CHAPTER 10

Cognitive Concepts and Techniques

INTRODUCTION TO COGNITIVE AND COGNITIVE-BEHAVIORAL THERAPY

Readers familiar with the work of Aaron T. Beck, Albert Ellis, Donald Meichenbaum, Lynn P. Rehm, Michael Mahoney, Vittorio Guidano, and Giovanni Liotti will recognize that there are numerous cognitive-behavioral models for a variety of disorders. In the separate chapters of the book on depression and anxiety disorders (Chapters 2–8), we review the more common cognitive-behavioral models, indicating how specific models are adapted to each disorder. For example, Beck's use of cognitive therapy for depression differs from his use of cognitive therapy for panic disorder. Moreover, we utilize more than one cognitive-behavioral model for each disorder, in order to provide the clinician with a range of tools and conceptualizations and with the opportunity to provide integrative therapy. We draw on earlier cognitive models (such as Beck's) and expansions and elaborations of cognitive models (such as those of David M. Clark, David A. Clark, Paul Salkovskis, and others). In addition, we indicate how the metacognitive model advanced by Adrian Wells and his colleagues can be helpful for understanding and treating a variety of disorders.

In this chapter, however, we describe some of the fundamental concepts and techniques of the major cognitive therapies. The basic premise of cognitive approaches to therapy is that dysfunctional or distorted ways of thinking can cause or exacerbate dysfunctional emotions and behaviors. Cognitive interventions identify and target specific distorted automatic thoughts, maladaptive assumptions, and negative or otherwise dysfunctional schemas. The cognitive-behavioral therapist also utilizes behavioral interventions (e.g., behavioral activation and exposure) to assist the patient in testing and challenging cognitive distortions. An information handout for patients about cognitive-behavioral therapy is provided in Form 10.1.

THE THREE LEVELS OF COGNITIVE DISTORTIONS

Beck identifies cognitive distortions at three levels of thinking: "automatic thoughts," "assumptions," and "schemas." Automatic thoughts are thoughts that come spontaneously and seem plausible to a person, but they may become distorted in depressed or anxious patients. Distorted

automatic thoughts can be associated with negative affect or dysfunctional behavior. They can be arranged into specific categories (see Form 10.2, which is also a handout for patients).

Assumptions are at a deeper cognitive level than automatic thoughts; they are more abstract and generalized. In depressed or anxious patients, assumptions can become maladaptive: They take the form of a set of rules, "shoulds," imperatives, or "if–then" statements that can have disabling effects. Examples of some maladaptive assumptions are provided in Form 10.3 (another patient handout).

Schemas exist at a still more fundamental level than assumptions; they reflect deep-seated models of the self and others. Depressed or anxious patients may have a selective focus on certain schemas that mark their vulnerability. Beck et al. (1990, 2004) have identified a variety of negative or otherwise dysfunctional schemas that characterize the various personality disorders (see Table 10.1), as well as various types of attempts to avoid or compensate for these schemas. For example, patients with obsessive–compulsive personality disorder (which, incidentally, is *not* the same thing as the anxiety disorder called obsessive–compulsive disorder) attempt to compensate for their problems by trying to achieve perfection; or, in some cases, they may avoid any tasks in which mistakes appear probable. These compensatory and avoidant strategies are also targets for cognitive therapy.

These three levels of cognitive distortions are related in a hierarchical fashion, such that distorted automatic thoughts are the most directly and easily accessible, followed by maladaptive assumptions and then dysfunctional schemas. For example, consider a female patient who goes to a party and thinks of approaching a man. Her automatic thought might be "He'll reject me." The underlying assumption could be "I need to be approved of by men in order to like myself." The patient's schema about herself might be "I'm unlovable," and her schema about men might be "Men are rejecting." These different levels are depicted in Table 10.2.

In therapy with a depressed or anxious patient, the therapist may elicit cognitive distortions at any level and intervene at any level. For example, the therapist may challenge automatic thoughts or focus on underlying assumptions or schemas. Or, if the therapist takes a more behavioral approach, he or she may wish to help the patient modify the environment so as to avoid specific "activating events."

IDENTIFYING AND CHALLENGING COGNITIVE DISTORTIONS

As just indicated, the essence of cognitive therapy is intervening with a patient's cognitive distortions at any level required. The therapist takes an active role in inquiring about and challenging the patient's thinking. The usual procedure in practice is to begin by working with the patient's distorted automatic thoughts, and then to do the same with maladaptive assumptions and dysfunctional schemas as needed.

Once the therapist has educated the patient about the nature of automatic thoughts and the various categories into which distorted thoughts can be classified (Form 10.2 is helpful in this regard), the patient is told that moods (such as sadness or anxiety) are related to the thoughts he or she is having at the time. The patient is therefore asked to keep regular records of events in his or her life and the moods and thoughts related to them, as well as to rate the intensity of these moods. The Patient's Event–Mood–Thought Record (Form 10.4) can be used for this purpose.

TABLE 10.1. Dysfunctional Schemas in Personality Disorders

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Avoidant	Vulnerable to depreciation, rejection Socially inept Incompetent	Critical Demeaning Superior	"It's terrible to be rejected [put down]." "If people know the real me, they will reject me." "I can't tolerate unpleasant feelings."	Avoid evaluative situations Avoid unpleasant feelings or thoughts
Dependent	Needy Weak Helpless Incompetent	Idealized Nurturant Supportive Competent	"I need people to survive [be happy]." "I need a steady flow of support and encouragement."	Cultivate dependent relationships
Passive–aggressive	Self-sufficient Vulnerable to control, interference	Intrusive Demanding Interfering Controlling Dominating	"Others interfere with my freedom of action." "Control by others is intolerable." "I have to do things my own way."	Passive resistance Surface submissiveness Evade, circumvent rules
Obsessive–compulsive	Responsible Accountable Fastidious Competent	Irresponsible Casual Incompetent Self-indulgent	"I know what's best." "Details are crucial." "People should be better [try harder]."	Apply rules Perfectionism Evaluate, control Use "shoulds," criticize, punish
Paranoid	Righteous Innocent, noble Vulnerable	Interfering Malicious Discriminatory Abusive motives	"Motives are suspect." "Be on guard." "Don't trust."	Be wary Look for hidden motives Accuse Counterattack

(cont.)

TABLE 10.1 (*cont.*)

Personality disorder	View of self	View of others	Main beliefs	Main compensatory/avoidant strategies
Antisocial	Loner Autonomous Strong	Vulnerable Exploitative	"I'm entitled to break rules." "Others are patsies [wimps]." "Others are exploitative."	Attack, rob Deceive Manipulate
Narcissistic	Special, unique Deserving special rules, superior Above the rules	Inferior Admirers	"Since I'm special, I deserve special rules." "I'm above the rules." "I'm better than others."	Use others Transcend rules Be manipulative Be competitive
Histrionic	Glamorous Impressive	Seducible Receptive Admirers	"People are there to serve or admire me." "They have no right to deny me my just deserts."	Use dramatics, charm Throw temper tantrums, cry Make suicide gestures
Schizoid	Self-sufficient Loner	Intrusive	"Others are unrewarding." "Relationships are messy [undesirable]."	Stay away

Note. Adapted from Beck, Freeman, and Associates (1990). Copyright 1990 by The Guilford Press. Adapted by permission.

TABLE 10.2. Relationship between Cognitive Levels

Event	Automatic thought	Maladaptive assumption	Schema (self and other)
Approaching man at a party.	He'll reject me.	I need the approval of men to like myself.	I'm unlovable. Men are rejecting.

Either the Patient's Form for Categorizing and Responding to Automatic Thoughts (Form 10.5) or the Patient's Daily Record of Dysfunctional Automatic Thoughts (see Form 2.10 in Chapter 2) can also be used, once the patient has received some coaching in methods of developing rational responses to automatic thoughts (see below). The identification of maladaptive assumptions and dysfunctional schemas is usually not as easy for a patient as the identification of distorted automatic thoughts; therefore, these two types of cognitive distortions are usually identified by the patient and therapist working together in sessions.

Once a patient's automatic thoughts, assumptions, or schemas have been identified, they are subjected to any of a wide variety of cognitive (and sometimes behavioral) challenges. In each case, the ultimate goal of this process of challenging is the production of a "rational response"—that is, a new, more logical, more realistic, and more adaptive version of the original thought, assumption, or schema. For example, the maladaptive assumption "Something is wrong with me if I am anxious" can be replaced by the rational response "Anxiety is normal; everyone has anxiety."

Appendix B of this book summarizes the cognitive techniques that can be used to identify and challenge cognitive distortions. For further descriptions of these techniques, the reader is referred to several books on cognitive therapy: *Cognitive Therapy of Depression* (Beck et al., 1979), *Anxiety Disorders and Phobias* (Beck et al., 1985), *Cognitive Therapy: Basics and Beyond* (J. S. Beck, 2011), *Cognitive Therapy for Challenging Problems: What to Do When the Basics Don't Work* (J. S. Beck, 2005), *Cognitive Therapy: Basic Principles and Applications* (Leahy, 1996), *Practicing Cognitive Therapy* (Leahy, 1997), *Cognitive Therapy Techniques* (Leahy, 2003), and *Handbook of Cognitive-Behavioral Therapies* (Dobson, 2010). Bennett-Levy et al. (2004) have provided an excellent guide to implementing behavioral techniques in examining and testing thoughts and assumptions in the *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. The schema-focused approach is represented by Young et al. (2003) in *Schema Therapy: A Practitioner's Guide*. Wells (2009) has advanced an innovative cognitive-behavioral model of depression, anxiety disorders, and psychotic disorders in *Metacognitive Therapy for Anxiety and Depression*. In addition, Gilbert (2010) has incorporated "compassionate mind" principles from Buddhist practices into an intriguing new approach, described in *Compassion Focused Therapy: Distinctive Features*. Finally, Leahy, Tirch, and Napolitano (2011) have advanced a cognitive-experiential model of emotion regulation that can be incorporated into a variety of other cognitive-behavioral models in *Emotion Regulation in Psychotherapy: A Practitioner's Guide*.

These approaches and techniques are not specific to any single disorder and may be used for depression, anxiety disorders, anger, substance use disorders, relationship conflict, and a variety of other problems. In the chapters on specific disorders in our book, we demonstrate how many of these techniques can be adapted to each disorder. The interested reader will wish to

review these techniques and determine which are the most relevant to his or her style of doing therapy.

EXAMPLES OF CHALLENGES TO SPECIFIC DISTORTED AUTOMATIC THOUGHTS

In this section, we provide several examples of how a therapist might use some of the cognitive techniques described in Appendix B to respond to a patient's distorted automatic thoughts in therapy sessions. In later sections, we provide similar examples of responses to maladaptive assumptions and to dysfunctional schemas.

Catastrophizing

Here are examples of how a therapist might challenge this catastrophic thought: "It's awful that I had that argument with my boyfriend."

"Exactly what will happen that is awful? Describe in detail exactly what you expect will occur. What is the probability that this will happen? How often does this happen to people? How often does this not happen? If this event occurs, what will you no longer be able to do? What will you still be able to do? List all the behaviors that you will still be able to do in the event that this does happen. If you can still engage in all these behaviors, then how is it awful?"

"What is the evidence for and against the idea that it's awful?"

"How will you feel about this a week (a month, a year, 10 years) from now? Have you experienced other events that you thought were awful and found that they weren't as bad as you thought they were? What made you change your evaluation?"

"If you had to make a scale of negative events, with 0 corresponding to the absence of negative consequences and 100 corresponding to a nuclear holocaust, where would you place this argument? How would you fill in every 10 points on this scale? How is this argument not as bad as other things that could happen?" (Figure 10.1 illustrates how this patient might actually construct such a scale or continuum.)

"Would everyone think that this argument is as bad as you think it is? Why? Why not? If you knew someone who had gone through a life-threatening illness, would you be able to convince him or her that this is as bad as you think it is? How would you feel about doing this?"

"Have other people gone through this before? How have they survived?"

Personalizing

The following are examples of possible challenges to this personalizing thought: "It's my fault that this problem happened."

"What are the costs and benefits of personalizing this problem?"

"What behaviors did you and others engage in that contributed to the problem?"

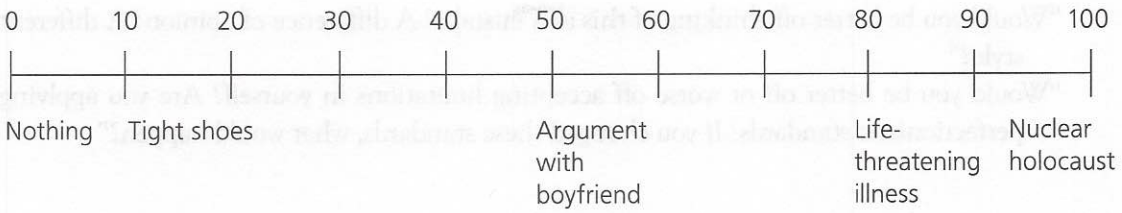

FIGURE 10.1. Example of how a patient might construct a continuum of negative events.

"Make a pie chart. Divide up the causes, assigning percentages of responsibility as follows: self, other(s), luck, task difficulty, and unknown causes."

"Are you confusing an event with the whole person? Doesn't your behavior vary across different situations? Across different times? Did these problems in this situation exist before you came on the scene?"

"Even if the event did not work out, did you learn anything, experience any pleasure, or grow in any way? Was there anything good about the event?"

"Is there some way that this can be corrected? Can you learn anything from this that you can use in the future? Can you engage in self-correction rather than self-criticism?"

"Are you blaming yourself because you tend to take an inordinate amount of credit for events? Do you always think that you are that important or that powerful? Are you the kind of person who thinks he or she has to control everything?"

Labeling

Here are instances of how a therapist might respond to this distorted labeling: "I'm a jerk for making that mistake."

"How do you define 'jerk'?"

"What are the costs and benefits of labeling yourself in this way?"

"Are all of your behaviors jerk-like, or just some? Does your behavior vary across situations? Across time? Are you looking at things in all-or-nothing terms? Do you ever do anything that is competent?"

"Are there extenuating circumstances? Other causes (such as provocation, lack of knowledge, duress, early history, lack of ability, or lack of effort)?"

"Would you label everyone in the world a 'jerk' if they made this mistake? Would you label your best friend (or a loved family member) in this way if he or she made a mistake? Don't we all make mistakes at times?"

"Do you think of yourself as the biggest jerk in the world? Have other people made worse mistakes? If you're a jerk, what are they?"

"If you think that you're a jerk, when did you become a jerk? Were you born a jerk? If someone makes a mistake, does that mean that that person is a jerk? Would that mean that everyone is a jerk? Why not?"

"If you had a successful experience, would you stop being a jerk? If you made another mistake later, would you then become a jerk again?"

"Would you be better off thinking of this as a mistake? A difference of opinion? A different style?"

"Would you be better off or worse off accepting limitations in yourself? Are you applying perfectionistic standards? If you changed these standards, what would happen?"

Fortunetelling

Here are various ways in which a therapist might challenge this fortunetelling thought: "I'll be rejected and fail if I do this."

"What are the costs and benefits of this prediction?"

"Describe in detail exactly what will happen. Can you form a visual image of your prediction?"

"Do certain situations generally elicit negative predictions from you—for example, interacting with strangers, going to the doctor, or taking an exam?"

"What is the evidence for and against your prediction? What is the quality of the evidence? Are you basing your prediction on emotional reasoning? Are you focusing on just one negative and exaggerating its importance? Are you discounting your positives in the situation?"

"Would everyone make your prediction, given the current facts? Why not?"

"What are five less negative predictions that you could make? What is the best possible outcome?"

"Even if the worst possible outcome occurred, would there still be some positive aspects to it?"

"Have you made other predictions that have not come true? Are you prone to making bad predictions? What do you learn when you make false alarms? Do you tend to forget your false alarms?"

"If your prediction came true, what would it mean to you? Do you have to be approved of by everyone or perfect all the time?"

"Are you assuming that because it's possible that something negative can happen, then it will happen?"

"Do you assume that if you don't know something for sure, then it's a negative?"

"Are you using all the evidence, or are you relying on your feelings to guide you?"

"If what you are predicting were to occur, what resources could you draw on to deal with it? What problem would you have to solve if it occurred? How would you solve the problem?"

"How would you feel about this 1 week, 2 weeks, 2 months, and 1 year later? Would it become less negative over time? Why would it become less negative over time?"

"Do you tend to act as if your predictions will come true? For example, do you avoid situations when you have a negative prediction? Have you ever acted against your negative predictions? What actually happened?"

"Would you be willing to test out your negative prediction by collecting more information or acting against your prediction?"

EXAMINING MALADAPTIVE ASSUMPTIONS

Many depressed, anxious, or angry people have maladaptive assumptions—sets of rules or guidelines that make them more vulnerable. Below, we give examples of how a therapist might respond to this "should" assumption by a patient: "I should be approved of by everyone."

"What are the costs and benefits of this assumption?"
"Are you confusing a preference or desire with a moral imperative—that is, with the idea that you *must* or *should* have or do what you would *prefer* to have or do?"
"Why should you be approved of by everyone? What is the evidence or logic that leads you to conclude this?"
"How do you measure approval? Do you demand or require intense, lavish approval? Would you be willing to settle for less than 100%?"
"What does it mean to you if you are not approved of by someone?"
"What would you do with all that approval? Would you have time for everyone? If you didn't have time for everyone, would you then have to 'reject' some people? Would that then make them worthless? Why not?"
"Are you getting yourself upset because you have other rigid and unrealistic rules and assumptions? Are you saying, 'I should, must, have to . . . , 'about other things? Do you have rules like 'If I don't succeed, then I'm a failure,' 'I have to be liked by everyone,' 'I have to be sure before I try,' or 'I have to feel like doing something before I do it'?"
"What are some of your other assumptions? What are your 'shoulds,' 'if–then' statements, 'must' statements, 'have-to' thoughts?"

The following are illustrations of how a therapist might respond to this distorted assumption reflecting perfectionism: "I've got to do a perfect job."

"How would you know what 'perfect' is if you saw it? If there are different standards, then what do you make of the fact that your criteria are different from those of others?"
"What are the costs and benefits of perfectionism? Of imperfectionism?"
"What would happen—what would it mean—if you did less than perfectly? Specify the exact consequences of doing imperfectly. If you did imperfectly on something, what would you still be able to do?"
"Have you ever achieved perfection? If not, how did you manage in the past?"
"Does everything have to be measured? Can't some things be enjoyed for their own sake? Can't you learn from experience?"
"Would you apply this standard to everyone? Why/why not?"
"Perfectionism means that you compare yourself to 100%. What would happen if you compared yourself to 0% or 50% or 75%?"
"What would happen if you rewarded yourself and took pride in achieving less than perfection? Would your work become mediocre?"
"Do you think that perfectionism motivates you? If so, then does it ever lead to procrastination? Are you afraid to take risks because you're a perfectionist? Are there some

potentially enjoyable, growth-enhancing experiences that you avoid because of your perfectionism?"

"How would you be able to start learning something if you're a perfectionist, since learning implies imperfection?"

"Are there some things that you are not a perfectionist about? What are they? What is rewarding about those activities?"

"What should we do about all the people who are not perfect?"

"What's the advantage of accepting less than perfection? If you did less than perfectly, wouldn't that be progress? Does perfectionism make you angry, self-critical, or impatient?"

"Describe five people you know well and think highly of. Are they perfect in everything? Ask them. Do you accept imperfection in your friends?"

"Ask your best friends whether they believe that you have to be perfect to be worthwhile or acceptable."

"What if you replaced perfection with growth, progress, learning, and appreciation? What would happen?"

"If you think that perfectionism is so great, then would you think that a self-help book would sell if it were entitled *How to Criticize Yourself into Perfectionism*?"

"Why is it that other people can be happy if they are not perfectionists?"

"Would you be willing to carry out an experiment in imperfection? For example, what would happen if you purposely wrote every check for $1 more than needed—that is, if you consistently made the same 'mistake' on your checks for a month?"

"Does anyone except you expect perfection from you?"

EXAMINING THE CONTENT OF DYSFUNCTIONAL SCHEMAS

As Table 10.1 indicates, patients' dysfunctional schemas (deep-seated models of self and others) may reflect underlying concerns or issues with any of the following: entitlement, dependence, unrelenting standards, deficiency, biological threat, trust, betrayal, control, autonomy, dominance, self-sacrifice, punishment (of others or self), dramatic display, impressing others, obtaining admiration/tribute, abandonment, humiliation, or embarrassment (and these are only some of the possibilities). In this section, we provide examples of how a therapist might challenge a patient's schema of unrelenting standards for the self.

"Identify some examples of when your standards are very demanding and difficult to live up to."

"Specify a situation where your standards seemed to be unrelenting and almost impossible. What thoughts and feelings did you have? What did you do to try to live up to these standards? Specifically, what were your standards for success? What was acceptable? Unacceptable?"

"What are the costs and benefits of your standards?"

"What would you still be able to do if you did not have these high standards?"

"Draw a continuum from 0 to 100, with 0 corresponding to no standards and 100 corre-

sponding to absolute perfection. Where do you put yourself? Others? Identify people at each 10 points on the continuum."

"Do you expect others to live up to your standards? Why/why not?"

"Are there certain areas where you allow yourself to lower your standards? What happens then?"

"Use vertical descent: 'If I don't live up to my standards, then it means . . . ' 'Do your conclusions follow logically? Are other, less negative conclusions possible?"

"Does anyone except you expect perfection?"

"What would happen if you aimed for growth and acceptance rather than perfection?"

"How have you been trying to live up to these standards during your life? Who taught you that you had to be perfect? What behaviors have you avoided? How has it affected your relationships, work, health, and ability to relax?"

"Can you remember an incident in your childhood that reminds you of these demanding standards? Close your eyes and try to recall the details—the feelings you had, how you felt in different parts of your body, your sensations. What was going on? Who was talking? What were you (and others) thinking?"

"Now try to rewrite this script so that you challenge the demand for perfect standards. Assert yourself in this image. Get angry at the demand for high standards. Tell the characters in the scene that you are going to accept yourself even if you are not perfect."

"Identify an area in your life in which you will intentionally try to practice imperfection. When you begin feeling guilty or inferior because you are not perfect, vigorously argue back against your demanding standards."

"Write out a 'bill of rights' for yourself that states your right to be human, to make mistakes, and to accept yourself."

SELF-INSTRUCTION AND SELF-CONTROL

Many patients' problems may be consequences of insufficient self-direction (Meichenbaum, 1977; Novaco, 1978; Rehm, 1990). Rather than being driven by emotions or situational determinants, such patients may be prepared for handling difficult situations through "self-instruction." Self-instructional training requires a patient to engage in the following components or steps:

1. Identify signs of anger, anxiety, sadness, or unwanted desires (e.g., hunger for junk food).
2. List and describe situations that elicit the unwanted feelings.
3. List all maladaptive behaviors in the situation.
4. Examine the consequences—both short-term and long-term.
5. Determine the costs and benefits of the unwanted feelings/behaviors.
6. Think of alternatives that are available to reduce these (e.g., leaving the situation, avoiding contact, responsible assertion, problem solving, rational responding, etc.).
7. Determine the costs and benefits of these alternatives.
8. Generate some "coping thoughts" for use in the situation (to cool the patient down or make him or her feel better or more in control).

9. Develop an image of the troubling situation and how you could handle it more effectively.
10. Practice "inoculation" with the therapist, who can play the role of someone provoking the patient, while the patient plays the role of someone coping effectively.
11. Reverse roles with the therapist in the inoculation practice.
12. Make a list of situations in which to practice the coping thoughts.
13. Practice these skills outside therapy, writing down predictions and outcomes.
14. Revise the script and the coping statements as necessary, and keep practicing.
15. Engage in a self-reward after each attempt at self-instructional training.

For example, consider the following use of self-instruction with an angry husband who is easily provoked by his wife and who acts out his aggression. The therapist asks the patient the following questions:

THERAPIST: What is it your wife says or does that bothers you?

PATIENT: She nags me, tells me to do things over and over.

THERAPIST: Any other situations?

PATIENT: She questions me about our finances.

THERAPIST: What are the signs of your anger?

PATIENT: I can feel my heart racing. I get tense. Initially I get quiet, and then when I talk, I'm loud. I clench my fists. I tell her to leave me alone. Sometimes I'll call her names.

THERAPIST: What is the goal? The target you are aiming for in this situation?

PATIENT: I don't know if I have a goal. I guess I'm trying to get back at her.

THERAPIST: What are the costs and benefits of this goal?

PATIENT: The costs are that I feel guilty, she gets upset, and we have a lot of tension. The benefits are that I can feel like she's not controlling me.

THERAPIST: What are the alternatives?

PATIENT: I could use the time-out procedure that you told me about, and tell her that I need to go in the other room until I cool off.

THERAPIST: What are the costs and benefits of this alternative?

PATIENT: The costs are minimal. I don't get to strike back at her. The benefits are that we can avoid a fight and I can feel more in control.

THERAPIST: What are some cooling thoughts that you can tell yourself when you're in that situation?

PATIENT: I can tell myself that it's better to control myself, that I can remain cool. That I don't have to fight back to prove that I'm a man. That I never feel better if I fight.

THERAPIST: What can you tell yourself to reinforce this?

PATIENT: I can tell myself that I'm more in control than I thought. I did a good job. I'm making progress. [The therapist and patient then agree to practice "inoculation" with role plays, and the therapist and patient develop a "coping card" that the patient reads several times a day.]

The following "coping card" may serve as self-instruction for this patient:

COPING CARD

Don't get provoked. Remain cool.

I'm in charge of my feelings.

There's no problem if she makes requests or even nags me. It can't hurt me.

If I get upset, I can always ask for time out and go in the other room to calm down.

I'm much better off staying cool. Easy does it.

We recommend the Patient's Self-Instruction Script (Form 10.6) for patients working on self-direction and self-control.

CASE CONCEPTUALIZATION

A frequent criticism of cognitive therapy is that it appears too "technique-oriented"—that is, too focused on a nontheoretical, or nonconceptual approach to the individual patient. In fact, Beck (1976) gave an early warning against the "trial-and-error" approach of technique-oriented cognitive therapy, urging clinicians to develop a treatment plan and conceptualization for each patient. More recently, Persons (2008), in *The Case Formulation Approach to Cognitive-Behavior Therapy*, has encouraged cognitive therapists to guide their therapy by "case conceptualization" rather than a "shotgun" approach to using techniques. There is no one kind of case conceptualization—and, indeed, each cognitive-behavioral approach will lead to its own model of conceptualizing. For example, a more traditional behavioral approach will emphasize the role of contingencies, learning history, role models, and problematic coping (e.g., isolation, passivity, rumination, complaining). In contrast, a more traditional cognitive approach will emphasize the role of core beliefs or schemas and their relationship to other levels of cognitive functioning (such as automatic thoughts and maladaptive assumptions). These are then linked to the developmental precursors and socialization experiences that gave rise to these problematic schemas. A metacognitive model will emphasize the beliefs about the function of thinking in regulating functioning and problematic strategies, such as worry and rumination. A compassion-focused approach will emphasize significant experiences of shame and humiliation that gave rise to self-loathing and the unwillingness to experience positive self-regard or emotion. An emotional schema model will focus on socialization of beliefs about emotion in the patient's earlier developmental history, as well as the patient's ongoing negative beliefs and coping styles for emotion regulation.

Here we provide a more traditional cognitive example of case conceptualization, to provide the reader with a sense of how this may be utilized. Consider the following schemas evident in a patient's history, as well as the "scripts" by which the patient, Bill, compensates for these schemas.

Schema: "I am weak and vulnerable physically."

Scripts of compensation: Bill becomes proficient in the martial arts, places himself in dangerous situations, and demonstrates counterphobic behavior. He is also compulsive about

checking his weight and his health, and is constantly hypervigilant about any physical problem.

Schema: "I am inferior."

Scripts of compensation: Bill compulsively achieves—conspicuously displaying his wealth, living beyond his means at times, and socializing with the rich and famous. He surrounds himself with people who "depend" on him: His father works for him, and his brothers need his financial support. He tries to prove to his girlfriend that he can make enough money to provide her with the lavish lifestyle she wants.

Schema: "I will be abandoned."

Scripts of compensation: Bill insists that others need him and that he will take care of them financially. If they need him, they won't leave him. Furthermore, some "friends" who have befriended him for his investment savvy cannot truly "abandon" him, because he knows that he will never get attached to them.

The developmental analysis reveals that Bill's father suffered significant business failures during Bill's early adolescence. In addition, his sense of physical vulnerability can be traced to physical abuse and threats of abandonment by his mother. The therapist is able to develop a case conceptualization to assist Bill in recognizing the early origins of these highly powerful schemas—and the ways in which they were relevant and adaptive to a different time in his life. This simple case conceptualization links current automatic thoughts, assumptions, schemas, and compensatory functioning to a developmental analysis. Using experiential techniques (the empty-chair technique, imagery rescripting), behavioral techniques (assertion training, activity scheduling), the double-standard technique, and examination of the evidence for and against these schemas should be helpful. In addition, patients whose current schemas are traceable to individual experiences with parents or others (as Bill's schemas are) can be helped by engaging in role plays challenging these figures and by writing assertive letters to the sources of the schemas.

CONCLUSION

We have outlined a wide range of cognitive therapy techniques that are applicable to almost any mood or anxiety disorder that clinicians will confront. Therapists need not limit themselves to the techniques covered here, however. In several chapters of this volume, we have suggested that patients may benefit from the use of schematic diagrams tracing the relationship between their current problem (e.g., panic disorder) and evolutionary models of psychopathology, genetics, earlier socialization experiences, coping strategies (e.g., avoidance, reassurance seeking), core beliefs or schemas, automatic thoughts and assumptions, and self-confirmation biases. Throughout this volume we have emphasized an integrative cognitive-behavioral approach, drawing on the wide range of techniques, conceptualizations, and strategies now available. Indeed, the exciting quality of cognitive therapy is the continuing development of new approaches and conceptualizations. The interested reader should consult the many volumes mentioned earlier in this chapter that describe the application of these techniques in more detail.

FORM 10.1. General Information for Patients about Cognitive-Behavioral Therapy

Issues	Answers
General description	Cognitive-behavioral therapy is a relatively short-term, focused psychotherapy for a wide range of psychological problems, including depression, anxiety, anger, marital conflict, fears, and substance abuse/dependence. The focus of therapy is on how you are thinking (your "cognitions"), behaving, and communicating *today*, rather than on your early childhood experiences. Numerous studies have demonstrated that cognitive-behavioral therapy is as effective as medication for depression, anxiety, obsessions, and other fears. Furthermore, because patients learn self-help in therapy, they are often able to maintain their improvement after therapy has been completed.
Evaluation of patients	When you begin cognitive-behavioral therapy, your therapist will ask you to fill out several self-report forms that assess a range of symptoms and problems. These forms evaluate depression, anxiety, anger, fears, physical complaints, personality, and relationships. The purpose of this evaluation is to gather as much information on you as possible, so that you and your therapist can learn quickly what kinds of problems you do (or do not) have and the extent of your problems.
Treatment plans	You and your therapist will work together to develop a plan of therapy. This might include how often you need to come; the relevance of medication; your diagnosis; your goals; skill acquisition; needed changes in the way you think, behave, and communicate; and other factors.
What are therapy sessions like?	Some other forms of therapy are unstructured, but in cognitive-behavioral therapy you and your therapist will set an agenda for each meeting. The agenda might include a review of your experience in the previous session, your homework, one or two current problems, a review of what you've accomplished in this session, and homework for the next week. The goal is to solve problems, not just complain about them.
Self-help homework	If you went to a personal trainer at a health club, you would expect to get guidance on how to exercise when the trainer is not there. The same thing is true in cognitive-behavioral therapy. What you learn in therapy is what you practice *outside* of therapy on your own. Research demonstrates that patients who carry out homework assignments get better faster and stay better longer. Your self-help homework might include keeping track of your moods, thoughts, and behaviors; scheduling activities; developing goals; challenging your negative thoughts; collecting information; changing the way you communicate with others; and other assignments.
Aren't my problems due to my childhood experiences?	*Part* of your problems may be due to how your parents, siblings, and peers treated you, but your solutions to your problems lie in what you are thinking and doing *today*. However, with many people we do find it useful at times to review the sources of your problems and help you learn how to change the way you think about them now.

(*cont.*)

FORM 10.1. General Information for Patients about Cognitive-Behavioral Therapy (p. 2 of 2)

Issues	Answers
Aren't my problems due to biochemistry?	*Part* of your problems may be due to biochemistry, but many other factors—such as the way you think, behave, and relate, as well as current and past life events—are important. Using cognitive-behavioral therapy does not rule out the use of medication. For most psychiatric disorders, there is considerable evidence that cognitive-behavioral therapy is as effective as medication. For very serious levels of depression and anxiety, we believe that it may be best to combine medication with therapy. An advantage of cognitive-behavioral therapy is that you also learn ways to solve your problems on your own.
How will I know if I'm getting better?	You and your therapist can identify specific goals at the beginning of therapy—and you can modify these goals as you continue. Then you can evaluate whether you are becoming less depressed, anxious, angry, or the like. You should feel free to give your therapist feedback on your progress. This feedback from you is useful in order to figure out what works and what doesn't work.
How can I learn more about cognitive-behavioral therapy?	Depending on the problems that you want to solve, your therapist can recommend a number of books or other readings for you. We believe that the more you know about yourself, the better off you will be. We hope that you can learn to become your own therapist.

FORM 10.2. Categories of Distorted Automatic Thoughts: A Guide for Patients

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."
2. **Fortunetelling:** You predict the future negatively: Things will get worse, or there is danger ahead. "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. "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. "I'm undesirable," or "He's a rotten person."
5. **Discounting positives:** You claim that the positive things you or others do are trivial. "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 filtering:** You focus almost exclusively on the negatives and seldom notice the positives. "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. "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. "I get rejected by everyone," or "It was a complete waste of time."
9. **Shoulds:** You interpret events in terms of how things should be, rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events, and you fail to see that certain events are also caused by others. "The 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. "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—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "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 on what you can do better now. "I could have had a better job if I had tried," or "I shouldn't have said that."
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. "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. "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. "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 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. "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."

FORM 10.3. Examples of Maladaptive Assumptions: A Guide for Patients

"I should be successful at everything I try."

"If I am not successful, then I am a failure."

"If I fail, then I'm worthless [I'm unlovable, life is not worth living, etc.]."

"Failure is intolerable and unacceptable."

"I should get the approval of everyone."

"If I am not approved of, then I am unlovable [ugly, worthless, hopeless, alone, etc.]."

"I should be certain before I try something."

"If I am not certain, then the outcome will be negative."

"I should never be anxious [depressed, selfish, confused, uncertain, unhappy with my partner, etc.]."

"I should always keep my eye out for any anxiety."

"If I let my guard down, something bad will happen."

"If people see that I am anxious, they will think less of me [reject me, humiliate me, etc.]."

"My sex life [feelings, behaviors, relationships, etc.] should be wonderful and easy at all times."

FORM 10.4. Patient's Event–Mood–Thought Record

Patient's name: _____

Date/time	**Event:** Describe what happened. What were you doing at the time?	**Mood:** Describe your feelings (sad, anxious, angry, hopeless, etc.), and rate their intensity on a 0–100% scale.	**Thought:** Write down your automatic thoughts at the time.

FORM 10.5. Patient's Form for Categorizing and Responding to Automatic Thoughts

Automatic thoughts: Write your negative thoughts and estimate your confidence in the accuracy of each one (0–100%).	**Distortions:** Identify the category into which each automatic thought falls (see "Categories of Distorted Automatic Thoughts: A Guide for Patients").	**Rational responses:** Substitute more realistic thoughts and estimate your confidence in the accuracy of each one (0–100%).

FORM 10.6. Patient's Self-Instruction Script

Questions to ask myself	Answers and solutions
What is the behavior I am trying to change?	
In what situations am I most likely to have this problem?	
What sensations and emotions are signs of this behavior?	
What are the costs and benefits to me of this behavior?	
What are some better alternatives?	
What are the costs and benefits of these alternatives?	
What are some more reasonable things I can say to myself to make me less upset?	
What plans can I make to carry out this new behavior?	
What are some rewarding things I can do for myself when I carry out my new behavior?	

APPENDIX A

Summary of Behavioral Techniques

Technique	Description
Assertiveness training	Training patients to use behaviors that protect their rights while respecting the rights of others.
Behavioral activation (reward planning and activity scheduling)	Helping patients to increase activities that are likely to bring feelings of pleasure and/or mastery.
Communication skills training	Training patients in skills that will make them more effective as both speakers and listeners.
Distraction	Teaching patients to use mentally absorbing activities to prevent themselves from dwelling on negative thoughts.
Exposure—Imaginal	Using guided imagery to expose patients to feared cues in their imaginations.
Exposure—*In vivo*	Exposing patients to actual anxiety-provoking cues in real-life situations.
Graded task assignment	Helping patients to break tasks they find overwhelming into small steps, and to start with the easiest step; as they gain confidence, patients are encouraged to try more difficult steps.
Mindfulness	Teaching patients to focus attention on immediate experience in order to break patterns of negative thinking, increase tolerance for avoided experience, and promote a sense of calmness.
Modeling	Demonstrating adaptive behavior so that patients may imitate it. Used in skills training and exposure, for example.
Problem solving	Training patients to generate, evaluate, and implement possible solutions to problems they face.

(*cont.*)

Technique	Description
Rebreathing	A technique for patients with panic disorder who hyperventilate; involves teaching patients to breathe in air they have already exhaled, in order to restore proper oxygen balance.
Relaxation	Training patients in various techniques to induce physical relaxation as a means of coping with anxiety.
Breathing relaxation	Teaching patients breathing exercises to induce a relaxation response.
Progressive muscle relaxation	Teaching patients a set of techniques in which different muscle groups are first tensed and then relaxed, in order to induce a relaxation response.
Self-reward	Teaching patients to reward themselves for positive behaviors.
Social skills training	Training patients in skills necessary for common social activities, such as meeting new people, initiating conversations, going on job interviews, and dating.
Visualization	Teaching patients to use pleasant imagery in order to distract themselves from negative thinking and to induce relaxation.

APPENDIX B

Summary of Cognitive Techniques

Technique	Description or example
	Socializing patient
Establishing therapeutic contract	Directly ask the patient about commitment to therapy, such as willingness to come regularly and do homework.
Bibliotherapy	Assign readings, such as patient information handouts or books (e.g., Leahy's *Anxiety Free* or *Beat the Blues before They Beat You*).
Indicating how thoughts create feelings	Example: "I feel anxious [mood] because I think I'll fail [thought]."
Distinguishing thoughts from facts	Example: "I can believe that it is raining outside, but that doesn't mean it's a fact. I need to collect evidence—go outside—to see whether it's raining."
	Identifying and categorizing distorted automatic thoughts
Identifying negative thoughts that come spontaneously and seem plausible	Examples: "I think I'll fail," "I always fail," "It's awful to fail."
Identifying the emotions these thoughts create	Examples: Sadness, anxiety.
Rating confidence in accuracy of thoughts, as well as intensity of feelings	Example: "I feel anxious [80%] because I think I'll fail [95%]."
Categorizing thoughts (see Form 10.2 for complete list of categories)	Examples: "I think I'll fail" (fortunetelling), "I always fail" (dichotomous/all-or-nothing thinking), "It's awful to fail" (catastrophizing).

(*cont.*)

Technique	Description or example
	Challenging distorted automatic thoughts
Providing direct psychoeducation	Example: Give information about elevator safety to a patient with a specific phobia of elevators.
Defining the terms (semantic analysis)	Example: Ask patient, "How would you define 'failure' and 'success'?"
Examining testability of thoughts	Can patient make any real-world observations that will confirm or refute thoughts?
Examining logic of thoughts	Is patient jumping to conclusions that don't follow logically from premises (e.g., "I'm a failure because I did poorly on that test")?
Examining limits on patient's information	Is patient jumping to conclusions without sufficient information? Is patient only looking for evidence that supports his or her thoughts, not evidence that might refute them?
Vertical descent	Ask, "What would it mean [what would happen, why would it be a problem] if X occurred? What would happen next? And what would that mean [what would happen, why would it be a problem]?"
Double standard	Ask, "Would you apply the same thought [interpretation, standard] to others as you do to yourself? Why/why not?"
Challenging recursive self-criticism	Is patient locked in a loop of self-criticism for being self-critical (e.g., "I think I'm a loser because I'm depressed, and I'm depressed because I think I'm a loser")?
Examining internal contradictions	Does patient have contradictory thoughts (e.g., "I'd like to meet as many people as possible, but I never want to be rejected")?
Reductio ad absurdum	Are implications of patient's thought absurd (e.g., "If I'm single, I'm unlovable; all people who are married were once single; therefore, all married people are unlovable")?
Distinguishing behaviors from persons	Example: Indicate how failing on an exam is different from being a failure as a person.
Challenging reification	In self-criticisms, is patient making "real" something that is abstract/unobservable (e.g., worthlessness)? Can patient change reifications into "preferences" (e.g., "I prefer doing better at exams")?
Examining variability/degrees of behavior	Help patient examine evidence that his or her behavior varies across time, situations, and persons, and that it occurs to varying degrees (not in all-or-nothing ways).
Weighing the evidence for and against a thought	Example of thought: "I'll get rejected."

Technique	Description or example
	Evidence in favor: "I'm anxious [emotional reasoning]," "Sometimes people don't like me."
	Evidence against: "I'm a decent person," "Some people like me," "There's nothing rude or awful about saying hello to someone," "People are here at the party to meet other people."
	For: 25%. Against: 75%.
	Conclusion: "I don't have much convincing evidence that I'll get rejected. Nothing ventured, nothing gained."
Examining quality of evidence	Would patient's evidence stand up to scrutiny by others? Is patient using emotional reasoning and selective information to support arguments?
Keeping a daily log	Have patient keep a daily log of behaviors/events that confirm or disprove a thought.
Surveying others' opinions	Have patient survey others for their opinions and see whether these confirm or disprove a thought.
Cost–benefit analysis	Example of thought: "I need people's approval."
	Costs: "This thought makes me shy and anxious around people, and lowers my self-esteem."
	Benefits: "Maybe I'll try hard to get people's approval."
	Costs: 85%. Benefits: 15%.
Alternative interpretations	Example: Ask patient, "If someone doesn't like you, might it simply be that the two of you are different? Or perhaps the other person is in a bad mood, or shy, or involved with someone else? Or perhaps there are many other people who can and do like you?"
Negation of problems	Have patient list all the reasons why the current situation is not a problem, rather than all the reasons why it is a problem.
Defense attorney	Tell patient, "Imagine that you have hired yourself as an attorney to defend yourself. Write out the strongest case you can in favor of yourself, even if you don't believe it."
Carrying out an experiment	Have patient test a thought by engaging in behavior that challenges the thought (e.g., for the thought "I'll be rejected," approaching 10 people at a party).
Continuum technique	Have patient place current situation or event on a 0–100 continuum of negative outcomes and examine what would be better and worse than this situation/event.

(*cont.*)

Technique	Description or example
Putting situation/event into perspective	What would patient still be able to do even if a negative thought were true? Or how does patient's situation compare to that of someone with, say, a life-threatening illness?
"Pie" technique	Have patient draw a "pie chart" and divide up responsibility for situation/event.
Examining mitigating factors; reattribution	Are there other causes for a situation/event that should be considered (e.g., provocation, duress, lack of knowledge or preparation, lack of intention, failure on others' part, task difficulty, lack of clear guidelines)? If so, can patient reattribute some of the responsibility for the situation/event to these causes?
Externalizing both sides of a thought through role play	Take the "con" aspects of a thought while patient takes the "pro" aspects, and engage in a role-play argument (e.g., say, "You'll fail the exam"; patient replies, "There's no evidence that I'll fail"; and continue in this manner).
Using role play to apply a negative thought to a friend	Take the role of a friend to whom patient applies a negative thought. How does it sound?
Acting "as if"	First in role play and then in actual situations, have patient act as if he or she does not believe negative thoughts.
Challenging absolutistic thinking	Example: Ask patient, "If you believe that no one will like you, is it plausible that no one in the whole world will?"
Setting a zero point for comparisons; depolarizing comparisons	If patient always compares him- or herself to the best, how does he or she compare to the worst? And how does patient compare to people in the middle of the distribution?
Positive reframing (finding positives in negatives)	Is there a more positive way of interpreting patient's behavior or situation (e.g., instead of saying, "I really bombed on the exam," can patient say, "I learned I can't procrastinate," or "Thank God that course is over")?
Decatastrophizing	Ask patient, "Why would X not be so awful after all?"
Examining the "feared fantasy"	Ask patient, "Imagine the worst possible outcome of X. How would you handle it? What behaviors could you control even if it happened?"
Anticipating future reactions	Ask patient, "How will you [or others] feel about X 2 days, a week, a month, and a year from now?"
Examining past predictions, failure to learn from false predictions, and self-fulfilling prophecies	Has patient generally made negative predictions in the past that have not come true? If so, has patient failed to learn that these predictions have been distorted and biased? Have these predictions turned into self-fulfilling prophecies (i.e., has patient behaved as if they will come true and thus ensured that they will come true)?

Technique	Description or example
Testing predictions	Have patient make a list of specific predictions for the next week and keep track of the outcomes.
Examining past worries	Has patient worried about things in the past that he or she no longer thinks about? If so, have him or her list as many of these as possible and ask, "Why are these no longer important to me?"
Examining future distractions	What are all the other events (unrelated to current event) that will transpire over the next day, week, month, and year and that will cause patient not to care as much about the current event?
Distinguishing possibility from probability	Example: Ask patient, "It may be possible that you will have a heart attack if you are anxious, but what is the probability?"
Calculating sequential probabilities	Have patient multiply the probabilities of a predicted sequence of negative events.
Fighting overgeneralization	Ask patient, "Just because X happened once, does that mean it will inevitably happen?"
Challenging the need for certainty	Tell patient, "You can't have certainty in an uncertain world. If you are trying to rule out absolutely all possibility of negative outcomes, you will be unable to act."
Advocating acceptance	Suggest to patient, "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 perhaps you can learn to appreciate what you can do."
Using "point–counterpoint" with difficult thoughts	For difficult thoughts that are resistant to other techniques, engage in "point–counterpoint" role play with patient.
Reexamining original negative thought and emotion, confidence in accuracy of thought, and intensity of emotion	Example: "I feel anxious [15%] because I think I'll fail [20%]."
Developing rational response to thought (new, more realistic, more adaptive thought)	Example: "There isn't much actual evidence that I'll fail; therefore, there's no real reason for me to think I'll fail, and no real reason for me to be anxious."
	Identifying maladaptive assumptions
Determining contents of patient's "rule book" ("shoulds," "musts," "if–then" statements underlying distorted automatic thoughts)	Examples: "I should succeed at everything I do," "If people don't like me, it means there's something wrong with me," "I must be approved by everyone."

(cont.)

Technique	Description or example
	Challenging maladaptive assumptions
Using techniques for challenging distorted automatic thoughts	See above.
Evaluating patient's standards	Ask patient, "Are you setting unrealistic expectations for yourself? Are your standards too high? Too low? Too vague? Do your standards give you room for a learning curve?"
Examining patient's value system	Ask patient, "What is your hierarchy of values? For example, do you place success above everything else? Are you trying to accomplish everything simultaneously?"
Examining social standards	Ask patient, "Are you trying too hard to measure up to society's standards—for example, beauty and thinness for women, or power and status for men? If you don't exactly meet these standards, do you think this makes you a bad or worthless person?"
Distinguishing progress from perfection	Help patient examine the advantages of trying to improve, rather than trying to be perfect.
Challenging idealization of others	Have patient try to list all the people he or she knows who are completely perfect. Since it's unlikely that there will be any, what does this mean about patient's achieving perfection? Or have patient ask an admired person whether he or she has ever made any mistakes or had any problems, and consider what this person's response implies about patient's idealization of others and devaluation of self.
Advocating adaptive flexibility	Help patient examine the benefits of being more flexible in standards and behaviors.
Borrowing someone else's perspective	Ask patient, "Instead of getting trapped by your way of reacting, try to think of someone you know who you think is highly adaptive. How would this person think and act under these circumstances?"
Emphasizing curiosity, challenge, and growth rather than perfection	Example: Suggest to patient, "If you do poorly on an exam, work on how you can develop curiosity about the subject matter or feel challenged to do better in the future, rather than focusing on your grade as a final measure of your worth."
Reexamining maladaptive assumptions and substituting new, more adaptive assumptions	Example: "I'm worthwhile regardless of what others think of me," instead of "If people don't like me, it means there's something wrong with me."
Examining costs and benefits of more adaptive assumptions	Example of more adaptive assumption: "I'm worthwhile regardless of what others think of me." Costs: "Maybe I'll get conceited and alienate people."

Technique	Description or example
	Benefits: "Increased self-confidence, less shyness, less dependence on others, more assertiveness."
	Costs: 5%. Benefits: 95%.
	Conclusion: "This new assumption is better than the one that I have to get other people to like me in order to like myself."
	Identifying dysfunctional schemas
Identifying negative or otherwise dysfunctional views of self and others underlying distorted automatic thoughts and maladaptive assumptions	Examples: "I'm incompetent," "I'm no good," "I must be admired," "Others are rejecting," "Others are all-powerful," "Others must pay tribute to me."
Explaining schematic processing	Indicate how dysfunctional schemas are formed and how they systematically bias the ways events are attended and responded to.
Identifying strategies of avoiding/compensating for schemas	Help patient determine how he or she avoids challenging a schema (e.g., "If you think that you are unlovable, do you avoid getting involved with people?") or compensates for a schema (e.g., "If you believe you are inferior to others, do you attempt to become perfect in order to overcome your 'inferiority'?").
	Challenging dysfunctional schemas
Using techniques for challenging distorted automatic thoughts and maladaptive assumptions	See above.
Activating early memories to identify sources of schemas	Ask patient, "Who taught you to think in this dysfunctional way? Was it your parents? Teachers? Friends? Do you think that their teaching was valid? Were they poor role models?"
Challenging the sources of schemas through role play	Have patient role-play him- or herself challenging the source of a schema and arguing vigorously against this person.
Imagery restructuring; rewriting life scripts	Have patient imagine going back in time and confronting a schema's source. Or have patient revise his or her negative life script so that it has a positive outcome (e.g, for a negative early image of humiliation, have patient write a script in which he or she rejects or criticizes the person responsible for the humiliation).
Writing letters to the source	Have patient write letters to a schema's source (which need not be sent) expressing his or her anger and frustration.

(cont.)

Technique	Description or example
Imagery and emotion	Have patient close eyes, evoke a negative feeling (e.g., loneliness), and then associate a visual image with this feeling. Ask patient to complete this sentence: "This image bothers me because it makes me think . . . "
Coping imagery	Help patient to develop an image of him- or herself coping competently with a feared person or situation.
Miniaturizing the frightening image	Help patient to develop an image of a feared person or thing as much smaller and weaker, instead of bigger and more powerful than the patient.
Desensitizing images	Have patient engage in repeated exposure to a feared image or situation, in order to diminish its capacity to elicit fear.
Nurturant self-statements	Have patient imagine him- or herself as a child and make nurturing statements to the child of the kind he or she wishes had actually been made.
"Bill of rights"	Help patient compose a personal "bill of rights" (e.g., the right to make mistakes, to be human, etc.).
Reexamining original schemas and developing new, more adaptive schemas	Examples: "I am competent" and "Others are only human," instead of "I am incompetent" and "Others are all-powerful."
	Problem solving and self-control
Identifying a problem	Is there a problem that needs to be solved? For example, if patient does poorly on an exam, perhaps he or she needs to study more.
Accepting the problem	Help patient to accept the existence of the problem and begin working toward its solution, instead of being self-critical or catastrophizing.
Examining the goal; generating alternative goals	What is patient's goal in the situation? If one goal has not worked, can patient modify the goal or generate alternative goals (e.g., replace "to be liked by everyone" with "to meet some new people" or "to learn how well I can do")?
Anti-procrastination steps	Guide patient through a series of steps to minimize procrastination (specifying a goal; breaking it down into smaller steps; examining costs and benefits of first step vs. an alternative; scheduling a specific time, place, and duration for the activity; role-playing resistance to engaging in the activity; carrying out the activity).
Self-correction	Encourage patient to learn from any mistakes instead of engaging in self-criticism.

Technique	Description or example
Developing self-instructional statements; creating a "coping card"	Have patient develop self-instructions for use in times of difficulty (e.g., "Don't worry about my anxious arousal. It's arousal. It's not dangerous. Anxiety doesn't mean I'm going crazy. I can tolerate it"). Put these statements, along with reminders and so on, on a "coping card" that patient can refer to easily.
Delaying a decision	For an impulsive patient, it may be useful to delay making a decision on a thought until a certain amount of time has passed or until the patient has had two good nights' sleep.
Canvassing friends	To reduce compulsiveness, a patient can be asked to survey five friends for their advice on the intended thought or action.
Anticipating problems	Have patient list the kinds of problems that might come up and develop rational responses to these.
Inoculation	With the patient, role-play the worst negative thoughts and problems that might come up, and have patient indicate how he or she would challenge them.
Self-reward statements	Encourage patient to list positive thoughts about him- or herself after doing something positive.
Problem solution review	Have patient review past problems and the solutions he or she has used.

APPENDIX C

Overview of Contents of Companion CD-ROM

The CD-ROM is designed to provide a quick reference to key clinical tools and guidelines from the book. The disk allows users to print the various forms and handouts that they will use with their patients. In addition, it includes lists of behavioral techniques and of cognitive concepts and techniques, along with a chart of medications often used for anxiety and depression.

CLINICAL TOOLS AND GUIDELINES

For each of the seven disorders covered in the book, the accompanying CD-ROM provides a brief outline of treatment; sample symptoms, goals, and interventions; specific therapy techniques; forms; and handouts. They are organized into sections by disorder, corresponding to the structure of the book:

Depression
Panic disorder and agoraphobia
Generalized anxiety disorder
Social anxiety disorder (social phobia)
Posttraumatic stress disorder
Specific phobia
Obsessive–compulsive disorder

In addition, the CD-ROM includes clinical forms applicable across all the disorders, as well as summaries of behavioral and cognitive techniques (Appendices A and B from the book).

MEDICATIONS

The CD-ROM also includes a table listing medications that are frequently prescribed in the treatment of depression and anxiety disorders, grouped by the major drug classes:

Antidepressants—monoamine oxidase inhibitors (MAO)
Antidepressants—tricyclics

Antidepressants—selective serotonin reuptake inhibitors (SSRIs)
Antidepressants—miscellaneous
Anxiolytics—benzodiazepines
Anxiolytics—miscellaneous
Stimulants
Antipsychotics—phenothiazines
Antipsychotics—miscellaneous
Antimanics
Hypnotics

USING THE CD-ROM

To read the files, users must have Adobe Reader 9 or higher, which can be downloaded for free at *http://get.adobe.com/reader/*.

To use the CD-ROM, insert it into your CD-ROM drive and open the file called Trmt_Plans_CD.PDF in Adobe Reader. From here you can access all of the content. If you prefer, you can copy the file called Trmt_Plans_CD.PDF in a convenient place on your local hard drive, so that you can access the contents from there in the future.

The CD-ROM is designed to allow you to view the files you want in three ways:

1. Use the hyperlinks included in the table of contents. Roll your mouse over the title. When you see the hand icon, click and you will go to that item.
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