgments/conclusions: "I want you to think about some of the things that really upset you this week or about which you're worried in the near future—things that got—or get—you really anxious, depressed, or angry—and pick one on which to focus. Think about how bad this event or situation feels and what your automatic thoughts are about it. Now write down what is bothering you—let's say, you're giving a talk next week, and you think that someone won't like it. How bad does this—someone not liking your talk—feel from 0% to 100%? Use this form [Form 9.2]. It illustrates what we call a "continuum," and it runs from 0% to 100%, where 0% represents the absence of anything negative, and 100% represents the Holocaust. Where would you put this event (someone not liking your talk) on this scale? Then fill in every 10-point marker on the scale with an event or situation that you would rate at that degree of negativity."

Possible Problems

Some patients may view the continuum technique as invalidating, perhaps even resenting the comparison to something so catastrophic that it would automatically diminish the grievousness of their problem. In this case the therapist should ask patients to consider the costs and benefits of viewing things as terrible or awful. Some people believe they need to catastrophize events, lest their needs are dismissed as trivial. The therapist can examine the origins of this invalidation schema through schematic work (see Chapter 10). Another common problem is that patients get frustrated filling in the points below 60%—and the therapist may be hesitant in pushing for completion of the form. We have found that persisting in filling in every 10-point increment on the scale, down to 10%, is "helpfully frustrating," because it drives home for patients the extremity of their initial ratings.

Cross-Reference to Other Techniques

Other relevant interventions include cost–benefit analysis, categorizing cognitive distortions (catastrophic thinking, emotional reasoning, labeling, all-or-nothing thinking), constructing alternatives, and double-standard technique.

Form

Form 9.2 (The Continuum Exercise).

TECHNIQUE: What I Can Still Do

Description

In many cases, a negative event is viewed in the extreme, and the loss of something (e.g., a relationship, a job, an opportunity) is viewed as devastating. The individual focuses on the one thing that is no longer there—what is lost—and fails to see the many possible sources of reward that are still available—or potentially available. For example, a man going through a breakup in a relationship focuses exclusively on the fact that he will not spend time with his girlfriend and fails to see the many other sources of reward currently available or available in the future. Or a woman goes to a party and a man she finds attractive shows no interest in talking to her. In each case mentioned here, the individual has become exclusively focused on the present moment—or present loss—and is unable to stand back and consider options that may still be available.

Questions to Pose/Intervention

"I can see you're upset that this has happened, and it seems you believe this is a terrible loss. Sometimes we focus exclusively on what is lost or experienced in the present moment and fail to consider the many other options that are still available. Let's imagine that I go to a buffet for dinner. I particularly like salmon, but they tell me they have run out of salmon. I'm disappointed, until I notice there are 20 other entrees available. I can choose other things to eat and still enjoy the buffet. So I'm wondering if you might ask yourself, 'Even if this has happened—the loss I'm upset about—what can I still do?' "

In addition, the clinician can ask, "As a result of this loss, what are some things that you can no longer do? Would you be able to do some of these things in the future? With someone else? In what

circumstances would you be able to do this? What would you have to do to pursue these alternatives? Do any of these seem possible?"

Example

THERAPIST: I can see you're upset over the breakup with "Jenny," and it seems to you there isn't much that can give meaning or pleasure in your life. This must be hard for you.

PATIENT: Yeah, it's like, there's nothing in my life right now but emptiness.

THERAPIST: That's a hard way to feel. Just empty, nothing. I wonder if we can take a look at this for a moment and see what else there is. Let's think this through. Given that Jenny is no longer available, what are some things you can still do? Let's start with work and friends.

PATIENT: OK. Well, I can still go to work. I do. I only missed a day of work—right after the breakup. But yes, I can still work. And I do get my mind off of things at work.

THERAPIST: How about friends?

PATIENT: Yeah. I still see my friends. Not as much as I used to.

THERAPIST: OK. Let's write down the names of some friends in your life—people you have seen in the past few months and people you haven't seen for a while.

PATIENT: (*writing names*) There's Phil, my best friend. I saw him the other night for dinner. And then there's Jim, Wendy, Xavier, Marianne. And, yeah, I haven't seen Alan for a while—he lives in Boston—but he's a friend.

THERAPIST: OK, so there are friends near and far. Those are still some things to do. And how about other activities, such as working out, going to movies, participating in sports, or pursuing other interests of yours?

PATIENT: Yeah, I should get back to working out. And I wanted to go down to the Film Forum and see this new French movie. There are a lot of things I can do.

THERAPIST: So, even though the loss is very difficult—not having her in your life, not having Jenny—there are a lot of things that you can still do.

PATIENT: That's true. I guess I was just focusing on one thing—the loss.

Homework

The therapist can have patients complete Form 9.3, which assesses "What I can still do," listing all of the activities in the near future in which they can engage. In addition, the therapist can have patients list all the things they can no longer engage in due to this event.

Possible Problems

Some patients may view these questions as invalidating the loss or the negative event that is currently so troubling. The therapist can indicate that the loss is real and important and that there are reasons to feel sad or angry or anxious, but that looking at alternative sources of reward and meaning can help cope with the loss, not negate it. Indeed, invalidating the negativity of the loss would mean that one is saying that there is nothing negative here. In contrast, looking for supportive activities and alternatives recognizes that there is a negativity that is real and with which one must contend. In some cases the patient will focus on what he or she truly will not be able to do—in the case above,

spend time with Jenny. This "loss" is real and unavoidable, but the loss in one area may create new possibilities in other areas. For example, the therapist can examine if new opportunities for travel, relationships, personal growth, and flexibility can now be pursued.

Cross-Reference to Other Techniques

Other relevant techniques include viewing events along a continuum, pleasure predicting, identifying long-term and short-term goals, and reframing change as gain rather than loss.

Form

Form 9.3 (What I Can Still Do).

TECHNIQUE: Constructing Alternatives

Description

George Kelly (1955) proposed "constructive alternativism" as a method for modifying rigid thinking. This approach involves considering multiple perspectives and actions that are possible, given the current situation. Anxious, depressive, and angry styles of thinking are often characterized by a rigidity or inflexibility that locks patients into one response—often a maladaptive one. Constructing alternatives allows patients to consider various other thoughts and actions that might mitigate their current response. The idea is that there is always another way of looking at things. Constructive alternativism fosters a form of psychological flexibility that allows one to imagine other ways of thinking and behaving.

Consider the individual who is taking a test and believes he is going to do poorly on it. Using this method, the person would consider a number of reasons why he might do well, why the test results are not essential to his survival, and what actions he could take if he does score poorly on the test. This framework places the test in perspective as a minor inconvenience rather than a life-changing evaluation. Constructing alternatives also is similar to the idea of psychological flexibility that is proposed in acceptance and commitment therapy. The ability to be flexible in goals, behaviors, thoughts, and the way we relate to experiences can help us cope more effectively (Hayes, Strosahl, & Wilson, 2012). Indeed, this flexibility could be equated with adaptation.

Questions to Pose/Intervention

"Let's imagine that this negative outcome you're dreading does happen. What kinds of thoughts could you have and what actions could you take that might lead to some positive outcomes for you? What could you still do? What alternatives are available to you? What are some short-term and long-term plans of action you could carry out?"

Example

THERAPIST: You are concerned that you and Ken might break up. How does this make you feel?

PATIENT: I feel really hopeless because I rely on him so much.

THERAPIST: Well, we never know what will happen, and it is always possible that the relationship could come to an end. If it did, we might want to examine some things that you could do for yourself to feel better.

PATIENT: It seems like I could never be happy without him.

THERAPIST: What kinds of enjoyable activities did you engage in before you met Ken?

PATIENT: Well, I like my work, and I like my friends. I saw my friends more often, and I enjoyed hiking and skiing and exercising. I haven't been going to the health club as much. I've gained weight in the last 2 months, worrying about this relationship.

THERAPIST: OK, so those could be some things you might do again. What other things would you be freer to do if Ken were not around?

PATIENT: I really like this guy Phil, whom I met at work. We flirt a lot.

THERAPIST: You might be able to follow up with Phil on something. Are there some negative things with Ken that you wouldn't have to worry about anymore?

PATIENT: I wouldn't have to worry about fighting and arguing and breaking up and what he's doing or thinking. It's a drag sometimes.

THERAPIST: OK, so these are some alternatives that you would have available if Ken were out of the picture?

PATIENT: I guess that's true. Things wouldn't be all bad. In fact, some things might be better.

Homework

Using Form 9.4, the therapist can ask patients to describe the current troubling situation and their negative thoughts about it. Then instruct patients to consider the various alternative behaviors and opportunities that are available to them. How do these alternatives compare to their current negative focus?

Possible Problems

Patients may believe their perspective is the only true view. The therapist can introduce the idea that there are many potential and actual truths—that is, there are many different angles or pieces of information or behaviors available. Consider the person going through a divorce. There are a number of "truths" in this complex situation: for example, far less time with the former spouse, less time with children, financial strains, freedom to pursue new relationships, giving up on something that is not working, clarifying goals, and learning how to have better relationships. Each is "true," but no single one is the entire truth.

Cross-Reference to Other Techniques

Other relevant techniques include vertical descent, examining the evidence, double-standard technique, continuum, time machine, problem solving, and role play.

Form

Form 9.4 (Considering Alternatives).

TECHNIQUE: Setting a Zero Point for Evaluation

Description

Depression and anxiety are often related to viewing events in terms of loss, deprivation, and negativity. Similar to Kahneman and Tversky's (1979) prospect theory that proposes that individuals often focus more on a loss than on a gain, many individuals will focus on how a current event or situation falls short of an expectation or standard that has been set. Politicians are quite adept at playing the "expectation game," trying to manage expectations of the electorate once they have been elected. Thus, a newly elected mayor or governor may wish to indicate how difficult the task is that has been inherited. Similarly, the value of a stock may be extremely negatively affected if "earnings fall short of expectations." Many depressed individuals compare themselves to a perfect person who is able to accomplish everything at a 100% peak level—and with little effort. They seldom consider the entire range of normal, and less-than-normal, performance. The best becomes the enemy of the better and the better becomes the enemy of "good enough." Often perfectionistic individuals compare themselves to the best they've ever performed. By reversing this pattern and setting a zero point for evaluation, patients are required to focus on *all* of the things that they do as a "positive."

Questions to Pose/Intervention

"You seem to compare yourself to the best you've ever done or the best that others have done. But what if you measured yourself against a zero-point evaluation? What have you done, or what do you have, that is better than zero?"

Example

For example, a retired manager who had experienced some success in his work and who was respected in his community would compare himself to people who were extraordinarily wealthy and famous. His focus was on what he did not have rather than what he did have. This focus reflected his dichotomous, all-or-nothing thinking and precluded any appreciation of what he did have.

THERAPIST: You seem to think about other people who have millions of dollars and who are famous. Do you ever compare yourself to the poorest person in your community?

PATIENT: No.

THERAPIST: Let's imagine you were to compare yourself to a homeless person. What does that person have, compared to you?

PATIENT: Well, I've seen homeless people on the streets, of course. I guess all that they have are the clothes on their backs and a few possessions. They have whatever they can beg from people.

THERAPIST: Now, let's look at what you have. You have a nice house, a pension, a wife, two daughters, you go to restaurants, and you have friends. How does that compare with what the homeless people have?

PATIENT: I guess I'm a lot better off.

THERAPIST: That's something to keep in mind when you're feeling like a failure.

A variation of this exercise is to ask patients what it would sound like to try to convince someone who is at the zero point that they (the patients) have nothing and therefore are failures. The

zero-point comparison can be used for people who criticize their own intelligence, looks, social skills, accomplishments, and other personal qualities. The therapist can point out that by thinking of what they have as "greater than zero," they can imagine themselves having more positive qualities rather than having less than the ideal.

Homework

The therapist can introduce this exercise by giving patients Form 9.5 and explaining that it is important to be creative at times in thinking about themselves. "One way of being creative is to think of anything you have or anything you do as being above, or better than, zero, and then focus on improvements that you could make in your present situation. Think of the things you feel bad about in your life. Make a list of them. Then indicate how each of these is better than zero. This is an exercise in developing appreciation for what is true today." Figure 9.2 offers an example of how one patient used this form.

Possible Problems

As with any undertaking that fosters a larger perspective, patients may view this exercise as invalidating. It is important to point out that the intention of the exercise is not to invalidate the suffering but to put the suffering in the context of appreciating what is also true in a positive sense. Rather than focus on what is missing, patients are asked to spend a few moments focusing on what they *do* have. Some people complain that comparing themselves to the zero point is not realistic, since their comparison group, or peers, are so much more accomplished. The therapist can point out that

The person at the zero point has these qualities or things	I have these qualities or things
No friends, no money, no interests	I have lots of friends, plus I make friends easily. I have a good income and I can do a lot of the things that I want to do.

How am I different from someone at the zero point? I have friends, money, and lots of interests.
How have I improved over a zero point? I have never been at the zero point. I am growing and learning new things all the time. I have more to offer now than I did 5 years ago.
Would I be able to convince someone that I'm at the zero point? Why not? No one would think of me as being at the zero point. I have too many positives in my life. Some people might admire and envy me.
What would be a more realistic way of looking at where I am? I don't have everything that I want, but I have a lot, and I can make things better if I take some risks, if I'm kinder to myself, and if I don't isolate myself when I feel down.

FIGURE 9.2. Zero-point comparisons.

comparing ourselves to the zero point helps us recognize and appreciate what we *do* have and keeps us aware of the fact that life can be much worse than it already may seem to be. This exercise can be used as an introduction to the one described below, Taking It All Away.

Cross-Reference to Other Techniques

Other relevant techniques include use of the continuum, positive tracking, depolarizing comparisons, rational role play, double standard, pie chart, and negation of problem.

Form

Form 9.5 (Zero-Point Comparisons).

TECHNIQUE: Depolarizing Comparisons

Description

Similar to the person who makes perfectionistic comparisons is the person who thinks entirely in terms of 0% versus 100%, all-or-nothing: "Either I'm extremely successful [beautiful, rich, interesting, etc.], or I'm a failure." Comparisons involve only the extreme poles. The consequence of this kind of thinking is the feeling, "No matter what I do, it's never good enough." Similar to the continuum technique, the exercise of depolarizing comparisons encourages patients to consider comparing themselves with people all along the range of evaluations—from 0% to 25% to 50% to 75% to 100% performance (attainment, ability, etc.).

For example, a woman believed she was "stupid" because she was not as smart as someone else in her office, who was an exceptionally brilliant lawyer. Her automatic thoughts were, "I'm an idiot. I can't do anything right. I'll never get anywhere." Her perfectionistic standards led her to compare herself to the smartest person that she could imagine and then polarize herself to the extreme.

She was introduced to the concept of the normal distribution curve, where the average IQ is 100 and 75% of the total sample population have no college degree. The therapist asked her to compare herself to 5 points along the distribution: (1) the point representing the stupidest person in the world, (2) the point indicating below-average IQ (85 IQ), (3) the point indicating average IQ (100), (4) the point for above-average IQ (115), and (5) the point for genius IQ (175). By depolarizing her comparisons and including a range of points for evaluation, she was able to recognize that she was much more intelligent and educated than 90% of the population. She was surprised to realize that she is smarter than 90% of people, rather than thinking that she is an idiot because one person is smarter than she is.

Similar to the zero-point technique, this exercise required her to identify how she differed from people who would score at each of the 5 points along the scale and what it would be like to try to convince these people that she was a loser because she was not smarter than everyone. This experience dramatically diminished her self-critical thoughts about her own competence.

Not all patients place in the top 10%, needless to say. What if the patient is average or below average? We have found that most people who are average are willing to accept the norm as their achievement, especially when they can point to qualities involving integrity and kindness that may be more important than achievement. For example, a foreman in a factory criticized himself because he was not a good writer. When we examined the evidence, it was clear that he was below average in this particular area. However, what actually bothered him more was his belief that he should be

an excellent writer. We reframed this idea as a *preference,* not a requirement, and examined other things that he did well (see Diversifying Criteria, below).

Questions to Pose/Intervention

"You seem to be comparing yourself to people at the very top—the absolute best in the field. What if you were to compare yourself to people at different levels—say, at 20%, 50%, 75%—rather than just 95% or 100%?"

Example

In this case the patient thought she was stupid because she did not do "well" on her chemistry exam. In fact, she received a B and had a very high cumulative grade-point average.

THERAPIST: You feel you did poorly on the exam because you got a B. How bad do you feel, from 0% to 100%?

PATIENT: I feel terrible. I'd say close to 90% bad. I expected to get an A. I guess I'm not that smart.

THERAPIST: OK, your thought is that you aren't so smart. What else does that thought lead you to conclude?

PATIENT: I guess that I'm really mediocre. Ken got an A, and I always thought I was as smart as Ken.

THERAPIST: Sometimes we focus on the person at the top when we compare ourselves to other people. I guess Ken did better than anyone else on the test. How would you compare yourself to the rest of the class—how did they do?

PATIENT: The average grade was C.

THERAPIST: So if you compared yourself to people at the midpoint—that's the C—you did better. What percentage of people got better than a B?

PATIENT: I'd say about 10% of the people.

THERAPIST: What percentile were you in?

PATIENT: Probably the 80th percentile.

THERAPIST: How would you compare yourself to people who were at the 40th percentile?

PATIENT: I did twice as well as they did.

THERAPIST: It sounds like the only percentile that was better than yours was the 90th percentile. Why would you feel bad about doing better than 80% of the people?

PATIENT: I guess it's not as bad as it feels. Most people didn't do as well as I did.

Homework

The therapist introduces the issue of depolarizing comparisons by suggesting that "we often compare ourselves to people at the top, but it is more realistic to compare ourselves to people performing at all different levels. Over the next week, I'd like you to consider the negative things you are saying about yourself [e.g., "I'm a failure/stupid/ugly"]. Using this form [Form 9.6], make a list of these negative qualities that you think you have and then compare yourself to people at each level—those at the 25% level, the 50% level, 75%, and 100%. How do you compare to people at these levels? How

does this comparison make you feel, and what does this make you think?" See Figure 9.3 for an illustration of how a client might fill out this form.

Possible Problems

Many perfectionistic patients have difficulty with this technique. They complain it does not make sense to use the full range, since they expect more from themselves. We have found several techniques to be helpful in such situations. First, consider the costs and benefits of using the entire range

Question	Answer
What quality am I criticizing in myself? Am I less successful than other people?	*I have some success. I graduated from college, I have a job, I make more than most people my age, I have a number of decent friends.*
How would I compare myself with people who have: 0% of this quality?	*I have so much more than they do. I have a job, friends, income, and I'm healthy.*
25%?	*Again, I'm doing much better than most people on all of these qualities that I mentioned.*
50%?	*Better than most of those people, although some of them are happier than I am. I'm unlucky, I guess, in that I tend to get depressed and worry a lot.*
75%?	*Probably as well as most of them, although some may have a better primary relationship.*
100%?	*I don't know anyone at 100%, but I can say that I'm certainly not at 100%.*
Have I been overlooking some positives?	*Yes, I focus on the recent conflicts in my relationship and overlook the positives in my life.*
Which positives?	*My job, friends, decent income, healthy, my intelligence, my character.*
What would be a more rational way of viewing myself?	*Seeing things in perspective and giving myself credit for my positives and recognizing that the negatives are few compared to the positives.*

FIGURE 9.3. Depolarizing comparisons.

of comparisons. By using the entire range, patients are able to appreciate what they have accomplished. However, patients may object that they will lose their motivation (their "edge") or become mediocre if they settle for comparing themselves with people in the bottom half. Second, examine the evidence that people lose their edge when they go beyond narrow comparisons at the topmost level. In fact, some people procrastinate because they believe they cannot perform at 100%. Third, consider possible positive outcomes from performing at a less-than-perfect level—that is, do the people at the 50% or 40% level have any positives in their lives, such as less pressure?

Cross-Reference to Other Techniques

Other techniques that might be helpful include cost–benefit analysis, construction of alternatives, using the continuum technique, vertical descent, and graded task assignments.

Form

Form 9.6 (Depolarizing Comparisons).

TECHNIQUE: Looking at How Others Cope

Description

As indicated above, many times we believe that people who have done worse than we have are much worse off than we are. In fact, this is often not the case. Consider income. We may believe we need to make a certain amount of money in order to have any self-esteem, but in fact there are millions of people who make less than we do who feel fine about themselves and enjoy a lot of things in their lives. In using this exercise we ask patients to consider people who have done worse as a positive role model of succeeding in spite of lower performance. This technique seems counterintuitive, but it may liberate patients from the demanding standards and unfair comparisons that contribute to lowered self-esteem.

A variation of this exercise involves asking patients to consider how people who have gone through a similar loss (trauma, setback, conflict, etc.) have coped with it in a productive way. For example, if the patient has lost his or her job, he or she might consider how others have coped well with losing their jobs. What's their secret?

Questions to Pose/Intervention

"You are focusing on how you did *not* measure up to your high standards. You are focusing on the negative things going on your life. Consider other people who have not done as well as you have [or who have experienced a loss like you have]. What positives do they experience in their lives? How have other people survived? What were they able to do that was positive?"

Example

THERAPIST: You sound like you are down on yourself because you didn't make as much money this year as you wanted to make. Are there people who make less money than you do?

PATIENT: Most people make less than I do, but I expected to make a lot more.

THERAPIST: So things didn't live up to your expectations. Do you know any people who make less?

PATIENT: Almost all the people I work with.

THERAPIST: Can you tell me about some of them? For example, are they able to experience any positive things in life?

PATIENT: Actually, Jane makes about half of what I make. She enjoys her friends. She has a simple but nice apartment, and she seems to have an upbeat attitude.

THERAPIST: How does she manage such pleasantness if she makes so much less than you do?

PATIENT: She doesn't have my expectations.

THERAPIST: Maybe there's something that Jane can teach you about life. What could that be?

PATIENT: How to have fun?

Another patient was worried about his impending divorce and suddenly seeing himself as a lonely failure.

THERAPIST: Do you have friends who are divorced?

PATIENT: Yeah. Larry is divorced, and Frank has been through it twice.

THERAPIST: How did Larry deal with things when he got divorced?

PATIENT: Well, he was actually fairly happy to get out of the marriage. He complained about the financial aspects of the divorce, but he got his own apartment, and he started dating on the Internet.

THERAPIST: What could you learn from Larry about how to handle this situation?

PATIENT: Well, I guess when there's money involved, it focuses your attention. (*laughs.*)

THERAPIST: That's true. That might help you deal with any guilt feelings. Probably once the lawyers get involved, you'll feel less guilty and more concerned with protecting your assets. By the way, how did Larry handle this aspect?

PATIENT: He got a good lawyer.

THERAPIST: OK. What else did he do to make the divorce work out for himself.

PATIENT: He got himself a nice apartment. That's going to be expensive.

THERAPIST: Are you worth it?

PATIENT: You're right. It's *my* money!

THERAPIST: OK. What else can you learn from him?

PATIENT: Don't sit around and stew over it. Get out and meet people. Do things.

THERAPIST: So, one way of putting things in perspective is to see how other people have handled divorce.

PATIENT: That's true. It doesn't seem so bad now. If they're able to manage it, why couldn't I?

Homework

Using Form 9.7, the therapist can ask patients to describe the conflict, loss of job, income, relationship, rejection, or disapproval on which they are focused. Then patients should consider any other

people they know (or have known in the past) who have experienced either a similar or more difficult situation and coped well in the face of the adversity. What could be learned from them? Describe the current situation. This includes describing the current situation, who else experienced something like this, how they viewed it and coped with it, what I can learn from their experience, and what I can do to move things forward, what skills I have, what resources I have, if I believed I had the skills and resources how would I think and feel now, and what I am willing to do this week to move things forward.

Possible Problems

Similar to other techniques that seek to place things in perspective, this exercise can be experienced as invalidating. One patient complained, "You're trying to make this seem OK—but it hurts me a lot." The therapist should attempt to balance validation of patients' painful emotional experiences with the recognition that others have coped successfully with painful losses and that we can gain wisdom and perspective from these people.

Cross-Reference to Other Techniques

Other relevant techniques include double standard, problem solving, constructing alternatives, decatastrophizing, negation of problem, and activity scheduling.

Form

Form 9.7 (How Have Others Coped?).

TECHNIQUE: Turning the Tables—Affirming the Negative

Description

Although many of the techniques one uses might challenge the idea that the negative is true, the technique of "Turning the Tables" affirms the negative while also affirming that negatives are part of being human and that one can cope well and have a meaningful life even if one accepts the negatives. In a sense, patients are asked if they can make room for their negatives, welcome their imperfections, and see the beauty in human frailty. By invoking acceptance, compassion, recognition of imperfection, and differentiating all the facets of the self, this technique allows patients to finally affirm the negative without denouncing the self.

Questions to Pose/Intervention

"All of us have behaviors or qualities that we view as negative. That is part of the human condition. You and I do not know anyone who is perfect, and it is unrealistic to strive for perfection. Let's take some of the things that you criticize yourself for—some things you don't like about yourself. You might dwell on these negatives. But what if you were to simply acknowledge them as behaviors, mistakes, choices, or qualities you have at times. These are all part of a larger picture of who you are—a complex, imperfect person who goes through life with ups and downs."

Example

THERAPIST: We often get upset when we come up with a negative thought that is central to the way we want to think about ourselves. For example, you get upset when you think you might fail, and this leads you to think, "I *am* a failure." The real fear is of "becoming a failure." So let's look at what this would mean. Please complete the following sentence, "If I became a failure, it would bother me because. . . ."

PATIENT: Oh, I just couldn't stand it. I don't know. I couldn't be happy—no one would want to be with me, and life wouldn't be worth living.

THERAPIST: Those sound like pretty bad things. So let's imagine for a moment that I have become a failure. I would like to do a role play with you in which I'm a failure and you have to convince me that all these terrible things are true. So try to make me feel bad.

PATIENT: [role play] Well, you're failure. You can't do anything anymore.

THERAPIST: [role play] I don't think that's true. I'm able to spend time with my wife and my son, and I can read, watch TV, see my friends, exercise, and do a lot of things.

PATIENT: But you can't enjoy any of those things.

THERAPIST: That's not true. Now that I'm a failure, I don't have to worry about succeeding or failing and I can simply enjoy daily life.

PATIENT: How can you enjoy daily life if you're a failure?

THERAPIST: I guess I just accept it. It's like losing your hair—you learn to live with it. And I have a lot more time and energy to enjoy simple things rather than constantly measuring myself, comparing myself, and criticizing myself.

PATIENT: But who would want to be with you?

THERAPIST: You know, given your definition that a failure is someone who is not excelling in everything, I have noticed that there are a lot of us failures around. We could outvote the perfect people and win every election. Yes, we are almost everyone in the world. So I have a lot of company. All of us who failed at something are really having a great time.

PATIENT: But your friends will think less of you.

THERAPIST: All of my friends have failed at something, so, according to you, they are also failures. But, you know, we find that we understand each other; we understand that we are not perfect, and it's kind of cool to be hanging out with people who are imperfect—the failures of the world.

PATIENT: [outside of the role play] You know, it's funny, in a way, to think of accepting being a failure. I know the exercise is funny, but it also makes me realize that I've been afraid of something that seems so silly.

THERAPIST: If all of us have failed—and therefore are "failures"—then we are the human race.

Homework

The therapist can ask patients to imagine that the feared quality is true—that they are a "failure," a "loser," "crazy," or "ugly." Now they can describe how they could accept that this quality is true and how it is true for so many others. Imagine how one can cope even if the feared quality were true. What would they be able to do? Patients can use Form 9.8 to examine how they would cope if it were true—by affirming the negative. See Figure 9.4 for an example of how one could use this form.

My negative quality or behavior	State some truth about this	Why this is not a problem. What I can still do that is positive. Other positive qualities that I have.
I tend to envy other people and complain about things at work.	Yes, it's true that I get envious of other people and complain things are not fair, and this might annoy other people and make my boss and my colleagues unhappy with me.	It is something of a problem if I continue to do this. But I can change. I don't see any advantage in the long term of complaining and being envious. I should focus on doing the best job I can and keeping my mouth shut.
I tend to procrastinate at times.	I do tend to put things off and get distracted with useless things on the Internet.	I can focus on my daily goals and monitor any time I go off onto websites that are not related to my work. I can give myself credit for getting things done.

FIGURE 9.4. How I could cope if this were true of me.

Possible Problems

Some patients may think affirming negative qualities is the same as criticizing themselves, and they may incorrectly believe that the therapist is joining with others to derogate them. The therapist can indicate that accepting that all of us are human and have imperfections is the opposite of criticism; it is acceptance, compassion, and understanding. In addition, the therapist can ask what the advantages and disadvantages are of affirming the negative as human imperfection. Moreover, if the patient loved a child who had imperfections, would this include affirming and accepting the child's imperfections? Isn't this different from criticizing the child?

Cross-Reference to Other Techniques

Other techniques include acceptance, universalizing human qualities, compassionate mind, seeing things from another person's perspective, feared fantasy, viewing things along a continuum, and why this is not a problem.

Form

Form 9.8 (How I Could Cope If This Were True of Me).

TECHNIQUE: Diversifying Criteria

Description

Quite often, we judge ourselves, or others, on the basis of one factor to the exclusion of many other possible factors. For example, the college student who receives an average grade on a history exam and concludes "I'm a failure, I haven't learned anything" is focusing only on the questions she got

wrong and disregarding all of the other questions she got right. Is this reasonable thinking on her part? Didn't she learn something in the course that was not on the test, in addition to those correct answers? How about her other courses? Surely she learned something in those courses as well. She also learned a lot from interacting with her friends and all the facets of college life—none of which was tested. She focused on one dimension to evaluate herself and did not consider the other areas in which she has learned many things.

Another example is the socially anxious individual who thinks "I looked like a fool at that meeting." The evidence he points to is that he hesitated when he spoke. But what would be some additional criteria or examples of competent behavior at this meeting or at all of the other meetings he has attended? The next Example section provides an excerpt of a dialogue with a socially anxious businessman.

Questions to Pose/Intervention

"Sometimes we think we don't have a certain quality because we do not do well in one or two situations. For example, I worked with a man who believed he was stupid because he didn't do well on his job review interview. But he had other ways of showing his intelligence—for example, he was good at his job, per se (just not at being interviewed), and he was good at dealing with people. When you criticize yourself, you may lose awareness of your positive qualities and behaviors. Think of the quality you believe you lack. Now think of some creative ways of observing that quality in yourself or in others."

Example

THERAPIST: You said you looked like a fool at the meeting because you hesitated. How long did the meeting run?

PATIENT: About 90 minutes.

THERAPIST: How many times did you speak?

PATIENT: Probably about 10 times.

THERAPIST: What would be some ways we could evaluate someone's competence at a meeting?

PATIENT: Well, I think showing up on time, having the information you need, communicating the information, convincing the other people, getting an agreement—those would be some signs of doing a good job.

THERAPIST: Did you do any of those things?

PATIENT: Yes, I did all of them.

THERAPIST: So when you focus on your one hesitation as signifying a poor performance, you are not considering all of the other ways in which you performed well at the meeting? Perhaps you need to expand your criteria for success.

The narrowness of these criteria was exemplified by a 73-year-old woman who had been married for almost 50 years. Her belief was, "My husband doesn't love me because he doesn't want to have sex with me." She had held this belief for most of her marriage. We decided to expand her criteria for "love."

THERAPIST: What are some other ways in which a husband shows he loves his wife?

PATIENT: He can be faithful, affectionate, give her things, help her when she's feeling down, do things with her.

THERAPIST: Has your husband done any of these things?

PATIENT: Yeah. And he tells me he loves me.

THERAPIST: Perhaps you're focusing on only one sign of love—sex. It sounds like you're saying that there are a lot of ways he does love you.

As we examined her husband's past history, it surfaced that her family doctor—who also was her husband's doctor before they married—had warned her that he was not that interested in sex. As it turned out, he suffered from a lifelong depression, which reduced his sex drive, but which did not preclude him from loving his wife in other ways.

Homework

Using Form 9.9, patients list one quality they want more of (i.e., they believe they are lacking in this quality), indicate all the different ways of observing that quality, and identify examples of demonstrating that quality.

Possible Problems

Some individuals are "negative trackers": They only count the negatives. They discount the positives because they believe the positives are "expected." This thinking can be challenged by asking them to list examples of people who lack some of these taken-for-granted positives. For example, if the patient believes "knowing how to be polite" is taken for granted, then he or she should list examples of people who have shown poor manners.

Cross-Reference to Other Techniques

Other relevant interventions include the semantic technique, evidence for and against, examining insufficient information searches, double standard, and positive tracking.

Form

Form 9.9 (Developing New Ways to Evaluate a Quality).

TECHNIQUE: Taking It All Away

Description

Much of what we experience in daily life we take for granted, assuming that it will always be there. Depression is often the consequence of discounting the positives in our lives, not appreciating the sources of rewards that are available, not noticing the good things around us. One form of therapy (Morita therapy) views depressed individuals as people who have lost touch with their environment—both the objects and the people. In treatment with this form of therapy, patients are isolated by the

therapist in a dimly lit room, where they contemplate the objects and people with whom they no longer have contact (Morita, Akihisa, & Levine, 1998). This deprivation heightens patients' awareness of the meaning of these objects and people. The therapist then reintroduces, one by one, objects and people to each patient. Patients are asked to focus on the object or person and to describe what they appreciate about it/him/her. For example, an orange is pealed and placed in front of the patient, who comments, "I can smell the fragrance of the orange, and I remember the sweetness of the juice." Similarly, patients' partners are brought in to the room, and patients describe the experiences they recall appreciatively. In this way, awareness and connection with the world is rebuilt.

I have adapted this exercise to our therapy format. I ask patients who believe they value nothing to imagine that *everything* has been taken away—their body, memory, family, job, house, car, all their possessions, their capacity to feel—everything. They must now ask a Supreme Being, who has removed all of these things, to return them one by one, not knowing how many they will get back. But patients have to make a case for each one of them. And they must prove that they are worth having. If not, then patients have to describe what their lives would be like without them.

Questions to Pose/Intervention

"Imagine everything you have—and are—were taken away. What would you want back and why would you want it? Imagine there is a Supreme Being from whom you must request the restoration of each person or thing you want back. You do not know how many of these requests will be granted. The Supreme Being has to be convinced that what you want back is really important to you—that you really appreciate it. I will play the role of the Supreme Being, and you can ask me to give you back the people and things that have been taken away from you. Keep in mind that *everything* has been taken away. You have absolutely nothing right now—no body, no mind, no memory, no friends, no family, no possessions. You have been reduced to absolutely nothing. Now begin by asking me for one thing at a time, and try to convince me that you really want it back and could really appreciate it."

Example

I used this technique with a young investor who believed his life was over and not worth living because he had made a bad decision about a trade.

THERAPIST: Close your eyes and imagine everything has been taken away—your memory, all your senses, your body, your family—your wife and child—your parents, friends, your job, house, car, all of your possessions. Now I want you to imagine you are asking God, or some Supreme Being, to return these things. God has to be convinced that you can make a good case for valuing these things if they were restored to you.

PATIENT: (*Seems uncomfortable, but asks for his senses back first. He justifies this prioritization by saying he could not appreciate any of the other things without the capacity to see, hear, and feel.*)

THERAPIST: What is it that you want to see, hear, and feel?

PATIENT: I want to see my wife, my son. I want to feel them close to me.

THERAPIST: But why do you want that? What good will it do you?

PATIENT: Because I love them.

THERAPIST: What if we limited your sensory abilities to perceiving only them? Would that be enough?

PATIENT: No. I want to be able to see the sun again. I want to hear my parents, by brother. I want to hear music.

THERAPIST: What if you never heard music again? Or saw the sun?

PATIENT: I'd miss that!

We then went through a variety of other things that he had to request be returned to him and justify his appreciation of them. What was intriguing to me was how emotionally charged this exercise was for him. Here was a "tough Wall Streeter" who had begun to see that the most important things in his life were literally right before his eyes.

Two weeks later his depression had lifted. He told me the exercise had impressed on him how important his life was—despite the bond deal that did not work. He recalled the following incident for me: "Our next-door neighbor came over the other day. She's a woman a few years older than my wife. To our shock, she said, 'You may have noticed that my son Jerry hasn't been coming around for the last month. I thought I should tell you that he's been upset since his father died from cancer.' I began to cry. I realized how much my family means to me and how much I mean to them."

Homework

Using Form 9.10, the therapist asks patients to engage their imagination in a fantasy in which they have lost everything—their body, senses, memory, family, possessions, job, friends—and are given the task of finding the meaning or importance of each of these losses and making a case for receiving them back: Describe why each is important and why each is appreciated. This is a powerful exercise that challenges the idea that nothing is worthwhile, and the state in which everything is taken for granted; Form 9.10 may be useful in eliciting some thoughts and feelings about the value of what is around us.

Possible Problems

Again, patients may consider this exercise to be invalidating, because the loss or conflict is "real" to them. Losses and conflicts *are* real, but so is everything else that we ask patients to consider. Whether patients live out these other possibilities or experiences in their lives will depend on their ability to recognize their role in their existence. This recognition comes from developing more mindfulness—more attuned awareness of the present reality. The therapist can say: "Consider that every second you are breathing, but you almost never notice it. Now focus on your breathing, and imagine that this is taken away for 5 minutes. Obviously, you would die. It is real, but you did not notice it until you imagined it stopping."

Cross-Reference to Other Techniques

Other relevant techniques include continuum, setting a zero point, decatastrophizing, constructing alternatives, problem solving, double standard, viewing it from the balcony, and activity scheduling (i.e., focusing on appreciating and becoming more mindful of the items in the list).

Form

Form 9.10 (Asking for Things That Are Important to Me).

TECHNIQUE: Examining Opportunities and New Meanings That Come from Loss or Conflict

Description

Losses and conflicts are inevitable aspects of life. While recognizing that these losses and conflicts may be painful and require significant adjustment, it is also possible to acknowledge that these losses also may provide opportunities for reconstructing meaning, opening new awareness, or responding to new challenges with personal growth. The patient who is experiencing divorce may report that she is depressed because of the loss of intimacy and continuity in her life, but the divorce also may (1) provide an opportunity for recognizing and redefining personal values of intimacy and attachment, (2) create new opportunities for new relationships with friends or a new intimate partner, and (3) catalyze growth in her work arena and in her experience of connectedness to others. Rather than looking on the dark side of the loss, the patient can be encouraged to consider the opportunities, challenges, and meanings that are possible consequences of the current situation. Tedeschi and Calhoun (1995) found that over 90% of survivors of a traumatic event described at least one positive experience or insight that was gained from their traumatic experience. Losses and trauma may help people recognize what is important in life, transform their values, and may lead to an increased resilience (Tedeschi & Calhoun, 2004).

This positive trajectory became clear for Rebecca who was 72 when her husband died. Always an extroverted person, she had focused a lot on her husband, her children, and her grandchildren. But she had not made an effort to make many friends. The death of her husband put her in a position where she would either feel lonely on a daily basis or she would have to reach out to friends and neighbors. She got involved in a volunteer organization for a local hospital, serving as treasurer to one of the fund-raising efforts. She started to go to church. She went out for dinner to a local diner where she began making new friends. And she traveled with her daughter and her husband. Rebecca learned how to cope as a single person, how to extend herself to new people that she had previously avoided, and how to get out by herself to do things. Losses may require new growth, new opportunities, and new relationships.

Questions to Pose/Intervention

"Although you may be focused right now on the loss [or conflict]—and it may feel very negative to you—it is also possible to consider it in light of new meanings you can give to your life. What good can come out of this situation? What have you learned about what you value? About what is important to you? Are there new opportunities, new behaviors, new relationships, new challenges, or new ways of seeing things that you can experience because of this loss [or conflict]?"

Example

THERAPIST: So, Jane, you're feeling down since the breakup with Bill? When you feel down, what kinds of thoughts do you have?

PATIENT: I think about how I no longer have someone I love in my life.

THERAPIST: It sounds like having a deep and meaningful relationship is important to you. It is something you value.

PATIENT: Yes, although I know I have friends, and my work is going well. But I do feel so much better when I'm close to someone.

THERAPIST: Does that say something good about you?

PATIENT: I guess it says I have a lot of love to give. I like the intimacy, the connection.

THERAPIST: It sounds like intimacy and connection and being able to love someone are important parts of who you are.

PATIENT: Yeah. It's hard to live without that.

THERAPIST: Yes, it's hard not to have those things right now. The pain you experience must be telling you something about who you are. What does it tell you?

PATIENT: It tells me I want to have love in my life.

THERAPIST: Perhaps we can look at what that says about you that is good, even if it is painful.

PATIENT: I want a meaningful relationship with someone who is special to me.

THERAPIST: So, being able to love and give and connect with someone is part of who you are. We don't want to change that.

PATIENT: No. But how will I find someone if I'm so depressed?

THERAPIST: It may not be the right time now. But since this is an important value to you, we need to keep in mind that this is something special you want to share only with a special person. Not everyone will measure up.

PATIENT: But I'll feel lonely.

THERAPIST: Perhaps, for a while, your loneliness can tell you that you have a lot to give. It's painful, but it says something good about you. Perhaps some of that love and kindness can be directed toward caring for yourself.

PATIENT: I like the sound of that.

Homework

The therapist can ask patients to focus on what the loss or conflict tells them about what they value and what is important to them: "A lot of negative experiences may help us clarify what we value and what is important to us. Does this experience teach you anything like that?" In addition, the therapist can ask patients to list some of the new opportunities for learning or growth or behavior that may develop from the current situation. Patients can use Form 9.11 to record their responses.

Possible Problems

For some patients, finding the meaning or significance of the event may trigger even more depression, because they believe they currently do not have what they want and may never get it. It is essential that the therapist validate the emotional distress in the current situation, but also point out how the values and desires implicit in patients' responses may point to potential strengths. Each value can be a motivating force in their life. As noted in the above dialogue, the person's response to the end of a relationship, triggering feelings of loneliness and thoughts of needing intimacy, can be turned into an important value—the importance of meaningful connections with others. This value can then motivate the patient to deepen other relationships and to relate in a more honest and direct way.

Cross-Reference to Other Techniques

Other relevant techniques include constructing alternatives, positive reframing, problem solving, role playing against the negative thoughts, activity scheduling, and identifying and modifying personal schemas.

Form

Form 9.11 (Examining Opportunities and New Meanings).

TECHNIQUE: Traveling to the Future

Description

People often lose perspective because they believe the current moment—or the current situation—will continue to have an effect on them indefinitely. This form of "affective forecasting"—that is, predicting how one will feel in the future—often leads individuals to overgeneralize their current experience to have extreme negative effects that will be long-lasting. Individuals who are caught up in their current emotional difficulties may predict their future emotion based on their current emotion ("emotion heuristic"), focus on a single element to the exclusion of other factors ("focalism"), and underestimate events that might intervene in the future or discount their own abilities to cope ("immune neglect"). The well-known adage, "Time heals all wounds," acknowledges that with time and experience, current events or losses are put into perspective. Indeed, the research on resilience clearly indicates that an overwhelming percentage of the general population recovers within 1 year to levels of psychological well-being that existed prior to the major life event (Bonanno, 2004). With this technique—examining how one could cope in the distant future—the patient is asked to step away from the current experience, "stretch time," and consider all of the intervening factors and coping skills that might reduce the negativity of the current experience.

Questions to Pose/Intervention

"We often find ourselves caught up in the way we feel in the present moment and have considerable difficulty imagining how we could cope in the long run. So, for example, people who experience a major life event such as divorce, death of a spouse, loss of income, or other major negative experiences actually do well a year later. This may be because they find ways to cope that help them overcome difficulties or that positive events or relationships occur during the following year of so. I wonder if you could imagine yourself a year of 2 from now and how you might feel about the current situation. What could happen over the next year or so that might make this seem less negative?"

Example

THERAPIST: I know the end of your marriage to Tom is a difficult time for you, and you tell me you are discouraged about the future. Right now, what do you see as your future?

PATIENT: I just see a lot of loneliness. I have an 8-year-old daughter, and it's really hard to find a man in the city—especially when you're getting older.

THERAPIST: So it sounds like you're predicting that you will be lonely, sad, and that your life won't involve a relationship for you. Sounds pretty discouraging.

PATIENT: Yeah. I really wanted the marriage to work out, but Tom wanted other things.

THERAPIST: Sometimes we predict the future based on our present feelings and what is going on at the current moment. Perhaps you might be doing that, thinking you will always be single, and being single will always be lonely and sad.

PATIENT: That's how I feel.

THERAPIST: You told me when you were younger you had a breakup. How did that work out for you?

PATIENT: Well, at first I was sad and lonely—I missed Brian—yeah, I thought I couldn't live without him. I cried a lot at first.

THERAPIST: And, then, what happened?

PATIENT: I began seeing my friends more and I got involved in my job. I traveled with my friends, going skiing—Brian didn't ski, by the way. And I went to the beach during the summer. I got more active. And I really grew during that time. It was a few years until my next relationship—that was Tom—but I was pretty happy then.

THERAPIST: So, it sounds like you really grew during that time, but you had anticipated that it would be sad, lonely, and that there would be very little fun. But your predictions were not accurate, were they?

PATIENT: No. I was too negative.

THERAPIST: Sometimes when we predict the future, we overlook our ability to cope and we overlook the positive things that might happen. What are some positive things that could happen this year?

PATIENT: I can spend more time with my friends, and I can avoid having arguments with Tom. That would be a positive. I could start getting my work going again. I had a small business that I set aside, but I really want to move that forward. I was thinking of getting a real-estate license. That would be a good thing to have.

THERAPIST: Are there some positive things that could happen to you?

PATIENT: Yeah. I guess I could find that my business could grow and I would have some extra money. But also some pride in building my own thing. And I might meet a guy I like, but I don't know if I am ready for that. Maybe just someone to spend some time with.

THERAPIST: Can you imagine having a good life this year without a new guy?

PATIENT: Yeah, I could. I think I need to find myself and grow and let myself find out who I am without a guy. So much of my feeling was tied up with Tom, and he wasn't really that committed.

THERAPIST: So, you might find out that you could see some new things and new relationships and even a new you during this coming year. That might require some planning.

PATIENT: Yeah. I need to think about taking charge of my life.

Homework

The therapist can ask patients to describe how they will feel in a year and why they would feel this way. Specific predictions about what will happen can be elicited and written down. The therapist can ask patients to consider the possibility that their predictions may be based on how they feel at the current moment, on recent events that might have been discouraging, and on a selective view of the negative possibilities in the future. The therapist can ask patients a series of questions: What could be some positive events in the future? What could be some new possibilities that could open

up? How would they feel if those positive things happened? How have they coped in positive ways with problems or losses in the past that have occurred? Patients can use Form 9.12 to consider how they could function in the future.

Possible Problems

Often patients claim that their predictions are accurate and that it is unrealistic and naïve to expect that there would be anything positive in the future. The therapist can acknowledge that these are valid thoughts and feelings, given how the patient sees things at the present moment, but that the future is open to possibilities that we are often not accurate in predicting. Past experiences of coping can be identified, as can past times of problematic coping. For example, if the patient has isolated him- or herself or become passive after a loss, then this behavior can be identified as an unhelpful style of responding that can be tested against more proactive behavioral prescriptions. Similarly, some patients may claim that considering positive outcomes in the future ignores how badly they feel at the present time and is invalidating. The therapist can indicate that the current emotions are real and important but that emotions change as circumstances change. Wounds can be healed.

Cross-Reference to Other Techniques

Other relevant techniques include making decisions for a future self, problem solving, setting longer-term goals, and clarifying values.

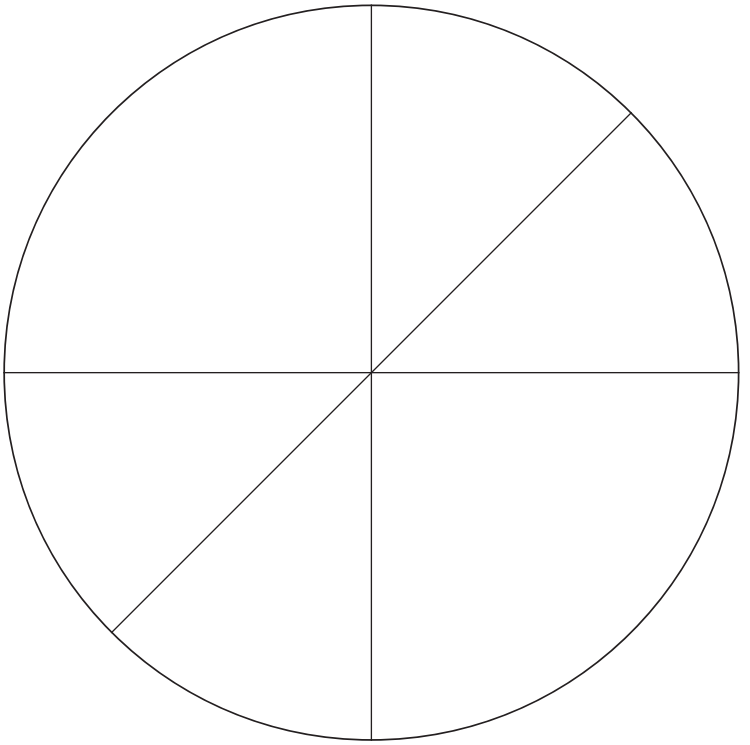
Form

Form 9.12 (Traveling to the Future).

FORM 9.1

Pie Chart Exercise

Consider the different pieces in the pie. Each piece represents a cause of the event; some causes may require a larger piece than others, because they had more influence on the event. Label each piece as a possible cause of the event. How big a piece is left for you as a cause of the event?



What is the negative event that bothers you: _____

List all of the possible causes of this event, including your own role in the event, and list the % of the pie that you would assign to that cause.

Causes	**%**

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FORM 9.2

The Continuum Exercise

Using the scale below, indicate where you would place the current event that is bothering you. Now fill in other negative events for each 10-point mark on the scale. Is it hard to fill in some points that are lower than your current event? Why is that? Would you consider rerating the current outcome or event after you have filled in this scale? What is the reason why you would—or would not—rerate the outcome or event?

0	10	20	30	40	50	60	70	80	90	100%
No negatives	↑	↑	↑	↑	↑	↑	↑	↑	↑	Holocaust

Question: Where would you place the current event?

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FORM 9.3

What I Can Still Do

We are often concerned that if something happens, it would be terrible or awful. The fact is that bad things do happen, and we may have to think how we could cope with these events. In the form below, write down the event that concerns you. Then, in the left-hand column, list the things you think would happen as a result. In the middle column, list all the things you could still do even if this did happen. In the right-hand column, list all the things you could no longer do.

The event I'm concerned about: _____

If this happened	I could still do	I could no longer do

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FORM 9.4

Considering Alternatives

When we are upset, we often focus on one point of view—our own—not realizing that there are many different ways of viewing things. Consider the current situation and your point of view. Describe the situation in the left-hand column and your negative thoughts—your "interpretations"—in the middle column. Now, in the right-hand column, list different ways of seeing the current situation—different interpretations, behaviors, and opportunities you might pursue, etc.

Describe the current situation that is bothering you.	**What are your negative thoughts?**	**What are some different ways of viewing this situation? Are there new opportunities made available? Are there different possibilities you could pursue? List these.**

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FORM 9.5

Zero-Point Comparisons

Think of someone who completely lacks the quality you think you lack—that is, the person at the zero point. What is he or she like? How do you differ? What do you have or do that represents an improvement over the zero point? What would it be like to try to convince someone at the zero point that you are a failure?

The person at the zero point has these qualities or things	**I have these qualities or things**

How am I different from someone at the zero point?
How have I improved over a zero point?
Would I be able to convince someone that I am at the zero point? Why not?
What would be a more realistic way of looking at where I am?

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FORM 9.6

Depolarizing Comparisons

Sometimes we compare ourselves to people who perform at the top level (100%) and find ourselves lacking. Try to use a full range of comparisons when evaluating yourself, using the questions below.

Question	Answer
What quality am I criticizing in myself? Am I less successful than other people?	
How would I compare myself with people who have: 0% of this quality?	
25%?	
50%?	
75%?	
100%?	
Have I been overlooking some positives?	
Which positives?	
What would be a more rational way of viewing myself?	

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FORM 9.7

How Have Others Coped?

When we go through a loss or a conflict, we often focus on the worst possible outcome or meaning. It can be helpful to realize that other people have gone through similar or even worse experiences. Many of these people found ways of coping or ways of thinking that were especially helpful. What can you learn from the way they coped?

Describe current situation	Who else has experienced something like this?	How did they view this situation and how did they cope?	What can I learn from their experience?	What specific things can I do to move forward and cope better?	What skills do I have to cope?	What resources do I have to cope?	If I believed that I had ways to cope, how would I think and feel now?	What am I willing to do this week to move forward in coping?

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FORM 9.8

How I Could Cope If This Were True of Me

Many times we dwell on something we view as negative about ourselves. It's almost as if we cannot accept mistakes, flaws, or imperfections. But we have them, nonetheless. Let's say that you notice you might be a bit boring in a conversation. Rather than argue against this, why not accept it—even embrace it? "Yes, I was boring in that conversation, but I can still go on in my life and do a lot of interesting things." In the left-hand column below, list some negative thoughts about qualities or behaviors that you've noticed about yourself. In the middle column, acknowledge that there is some truth in these thoughts at some times. In the right-hand column, indicate why these negatives are not a problem because you have a lot of other positive qualities and you can do a lot of positive things.

My negative quality or behavior	**State some truth about this**	**Why this is not a problem. What I can still do that is positive. Other positive qualities I have.**

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FORM 9.9

Developing New Ways to Evaluate a Quality

We often think we lack a particular quality (e.g., intelligence) because we do not do well in certain situations (e.g., chemistry exams). However, there are many ways to show different aspects of intelligence or other positive qualities. Think about the quality you want more of, and then think of examples of positive behaviors that might show that you have some of that positive quality. Use positive rather than negative terms when wording the quality to be evaluated—for example, "successful experiences" rather than "failure." Focus on observable, verifiable behaviors or performances, rather than inferences about underlying qualities. Think about things you could do to make progress on these qualities.

Example:

Quality to be evaluated: *I have successful experiences.*
Different ways to observe it: *Performance throughout school years, scores on tests, feedback from professors.*

Indicate how you might demonstrate some of this quality in different situations.

Quality to be evaluated:
Different ways to observe it:
What are some other examples of this quality?
Do I demonstrate any examples of this quality? Specify:
What are some things that I could do to improve on these qualities? Specify:
What am I willing to do this week to make progress in this area?

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FORM 9.10

Asking for Things That Are Important to Me

Imagine you have lost everything—your senses, your body, your memory, your family, job, possessions—absolutely everything. Then list what you want back, in order of importance, and make a case for why you want each back.

What I want back	Why it's important to me

What have I not been appreciating in my daily life?
Was there a time when I did not have these things or these people in my life?
Why have I ignored these things/people?
What have I been focused on that has distracted me from appreciating these things/people?
How can I show appreciation this week for these things/people?
How will I feel if I do appreciate these things/people?

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FORM 9.11

Examining Opportunities and New Meanings

Each event in our lives carries new opportunities as well as potential losses. In the form below, list the current situation or loss, indicate what this tells you about your values and needs, and then list what new opportunities or challenges this situation or loss can lead to in your life. Answer each of the questions below.

Current situation (or loss)	What this tells me about my needs and values	New opportunities and challenges in my life

Which values now seem less important to me?
Which values seem more important to me?
How can I use this experience to deepen my relationships with people?
How can this help me live each day more fully?
What am I willing to do this week to move in the direction of greater meaning in my life?

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FORM 9.12

Traveling to the Future

We often feel anxious and sad because we have a hard time imagining how things could be better in the future. This is partly because we get so focused on something happening right now or on our feelings right now. But let's imagine that you get into a time machine that takes you to a future where things are better. Use your imagination. What could you be doing that could make things better a year from now? What experiences could you have that would be better? What relationships could begin or become more meaningful for you?

What new experiences could you have?
What new relationships could develop?
Are there things that could happen that would make things better?
Can you imagine being happy? How?
Form a visual image of feeling better a year from now. Describe a story about your life in that future time.

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CHAPTER 10

Identifying and Modifying Schemas

Schemas may be defined as patterns of information processing that bias attention, memory, value, or interpretation of stimuli. For example, if I believe Mr. Jones is extroverted, I will selectively attend to any examples of his extroversion while selectively ignoring any introverted behavior on his part. I will selectively recall more examples of his extroversion and may, in many cases, "falsely recall" extroverted behavior that never occurred. I will place greater value on exemplars of his outgoing behavior while discounting his more inhibited behavior, and I will interpret his motives, past performance, and current performance in terms of exemplifying extroversion. In short, schemas function as biased lenses through which we view and interpret the world. We have schemas about our personal traits and those of others, about how people will respond to us, about our emotions, and about any content that we might conceptualize.

The idea that schemas might affect memory was first advanced by Bartlett (1932), who proposed that memory is reconstructive and is often determined by concepts or schemas that may lead to an incorrect recollection of events. Moreover, these schemas operate out of conscious awareness such that the individual automatically processes information consistent with the schema. A similar concept was reflected in Piaget's (1970) view that information or experience is "assimilated" into preexisting schemas, George Kelly's (1955) concept of "personal constructs," and the idea of "schematic processing," whereby information is processed and reconstructed through the filtering system of schemas. Schemas are characterized by "automaticity"—that is, they involve information processing that is outside the individual's awareness, such that the schema is determining the process itself. This "implicit" learning operates quickly and tends to be reaffirming—that is, schemas lead to "confirmation bias," whereby the search for information, attention, and the weighted value of information tend to confirm or support the preexisting schema. Thus schemas are "conservative" or "self-maintaining" and are perpetuated even in the face of countervailing information. Schematic processing is one of several processes that underlie self-consistency. Other theories regarding these processes include cognitive dissonance theory, self-verification theory (Swann & Ely, 1984; Swann, Stein-Seroussi, & Giesler, 1992), and the theory of innate needs for perceptual and cognitive consistency as evidenced by Gestalt principles of perception (e.g., closure, fitness; see Koffka, 1935; Köhler, 1929). And, as indicated in an earlier chapter, schemas can be viewed as a component of other heuristics or rules of thumb that lead to rapid cognitive responses when there is limited

information. The important point to grasp is that schematic processing and heuristics are implicit or automatic. The individual does not *want* to be negative or *want* to view him- or herself as a "loser." It is simply that the schemas are prepotent, determinative, and operate out of conscious awareness.

Beck's earlier description of psychopathology was part of the cognitive revolution in cognitive science and social psychology that took hold in the 1970s. Beck proposed that each diagnostic condition was characterized by schemas that subserve a vulnerability to depression and anxiety (Beck, 1976; Weissman & Beck, 1978). Depressive schemas reflect concerns about loss, failure, rejection, and depletion; anxiety schemas reflect lenses of threat and injury; and anger schemas reflect humiliation, being blocked in instrumental endeavors, and domination. Beck has advanced this model to include the idea of "modes," which are organizing systems and strategies that incorporate automatic thoughts, assumptions, core beliefs, and motivational and affective strategies for coping (Beck & Haigh, 2014).

Beck and his associates (Beck et al., 2014) developed a model of specific schemas for the various personality disorders, relating avoidant personality to schemas of inadequacy and rejection, narcissistic personality to schemas of entitlement and special status, and so forth. Moreover, each personality disorder included specific schemas about the self (e.g., inadequate) and about others (e.g., rejecting). Beck (Beck et al., 2014) placed these schemas within an evolutionary model of adaptation: for example, schemas related to abandonment would be helpful in maintaining attachment and therefore would have evolved to be maintained to some degree in almost everyone. The view in Beck's schema model is that schemas can be overdeveloped or underdeveloped and that individuals cope with these schemas by compensating for or avoiding situations where these schemas are activated. Each personality disorder is characterized by problematic strategies for coping—for example, dependent personality copes through clinging and deferring, compulsive personality copes by overworking and organizing, and avoidant personality copes by hiding from others.

Similarly, Young (Young & Brown, 1990; Young, Klosko, & Weishaar, 2003) developed a schema model focused on the specific content of personality vulnerability. Young's model describes 18 schemas (e.g., abandonment, mistrust, emotional deprivation), different modes (e.g., the child modes, the maladaptive coping modes, the maladaptive parent modes, and the healthy adult mode), and three coping styles (surrender, avoidance, and overcompensation). Research supports the efficacy of Young's schema-focused therapy for treatment of borderline personality disorder (Arntz & Van Genderen, 2011).

In this chapter I examine how the therapist can assist patients in identifying and modifying their individual schemas. Work on modifying long-existent schemas may require a longer duration of therapy and may lead to the activation of schemas in the therapeutic relationship. For example, schemas about others as judgmental and rejecting may be activated in therapy when the patient, harboring beliefs about the self as boring and inadequate, may view the therapist as condescending and rejecting. Or the patient with schemas about abandonment and helplessness may seek reassurance from the therapist that he or she really cares (Leahy, 2005a).

TECHNIQUE: Identifying Schemas—Consistent Patterns

Description

The cognitive model proposes that a key vulnerability to depression, anger, and anxiety is the core set of beliefs one holds about self and other. For example, the depressed individual may believe that the self is boring and others are judgmental, the anxious individual may believe that the self is

helpless and others are threatening, and the angry individual may believe that the self is blocked from achieving goals and others are humiliating. Beck et al. (2014) identify a number of core schemas that individuals endorse, and they suggest a correspondence between these schemas and personality disorders. In the present context I do not limit the discussion to the schemas corresponding to personality disorders, but rather recognize that individuals may have their own idiosyncratic schemas that may include any consistent manner in which each individual views self or other.

Examples of core beliefs from Beck et al. (2014) include beliefs about being vulnerable, socially inept, incompetent, needy, weak, helpless, self-sufficient, easily controlled by others, responsible, competent, righteous, innocent, special, unique, glamorous, and impressive. Young et al. (2003) identify the following as personal schemas: abandonment, mistrust, emotional deprivation, defectiveness, social isolation, dependence, vulnerability, enmeshment, failure to achieve, entitlement, insufficient self-control, subjugation, self-sacrifice, approval seeking, negativity, emotional inhibition, unrelenting standards, and punitiveness.

We can identify the content of the patient's schemas by examining consistencies of behavior across time and situations. For example, in taking a detailed history of the patient's life, we can notice the content of a schema when difficulties recur. These may include difficulties in work or in intimate or peer relationships, or precipitating factors for depressive episodes.

The therapist might comment: "I noticed in your discussions that you keep focusing on [common pattern]." Examples of common patterns include viewing the self as ugly, undesirable, incompetent, evil, helpless, or unlovable. The patient who continually refers to what she perceives as her unappealing looks is revealing her personal schema of being physically defective and possibly unlovable. Of course, the therapist might inquire further: "What would happen if you were not lovable [or if you were defective, ugly, etc.]?" In one case, the patient believed, "My husband would abandon me. I can't be happy without being married." Her personal schemas involved the themes of physical defectiveness, being abandoned, feeling needy, and unable to take care of herself. In this particular case, it was helpful to identify these schemas, since prior to her marriage, she was much happier on her own. She was able to recognize that she did not need a man to be happy.

Questions to Pose/Intervention

"Let's look back at the times in your life—currently and over your entire life—to see if there is a pattern of difficulties. For example, are your difficulties primarily in work and study, intimate relationships, family relationships, or other domains or areas of life? Are there specific points of conflict or difficulty that keep coming up? Are there patterns of coping that keep recurring that might be troublesome?"

Example

THERAPIST: You said you are really stressed at work, but at the same time you get energized. Can you tell me more?

PATIENT: Well, I really put in 100% at work, and I guess there are times that I get really irritable with my colleagues. They seem to waste time and don't seem to be as focused as they should be. And I think that they probably don't like me.

THERAPIST: So at work you are very conscientious and think others are not as conscientious, not as hard-working, as you think that they should be? And the stress there is that there are conflicts with people at work.

PATIENT: Yeah, but I also get really intense and it feels like a high at times. Like I'm really going to solve these problems.

THERAPIST: So you take some pride in being conscientious and competent. Does that stress you, too?

PATIENT: Well, I give myself 8 or 9 hours a day, but things come up and it can take a lot longer, and I don't really enjoy my weekends. I'm working all the time.

THERAPIST: So being conscientious takes a toll. And I wonder if this absorption in work and productivity has been something that has stressed you in the past.

PATIENT: Yeah. I was stressed out in college. I had a learning disability and things just didn't come easily, so I worked all the time just to get a decent grade.

THERAPIST: Has this every interfered with relationships?

PATIENT: Well, with the prior relationship I told you about—it went on for 4 years—I kept complaining about work, complaining about my coworkers, and I was just negative all the time, it seemed. Couldn't really relax.

THERAPIST: So, being conscientious has been an ongoing problem. Let's look at your thoughts here. Try completing this sentence: "I worry about work because I think . . ."

PATIENT: It won't get done, and I will have screwed up.

THERAPIST: And I'm irritated with my coworkers because I think . . .

PATIENT: They're just wasting time. I can't stand inefficiency.

THERAPIST: So, it sounds like you have strong beliefs about efficiency and productivity and responsibility in work. And it goes back a long way. What was it like with your parents?

PATIENT: They were always arguing and screaming. And I never was good at talking with people. I didn't even have a personality. So I thought, I can work on this software and solve these problems.

THERAPIST: So it sounds like you had these negative beliefs about yourself as lacking a personality and that you then focused on productivity and being competent with software and threw everything into that. Like, "If I can be competent at this, then I will be good enough."

PATIENT: Yeah, I guess that's true. But I'm burned out and if it weren't for the Adderall, I wouldn't be able to function.

THERAPIST: So the recurring themes are "I don't have a personality" and "I have to produce all the time" and then—about others—"They're wasting time and they are irresponsible."

Homework

The patient can review patterns of difficulties in relationships, work, school, and daily functioning. What events triggered anxiety, depression, and anger in the past? Currently? Is there a pattern? What thoughts about self and others get triggered? How did the patient cope with these problems? Were there problematic strategies of coping, such as avoidance or overcompensation? Patients can use Form 10.1 to track their vulnerabilities across a wide range of domains of functioning. For example, the patient may be able to identify problems at work, friendships, family relationships, health issues, financial issues, or education where they had difficulty coping. The patient can identify the triggers for each of these domains or issues, the thoughts and feelings elicited, and the strategies (both problematic and adaptive) that were used. See the example in Figure 10.1.

Problematic experiences I have had in the past	What I thought during that time about myself, others, or the experience	What was my problematic way of coping?
Breakup in relationship	I must be a loser. No one loves me. I'll always be alone. Nothing works out. You can't trust people.	Isolating myself, drinking, binge eating, blaming people, dwelling on the past, feeling like a victim

FIGURE 10.1. Reviewing problematic patterns.

Possible Problems

Some patients consider this review of patterns of past difficulties as further evidence that they have enduring negative traits. For example, the patient may respond, "Do you see what a loser I am? I keep messing up?" The therapist can indicate that reviewing past difficulties may help us understand a number of things: (1) Are there patterns of making choices that lead to problems? (2) Do these difficulties reflect biased or possibly incorrect ways of viewing the self? (3) Is there a pattern of coping (e.g., overcompensating or ruminating or attacking) that could be changed in the future? And (4) if the beliefs about self and other could be changed, would this help the person avoid repeating the pattern of difficulties?

Cross-Reference to Other Techniques

Additional relevant techniques include vertical descent, identifying automatic thoughts, identifying and modifying assumptions, and confirmation bias.

Form

Form 10.1 (Reviewing Problematic Patterns).

TECHNIQUE: Identifying Schemas—Vertical Descent

Description

The therapist can identify schemas by inquiring about the implications that arise from automatic thoughts. For example, the patient may have the automatic thought, "I won't enjoy my time at the party." The therapist can inquire, "What would that make you think if that happened?," and the patient might respond, "I must be boring." The therapist then follows with, "If that were true, what would it mean to you?" to which the patient might say, "If other people don't like me, it must mean that no one will like me." The therapist might then ask, "And the reason for that would be because . . . ?" The patient might say, "Because I *am* boring, I have nothing to offer." Vertical descent allows us to go from a series of negative thoughts—including mind-reading and fortune-telling types of thoughts—to underlying assumptions or conditional rules ("if–then" statements)—to core beliefs about the self or others. One can even continue the vertical descent beyond the core belief—for example, "And if I'm a boring person, then I will be alone forever."

Questions to Pose/Intervention

"When you think that [such and such would happen], it would bother you because it would make you think. . . . And if this were true, you would feel bothered because you would think [or it would mean]. . . . An example is the following: 'If I don't do well on the exam, then it would mean that I failed. What would it mean to you if you did fail?' 'That I'm a failure.' 'And what would that make you think?' 'I won't be able to take care of myself.' 'And what would happen then?' 'I might starve to death.' In this case, the core belief or schema is a vulnerability to harm/loss, failure, or 'biological vulnerability.'"

Example

Vertical Descent

THERAPIST: You said you're worried that your face is not exactly the way you want it to be. You're focusing a lot on some imperfections that you see. Is that right?

PATIENT: Yes. I think I'm looking older.

THERAPIST: OK. So let's see what looking older would mean to you. "If I look older, it would bother me because it means what to me?"

PATIENT: It means I'm not attractive.

THERAPIST: OK. So you're equating "older" with "not attractive." And if you are not attractive, this would bother you because it would mean . . . ?

PATIENT: My husband won't want me anymore.

THERAPIST: And if that happened, then what?

PATIENT: Then I would be alone. And then . . . I don't know . . . life would be miserable.

THERAPIST: So your thought is that you would look older, not attractive, get rejected and abandoned, and end up alone and miserable?

PATIENT: Right. That's how I feel.

THERAPIST: Why would you be miserable if you didn't have a husband?

PATIENT: I guess I don't think I could make myself happy.

THERAPIST: So your thought is that life can't be rewarding without a husband?

PATIENT: Right.

In this particular case the patient revealed several schemas about herself—themes of being unattractive, abandoned, and unable to be happy while alone. She also discounted, in further inquiry, the many other positive qualities she brought to her marriage, such as intelligence, common interests, common bond, empathy, and support for her husband. Men, in her schemas, focused only on looks and could not be trusted to value anything else.

Noticing Common Patterns

THERAPIST: You've told me that in your relationships with men, you always find yourself in this one-down position. For example, your ex-husband, you said, treated you like a servant and never met your needs sexually or emotionally. Your current boyfriend seems to take advantage of you,

and you also described how your father ignored you when you were depressed as a child. Is there a pattern here?

PATIENT: Yeah, men treat me like shit.

THERAPIST: OK. So that is what you are seeing about the men. But is there a pattern in how you see yourself in these relationships?

PATIENT: I guess I see myself as someone who never gets her needs met.

THERAPIST: When you think about that pattern—never getting your needs met—does that make you think anything about yourself?

PATIENT: My needs aren't important.

THERAPIST: OK. So if you saw yourself as having needs that were not important, does that make you think anything about yourself?

PATIENT: I guess *I'm* not important.

THERAPIST: Why would you not be important?

PATIENT: Because I'm fat, and I was never as pretty as my older sister who got all the attention.

THERAPIST: So your view of yourself is that you are fat, and that is why your needs are not important?

PATIENT: I never put it in those words before. But that is how I see it, I guess. Who could love a fat, ugly kid?

THERAPIST: So you see yourself, then, as not really deserving love. Perhaps that is why you find yourself in relationships with men who don't meet your needs?

PATIENT: Yeah, it just feeds on itself, doesn't it?

THERAPIST: It feeds back into your negative belief about yourself—"I'm fat and ugly, I'm unlovable, my needs don't count, men don't meet my needs, and that proves my point." I guess that it becomes a self-fulfilling prophecy?

PATIENT: Yeah. Always happening the same way.

THERAPIST: Your view of yourself as fat, ugly, defective, and unlovable is what we call your own personal schema or self-concept. This schema is maintained by the choices you make in men. Your personal view or schema of yourself as defective and unlovable is maintained.

PATIENT: It's a never-ending pattern.

Homework

To help patients identify common schemas, the therapist can ask them to identify several automatic thoughts during the week and conduct vertical descent on each one. The core beliefs, identified by vertical descent, should yield a number of common schemas. In addition, patients may complete the Personality Belief Questionnaire—Short Form (Butler, Beck, & Cohen, 2007; Form 10.2). It is also useful for patients to review previous homework assignments (e.g., thought records) and determine if any schemas about self or others emerge.

Possible Problems

Some therapists may not go far enough in vertical descent. For example, it is not uncommon for a therapist to simply stay at the level of automatic thoughts: "So you think people will find you boring.

What is the evidence?" This may be sufficient in some cases, but with patients with long-standing problems, the automatic thought level may be insufficient. Indeed, some people *do* find us boring. Moreover, simply going to the next level—the conditional beliefs ("If someone doesn't like me, it must be my fault")—may also be insufficient, because sometimes it is our fault. For example, the socially shy individual may be quite taciturn and be reluctant to engage in conversation. It is in the more general, personal, and pervasive level of the schema—"I'm boring" or "Everyone is judgmental"—that the fuel for the fire is found. Thus, if one does not believe one is intrinsically boring, one can accept that sometimes one can appear boring to others.

In addition to the therapist's reluctance to go far enough, some patients may confuse their beliefs about themselves with reality. Since they've been holding onto a belief for such a long time, they may have difficulty doubting themselves. Moreover, in some cases the patient may have evidence that supports the belief. For example, the patient who is shy may become withdrawn, thereby supporting the belief that he or she has nothing to say. The therapist can indicate that there is a difference between "being a boring person" and "acting in a boring way in a specific context." The therapist can help the patient evaluate examples of when he or she does not interact in a schema-consistent way: "Can you tell me about conversations with people when you seem engaged with them and they are interested in what you say? What is different about these situations from the ones in which you come across as boring?"

Some patients confuse *schemas* with *reality,* believing that their habitual patterns of viewing things are not personal constructions but simply "the facts." The therapist can help these patients realize that, at this stage, we are only trying to identify patterns in the way people view things—we are not challenging or disputing anything. It may be, for example, that the patient's view that "others are rejecting" can be supported by the "facts"—simply because the patient consistently chooses rejecting partners.

Cross-Reference to Other Techniques

As indicated, the vertical descent procedure is very helpful in identifying schemas. Other useful exercises include identifying automatic thoughts, assumptions, and conditional rules; case conceptualization; looking for variations in a belief (i.e., identifying triggers), and guessing the thought.

Form

Form 10.2 (Personality Belief Questionnaire—Short Form).

TECHNIQUE: Explaining Schematic Processing

Description

Most of us have some bias in the way we process information about ourselves or others. In explaining schematic processing to patients, it is important to recognize this is simply part of being human. We all have underlying beliefs about ourselves and others, and these beliefs may lead to selective attention to information consistent with the belief ("confirmation bias"), more rapid recall of information that is schema consistent, failure to recall information inconsistent with the schema, and a tendency to discount information not consistent with the schema. For example, an individual with schemas about demanding standards will attend to any imperfection in her performance on tests, will worry

about performing well, and will discount past excellent performance. The schema could be compared to a lens through which one sees a biased world. If the lens is dark, then the world appears to be dark. The therapist can indicate that the goal here is to determine if the individual is using a biased lens and may not be seeing the full range of reality.

Questions to Pose/Intervention

"We all are somewhat selective in what we focus on and what we think is important. We tend to notice and remember some things that others might not notice or recall. Let's imagine you put on some glasses that had red lenses. You might notice that almost everything you look at is tinted red. This red lens is a metaphor for the *schema* through which you view yourself and the world. Examples of these kinds of schemas include being overly focused on achievement, rejection, abandonment, control, approval, helplessness, or attractiveness. There are many different kinds of schemas or concepts that we all use. We are going to try to see if there are certain kinds of schemas or concepts that you are using on a regular basis.

"One thing about schemas is that they make us pay attention to some things more than to others. For example, if you have a schema about rejection, you might attend to lots of things that you interpret as rejection—the way people look at you, what they say, or how they act. They might not be rejecting you, but you might have this bias to see rejection in lots of things. And if you were really focused on rejection—if that was your schema or concept—then you might remember lots of things about rejection. And you might not notice people liking you or approving of you. You might have this bias that determines how you focus on and remember things. So that is what we mean by the idea of a schema; it makes you focus your attention on, remember, and think about certain things more than others."

Example

THERAPIST: You seem to get really anxious at work and feel a lot of stress there. And you tell me when you were in college, you got so anxious you had to take a leave of absence. Do you see a pattern here?

PATIENT: Yeah. I want to do the best I can, but I get overwhelmed at times and it seems like too much.

THERAPIST: So this idea of doing the best you can seems to be a theme that runs across different times in your life. How are you doing at work?

PATIENT: I guess some people might say that I'm doing OK, but I could do better and I worry that not everything is getting done.

THERAPIST: So, it seems that you have very high standards—maybe what we might call *demanding* standards. Do you focus on the imperfections in your work?

PATIENT: I guess I do. I can always see a better way that it could have been done.

THERAPIST: And how does your boss feel about your work?

PATIENT: I guess she thinks it's OK, but I have to be honest. I worry she thinks that I'm not doing as well as I could.

THERAPIST: So, let's look at this. You have a concept or schema about demanding standards. It's like

wearing a dark lens and seeing everything as dark—and then not realizing that maybe it's the lens that is biasing things.

PATIENT: Yeah, I see my work in really dark terms at times. And even though I put in longer hours than anyone, I have procrastinated at times.

THERAPIST: So, if we think about the lens or schema—a schema is a biased way of viewing things—the schema here is one of demanding standards. And this leads you to pay attention to the slightest imperfection, which you blow up in your mind to be much larger than it really is, predict that the imperfection will lead to a catastrophe, and mind-read that your boss thinks you're not doing well enough.

PATIENT: I never thought of it that way. But, you know, my work is not perfect.

THERAPIST: No one's work is perfect. But with the schema of demanding standards, you demand perfect work—*and* you discount the good work that you do and you trivialize your accomplishments. So you're always stressed and you get burned out.

Homework

Patients can be assigned the reading on schemas in Form 10.3.

Form

Form 10.3 (What Are Schemas?).

TECHNIQUE: Identifying Schema Compensation and Avoidance

Description

Many individuals compensate for a sense of inferiority by striving for power or superior functioning. Individuals who view themselves as weak might compensate by acting in an aggressive manner. The schema-focused model stresses the importance of identifying compensatory functioning. Examples of compensatory strategies, with the underlying negative schema in parentheses, follow: body building (weak, "unmasculine"), clinging in relationships (helplessness, unlovability), obsession with accumulating money (failure, "ordinary," not special), and trying to appear glamorous (unattractive, unlovable). For example, a young man who viewed himself as physically frail as a child became proficient in martial arts. His thought was, "If I can defeat people in hand-to-hand combat, then I will never be weak again." A woman who held a schema since childhood that she was fat and ugly became seductive and sexually adventuresome during adolescence to prove that she was attractive.

Related to schema compensation is schema avoidance. As noted, with the avoidance pattern, individuals do not put themselves in a position where the schema can be activated. For example, the individual with a schema related to personal undesirability or defectiveness (i.e., who views herself as unlovable) might use schema avoidance by not allowing herself to enter into relationships. She may scan the environment for any sign of rejection and quickly exit the scene. The individual who believes that she is incompetent will avoid situations that are challenging. An individual who believes that he is unattractive or boring will settle on a relationship because he believes no one else would want him. An individual who believes that she is lazy or incompetent may become compulsive at work, thereby compensating for her perceived lack of motivation or skill.

Questions to Pose/Intervention

The therapist should provide the patient with the form for identifying ways of avoiding and/or compensating for his or her schemas (Form 10.4). Then the therapist can ask, "Now that you have identified your schemas, can you think of how you try to avoid situations where your schema might upset you? Are there things you do to compensate for your schema?"

Example

THERAPIST: You seem to spend a lot of time at work, sometimes working until late at night, and you come home exhausted. What is the reason for this, in your view?

PATIENT: I really need to get the job done. I mean, I can't stand the idea of failing.

THERAPIST: Do you think that you would fail if you didn't work these long hours?

PATIENT: I guess I do. I just don't trust myself to get things done. I can't stand making mistakes.

THERAPIST: You sound like you have an assumption that you need to be perfect in your work and to work all the time to avoid failure. If you didn't work all this much and you didn't drive yourself as hard as you do, what would that make you fear?

PATIENT: I guess I fear I would get lazy.

THERAPIST: Is this a concern you have had in the past?

PATIENT: Yeah, ever since sophomore year in college. I just screwed around, did almost nothing, and then I almost flunked a course. So I know I can be lazy.

THERAPIST: Is this view that you are lazy something that makes you work extra hard, giving up any social life?

PATIENT: I guess it does. But sometimes I just want to give up.

THERAPIST: Yeah, I can imagine being a perfectionist is hard to do. So you compensate for your perceived laziness by being a perfectionist. And how does this relate to your worries?

PATIENT: I worry that I'll get criticized. And I try to do everything right, but I know it's not possible. If I'm rational, I know I can't do it.

THERAPIST: So your underlying belief—your schema—as we discussed, is that you're basically lazy and not really that competent, so you compensate by being a perfectionist, and then this effort leads you to worry.

Homework

The therapist can ask patients to identify (1) various negative labels they apply to themselves and others, and (2) the things they do to compensate for or avoid these "problems." For example, if the patient believes "I'm really ordinary," what behaviors does he engage in to make sure that his ordinariness does not manifest itself? If the patient is worried that she is really helpless and unable to take care of herself, what strategies does she use to assure herself that others will take care of her? If the patient's schema is one of incompetence, what behaviors or challenges are avoided? Form 10.4 can be used to assist patients in identifying coping strategies (avoiding, compensating) used in response to their schemas; see the example in Figure 10.2.

Personal schemas	Things I do to avoid or compensate
Incompetent or inept	*I avoid any difficult work. I avoid getting up in front of other people at work. When I work on something I procrastinate finishing it because I am afraid of being criticized.*
Helpless	*I sometimes feel helpless about getting my work done. I think no matter what I do it won't be good enough. So I try to avoid taking on challenging work, I let others take the lead.*
Weak	*I feel embarrassed by my depression because I see it as weakness. So I avoid telling people and I don't get much support.*

FIGURE 10.2. Avoiding and/or compensating for my schema.

Possible Problems

Because schemas are often deeply embedded in the individual's personality—and have functioned as habitual patterns for many years—some individuals have difficulty gaining any distance from them. For example, the individual who believes that she is basically unlovable may have avoided pursuing intimacy or chosen partners who reinforced her negative schema. She may not look at her behavior as one of compensation or avoidance; she may simply look at it as logical, if unfortunate. The therapist can point this out to the patient: "You may view a lot of the negative things that happened to you as just natural. But let's at least consider the possibility that some of these things may be related to your personal schema." One useful question to ask is, "If you'd had a different personal schema, what choices would you have made?"

Lastly, examples of schema activation, avoidance, and compensation can be elicited in session or as homework assignments. Patients can identify triggers that activate these negative schemas: "When do you think you're likely to think ['I'm inadequate/inferior/helpless']?" These triggers can then be utilized as targets for trouble times, when cognitive therapy techniques can be utilized (e.g., cost–benefit analysis, examining the evidence, using the double standard, arguing back at the thought, and acting against the thought [schema]).

Cross-Reference to Other Techniques

Other relevant techniques include vertical descent (to identify the personal schemas), identifying assumptions and conditional rules, and examining the value system.

Form

Form 10.4 (Avoiding and Compensating for My Schema).

TECHNIQUE: Developing Motivation to Modify the Schema

Description

Schemas are, by nature, resistant to change (Beck, 1976; Beck et al., 2014; Guidano & Liotti, 1983; Leahy, 2001b; Young, 1990), and patients typically utilize a number of mechanisms to avoid

change—such as cognitive and emotional avoidance, compensation for the schema, and schema avoidance. In the course of modifying schemas in cognitive therapy, this resistance to change may include inability to recollect important memories, dissociation, avoiding therapy, noncompliance with homework, and challenging the therapist. Schemas are self-preserving, and attempts to modify them may not be easy. Moreover, the schema has been reinforced or confirmed by selective exposure and information processing for many years. Some patients may believe that their schemas about self and others are painful but accurate and that attempts to modify these foundational beliefs will leave them exposed and without any adaptive strategies. Other patients may believe that the process of schema modification will be a painful and unending endeavor that will accomplish nothing useful.

The approach I advocate is to demystify this process for patients. Rather than give patients the impression that they are embarking on a long journey into the dark regions of the unconscious, thereby replicating the psychoanalytic treatment patients may fear, the cognitive therapist describes a straightforward approach in which schemas are treated like all other thoughts—that is, they can be identified and tested against reality. Schemas can be temporarily replaced by alternative beliefs, which can be tried out in the real-life contexts that patients encounter.

In order to engage in this work, however, patients' motivation for changing the schema must be elicited and discussed. This stage includes providing patients with an idea about what schema work entails, examining any fears or apprehensions about accessing earlier memories, dissuading patients from the view that this is a form of watered-down psychoanalysis, and emphasizing the pragmatic and commonsense approach of cognitive therapy.

Questions to Pose/Intervention

"If we work on your schemas, you will likely encounter some thoughts and behaviors that might feel uncomfortable. Just like getting over a fear of elevators means getting on the elevator and feeling uncomfortable, we will work on your schemas in a way in which you might do things and think things that will involve some discomfort. But the goal is to get past that discomfort and challenge and change the schema. Let's look at the costs and benefits to you of modifying the schema. How would your life be different? How would your relationships, work, self-confidence, and other areas be different if you were no longer so negatively affected by these schemas?"

Example

THERAPIST: It sounds like you have a schema about yourself as helpless and unable to take care of yourself. Does it concern you that you have been thinking this way?

PATIENT: Yes. I think this is the way I've been thinking since I was a kid.

THERAPIST: So it's a long-standing problem? If we were to look at how this schema affects different parts of your life, what do you think we would find?

PATIENT: It affects a lot, like my relationship with my husband. He treats me like I'm a kid, and I let him do it. I haven't learned to drive—and I'm 45 years old! I'm like a baby.

THERAPIST: What other areas of your life have been affected by the schema of helplessness and incompetence?

PATIENT: Well, I lived at home for a long time, and I took a job that wasn't really challenging. I don't do much to make myself independent.

THERAPIST: What are the costs for you of this schema?

PATIENT: I don't assert myself with my husband—or anyone. I stayed in a lousy job for 12 years. I don't do things on my own. I feel lousy about myself.

THERAPIST: Any benefits to thinking you are helpless?

PATIENT: Maybe I get my husband to do things for me.

THERAPIST: Any downside to that?

PATIENT: It makes me feel like I'm stupid and powerless.

THERAPIST: Challenging and changing your schema might involve doing things that are uncomfortable. I mean, if you had a fear of elevators, you would have to get on elevators over and over. That would be uncomfortable. So challenging your schema will be uncomfortable at times. What do you think about that?

PATIENT: I won't change overnight, I know. But what do you expect me to do?

THERAPIST: Well, we can identify the different ways your schema gets activated. We can identify the thoughts and feelings you have in this area. We can try to come up with some more rational, more adaptive ways of thinking. How would that be?

PATIENT: That sounds good.

THERAPIST: Yeah, but your schema will fight back. It'll say, "This is a bunch of lies. You know you're helpless and incompetent. Who are you kidding?" Your schema is not going to give up so easily.

PATIENT: I know. It keeps coming back to me. My mother made me feel this way.

THERAPIST: We can get into that material as well. Not that this is psychoanalysis. No. This is different. We are going to actively and energetically fight these negative beliefs. We will use all of the cognitive therapy techniques at our disposal.

PATIENT: Well, I heard that this was short-term therapy.

THERAPIST: This kind of work might require a longer period. Maybe a year, at least. It depends on you, on what you want and how motivated you feel. We can both try hard, and you can learn some new skills.

PATIENT: I've been like this all my life, I guess.

THERAPIST: Maybe you've suffered enough! As I said, this therapy will ask you to do things your schema doesn't want you to do. For example, if you think of yourself as helpless, maybe you will have to do some things that are independent and uncomfortable. Maybe learn to drive?

PATIENT: Oh, I'm too old.

THERAPIST: That's the schema talking, I think. Too old? How smart are the people driving on the highway?

PATIENT: Some of them are morons.

THERAPIST: Is your schema telling you that you are less than a moron?

PATIENT: Yeah.

THERAPIST: How would you argue back at that statement? How would you tell the schema that it's wrong?

PATIENT: I guess I would have to say, "Moron? I graduated from college. I read all the time. I have done well on my job. I am no moron!"

THERAPIST: So, you have started to challenge your schema. How does it feel?

PATIENT: Pretty good.

THERAPIST: That's a beginning.

Homework

The therapist can ask patients to complete Form 10.5 to examine the implications of modifying their personal schemas. In addition, the therapist can ask patients how their lives would be different if they had more positive schemas: "What new relationships, experiences, feelings, and thoughts would come if you had more positive schemas about yourself and other people?"

Possible Problems

One major problem for patients is confusing schema work with psychoanalysis. Schema work can be completely subsumed within cognitive therapy (Beck et al., 2014) with no references to the unconscious or any other psychoanalytic concepts. We stress to patients that (1) work on schemas will be structured, (2) the therapist will provide self-help homework assignments, (3) sessions will have agendas, and (4) the focus will remain on actively challenging, testing, and even acting against the schemas.

Another problem that commonly arises is the feeling of hopelessness about modifying the schemas. Patients may find it unrealistic that their personalities will be modified in therapy, when they have been "this way" their entire adult lives. The therapist can respond by indicating that the goal is not to change their personalities, but rather to change the impact their schemas have on them. They will remain basically the same people. However, the schemas about being incompetent or helpless, for example, may have less of a negative impact if therapy is pursued. There are no guarantees, of course, but since patients have never tried schema-focused work, it is unlikely that they have evidence against its efficacy. We encourage patients to take an experimental attitude—that is, "Let's see if some things improve." Moreover, it is important to encourage modest expectations—for example, "This is not an all-or-nothing cure."

Cross-Reference to Other Techniques

Other relevant techniques include cost–benefit analysis, looking for variations in schema-related beliefs across situations, identifying hidden assumptions, conditional rules, vertical descent, and case conceptualization.

Forms

Form 10.5 (Developing Motivation to Change My Schema).

TECHNIQUE: Activating Early Memories Related to Schemas

Description

In order to gain distance from a dysfunctional schema, patients can examine the origins of the schema during childhood or adolescence. For example, the patient who currently believes he is ugly and fat can examine where he learned this negative self-attribution. Did his siblings or peers ridicule him? Did his father or mother criticize his appearance? Were there perfectionistic preoccupations

about appearance in his family? The therapist can activate early memories by asking directly, "Who taught you this?" or "Does this label of yourself as [fat, stupid, worthless, etc.] bring back any memories from your childhood?" Alternatively, the patient can focus on a negative emotion (e.g., shame) and attempt to form an image that goes with that emotion. This emotional induction can then be used to access earlier memories: "Can you recall when you first had this feeling? Are there any images from your childhood?" As the patient accesses these memories, the therapist should elicit additional details, emotions, and thoughts. (For further examples, see Beck et al., 2014; Hackmann, Clark, & McManus, 2000; Wild, Hackman, & Clark, 2008; Young et al., 2003).

Questions to Pose/Intervention

"A lot of times we can trace the source of our negative beliefs and schemas to early memories—things that we experienced as a kid. Let's try to get in touch with your schema for helplessness [or whatever]. Close your eyes and focus on the thought of being really helpless. Try to get the feeling that goes with that thought. Now try to put a picture or a scene in your mind from childhood or sometime longer ago when you had that feeling and that thought. In the picture, try to find the details, the colors, the sounds, the smells, and the sensations. Imagine being there in that moment right now."

Example

THERAPIST: You have this thought that you are helpless. That seems to be one of your core schemas. Close your eyes and try to focus on the thought "I'm really helpless; I can't do anything." Keep your eyes closed and try to get the feeling that goes with that thought.

PATIENT: (*eyes closed*) I feel like my body can't move. Like I am frozen.

THERAPIST: Can you find an image in your mind that goes with that feeling of being frozen and helpless?

PATIENT: I remember—I must have been about 5 years old—and I was walking across the living room and I stopped and I thought, "I don't know which way to go. I need my mother to tell me."

THERAPIST: So that feeling of being helpless and frozen. That's the image?

PATIENT: Yeah. And I asked my mother, "Where should I go?"

The following dialogue occurred with a patient who thought he could never be good enough. His schema was that others would expect perfection from him.

THERAPIST: You identified your schema that you have to do a perfect job. Now close your eyes and concentrate on that thought "I have to be perfect" and the thought "I'm not measuring up."

PATIENT: I'll try.

THERAPIST: Focus now on "I'm not measuring up." Notice any sensations or feelings in your body.

PATIENT: I notice that my heart is racing. I'm tense.

THERAPIST: Where?

PATIENT: All over.

THERAPIST: Keep focusing on "I'm not good enough." Is there a memory or image that comes to you?

PATIENT: Yeah. My mother complaining that I got a B, when I had one B and four A's. I felt my heart sink.

Homework

The homework parallels the demonstration of this technique in session. Patients are asked to identify their various schemas (from the schema questionnaire and from prior sessions). These schemas are then listed. The task is to take three 20-minute periods in which they focus on the early memories or images that accompany each schema, recording these on Form 10.6, along with sensations, feelings, and thoughts associated with the memory.

Possible Problems

Sometimes patients find the memories to be so painful that they begin to doubt the value of the therapy. The therapist should remind these patients that some memories and experiences in schema work are painful. However, the memories may become much less painful as therapist and patient work at reconstructing the schema and establishing new and more adaptive ways of seeing self and other. The therapist can indicate that if a memory is too painful to stay with, then it should be set aside to be discussed in session.

Recollections of schema-relevant memories may, for a short period of time, "reconfirm the schema." Recalling her mother telling her that she was not attractive reinforced the defectiveness schema for one adult woman. The therapist can explain that the first step in changing something is to find out more about it. Identifying the source of the schema does not automatically modify anything. Those techniques will be utilized in subsequent sessions.

Cross-Reference to Other Techniques

Many of the emotional processing (or experiential) exercises are relevant here, including accessing the emotion, writing a story, and identifying hot spots. In addition, the recollection of the early memory also can involve identifying and categorizing automatic thoughts, vertical descent, and guessing the thoughts.

Form

Form 10.6 (Early Memories of Schemas).

TECHNIQUE: Writing Letters to the Source

Description

One technique that has proven to be useful in modifying the effects of traumatic or difficult experiences is to have patients engage in the assertive act of writing a letter to the source of the trauma or schema. Patients need not—and almost never do—send the letter to the source of the schema. However, rather than feel dominated and controlled by the earlier experience, patients are encouraged to write a self-affirming statement that depicts what happened, the feelings and thoughts that were generated, and how the source of the schema was wrong, malicious, or unfair.

Questions to Pose/Intervention

"This person who taught you to believe these negative things about yourself—who taught you your negative schemas—is still affecting you today. You have some unfinished business here. Let's go

back to your memory of what happened—the time[s] you were taught to believe these negative things. I want you to compose an assertive statement to that person. You never have to send it to anyone. But you are now going to think of yourself as strong and as someone who is defending [him- or herself]. The stance is one of 'I'm not going to take it anymore.' In this letter, describe the memory of being taught that negative schema. Tell that person why [he or she] is wrong, how you felt, and what [he or she] should have done and should have said."

Example

THERAPIST: When you recall your father telling you that you were stupid, how does it make you feel today?

PATIENT: I have mixed feelings. Part of me is angry—but then I feel afraid. I guess I still have this feeling that he could hit me. If I get angry, he will beat me.

THERAPIST: This happened when you were a child. What do you think about the likelihood that he would hit you today?

PATIENT: He would never touch me. I'm bigger than he is! I remember telling him, when I was 15, that if he ever hit me again, I'd kill him.

THERAPIST: OK, so that fear is from the past. But it sounds like you feel that he kept telling you that you were stupid. But then you feel afraid, even thinking about asserting yourself with him.

PATIENT: I guess that's still true.

THERAPIST: OK. What I'd like you to do as a homework assignment is to write a letter to him. You are not to send the letter. Just write a letter to him that recalls the lousy things he did to you, the times he called you stupid. Tell him how you felt then and how you feel now. Then tell him what that made you feel about him and why he is wrong.

PATIENT: OK. It makes me nervous, though, to think about this.

THERAPIST: Why?

PATIENT: Because whenever I stood up to him when I was a kid, he would yell at me and hit me.

THERAPIST: You're not a kid anymore.

The patient wrote out his personal letter to his father and brought it to the next session.

PATIENT: (*reading letter*) "You never gave me any credit for anything that I did. All you did was tell me that I should follow your stupid rules. You were a bully. You would tell me that I was stupid, irresponsible, and careless. You were the one who was stupid. You were a terrible father. A good father would make his kid feel good about himself and teach him self-confidence. You never did that. You weren't responsible either. You were drunk when you came home, and you would yell at me and Mom. That's not responsible. There are times that I hated you. I am *not* stupid. I went to college, but you didn't. Maybe you couldn't stand it that your son might have a mind of his own. My friends think I'm smart, and my boss thinks I'm doing a good job. Is that stupid? Maybe I should forgive you, but I can't right now. I'm just really angry."

THERAPIST: How did it feel to write this out?

PATIENT: Scary. Like I was going to get punished. But I felt better after. I got something off my chest. And it made me think that he was wrong about me.

Homework

The therapist can restate the instructions in the preceding section about writing a letter to the source of the negative schema, using Form 10.7.

Possible Problems

As illustrated in the case example, many patients are reluctant to write a letter to the source. They fear they will suffer retaliation, they may fear that writing the letter will only reopen old wounds, and they may feel guilty. Some patients believe that this exercise is another attempt at "positive thinking" and that the source may be correct about the negative schema. The therapist should inquire about any reluctance or fears and address them by helping patients normalize the fears (e.g., "You were taught to believe this and not to stand up for yourself—naturally you have mixed feelings now"). In addition, the therapist can elicit the negative thoughts about assertion (e.g., "I don't have any right," "Maybe she was right," "This will make things worse"). These thoughts can be addressed by using the double-standard technique (e.g., "Who would have a right to assert themselves?"), examining the evidence against the thought (e.g., "What evidence do we have now that the schema is incorrect?" or "How could we test out this negative belief?"), and taking an empirical approach to whether it would make things worse to address the source of the schema (e.g., "Let's test your prediction that you will feel worse. What would it tell you if you did not feel worse? Is this another way that the schema protects itself from changing?").

Cross-Reference to Other Techniques

Other relevant techniques include ventilation stories, accessing the emotions and images, rewriting the story, imagery rescripting, examining the evidence for and against, case conceptualization, double standard, and rational role play.

Form

Form 10.7 (Writing a Letter to the Source of Your Schemas).

TECHNIQUE: Challenging the Schema

Description

The negative schema is like any other negative thought that can be addressed using cognitive therapy techniques. Once the schema is activated and identified, the therapist can utilize the full range of cognitive therapy techniques. These techniques include the following, as discussed in earlier chapters:

1. Distinguishing thoughts from facts
2. Rating degree of emotion and degree of belief in the thought
3. Looking for variations in a specific belief
4. Categorizing the distortion in thinking
5. Conducting a vertical descent
6. Calculating probabilities in the sequence

7. Guessing the negative thought
8. Defining the terms
9. Conducting a cost–benefit analysis
10. Examining the evidence
11. Examining the quality of the evidence
12. Role playing defense attorney
13. Role playing both sides of the thought
14. Distinguishing behaviors from persons
15. Examining variations of behavior in various situations
16. Using behavior to solve the negative thought

Questions to Pose/Intervention

"Now that we have identified your negative schema, we can utilize a lot of techniques to modify it. For example, we can use all of the cognitive therapy techniques that you use for any other thought."

Example

THERAPIST: Your negative schema seems to be that you are basically stupid and incompetent. Isn't that what your father taught you?

PATIENT: Yeah. He was always labeling me as stupid.

THERAPIST: OK. Let's look at this label of "stupid." What kinds of experiences trigger this thought for you?

PATIENT: Well, whenever I have to take an exam, I worry before that I'll fail.

THERAPIST: OK. Do you have an exam coming up?

PATIENT: Next week.

THERAPIST: What automatic thoughts do you have when you think about the exam?

PATIENT: I think "I'll really screw up. I don't know all of the material. There are things I didn't read."

THERAPIST: And if you didn't know all the material, then . . .

PATIENT: I'd fail.

THERAPIST: And what would it mean to you if you failed?

PATIENT: I'm stupid. There it is again!

THERAPIST: OK. How much do you believe, from 0% to 100%, that you are stupid when you think about the exam?

PATIENT: Maybe 75%.

THERAPIST: And what feelings and emotions go with that thought "I might fail the exam—I'm stupid"?

PATIENT: Anxious. Really anxious. And humiliated.

THERAPIST: How anxious, from 0% to 100%?

PATIENT: About 90%.

THERAPIST: OK. What is the cost of thinking that you might be stupid?

PATIENT: I'm always anxious before an exam. I walk around worrying all the time. I can't sleep.

THERAPIST: And what is the benefit of these thoughts that you are stupid and might fail?

PATIENT: Maybe I'll try harder.

THERAPIST: Is there evidence that you try harder?

PATIENT: Sometimes. But a lot of the time I procrastinate. And a few times I even dropped out of courses early on because I was afraid I wouldn't do well.

THERAPIST: So those are additional costs to this idea that you are stupid. You also said that you had this thought that you don't know everything for the course. Is "not knowing everything" evidence or a reason that you will fail?

PATIENT: Sometimes I think that.

THERAPIST: Does anyone taking this course know everything?

PATIENT: No. I know some of the people in the class haven't done most of the reading.

THERAPIST: Your assumption, though, is "If I don't know everything, then I will fail"—kind of a perfectionistic belief, don't you think?

PATIENT: Yeah. But that's how I feel a lot of the time.

THERAPIST: I can see that. But I wonder if there is any evidence that you could do well on an exam even when you don't know everything.

PATIENT: I've done well on lots of exams, and there are a lot of things I don't know.

THERAPIST: Let's go back to the meaning of the word "stupid." How would you define it?

PATIENT: Not knowing things. Not doing well.

THERAPIST: What is the opposite of "stupid"?

PATIENT: "Brilliant." Someone who just knows everything.

THERAPIST: So you just thought, "I don't know everything, therefore I might fail, because I might be stupid." It sounds like you have only two points on the intelligence continuum—stupid and brilliant.

PATIENT: Yeah. That's the all-or-nothing thinking you talked about.

THERAPIST: Right. What are some points along the continuum that fall between 0% and 100% and reflect some intelligence?

PATIENT: I guess points that mean "bright enough" or "smart." Or "average." Maybe "above average."

THERAPIST: Do any of those other points apply to you?

PATIENT: It depends on the task, I guess. Maybe on some tasks I'm average. But most things I'm above average. Sometimes I'm really very smart.

THERAPIST: OK. How does what you just said reconcile with the idea that you're stupid if you don't know everything?

PATIENT: It doesn't. I don't have to know everything. No one does.

THERAPIST: If your friend John were taking the exam and he said, "I haven't read everything, so I'm going to fail," what would you tell him?

PATIENT: (*laughing*) That's stupid! No. I'd tell him that he's smart and that he's done well on other exams. No one knows everything. The exam is graded on a curve, anyway.

THERAPIST: Is there some reason why you would have a different standard for yourself than for your friend John?

PATIENT: I guess I was always told that I was stupid if I didn't do perfectly.

THERAPIST: And what do you think about that kind of standard?

PATIENT: It's not fair.

THERAPIST: Is it wrong? Are you stupid?

PATIENT: No.

THERAPIST: How do you know?

PATIENT: I've done well in my classes, and my SATs were pretty high. I may not be a perfect genius, but I am *not* stupid.

Homework

The therapist can list the targeted negative schemas (e.g., ugly, incompetent, helpless) on Form 10.8 and ask patients to use several cognitive therapy techniques to challenge the schemas. For example, a typical homework assignment might be the following:

1. Write out five negative schemas about yourself and about how you view other people.
2. Identify situations (or people) that trigger the negative schemas.
3. Rate your degree of belief in the schema of each situation. Identify your emotions for each and rate them.
4. List the evidence for and against each negative schema.
5. Write out arguments why the schemas are not realistic.
6. Rerate your negative belief in each schema and rerate your emotions.

Possible Problems

Simply challenging a negative schema in a homework assignment is not likely to induce permanent, or even dramatic temporary, change. Some patients may say, "I know it's irrational, but I still feel that it is true." The therapist can explain the following: "Beliefs that you've held most of your life take a long time to change. Just as it takes a long time of repeated exercise to get into shape physically, it takes a long time to change your schemas. Change is not an all-or-nothing undertaking. There are degrees of change. Slight modifications in the degree of belief or in the emotions triggered can count as change. Even being more aware of the schema is a change."

Another problem that arises is that the therapist may not have identified the interventions best suited to a particular patient. Some patients get more out of some exercises (e.g., double standard) than others (e.g., examining the logic). The therapist and patient can take an experimental approach: "Let's keep trying different exercises and see which ones work best for you. Then we can really concentrate on those methods."

Cross-Reference to Other Techniques

As indicated, all of the cognitive therapy techniques discussed earlier are relevant to challenging negative schemas. In addition, the therapist and patient can make up flash cards, on which the patient writes down the most common negative thoughts on one side and the best rational responses on the opposite side. These flash cards can be read daily, especially before going into situations (e.g., tests, social interactions, making phone calls) that act as triggers for the negative schemas.

Form

Form 10.8 (Challenging Personal Schemas).

TECHNIQUE: Examining Your Life Using a More Positive Schema

Description

Our life stories are often experienced as if there were only one way that things could go. The individual who has the schema that he or she is inferior may view his or her life experiences as entirely logical and reasonable. Experiences of not pursuing more challenging and independent work or procrastinating or getting rejected all will seem consistent with the schema: "Of course these things happened this way. I'm inferior. This is what happens to inferior people."

In contrast, developing an alternative perspective of one's life history—and viewing choices and events as maintaining the schemas—can help the individual realize how his or her schemas affect outcomes. With this technique we ask patients to consider how their life choices might have been different had they used a more positive schema. For example, one patient had the schema that he was incompetent and undeserving. When he imagined applying the opposite schema—one of competence and worthiness—he realized that he might have made very different choices. He might have completed his homework in college, taken more challenging work, been less risk-aversive, and pursued more desirable partners. By recognizing that his life experiences—which he uses as evidence that he is incompetent—might really be more of a function of *believing* that he is incompetent, he might consider how his future choices could be affected by developing a more positive schema.

An alternative is to consider how the self would have developed under the care of more nurturing and reliable parents. For example, the man who was physically abused by his father and told he was stupid could consider how he would have turned out differently had his father been caring, supportive, and rewarding. The value of this exercise is the realization that there might be a potential for developing a new perspective by becoming more caring and supportive toward oneself. After all, if the negative schema was learned, then a more positive schema can replace it via new learning.

Questions to Pose/Intervention

"We all go through life thinking about ourselves in certain ways. But if you have a negative schema—let's say, the schema that 'I'm not competent'—then you might make certain choices in school, at work, and in relation to friends and partners. Those choices are then cited as evidence that your schema is true. For example, if you think of yourself as incompetent, you might procrastinate in school, pursue work that is not challenging, and give up easily. However, your schema of incompetence led you to those choices. What if you had started out with a more positive schema—let's say, 'I'm really smart'? Then you might have made different choices, and these different choices would have supported your more positive schema. So schemas are like self-fulfilling prophecies.

"Let's go back over various aspects of your life and examine how you would have approached them if you'd had more positive schemas. What different choices would you have made about things at school? Work? Friends? Partners? [Eating, health, exercise, drinking, drugs, money, how you live, etc.?]

[Alternatively] "Let's imagine that your parents were more supportive and more caring and reliable. What if they had been really terrific parents? How would that have affected your schema? Your choices?"

Example

THERAPIST: Let's imagine you had a more positive schema about yourself as a child. Rather than viewing yourself as stupid, you would have viewed yourself as really smart and decent. Let's go back to choices and experiences in your life that might have been affected by this more positive schema.

PATIENT: You mean, go back and think about a different life?

THERAPIST: Yes. Let's see how your negative schema affected things by looking at how your life might have been different—and still could be different in the future—with a more positive schema.

PATIENT: OK. You mean, if I had started off thinking, as a kid, that I was smart, not stupid, like my father told me?

THERAPIST: Yeah.

PATIENT: I don't know. I'd probably have studied more in school, actually done the homework. In college, I would have worked harder, maybe taken some courses that I thought were too hard for me.

THERAPIST: How about work?

PATIENT: Well, I would not have stayed in that no-win job for 6 years, that's for sure! I probably would have worked harder to get more training and advance further than I did.

THERAPIST: How about your drinking? What if you'd had a more positive schema about yourself?

PATIENT: Definitely. My drinking is all tied up in that negative stuff about being stupid and a failure. I probably would have been better at work if I hadn't been drinking as much.

THERAPIST: What if you'd had parents who were really loving and supportive? What if your father—rather than hitting you and calling you stupid—had told you that you were smart and really a terrific kid?

PATIENT: I wouldn't have been so screwed up. I certainly would have been more successful in things. I would have worked harder in school to make him proud of me.

THERAPIST: If you'd had more loving and supportive parents, then you would have a more positive schema. And if you had a more positive schema—like thinking of yourself as smart and decent—you would have made different choices.

PATIENT: Yeah, but life didn't turn out that way.

THERAPIST: Well, we can start to change that. Two things can happen. First, you can start being the good parent to yourself. That is, you can start loving and supporting and caring for yourself. And, second, you can develop a new, more positive schema—and start making choices based on this new schema.

PATIENT: That would be terrific if I could. But can I?

Homework

Patients are asked to go back to childhood and through each stage in life and examine important choices, behaviors, and relationships from the perspective of the following: "How would these things have been different if you'd had a more positive schema from the beginning?" Form 10.9 lists 12 life areas to help patients revision their experiences.

Possible Problems

As with any retrospective report from people who may be depressed, reflecting on the past may lead to regret and self-criticism: "I could have had a better life if I hadn't been thinking so negatively. I'm such an idiot!" The therapist should caution that this exercise is not meant to encourage regret but rather to help patients recognize how powerful schemas are and how their lives can be changed by developing new, more positive schemas. The focus is on developing these new positive schemas, so that whatever mistakes were made in the past can be avoided.

Cross-Reference to Other Techniques

Other relevant techniques include identifying the underlying assumptions, challenging the "should" statements, identifying conditional rules, examining the value system, using case conceptualization, developing a new adaptive assumption, and activating early memories that are the source of the schema.

Form

Form 10.9 (Life through the Lens of a Different Schema).

TECHNIQUE: Challenging the Source of the Schema through Role Play

Description

Many individuals feel trapped by their memories of someone close hurting them in the past, and they feel helpless to reverse the effect. In this exercise patients engage in an empty-chair role play in which they challenge and argue against the source of the negative schema. The purpose here is to engage patients in dominating and defeating the credibility of the person who demoralized them at an earlier time.

Questions to Pose/Intervention

"I'd like you to imagine the person who treated you so badly sitting here, in this empty chair. Imagine that this person is right here, and you are going to tell [him or her] how wrong [he or she] is."

Example

THERAPIST: Remember when your mother told you that you were being selfish because you were crying and upset?

PATIENT: Yeah. She made me feel like my needs didn't matter, like I was selfish just to be alive.

THERAPIST: OK. Let's imagine that she is sitting here in this chair, and I have given you truth serum so you have to tell her exactly what you think. You can't hold anything back. Tell her why she is wrong.

PATIENT: (*talking to empty chair*) You were being selfish, not me. A good mother should make her kid feel like she's loved. You failed me. You were too wrapped up with your own problems to pay any attention.

THERAPIST: Tell her why you are not selfish.

PATIENT: I'm not selfish at all. First of all, I took care of *you*. And I helped at home all the time. I took care of Billy [younger brother]. And then when I got married, I took care of my husband and my children. If anything, I should be more selfish.

THERAPIST: Tell her how you feel toward her.

PATIENT: I feel angry and hurt. You let me down. You hurt me.

THERAPIST: Tell her about the future—what she can't do to you.

PATIENT: You can't hurt me anymore. You can't tell me I'm selfish. I won't take it.

Homework

This in-session technique should be used in conjunction with the exercise of writing a letter to the source (see Form 10.7).

Possible Problems

Assertive role plays in session sometimes evoke feelings of fear, defeat, and humiliation. Many individuals who have been taught their negative schemas through psychological humiliation or abuse experience considerable fear, shame, and guilt when engaged in the role play. The therapist can help patients examine how these were the very feelings experienced in learning the schema, and these are the feelings that come *from* the schema. Thus, to challenge and defeat the source of the schema will involve challenging any thoughts related to shame (e.g., "This happened to me because I'm worthless") or fear (e.g., "I'll get punished").

Cross-Reference to Other Techniques

Other techniques that can be used include writing a letter to the source, activating memories of the source of the schema, activating the emotion, examining how life would have been different with a different schema, and examining strategies of compensation and avoidance of the schema.

Form

Refer back to Form 10.7.

TECHNIQUE: Developing a More Positive Schema

Description

The goal of schema therapy is to reduce the impact of the negative schema on current functioning. This goal is ultimately accomplished by conceptualizing a new, more positive and adaptive schema. Because most individuals have more than one schema, this new adaptive schema needs to be multifaceted. The therapist can assist patients in identifying a new balanced schema and examining how this new schema might affect their choices and experiences. One tip: To make the new schema more flexible, encourage patients to use qualifiers—for example, "*Sometimes* I'm really smart," "*Often* I'm appealing to people."

Questions to Pose/Intervention

"Let's imagine that you feel a lot better about yourself because you have a new schema. Rather than thinking of yourself as incompetent [or any other negative schema], you think of yourself as being *fairly competent.* What would be the consequence of thinking of yourself in this new way? What cognitive therapy techniques might you use to support your new schema?"

Example

THERAPIST: You think of yourself as being really stupid and irresponsible because of how your father treated you. What could be a new, more positive schema about yourself?

PATIENT: That I'm smart and a really decent guy.

THERAPIST: OK. What would be the evidence that you are smart?

PATIENT: I finished college, got a master's degree, and am doing reasonably well at work. I have a high IQ.

THERAPIST: If you think of yourself as being smart, what kinds of thoughts would you have when you meet people?

PATIENT: I'd think about how they'd see that I'm on the ball.

THERAPIST: And how about work—would anything change in that context if you see yourself in these positive terms?

PATIENT: I would take on more challenging work, maybe try to advance further.

THERAPIST: How about getting your finances straightened out?

PATIENT: Yeah. I should get my credit cards paid down and start saving some money—that would definitely be smart!

Homework

Patients can examine all of their negative schemas and how they can be rephrased into positive and more adaptive schemas. For each new schema, patients should use Form 10.10 to list all of the different decisions, opportunities, thoughts, and experiences that should be made more probable as a result of the new schema.

Possible Problems

Some patients view this as just "feel-good talk"—that it is not real and does not feel real. The therapist can explain that "trying on" a new schema requires time to feel comfortable with it. Reviewing the costs and benefits of the new schema, the evidence in support of it, and using the double-standard technique and rational role plays, when needed, to support the new schema on an ongoing basis are important. Simply repeating "I am competent," for example, will not be sufficient. Continued practice with cognitive techniques to challenge the negative schema and the old negative thoughts will be essential.

Cross-Reference to Other Techniques

Patients can utilize many of the cognitive therapy techniques to support the new, more positive schema. For example, what positive automatic thoughts, assumptions, and behaviors follow from the positive schema? What new positive vertical descent could be utilized? How could patients act as if they believed the positive schema and engage in problem solving and planning based on it?

Form

Form 10.10 (Effects of My Positive Schema).

TECHNIQUE: Transcendence: Affirming the Schema

Description

An assumption underlying much of the schema approach is that one needs to modify or change the schema about self and others. For example, the therapist might assist the patient in modifying beliefs that he or she is helpless, defective or unlovable. Although this might be useful in many cases, a different approach would be to affirm that there is some universal truth in the schema, but that one can accept and love oneself (and others) despite these qualities. In using the technique of "transcendence," the therapist encourages the patient to accept some universal truths for all human beings—that is, that we all have qualities that are defective; at times we're all unlovable, prone to social isolation, overly dependent, etc. Affirming that there is some partial truth in these universal qualities of imperfect human nature allows one to accept them without generalizing to the entire self. For example, one can say, "Yes, it's true, there are some defective and unlovable qualities that I have, but I accept that in myself and I can still love and respect myself even with these qualities." The idea with "transcendence" is that imperfections or "defects" are viewed as universals that can evoke acceptance and compassion rather than the attempt to struggle against the inevitable shortcomings of all human beings.

Questions to Pose/Intervention

"You often view yourself in these global negative terms—for example, that you are [defective, helpless, will be abandoned]—and then you criticize yourself or avoid situations where you are reminded of these qualities. We have discussed ways in which you might challenge these ideas about yourself, and we have examined how these schemas or concepts came about in your childhood experiences. But another way of looking at your schemas is to accept your imperfections or undesirable qualities. For example, we might say that every human being has some defective or unlovable qualities at times. Every human being will be abandoned—people will die, for example. And every human being experiences deprivation and emptiness at times. These are universal qualities of the human condition. The key thing is to accept that this is part of who we are and part of our life and that we can love and respect ourselves and have compassion for ourselves even when we know we have these qualities."

Example

THERAPIST: You have been ruminating—dwelling on—the idea that there are things about yourself that are unlovable. You remember some things that you said to your husband that you feel guilty about—things that were hostile and, you feel, even reprehensible. Yes, I can see where you might think that. And I know all of us have things to regret at times.

PATIENT: But I really shouldn't have said those things. They really hurt him. I was drunk, and I know I have a problem but I keep screwing up.

THERAPIST: Have you noticed that everyone that we know well screws up? Everyone has things to regret?

PATIENT: I don't think other people have been as horrible as I have been.

THERAPIST: Let's say you said and did some things that were wrong, and that these are qualities that are unlovable about you. You might say, "Here are some things about me that are unlovable." Now what?

PATIENT: I can never get past it. Never not regret it.

THERAPIST: That's a hard place to be, stuck in the past, constantly ruminating and regretting. What if you were to think everyone has things to regret? We all are disappointing at times.

PATIENT: I guess that's true. But how can I get past it?

THERAPIST: Why get past it? Why not carry your regrets with you? I guess what I'm saying is, "Let's accept that we regret things we have done. Let's recognize that these were the wrong things to say or do." But we can also say that we know that we have flaws, defects, even qualities that are unlovable, but we can still accept ourselves, accept that we disappoint ourselves, and accept that we can love ourselves as imperfect as we are.

PATIENT: But I don't deserve that acceptance.

THERAPIST: You know, when we love someone we don't measure what they deserve. We ask what they need. Don't you need your own love and respect?

PATIENT: I guess I do. But how can I love myself when I have done such disgusting things?

THERAPIST: By forgiving yourself. Love and acceptance include forgiveness.

PATIENT: It's hard to do.

THERAPIST: Aren't we always forgiving the people that we love?

PATIENT: Yeah. I guess I had to do that with my sister. I know she's screwed up. She's bipolar, and she says things that are outrageous. But I love her.

THERAPIST: We can either get stuck on a negative quality and it becomes an anchor that sinks us and we drown in self-hatred. Or we can acknowledge that we have defects, that there are things about us that are unlovable at times—but that we accept that these less desirable qualities come with the territory of being an imperfect human being.

PATIENT: I wish I could do it.

THERAPIST: Let's try a role play. You play the negative voice telling me that I am unlovable and defective, and I will play the transcendent voice that accepts and loves me regardless of my faults.

PATIENT: [as negative voice] What you said to your husband was disgusting. How can you live with yourself? You are a disgusting person!

THERAPIST: You know, you're right—partly. Yes, I said something that was disgusting, even reprehensible. And there are things I have said and done that I think are disgusting. I accept that. I accept that I have good qualities and, at times, some really bad qualities.

PATIENT: [in role] How can you respect yourself?

THERAPIST: [in role] I guess I accept that all of us who are human have some disgusting and unlovable qualities at times. We let ourselves down—don't you notice that? We screw up. And I have just decided that although I will try to do better, I will love myself anyway.

PATIENT: [in role] How can you love yourself if you screw up?

THERAPIST: [in role] It's *because* I screw up that I need my love and my forgiveness.

PATIENT: [in role] You're just kidding yourself.

THERAPIST: [in role] No, I'm transcending my faults by accepting them and accepting and loving myself.

Homework

Patients can list some qualities or behaviors that they do not like about themselves or that they see as ongoing problems. These can include beliefs that they are defective, unlovable, lacking self-control, etc. The therapist can indicate "you can acknowledge that some of these have some truth." Some of the time, "I am unlovable, defective, out of control, etc." And then they can consider how they can accept some partial truth in these statements, that this partially describes them and that these statements can be applied, to some extent, with everyone. They can be encouraged to universalize problems and flaws while accepting and directing forgiveness and compassion toward the self. Patients can use Form 10.11 to begin to transcend their negative schemas.

Possible Problems

Some patients have difficulty acknowledging that they have qualities or behaviors that they do not like. They equate a behavior or a quality with their entire identity. The therapist can ask, "Do you know someone that you respect who has done something that was stupid, inappropriate, or something that they would regret? How do you accept them if they have done something like this?" Further, "What would be the costs and benefits of loving and caring for yourself even though you have flaws? What are the costs and benefits of loving and caring for others who are imperfect?" The therapist can indicate that forgiving oneself and accepting oneself does not mean that you will not try to improve. It only means that you recognize that you are human.

Cross-Reference to Other Techniques

Other relevant techniques include acceptance, compassionate mind, mindfulness, making life problems universal, and double-standard technique.

Form

Form 10.11 (Transcending My Schema).

FORM 10.1

Reviewing Problematic Patterns

All of us have vulnerabilities, and they may lead to a pattern of difficulties that we have with work, school, intimate relationships, friendships, family relationships, and other areas of our lives. The purpose of this exercise is not to make you feel bad about yourself or make you have regrets. It's really about taking a history to see if there are patterns that have led to difficulties and how these can be changed. In the left-hand column, describe the situations or experiences in the past that have led to difficulties. In the middle column, try to recall the negative things you thought about yourself or others during those times. And in the right-hand column, describe the problematic ways that you coped with those situations at the time. For example, problematic coping might include avoiding things; ruminating; worrying; complaining; using alcohol, food, or drugs; complaining, etc.

Problematic experiences I have had in the past	**What I thought during that time about myself, others, or the experience**	**What was my problematic way of coping?**

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FORM 10.2

Personality Belief Questionnaire—Short Form

Name: _____ Date: _____

Please read the statements below and rate *how much you believe each one*. Try to judge how you feel about each statement *most of the time.*

4	3	2	1	0
I believe it totally	I believe it very much	I believe it moderately	I believe it slightly	I don't believe it at all

Example	How much do you believe it?				
1. The world is a dangerous place. (Please circle)	4 Totally	3 Very much	2 Mod-erately	1 Slightly	0 Not at all
1. Being exposed as inferior or inadequate will be intolerable.	4	3	2	1	0
2. I should avoid unpleasant situations at all cost.	4	3	2	1	0
3. If people act friendly, they may be trying to use or exploit me.	4	3	2	1	0
4. I have to resist the domination of authorities but at the same time maintain their approval and acceptance.	4	3	2	1	0
5. I cannot tolerate unpleasant feelings.	4	3	2	1	0
6. Flaws, defects, or mistakes are intolerable.	4	3	2	1	0
7. Other people are often too demanding.	4	3	2	1	0
8. I should be the center of attention.	4	3	2	1	0
9. If I don't have systems, everything will fall apart.	4	3	2	1	0
10. It's intolerable if I'm not accorded my due respect or don't get what I'm entitled to.	4	3	2	1	0
11. It is important to do a perfect job on everything.	4	3	2	1	0
12. I enjoy doing things more by myself than with other people.	4	3	2	1	0
13. Others will try to use me or manipulate me if I don't watch out.	4	3	2	1	0
14. Other people have hidden motives.	4	3	2	1	0
15. The worst possible thing would be to be abandoned.	4	3	2	1	0
16. Other people should recognize how special I am.	4	3	2	1	0
17. Other people will deliberately try to demean me.	4	3	2	1	0

(continued)

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	Totally	Very much	Mod-erately	Slightly	Not at all
18. I need others to help me make decisions or tell me what to do.	4	3	2	1	0
19. Details are extremely important.	4	3	2	1	0
20. If I regard people as too bossy, I have a right to disregard their demands.	4	3	2	1	0
21. Authority figures tend to be intrusive, demanding, interfering, and controlling.	4	3	2	1	0
22. The way to get what I want is to dazzle or amuse people.	4	3	2	1	0
23. I should do whatever I can get away with.	4	3	2	1	0
24. If other people find out things about me, they will use them against me.	4	3	2	1	0
25. Relationships are messy and interfere with freedom.	4	3	2	1	0
26. Only people as brilliant as I am understand me.	4	3	2	1	0
27. Since I am so superior, I am entitled to special treatment and privileges.	4	3	2	1	0
28. It is important for me to be free and independent of others.	4	3	2	1	0
29. In many situations, I am better off to be left alone.	4	3	2	1	0
30. It is necessary to stick to the highest standards at all times, or things will fall apart.	4	3	2	1	0
31. Unpleasant feelings will escalate and get out of control.	4	3	2	1	0
32. We live in a jungle and the strong person is the one who survives.	4	3	2	1	0
33. I should avoid situations in which I attract attention, or be as inconspicuous as possible.	4	3	2	1	0
34. If I don't keep others engaged with me, they won't like me.	4	3	2	1	0
35. If I want something, I should do whatever is necessary to get it.	4	3	2	1	0
36. It's better to be alone than to feel "stuck" with other people.	4	3	2	1	0
37. Unless I entertain or impress people, I am nothing.	4	3	2	1	0
38. People will get at me if I don't get them first.	4	3	2	1	0
39. Any signs of tension in a relationship indicate the relationship has gone bad; therefore, I should cut it off.	4	3	2	1	0
40. If I don't perform at the highest level, I will fail.	4	3	2	1	0
41. Making deadlines, complying with demands, and conforming are direct blows to my pride and self-sufficiency.	4	3	2	1	0

(continued)

	Totally	Very much	Mod-erately	Slightly	Not at all
42. I have been unfairly treated and am entitled to get my fair share by whatever means I can.	4	3	2	1	0
43. If people get close to me, they will discover the "real" me and reject me.	4	3	2	1	0
44. I am needy and weak.	4	3	2	1	0
45. I am helpless when I'm left on my own.	4	3	2	1	0
46. Other people should satisfy my needs.	4	3	2	1	0
47. If I follow the rules the way people expect, it will inhibit my freedom of action.	4	3	2	1	0
48. People will take advantage of me if I give them the chance.	4	3	2	1	0
49. I have to be on guard at all times.	4	3	2	1	0
50. My privacy is much more important to me than closeness to people.	4	3	2	1	0
51. Rules are arbitrary and stifle me.	4	3	2	1	0
52. It is awful if people ignore me.	4	3	2	1	0
53. What other people think doesn't matter to me.	4	3	2	1	0
54. In order to be happy, I need other people to pay attention to me.	4	3	2	1	0
55. If I entertain people, they will not notice my weaknesses.	4	3	2	1	0
56. I need somebody around available at all times to help me to carry out what I need to do or in case something bad happens.	4	3	2	1	0
57. Any flaw or defect in performance may lead to a catastrophe.	4	3	2	1	0
58. Since I am so talented, people should go out of their way to promote my career.	4	3	2	1	0
59. If I don't push other people, I will get pushed around.	4	3	2	1	0
60. I don't have to be bound by the rules that apply to other people.	4	3	2	1	0
61. Force or cunning is the best way to get things done.	4	3	2	1	0
62. I must maintain access to my supporter or helper at all times.	4	3	2	1	0
63. I am basically alone—unless I can attach myself to a stronger person.	4	3	2	1	0
64. I cannot trust other people.	4	3	2	1	0
65. I can't cope as other people can.	4	3	2	1	0

(continued)

Personality Belief Questionnaire—Short Form (PBQ-SF)
Scoring Key

Patient name: _____ Date on PBQ: _____

Scored by: _____ Date of scoring: _____

PBQ scale	Sum of items to calculate raw score	Raw score	Use formula to calculate *Z*-score	*Z*-score
Avoidant	Sum of items 1, 2, 5, 31, 33, 39, & 43	_____	(Raw score – 10.86) / 6.46	_____
Dependent	Sum of items 15, 18, 44, 45, 56, 62, & 63	_____	(Raw score – 9.26) / 6.12	_____
Passive–Aggressive	Sum of items 4, 7, 20, 21, 41, 47, & 51	_____	(Raw score – 8.09) / 5.97	_____
Obsessive–Compulsive	Sum of of items 6, 9, 11, 19, 30, 40, & 57	_____	(Raw score – 10.56) / 7.20	_____
Antisocial	Sum of items 23, 32, 35, 38, 42, 59, & 61	_____	(Raw score – 4.25) / 4.30	_____
Narcissistic	Sum of items 10, 16, 26, 27, 46, 58, & 60	_____	(Raw score – 3.42) / 4.23	_____
Histrionic	Sum of items 8, 22, 34, 37, 52, 54, & 55	_____	(Raw score – 6.47) / 6.09	_____
Schizoid	Sum of items 12, 25, 28, 29, 36, 50, & 53	_____	(Raw score – 8.99) / 5.60	_____
Paranoid	Sum of items 3, 13, 14, 17, 24, 48, & 49	_____	(Raw score – 6.99) / 6.22	_____
Borderline	Sum of items 31, 44, 45, 49, 56, 64, & 65	_____	(Raw score – 8.07) / 6.05	_____

Note. *Z*-scores are based on a sample of 683 psychiatric outpatients with mixed diagnoses.

FORM 10.3

What Are Schemas?

People differ in what gets them depressed, anxious, or angry. We all tend to have biases or preferences in what we focus on. Some people focus on extremely high standards for themselves, others focus on fears of being abandoned, others might focus on a sense of emotional deprivation, and some might focus on feeling controlled by others. There are many different issues that make us different from one another. We refer to these differences as "schemas." Schemas are the habitual ways in which we see things. For example, depression is characterized by schemas about loss, deprivation, and failure; anxiety is characterized by schemas about threat or fear of failure; and anger is characterized by schemas about insult, humiliation, or violation of rules. Research on personality indicates that people differ in the themes that underlie their depression, anxiety, or anger. One of the things that we can do is see if there are particular themes or issues that keep coming up for you that might account for some of the difficulties that you might have.

Each of us looks at our experiences in terms of certain habitual patterns of thinking. One person might focus a lot on issues of achievement, another on issues around rejection, and someone else on fears of being abandoned. Let's say that your schema—your particular issue or vulnerability—is related to achievement. Things can be going well for you at work, but then you have a setback that activates your schema about achievement—your issue about needing to be very successful so that you will not see yourself as a failure. The setback at work might lead to the schema about being a failure (or being "average," which is equated with failure), and then you get anxious or depressed.

Or let's say that your schema is related to issues about abandonment. You might be very vulnerable to any signs of being rejected and left alone. As long as a relationship is going well, you are not worried. But because of this schema, you might worry about being left or being rejected. If the relationship breaks up, it leads you to feel depressed because you can't stand being alone.

Now, because we might have a schema that determines how we look at things, we might pay more attention to things related to this schema. For example, if we are concerned about achievement, we focus a lot on imperfections in our performance; and if we are concerned about abandonment, we focus on whether our loved ones will leave us. Schemas also affect our memory: We are more likely to remember things that support our schemas and are more likely to forget things that are not consistent with our schemas. And, because our schemas bias our perceptions of reality, we are likely to discount or trivialize information that is not consistent with those schemas. For example, we might say, "That achievement doesn't count because anyone could do that." We might also think that other people are viewing us in a particular way—for example, "They think I'm mediocre" or "They will leave me" or "They are trying to control me." As a result of these continuous biases in our thinking, our schemas become more fixed and rigid.

How We Compensate for Our Schemas

If you have a schema about a specific issue, you might try to compensate for this vulnerability. For example, if you have a schema about failure or that being average is bad, you might work excessively hard because you're trying to compensate for your perception that you might turn out to be inferior or not live up to your standards of perfection. You might compensate by checking your work over and over again. As a consequence, people might see you as *too* absorbed in your work. You might have a hard time relaxing because you are worried that you are not working enough, that something is left undone, or that you are losing your motivation.

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If your schema is about being abandoned, you might compensate for it by giving in to your partner all the time. You might be afraid of asserting yourself, because you fear being abandoned. Or you might constantly seek reassurance from your partner so that you can feel secure, but the reassurance doesn't work for very long. You keep seeing signs of your partner pulling away. Another way that you might compensate for your schema about abandonment is to form relationships with people who do not meet your needs but with whom you are willing to connect because you don't want to be alone. Or you stay in relationships far beyond a point that seems reasonable to you, because you think you can't stand being on your own.

As you can see, trying to compensate for your underlying schemas can create problems of their own. The "compensation" may lead you to sacrifice your needs, work compulsively, pursue no-win relationships, worry, demand reassurance, and engage in other behaviors that are problematic for you. And the most important point about these compensations is that you never really address your underlying schema. For example, you might not ever question your belief that you have to be special, superior, avoid being average, avoid being alone, etc. Therefore, you never really change your schema. It's still there—ready to be activated by certain events. It is your continual vulnerability.

How We Avoid Facing Our Schemas

Another process that creates problems is "schema avoidance," which means that you try to avoid facing any issues that tap into your schema. Let's say that you have a schema about being a failure. Your view is that deep down inside, you might really be incompetent. One way you might avoid testing out this schema is to never take on challenging tasks or to quit early on tasks. Or let's say you have a schema about being unlovable or unattractive. How do you avoid facing the schema? You might avoid socializing with people you think won't accept you. You might avoid dating. You might avoid calling friends because you already assume that people think you have nothing to offer. Or let's say that you're afraid of being abandoned. You could avoid this schema by not allowing yourself to get close to anyone, or you could break off with the person early in the relationship so that you don't get rejected later.

Another way people avoid their schemas—whatever those schemas are—is by emotional escape through substance use or extreme behaviors such as drinking too much, using drugs to dull your feelings, binge eating, or even acting out sexually. You may feel that dealing with your thoughts and feelings is so painful that you have to avoid or escape them by these addictive behaviors. These behaviors "hide" your underlying fears from you, at least while you are bingeing or drinking or using drugs. Of course, the bad feelings come back again, because you are not really examining and challenging your underlying schemas. And, ironically, these addictive behaviors feed into your negative schemas, making you feel even worse about yourself.

Where Do Schemas Come From?

We learn these negative schemas from our parents, siblings, peers, and partners. Parents might contribute to these negative schemas by making you feel that you're not good enough unless you're superior to everyone, telling you that you're too fat or not attractive, comparing you to other children who are "doing better," telling you that you're selfish because you have needs, or intruding on you and ordering you around, or threatening to kill themselves or abandon you. There are many different ways in which parents teach children these negative schemas about themselves and others.

For example, think about the following actual experiences that some people recalled about how their parents "taught" them their negative schemas:

(continued)

1. "You could do better—why did you get that B?": schema about the need to be perfect or avoid inferiority.
2. "Your thighs are too fat and your nose is ugly": schema about fatness and ugliness.
3. "Your cousin went to Harvard—why can't you be more like him?": schema about demanding standards, inferiority, and incompetence.
4. "Why are you always complaining? Can't you see that I have problems taking care of you kids?": schema about the selfishness of needs.
5. "Maybe I should just leave and let you kids take care of yourself": schema about burden and abandonment.

Another source of schemas, as indicated, might be people other than your parents. Perhaps your brother or sister mistreated you, leading you to form schemas of being abused, unlovable, rejected, or controlled. Or perhaps your partner has told you that you're not good enough, leading to schemas of being unattractive, unworthy, and unlovable. We even internalize schemas from popular culture, such images of being thin and beautiful, a perfect body, "what real men should be like," perfect sex, lots of money, and enormous success. These unrealistic images reinforce schemas about perfection, superiority, inadequacy, and defectiveness. And your current environment might emphasize certain issues or schemas. For example, if you are in a highly competitive environment, then you might develop schemas about demanding standards, incompetence, inferiority, etc. If you have a partner who is unreliable or dishonest, you might develop schemas about betrayal or abandonment. These more recently developed schemas may not be as powerful or rigid as schemas developed in childhood, but they may affect you nonetheless. You might want to ask if your current environment or relationships are leading you to focus on certain issues that may or may not have been as important in the past.

How Will Therapy Be Helpful?

Cognitive therapy can help you in a number of important ways:

- Learn what your specific schemas are.
- Learn how you are avoiding and/or compensating for your schemas.
- Learn how your schemas have affected your ability to enjoy your life.
- Learn how your schemas are maintained or reinforced by the choices you've made or the experiences you've had.
- Examine how your schemas were learned.
- Challenge and modify these negative schemas.
- Develop new, more adaptive, and more positive schemas.
- Learn how to make choices based on healthy interests and values rather than old issues that have haunted you in the past.

FORM 10.4

Avoiding and Compensating for My Schema

In the form below are a number of ways people may view themselves or others. Examine the list in the left-hand column to see which of these thoughts look familiar to you. If any strike you as one of your schemas, list what you did to avoid or compensate for the problem in the right-hand column. For example, a man who thought he was basically "not masculine" worked out excessively with weights and learned karate (i.e., compensation). A woman who thought she was really not that smart (i.e., incompetent) worked excessively hard in school (i.e., compensation). Another woman who thought people could not be trusted avoided dating (i.e., avoidance). Try to examine how you have handled your own personal schemas. You can even add some other examples of personal schemas in the left-hand column.

Personal schemas	**Things I do to avoid or compensate**
Incompetent or inept	
Helpless	
Weak	
Physically vulnerable (to sickness or injury)	
Cannot trust others	
Responsible/ irresponsible	
Immoral or evil	

(continued)

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Avoiding and Compensating for My Schema *(page 2 of 3)*

Personal schemas	**Things I do to avoid or compensate**
Cannot be controlled by others	
Unable to control emotions	
Tough	
Special/unique	
Need to be outstanding	
Glamorous	
Impressive	
Unconnected to others	
Overly involved with another person	
Unlovable	

(continued)

Avoiding and Compensating for My Schema *(page 3 of 3)*

Personal schemas	**Things I do to avoid or compensate**
Uninteresting	
Disorganized	
Undeserving	
Selfish	
Others are judgmental of me	
Emotionally deprived	
Sacrificing my needs to others	
Other schemas:	

FORM 10.5

Developing Motivation to Change My Schemas

Changing your schemas will involve hard work and some discomfort at times—for example, doing things your schemas say you can't do. What are the advantages and disadvantages to you of changing your negative schemas?

Personal schemas	Advantages	Disadvantages

(continued)

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Developing Motivation to Change My Schemas *(page 2 of 2)*

Are you willing to be uncomfortable?
Are you willing to tolerate uncertainty?
Are you willing to keep at it until things improve?
If you changed your schemas to be more realistic and positive, how would these changes affect your relationships?
How would these changes affect your work?
How would these changes affect your enjoyment in life?

FORM 10.6

Early Memories of Schemas

We are interested in identifying the early memories that are related to your personal schemas. In a quiet room, with no distractions, close your eyes and focus on the schema most troubling to you. Repeat your schema in your mind—for example, "I'm unlovable" or "I'm incompetent."

Try to get in touch with the feelings behind that schema. Make the feelings more intense. Now, once you have the feelings and thoughts in your mind, try to recall experiences from childhood, or other times in your life, when you had these feelings and thoughts. Let yourself see the scene in detail. What was happening, what did the people look like, what were they doing? Focus on your physical sensations (e.g., tense, heart pounding, sweating, feeling cold), your emotions (e.g., angry, helpless, afraid, sad), and your thoughts in this image. When you feel "done," open your eyes and record your experience below.

Personal schema	Memory of first thinking and feeling this way	Sensations, feelings, and thoughts that go with this memory

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FORM 10.7

Writing a Letter to the Source of Your Schemas

Write a letter or statement to the person (or people) who is the source of your negative beliefs about yourself and others. Be assertive and strong. Tell this person why he or she is wrong and how you are different from the way he or she viewed you. Tell this person that you are standing up for yourself and how he or she failed you. In the bottom part of the form, write out any thoughts and feelings you had while doing this exercise.

Your assertive letter or statement to the source of your negative schemas:
The thoughts and feelings you have about writing this letter:

(continued)

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Which parts of this letter stand out as most upsetting to you? Why?
How do you think the other person would respond if he or she read this?
How would you want the person to respond to this? What would help you?
What has been the effect on you of holding this in you all these years?

FORM 10.8

Challenging Personal Schemas

We often have beliefs about ourselves and other people that we do not adequately examine. These beliefs are called "schemas." In the right-hand column, write your answer to each statement in the left-hand column. For example, let's say you often have the belief that you are not competent (personal schema). List "incompetent" in the right-hand column in response to "Identify personal schema." In response to "Define your schema," write out how you would define "incompetent." Go through each of the statements in the left-hand column and respond to it in the right-hand column.

Technique	**Response**
Identify personal schema	
Define your schema	
Degree of belief in schema (0–100%)	
Emotions triggered by schema	
What would be the opposite of this schema?	
What would be a moderate degree of this schema that you could accept?	

(continued)

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Challenging Personal Schemas *(page 2 of 2)*

Technique	**Response**
What situations trigger your schema?	
Cost and benefit of schema	Cost Benefit
Evidence for and against	For Against
Use the double-standard technique: Would you apply this to someone else?	
Why is this schema unrealistic?	
View yourself on a continuum—not in all-or-nothing terms (e.g., rate yourself and others on a scale from 0% to 100%)	
Act against your schema (What can you do that opposes your schema?)	
Rerate belief in schema	

FORM 10.9

Life through the Lens of a Different Schema

Consider how your choices and behaviors in each of the areas listed below would have been different if you'd had a more positive schema.

Areas, choices, and behaviors	**How things would have been different with a more positive schema**
School	
Choice of jobs	
Performance on jobs	
Procrastination	
Friendship	
Partner/intimate relationships	
Health	
Smoking	
Drinking	
Sexual behavior	
Money	
Leisure	
Where I live	
Taking risks (too many or too few)	
Other	

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FORM 10.10

Effects of My Positive Schema

Just as we might have negative views or schemas, we can also consider the possibility of having a more positive schema about ourselves and experiences. For example, a new positive schema might be "I'm good enough without needing to be perfect." List some new positive schemas that you might have and indicate how things would be different for you in the different areas of your life, the choices that you make, and your behaviors.

My new positive schema is that I am: _____

Areas, choices, and behaviors	**How it will be different in the future for me**
School	
Choice of jobs	
Performance on jobs	
Procrastination	
Friendship	
Partner/intimate relationships	
Health	
Smoking	
Drinking	

(continued)

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Effects of My Positive Schema *(page 2 of 2)*

Areas, choices, and behaviors	**How it will be different in the future for me**
Sexual behavior	
Money	
Leisure	
Where I live	
Taking risks (too many or too few)	
Other	

What main areas of my life would be different with a more positive schema?

FORM 10.11

Transcending My Schema

One way of looking at our negative qualities or behaviors is to acknowledge them and recognize that these are true of us at times. It doesn't mean that we are condemned entirely if we do one wrong thing. It simply means that we recognize our imperfections, and we also recognize that all humans have imperfections. In the form below, you can list some negative behaviors or qualities in the left-hand column. In the middle column, give some examples of people you know who also have negative qualities or behavior. And in the right-hand column, list some things you can say to yourself that would allow you to accept your imperfections and still love and care for yourself.

Qualities or behaviors I don't like about myself	**Who else has these qualities or engages in these behaviors at times?**	**What can I say to myself to help me accept and love myself with these qualities or behaviors?**

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CHAPTER 11

Emotion Regulation Techniques

In recent years there has been an increasing emphasis on the importance of emotional processing in CBT (Greenberg, 2015; Mennin & Fresco, 2014; Leahy, 2002a, 2015; Leahy, Tirch, & Napolitano, 2011). Of particular interest is the recognition that "experiential" or "emotional avoidance" can underlie a wide range of psychopathology and can maintain or exacerbate problematic coping (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). For example, problematic emotion regulation strategies such as avoidance, suppression, rumination, and worry are related to depression. The degree or absence of emotion regulation predicts symptoms of depression over 5 years (Berking, Wirtz, Svaldi, & Hofmann, 2014), anxiety, eating disorders (Oldershaw, Lavender, Sallis, Stahl, & Schmidt, 2015), and borderline personality disorder (Linehan, 2015). In contrast to emotional avoidance is the recognition that activating the "fear schema" is essential in utilizing exposure and in "relearning" new associations or implications of "feared emotions" (Foa & Kozak, 1986). For example, more effective exposure is conducted if the individual actually feels afraid—but is able to carry out the exposure regardless of the fear.

Accordingly, in this chapter I review a wide range of techniques relevant to emotional processing and regulation. Of course, all of the techniques in this book that involve cognitive restructuring, problem solving, or behavioral activation can be used to regulate emotions. In this chapter I focus on what one can do once an emotion has arisen. One can view emotion regulation as involving a number of "steps" or "techniques": activation of emotion, labeling and differentiating emotions, identifying problematic beliefs about emotion, linking emotions and beliefs to unhelpful coping strategies, and identifying and practicing more helpful coping strategies. A more comprehensive discussion of each of these issues can be found in my books *Emotional Schema Therapy* (Leahy, 2015) and *Emotion Regulation in Psychotherapy* (Leahy et al., 2011).

Greenberg's emotionally focused therapy is often viewed as an experiential approach that is somewhat different from the traditional cognitive therapy model. However, in the current context of attempting to identify and modify thoughts, I view Greenberg's work as extremely valuable. It can be used to assist patients in (1) identifying specific emotions, (2) experiencing the thoughts that are contained within the "emotional scheme" (as Greenberg uses this term), (3) identifying what they need, and (4) gaining direction in getting their needs met. In this chapter I examine various techniques that assist patients in accessing emotion, thoughts associated with emotion, metacognitive or metaemotional beliefs, and modifying the emotional impact through rescripting.

TECHNIQUE: Accessing the Emotion

Description

As indicated earlier, the therapist can distinguish between a thought ("He thinks I'm boring"), an emotion ("I feel anxious"), and reality ("I may not know what he thinks"). Some patients will confuse an emotion with a thought— "I feel that he thinks I'm a loser." Using the technique "accessing the emotion," the therapist places an emphasis on noticing, labeling, identifying, and differentiating emotions. In contrast to cognitive therapy, which stresses the central role of thoughts and beliefs in the activation and maintenance of depression and anxiety, the emotionally focused approach views emotions as primary. Indeed, emotions are viewed as comprising an "emotional schema" that "contains" the important cognitive content examined by cognitive therapists (Greenberg, 2002, 2015).

Thus, activating the emotion or emotions is the first step to activating the thoughts and needs that are "contained" in the emotion. Greenberg (2015) distinguishes between primary and secondary emotions: The primary emotion is the basic feeling, and the secondary emotion may be the individual's more overt emotion—one that covers or defends against the primary emotion. For example, the individual may overtly express or experience anger (i.e., the secondary emotion), but the primary emotion behind the anger may be feeling hurt. It may be "easier" for a particular person to experience anger, because feeling hurt may convey a sense of weakness or failure that is intolerable. In addition, Greenberg (2015) proposes that some individuals express "instrumental emotions"—that is, their emotional expression is "aimed" at evoking responses in others. For example, a patient may cry in order to make others feel guilty, but his or her underlying, more primary emotion is fear. Finally, Greenberg indicates there are adaptive and maladaptive uses of emotions and that therapy can help the patient clarify the options available. In any case, the therapist should assist patients in identifying these different layers of emotions. Greenberg (2002, 2015) suggests a number of experiential techniques that may prove useful. These include asking patients to name the emotion; notice feelings in the body; focus on, and stay with, the emotion; identify thoughts that go with the emotion; identify what information is contained in the emotion; keep an "emotion log"; notice interruptions or interferences with feeling the emotion; state what the emotion is saying; and state what patients need for themselves.

In the current context, emotion-focused techniques and conceptualization can be very helpful to cognitive-behavioral therapists, because activating and accessing emotional experiences assist patients in recognizing the cognitive elements that are contained in each emotional scheme. These techniques also can be useful in accessing fundamental personal schemas, which are often associated with intense emotion. Finally, in attempting to access emotions, the therapist can notice if the patient blocks an emotion, seems confused or afraid of an emotion, or has difficulty labeling the emotion.

Questions to Pose/Intervention

"I notice when you talk about [identify problem area], you seem to feel something very deeply. It seems there are some emotions that you may be experiencing. When we talk about emotions, we will be talking about those feelings that you have, such as anxiety, sadness, anger, helplessness, joy, curiosity, and so forth. Try to focus on a situation that represents or symbolizes the issue that bothers you. Close your eyes and try to feel the emotion that comes with this memory [or image]. As you focus on this emotion, try to notice any feelings in your body. Notice your breathing. Notice your physical sensations. Are you noticing any feelings? Any thoughts? Images? Does this emotion make you feel like saying something, asking for something, doing something?"

In addition, the therapist can explore the possibility of emotional avoidance by asking the following questions: "Are there any ways in which you notice yourself interrupting or interfering with the experience of this emotion? Are you finding that you drift away, try to keep yourself from having the emotion, or tell yourself you can't handle it? Focus on your internal sensations and describe them."

Example

The patient had recently gone through a breakup with a woman he had been involved with for 2 years.

THERAPIST: You said you were feeling sad. Do you notice any other emotion or feeling?

PATIENT: I don't know. It's hard for me to put my finger on it.

THERAPIST: Do you notice any sensations or feelings in your body?

PATIENT: It's a feeling in my chest, like I want to cry. And my stomach—some kind of tension. And then a feeling like my heart is beginning to race.

THERAPIST: Let's stay with that feeling in your chest. Close your eyes and try to concentrate on it. What do you notice?

PATIENT: It's a feeling in my chest . . . a feeling of heaviness, and then I can feel my heart racing, and then I feel like I'm going to cry. But I stop myself.

THERAPIST: So, you notice that this crying might come out, and you stop it, and then what does that feel like?

PATIENT: My heart is racing.

THERAPIST: OK. If you *did* cry, what would that feel like, do you think?

PATIENT: I don't know. Like getting something out. Like letting go. But then I would feel, maybe I would lose control. I would look like I lost control.

THERAPIST: And then what would happen?

PATIENT: You might think less of me.

THERAPIST: So, if you cried, I would think less of you. That's how you feel. And if you cried, what would happen to that racing heartbeat?

PATIENT: I don't know. I try not to think about it.

THERAPIST: OK. Let's go back to the feeling in your chest and this feeling that you are going to cry. Can you focus on this feeling now? Can you let that feeling happen?

PATIENT: (*beginning to cry*) I just don't know. I feel so terrible. Excuse me.

THERAPIST: OK. That's the way you are feeling at this moment. And can you tell me, with this feeling, are there any thoughts that go with the crying?

PATIENT: I feel like saying, "I can't stand being alone." It's always going to be this way.

THERAPIST: In that feeling is the fear that you will always be alone. And when you are crying, if you were to ask for something, what would it be?

PATIENT: "Please come back."

THERAPIST: So you want her to come back?

PATIENT: Yes. I know it wasn't good, but I can't stand this loneliness.

THERAPIST: And your racing heartbeat?

PATIENT: I feel ashamed. I want to hide.

THERAPIST: Why do you want to hide?

PATIENT: Because I seem so pathetic.

THERAPIST: So you are feeling that it is pathetic to be sad and to cry?

PATIENT: Yes.

THERAPIST: Let's go back to this sadness, this feeling in your chest, and the feeling of wanting to cry. Close your eyes and concentrate on that feeling of sadness. Let's imagine a blank screen, and now a picture drifts onto that screen. Your sadness puts that picture on the screen. What image comes up on the screen?

PATIENT: I see myself in my room, bent over. It's dark. I'm alone (*crying*).

THERAPIST: And what are you feeling in that room all alone?

PATIENT: I'll always be alone—like my heart is breaking.

Homework

Important elements of emotion-focused therapy are awareness, recognition, labeling, and differentiating emotions that are experienced. Moreover, remembering the emotions experienced and the variation of emotion across time and situations can be an important component in modifying beliefs that emotions permanent or that nothing will change an emotion. Patients can use Forms 11.1 and 11.2 to keep track of their emotions.

The therapist can explain the following: "It's important for both of us to find out about the feelings you are having. These are the emotions that are so important to you. They can be emotions of any kind—sad, happy, afraid, curious—anything. I'd like you to try to notice these emotions during the week and record them in your emotion log. We can use this log later to see the range of feelings you are experiencing. I also would like you to write down any examples during the week when you begin to notice an emotion but then try to block it from happening. Maybe you notice you're feeling anxious and you try to make it go away, or maybe you distract yourself. Perhaps you notice some sadness or you feel like crying and you try to block it. Try to notice if you are trying to block some of these feelings. Write down any examples."

Possible Problems

Some patients may have difficulty noticing an emotion when it occurs, linking an emotion to an event, or labeling an emotion. These patients may be "alexithymic"—that is, they lack a language or awareness of emotion, and it is precisely for this difficulty in noticing, labeling, differentiating, and "staying with" an emotion that the emotion-focused approach and other emotion regulation approaches can be particularly helpful. The therapist can introduce the emotion log in the session, asking the patient when he or she feels something: "Notice if you have sensations in your body," "Notice if you are feeling something," or "Notice if you are spacing out." The therapist can then ask the patient to stay with that experience, notice where the sensations occur, attempt to intensify these sensations, identify what was said or thought before or during the sensations, suggest some possible "labels"—anxious, sad, angry, bored—and have the patient monitor these experiences during the session and between sessions.

Some patients who pursue cognitive therapy have the misconception that this therapy is anti-emotions. Indeed, they may view the goal of therapy as avoiding or eliminating "bad emotions." They think the goal is to feel and behave in entirely "rational ways." The therapist can explain that the role of rationality is only to help patients handle emotions more productively. The goal is not to eliminate emotions. Furthermore, the therapist can stress that emotions are like hunger and pain—they teach us what we need. Emotions contain thoughts, and focusing on the emotion is like opening up a file cabinet with a wealth of important information. Other patients may fear that gaining access to their emotions will lead to a flood of negative feelings that will engulf them. The therapist can identify their response as a belief about the danger and control of emotions and beliefs about "good and bad" emotions—that is, "emotional schemas." These beliefs are discussed later in this chapter; the therapist can note for the patient how these beliefs may lead to problematic coping, such as avoidance, escape, rumination, and other unhelpful strategies.

Cross-Reference to Other Techniques

Other relevant techniques include explaining how thoughts create feelings, imagery induction, identifying hot spots, identifying emotional schemas, and examining costs and benefits of emotion regulation strategies.

Forms

Form 11.1 (Daily Emotion Log); Form 11.2 (Emotions I Avoid).

TECHNIQUE: Expressive Writing

Description

Pennebaker and his colleagues proposed that expressing emotion by freely writing down recollections of traumatic or troubling events may have a palliative effect on anxiety, depression, and physical well-being (Pennebaker, 1993; Pennebaker & Beall, 1986; Frattaroli, 2006). In the free expression of emotion—that is, *ventilation*—patients recall a troubling event and write down a detailed description of it, paying close attention to the emotions that surface and the meaning of the event. Although the immediate effect may be an increase in negative feelings as the negative event and the memories become more salient, there is often a decrease in negativity and a reduction in stress within days or weeks. Research on the use of expressive writing has shown that there are positive effects on outcome for a range of psychological and physical health indices, ranging from small to moderate effects (Petrie, Booth, & Pennebaker, 1998; Pennebaker & Seagal, 1999; Travagin, Margola, & Revenson, 2015; Pennebaker & Chung, 2011), although the findings have also been mixed (Harris, 2006; Sloan & Marx, 2004). Expressive writing may work as a result of a number of processes: attentional processing, habituation, and/or cognitive processing (Travagin et al., 2015).

Questions to Pose/Intervention

"I'd like you to think back about this event that bothered you so much. Try to get a clear recollection of the event and the experience you had. I'd like you to take about 20 minutes and write down all of your thoughts and feelings about that event. What was it like for you? It would be helpful to give as many details as possible. Try to make your recollection feel as real as possible."

Of particular importance in "effective expressive writing" is the degree to which the individual is able to "make sense of events." The therapist can inquire about the narrative that is written: "Which parts of this make sense? Which parts don't make sense? Which parts are particularly difficult for you? Are there images, thoughts, or memories that make you have more intense emotions? Are there parts that you wanted to avoid? Are there parts that you just felt numb?"

Example

The patient was a woman in her 30s who recalled being sexually abused as a child by a friend of her brother.

THERAPIST: You described how this older kid sexually abused you when you were a kid. It might be hard to go back and describe that experience, but let's try to find out more together about what that was like for you. I know it must have been very hard and will be very hard now thinking about it.

PATIENT: It was terrible.

THERAPIST: OK. What we will do is look back at that experience. Get the details and your feelings about it. You can write these down as your memory comes back; describe all of the details and feelings. Write out any thoughts that you remember having then.

The patient returned to the next session with the homework assignment completed.

THERAPIST: Let's look at what you wrote and see what it felt like and what you thought. Could you read the story you wrote to me?

PATIENT: (*reading*) "He was my brother's friend. I was 13 and he was 17. His name was Ken, and he was bigger than me, and my brother looked up to him. My parents were away for the day. My brother had gone downstairs to the den to be with his girlfriend, and Ken was upstairs with me, joking around. He told me he had a knife, then he showed me the knife, and I felt afraid. He took me into the bedroom and told me that we were going to play a game. I was afraid to say anything because I thought he was crazy. Then he began kissing me. I told him to stop, but he said he was going to play the game whether I liked it or not. Then he showed me the knife again and said I'd better do what he said. Then he said, 'You'll like it anyway.' I was terrified. But I did what he told me to do. He made me suck him. I felt like throwing up. But I was completely aware of what was happening. When it was over, I put my clothes on, and he told me that if I told anyone, he would kill me. I never told my brother or my parents. I felt afraid and then I felt ashamed."

THERAPIST: Which part of this memory bothers you the most in reading it?

PATIENT: The part where I thought he threatened to kill me if I told.

THERAPIST: You read it to me and you are sitting here in my office. How do you feel about it now?

PATIENT: I guess I feel nervous. But I also feel safer. I told the story, and nothing is going to happen to me now. It was a long time ago.

THERAPIST: Have you ever told the whole story before?

PATIENT: No. I just wanted to forget it, and I didn't think it would do any good—just make me more anxious. And I felt ashamed, anyway.

THERAPIST: How do you feel now?

PATIENT: Well, I don't really feel ashamed telling you. You're a professional. But I wonder how my husband would feel. He might judge me. So I feel that part of me needs to keep this to myself, because someone else might not understand.

Homework

The therapist can say the following (Forms 11.3 and 11.4 may be helpful to the client): "It's important to be able to recall some memories that were painful and hurt you, because they may still linger on for you. Getting that memory out by writing it down and then telling the story can help us understand what the experience meant to you and what it felt like. We can also use the memory in some new ways in therapy—ways in which you will feel more in control later and that can help you understand things and move beyond the past. Right now, though, it may be painful to recall some of these things, but that pain may be the beginning of a much better process for you.

"I'd like you to think back about this event that bothered you so much. Try to get a very clear recollection of the event and the experience you had. Now I'd like you to take about 20 minutes to write down all of your thoughts and feelings about that event. What was it like for you? Please provide as many details as possible. Try to make the recollection feel as real as possible."

Possible Problems

The therapist should be careful to avoid resensitizing patients by having them recall traumatic memories without guidance. It is recommended that patients describe the event in session prior to writing down the longer story. If the recollection during the session is too upsetting—for example, the patient seems overwhelmed by it—then the therapist can help him or her gain some distance by using relaxation techniques prior to telling the story. The therapist also can interrupt the storytelling to initiate anxiety management through deep breathing, muscle relaxation, attentional distraction, etc. Moreover, the therapist can remind the overwhelmed patient that the office is safe and the therapist is the patient's ally; the therapist can even ask the patient to identify all the reasons why he or she is safe today in this office, telling the story, and how the abusive individual or terrible experience is not going to appear or happen today.

Some patients believe accessing their emotions and reliving the trauma will set them back even further. This is a metaemotional belief: "If I have a bad feeling, it will never go away." The therapist can identify this belief and examine how it operates to inhibit full emotional processing. For example, the belief that a negative emotion must be avoided, at all costs, contributes to the inability to fully reexperience the memory, discover that it can be tolerated, and learn that current reality is different from the original traumatizing experience. Attempts to block the memory (as indicated in the upcoming discussion of "hot spots") include racing through the story, leaving out details at crucial moments, not reporting feelings associated with an apparently traumatic event, dissociating in the session, or displaying inappropriate affect (e.g., laughing or responding in a rote or bland fashion).

Cross-Reference to Other Techniques

As indicated above, the therapist can provide reassurance, have patients identify evidence of current safety, utilize breathing and muscle relaxation techniques, and elicit elements of the story in session prior to the written ventilation assignment. Other techniques that suitably follow the ventilation

assignment include vertical descent, identifying schemas, safety behaviors, writing letters to the source of the schema, and imagery rescripting.

Forms

Form 11.3 (Keeping a Journal); Form 11.4 (Writing a Story).

TECHNIQUE: Identifying "Hot Spots"

Description

The patient may get "stuck" in certain parts of the image or memory. These "hot spots" may elicit either strong emotions (e.g., tearfulness, anxiety, fear) or inhibition of emotion (e.g., dissociation, mechanical responses). As patients recall the image or story, the therapist should attend to any strong shifts in emotion and ask patients to repeat that specific image or part of the story. These hot spots often entail the emotional schemas that contain the most problematic automatic thoughts (see Grey, Holmes, & Brewin, 2001; Cason, Resick, & Weaver, 2002; Grey & Holmes, 2008; Holmes & Bourne, 2008; Holmes & Mathews, 2010). In some cases the patient may recall an image or scene without any apparent emotion—sometimes becoming numb, distant, or even robotic. This kind of response may indicate that the patient is avoiding the memory and the emotion and further inhibiting the processing of the experience.

Questions to Pose/Intervention

"As you recall the story [or form the image], try to notice if any specific details or parts of the story are especially difficult for you. Notice if there is any change in your emotion or feeling; you might become more upset with a specific image or detail. Or you might find yourself 'spacing out' at a specific detail, perhaps because it is too difficult to pay attention to it. As you repeat that detail or image, ask yourself what about it is especially upsetting. What thoughts does this detail generate? What feelings?"

Example

THERAPIST: As you read the story about your mother hitting you, I noticed that you sort of spaced out. You seemed to have no emotion at the part where she began to yell at you.

PATIENT: Really? I didn't even notice that.

THERAPIST: OK. Let's go back. Read that part again, the part where she is yelling at you.

PATIENT: (*reading from her story*) "Then she began to yell at me, 'You're stupid! I never should have had you!'" (*visibly nervous now*)

THERAPIST: What feelings did you have then?

PATIENT: I felt afraid . . . and ashamed.

THERAPIST: Tell me about the feelings of being afraid and ashamed.

PATIENT: I felt that I was nothing, and that she was going to stomp me into the ground. And I felt like I was pretty worthless, worth nothing, actually.

THERAPIST: That part was hard to take, so you spaced out rather than feel what was happening.

PATIENT: Right. It's hard to recall it even now.

Homework

The therapist can ask patients to write down a memory of a traumatic or upsetting event with as much detail as possible. Next patients should read the story aloud several times, noting specific parts that are most upsetting, and writing down any feelings and thoughts that go with these hot spots. Also, patients can note which images or memories are associated with numbing or intense distraction. In reviewing images or memories associated with intense emotion or numbing, patients can write down what is upsetting about this particular image or memory. Form 11.5 can be used; see Figure 11.1 for an example from one patient.

Possible Problems

Hot spots are, by their very nature, difficult to handle. Patients may become so upset that they refuse to do the homework. In these cases, it may be more useful to have patients schedule longer (double) sessions, in which these more difficult memories can be accessed and the hot spots identified during the session—*in vivo*. Furthermore, because dissociation is, by its nature, difficult for patients to notice, the therapist should have patients repeat the story in the session, while the therapist looks for any signs of emotional avoidance (e.g., mechanical/rote reading of the story, reading certain parts very rapidly, or spacing out and drifting).

Cross-Reference to Other Techniques

Other techniques that can be useful include written ventilation, identifying emotional schemas, imagery rescripting, identifying automatic thoughts, and looking at the trauma from the balcony.

Form

Form 11.5 (Identifying Hot Spots).

Describe the story or image in as much detail as you can. *I was driving along when this car came through the intersection, and I remember seeing myself crashing into the side of her car and I was thrown against the windshield. I think I must have been unconscious because when the ambulance came, I was wondering what had happened.*
Which specific parts of this story are most upsetting? These are the hot spots. *Feeling like I'm being thrown into the windshield.*
What feelings and thoughts do you have at these hot spots? *I'm afraid I might die. I almost got killed. This could happen again.*

FIGURE 11.1. Identifying hot spots.

TECHNIQUE: Describing Emotional Schemas

Description

Individuals differ as to their conceptualizations of, and strategies for dealing with, emotions (Leahy, 2002a, 2011, 2015). Once an "unpleasant" emotion (e.g., sadness, anger, anxiety) has been activated, the individual may respond with a variety of thoughts or behaviors. For example, some individuals, noticing that they feel anxious, may respond with the following problematic ideas about their anxiety: It will have a long duration, they will have no control over this emotion, others would not have the same feelings (low consensus), they feel ashamed or guilty about feeling the anxiety, and they do not accept the emotion. Moreover, these individuals may then believe that they cannot allow themselves to experience this emotion, let alone express it, because others would not understand or validate them; they should be entirely rational and certainly not have mixed feelings. These interpretations, evaluations. and strategies are referred to as "emotional schemas," reflecting the idea that emotion is partly "constructed" by the individual. I have developed the Leahy Emotional Schema Scale–II (LESS-II; Leahy, 2002a, 2011), which can be used to identify these various emotional schemas. Many of these dimensions are related to depression, anxiety, and various personality disorders (Leahy, 2000, 2012; Leahy, 2015; Tirch, Leahy, Silberstein, & Melwani, 2012).

Questions to Pose/Intervention

"All of us have emotions such as sadness, anxiety, anger, boredom, happiness, and helplessness. These are all part of being human. When we have an emotion, we also respond to that emotion. Imagine that a young man is going through a breakup and feels sad, angry, and a little relieved. But imagine also that he has really problematic ways of thinking about his emotion. He might think, 'I should only have one emotion—not all these different emotions.' Or he might think, 'Other people wouldn't feel this way,' or he might think that his emotions will last indefinitely or go out of control and escalate even further. He might then think he has to get rid of these negative feelings immediately or they will ruin his life.

"Now I'm going to show you a diagram (see Figure 11.2) that illustrates how people might respond to their emotions. In some cases, the individual might think these painful emotions are normal, that they won't last indefinitely, and that many other people would feel the same way. This person can also relate painful emotions to her values—things matter to her. She can accept her emotion. That is, this individual, as opposed to our imagined young man, values commitment, and losing a relationship matters to her because intimacy is an important value. You can see in the diagram how this person responds. On the other hand, another person might have the same emotions—sadness, anger, relief, and anxiety—but he thinks these emotions are problematic. He thinks his emotions might last a long time or he might go out of control; he might feel ashamed or guilty about these emotions, and he thinks that he has to get rid of them. So he might drink, misuse drugs, or avoid situations that make him have these feelings. He might worry, ruminate, or blame people.

"Some people believe that they should not have certain feelings, whereas others accept these feelings. We can find out how you think, react, and feel about your emotions and feelings by having you complete this form [LESS-II; Form 11.6]."

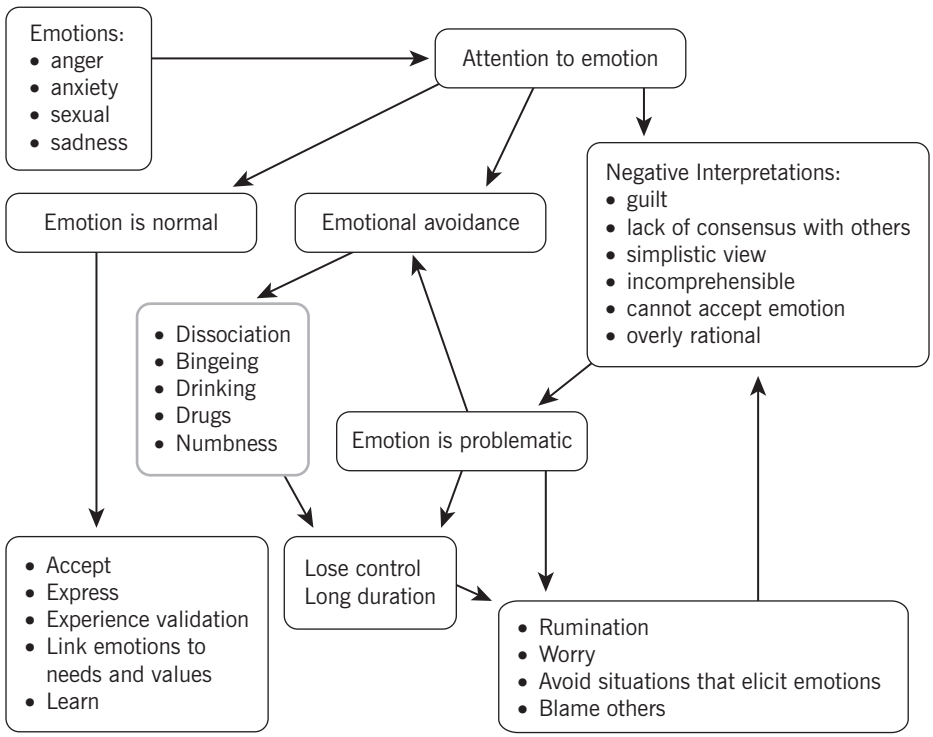

FIGURE 11.2. A model of emotional schemas.

Example

The patient came to therapy complaining of anxiety and sadness following her separation from her husband after 12 years of marriage.

THERAPIST: You seem confused that you are sad and anxious since the separation. What is confusing about this to you?

PATIENT: I'm generally pretty happy and I can't understand why I'm crying—at times, it seems to come out of nowhere. I'm usually not this way, but I've been crying a lot and I feel sad. I don't know what's wrong with me.

THERAPIST: So you're having feelings of sadness and you just don't think your crying makes sense, and you shouldn't be this way.

PATIENT: Yeah. I don't know. I miss having the family together. I love the holidays when everyone is together.

THERAPIST: So, I see on the form [LESS-II; Form 11.6], that you say that your emotions don't make sense and that other people wouldn't feel this way. How do you think other people feel when they are separating after 12 years of marriage?

PATIENT: (*smiling*) I don't know. I'm not like that.

THERAPIST: You mean you are not an emotional person who cries?

PATIENT: (*laughing*) Yeah. I'm usually pretty happy. My sister—she's the crazy one. She has bipolar disorder. She drives my parents crazy.

THERAPIST: So, you think that if you cry and feel sad, you risk being like your sister?

PATIENT: I'm not like her. She's crazy.

THERAPIST: Do you have to be crazy to feel sad and to cry?

PATIENT: I guess not. (*pausing*) But I don't know how long I will feel this way. Paul moved out last month and I'm still having these periods when I cry.

THERAPIST: It sounds like you worry that these feelings will last a long time and that you are confused about having these feelings.

PATIENT: Yeah.

Homework

The therapist should have patients complete the LESS-II (Form 11.6). See the section above ("Questions to Pose/Intervention") for instructions regarding this homework assignment. The LESS-II has 14 dimensions regarding thoughts and feelings about emotion (see Form 11.7). The patient's responses to the LESS-II can be the focus of further inquiry.

Possible Problems

Some patients may have difficulty reflecting on how they think about and handle their emotions. They may believe, "Emotions happen to me," and that thinking about them will only make matters worse. One patient describes reflection on emotion and expressing emotion as "opening a can of worms," indicating that his emotions have a disgusting and uncontrollable quality. This difficulty is often evident in patients who utilize emotional avoidance as a coping strategy. The LESS-II scale can be used with these patients in the session. For example, the therapist might say, "When you come home to your apartment and first walk in the door, what feeling do you have?" For one patient, who binged and abused alcohol, her first thoughts were "This is so empty, my life is so empty." The therapist could then go through some of the items on the LESS-II to identify her beliefs that she had to get rid of her feelings, that these feelings would overwhelm her, and that no one could ever understand her.

Furthermore, patients may have different emotional schemas for different kinds of emotions. The same individual may have different emotional schemas for anxiety and for sexual feelings. For example, one patient believed that her anxiety about taking a test would not last forever, that other people might have the same kinds of feelings, and that they would understand hers. In contrast, her belief about her sexual fantasies was that she should be in control of her feelings, that these feelings could go out of control, they were shameful, and people would think less of her if she shared them. She then blamed others for these feelings. Thus the therapist can explore if the patient has different "theories" or "strategies" for dealing with different emotions.

Cross-Reference to Other Techniques

As we will see in the sections on modifying emotional schemas and accepting emotions, the cognitive therapist can utilize a wide range of techniques to examine each dimension of the emotional

schemas. This range can include eliciting or accessing the emotion, examining the costs and benefits of certain strategies, evidence for and against these beliefs, the double-standard technique, carrying out experiments (e.g., to see if others reject them for their emotions), conducting vertical descent, examining the relationship between emotional schemas and personal schemas, identifying the source of beliefs about emotions, engaging in role playing, etc.

Forms

Form 11.6 (LESS-II); Form 11.7 (Scoring Guide for the 14 Dimensions of the Leahy Emotional Schema Scale-II).

TECHNIQUE: Modifying Emotional Schemas

Description

Once the individual emotional schemas are identified, the therapist can assist the patient in examining the implications of these beliefs, evaluating the consequences of problematic coping strategies, and examining alternative interpretations and strategies. Each emotional schema dimension has implications for helpful or unhelpful coping strategies. For example, the belief that emotions will last indefinitely and are out of control may lead the individual to utilize avoidance or suppression, including binge eating, drug or alcohol misuse, rumination, worry, or other strategies. Attempts to suppress emotions may lead to their rebound, further contributing to the belief that emotions last indefinitely and go out of control, in turn leading to further failed attempts to suppress them. The belief that others would not have similar emotions may lead to shame, social isolation, and rumination (e.g., "What's wrong with me?"). For more detailed descriptions of emotional schemas and how to address them, see Leahy (2015).

Questions to Pose/Intervention

"When we have emotions, such as anxiety, sadness, anger, resentment, or jealousy, we often respond to them in terms of our beliefs about them. For example, we might think our sadness will go on and on, overwhelm us, or doesn't make sense, and that other people might not feel the same way that we do. And we might also respond to our sadness by worrying about the future, by seeking reassurance, by avoiding people, or by drinking or overeating. I'm interested in learning more about how you think about the emotions that are troubling you and how you respond to them. For example, let's take the emotion [*X*]. When you have this emotion or feeling, do you think it will go on and on? Do you think other people might have this same feeling? Or do you think there is something different about you? Do you believe your emotions go out of control? Do you think you can express your feelings? Do you think other people understand and can comfort you? Do you feel confused when you have mixed feelings?"

Example

The patient described above, who was going through marital separation, continued her discussion of her emotional schemas.

THERAPIST: Now, you said that you have feelings that others would not have. I was wondering if you know people who have been separated or divorced.

PATIENT: Yeah, a number of my friends.

THERAPIST: How do they feel?

PATIENT: Well, most of them feel pretty sad; some feel angry. My friend Ken felt relieved—he was always arguing with his wife. But come to think of it, he also felt sad, too. I guess people feel a lot of things.

THERAPIST: Maybe your emotions are similar to those of a lot of other people. Could that be?

PATIENT: I guess so, but I don't know why I have so many different feelings. You know there are times I feel pretty good, like I don't have to deal with Paul having one foot in and one foot out.

THERAPIST: Is it hard to make sense of having mixed feelings?

PATIENT: I just want to know how I *should* feel.

THERAPIST: Could it be that you have mixed feelings because each feeling makes sense? It makes sense to feel a little relieved that you are no longer dealing with Paul's wavering, it makes sense to feel sad because you lost that connection, and it makes sense that you feel anxious because you're not sure about the future.

PATIENT: But my feelings are all over the place.

THERAPIST: Well, each feeling is for the present moment and those moments come and go. So when you think about not having arguments, you feel relieved, and when you worry about the future, you feel anxious.

PATIENT: It's so confusing.

THERAPIST: Only if you think that you should feel one way. It's like being annoyed that a symphony has a lot of different notes or a painting has a lot of different colors. Perhaps your range of feelings says something about your capacity to feel and experience a lot of things in life.

PATIENT: But I want to get myself together. I want to get my old self back.

THERAPIST: This is also part of your self—the full complexity and richness of who you are. I notice that your face expresses so many different feelings and your hands move as you talk, and I think "You're really here at this moment." This is part of that range of all experiences that makes you a full, complete, living human being.

PATIENT: (*crying*) I just hurt so much.

THERAPIST: Maybe you hurt because things matter to you, because you are not superficial, because you have the capacity to feel things deeply.

Homework

The patient can identify each of the emotional schemas that seem problematic—for example, the belief that emotions will last a long time, are out of control, don't make sense, or are different from the emotions of others. The therapist can assist the patient in identifying these beliefs using the LESS-II (Form 11.6) described above. Once these beliefs are identified, the patient can examine their costs and benefits and which coping strategies he or she uses (e.g., suppression, distraction,

complaining, ruminating, problem solving, looking at things a different way, activating positive behavior, seeking social support).

Each of the emotional schemas can be addressed with a few questions for patients to consider. In each case patients should identify the emotion (e.g., sadness, anxiety, fear, loneliness) that seems problematic to them. Then patients can examine the costs and benefits of their beliefs about their problematic emotion. What would be the advantage of believing that emotions do not last indefinitely, that they are not out of control, that they are similar to the emotions that others have, or that they make sense?

Possible Problems

Some patients may believe that examining their emotions is invalidating or too rational. They may claim that their emotions are their emotions, and that they have a right to feel whatever they feel. This is an important issue—and, in fact, is an emotional schema in its own right: that is, the belief that one's emotions need to be validated and that validation precludes examination of beliefs or any change in the emotions. The therapist can indicate that patients have every right to feel what they feel, but the question in therapy is which emotions they would like to feel more often. For example, would one want to feel happy, satisfied, curious, relaxed, etc.? Acknowledging that one starts with an emotion as a "given"—that is, "given that I feel sad"—the next question is "How do I want to feel later?" Moreover, examining beliefs about emotions does not invalidate that one has an emotion at the present moment or that these beliefs lack any validity. The only question is whether the beliefs about emotion are helping or harming patients.

Cross-Reference to Other Techniques

Other relevant techniques include costs and benefits of beliefs, alternative interpretations, collecting the evidence, and examining predictions about emotions.

TECHNIQUE: Challenging Guilt about Emotions

Description

Some individuals attempt to suppress or hide their emotions from others, fearing that their feelings or fantasies are shameful or are a sign of moral failing. This guilt and shame over emotion may result in less expression of emotion, less validation, decreased recognition that their emotions are universal, and greater rumination (Leahy, Tirch, & Melwani, 2012; Leahy, 2011, 2015). Moreover, guilt and shame over emotion often leads to failed attempts to suppress the emotion, along with self-monitoring of the emotion, adding further to concerns about lack of control and personal relevance of the emotion.

A number of techniques can be useful in addressing guilt or shame about an emotion. The therapist can inquire as to the rationale for why an emotion is "forbidden." In addition, the therapist can explain the difference between an emotion and a willful action, indicating that it is willful action that constitutes a moral issue (if one exists), not the occurrence of an emotional experience. Further, emotions can be "universalized," suggesting that almost everyone has these emotions and that they are part of the human experience.

Questions to Pose/Intervention

"Sometimes we feel guilty or ashamed of an emotion—as if there were something we are doing wrong if we feel anxious or sad, or if we have sexual feelings and fantasies. We can look at certain emotions or even thoughts and fantasies and see if you feel guilty about them or feel ashamed. Think about what those might be, and then tell me more about why you think you should not have those feelings, thoughts, or fantasies. What happens when you think you should not have these responses? How does your negative judgment about your [feeling/thought/fantasy] make you feel about yourself and about being around other people or about opening up to people?"

Example

THERAPIST: You said you felt ashamed of your sexual feelings for Mike. What makes you feel ashamed of these feelings?

PATIENT: I'm married to Larry. A good wife doesn't have these kinds of feelings.

THERAPIST: Your thought is, "I can't be a good wife and have fantasies about other men"? When you have these feelings for Mike, what do you do with them?

PATIENT: I try to tell myself I shouldn't have these feelings—I shouldn't think about them. But then I just feel nervous, and I can't get him out of my mind. I know he wouldn't be right for me anyway. I'm afraid if I let myself go with this fantasy, I would just act on it. But, I don't know—I probably would never do that.

THERAPIST: OK. So you feel guilty and ashamed, and then you try to stop having these feelings, but they get stronger. What would happen if you just simply acknowledged that you had these feelings and didn't try to suppress them?

PATIENT: Maybe they'd get stronger?

THERAPIST: Do you think other married people fantasize about other people? Or do you think of yourself as the only one?

PATIENT: Oh, I'm sure almost everyone fantasizes.

THERAPIST: Is there a difference between having a fantasy and acting on it? Aren't your thoughts different from your behavior?

PATIENT: Of course. Right. I would never do anything. It's just a fantasy.

THERAPIST: It sounds like you think you should have only one set of feelings—feelings of fidelity, 100% of the time. What would it mean if you had doubts or fantasies?

PATIENT: Part of me thinks it means I'm a bad person, but another part makes me think—well, it's human.

THERAPIST: If you thought of these feelings as another way of being human, what would happen?

PATIENT: I might feel a lot less guilty—and maybe I wouldn't fantasize as much.

Homework

Utilizing Form 11.8, the therapist can have patients examine some of the dimensions of their emotional schemas and respond, in writing, to each of the questions provided.

Possible Problems

Some patients may believe that they should not have certain emotions or fantasies—for example, sexual desires or aggressive feelings or fantasies. They confuse a feeling with a moral failing. It is sometimes helpful to point out that morality involves making a choice not to act in certain ways, even in the face of temptation or desire. Thus, to have a sexual fantasy about infidelity and to choose *not* to act on it entails a moral choice. Relatedly, some patients adhere to a belief in what I refer to as "pure mind"—that is, the belief that one's mind should be free of temptation, irrational thoughts, fantasies that are unwanted, and similar "mental noise" (Leahy, 2015). This kind of mental or emotional perfectionism leads to considerable self-vigilance wherein the individual monitors any unwanted thoughts and feelings—a metacognitive factor in the cognitive self-consciousness described by Wells (2007, 2009, 2011). The therapist can suggest that rather than "watch" his or her fantasies or emotions with the intention of controlling them, the patient can simply observe "There is another fantasy or feeling," and notice that it comes and goes. The vertical descent technique can be helpful when patients have the belief that an emotion or fantasy should not be allowed. For example, one patient believed that accepting a sexual fantasy would lead to his acting out with other women, the end of his marriage, and alienation from his children. The therapist inquired why he had not acted out and had affairs, and he responded that there was too much at stake and he did not want to hurt his wife. The therapist suggested that he had been demonstrating, countless times, his ability to make a "moral choice" and should be proud of himself for protecting what was important to him.

Cross-Reference to Other Techniques

Many of the techniques used to challenge automatic thoughts and modify dysfunctional assumptions are relevant in evaluating emotional schemas. These include examining the costs and benefits, evidence, double standard, vertical descent, role play, and behavioral experiments.

Form

Form 11.8 (Emotional Schemas: Dimensions and Interventions).

TECHNIQUE: Accepting Emotion

Description

Rather than attempting to suppress an emotion or to criticize oneself for having an emotion, one can accept that an emotion occurs or exists. "Radical acceptance" or "acceptance" of an emotion (or other aspects of reality) can be considered a first step in coping effectively with that reality (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Hayes et al., 2003; Linehan, 2015). "Accepting reality" simply means recognizing it for what it is, acknowledging that "what is" does exist, and tolerating the simple recognition of what is. For example, if you are walking outside without an umbrella and there is a sudden downpour, you might simply accept that you are going to get wet. This doesn't mean you will not find some means to cope—for example, going indoors—and it does not mean you are pleased with getting wet. It simply means that you see things as they are. Acceptance of an emotion or a thought entails recognizing that the emotion or thought exists, that one can take the perspective of an observer toward this internal experience, and that one is not "fused" or "equated"

with the inner experience (Hayes et al., 2006; Hayes et al., 2012). Exercising mindfulness enhances acceptance—that is, standing back in a nonjudgmental way without attempting to control what is given in the present moment. For example, the feeling of sadness may be an emotion I recognize for the moment, accept it as part of this current moment, stand back and observe this emotion for what it is right now, give up struggling against it, not equate the emotion with "who I am" or "what I can do," and live and experience life with this emotion alongside of my awareness as I pursue valued goals.

One can view acceptance as the first step in coping with the way things are at the present moment, rather than ruminating, criticizing, or complaining. It is what *it is*. Acceptance is particularly important when what is given is out of one's immediate control. For example, one's intrusive thoughts or current emotional experience may be viewed as somewhat or entirely out of one's willful control. Acceptance is in contrast with suppression.

Questions to Pose/Intervention

"Rather than struggle against the emotion that you are experiencing at the present time, what if you were to accept it for right now and say, 'At the present moment, I am feeling this way'? To accept what is given in the present moment does not mean that you are saying it's fair or that you like it or that it will never change. It just means you are observing where you are right now—what you are feeling, what you are thinking, what is at the present moment. Imagine that you were beginning a long journey and you were taking out a map. You would accept that you are where you are right now, and then you might examine the route you want to take to get to your destination. Accepting an emotion is different from trying to suppress it or telling yourself that you should not have the emotion. It is where you start from."

Example

THERAPIST: I know you have been feeling anxious since you lost your job a couple of weeks ago. When you feel anxious, what do you do next?

PATIENT: I don't know. I guess I worry about getting a job—will I be unemployed forever? Sometimes I drink too much, I know, but it helps calm my anxiety, at least for a while. And sometimes I try to tell myself to calm down.

THERAPIST: I see, so it sounds like you do a number of things when you are anxious. You worry about the future, you drink, and then you try to tell yourself to stop feeling anxious. Do any of these things work for you?

PATIENT: Not really. I mean the drinking might distract me and make me feel calmer for a little while, but the anxiety comes back and my wife begins to criticize me for my drinking, so it doesn't help.

THERAPIST: That must be hard for you. It sounds like you're trying to get rid of the anxiety as quickly as possible. I wonder if you might consider accepting that you feel anxious right now, but at the same time focus your attention and behavior on positive goals, like exercising, contacting people in your network, looking for a job, getting out of the house—that is, accept "I feel anxious right now, but I'm going to take some positive action."

PATIENT: It's hard to do when you're anxious.

THERAPIST: What would happen if you did some of these behaviors even if you were anxious? Like, taking your anxiety along with you when you exercise or contact friends or do other things?

PATIENT: That's hard.

THERAPIST: Maybe one of the things to think about is doing the hard things that you can do until they are easier. Is it worth giving a try? Say to yourself, "Yeah, there's my old friend, anxiety. I see you there, and now I'm going to focus on some positive goals."

PATIENT: I guess I have let the anxiety stop me.

THERAPIST: Waiting for the anxiety to go away so you can commit to action might mean you will wait a long time—and get more anxious. I wonder if you have ever exercised even when you felt tired or just didn't feel like exercising.

PATIENT: Yeah. Last Saturday I decided to exercise even though I was a little hung over. It was hard at first, but I felt better because I did it.

THERAPIST: So you accepted that you felt pretty lousy, but you exercised anyway?

PATIENT: I guess I did.

Homework

The patient can identify some emotions that he or she believes are problematic—for example, sadness, loneliness, anger, or anxiety—and consider accepting them as experiences that he or she is having at the present moment. The patient can be encouraged to respond to the emotion by saying or thinking, "There is the sadness [whatever emotion] that I'm feeling at the present moment." The patient is encouraged to pursue meaningful and rewarding activities even while recognizing that he or she is having, and can accept, the emotion for the present moment. In short, having unpleasant emotions does not preclude meaningful action. The patient can use Form 11.9, with the therapist indicating, "Rather than try to get rid of an unpleasant emotion, we can choose to accept it as an experience we are having at the present moment. And once you accept that you have an emotion, you can still choose to engage in some meaningful or pleasurable behavior." Figure 11.3 provides an example of how one patient used this form.

Possible Problems

Some patients believe that accepting an emotion means that they will have this emotion indefinitely, and so they must struggle against the emotion, get angry at it, and eliminate it immediately or it will go out of control. The therapist can indicate that accepting an emotion does not imply an unwillingness to do some things to improve the moment, distract oneself from what is going on, problem-solve, or modify the emotion. Acceptance is the starting point and implies that one sees things as they are and is willing to experience that discomfort until one another feeling or sensation replaces it.

Cross-Reference to Other Techniques

Additional relevant techniques include mindful detachment; examining beliefs about duration, control, and danger of emotion; and examining evidence that past emotions have passed.

Form

Form 11.9 (Accepting Emotion).

Emotion or sensation I notice	Words of acceptance	Meaningful activity
Feeling a little dizzy	I can accept that I may be dizzy and that this will pass and will not keep me from living the life I want to live. It's like feeling a little woozy.	I can still go to work and see my friends for dinner. I can still go to the gym and work out. The dizziness is temporary, and my doctor tells me that there is nothing dangerous happening.
Angry	I can accept that I feel angry toward Ken because he was rude to me, but I understand that my anger is an emotion that comes and goes. I don't have to struggle against it. I can let it happen. My doctor tells me to breathe in and let the anger out as I breathe out. I can notice it and let it happen and let it go.	I can still do everything I have always done. Today I'm having lunch with Greta and it should be nice. I can put the anger in the background. And I can still see Ken because our relationship is large enough to allow a little anger once in a while.

FIGURE 11.3. Accepting emotion.

TECHNIQUE: Imagery Rescripting

Description

Traumatic experiences may persist in memory for years, resulting in PTSD. Attempts to modify traumatic images by relying solely on verbal disputation may not adequately activate the fear structure and may not provide the patient with a powerful enough counter to the thoughts and feelings contained in the image. Imagery rescripting allows patients to re-create their story, in dramatic detail, in a way that changes the nature of the original traumatic event. For example, the patient who recalls being beaten by his father as a child can rescript the image so that the father is small, weak, and foolish, and the patient is strong, aggressive, and hostile toward the father. The imagery rescripting activates a stronger, more competent emotional component of the self that counters the defeated and victimized weaker self. Valuable descriptions of this technique, and variations on it, can be found in the work of Arntz and Weertman (1999), Stopa (2009), Tatham (2011), Wild and Clark (2011), Resick (2001), and Smucker and Dancu (1999). Imagery rescripting is especially helpful for individuals who have been abused or have experienced other trauma.

Questions to Pose/Intervention

"When you have these terrible images and memories, you feel defeated and attacked. Let's go back and change the image and the story. This time I want you to imagine that you are strong, tall, aggressive, and angry. Your [abuser] is weak, small, and stupid. I want you to imagine yourself dominating and criticizing and punishing your [abuser]. Tell him [or her] how stupid and awful he [or she] is. Tell him [or her] that you are a much better person."

Example

THERAPIST: You said that your father used to beat you and lock you in the basement. What did that feel like for you?

PATIENT: I felt like I was a piece of shit. I felt weak, like no one cared about me, and I couldn't do anything. I was just beaten.

THERAPIST: I wonder how you feel right now, as we are talking about this?

PATIENT: Scared. Like it could happen again.

THERAPIST: OK. So as you described it [earlier], he would come home drunk, start shouting, and then he'd hit you, over and over.

PATIENT: Yes, there was no escaping him.

THERAPIST: OK. Let's imagine that he is really, really small, about 2 feet high, and that he has this little, tiny, high-pitched voice. And let's imagine you are really big and strong and ferocious. I'd like you to clench your fists, as if you were going to punch someone. Let's imagine you are towering over him.

PATIENT: (*clenching her fists*) I can see him as this little midget with this squeaky voice, screaming at me that I'm not doing what I'm supposed to be doing.

THERAPIST: OK. Now let me hear you tell him off. Tell him you're in charge.

PATIENT: (*talking loudly down to the imaginary father*) You can't tell me what to do, you little piece of crap! You are *nothing* compared to me.

THERAPIST: Tell him why he's nothing compared to you.

PATIENT: You're just a drunk and a failure and a lousy father. I went to college—no thanks to you—and I raised a kid and I earn a living and I'm a decent person. And you are nobody!

THERAPIST: Tell him what you will do if he hits you again.

PATIENT: I'll kill you. I'll stomp on you until you are nothing. I'll throw you out of the goddamn window!

Homework

The therapist can ask patients to recall a former experience of abuse or humiliation and to write down the details of the traumatic experience. A new fantasized script then follows this reality-based recounting. In this rescripted story, patients are instructed to describe themselves as strong, confident, aggressive, and confrontational. The patients dominate the scene, reducing their abuser or humiliator to a piddling annoyance. Afterward, patients can write down their thoughts and feelings about doing this exercise, using Form 11.10 to rewrite their story with a more adaptive and resilient outcome for them.

Possible Problems

Some patients become even more anxious when they confront their feared abuser in the rescripted version. Magical thoughts such as "The abuser will come back and hurt me" or "If I am assertive, I'll be punished" are not uncommon. The therapist should be aware of patients' hesitancy in utilizing this rescripting technique. Any signs of increased anxiety, dissociation, responding in a rote

and mechanical way, or the sudden desire to terminate therapy should be addressed. The therapist can ask about the automatic thoughts, perhaps supplying the sentence stem: "If I stand up to the abuser in this image, I become afraid because I think. . . ." These kinds of automatic thoughts and assumptions often reflect the sense of powerlessness, shame, and humiliation that accompanied the abuse. Standard cognitive therapy techniques can be utilized to challenge these negative thoughts about self-esteem or assertion. For example, one patient noticed that she had thoughts "I deserved the abuse," "If I stand up to them, they will kill me," and "Passivity will protect me." These fearful thoughts were then examined through cost–benefit analysis, rational role play, double standard, and empty-chair techniques.

Cross-Reference to Other Techniques

Additional helpful techniques include imagery induction, schema work (identifying core schemas, schema avoidance, schema maintenance), case conceptualization, feared fantasy, assertion, writing letters to the source, and double-standard techniques.

Form

Form 11.10 (Rescripting the Story).

TECHNIQUE: Doing What You Don't Want to Do

Description

A great deal of CBT involves patients making a conscious choice to do things they may find anxiety-provoking or just unpleasant. In some cases, patients may be reluctant to do these things because they believe that they should not do what they don't want to do. Patients may believe in an illusion of "spontaneity" ("I should do what comes to me spontaneously") or "readiness" ("I need to be ready" or "I need to be motivated"). Or they may believe they should be comfortable, avoid risks, or wait until it seems like the right time. All of these beliefs result in further procrastination and avoidance. An alternative belief is that a great deal of progress can be made if people are willing to so what they don't want to do. For example, I have suggested that patients ask themselves the following questions: (1) What is my goal?; (2) what do I have to do to reach that goal?; and (3) Am I willing to do it? Notice there is no mention of what patients *want* to do (Leahy, 2005, 2015). The therapist can present this ability to do what you don't want to do as a skill in being willing to change, tolerate discomfort, and transcend current inertia and avoidance, what we can call "constructive discomfort."

Questions to Pose/Intervention

"Many times we feel stuck because we just don't want to do something. It's like our mind tells us, 'I don't want to do that,' and we just obey and do nothing. We have the belief that we can't or won't do things we don't want to do. But imagine if I had a pill that would allow you to do things you don't want to do, like exercise, work, or relate to people in ways that are effective—all the things that you might not want to do. Would this be a pill you would want to take? Are there things in your life, currently or in the past, that you have done that you didn't want to do? What happened? What will happen now if you do some things that you don't want to do?"

Example

THERAPIST: So often in our lives, something comes along and we just don't want to do it. It could be exercise, working on something that is unpleasant, acting in a polite way with someone we don't like, or experiencing discomfort for some important goal. Have you had those experiences?

PATIENT: It seems like I have those experiences all the time. I just avoid them.

THERAPIST: Yeah, that's human nature, isn't it? But let's say I have a pill that would allow you to do things, even though you don't want to do them, because they are good for you to do. You take the pill and you just do those things anyway. Your mind is telling you, "It's unpleasant," or "You shouldn't have to do those things," but you take the pill and do them anyway. What would happen?

PATIENT: (*pausing*) My life might be a lot better. But, you know, I really don't want to do some of these things.

THERAPIST: I'll bet you have done a lot of things you didn't want to do. Like in college, did you do things you didn't want to do?

PATIENT: Yes, that's how I managed to graduate. I just studied and worked hard, and sometimes I didn't see my friends because I really focused. Toward my junior year, I pulled it together.

THERAPIST: And how did you feel about that?

PATIENT: I guess I felt proud.

THERAPIST: So let's make a list of some things you don't want to do, but that, when you are rational, you realize might be better if you did them. Let's make a list of those target behaviors. And then let's see if you can say to yourself, "I am choosing to do these things even though I don't want to do them."

PATIENT: That goes against my nature.

THERAPIST: You just told me you did it in college.

Homework

The therapist can ask patients to make a list of behaviors that would be good to get out of the way. The focus is on longer-term goals and on mastering self-discipline. With each behavior, patients asked to say, deliberately, "I know I don't want to do this, but I am choosing to do it anyway." Patients are then asked to make predictions about what it was like doing these things and how they felt afterward. Patients can use Form 11.11 to identify behaviors they are reluctant to do and to examine the outcomes they could achieve by doing what they did not want to do.

Cross-Reference to Other Techniques

Other techniques that are helpful are opposite action, pleasure prediction, practicing successful discomfort, and focusing on longer-term versus shorter-term goals.

Form

Form 11.11 (Doing What I Don't Want to Do).

FORM 11.1

Daily Emotion Log

Every day we experience a wide range of emotions. Using the form below, note which emotions you experience each day by checking the box next to the emotion. For example, if you felt afraid, check the box next to that emotion. Do this each day. When you are finished for the day, go back and circle the three emotions that were the most difficult for you and the three emotions that were the most pleasant for you. Do this for every day of the week. Do you notice a pattern? Are there certain events or people who trigger certain emotions? What kinds of thoughts are you having when you have these emotions?

Day: _____

- ☐ Active
- ☐ Afraid
- ☐ Alert
- ☐ Angry
- ☐ Anxious
- ☐ Ashamed
- ☐ Awed
- ☐ Bored
- ☐ Challenged
- ☐ Compassionate
- ☐ Confident
- ☐ Curious
- ☐ Courageous
- ☐ Determined
- ☐ Disappointed
- ☐ Distressed
- ☐ Distrustful
- ☐ Eager
- ☐ Embarrassed
- ☐ Envious
- ☐ Excited
- ☐ Frustrated
- ☐ Guilty
- ☐ Helpless
- ☐ Hopeless
- ☐ Hostile
- ☐ Hurt
- ☐ Interested
- ☐ Inspired
- ☐ Jealous
- ☐ Lonely
- ☐ Loved
- ☐ Loving
- ☐ Overwhelmed
- ☐ Proud
- ☐ Rejected
- ☐ Sad
- ☐ Strong
- ☐ Trapped
- ☐ Vengeful

Other emotions:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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FORM 11.2

Emotions I Avoid

There are some emotions you may find yourself avoiding or trying to get rid of immediately. Keep track of these attempts to avoid or get rid of emotions using the form below. Indicate what you do to avoid the emotion. For example, do you avoid situations where you might have the emotion, do you distract yourself, overeat, try to suppress the emotion, etc.?

	Emotion I tried to avoid	**What I did to avoid the emotion**
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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FORM 11.3

Keeping a Journal

Over the next week it might be helpful to keep track of experiences when you have positive or negative feelings. This can be a journal—a daily recollection of what you experience. In the left-hand column, write down a daily experience when you had some emotions—either positive or negative. Then write, in your own words, what it was like for you—how you felt, what you thought, what happened, what made sense, what did not make sense. Look back at your journal each day to see if there is a pattern to your experiences and feelings.

Situation I recall today	**Description of what happened, how I felt, what I thought, what made sense, what did not make sense**

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FORM 11.4

Writing a Story

Sometimes it is helpful to write out a story about what you recall happening. Using the form below, please answer each of the questions.

Describe your memory of your story in as much detail as you can. Try to visualize the details, what was going on, what things looked like, what sounds you recall, how you felt, what sensations you recall, and so on:
What feelings or emotions did you experience in this story?
What thoughts do you have looking back at this story?
Which thoughts bother you in looking back?
What parts of this story—what memories—were the most painful? Why?
Are there parts of the story that are difficult to remember? Describe what precedes that part that is difficult and what follows after.
How do you feel after writing this story?

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FORM 11.5

Identifying Hot Spots

When we recall experiences, there may be some details that are hard to recall because we may block them or because they are upsetting to recall. These are "hot spots" in our memory, and sometimes recovering these details can lead us to understand our emotions and thoughts better. In the left-hand column, describe the story or image in as much detail as you can. In the middle column, describe the parts that are most upsetting. In the right-hand column, try to identify the feelings and thoughts that you have with these hot spots.

Describe the story or image in as much detail as you can.	**Which specific parts of this story are most upsetting? These are the hot spots.**	**What feelings and thoughts do you have at these hot spots?**

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FORM 11.6

Leahy Emotional Schema Scale–II (LESS-II)

We are interested in how you deal with your feelings or emotions—for example, how you deal with feelings of anger, sadness, anxiety, or sexual feelings. We all differ in how we deal with these feelings—so there are no right or wrong answers. Please read each sentence carefully and rate how true or untrue it is for you—using the scale below—to see how you dealt with your feelings during the past month. Put the number of your response next to the sentence.

1 = very untrue of me
2 = somewhat untrue of me
3 = slightly untrue of me
4 = slightly true of me
5 = somewhat true of me
6 = very true of me

1. _____ I often think that I respond with feelings that others would not have.
2. _____ Some feelings are wrong to have.
3. _____ There are things about myself that I just don't understand.
4. _____ I believe that it is important to let myself cry in order to get my feelings "out."
5. _____ If I let myself have some of these feelings, I fear I will lose control.
6. _____ Others understand and accept my feelings.
7. _____ My feelings don't make sense to me.
8. _____ If other people changed, I would feel a lot better.
9. _____ I sometimes fear that if I allowed myself to have a strong feeling, it would not go away.
10. _____ I feel ashamed of my feelings.
11. _____ Things that bother other people don't bother me.
12. _____ No one really cares about my feelings.
13. _____ It is important for me to be reasonable and practical rather than sensitive and open to my feelings.
14. _____ When I feel down, I try to think of the more important things in life—what I value.
15. _____ I feel that I can express my feelings openly.
16. _____ I often say to myself, "What's wrong with me?"

(continued)

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17. _____ I worry that I won't be able to control my feelings.

18. _____ You have to guard against having certain feelings.

19. _____ Strong feelings only last a short period of time.

20. _____ I often feel "numb" emotionally—like I have no feelings.

21. _____ Other people cause me to have unpleasant feelings.

22. _____ When I feel down, I sit by myself and think a lot about how bad I feel.

23. _____ I like being absolutely definite about the way I feel about *someone else*.

24. _____ I accept my feelings.

25. _____ I think that I have the same feelings that other people have.

26. _____ There are higher values that I aspire to.

27. _____ I think it is important to be rational and logical in almost everything.

28. _____ I like being absolutely definite about the way I feel about *myself.*

FORM 11.7

Scoring Guide for the 14 Dimensions of the Leahy Emotional Schema Scale–II

Note: R = Reversed Score (1 = 6; 2 = 5; 3 = 4; 4 = 3; 5 = 2; 6 = 1)

Invalidation = (Item 06**R** + Item 12) / 2

Item 6. Others understand and accept my feelings. **(reversed score)**

Item 12. No one really cares about my feelings.

Incomprehensibility = (Item 03 + Item 07) / 2

Item 3. There are things about myself that I just don't understand.

Item 7. My feelings don't make sense to me.

Guilt = (Item 02 + Item 10) / 2

Item 2. Some feelings are wrong to have.

Item 10. I feel ashamed of my feelings.

Simplistic View of Emotion = (Item 23 + Item 28) / 2

Item 23. I like being absolutely definite about the way I feel about someone else.

Item 28. I like being absolutely definite about the way I feel about myself.

Devalued = (Item 14**R** + Item 26**R**) / 2

Item 14. When I feel down, I try to think of the more important things in life—what I value. **(reversed score)**

Item 26. There are higher values that I aspire to. **(reversed score)**

Loss of Control = (Item 05 + Item 17) / 2

Item 5. If I let myself have some of these feelings, I fear I will lose control.

Item 17. I worry that I won't be able to control my feelings.

Numbness = (Item 11 + Item 20) / 2

Item 11. Things that bother other people don't bother me.

Item 20. I often feel "numb" emotionally—like I have no feelings.

Overly Rational = (Item 13 + Item 27) / 2

Item 13. It is important for me to be reasonable and practical rather than sensitive and open to my feelings.

Item 27. I think it is important to be rational and logical in almost everything.

Duration = (Item 09 + Item 19**R**) / 2

Item 9. I sometimes fear that if I allowed myself to have a strong feeling, it would not go away.

Item 19. Strong feelings only last a short period of time. **(reversed score)**

(continued)

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Low Consensus = (Item 01 + Item 25**R**) / 2

Item 1. I often think that I respond with feelings that others would not have.

Item 25. I think that I have the same feelings that other people have. **(reversed score)**

Non-Acceptance of Feelings = (Item 24**R** + Item 18) / 2

Item 24. I accept my feelings. **(reversed score)**

Item 18. You have to guard against having certain feelings.

Rumination = (Item 22 + Item 16) / 2

Item 22. When I feel down, I sit by myself and think a lot about how bad I feel.

Item 16. I often say to myself, "What's wrong with me?"

Low Expression = (Item 04**R** + Item 15**R**) / 2

Item 4. I believe that it is important to let myself cry in order to get my feelings "out." **(reversed score)**

Item 15. I feel that I can express my feelings openly. **(reversed score)**

Blame = (Item 08 + Item 21) / 2

Item 8. If other people changed, I would feel a lot better.

Item 21. Other people cause me to have unpleasant feelings.

FORM 11.8

Emotional Schemas: Dimensions and Interventions

Validation

Are there some people who accept and understand your feelings? Do you have arbitrary rules for validation? Do people have to agree with everything you say? Are you sharing your emotions with people who are critical? Do you accept and support other people who have these emotions? Do you have a double standard? Why?

Comprehensibility

Do the emotions make sense to you? What could be some good reasons why you are sad, anxious, and angry, etc.? What are you thinking (what images do you have) when you are sad, etc. What situations trigger these feelings? If someone else experienced this event, what kinds of different feelings might he or she have? If you think your feelings don't make sense right now, what does this make you think? Are you afraid you're going crazy or losing control? Are there things that happened to you as a child that might account for why you feel this way?

Guilt and Shame

Why do you think your emotions are not legitimate? Why shouldn't you have the feelings you have? What are some reasons your feelings make sense? Is it possible others could have the same feelings in this situation? Can you see that having a feeling (e.g., anger) is not the same as acting on it (e.g., being hostile)? Why are certain emotions good and others bad? If someone else had this feeling, would you think less of him or her? How do you know if an emotion is bad? What if you looked at feelings and emotions as signs telling you that something is bothering you—like a caution sign, a stop sign, or a flashing red light? Is anyone harmed by your emotions?

Simplicity versus Complexity

Do you think having mixed feelings is normal or abnormal? What does it mean to have mixed feelings about someone? People are complicated, so why wouldn't you have different, even conflicting, feelings? What is the disadvantage of demanding that you have only one feeling?

Relationship to Higher Values

Sometimes we feel sad, anxious, or angry because we are missing something that is important to us. Let's say you feel sad about a relationship breakup. Doesn't this mean you have a higher value that's important to you—for example, a value of closeness and intimacy? Doesn't this value say something good about you? If you aspire to higher values, doesn't this mean you will have to be disappointed at times? Would you want to be a cynic who values nothing? Are there other people who share your higher values? What advice would you give them, if they were going through what you are going through?

(continued)

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Controllable

Do you think you have to control your feelings and get rid of the "negative" ones? What do you think would happen if you couldn't get rid of that feeling entirely? Is it possible that trying to get rid of a feeling completely makes that feeling too important to you? Are you afraid that having a strong feeling is a sign of something worse? Perhaps going crazy? Losing complete control? Isn't there a difference between controlling your actions and controlling your feelings? Identify an emotion that is of concern to you (e.g., sadness). Keep track of that emotion every hour for the next week, rating it from 0 to 10. Does the intensity of your emotion vary?

Numbness

Are there situations that trigger "spacing out"? No feelings? Are there situations that bother most people but don't bother you? Do people think you are blunted in your feeling? Unfeeling? What kinds of strong feelings do you have? Do you ever notice having a strong feeling and then try not to have it? Do you ever have the feeling that you are going to cry, but you stop it? What do you fear would happen if you let go and let yourself have those feelings? What kinds of thoughts do you have when you experience strong feelings? Do you ever drink or use drugs or binge on food to get rid of those strong feelings?

Rationality, Anti-Emotion

Do you think you should always be logical and rational? What would you be concerned about if you were not rational/logical? Do you think people who are rational or logical are better people? What happened in the past when you weren't logical/rational? Is it possible that some experiences are not logical/rational but simply emotional? Is there such a thing as a rational painting? A rational song? Can your emotions tell you about what hurts you? What needs to be changed? Are emotions an important source of information about our needs, desires, and even our rights as human beings? Do you know other people who are less rational than you, but who have a happier or fuller life?

Duration of Strong Feelings

Do you have fears that a strong feeling will last too long? Have you had strong feelings before? What happened? Did they end? Why did they end? Do strong feelings go up and down? If you had a strong feeling in our session, what do you think would happen? If you cried or felt really bad for few minutes, what do you think would happen? What would you gain by finding out that your strong feelings can be expressed and then go away? What strategies are you using to control your emotions? For example, are you telling yourself to stop feeling this way? Are you asking for reassurance? Are you avoiding or escaping unpleasant situations? In contrast to these unhelpful strategies, try the following: Imagine that you are standing back and observing what is going on at the present moment. Imagine observing your breath as it goes in and out. Just observe and let it be as it is without controlling it. Notice if your mind wanders off and bring your attention back to your breath. Practice this mindful breathing for 15 minutes and notice where your attention wanders. Staying with the present moment, observing what is there at the present moment in your breathing, notice that your breath goes in and out, and let go.

(continued)

Consensus with Others

Exactly what feelings do you have that you think other people don't have? If someone else had these feelings, what would you think of him or her? Why do you think very emotional plays or movies, novels, or stories appeal to people? Do you think that people like to find out that other people have the same feelings? Are there other people who are sad, angry, or anxious? Is it normal to be upset or to have fantasies? If you are ashamed of your feelings and don't tell people, might this concealment keep you from finding out that others have the same feelings?

Acceptance or Inhibition

What will happen if you allow yourself to accept an emotion? Will you act on it? Do you fear that if you accept an emotion, it won't go away? Or do you think that *not* accepting your emotions will motivate you to change? What are the negative consequences of inhibiting a feeling? Excessive use of attention and energy? Rebound effect? Does the emotion conflict with a belief about good versus bad feelings? If you deny that something bothers you, how can you fix the problem?

Rumination versus Instrumental Style

What are the advantages and disadvantages to focusing on how bad you feel? When you are focusing on how bad you feel, what kinds of things are you thinking and feeling? Do you sit and think "What's wrong with me?" or "Why is this happening to me?" Do you focus on sadness, replaying in your mind the same things over and over? Do you sometimes think that if you keep thinking about what is upsetting you, a solution will come to you? Does your worrying make you feel that you can't control your stressful thoughts? Try setting aside 30 minutes each day, during which time you will worry intensely. You have to set aside all your worries until that time. Rephrase your worries into behaviors you can carry out, problems you can solve. Distract yourself by taking action or calling a friend and talking about something other than your worries. Exactly what do you predict will happen? Have your predictions ever proved to be false? When you are ruminating, you are chewing things over. Is there some "truth" or "reality" that you just refuse to accept?

Expression

If you expressed a feeling, do you think you would lose control? Feel worse? How long would you feel worse? Can expressing a feeling help you clarify your thoughts and other feelings? Conversely, if you focus only on expressing a feeling, will you overfocus on it? Will you become self-absorbed? Are there things that you could do to distract yourself or solve your problems?

(continued)

Blaming Others

What did other people say or do that made you feel the way you do? What thoughts did you have that made you feel sad, angry, or anxious? If you thought about this situation differently, what would you feel or think? Are your feelings dependent on what others think of you? Are you focused on getting approval, respect, appreciation, or fairness? What would be the advantage and disadvantage of not needing approval, etc.? What rewards does the other person currently control? Can you have rewarding experiences despite what that person said or did? Is it possible that your feelings are a combination of what is happening to you and what you are thinking? What would you like to feel: angry, sad, curious, indifferent, accepting, challenged? What are the costs and benefits of these different feelings? Given the situation, what would you need to think in order to have each of these feelings? What would you like to have happen? How can you be more assertive? Solve problems? What thoughts would you have to change?

FORM 11.9

Accepting Emotion

Rather than try to get rid of an unpleasant emotion, we can choose to accept it as an experience we are having at the present moment. And once you accept that you have an emotion, you can still choose to engage in some meaningful or pleasurable behavior. For example, you might notice that you feel sad, but you can still see your friends or do your work. In the form below, write down some examples of an emotion you might experience in the left-hand column. In the middle column, write down some words of acceptance for that emotion. "Words of acceptance" can include the following: "I notice that feeling," "There it is," "I am feeling [*X*] at the present moment." In the right-hand column, write down some meaningful activity that you can engage in.

Emotion or sensation I notice	**Words of acceptance**	**Meaningful activity**

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FORM 11.10

Rescripting the Story

When you initially experienced a trauma or stressful event, you may have viewed the other person as superior or more powerful. In the left-hand column, write down a detailed description of what happened: what the other person looked like, sounded like, said, did, etc. In the right-hand column, rewrite, or rescript, this entire story. This time you are more powerful, and the other person is weak and scared. You are bigger, the other person is smaller. You are loud, he or she is quiet. You are active, aggressive, and hostile, and the other person is afraid of you. Rewrite this story in a way that is going to make you the more powerful and dominant one. Then write down your thoughts and feelings about doing this exercise.

Description of original traumatic or stressful event	**Rescripting the story: describing the event from a new perspective**
What thoughts and feelings did you have about the other person and yourself when this happened?	**What thoughts and feelings do you have now?**

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FORM 11.11

Doing What I Don't Want to Do

A lot of us get stuck because there are some things we just don't want to do. It may be because we think those things will be unpleasant, we might not do well, or we shouldn't have to do things we don't want to do. Some of us wait to feel "ready," but that seldom occurs—so we keep procrastinating. In the first column of the form below, list a few behaviors that, if you did them, would make things better. These are behaviors you currently avoid. In the second column, list some of the reasons why you don't do this behavior. In the third and fourth columns, list the costs and benefits of doing the behavior.

Behaviors I avoid doing because I don't want to do them	**Why I don't want to do them**	**Costs of doing them**	**Benefits of doing them**

(continued)

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Doing What I Don't Want to Do *(page 2 of 2)*

Now let's see what happens when you actually choose to do things you don't want to do. In the first column below, list the behaviors you don't want to do. In the second column, list behaviors you are *willing to try*, even if you don't want to do them. If you did this behavior, in the third column list the feelings and thoughts you had while doing it. In the fourth column, list how you felt and what you thought after doing this. What do you conclude?

Behaviors I avoid doing because I don't want to do them	**What I am willing to try doing**	**What I felt and thought while doing it**	**What I felt and thought after I did it**
What conclusions do you draw from doing this exercise?			
Could this be a way to develop self-discipline?			

PART III

Specific Applications

CHAPTER 12

Examining and Challenging Cognitive Distortions

The cognitive therapy model proposes that depression, anxiety, and anger are often the result of recurring patterns of cognitive biases or distortions. For example, the depressed individual may engage in mind reading ("He thinks I'm a loser"), fortune telling ("I will fail"), or labeling ("I'm a failure"). The angry individual also has his or her automatic thoughts, such as "He's trying to block me" (mind reading and personalizing), "They're doing this to insult me" (mind reading and personalizing), or "I can't stand it when people don't agree with me" (catastrophizing). Of course, the same automatic thought may qualify as two categories of distortion, as indicated above. Many cognitive therapists may object to the use of the word "distortion" and prefer to label these as biases, styles, or categories. In this chapter, I use the word "distortion" while recognizing that many may prefer another label for these categories of thinking.

Indeed, many automatic thoughts may be true—the individual may fail the test or others may dislike him or her. In the case in which the "distortion" is true—people don't like the person or he or she failed at a task—the therapist can utilize problem solving, reattribution to effort, changing the goals, or considering a diverse range of meaningful and pleasurable activities that can indicate that the issue about which the patient is upset may not be that important. Further, as indicated in Chapter 4 on examining assumptions, an automatic thought may be true, but it may be the underlying assumption or conditional belief that is the more important thought. For example, "He doesn't like me" may be a true statement, but the underlying assumption, "I must be liked by everyone to accept myself," may be the more important thought to address.

In the rest of this chapter, I provide a checklist of the most common cognitive distortions and some helpful interventions or questions that can be utilized to examine and challenge them. Of course, many of the other techniques discussed in this book can be used to address cognitive distortions. This chapter is intended to serve as a convenient reference source for techniques, questions, or interventions that can be quickly applied to modify negative beliefs. (*Note*: The lists that follow the "Techniques" headings are worded as if the therapist were addressing the patient.)

1. ***Mind reading: You assume that you know what people think without having sufficient evidence of their thoughts—for example, "He thinks I'm a loser."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your prediction is—for example, "He doesn't like me, so he won't talk to me."
3. Collect information about what actually happens. For example, when you spoke to the person, did he or she respond?
4. Conduct a cost–benefit analysis for viewing things this way:
   a. Do you think that mind reading gives you valuable information? Does it make you anxious? Are you less likely to do certain things? Weigh the costs and benefits.
   b. Will mind reading help you prevent being taken by surprise, or will it prevent something bad from happening?
   c. What is the evidence that your mind reading has actually helped you cope better?
   d. How would your thoughts, feelings, and behavior change if you did less mind reading?
   e. Do you think that people who do less negative mind reading cope better or worse? Why is that?
5. Examine evidence for and against your mind reading. What is the evidence that people think what you believe they think? Is there evidence against this?
6. What is the quality of the evidence that supports your mind reading? Is the evidence of such high quality that almost everyone would agree with you?
7. What cognitive distortions are you using to support your belief? Are you personalizing, fortune telling, labeling, discounting positives, or using a negative filter?
8. How could you prove that your thought is wrong? Is it testable?
9. Let's do a vertical descent exercise: What if your thought were true? Why would it bother you? If people are thinking what you think they are thinking, does this mean something about you (e.g., "I'm undesirable" or "I'm foolish") or something about them (e.g., "They're mean")?
10. Let's challenge your need for approval: What if someone doesn't like you? Exactly what will happen? What things will remain the same? How could you live a full life even if some people didn't like you?
    a. What does it make you think if someone doesn't agree with you or approve of you? Does this disagreement or disapproval mean that you are less worthwhile? Is the other person less worthwhile? Why or why not?
    b. List all of the things you can still do even if the person doesn't like you.
    c. No one gets approval from everyone. Why should disapproval bother you?
    d. What would happen if you accepted the fact that someone might not approve of you? What would be the costs and benefits to you?
11. Is anyone liked by everyone?
12. Are there people you like that others don't like? Why?
13. Practice repeating the following statement 20 minutes each day: "No matter what I do, some people won't like me." What happens to the thought? Does it become boring?
14. Act against your thought. Do something positive toward the person you think doesn't like you. See what happens.
15. Practice indifference. What would be the consequence of becoming indifferent to this disapproval?

16. Maybe it is not relevant what someone else thinks. How could this be true? What goals can you still pursue even if someone doesn't like you?
17. Rather than focus on what others might think of you, focus on what you are saying or thinking. Focus on your goals.

2. ***Fortune telling: You predict the future in negative terms involving failure or danger—for example, "I'll fail that exam" or "I won't get the job."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your prediction is—exactly what will happen and when and where it will happen.
3. Let's conduct a cost–benefit analysis:
   a. Do you think that worry protects and prepares you? Do you think that your negative predictions will motivate you? What is the evidence?
   b. Do you fear that you can't control your worries? Do you think that your worries will escalate if you don't control them?
4. Examine evidence for and against your fortune telling.
5. What is the quality of the evidence that supports your fortune telling? Would you be able to convince an impartial jury?
6. What cognitive distortions are you using to support your belief?
7. How could you prove that your thought is wrong? Is it testable?
8. Let's do a vertical descent exercise: What if your thought were true? Why would it bother you? What would happen next? And after that—what would happen? What would it mean about you if the thought were true?
9. Practice repeating the following statement 20 minutes each day: "No matter what I do, it's always possible something bad could happen to me." What happens to the strength of the thought?
10. How many times have you made incorrect predictions? Could this be another incorrect prediction?
11. What is your worst feared outcome—your most feared fantasy? How likely is that to come true? Why? Why not?
12. What is the worst, best, and most likely outcome?
    a. Write down a detailed description of your worst feared outcome.
    b. List all the things that would have to go wrong for this outcome to happen.
    c. List all the things that might prevent this outcome from happening.
13. Practice repeating the image and story of the worst outcome for 20 minutes each day.
14. Describe in detail three positive outcomes. Write down detailed stories about how these positive outcomes could occur.
15. Imagine that you are observing the thought and letting it come and go.
16. Think of the thought as a telemarketing call you don't take. Or imagine that you are standing in a train station and this thought is on a train that you don't board.
17. Think of the thought as a "thought balloon" or "thought clown" that is in the background and that you let go (balloon) or observe as entertainment (clown).

3. ***Catastrophizing: You believe what has happened, or will happen, will be so awful and unbearable that you won't be able to stand it—for example, "It would be terrible if I failed."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your prediction is: Exactly what will happen and when and where will it happen?
3. Let's conduct a cost–benefit analysis:
   a. Do you think that worry protects and prepares you?
   b. Do you fear that you can't control your worries?
4. Examine evidence for and against your catastrophizing thinking. What is the evidence that it will be awful and that you won't be able to stand it?
5. What is the quality of the evidence that supports your catastrophizing thinking? Is it really good-quality evidence? Would a jury believe you? Why not?
6. What cognitive distortions are you using to support your belief? Are you fortune telling, discounting positives, using "should" statements, using negative filters?
7. How could you prove that your thought is wrong? Is it testable?
8. Let's do a vertical descent exercise: What if your thought were true: Why would it bother you? Exactly what would happen?
9. Practice repeating the following statement 20 minutes each day: "No matter what I do, it's always possible that something absolutely terrible could happen to me."
10. How many times have you made incorrect predictions?
11. Exactly what would make this event terrible and awful?
12. How would you feel about this event a month later, a year later, 2 years later?
13. Are there people to whom this "catastrophe" has happened but who have gone on to experience positive things in their lives? How did they manage to go beyond the negative event to positive experiences?
14. Even if this catastrophe happened to you, what positive things could you still experience? How could you cope?
15. Would other people think that what is happening or has happened is terrible and awful? Why would they see it differently from the way you see it?
16. Even if this "terrible" thing happened, could something positive come out of it? Could it lead you to learn something? Open up new opportunities? Motivate you to reexamine your values?
17. Rather than focus on thinking that something is awful or catastrophic, are there some positive goals or behaviors that you could pursue today, this week, this month?
18. Are there some positive things that could happen even if this did happen? Are you underestimating your ability to cope with difficulty?

4. ***Labeling: You assign global negative traits to yourself and others—for example, "I'm undesirable" or "He's a rotten person."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what you predict about your own (or another person's) behavior.
3. How would you define (the label)? For example, how would you define "worthless" or

"stupid"? What is the opposite of (the label)? For example, what is the opposite of "worthless person"? How would you define the opposite? How would we know it if we saw it?

4. Let's conduct a cost–benefit analysis:
   a. Do you think that labeling yourself will motivate you? Does it encourage or discourage you?
   b. Do you think that labeling yourself is realistic?
   c. If you didn't label yourself, how would your thoughts, feelings, and behavior change?
5. Examine evidence for and against your negative label.
6. What is the quality of the evidence that supports this belief that you are (rotten, undesirable, etc.)? Could you convince a jury?
7. What cognitive distortions are you using to support your belief? Are you thinking in all-or-nothing terms, discounting positives, using "should" statements, using a judgment focus, applying negative filters?
8. How could you prove that your thought is wrong? Is it testable?
9. Rather than focus on labeling the whole person, think about some different behaviors—positive, negative, and neutral—that you see in this person.
10. Describe the situations in which you or this person display a positive and a negative behavior. Is there any pattern?
11. Does your behavior or the behavior of the other person vary with the situation? Are there times when you observe different behavior?
12. Rather than label yourself or the person, simply describe a single behavior that you observe—such as, "He was speaking loudly" or "I had a hard time with that question."
13. Is it possible that you or the other person can change a behavior or acquire new skills? Have you ever changed anything or learned anything?
14. How was this person seeing the situation? Did he or she have a different point of view, a different need, or different information?
15. Using the double-standard question, ask yourself, "Would everyone label this person in such a negative way? Why not?"
16. Distinguish between self-*criticism* and self-*correction*. What behavior could you improve? What could you learn? What could you do differently in the future?
17. What if you were to affirm that part of this is true? For example, "Yes, sometimes I fail" or "Sometimes I'm boring," and then say, "I accept that."

5. Discounting positives: You claim that the positive things you or others do are trivial—for example, "That's what wives are supposed to do, so it doesn't count when she's nice to me" or "Those successes were easy, so they don't matter."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what you are discounting.
3. Let's conduct a cost–benefit analysis:
   a. Do you think that being strict and demanding will motivate you or others?
   b. Do you think you're being "moral" or "standing up for what's right"? Where did you get this rule? Is it a good rule? Does it make you or others unhappy?
   c. If you didn't discount the positives, how would your thinking, feeling, and behavior change?

4. Examine evidence for and against discounting positives.
5. What is the quality of the evidence that supports discounting positives?
6. What cognitive distortions are you using to support your belief? Are you using dichotomous thinking, negative filters, labeling, "should" statements, a judgment focus?
7. Are you using all of the information available or limiting your search to information that supports your belief? What is the consequence of this way of thinking?
8. Do you fear that if you give yourself credit for positives that you will become conceited and arrogant? How likely is this?
9. Let's try a double-standard exercise: Would everyone see it this way? Why not?
10. What is your underlying assumption? Complete this sentence: "These things don't count because. . . ."
11. What if we made your view that these things don't count a universal one for everyone? What would be the consequence?
12. Let's try another double-standard exercise: If you really loved someone or cared about him or her, would you count these positives? Why? What would be a reason not to count them here?
13. Try positive tracking: Keep track of your positives (or the other person's positives) every day for a week. What does this record tell you?
14. Try to reward positives: Every time you or someone else does something positive, praise yourself or the person. Will this praise increase or decrease the positive behavior?
15. If you treated yourself with compassion, how would you think of your positives?
16. Are you discounting positives because you have a core belief about yourself that is negative? If you only count as evidence things that are negative, does this keep confirming your core belief?
17. If someone else observed these positive things, would he or she view them differently? How would they view these positive things? Why is their perception different from yours?

6. ***Negative filtering: You focus almost exclusively on the negatives and seldom notice the positives—for example, "Look at all of the people who don't like me."***

Techniques

1. List all of your negative filter statements.
2. What are the costs and benefits of filtering everything through negatives?
3. Are you not looking at all of the information? Is there some information that you are ignoring? Why?
4. Exactly what would happen, or what would it mean to you, if you did count this positive information?
5. Apply the double-standard technique: Would everyone see things this negatively? Why not?
6. What is your underlying assumption? Complete this sentence: "These things don't count because. . . ."
7. What if we made your view that these things don't count a universal one for everyone? What would be the consequence?
8. Apply another double standard: If you really loved someone or cared about him or her, would you count these positives? Why? What would be a reason not to count them here?

9. Try positive tracking: Keep track of your positives (or the other person's positives) every day for a week. What does this record tell you?
10. Try to reward positives: Every time you or someone else does something positive, praise yourself or the person. Will this praise increase or decrease the positive behavior?

7. ***Overgeneralizing: You perceive a global pattern of negatives on the basis of a single incident—for example, "This generally happens to me. I seem to fail at a lot of things."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what you predict about your own (or another person's) behavior.
3. Let's conduct a cost–benefit analysis:
   a. Do you think that overgeneralizing will motivate you?
   b. Do you think that overgeneralizing is realistic?
   c. How would your thoughts, behavior, and feelings change if you didn't overgeneralize?
4. Examine evidence for and against your overgeneralizing.
5. What is the quality of the evidence that supports your belief, "This is always happening"?
6. What cognitive distortions are you using to support your belief? Are you using negative filters, labeling, discounting positives?
7. How could you prove that your thought is wrong? Is it testable?
8. Are there situations when this (behavior, outcome, emotion, etc.) is not happening? How would you describe these situations? Keep track of your behavior, thoughts, and feelings for the next week. When is this problem *not* happening?
9. Apply the double-standard exercise: Would everyone see things this way? Why not?
10. Try positive tracking: Keep track of your positives (or the other person's positives) every day for a week. What does this tell you?
11. Try to reward positives: Every time you or someone else does a positive, praise yourself or the person. Will praise increase or decrease the positive behavior?
12. Try mindfulness rather than judging. Focus only on describing what has happened without using any judgmental words. Avoid using words such as "always" and "never"—for example, "He's always like that" or "I'm never going to succeed." Focus only on behavior that you can observe—for example, "He was driving fast"—and on how you felt—"I felt nervous." Stay in the present moment. How does this feel?
13. Imagine that you are looking down from a balcony on what is happening, and you must describe what you see to a stranger. Exactly what would you say is being said and done?
14. Try thinking about yourself or others from a compassionate, loving-kindness perspective. How does this affect your negative filter?

8. ***Dichotomous thinking: You view events or people in all-or-nothing terms—for example, "I get rejected by everyone" or "It was a complete waste of time."***

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what you predict about your own (or another person's) behavior.

3. Let's conduct a cost–benefit analysis:
   a. Do you think that viewing yourself in all-or-nothing terms will motivate you?
   b. Do you think that dichotomous thinking is realistic?
   c. How would your thinking, behavior, and feelings change if you were less dichotomous in your thinking?
4. Examine evidence for and against your dichotomous thinking. Are there exceptions to your all-or-nothing thinking?
5. Keep track of your behavior, thoughts, and feelings for a week. When is this not happening?
6. What is the quality of the evidence that supports your belief that things are "all-or-nothing"?
7. What cognitive distortions are you using to support your belief? Are you discounting positives, using negative filters, labeling?
8. How could you prove that your thought is wrong? Is it testable?
9. What if you looked at things along a *continuum* from 0% to 100%? Fill in each 10-point mark on the scale with a behavior. What is a realistic way of viewing this behavior?
10. What are some behaviors that are worse, better, or the same as this behavior?
11. Are there situations or times when this behavior is not happening? How would you describe these situations or times?
12. Apply the double-standard technique: Would everyone see it this way? Why not?
13. Try the positive tracking: Keep track of your positives (or the other person's positives) every day for a week. What does this record tell you?
14. Try to reward positives: Every time you or someone else does a positive, praise yourself or the person. Will praise increase or decrease the positive behavior?

9. "Shoulds": You interpret events in terms of how things should be, rather than simply focusing on what is—for example, "I should do well. If I don't, then I'm a failure."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your "should" rule is—for example, "I should be perfect" or "I should get everyone's approval."
3. Let's conduct a cost–benefit analysis:
   a. Do you think that being strict and demanding will motivate you or others?
   b. Do you think you're being "moral" or "standing up for what's right"?
   c. How would your thinking, behavior, and feelings change if you were less "should" oriented?
4. Examine evidence for and against your "should" rule. Are there people who do not have this "should" rule? What do you think of them? How do they function without this rule?
5. What cognitive distortions are you using to support your belief? Are you using labeling, discounting positives, dichotomous thinking, overgeneralizing?
6. Do you label yourself in all-or-nothing terms when you don't live up to your rigid rules? What is the consequence of this labeling?
7. Double-standard technique: Would everyone see it this way? Why not? If people are not using your "should" rules, how are they looking at these things?
8. Sometimes we use a "should" statement that is a moral statement for something that is simply a convention or preference. For example, you might find yourself using a "should"

statement about the way someone dresses or uses a fork. But that is a "category error." You are making a moral judgment about a convention or preference. There is no moral issue involved. Think about your "shoulds" and ask yourself if these are really moral issues. Or are they conventions?

9. What if we made it a universal rule that everyone follow your "should" rules? What would be the consequence? Would this be fair?
10. Morality should advance human dignity. Do your "should" rules treat people in a humane and dignified way? Or are they aimed at condemning and criticizing people?
11. Does your "should" rule come from any religious, moral, or legal beliefs? Specify exactly where you learned this "should" rule. Is this current version perhaps a misperception of what was originally taught or written?
12. Apply another double standard: If you really loved someone or cared about him or her, would you apply this "should" rule to him or her? Why? Is there some reason why you would use this rule for some people but not for others?
13. What if you replaced your "should" rule with the statement that you might *prefer* something to be true? What if you were less extreme in your statement? For example, rather than saying "I should be perfect," you were to say "I'd prefer doing well"? Try restating all of your "should" rules in terms of less extreme preferences. How does this feel?
14. What are the costs and benefits of this new preference that is less extreme?
15. List a range of preferences (in relation to your "should" rule) from 0% to 100%. What do most people think is sufficient or adequate? How is this different from the rigid and demanding "should" rule that you are using?
16. Try mindfulness rather than judging: Focus only on describing what has happened, without using any judgmental words and without using any "shoulds." Avoid using words such as "always" and "never"—for example, "He's always like that" or "I'm never going to succeed." Focus only on behavior that you can observe—for example, "He was driving fast"—and on how you felt—"I felt nervous." Stay in the present moment. How does this feel?
17. How will staying in the present moment change this moment? What will happen an hour from now, a day from now, a week from now?
18. Imagine that you are looking down from a balcony on what is happening, and you must describe what you see to a stranger. Exactly what would you say is being said and done?
19. Imagine if you accepted the way things are, without judging them. Would you still be able to function, get things done, pursue meaningful activities?
20. Imagine if someone—including yourself—did something he or she should not have done. What if you accepted the person and forgave him or her?
21. What if you thought of ways of doing things in a better way rather than focusing on your judgment? What could be some better behaviors? How can things improve?

10. Personalizing: You attribute a disproportionate amount of the blame for negative events to yourself—for example, "The marriage ended because I failed"—and you fail to see that certain events are also caused by others.

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your statement or thought is—for example, "This is entirely my fault."

3. Let's conduct a cost–benefit analysis:
   a. Do you think that taking it personally motivates you to try harder, or does it protect you in some way?
   b. Do you think that personalizing this event/situation is realistic?
   c. What thoughts, feelings, and behaviors would change if you personalized your experience less?
4. Examine evidence for and against your personalizing statement.
5. What is the quality of the evidence that supports your belief?
6. What cognitive distortions are you using to support your belief? Are you overgeneralizing, mind reading, discounting positives, using negative filters, labeling, catastrophizing, or using "should" statements?
7. How could you prove that your thought is wrong? Is it testable?
8. Use the pie chart technique. Distribute the possible causes for this event, using a pie metaphor. To what degree was the outcome due to causes other than yourself or the other person?
9. What variations do you see in this behavior? Are you (or the other person) always this way? What would you conclude if there were variation?
10. What were your intentions? The other person's intentions? Are you certain your belief about his or her intentions is correct? How could you know?
11. If someone else other than you were there, would the same outcome have occurred?
12. Sometimes when we personalize, we think of ourselves as the center of things. If a stranger observed what happened, would he or she think it was personal to you? Why or why not?
13. Rather than personalize what happened, try to describe the behaviors that you observed in a nonjudgmental way.
14. Rather than personalizing and blaming, what if you were to ask what problems needed to be solved? For example, if you are going through a breakup in a relationship, rather than blame yourself or the other person, why not ask yourself what practical problems you need to solve right now? What would be the consequences of this new way of thinking?
15. Imagine that you are a grain of sand on the beach, drifting back and forth. Now consider the current situation from the perspective of a grain of sand.

11. Blaming: You focus on the other person as the source of your negative feelings, and you refuse to take responsibility for changing yourself—for example, "She's to blame for the way I feel now" or "My parents caused all my problems."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your statement or thought is—for example, "This is entirely [his or her] fault."
3. Let's conduct a cost–benefit analysis:
   a. Do you think that blaming others will motivate them to try harder?
   b. Does blaming them protect you in some way?
   c. Do you think that blaming others is realistic?
   d. What thoughts, feelings, and behaviors would change if you blamed others less?
4. Examine evidence for and against your blaming statement.

5. What is the quality of the evidence that supports your belief that others are at fault?
6. What cognitive distortions are you using to support your belief? Are you overgeneralizing, mind reading, personalizing, discounting positives, using negative filters, labeling, catastrophizing, or using "should" statements?
7. If you look at the person's behavior along a continuum, is it really as bad as it seems to you?
8. Even if this person did this negative thing, what are some rewarding behaviors that you can still experience?
9. How could you prove that your thought (i.e., "This is entirely [his or her] fault") is wrong? Is it testable?
10. Use the pie chart technique. Distribute the possible causes for this event, using a pie metaphor. To what degree are the causes of the event due to things about you, others, or the situation?
11. What variations do you see in this person's behavior? Does (he or she) always behave this way?
12. What were your intentions? Are you sure about your belief regarding this person's intentions? How could you know (his or her) intentions?
13. What information was (he or she) using? What information did you have?
14. Distinguish between criticizing others and requesting a change in their behavior. What behavior could this person improve? What could you learn? What could you and (he or she) do differently in the future?
15. Do you label people in all-or-nothing terms when they don't live up to your rigid rules? What is the consequence of this labeling?
16. Apply the double-standard exercise: Would everyone see it this way? Why not?
17. What if we made your belief a universal rule for everyone: That is, everyone should be blamed severely for this behavior. What would be the consequence?
18. Morality should advance human dignity. Does your "should" rule treat people in a humane and dignified way? Or is it aimed at condemning and criticizing people?
19. Does your "should" rule come from any religious, moral, or legal beliefs? Specify exactly where you learned this rule. Is this rule possibly a misperception of what was taught or written?
20. Apply another double-standard exercise: If you really loved someone or cared about him or her, would you still apply this "should" rule to this person? Why? Is there some reason why you would use this rule for some people but not for others?
21. What if you replaced your "should" rule with the statement that you might *prefer* something to be true? What if you were less extreme in your statement? For example, what if, rather than saying "They should be perfect," you were to say "I'd prefer that they do well"? Try restating all of your "should" rules in terms of less extreme preferences.
22. What are the costs and benefits of this new preference that is less extreme?
23. List a range of preferences, from 0% to 100%. What do most people think is sufficient or adequate in regard to the behavior we are discussing?
24. What if you accepted this behavior in a nonjudgmental way? What if you simply said, "It is what it is," without blaming or judging?
25. Imagine that you are feeling compassionate, loving, and caring. You now observe this behavior. Approach it with compassion and care.
26. What if you were to forgive the other person? What would be the consequence of this?

12. Unfair comparisons: You interpret events in terms of unrealistic standards. You focus primarily on others who do better than you and find yourself inferior in the comparison—for example, "She's more successful than I am" or "I'm a complete failure because others did better than I did on the test."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what standard you use for your own (or another person's) behavior.
3. Let's conduct a cost–benefit analysis:
   a. Do you think that viewing yourself in extreme terms will motivate you?
   b. Do you think that using extreme standards is realistic?
   c. Do you fear "compromising" your standards? What would that mean? What would happen if you did compromise?
   d. Are you "proud" of your high standards—even if you criticize yourself when you don't live up to them?
   e. What thoughts, feelings, and behaviors would change if you used less extreme standards?
4. Examine evidence for and against your use of extreme standards. Do these standards really motivate you? Do you avoid certain things because of these standards? Are they really realistic?
5. Is it possible to have adaptive high standards without being a perfectionist? Could these high standards be achievable, but not overly demanding? What if your standards were to do a little better rather than be perfect?
6. What would happen if you stopped comparing yourself with others? Would you be worse off or better off?
7. Rather than compare yourself with others, simply compare yourself with the last thing you did. Try to learn and improve.
8. What if you compared yourself with the zero point on the scale?
9. Rather than comparing yourself to anyone else, focus on doing something that is meaningful and pleasurable.
10. What is the quality of the evidence that things should be viewed in such extreme ways? Are these extreme standards common in our society?
11. What cognitive distortions are you using to support your belief? Are you discounting positives, using negative filters, labeling, or using perfectionistic "should" statements?
12. What if you looked at things along a continuum, from 0% to 100%? Fill in each 10-point increment with a behavior. How would you describe these behaviors that come between 0% and 100%?
13. Where does the average person place on this continuum? Are you using the full range of human behavior? For example, the average IQ is 100, and the average family income is $55,000. Is there some reason why you would not use the average as a baseline for your standards?
14. What are some behaviors that are worse, better, or the same as this behavior?
15. Specifically, what does it mean if someone does not "live up to the standard"? Exactly what will happen?
16. Are there some people who have not lived up to the standard at times? Exactly what has happened to them?
17. Does everyone have the same standard that you have?

18. Use indifference. What if you were indifferent?
19. Apply the double-standard technique: Would everyone see things this way? Would everyone use these standards? Why not?
20. Try positive tracking: Keep track of your positives (or the other person's positives) every day for a week. What does this record tell you?
21. Try to reward positives: Every time you (or someone else) does something positive, praise yourself (or the other person). Will this praise increase or decrease the positive behavior?

13. Regret orientation: You focus on the idea that you could have done better in the past—for example, "I could have had a better job if I had tried" or "I shouldn't have said that"—rather than paying attention to what you could do better now. You believe that you should have known something in the past that would have prevented a bad outcome, but you really were not in a position to know for sure—for example, "I should have known that the stock market was going to collapse" or "I should have known that [he or she] would not be trustworthy."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your regret is. For example, complete the following sentence: "I should have known that [*X*] was true."
3. Let's conduct a cost–benefit analysis:
   a. Do you think that regretting the past motivates you to be more careful in the future?
   b. Do you think that regretting things is realistic?
   c. What thoughts, behaviors, and feelings would change if you regretted things less?
4. Are you reluctant to make decisions because of your fear that you will regret things?
5. What if you were to look at regret or bad outcomes as inevitable in making decisions?
6. Think about decision making as risk versus risk—there is no risk-free alternative.
7. Do good decision makers ever have bad outcomes?
8. What opportunities would you miss out on if you tried to eliminate regrets?
9. Is it possible to regret what you did or did *not* do? Isn't it possible that regret is inevitable?
10. Examine evidence for and against your regrets.
11. What is the quality of the evidence in support of your regrets?
12. Why should you have known before [*X*] happened? Should you know everything? Should you be able to read people's minds? Foretell the future? Never make mistakes? What is the consequence of this way of thinking?
13. What evidence was available to you? What seemed to be the most important thing at the time?
14. Is it possible you made a good decision, given the information available at the time?
15. What cognitive distortions are you using to support your belief? Are you personalizing, discounting positives, mind reading, labeling?
16. How could you prove that your thought is wrong? Is it testable?
17. Apply vertical descent: What if your thought were true? Why would it bother you? Do you think this means that you can't make good decisions, that you should be overly cautious, never take risks, blame yourself if things don't work out, never trust anyone?
18. Do you conclude that since you didn't make the best decision, you're stupid, incompetent, or bad at making decisions?
19. Have you made other good decisions? What do you conclude from these decisions?

20. Apply the double-standard exercise: How would most people see this situation? Would they think you should regret it? Take all the blame?
21. Rather than criticize yourself, try self-correction. What could you learn from this experience? What could you do differently in the future?
22. Even though this decision did not work out, what are some positives that came from it? What are some positive things that you could do now or in the future?
23. Sometimes a regret can last a minute, sometimes it goes on for a long time. What if you were to acknowledge a regret for 1 minute—"I regret that I took that direction"—but then move on to productive behaviors?
24. Are you ruminating about your regret? What are the costs and benefits of dwelling on it? Set aside 20 minutes each day for "regret time." Is focusing on regret going to lead to any productive action? What action would that be?

14. What if?: You keep asking a series of questions about "what if" something happens, and you fail to be satisfied with any of the answers—for example, "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your prediction is.
3. Let's conduct a cost–benefit analysis:
   a. Do you think that worry protects and prepares you?
   b. Do you fear that you can't control your worries?
   c. Do you think that you need a solution for every possible problem?
   d. How would your thoughts, feelings, and behaviors change if you were not using "what if" thoughts as much?
4. What cognitive distortions are you using to support your "what if" thinking (fortune telling, mind reading, emotional reasoning, etc.)?
5. Are you trying to make things absolutely certain? Is it possible to have certainty in an uncertain world?
6. What uncertainty do you currently accept? Why? What if you demanded certainty about everything?
7. Are you equating uncertainty with a bad outcome? Is that logical?
8. Apply vertical descent: What if your thoughts were true? Why would that bother you? How likely are these imagined outcomes?
9. Do you think that things are dangerous unless you can make sure they are completely safe? What are the costs and benefits of this belief?
10. Do you think that coming up with ideas based on "what if something goes wrong" helps you solve problems that need to be solved?
11. Do you have to solve every problem that you can imagine?
12. Are you good at solving problems that actually exist? Give examples.
13. Focus on current problems and behaviors. Rather than trying to solve every possible problem in the future, focus right now on some short-term problems—that is, problems that need to be addressed today or this week. Do you feel more competent with this time-limited perspective?
14. Does reassurance really work for more than a few minutes? Do you find that no matter

how many times you get reassurance, it doesn't last? Is this because there is no complete certainty about the future?

15. Practice repeating the following sentence 20 minutes each day: "No matter what I do, it's always possible something bad could happen to me." Does the thought become more or less powerful?
16. How many times have you made incorrect negative predictions? Could making negative predictions be a bad habit?
17. What is your worst feared outcome, your feared fantasy?
    a. What is the worst, best, and most likely outcome?
    b. Write out a detailed description of your worst feared outcome.
    c. List all the things that would have to go wrong for this fear to happen. What is the probability of this sequence?
    d. List all the things that would prevent this fear from happening. What is the probability of this sequence?
    e. Practice repeating the image and story of the worst outcome for 20 minutes each day. How do you feel?
18. Describe in detail three positive outcomes and write stories about how these positive outcomes could occur.
19. Are you afraid of making positive predictions? Do you have a superstition that you should never "tempt fate" by making positive predictions? Test this belief by making five positive predictions for this week and repeat each one 50 times.
20. Stand back and practice mindfulness of your "what-if" thoughts. Observe them, notice them, do not struggle with them. Allow them to come and go.
21. Treat your "what-if" thought as a telemarketing call you do not take. Let it ring and don't answer it.
22. Rather than focus on your "what if" thought, focus on positive behavior.
23. Imagine your "what if" thought as a thought balloon that drifts away. Let go of the string and watch it rise and drift away from you.

15. Emotional reasoning: You let your feelings guide your interpretation of reality—for example, "I feel depressed; therefore, my marriage is not working out."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your emotional reasoning thought is—for example, "I feel anxious, so something bad is going to happen."
3. Distinguish between an emotion and a fact. Describe the facts—things that you can see or hear—rather than your emotional response to them.
4. Let's conduct a cost–benefit analysis:
    a. Does relying on your emotions make you feel like you are on a roller coaster?
    b. Do you think that your emotions protect you from, and prepare you for, the worst?
    c. How would your thoughts, feelings, and behavior change if you relied less on your emotions to make predictions or judgments? What would happen if you relied on facts and logic?
5. Examine evidence for and against your use of emotional reasoning. Does the evidence support your thought that your emotions have generally been a good or bad guide to reality?

6. Would you pick stocks based on your emotions? Why not?
7. What cognitive distortions are you using to support your belief? Are you discounting positives, personalizing, mind reading, fortune telling, catastrophizing, using negative filters?
8. How could you prove that your thought is wrong? Is it testable? How could you test the belief that your emotions predict reality?
9. Keep track of your mood during the week. When you're feeling down, make a prediction about something. When you're feeling really good, make a prediction about something. Is there a pattern?
10. Sometimes we think our emotions or thoughts determine reality. If we feel bad, things must be bad. This is thought–action fusion. But how could your emotions or thoughts determine reality?
11. Apply vertical descent: What if your thought were true? Why would it bother you?
12. Apply the double-standard exercise: What advice would you give a friend who relied primarily on his or her emotions to judge reality?
13. Try to recall some really wonderful, warm experience that you have had. Get yourself into a really positive mood. Now think about something in the future and see if your view of it is more positive.
14. Try mindful meditation. Observe your breath, inhaling and exhaling, letting it go. Similarly, let go of judging things, controlling things. Try accepting your breath and accepting what is in front of you.
15. See things as they are by describing them in nonjudgmental terms.
16. How would someone who is feeling really confident and happy see things?

16. Inability to disconfirm: You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as irrelevant any evidence that people like you—for example, "That's not the real issue; there are deeper problems and other factors." Consequently, your thought cannot be refuted.

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly what your thought is.
3. Let's conduct a cost–benefit analysis:
   a. What is the consequence of thinking in this vague and indefinable way?
   b. What is the consequence of thinking in terms that no one else can quite understand?
   c. Are you assuming that because your thinking is vague and difficult to pin down, you are a deep thinker? Is it possible you are just confused right now?
4. Examine evidence for and against your position: Is it possible to collect evidence that goes against your thought?
5. What is the quality of the evidence that supports your thought or goes against your thought? Would others be convinced?
6. What cognitive distortions are you using to support your belief? Are you relying on emotional reasoning, discounting positives, or negative filters?
7. How could you prove that your thought is wrong? Is it testable? If your thought can't be tested—if there is no way we could possibly prove that you are wrong—then isn't your thought really "meaningless"?
8. Imagine that a scientist who doesn't know you was collecting data. You say, "Test the validity

of this thought of mine." How would the scientist collect data on your thought? How is this different from the way you evaluate information?

9. Apply the double-standard exercise: If someone else thought this way, what advice would you give him or her?
10. If your thinking is so vague that it can't be tested, does this make you feel helpless about changing things?
11. What actions could you take that would "act against" your thought?
12. Imagine having to set up an experiment to test your thought. How would you go about collecting information? How would you describe this experiment to a stranger?

17. Judgment focus: You view yourself, others, and events in terms of evaluations as good–bad or superior–inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself—for example, "I didn't perform well in college" or "If I take up tennis, I won't do well" or "Look how successful she is; I'm not successful at all."

Techniques

1. Rate the degree of your belief and identify and rate your emotions.
2. Identify exactly the nature of your judgment—for example, "I should be perfect" or "I should get everyone's approval" or "They should do what I want them to do."
3. Let's conduct a cost–benefit analysis:
   a. Do you think that being strict and demanding will motivate you or others?
   b. Do you think you're being "moral" or "standing up for what's right"?
   c. Where did you get this rule?
4. Examine evidence for and against your judgments. Do other people make these judgments as severely and as often as you do?
5. What cognitive distortions are you using to support your belief? Are you using labeling, discounting positives, dichotomous thinking, or overgeneralizing?
6. Do you label yourself and others in all-or-nothing terms when you or they don't live up to your rigid rules? What is the consequence of this labeling?
7. Apply the double-standard technique: Would everyone see it this way? Why not?
8. What if we made this good–bad standard a universal rule for everyone? What that be humane and reasonable? Why or why not?
9. Morality should advance human dignity. Do your judgments treat people in a humane and dignified way? Or are they aimed at condemning and criticizing people?
10. Apply another double-standard exercise: If you really loved someone or cared about him or her, would you judge him or her this way? Why? Is there some reason why you would judge yourself in this way but not others?
11. What if you replaced your judgments with the statement that you might *prefer* something to be true? What if you were less extreme in your statement? For example, what if you were to say "I'd prefer doing well" rather than "I should be perfect"? Try restating all of your "should" rules in terms of less extreme preferences.
12. Consider replacing judgments with improvement. For example, "I could improve my performance" or "They could also improve." What could you say or do to encourage improvement?

13. Rather than judging the negative, what if you were to praise the positive? Encourage more of the positive?
14. Try mindfulness rather than judging. Focus only on describing what has happened, without using any judgmental words. Avoid using temporal words such as "always" and "never"—for example, "He's always like that" or "I never measure up." Focus simply on behavior that you can observe—for example, "He was driving fast"—and on how you felt—for example, "I felt nervous." Stay in the present moment.
15. If you stay in the present moment, how will this moment change? What will happen an hour from now, a day from now, a week from now?
16. Try seeing this situation from the vantage point of a balcony. Imagine that you're looking down from a balcony on what is happening, and you're asked to describe what you see to a stranger. Exactly what would you say is being said and done?
17. Consider replacing your judgment with acceptance. You might say, "I accept that this is the way someone behaved." If you accepted it rather than judged it, what would happen? What are the costs and benefits of accepting?
18. Rather than judging others and yourself, imagine directing compassion and care toward others and yourself. Imagine thinking and wanting good things, warmth, love and acceptance for others and yourself. What happens when you direct compassion, rather than judgments, toward others and yourself?

CHAPTER 13

Modifying Need for Approval

A key element in depression and anxiety is excessive need for approval. The individual who has an excessive need for approval is likely to have a full range of automatic thought distortions. These include mind reading ("He thinks I'm boring"), personalizing ("She yawned because I'm a dud"), catastrophizing ("It's awful when people don't like me"), fortune telling ("I'll get rejected"), overgeneralizing ("This just keeps happening to me"), labeling ("I'm a drag to be around"), and other thoughts. In addition, the individual may have conditional rules or assumptions, such as the following: "I should be interesting all the time," "I should get approval all the time," "If people don't like me, then there must be something defective about me," "You can't enjoy life unless everyone likes you," and "If someone doesn't like you, then you should avoid them." Further, these assumptions and thoughts are often related to underlying personal schemas, such as viewing the self as defective, incompetent, or unable to function independently. The clinician should also evaluate problematic coping strategies such as worry, rumination, avoidance, escape, deferring to others, and overuse of alcohol or drugs to lower situational anxiety.

Beck (1987) proposed that one personality dimension related to vulnerability for depression is sociotropy, which is characterized by excessive concern about threats to the stability or security of a relationship. This dimension is in contrast to autonomy, which is characterized by concerns over achievement or performance that are independent of interpersonal relationships. Both styles, in the extreme, are vulnerabilities, with sociotropy activated by loss or threat to a relationship, whereas autonomous issues are activated by threats or loss in achievement or individual functioning (Clark, Beck, & Brown, 1992; Hammen, Ellicott, Gitlin, & Jamison, 1989). The clinician should evaluate the degree to which general sociotropic tendencies may underlie the patient's set of problems. For example, patients with a sociotropic style may be more likely to score higher on measures of dependent and avoidant personality and may often show borderline features, wherein threats to a relationship may trigger problematic dysregulation. Sociotropic issues often underpin social anxiety disorder and may account for excessive threat detection efforts, withdrawal, deference, and general social avoidance. Thus, need for approval may be considered only one part of a more complex case conceptualization.

In the following example, I review portions of discussions in therapy with a patient who felt self-conscious and marginalized at work. As indicated in the dialogues, his current concerns about

approval and marginalization can be traced to early childhood schemas of being boring, defective, or different from his peers, and his problematic coping efforts in the present context are examined.

Initial Session

THERAPIST: You say that if somebody disagrees with something that you do, then you will be marginalized.

PATIENT: Yeah, I'm afraid that people will turn on me.

THERAPIST: What is the evidence that people will turn on you? [EXAMINING EVIDENCE]

PATIENT: I don't know—when I was a kid, some of the other kids didn't like me.

THERAPIST: So what did they do?

PATIENT: It's not like they really did anything; it's just that I never felt like I was part of the group.

THERAPIST: So it sounds like this is an old issue for you: that people might not like you and they might exclude you.

PATIENT: Yeah. I've always felt like I was odd man out.

THERAPIST: So at work when you think that you are the odd man out, how do you respond? Are you friendly? [EXAMINING COPING STRATEGY]

PATIENT: You know, I'm not really that outgoing. I guess I'm a little shy. So, when I get to the office, sometimes I feel anxious and I don't act that friendly.

THERAPIST: How do you think people interpret that behavior? Do they think you're shy or could they think something else? [ALTERNATIVE INTERPRETATION]

PATIENT: Maybe they think I'm unfriendly.

THERAPIST: So your way of coping with your anxiety is that you are withdrawn and a bit cautious around people, and they may interpret that as your unfriendliness on your part. Is it possible that some of them might even think that you don't like them?

PATIENT: Yeah, I guess that's true—maybe they think I'm unfriendly.

THERAPIST: So there's this old issue from your childhood about feeling like you don't belong, like a view of yourself as an outsider who is marginalized by the group. [IDENTIFYING SCHEMA] Is there any reason you can think of why some of the kids might not have been as friendly when you were a kid? [ALTERNATIVE INTERPRETATION]

PATIENT: I don't know—you know, maybe they thought, because I was smarter and I wasn't really interested in some of the stupid things they did. that I was judgmental of them.

THERAPIST: So maybe you felt like you didn't belong with those kids because you have different interests, and in fact maybe you even didn't want to be part of their group.

PATIENT: You know, you might have a point there, but in some ways I *did* want to be accepted.

THERAPIST: So do you think this idea that you're an outsider goes back to childhood and that you do a lot of mind reading that people don't like you and as a result of that, you avoid people and you're not outgoing? [RELATING SCHEMA TO AUTOMATIC THOUGHTS]

PATIENT: Yeah, that could be true.

THERAPIST: So let's set up an experiment where you act friendly toward people in the office on a

daily basis. Like you say, "Hello, how are you? How was your weekend?" and so forth. How do you think people will respond? [TESTING OUT THE THOUGHT, COLLECTING EVIDENCE, MAKING PREDICTIONS]

PATIENT: I don't know—good question. Maybe they'll be unfriendly, maybe they will be friendly, I just don't know.

THERAPIST: So we can test out your idea that people don't like you by setting up an experiment.

Later Session

THERAPIST: So, we found out that some people do seem to respond positively to you when you are friendly toward them. Is it possible that some of the "unfriendly" behavior you've experienced from your colleagues is part of a self-fulfilling prophecy in which you don't act that friendly toward them, and they in turn don't act friendly toward you? [COLLECTING EVIDENCE, EVALUATING THE EXPERIMENT, EVALUATING SELF-FULFILLING PROPHECY]

PATIENT: Yeah, that's definitely a possibility.

THERAPIST: OK, so let's try something different this week. You've been very concerned about people not liking you. And you've told me at other times that you act in a very formal manner, and many times you don't make eye contact. [IDENTIFYING COPING STYLE] We've been talking about acting in a friendlier and more casual manner in the office, and that seems to be leading to people's friendlier manner toward you. But let's try something different. Let's try actually intentionally doing something that some people might not like. I don't mean being obnoxious, but simply making requests with which people are not likely to comply with. [ACTING AGAINST THE THOUGHT, OPPOSITE ACTION]

PATIENT: What do you mean?

THERAPIST: I mean, let's imagine you go to the store and ask the person behind the counter to show you different shirts. And then when he tells you what the prices are, you tell him, "I'd like a 30% discount." Now you know he won't give you a 30% discount. But you keep asking for it even when he says "no" several times. In other words, you do something that probably the other person will not approve of. So the goal is to actually provoke disapproval. [TESTING PREDICTIONS, EXPOSURE, PRACTICING THE FEAR]

PATIENT: That sounds a bit funny.

THERAPIST: What do you think would happen if the clerk actually disapproved of you?

PATIENT: I don't know. I guess my old self—I would think it was the end of the world. I might think I'm a bad person or obnoxious. [IDENTIFYING PREDICTIONS]

THERAPIST: Well, I can see why those thoughts would keep you from asserting yourself. But let's think it through: What if the clerk really doesn't like you. What would you still be able to do in your life even if this clerk does not like you? [EXAMINING WHAT YOU CAN STILL DO, DECATASTROPHIZING]

PATIENT: I guess I could probably do everything I ever did before.

THERAPIST: So this would be an experiment where you intentionally try to get disapproval. And then you can see after that if things in your life change for the better, worse, or simply don't change at all. [SETTING UP THE EXPERIMENT, TESTING PREDICTIONS]

PATIENT: I've never thought of it that way.

THERAPIST: Most people don't try to get rejected. But here the goal is to find out that rejection may actually lead to nothing that changes in your life.

Later Session

THERAPIST: What happened when you kept asking for discounts on shirts?

PATIENT: The clerk said that the price is the price.

THERAPIST: And did you keep asking for the lower price?

PATIENT: Yes, I did and he kept refusing. And then he seemed kind of irritated with me. And at first I was a little anxious and felt embarrassed, but then I realized that this is an experiment to find out what it's like to get rejected. [TESTING PREDICTIONS]

THERAPIST: Let's imagine that this clerk really does not like you, and in fact he's thinking about what a jerk you are right now. What can you still do even if he doesn't like you? [EXAMINING WHAT I CAN STILL DO]

PATIENT: I don't know. I guess I can still go to work, and see my friends, and do everything I've ever done before.

THERAPIST: So if you can do everything you've ever done before, then it is a very trivial thing if someone doesn't like you. [PUTTING THINGS IN PERSPECTIVE]

PATIENT: I guess if I look at it that way, you're correct.

THERAPIST: How do you think you'll feel about this in a month, knowing that this person may not like you? [FUTURE TIME PERSPECTIVE]

PATIENT: I guess I won't even think about it.

THERAPIST: One technique that you can use is the "so what" technique? For example, you can say to yourself "'So what' if the clerk doesn't like me." Have you found that you sometimes think about that? You sometimes say, "So what—who cares?" [SO WHAT—MAKE IT UNIMPORTANT, WHY IT'S NOT A PROBLEM]

PATIENT: I probably don't say "so what" enough.

Later Session

THERAPIST: So we've been talking about how you interact with people at work. You collected some rejections from the clerk in the store, and you found out that it was not the end of the world that you got rejected or that somebody in that store might not like you. Now let's think about another possibility. Let's imagine your worst fear that you have been marginalized. I'll start a sentence, and you finish it. "I've been marginalized at work, and people don't like me and now I'm afraid that . . ."—what is going to happen"? [VERTICAL DESCENT]

PATIENT: I don't know—I'll get fired. I guess I see myself unemployed, sitting at home alone.

THERAPIST: "And when I think about sitting at home alone, I worry that . . ."—what is going to happen?

PATIENT: I don't know . . . I'll never get another job.

THERAPIST: "If I never get a job, what I worry about is . . ."—what? [VERTICAL DESCENT, FEARED FANTASY]

PATIENT: I guess I'll go bankrupt and end up homeless.

THERAPIST: OK, that's a very strong image. Can you get a very clear visual image of yourself homeless?

PATIENT: Yeah, I see myself sitting on the sidewalk with a little cardboard sign.

THERAPIST: OK, so let's hold that image in mind for a while—you're sitting on the sidewalk, homeless with a cardboard sign. [VISUAL IMAGE OF FEARED FANTASY, EXPOSURE TO IMAGE]

PATIENT: (*smiling*) It's hard to imagine that would ever come true.

THERAPIST: Why is that?

PATIENT: Because I have good skills, and I know I would get a job.

THERAPIST: OK. So let's call this your "feared fantasy": that you are sitting on the sidewalk homeless, in ragged clothing, holding a cardboard sign. This is your fear if people don't like you.

PATIENT: Yeah. I know it's totally absurd—almost funny.

THERAPIST: OK, it's absurd, but it's also a fantasy that on some level, you have some fears about. So like any fear, we can do exposure. That's where you face your feared image over and over and over again until it becomes so boring that it's hard to pay attention to it. So here's my idea, if you're willing to try it. I'd like you to find some pictures of homeless people sitting on sidewalks. Google "homeless people images." I'd like you to put them on your screen saver on your computer and look at them every day. And when you look at them, I want you to say, "Well, I guess if somebody doesn't approve of something I say or do, I'll end up like this homeless person." [FLOODING OF FEARED FANTASY]

PATIENT: That seems very funny in a way. Are you sure you're not joking with me?

THERAPIST: A little bit of a joke. But actually a serious joke—what I want you to do is to take your feared fantasy and see it as a joke.

CHAPTER 14

Challenging Self-Criticism

Self-critical thinking, guilt, and shame are key components of major depressive disorder, and are also found in the full range of anxiety disorders and in trauma. The individual prone to self-criticism is more likely to be focused on regret, which contributes to indecisiveness and risk aversion. Self-critical thinking is also a significant content of rumination, wherein individuals may dwell on mistakes that they believe that they have made. In the dialogues below, taken from a number of sessions, we can see how the therapist can utilize a wide range of cognitive therapy techniques to address self-critical thinking.

First Session after Intake

The patient is a 35-year-old male who recently lost his job working in a marketing firm. He has been criticizing himself, ruminating and isolating himself from his friends in recent weeks. In the dialogues here, the therapist utilizes a number of cognitive therapy techniques to address his self-criticism, shame, and regret orientation.

PATIENT: I'm really worried that I won't be able to get a good job, and I'm just sitting around a lot thinking about what a loser I really am.

THERAPIST: So it sounds like this is a very difficult situation, as it would be for anybody. When you're sitting in your apartment and you're feeling down, what kind of thoughts go through your mind? [ELICITING THOUGHTS]

PATIENT: I just think I'm a real failure.

THERAPIST: That's a very difficult thought to be dwelling on, especially when you're all alone. Tell me what you mean by "failure." [SEMANTIC TECHNIQUE]

PATIENT: I don't know—somebody who just can't get his act together. I feel I'm just a loser.

THERAPIST: What would be some signs that a person is a failure?

PATIENT: I guess I would say, somebody who can't get anything done.

THERAPIST: OK, so a failure is someone who gets nothing done, right?

PATIENT: Yeah, that's right.

THERAPIST: And would you say that someone who is *not* a failure gets things done?

PATIENT: I guess so, OK—right.

THERAPIST: OK, so let's take a look at that—"someone who doesn't get anything done." How much do you believe, from 0% to 100%, that you are a failure? [RATING DEGREE OF BELIEF IN THOUGHT]

PATIENT: As I'm sitting here right now, I'd say 90%.

THERAPIST: When you think you're a failure at 90%, what kind of emotions or feelings do you have? [LINKING THOUGHTS TO EMOTIONS]

PATIENT: I feel sad, hopeless, and anxious, I guess.

THERAPIST: And from 0% to 100%, how sad, hopeless, and anxious do you get?

PATIENT: Sad, at about 95%, hopeless 90%, and anxious 80%.

THERAPIST: Let's look at the evidence that you think you can't get something done or anything done. What is the evidence that you are considering? [EXAMINING EVIDENCE]

PATIENT: I guess that I think I'm a loser because I just lost my job.

THERAPIST: Is there any other evidence that you can't get anything done?

PATIENT: I don't know, I can't think of anything else.

THERAPIST: Do you think that when you have a negative thought like this one—"I'm a failure"—that you look for evidence that you're a failure, and then, when you find that evidence, you stop looking and don't look for evidence against your thought? [CONFIRMATION BIAS, LIMITED SEARCH]

PATIENT: I guess that's true. I can be pretty negative.

THERAPIST: Perhaps the consequence of limiting your search for information only to negatives is that your negative beliefs get stronger and stronger. We call this "confirmation bias" because your thinking is automatically focused on negatives. OK, so let's look at some evidence that you *do* get some things done. Can you think of anything? [EXAMINING EVIDENCE]

PATIENT: Well, actually I did a pretty good job at work, and I did get some good feedback in the last 2 years. And I guess I did graduate from college, and I do have a number of good friends.

THERAPIST: So when we look at the evidence that you can get some things done, there are a number of factors: You did a pretty good job at work that got good feedback, you graduated from college, and you have a number of good friends. But the evidence that you're a loser or can't get anything done is that you lost your job. [WEIGHING EVIDENCE]

PATIENT: Yeah, but a lot of people have friends who graduated from college.

THERAPIST: It sounds like what you do when you look at the evidence is that you discount the facts that you get good feedback, and you graduated from college, and you have good friends. What do you think the consequences are of discounting these positives? [IDENTIFYING COGNITIVE DISTORTION, DISCOUNTING POSITIVES]

PATIENT: I guess it makes me feel bad about myself.

THERAPIST: And also what you're doing is labeling yourself. Let's take your idea that you're a failure because you lost your job. Would you consider everybody who's ever lost a job to be a failure? [DOUBLE STANDARD]

PATIENT: No, not at all. My sister lost her job a few years ago, and she certainly is not a failure. They had downsized her company, and they let a lot of people go.

THERAPIST: You seem to be very judgmental about yourself but very understanding about your sister. Do you think you may have a double standard here?

PATIENT: Yeah I, guess I do. I'm much tougher on myself than I would be on anybody else.

THERAPIST: If you had to weigh the evidence for and against the idea that you're a loser, would it be 50/50, 60/40, 40/60, or what? [WEIGHING EVIDENCE]

PATIENT: I'd say the evidence is 90% I'm not a loser and 10% I *am* a loser.

THERAPIST: Let's look at this tendency that you have to hold these demanding standards for yourself. [IDENTIFYING ASSUMPTION] What are the costs and benefits of this very demanding standard? Let's look at the costs to you of being so demanding of yourself. What are the costs to you? [EXAMINING COSTS AND BENEFITS]

PATIENT: I guess that makes me very self-critical, depressed, and anxious.

THERAPIST: Are there any benefits that you get from having these very demanding standards?

PATIENT: Well, maybe the high standards will motivate me to try hard.

THERAPIST: Let's look at the evidence that you need to have very demanding standards to be motivated. What is the evidence that favors that viewpoint? [EXAMINING EVIDENCE FOR ASSUMPTION]

PATIENT: Sometimes I work really hard, but sometimes, you know, I get so perfectionistic that I have a hard time doing things and I procrastinate. [EXAMINING COSTS AND BENEFITS OF ASSUMPTION]

THERAPIST: So it may be that having good standards or high standards might help, but sometimes it may seem impossible and then you put things off and just avoid things and procrastinate. I'm wondering what would happen if you had healthy high standards—but, say, rather than aiming for 100% you aimed for 85%? [EXAMINING COSTS AND BENEFITS OF ADAPTIVE ASSUMPTION]

PATIENT: You know, thinking about that makes me a little anxious but also a little bit more hopeful.

THERAPIST: Why would it make you more anxious to have 85%?

PATIENT: Because I'm afraid that if I give up on my high standards, I'll become really mediocre.

THERAPIST: That's interesting. You're afraid of giving up your perfectionism because you think that you would become mediocre? It seems that you might look at things in an all-or-nothing way. That is, you think "Either I put in 100% or I don't put in anything at all." [IDENTIFYING COGNITIVE DISTORTION OF ASSUMPTION]

PATIENT: I guess that's a problem for me—and why I get self-critical at times.

THERAPIST: Let's look at what we've been talking about. You think that you're a loser because you lost your job and you define being a failure as someone who can't get anything done. But then when we look at who you are, you've done well on the job at times, you've gotten good feedback, graduated from college, and you have lots of friends. And it seems that you have a double standard whereby you're not judgmental about other people, including your sister, but you are very judgmental about yourself. And, in addition, you have these very perfectionistic standards that if you don't do 100% on something, then you think of it as a failure. And you also discount your positives, so you don't give yourself much credit for what you do. Now, if you changed some of these thoughts, what do you think would happen with your self-criticism?

PATIENT: I guess I would feel a lot better about myself

Next Session

THERAPIST: We discussed how you criticize yourself and think that you're a failure because you lost your job. Now there can be a number of reasons why something doesn't work out. What was going on at work that might've led you to lose your job? [ALTERNATIVE EXPLANATION, REATTRIBUTION]

PATIENT: Well, there were a lot of things going on. They brought in the new boss, and she began to rearrange the staff. And I guess she wanted to bring in somebody that she had worked with before. And I guess there just wasn't room for me and for her plans.

THERAPIST: So one reason you may have lost the job is that you had new management.

PATIENT: Yeah.

THERAPIST: Let's imagine that we had a pie chart, and we divided up the different reasons why you might've lost the job. And let's say the pie chart represents 100%. What percent of the reason for your losing your job was due to new management? [PIE CHART, PUTTING THINGS IN PERSPECTIVE]

PATIENT: I guess I'd have to say 75%.

THERAPIST: What could be some other reasons why you lost your job?

PATIENT: I guess I was late sometimes in getting some things done because I procrastinate.

THERAPIST: Well, that's interesting. Procrastination seems to be something that might be related to your perfectionism, as we discussed earlier. Do you think that that procrastination is something that could change if we worked on it? [EXAMINING CONSEQUENCES OF RULES AND ASSUMPTIONS]

PATIENT: I guess it probably could.

THERAPIST: If you look at the reason you lost your job and ask yourself, "To what extent did I lose my job because of lack of ability?," how would you answer?

PATIENT: I guess I'd have to say only about 10% is lack of ability and 15% is just bad luck—things changing at work.

THERAPIST: So the large percentage of the reason—that is, 75%—is due to new management and bringing in new people, and only 10% is due to your lack of ability and part of it is due to procrastination. And you think the procrastination can change if you were to work on it? [REATTRIBUTION, EXAMINING FIXED VS. GROWTH VIEW OF PERFORMANCE AND ABILITY]

PATIENT: Yeah, I guess that's true. But how stupid of me to procrastinate on things. It's a tough job market. I should have known better.

THERAPIST: So if we look at things that could change in the future, we could say that your procrastination could change, your effort could change, and it might be that you won't have a job when the management keeps changing. If we thought about it, there are some things that might be more stable or fixed, like your ability, which was only 10% of the cause of losing your job, and the other 90% are things that could change in the future.

PATIENT: So I see what you're saying that some of these things could change. But I was dumb to procrastinate, still.

THERAPIST: You know, we all do things that we could regret. I see that you are beginning to criticize yourself. Let's imagine that you had a tennis coach and you hit the ball into the net. Now this coach comes over to you and takes your racket and hits you over the head ten times. Would that help improve your tennis game? [EXAMINING COSTS OF SELF-CRITICISM VS. SELF-CORRECTION]

PATIENT: No, it might hurt my head.

THERAPIST: So slamming yourself over the head doesn't help. What if the coach showed you the proper swing? And then you hit it over the net?

PATIENT: That would be better.

THERAPIST: So, there is a difference between self-criticism and self-correction. Self-correction helps you improve, so we can look at how to change the procrastination, how to get things done on time. That would be more productive than self-criticism and getting stuck on regret, wouldn't it?

PATIENT: I know, I just go on and on with my self-criticism. Good point.

THERAPIST: When we think about criticizing ourselves, we have to think about those things that could change and those things that don't change, and in your case, almost all of this is something that could change for the better. And in fact we might even say that maybe you had bad luck in having the new management person come in and wanting to bring in her own people.

PATIENT: I think that's right. I think that's correct.

THERAPIST: And, as you know, luck can change. And your procrastination can change in the future. Let's try a role play: I'll be your very negative thoughts and you try to challenge me. [ROLE PLAYING AGAINST NEGATIVE THOUGHTS] [as critic] You can't do anything right.

PATIENT: (*defending himself*) That's not true! I went to college, I got good feedback on the job, I did a lot of things right, and I have a lot of friends. I do a lot of things right.

THERAPIST: [as critic] None of those things count. The only thing that counts is that you lost your job—which makes you a total loser!

PATIENT: That's not true. Millions of people lose their jobs, including Steve Jobs, who lost his job at Apple.

THERAPIST: [as critic] Yeah, but the reason that you lost your job was that you couldn't do anything right.

PATIENT: No, that's not true. The reason I lost my job is that they brought in new management. And part of it was that I procrastinated, but that's something that I might be able to change—at least, according to my therapist.

Next Session

THERAPIST: You know, you've been saying that you think you're a failure, and I want to explore with you what it would mean if you were a failure. So let's take some sentences and you tell me what comes to mind. "If I fail and I'm a failure, then I worry that. . . ." Now you complete that thought—what would happen? [VERTICAL DESCENT]

PATIENT: I worry that people would reject me and not want to be around me.

THERAPIST: "And if I'm a failure and people don't want to be around me, that bothers me because. . . ." What do you think would happen?

PATIENT: Then I'd be all alone.

THERAPIST: "And if I'm all alone, then. . . ." What would happen?

PATIENT: I'd get depressed.

THERAPIST: "And if I get depressed, I'm worried that. . . ." What would happen?

PATIENT: My life won't be worth living, and I may as well kill myself.

THERAPIST: So your thought is that if you're a failure, people won't want to be around you and then eventually life would not be worth living. [IDENTIFYING ASSUMPTIONS] Let's do a role play. I'm going to be you, acknowledging that I'm a failure, and I want you to try to make me feel bad about it. I want you to really go after me with the most negative thoughts possible. [ROLE PLAYING AGAINST THOUGHT]

PATIENT: OK, so you want me to try to make you feel bad?

THERAPIST: Yes, that's right. Try to make me feel bad about being a failure. OK? [as failure] I just realized that I'm a failure, but I don't really feel that bad about it.

PATIENT: [as critic] Well, if you're a failure, no one will want to be around you.

THERAPIST: [as failure] I don't think that's true because a lot of my friends have failed at something, and according to you, they are failures. And we like hanging around with each other just fine. We have a lot in common. [TRANSCENDING THE NEGATIVE LABEL BY ACCEPTANCE]

PATIENT: [as critic] Well, they're just a bunch of losers.

THERAPIST: [as failure] There are a lot of us in the world who have failed at something, and we losers really outnumber the perfect people that you think we should be concerned about.

PATIENT: [as critic] Well, you can't be happy being around people who are losers, can you?

THERAPIST: [as failure] Oh, yes, I can be very happy being around ordinary people and really nice people and kind people and fun people who all have failed at something. And guess what? All of us will fail at more things in the future because we're kind and fun-loving and, you know what, we're going to be supportive to each other.

Later Session

THERAPIST: So when you are feeling pretty bad about yourself, it sounds like you're sitting in your apartment and isolating yourself from your friends. Why is that? [LINKING FEELINGS AND THOUGHTS WITH PROBLEMATIC COPING]

PATIENT: I guess I feel a bit embarrassed about being unemployed.

THERAPIST: Have any of your friends been unemployed or any of your family members?

PATIENT: Yeah, a number of my friends and my family members have been unemployed at different times. My friend Bethany is unemployed.

THERAPIST: So it sounds like you feel ashamed about being unemployed. When you feel ashamed about being unemployed and you think about seeing your friends, what do you think they would be thinking about you—what do you think goes through their minds? [EXAMINING MIND READING]

PATIENT: I guess I think that they'll think I'm a loser and not want to be around me.

THERAPIST: So you're doing some mind reading. What is that based on? [EXAMINING EVIDENCE]

PATIENT: I guess I'm just thinking as though they think as badly about me as I do about myself.

THERAPIST: So you are mind reading. Sounds like you think your friends are as critical of you as you are of yourself? But I wonder how do you think your friends would really think of you? [EXAMINING EVIDENCE]

PATIENT: I actually would think they would be supportive.

THERAPIST: So, let's carry out an experiment. Over the next week, why don't you talk to four friends and tell them about the fact that you lost your job and see what happens? How do you think they will respond? [CANVASSING FRIENDS, COLLECTING EVIDENCE]

PATIENT: I guess they probably would be supportive.

THERAPIST: And what would be the advantage of getting that support and being able to see your friends?

PATIENT: I guess I wouldn't feel all alone.

THERAPIST: And one thing that can happen when you talk to other people is you find that what you're going through in losing a job is pretty normal, and you begin to normalize what you're going through, and you feel more like you're part of the human race and you're not alone. [UNIVERSALIZING PROBLEMS]

PATIENT: That would be very helpful to me—to feel like I'm not weird.

Later in Session

THERAPIST: Now we talked about how you're self-critical and you're pretty harsh with yourself. An alternative to this is to find some compassion for yourself. If you were to think of a very good friend who you cared for very deeply and who was going through a rough time, what kind of compassionate things would you say to him or her during that time? [COMPASSIONATE MIND]

PATIENT: I would tell my friend that I care about him, and I love him, and I'm always there for him.

THERAPIST: Well, let's imagine that you direct that compassion toward yourself. Close your eyes and put your arms across your chest like you're holding yourself very deeply and dearly. And now say out loud to yourself those loving words of kindness that you just said. [ROLE PLAYING SELF-COMPASSION]

PATIENT: I care about you, you are a good person, you have done good things, I'm always here for you, and I'm always on your side.

THERAPIST: And now with your eyes closed, keeping in mind this loving-kindness, try to imagine a person in your life—maybe when you were a child—who was the kindest, the most loving. Who would that be? [COMPASSIONATE IMAGERY]

PATIENT: I would say it was my grandmother.

THERAPIST: Imagine that she is saying those things to you. Close your eyes and imagine what your grandmother would say to you at this time. Can you say out loud what she would say? [ROLE PLAYING COMPASSION]

PATIENT: [ROLE PLAYING HIS GRANDMOTHER] You know how much I love you, and how much I care about you, and you will always be in my heart.

Next Session

THERAPIST: Let's look at what you do when you're dwelling on these negative thoughts about yourself. What do you think you end up doing after you start thinking so negatively? What do you do next? [LINKING BEHAVIOR TO NEGATIVE EMOTIONS]

PATIENT: I guess I stay in my apartment and I don't see my friends. And then I just keep thinking about how bad things are.

THERAPIST: So when you criticize yourself, you dwell on these negative thoughts and you tend to be alone and then you intentionally isolate yourself. [IDENTIFYING RUMINATION] And so you don't see your friends. And as a result, you don't have any fun with the people who care about you. And then you isolate yourself and criticize yourself more. [EXAMINING COSTS OF RUMINATION AND ISOLATION]

PATIENT: Yeah, that does describe what I do. I guess I start thinking I'll just be a burden on my friends, and I also think that they're going to think I'm a loser because I lost my job. I think I sound like a downer, and I don't want them to feel worse about me. So I just don't see them.

THERAPIST: It sounds like you're more likely to have the self-critical thoughts when you're alone. And you tend to repeat them over and over. We call this "rumination," which is focusing on the negative thought over and over. We can come back to that later. Let's look at your thought that you are a burden to your friends. When you saw your friends in the last few weeks, what did you tend to do? [SELF-FULFILLING PROPHECY]

PATIENT: To be honest with you, I think I complained a lot about losing my job. And then I went on and on, ruminating, as you say, and I guess I did sound like a drag.

THERAPIST: So you do tend to ruminate out loud with your friends. I wonder if this might be a downer for you as well as for your friends. On the other hand, it certainly does make sense to get some support. When your friends give you support, how do you respond?

PATIENT: Well, I realize in talking to you that I complain even more, and sometimes I get irritable with my friends when they give me advice—like the other day, when my friend Roger suggested I contact some colleagues in my business—I got angry with him and said, "You don't realize how hard it is," and I think he was a bit surprised by my irritability.

THERAPIST: I guess there's something to be learned here, which is that if people give you advice, don't get irritated or angry with them because you drive them away. You know, one thing to keep in mind when you're talking to friends for support is to be supportive toward the people who support you. For example, you might say, "Roger, thanks for being understanding and offering your support." That way your friends know that you hear them and value their support. [REINFORCING SUPPORT]

PATIENT: Yeah, I can sound pretty negative at times.

THERAPIST: Well, you're going through a hard time. But you might also try to mention some positives that you are doing, so that people can hear that you are being supportive of yourself.

PATIENT: I *am* doing some positives, that's true. I did do some searching and I did contact some leads. Who knows, maybe I will get a job.

THERAPIST: Now, you said that you thought your friends would look down on you. Do you think any of your friends would look down on you? Which of your friends do you think really looks down on you because you don't have a job? [EXAMINING EVIDENCE]

PATIENT: Well, probably none of them. Although Valerie is a pretty judgmental person; she's intolerant of other people, so I wouldn't be surprised if she looked down on me for being out of work.

THERAPIST: Would you really consider avoiding your good friends because you might have one friend who's intolerant? Do you want to give Valerie all that power?

PATIENT: You know, you're right. I never really liked Valerie anyway.

THERAPIST: Well, let's do a role play. I'll be Valerie being really judgmental, and you challenge what she says. [ROLE PLAYING AGAINST CRITIC] [playing the role of Valerie] Well, I think you're kind of a loser because you've lost your job.

PATIENT: That's absurd. Millions of people are out of work at any given time. I'm not a loser because I've lost a job—I've only lost a job.

THERAPIST: [as Valerie] Only people who have no abilities lose jobs.

PATIENT: That's absurd. People with lots of abilities lose jobs. New management comes in, companies downsize, people have disagreements with management, and there are lots of reasons. And I have a lot of abilities and I've done a good job before.

THERAPIST: [as Valerie] Well, I look down on you and you should be concerned about that—because my opinion is the most important opinion in the world.

PATIENT: Your opinion is only important to *you*. I don't need you to like me in order to like myself. I always thought of you as an intolerant and judgmental person. And I'm sorry for you that you are that way, because it must make you obnoxious with other people—and probably a lot of people don't like you. What a shame, Valerie.

THERAPIST: Now, step outside the role play. How do you think you're doing, challenging these obnoxious statements from the imaginary Valerie?

PATIENT: You know, when I think about it, it's kind of absurd. I actually don't think that Valerie would be as obnoxious as you're portraying her. But if she were, it probably is absurd for me to think about trying to get her approval.

THERAPIST: That's kind of ironic in a way because you might think of avoiding your good friends simply to avoid Valerie. And when you think it through, if Valerie were that judgmental, you would think she's kind of a jerk. So you would be making yourself more vulnerable to self-criticism and isolation in order to please a judgmental jerk.

PATIENT: You know, you have a good point there. I really shouldn't care much about what a jerk thinks.

Next Session

THERAPIST: I wonder where you got this idea that you can never fail at anything. Was there anybody in your family who had these very demanding standards for you and who was critical of you? [IDENTIFYING ASSUMPTIONS AND SCHEMA, EXAMINING ORIGIN OF SCHEMA]

PATIENT: Definitely, my father. He really wasn't a bad person; I think he might've been depressed, but he was very critical of me at times. And, you know, when I would do well at something, he would say, "That's what I expect of you." So I never really felt like I was ever good enough in his eyes.

THERAPIST: So we can see where your demanding standards come from—that is, it seems to come from this very critical voice that your father had toward you. And as a result, you internalized that critical voice, "I'm never good enough." And you learned to discount your positives because that's what your father would do—"Never good enough."

PATIENT: Yeah, I got to think that no matter what I did, I was never good enough. I could never be satisfied with what I did because my father was never satisfied.

THERAPIST: So what do you know about your father's parents? What were they like toward him? [EXAMINING ORIGIN OF SCHEMAS]

PATIENT: His father really struggled and was a heavy drinker, I think. And so his father was a pretty critical and negative person, and his parents used to argue a lot. His mother used to criticize his father because she felt he wasn't as successful as he should be or that she wanted him to be. She came from a more well-to-do family, and she kind of looked down on him. I think that her attitude made him feel pretty bad about himself at times. Probably why he drank a lot, too. I don't know which comes first.

THERAPIST: So your dad came from a family in which he was criticized. And then he married somebody who also criticized him for not being successful enough. It seems pretty clear that you ended up getting the kind of criticism that your dad himself received, not only from his dad but from your mom as well. It's like there's criticism across the generations between mom and dad and then down to you.

PATIENT: You're right. I can see that pretty clearly now: one criticism after another.

THERAPIST: But you have a choice now, don't you? You can choose to buy into that critical voice or you can choose to reject it. [STANDING BACK FROM SCHEMA, IDENTIFYING ADAPTIVE COPING]

PATIENT: It's hard to reject something you've been experiencing all your life.

THERAPIST: That's true—that won't happen overnight. But you can start now. You can say to yourself, "I don't have to criticize myself. I can accept myself, and I can see that my father had a very difficult time with his father, and he bought into that self-critical voice himself. But it's up to me now to let it go and to have more love and kindness toward myself." [EXAMINING ADAPTIVE ASSUMPTION AND SCHEMA] You might say to yourself, "And I can see that it didn't work for my father, and it won't work for me. I can decide to show more kindness and love and acceptance toward myself. I can be better to myself than my parents were to me or my grandfather was to my father."

PATIENT: That would be great if I can do that.

THERAPIST: Let's do a role play wherein you imagine talking to your father, who is in this empty chair here. And in this role play, you tell him that you won't stand for his negativity toward you, that you've rejected his negativity. [ROLE PLAYING AGAINST ORIGIN OF SCHEMA]

PATIENT: [ROLE PLAYING TALKING TO HIS FATHER] You know, you never seemed to think I did well enough. You were never that supportive of me. And it really pisses me off because now for so many years, I've been so self-critical and never feeling good enough. And I know that your father was a very difficult man—a very difficult man—and that he was very critical of you, and I know that mom was very critical of you, but this has to stop somewhere. I always tried to do what I could to please you, but you seemed to say, "That's what I expect of you"—as opposed to saying that you really are proud of me and love me and care about me.

THERAPIST: That sounds really good, really strong. And you might add that you can take care of yourself, praise yourself, give yourself credit, and accept yourself as someone who doesn't have to be perfect to be good enough. Good enough is good enough.

CHAPTER 15

Managing Anger

Anger and hostility are frequent issues in CBT and may, at times, pose a significant crisis. Every clinician should be skilled in dealing effectively with anger management issues, since anger problems often lead to depression and relationship conflicts and may mask anxiety. There are excellent reviews on the use of CBT for anger issues (DiGiuseppe & Tafrate, 2007; Kassinove, Roth, Owens, & Fuller, 2002) as well as self-help books for patients dealing with this frequent problem. In particular, I have found *Anger Management for Everyone: Seven Proven Ways to Control Anger and Live a Happier Life*, by Tafrate and Kassinove (2009), to be especially helpful. In the dialogues that follow, the clinician can see that a wide range of CBT techniques are used and, with many patients, the emphasis on homework is an essential part of treatment.

The patient described here is a man in his 50s who has come to therapy because his wife has threatened separation due to his hostile outbursts. Like many patients presenting with anger problems, he was initially reluctant to enter treatment, suggesting that he was "here" because his wife insisted that he get help. He believes his wife is disrespectful, does not listen, and will not do what she is "supposed to do."

First Session

THERAPIST: Can you tell me a little about the times that you get really angry and hostile with your wife?

PATIENT: She seems not to listen to me. I mean, she'll just do whatever she wants. I told her that she needs to stay on top of things with our son, who isn't doing all his homework, and she just doesn't do it. She just doesn't listen.

THERAPIST: So, what happened then?

PATIENT: I yelled at her—I told her that she is selfish and stupid. I just couldn't stand it.

THERAPIST: How did she respond?

PATIENT: She got upset and walked out of the room and then, later that night, she told me that if I don't get help with my anger, she would want to separate. I don't want to get divorced, but I just don't know what to do. I just get really angry.

THERAPIST: Yeah, I can see that this is a problem. One of the things to keep in mind is that there is a difference between feeling angry and acting in a hostile way.

PATIENT: I don't understand. What do you mean?

THERAPIST: Anger is an emotion. Hostility is a behavior. You can feel angry but choose not to be hostile. [DISTINGUISHING EMOTION FROM BEHAVIOR]

PATIENT: I guess you're right, but when I get angry, it just happens.

THERAPIST: So that must be a problem for you—your hostility is like a reflex, as you experience it. There's no awareness or reflection or sense of a choice. Now, let's think this through, because it's important to recognize the difference between a feeling and a behavior. Have you ever been on the subway and noticed a couple of really tough-looking guys acting in a way that makes you angry, but then you realize that if you criticize them—if you say anything that sounds hostile—that things will be very bad for you? You realize that if you get hostile with them, they could beat you up. So, you choose to keep quiet and say nothing?

PATIENT: That happened a few months ago. Yeah. I realized that I didn't want to get into a fight, so I said nothing, but I was really pissed off.

THERAPIST: If we work backward, we can see that it is the hostile behavior that gets you into trouble, not necessarily the angry feeling. What if you were able to stand back and say, "I notice I'm feeling angry, but I have a choice about acting in a hostile way"? You make the behavior a choice, not a reflex. [MAKING BEHAVIOR A CHOICE]

PATIENT: That would help a lot. But it just seems to happen. *Bam*. I explode.

THERAPIST: So noticing that you might be getting angry and then standing back would be a challenge. But would it help?

PATIENT: If I could do it, it would.

THERAPIST: But you *are* doing it on the subway, right?

PATIENT: Yeah, I guess so.

THERAPIST: Now let's look at your motivation to change. I know you told me that the reason you're here is that your wife warned you—so you're here because of that. But what is the disadvantage to *you* of the hostile behavior? [EXAMINING DISADVANTAGES]

PATIENT: I end up here. (*laughing*) I guess I regret it later, and my wife is angry with me for days. No conversation, no sex. And my son thinks I'm a jerk.

THERAPIST: Those consequences sound important, so we should keep them in mind. But there must be some advantage that you think you get from being hostile. What could that be? [EXAMINING ADVANTAGES]

PATIENT: I can't see any.

THERAPIST: There's always an advantage that we think we'll get. Don't be rational; try to think like you think when you're really angry and hostile.

PATIENT: I guess I think that she'll hear me and do what I tell her to do. I guess it's about getting respect.

THERAPIST: Those are important, of course. But how do you think the hostility is working in terms of getting her to hear you and respect you? [EXAMINING EVIDENCE]

PATIENT: It never works.

THERAPIST: So, if you were thinking ahead, and you would know that you will get angry again with your wife. What can you say to yourself so that you don't act out and get hostile?

PATIENT: I guess I could remind myself of what we are talking about. It won't work. She won't respect me if I get hostile.

THERAPIST: So the first steps to consider involve standing back and noticing what's happening inside you: "I'm feeling angry; I recognize that I have a choice about acting in a hostile way, and I realize that being hostile won't get respect and won't get her to hear me." It's about realizing that you can have a choice and that you are not controlled by your anger. [INTRODUCING SELF-INSTRUCTION]

PATIENT: That's a lot to do when I'm angry.

THERAPIST: You've done it on the subway. How about when you're driving and someone cuts you off? Do you chase them on the highway to get revenge? [EXAMINING PAST EXAMPLES OF SELF-CONTROL]

PATIENT: I used to be really aggressive, but I realized it's stupid, so I just let it go.

THERAPIST: So you've been practicing some of this before. How is it working?

PATIENT: I'm less stressed. It's less dangerous.

Later in the Session

THERAPIST: Now we want to see what kinds of situations trigger your anger and what you're thinking when you get really angry and sometimes become hostile. Let's start with the recent example where you're telling your wife to do something with the kids and she didn't agree with you. Your thoughts were that "She doesn't hear me and she doesn't respect me." Right? [EXAMINING AUTOMATIC THOUGHTS]

PATIENT: Yeah, sometimes I think that she just doesn't listen.

THERAPIST: OK, if she doesn't hear you and doesn't respect you, what does that mean to you? [VERTICAL DESCENT]

PATIENT: If she doesn't respect me, then it means that she treats me like a loser. [IDENTIFYING CONDITIONAL RULE/ASSUMPTION]

THERAPIST: OK, and if that were true, what does that mean?

PATIENT: It means that I'm a loser. I know I'm not, but that's what I feel like at times. [IDENTIFYING SCHEMA]

THERAPIST: I can see why it becomes upsetting to think that she thinks you're a loser and then you feel like you *are* a loser. But sometimes there can be other reasons why someone does something. What could be some reasons why she doesn't agree with you about how you deal with your son? [ALTERNATIVE INTERPRETATION]

PATIENT: It could be that she thinks I'm putting too much pressure on my son and making him feel inferior, and she's just trying to protect him.

THERAPIST: So, when she disagreed about this parenting issue, the intention she had was to protect your son from pressure, but the impact it had on you—how you experienced it—was that she was disrespectful. If I asked her, "Did you want your husband to feel badly?," what would she have said? [DISTINGUISHING INTENTION AND IMPACT]

PATIENT: She doesn't want me to feel bad, she never does.

THERAPIST: So we can make a distinction between someone's intention and the impact. The impact on you was feeling disrespected.

PATIENT: Yeah, she was just trying to protect our son from pressure. I'm sure she wasn't intending to disrespect me or make me feel bad.

THERAPIST: I guess you were doing what we call "mind reading"—thinking that you knew that she was intending to disrespect you. A lot of us do mind reading, but sometimes we're wrong about what we believe that people are thinking. Do you tend to interpret her behavior at times as if she intends to disrespect you? Do you tend to take things personally? [CATEGORIZING AUTOMATIC THOUGHT]

PATIENT: I guess I do. I sometimes treat her silence as if she's trying to punish me, but I guess if I thought about it, I'd realize that she has other things on her mind.

THERAPIST: You sound like you take her behavior personally—as if it is personally directed at you. What other things does she have on her mind?

PATIENT: She tells me she worries a lot about the kids and about making sure the house is run right. You know, she has a hard time sometimes getting everything organized. But I know there is a lot that she does.

THERAPIST: So you're getting angry because you're mind reading and personalizing when you think that she doesn't respect you. I wonder if you can think of any evidence that she *does* respect you. [RELATING EMOTION TO AUTOMATIC THOUGHTS, EXAMINING EVIDENCE]

PATIENT: She does. She tells me that she is very proud of how well I do at work, and she brags to her friends about me at times. I don't know why I think these things about her.

Later Session

THERAPIST: You said that when you think she doesn't respect you, it makes you think that you are a nothing, a failure. I wonder who in your family might have given you that message. [IDENTIFYING CONDITIONAL RULES AND SCHEMA, EXAMINING ORIGIN OF NEGATIVE SCHEMA]

PATIENT: My father was really critical, and he would just dismiss me even when I did well at school. Nothing was ever good enough for him. He would humiliate me and tell me that I didn't know what I was talking about. And, when I would do well, he would say, "Well, you're expected to do well."

THERAPIST: He sounds like a difficult person. So there was this dismissive and critical attitude toward you, and it must have made you feel awful.

PATIENT: I remember when I was about 16, I really felt like hitting him—but I kept it in. Then one day I just told him what a jerk he is; I just screamed at him and he looked like he couldn't believe this was happening. [IDENTIFYING PAST COPING]

THERAPIST: When he would humiliate you, dismiss you, what kinds of thoughts did you have?

PATIENT: I guess I thought that he was an asshole, but I also thought that I must be a loser. He made me feel inferior. [EXAMINING ORIGIN OF SCHEMA]

THERAPIST: So it may be that this is what happens when your wife disagrees with you: This old concept of yourself comes out—that you're a loser—and that the other person is humiliating you, so you want to strike back. [RELATING EARLY SCHEMA TO PRESENT SCHEMA]

PATIENT: Yeah, but my wife is nothing like my father.

THERAPIST: How is she different from your father?

PATIENT: In every way. She's caring, respectful. She's not a control freak like he was. Just totally different. [DISTINGUISHING SCHEMA FROM REALITY]

THERAPIST: She sounds very different from your father, but it seems that you respond to her as if it were your father dismissing you. At the time it may feel that way. I wonder what you wish you could say to your father to tell him off. Like, imagine this: Imagine that he is sitting right here and you had to tell him off. What would you say? [ROLE PLAYING AGAINST THE ORIGIN OF SCHEMA]

PATIENT: I'd tell him he's a jerk.

THERAPIST: OK, just talk to the chair like it's your father. [EMPTY CHAIR ROLE PLAY]

PATIENT: You're a jerk! I know that your father was mean to you, but that doesn't give you the right to put me down. I was a good kid. I wasn't perfect, but I tried my best. You should have been supportive to me. You never made me feel like I was good enough.

THERAPIST: That's a good start. Good work, standing up to that critical voice. It's like his voice is what you're hearing when your wife disagrees with you, but she is different from him, isn't she?

PATIENT: Totally different. She really is a good person.

THERAPIST: Is she supportive of you?

PATIENT: Yes, she tells me that I'm a good person and that I work hard—I try to do my best. I feel so bad about how I treat her.

THERAPIST: That's understandable. How about doing this as a homework assignment? How about writing a make-believe letter to your father where you tell him how he let you down, how he wasn't fair, how he should have acted toward you? [WRITING LETTER TO THE SOURCE OF SCHEMA]

PATIENT: I can give that a try. But it will probably piss me off even more.

THERAPIST: And toward the end of the letter that you write and don't send, you tell him why you will forgive him now, why you will let this go. [PRACTICING FORGIVENESS]

PATIENT: I wish I could do that. It's going to be hard.

THERAPIST: Give it a try. See what you can do.

Next Session

THERAPIST: So it seems that when you get angry, you're thinking that something really bad has just happened. For example, when your wife kind of laughed at what you said and turned away, you got extremely angry. How angry—from 0% to 100%—do you think you felt at that moment? [RATING DEGREE OF EMOTION]

PATIENT: Oh, I don't know. I was filled with rage. I'd say close to 100%.

THERAPIST: So let's say you felt 100% angry. Now let's look at what actually happened. Your wife laughed a little bit and turned away. So, draw a line across this piece of paper, and on the left side of the line put zero and on the right side of the line put 100. This would be "bad things that could happen." One hundred percent would represent the worst thing that we could imagine. Let's call that the Holocaust. And on the left side, at zero, let's say that this represents the absence of anything negative. And then at 5%, we would say something rather trivial, like tight shoes. Now what could be a bad thing that could happen at 90%? [CONTINUUM TECHNIQUE]

PATIENT: I don't know. Maybe getting mugged and having all your money stolen.

THERAPIST: OK, and what would be 80%?

PATIENT: It's hard to say. Maybe getting fired. I know that might be worse than getting mugged. I don't know, it's hard to say.

THERAPIST: What would be at 50%?

PATIENT: Maybe getting into an argument with someone that you care about.

THERAPIST: What would be at 25%?

PATIENT: I'm not sure. Maybe having a bad cold for a couple of days.

THERAPIST: Do you get the sense that it's hard for you to fill out these different points along this continuum?

PATIENT: Yeah, it *is* hard for me.

THERAPIST: Maybe it's because you look at things in an all-or-nothing way. [IDENTIFYING DICHOTOMOUS THINKING] So, 100% Holocaust; 0% the absence of anything bad. But your anger is at close to 100% because your wife laughs a little bit and looks away. Is it possible that you were seeing things out of proportion? That something that might be an inconvenience, or unpleasant, seems like it's bad at a 100% level?

PATIENT: I think, yes. I think you have a point here, yeah—I do see things out of proportion.

THERAPIST: So if you were to use this continuum technique, and we had 5% as tight shoes, where could you put my "wife laughs a little bit and looks away"? Where would you put that in terms of bad things happening?

PATIENT: I guess it's something like maybe 10%. Really not that bad.

THERAPIST: So it's maybe 10% or 15%, not 100%?

PATIENT: Yes, that's right, yes.

THERAPIST: OK, so one way of looking at things is, "What can I still do even if my wife looks away?" [WHAT ELSE CAN I STILL DO?]

PATIENT: I could do anything I've always done even if my wife looked away.

THERAPIST: So if you can still do everything you've always done, then it really is rather trivial. Is that correct?

PATIENT: Yeah, definitely. And if we take tight shoes, you can just take them off and so it's only bad for a few minutes.

THERAPIST: But let's say that somebody beat you up and mugged you and you go to the hospital. That's something that will last for quite some time—you might be injured and need surgery. Could it be that when you get angry, you're looking at things out of proportion? Could it be

that it's almost automatically true that it's out of proportion? And if I stand back and I look at it more rationally, more calmly, that I can see that it's not really as bad as it feels to be right at that moment? [PUTTING THINGS IN PERSPECTIVE]

PATIENT: It's hard to do at the moment—to stand back like that.

THERAPIST: So maybe a new rule to have is, "If I'm feeling angry, I can ask myself to see if I am viewing this out of proportion"? That might help me stand back and realize that my response is just simply out of proportion. And I can say to myself, "Maybe it's not as bad as it feels." [IDNENTIFYING EMOTIONAL REASONING]

PATIENT: That would be good if I could. I just don't know, though.

THERAPIST: So maybe what you need to do when you feel angry, especially very angry, is kind of put yourself in timeout. [EMOTION REGULATION, STANDING BACK, MINDFUL AWARENESS] And what I mean by that is just stand back in your mind for a minute or for two minutes and breathe slowly. And then say to yourself, "Maybe I'm over-responding. I'm more emotional than the situation merits. And maybe I can look at this and say, 'maybe this isn't as bad as it feels'." [SELF-INSTRUCTION]

PATIENT: That could be helpful if I were able to do it.

THERAPIST: A lot of times we use emotional reasoning. And what I mean by that is that we act as if our emotions—which may be intense- make us think that something bad is happening. It's like "I feel very angry, therefore something terrible must be happening." A better way is to be more rational—to think that there is another way of viewing it. It might be I feel very angry but maybe I'm looking at things out of perspective and I need to stand back and realize that maybe this isn't worth getting that angry about in the first place. [EXAMINING EMOTIONAL REASONING, MINDFUL DETACHMENT, EXAMINING CONSEQUENCES OF THINKING AND ACTING]

Next Session

THERAPIST: So when you think that she doesn't respect you, then you think that this means that you're not worthy of being respected. [IDENTIFYING ASSUMPTION]

PATIENT: Yeah I think that I must be somebody who doesn't really deserve to be taken seriously. I know it's irrational.

THERAPIST: OK so let's try doing role play. I'll play your negative thought and you challenge me. [ROLE PLAYING AGAINST AUTOMATIC THOUGHT, ASSUMPTION, AND NEGATIVE SCHEMAS]

THERAPIST: [as negative thought] When your wife doesn't agree with you that proves that you're a nothing.

PATIENT: (*challenging*) No that just means that she disagrees with me.

THERAPIST: [as negative thought] But people disagree with you because your ideas are completely worthless.

PATIENT: No, that doesn't make any sense, because people disagree with people all the time—because people have different points of view.

THERAPIST: Your wife is the sole judge of whether you are worthwhile so if she disagrees with you it means that you are not worthwhile.

PATIENT: That's not logical at all—that's absurd. There are things about me that are worthwhile.

THERAPIST: I can't think of anything worthwhile about you.

PATIENT: (*laughing*) No that's absurd. I'm very intelligent, I have a good job, I'm an honest person, I have friends, and a lot of other things about me are worthwhile.

THERAPIST: Your wife doesn't agree with anything that you say ever.

PATIENT: No, that's not true. We agree on many things, almost everything. We agree for the most part on how to handle the kids and we agree on values in almost every area of our lives.

THERAPIST: But you need your wife to agree with you on everything so that you can feel comfortable and respected.

PATIENT: I guess that's how I think when I'm angry but I guess I just have to get used to the fact that we don't always agree on everything. No couple agrees on everything. It's unrealistic.

THERAPIST: So let's step outside the role play. How do you think this works for you?

PATIENT: I guess I realize that sometimes I think I need her approval and then I think that there's something wrong with me if we do not agree and I take it as a personal insult. And then I get angry. [EXAMINING CONSEQUENCE OF ASSUMPTION]

THERAPIST: So in a sense you think that your wife has to validate everything that you say. If she doesn't she does not respect you as a person and if that were true then you cannot respect yourself. So it's almost like you desperately need her approval—which is unrealistic in any relationship to have approval 100% of the time. What if you were to normalize disagreeing on things, and think that people who care for each other can disagree at times and still respect each other? That would be a new assumption. How would that work for you? [ALTERNATIVE ADAPTIVE ASSUMPTION]

PATIENT: That would be much more realistic because then we could have discussions and agree that we disagree. And I know that I respect her even though we might disagree on politics sometimes or we might disagree on friends.

THERAPIST: So let's see if we took this new assumption that we can disagree with each other and still respect each other. Do you see that with friends and with coworkers? That you disagree at times and still respect each other? [EXAMINING ADVANTAGES OF NEW ASSUMPTION, EXAMINING CURRENT USE OF ADAPTIVE ASSUMPTION]

PATIENT: I guess I see that-I do that—on a pretty regular basis with people. I can see that we respect each other but we disagree on some things.

THERAPIST: So let's look at why you would start yelling when there is a disagreement. It's almost as if you think she can't hear me and if I yell she'll finally get the point. But how does that work out? [RELATING EMOTION AND BEHAVIOR TO AUTOMATIC THOUGHT AND ASSUMPTION]

PATIENT: It never works out. Because what happens is that she's upset about the yelling and I get upset that she's upset. And then when I yell and she gets upset nobody really hears—nobody really hears anything. And we are just upset with each other.

THERAPIST: So if you want to make your point, yelling may not be the best way to do it. What if you were to just accept that you disagree? For example, you could say I guess we can accept that we disagree on that. And say that in a soft and gentle voice. What do you think would happen if you simply made that calm statement of acceptance? [PRACTICING ACCEPTANCE]

PATIENT: If I were able to do that, and it would be hard for me to do it, things might be a lot better.

THERAPIST: You say it would be hard to do probably because you're feeling very intense at the moment and feeling very angry and so your emotions are sort of pushing you to say something intensely. It's like "intense emotion, intense statement." [EMOTIONAL REASONING] But this is an example of where you could act in the opposite way. [OPPOSITE ACTION] You could pull back and be calm in the way you speak and be gentle in the way you speak. [MINDFUL DETACHMENT] This is what we call opposite action, you act as if you're feeling calm. And it may be if you were able to do that, act as if, you eventually might become calmer. Is this worth trying?

PATIENT: I could give it a try. But I know it's going to be hard to do.

THERAPIST: That might be hard not to do it. Now I'm wondering if there are times in your business dealings with people if you actually are already doing this. For example, are there times with people that you need to work with, someone who might be a difficult person, where you pull back from your anger and act in a diplomatic and professional manner? [EXAMPLES OF CURRENT ADAPTIVE BEHAVIOR AND USE OF NEW ASSUMPTION AND ACCEPTANCE]

PATIENT: You know, I do that on a pretty regular basis.

THERAPIST: So this might be something you are quite capable of doing and all you need to do is start doing that with your wife. Think about your dealing with your wife as the most important client you will ever have.

PATIENT: That would be good if I could do that. I'm a lot saner with strangers than I am with my family.

THERAPIST: Maybe all of us are a little crazy at times with family members.

CHAPTER 16

Concluding Comments

The goal of this book is to give clinicians an opportunity to review a wide range of cognitive-behavioral techniques that might be useful in treating the full range of psychopathology. My observation is that it is easy for us, as clinicians, to focus on our favorites and to apply the same few techniques to almost everyone who walks in the door. That might work for a lot of patients; it might be expeditious if we are training people for a modularized, short-term approach where efficiency and simplicity are the prime issues. But for experienced clinicians who are accustomed to running into roadblocks and complexity in their work, a few techniques will not be enough. Having a range of techniques that are drawn even from "competing" CBT schools might be more realistic. My observation is that cognitive restructuring works for some people, problem solving works for others, and mindfulness and acceptance for others. It may be you will not know until you try something different.

Here's an interesting exercise to conduct with your friends and colleagues. Ask them the following question: "When you are upset with something, what do you do to cope with your feelings?" I ask this question periodically of clinicians at workshops and at the American Institute for Cognitive Therapy in New York City. Think about the range of answers that you might get. People use social support, problem solving, behavioral activation, mindfulness, avoidance, food, alcohol, humor, acceptance, and a range of other coping skills. Some skills work better than others, some have longer-term negative consequences. If I take myself as an example, even though I believe in many of the more helpful techniques, I realized when I asked this question that I tend to be goal oriented. I focus on what I can do. So, when I get upset—as I do, like everyone else—I tend to focus on problem solving and changing my goal. I might stand back and "accept" something as the starting point—or the "given." But that's what I do. I ask, "What is the problem to solve?" or "What goal can I focus on?" and "Maybe I can change my goal." This is not to imply that I am some paragon of mental health; it simply suggests that even cognitive restructuring might be superseded by problem solving if the person is a bit obsessive, like I might be. But others use social support—to good advantage—and others use restructuring, and a few, in their natural environment, use mindfulness. The thing that is interesting about mindfulness is that it is effective, as I have come to recognize. But I don't think that people are doing it naturally in their daily lives. It's a skill that requires a lot of training and attention. It is a skill worth cultivating. But it does not come naturally, in my view.

What have we covered in this book? Some may observe correctly that not everything is here. True, but necessary. We are living in a time when we have such a wealth of clinical approaches that have value, it is impossible to cover everything. Even CBT advocates can acknowledge that mentalization therapy, transference-based psychodynamic therapy, and interpersonal psychotherapy are effective—and all three are psychodynamic. These approaches have excellent spokespeople who have made a strong case that there is something of value there. But the current book is, by necessity, one with a focus on CBT. Behavioral therapists have a full range of techniques with proven effectiveness, but in order to make this book manageable, I have referred the reader elsewhere for that approach. And, of course, medication is often an important part of treatment, and therapy can assist in helping patients come to terms with this (e.g., in the treatment of bipolar disorder), comply with the regimen, and cope with side effects. Indeed, some of the techniques in this book can help in that important endeavor.

We have covered a lot in this book. We began by reviewing how we elicit and identify thoughts and how we help the patient recognize that a thought is a thought and not reality, a feeling, or a behavior. We have reviewed how the patient can learn to evaluate and test thoughts to determine their utility, consequences, implications, and validity. Keep in mind (no pun intended) that cognitive therapy does not involve the negation or suppression of thoughts, but rather the elicitation and examination of thoughts. The goal is not to get rid of thoughts, but rather to change the credibility and impact of these thoughts. I can have the thought every day that I am a zebra, but when I look in the mirror I will recognize, I hope, that this thought is not realistic.

As we have seen, the automatic thoughts that are the first line of cognitive assessment and intervention are driven by underlying assumptions or conditional rules. These "should" statements and "if–then" rules give fuel to the fire of the biased and habitual negativity of the automatic thoughts. Thus, the individual may find that his or her mind reading is accurate—that person really did not like him or her—but it is only the underlying assumption ("I need everyone's approval") that makes this matter. There are numerous ways of examining and modifying these rigid and self-defeating assumptions, rules, and beliefs that can free people from caring so much about the inevitable negative experiences that we all will have. We have also seen that negativity may be maintained and exacerbated by recurring logical errors and inferences. It's difficult to be logical—we may rely instead on intuition, stereotypes, labels, emotions, recency, salience, and selective information gathering. But these errors and biases can be modified with the tools outlined here.

Many patients find themselves stuck because of difficulties in making decisions. The chapter on decision-making processes and how to modify them is rather detailed—and I could have gone on even further. Change is, after all, about making decisions, and if the individual is making decisions based on short-term gains rather than long-term goals, or is stuck in rescuing a sunk cost that has already proven to be a failure, then negativity and helplessness will continue unabated. Fortunately, cognitive science has advanced considerably to inform us as to how distortions and problems arise in decision making and how (thinking things through deliberately) we can possibly reverse this. To paraphrase Kahneman, "Thinking slowly may be better than a quick solution."

The chapter on intrusive thoughts and worry provides clinicians with a range of helpful strategies and techniques that are drawn from cognitive therapy, metacognitive therapy, emotional avoidance theory, behavioral models, problem-solving therapy, mindfulness, acceptance, uncertainty training, and other approaches. We know that rumination and worry are significant vulnerabilities for depression, and that these processes maintain depression and anxiety even in the face of the lack of negative events. Clinicians are now in an excellent position to help patients cope more effectively with these issues—a significant advantage over where we were just 20 years ago. In the chapter on

putting things in perspective, there are numerous techniques that one can use to decrease the intensity of a perceived or anticipated event. So often we respond to an inconvenience as if the world has ended, only to realize a week later that we cannot actually recall what upset us so much. A helpful reminder is to realize that the word "rational" is derived from the Greek word "ratio." Perspective is everything at times. But often we do not fully appreciate it until it is too late. The ability to put things in perspective is a key issue in decreasing anxiety, anger, and sadness, and may go a long way in helping the patient realize, "It's not worth getting upset about."

In the chapter on schemas I have drawn from Beck, Freeman, Davis, Young, and others, realizing that this chapter can only touch on the many complex issues that arise in working with long-established schemas. Some therapists may be focused on the level of automatic thoughts, conditional rules, behavioral activation, acceptance, or other phenomena. I have found that therapy can be deepened and made more meaningful by incorporating work on schemas. For example, it is difficult to imagine developing a sophisticated case conceptualization without reference to schemas. These issues are especially important for our patients who have long-standing problems in relationships and in work settings with schemas about being defective, abandoned, controlled, or about being a special and unique person. These schemas may surface, leading to a cascade of negativity and problematic coping. I have also suggested here that one can transcend negative schemas by accepting the universal frailty of human nature—that all of us have parts that are defective, unlovable, helpless, etc. Therapists can incorporate work on compassion and self-acceptance in addressing these long-standing schemas, often with good results. Once again, therapists need not limit themselves to one approach.

The chapter on emotion regulation reviews a number of approaches that one can use to cope with emotional intensity. Again, clinicians can sample techniques from DBT, ACT, Beckian therapy, problem-solving therapy, emotional schema therapy, and other approaches. With some patients who present with intense affective dysregulation—for example, patients at risk for self-injury, hostility, and other impulsive and destructive behaviors—we might begin therapy with an emphasis on emotion regulation. It may be difficult to engage someone in cognitive restructuring or exposure to feared situations when he or she feels overwhelmed by emotions that trigger seriously problematic behavior.

I have included four chapters on specific applications. Of course, there are many more than four applications that we could have considered, but I think that these chapters provide some helpful examples of techniques in action. The chapter on addressing cognitive distortions is a handy list of techniques that therapists can use, along with short questions, which can guide the process of helping patients reverse the negative effects of these biases in thinking. The chapter on need for approval illustrates how patients can use techniques that include cognitive restructuring, behavioral exposure, behavioral experiments, and acceptance to modify their reliance on anticipated approval from others. Since no one is liked by everyone, this is an important topic affecting social anxiety, avoidance, assertion, and other issues. The chapter on self-criticism also reviews a range of techniques that help patients develop a more realistic and less pejorative view of themselves. Rather than take a "positive thinking" approach to the self, this chapter reflects the importance of putting human imperfection in perspective, while accepting that no one ever quite lives up to every expectation. And, the chapter on anger management illustrates how the clinician can use behavioral and cognitive techniques to help patients distinguish between emotions (anger) and behavior (hostility), stand back and take a mental break to observe and consider consequences and alternatives, recognize the triggers that evoke angry responses, and reverse the vulnerability to being hijacked by provocation.

In each of these chapters, as I have done throughout the book, I give examples of patient–therapist dialogues. I understand that each therapist will have his or her own style—some may be softer and gentler, others may be more energized, even confronting patients. I do not believe that there is one style that works across all people. And I also do not believe that any one therapist works well with everyone. The style is yours—it may be modified if you wish—but it is helpful to recognize that what I have written here may need to be changed to fit your style. The important point to remember in using any technique or school of therapy is that we need to keep trying to find the right interventions for the people we treat. We cannot get too committed to one style, one technique, or one school of thought. We need to keep trying. And we all need to keep learning.

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