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The Clinician's Guide to CBT Using MIND OVER MOOD

Christine A. Padesky
with Dennis Greenberger

THE CLINICIAN’S GUIDE TO CBT USING *MIND OVER MOOD*

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Christine A. Padesky

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About the Authors

Christine A. Padesky, PhD, a clinical psychologist, is cofounder of the Center for Cognitive Therapy in Huntington Beach, California; codeveloper of strengths-based CBT; and coauthor of six books, including the bestselling self-help resource *Mind Over Mood, Second Edition.* Dr. Padesky is a recipient of the Aaron T. Beck Award for significant and enduring contributions to the field of cognitive therapy from the Academy of Cognitive Therapy (now the Academy of Cognitive and Behavior Therapies; ACBT), the Distinguished Contribution to Psychology Award from the California Psychological Association, and the British Association for Behavioural and Cognitive Psychotherapies (BABCP) Award for Most Influential International CBT Therapist. She has been named a Distinguished Founding Fellow of the ACBT and an Honorary Fellow of the BABCP. The BABCP voted *Mind Over Mood* the most influential CBT book of all time. Dr. Padesky has taught workshops to more than 50,000 therapists internationally and is renowned for her ability to integrate theory, empiricism, creativity, and practical therapy skills. She consults worldwide and develops audio and video training materials for therapists. Her websites are *www.mindovermood.com* (for the general public) and *www.padesky.com* (for mental health professionals).

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Preface

Thank you for incorporating the second edition of *Mind Over Mood* (*MOM2*) into your practice. *MOM2* is written to guide readers to build skills that can alleviate depression, anxiety, anger, guilt, and shame; improve relationships; and achieve greater well-being. This clinician's guide illustrates in step-by-step detail how to unpack all the learning *MOM2* can offer your clients, and how and when to make best use of its 60 worksheets. It also incorporates updated practice guidelines and principles that reflect the growth in cognitive-behavioral therapy (CBT) approaches and methods since the first edition was published.

Keep this guide close at hand to dip into its expertise whenever you need to do so. Its step-by-step layout means that planned therapy interventions can be easily reviewed in the minutes between sessions. For example, if you plan to set up a behavioral experiment, you can review the steps for doing so in Chapter 7 before your session. If you and your client planned a behavioral experiment in your preceding session, Chapter 7 also offers suggestions for debriefing whatever happened. The guidance offered varies according to whether the outcomes of your client's experiments do or do not support their predictions made in the previous session.

I (Christine A. Padesky) wrote the first 14 chapters of this book, drawing on my four decades of experience in practicing CBT and teaching it worldwide to more than 50,000 therapists in workshops, classrooms, and webinars. *The Clinician's Guide to CBT Using Mind Over Mood, Second Edition,* closely captures my vision of how CBT is best practiced. Feedback and questions from therapists who have attended my workshops or consulted with me have helped me identify how *MOM2* can help therapists navigate common misunderstandings, stuck points, and dilemmas in order to improve therapy outcomes. Dennis Greenberger wrote the final chapter of this book, which teaches how best to integrate *MOM2* into group therapy, an often underutilized treatment modality. Informed by his 35 years of clinical experience and considerable expertise in conducting and supervising group CBT, Chapter 15 illustrates session-by-session protocols for two types of *MOM2*-based group therapy.

We have done our best to describe *MOM2* and CBT methods in clear and practical terms that are easy to follow even for therapists new to CBT. At the same time, highly experienced CBT therapists will appreciate that the therapist–client dialogues throughout this book are nuanced and reflect complications that occur in real therapy sessions. Even when evidence-based practices are used, therapy does not always progress smoothly. Throughout this book, our Troubleshooting Guides address many of the common issues that therapists face.

We not only show what to do in therapy and how to do it, we also explain when and why to use or not use *MOM2* for particular issues. Also, we reference the research that supports the methods taught. Keeping abreast of current research is important. Sometimes therapy practices that both therapists and clients assume are helpful can actually reduce clients' chances of recovery. By finding out if what we do in psychotherapy is more or less helpful than doing other things, including doing nothing, we gradually learn how to help our clients more effectively. And yet the sheer number of evidence-based findings can make it challenging for therapists to keep their knowledge current. This guide is based on and references a succinct summary of relevant research findings that are likely to stand the test of time. Therapists can follow the principles recommended in this clinician's guide and know that they are using *MOM2* in ways consistent with evidence-based practice at this writing.

By showing you the best ways to use *MOM2,* we hope that this guide enhances your enjoyment of collaborating with your clients, guiding their discovery, and helping them acquire the types of skills that can support enduring and positive change. If you identify problems not addressed here in your use of *MOM2,* please write us. We may be able to suggest strategies to help you resolve roadblocks you encounter. With your constructive feedback, future editions of *Mind Over Mood* and of this clinician's guide can help an even greater number of people.

CHRISTINE A. PADESKY

Acknowledgments

Whenever I write, I am inspired and informed by the countless therapists whom I have had the pleasure of teaching and becoming friends with over the years. Kate Gillespie deserves special thanks because she convinced me over multiple conversations that therapists learning CBT really needed and wanted us to write this book. Max Eames suggested that I organize the book around step-by-step guidance for each chapter of the second edition of *Mind Over Mood* (*MOM2*), as an alternative to the more purely diagnostic approach in the first edition. His suggestion was brilliant and yielded a much more practical and useful book than the one I had begun to write. Therapists who met with me in consultation while I was writing this book influenced this project by asking questions that prompted greater detail in many of the clinical case illustrations. The many therapists who enthusiastically participated in my workshops over the past several decades informed my awareness of which ideas were inspirational and noteworthy to include, and which ones were potentially confusing and required more explanation. Questions asked in city after city around the world were ones I made sure to address in this book.

Thank you to our editor, Kitty Moore, and my coauthor, Dennis Greenberger, who gave me unpressured room and time to write the book I envisioned. Their trust that something worthwhile would emerge, and the encouragement they each offered along the way, helped sustain me throughout the long writing process. Dennis was always ready to read and discuss chapter drafts; he also sent me a steady stream of encouraging emails. Barbara Watkins provided her meticulous editorial perspective and proposed constructive solutions to each challenge she detected in the text. The entire editorial and production teams at Guilford gave it their all. Special thanks go to eagle-eyed copy editor Marie Sprayberry, Editorial Project Manager Anna Brackett, cover design wizard Paul Gordon, and Marian Robinson's marketing team.

My deepest gratitude goes to Kathleen Mooney, my partner and therapy innovation collaborator for the entire span of my career. Once I completed the manuscript draft, she spent countless weeks editing each of my chapters and suggesting improvements that led to much greater clarity and readability. She even designed the clinical

tips and reminder icons in this book. Kathleen is a gifted psychotherapist, and I trust her judgment in all things clinical. Whatever was good in this book became better because she generously offered her time and attention to help improve it. We have worked so closely together since the beginnings of our careers as psychologists that she, more than anyone else, is able to recognize when my clinical voice is "true." As codeveloper of all our training programs since 1983, Kathleen also has helped shape my clinical heart and mind. She encouraged me to edit this book again and again until it reflected both.

Aaron T. Beck has been my mentor and friend since the beginning of my career. As a testament to his many kindnesses to me, I have tried to follow in his footsteps and offer inspiration to subsequent generations of therapists. In recent years, I've especially enjoyed meeting with graduate students. These students are the future of psychotherapy and were constantly in my mind as I wrote, creating a press to get this book "right." Each new generation of therapists needs to learn how to do therapy from A to Z. I did my best to write a book that I would have wanted to read when I was learning to be a therapist, and that would still be on my bookshelf today. I hope I have succeeded.

CHRISTINE A. PADESKY

First and foremost, my deepest gratitude goes to my wife, Deidre, and my children, Elysa and Alanna. Throughout my life, they have been a source of unwavering support. They provide meaning and texture to my life and are the source of life's richness.

I also extend my appreciation and gratitude to my colleagues at the Anxiety and Depression Center—Perry Passaro, Shanna Farmer, Robert Yielding, Jamie Lesser, David Lindquist, and Jeannie Morgan. It is a source of inspiration to work alongside them, and I have learned and continue to learn from them every day.

Finally, I want to acknowledge my teachers and mentors, Aaron and Judith Beck. My professional life has been defined by our time together, and I hope that my contributions to this book help move the field and their vision forward.

DENNIS GREENBERGER

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Section I

Mind Over Mood Unpacked

1

How to Use This Clinician's Guide

This clinician's guide is more than a text on how, when, and why to integrate the second edition of *Mind Over Mood* into therapy. It demonstrates many of the best ways to practice cognitive-behavioral therapy (CBT). It functions like an experienced CBT therapist, sitting in the room with you, helping you make therapy choices and guiding you along the way.

We provide detailed guidance for *every* exercise and worksheet in the second edition of *Mind Over Mood: Change How You Feel by Changing the Way You Think* (*MOM2;* Greenberger & Padesky, 2016). This clinician's guide will help you find practical and creative approaches for using *MOM2* with your clients. **We recommend that you keep *MOM2* open alongside you as you read this guide.** The commentary and clinical examples in this book will make more sense when you see the companion text and worksheets that are being described. Whether you are new to using *Mind Over Mood* with your clients or someone who has been incorporating this workbook into therapy for a long time, this clinician's guide will enhance your knowledge and offer new insights to bolster your work with individuals, couples, and groups. We believe it will help you become a better CBT therapist.

STRUCTURE OF THIS CLINICIAN'S GUIDE

Chapters 2–13 of this clinician's guide (the remaining chapters in Section I) unpack and elaborate on the information taught in each chapter of *MOM2*. They provide detailed guidance for how and when to use each of the 60 worksheets in *MOM2* in ways that are consistent with evidence-based therapy practices. These chapters provide clinical rationales for therapy methods, as well as the reasons why we teach selected skills in a particular order to clients with specific diagnoses. Critical therapy procedures are illustrated with in-depth therapist–client dialogues that fit with broader CBT theory and evidence-based practice. Each of these chapters, except for Chapter 13, also includes a Troubleshooting Guide to address common clinical challenges and strategies for

Reminder Box

This guide is designed to be read by experienced clinicians as well as graduate students in mental health fields, whether they have a background in CBT or not.

We recommend keeping *MOM2* open for easy reference as you read. After this first chapter, each chapter of this guide:

- Summarizes state-of-the-art research and evidence-based clinical methods.
- Offers tips for individualizing *MOM2.*
- Includes a Troubleshooting Guide for common clinical challenges encountered with the client issues addressed in that chapter. (An exception is Chapter 13, which, instead of a Troubleshooting Guide, includes a discussion of how the Epilogue in *MOM2* can assist with particular client issues.)
- Features therapist–client dialogues to enrich your understanding of how to carry out critical therapy steps effectively.

Until you are fully familiar with *MOM2,* review the relevant chapter guides that pertain to the worksheets and chapters you are using with your clients. Your periodic review will help you recall the "best use" for *MOM2.*

handling them. Chapter 13 instead describes how the Epilogue to *MOM2* can help address several common client issues.

Section II of this book, *Mind Over Mood* in Context (Chapters 14 and 15), highlights CBT principles and illustrates how these inform the use of *MOM2* in therapy with individuals, couples, and groups. Each of these chapters also includes a Troubleshooting Guide.

APPLICATIONS OF THIS CLINICIAN'S GUIDE

Research suggests that CBT is more effective when practitioners are faithful to a CBT model and therapy principles (Simons et al., 2010). *MOM2* and this clinician's guide have been written to make it easier for you to adhere to this model, follow the principles that have been demonstrated to be effective, and help you achieve consistent, effective results.

How This Guide Helps Experienced Therapists

Even experienced CBT therapists fall prey to "drift" and stop following best practices. Occasionally, therapy with one or more clients becomes chaotic or unfocused. Therapists can get pulled out of an evidence-based treatment plan and be uncertain how to

get back on track. The Troubleshooting Guides address the causes of these difficulties and propose solutions, along with case illustrations. The succinct summaries of evidence-based practice guidelines provided here can help fill information gaps for disorders that therapists treat only occasionally.

Also, experienced CBT therapists sometimes move too quickly and skip over the processes of teaching clients the fundamental skills that research studies link to better treatment outcomes and lower relapse rates. This clinician's guide provides detailed explanations for teaching these skills, and *MOM2* offers written exercises to assess client understanding and mastery of them. Therapists can periodically review what skills their clients have learned and still need to learn by referencing the *Mind Over Mood* Skills Checklist (Worksheet 16.1, *MOM2,* pp. 282–285). This worksheet lists core skills and ones linked to therapy for particular mood issues. It helps therapists make sure that clients are learning the skills most likely to help them improve and stay well.

How to Use This Guide in Training and Supervision

MOM2 and this clinician's guide can be used as companion texts in graduate and postgraduate therapist training programs. Together, these books offer therapists and graduate students an overview of central CBT methods and processes. Succinct reminders of CBT protocols, accompanied by key references for common client diagnoses and presenting issues, are features of this clinician's guide. The Troubleshooting Guides throughout this book alert novice and experienced therapists alike to potential setbacks that can occur in therapy and strategies for handling them.

Classroom Use

This clinician's guide offers an integrative blueprint for therapists in training by pairing practical guidance for therapy applications of *MOM2* with references to the evidence base from which these methods were derived. The explanations and worksheets in *MOM2* provide a detailed view of what CBT skills can benefit clients, and this guide shows how to teach these skills more effectively.

When novice CBT therapists focus on the practice of a few component skills at a time, such as setting agendas or identifying automatic thoughts, learning is often easier. By practicing component skills with a few clients, therapists can learn how to vary clinical methods for clients with different diagnoses, personality styles, cultural backgrounds, and learning styles. When learning CBT in a group or classroom setting, each therapist can discuss their experiences in practicing component skills, so that members benefit from the learning and insight of all. The group can discuss strategies for managing any barriers that individual therapists have found insurmountable. In this way, therapists learn how to vary standard clinical methods creatively to provide effective help for a broad range of clients.

Clinicians who supervise or teach CBT can use *MOM2* and this clinician's guide to illustrate CBT processes for students. For example, the questions and Helpful Hints boxes in *MOM2* provide templates for a therapist's questioning strategies in session. *MOM2* provides concrete, standardized clinical illustrations for therapist discussion and practice. For example, a course on CBT for depression can illustrate client responses to

CBT by highlighting the sections in *MOM2* pertaining to Ben and Marissa, both of whom were depressed. The instructor can ask participants to compare Ben and Marissa in terms of depression symptoms, history, therapy alliance, and cognitive therapy skill level, as demonstrated in particular therapist–client dialogues and thought record examples (e.g., *MOM2* Chapter 9). Since Ben and Marissa illustrate two quite different faces of depression and treatment response, they provide rich instructive material for therapists learning the nuances of CBT for depression.

Students in many universities around the world have practiced and learned CBT skills during their coursework by applying CBT methods to their own moods, beliefs, and behaviors, using *Mind Over Mood* worksheets. Client examples in *MOM2* and this clinician's guide provide clinical data to help examine negative therapist beliefs about aspects of CBT. For example, did the structure of the therapy inhibit Marissa from experiencing her emotions in *MOM2*? In what ways is the therapist controlling or not controlling sessions in the dialogues in this clinician's guide? In what ways does structure put the client more in control? Can students find examples in *MOM2* in which structure inhibits or enhances the therapy relationship?

Supervision

In the beginning of supervision, supervisees can rate their current knowledge and skills on a variety of core CBT competencies, using the *Mind Over Mood* Skills Checklist (Worksheet 16.1, *MOM2,* pp. 282–285). Supervisors can modify this worksheet by asking supervisees to rate their prior experience and confidence in teaching clients each skill. Supervisees' responses can help shape learning goals for supervision. Supervisors can encourage supervisees to circle the skills they most want to develop in supervision, and the supervisors can then recommend any additional skills that are important to learn. It is ideal if supervisors collaborate with supervisees in making supervision plans that support learning and are suited to the types of clients in the supervisees' caseloads. Supervisees can be periodically asked to rerate their use of skills that are targets in supervision.

MOM2 and this book provide useful templates for many clinical procedures that supervisees need to practice. Role plays can be incorporated into supervision to help supervisees rehearse strategies they are planning to use with their clients. Clinical case examples and/or dialogues from either text can serve as practice samples when a supervisee does not have a relevant clinical situation to role-play. The same CBT principles outlined in Chapter 14 of this clinician's guide can be incorporated into supervision. Ideally, supervision is collaborative, incorporates guided discovery, and focuses on the development of enduring therapeutic skills. Additional guidance on supervision can be found in Kennerley, Kirk, and Westbrook (2017).

Self-Supervision or Peer Supervision

For self-supervision and peer supervision, practitioners are encouraged to record and review their own sessions. It is usually best to target one or two areas of improvement at a time. For example, one month you may choose to improve your skill in helping

clients identify automatic thoughts; another month you may choose to improve your understanding of behavioral experiments. Once your initial learning goals have been met, additional goals can be set. Worksheets in the *MOM2* chapter on goal setting (Chapter 5) can help you establish and prioritize goals for self-supervision and peer supervision. Client dialogues from relevant chapters in this guide can be used as models for therapy interventions you are practicing.

Most therapists are highly motivated to improve their practice skills. Self-supervision is generally the most demanding any of us will ever receive. We urge you to adopt an attitude of encouragement instead of perfectionism. Emphasize observation and problem solving over critique and judgment. Be collaborative and curious with yourself. And, of course, you can use the exercises and worksheets in *MOM2* to evaluate your thoughts whenever you become discouraged or impatient with progress made. Just as is true for clients, the irritants and problems you experience as a therapist can become the seeds for valuable learning.

Practitioners Working in Isolation

Some therapists do not have the benefit of regular supervision and training because their practice is geographically isolated. Other clinicians are the sole CBT practitioners in their groups or regions. Practitioners working alone often recognize a need for additional training, yet the means to obtain it can seem remote. Again, this clinician's guide provides Troubleshooting Guides that address commonly encountered difficulties, along with recommended remedies.

Isolated practitioners are encouraged to avail themselves of phone- or Internet-based supervision or consultation. Most CBT training centers throughout the world offer distance consultation services. One of us (Christine A. Padesky) spends a good portion of her work week in video consultation meetings with therapists from many parts of the world. Consultation with a more experienced CBT therapist can address particular case questions or general CBT skills development.

Personal Use of *MOM2* to Facilitate Learning

One of the best ways to learn CBT is to practice the clinical methods on one's own professional or personal issues (cf. Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). Many therapists have used *Mind Over Mood* themselves, completing many of the worksheets for personally relevant situations. When therapists apply CBT methods to their own lives, they can experience personal benefits and also improve their therapy skills by developing a deeper understanding of the potential uses for each exercise. Personal use of *MOM2* helps therapists learn what it is like to work on CBT exercises during times of emotional arousal. It also increases familiarity with the information and exercises included in *MOM2*. The ability to select learning assignments and tailor them to client needs is determined, in part, by familiarity with *MOM2*.

Many therapists struggle with the structure or other aspects of CBT. They may hold beliefs such as "Structure interferes with client experience of emotions," "Structure inhibits a good therapy relationship," or "Structure is controlling on the part of the

therapist." It is important to test these types of therapist beliefs, which can interfere with CBT practice. This is especially true for beliefs about therapy structure, because adhering closely to CBT's structure has been linked to better treatment outcome (Shaw et al., 1999). Therapist beliefs can be tested on thought records, using the methods described in *MOM2* (see Chapters 4 and 5 of this clinician's guide). In addition to completing thought records, therapists can conduct behavioral experiments (see Chapter 7 of this guide) and actively seek feedback from clients regarding the impact of changes in their style or procedures.

Use of *MOM2* by Therapists Who Do Not Practice CBT

Therapists who do not practice CBT might want their clients to learn particular CBT skills when there is evidence that these skills will help promote lasting change and reduce the risk of relapse. As described throughout this clinician's guide, sometimes a number of different types of psychotherapy have proven effectiveness for various moods and issues for which people seek help. CBT is often one of these therapies, and it is has been shown to have enduring effects, especially when clients learn and practice relevant skills. *MOM2* is written in step-by-step fashion to reflect the learning sequence that most clients follow to acquire the skills linked to lower relapse rates.

The CBT model presented in Figure 2.1 (p. 7) of *MOM2,* and provided in this guide (also as Figure 2.1), is a simple model linking thoughts, moods, behaviors, physical reactions, and environment, as a starting point for helping clients understand their presenting issues. This model is compatible with most forms of psychotherapy, as it simply teaches people that these five areas of life are interconnected, with each part influencing the others. Different psychotherapies emphasize different aspects of this general model. *MOM2* will be particularly helpful when therapists want to address mood, thoughts, or behaviors as targets for change. Although CBT therapists may intervene in any or all of the five areas to help someone, CBT places particular emphasis on improving moods through behavioral change and/or identifying, evaluating, and possibly changing thoughts.

Another circumstance in which therapists who do not generally practice CBT might choose to follow a CBT protocol is when the evidence strongly supports its effectiveness for a particular client issue. *MOM2* can be used to structure and guide the treatment of clients with a wide variety of presenting issues. Specific mood Reading Guides (reprinted in this book in Appendix A, pp. 456–459) can help guide non-CBT therapists to the types of skills and learning that are likely to be helpful for clients struggling with depression, anxiety, anger, guilt, and shame. These Reading Guides can also be found on The Guilford Press's companion website to *MOM2* (see the box at the end of the *MOM2* table of contexts, p. vi there, for this website's URL).

WHEN TO USE *MOM2*: A DECISION TREE

Over the past several decades, therapists around the world have embraced the use of *Mind Over Mood.* Its two editions have been translated into more than 25 languages.

Even so, you may be among the many therapists who have never used a workbook as part of therapy. Figure 1.1 provides a decision tree to help you decide whether *MOM2* can be helpful for you and your clients.

TWO WAYS TO USE *MOM2* AND THIS CLINICIAN'S GUIDE

Once you and your clients make the choice to integrate *MOM2* into therapy, you can use the workbook in a variety of ways to enhance your clients' self-understanding and foster skill development. Most commonly, *MOM2* is either fully integrated into therapy, or used as an adjunct to therapy to pinpoint specific skills for development. Whichever of these two approaches you choose, you will find relevant guidance throughout this book.

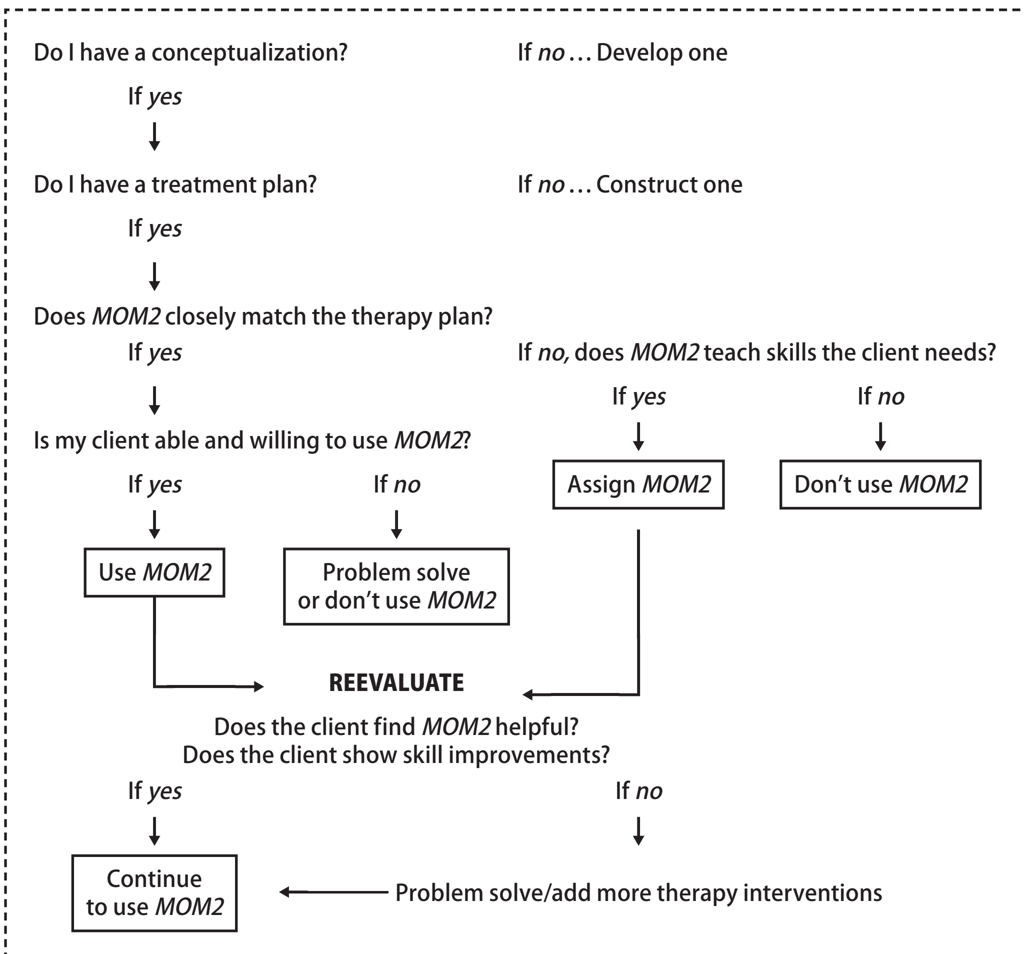


FIGURE 1.1. Decision tree for use of the second edition of *Mind Over Mood* (*MOM2*).

Clinical Tip

Make sure you are using the second edition of *Mind Over Mood* (*MOM2*) as you apply the principles taught in this guide. If you are working with a copy of *Mind Over Mood* translated into another language, the copyright of that book will help you know whether it is the second edition (the publication date will be 2016 or later). Also, *MOM2* has 16 chapters, whereas the first edition only had 12 chapters.

Fully Integrating *MOM2* into Therapy

When *MOM2* is fully integrated into therapy, it can be used as a template throughout the course of therapy. Once therapy has ended, *MOM2* becomes a summary of skills learned and can serve as a form of continuation therapy. For many clients, *MOM2* provides a useful step-by-step treatment plan, with little modification or additional information needed. For example, *MOM2* is designed to fit with evidence-based therapy practices for working with clients on mood issues such as depression, anxiety, anger, guilt, or shame. To increase the likelihood of enduring mood improvements, *MOM2* can fulfill an important role in encouraging skills practice after therapy ends. Therapists who lead groups, whether skills-based or for mood-related problems, can also use *MOM2* as a ready-made therapy program. Chapter 15 of this guide describes how to use *MOM2* effectively for these purposes.

Use Reading Guides to Individualize *MOM2*

While many of the skills taught in CBT are similar across client problems, the order and manner in which the skills are taught vary according to clients' characteristics and diagnoses, therapy settings, and length of treatment available. Depending upon the mood, different *MOM2* chapters are recommended to readers in a specific order.

Reading Guides that describe the recommended *MOM2* chapter order for depression, anxiety, anger, and guilt or shame are provided in Appendix A on pages 456–459 and on Guilford's companion website to *MOM2* (this URL is listed in the box at the end of the *MOM2* table of contents). These chapter sequences are designed to teach the most relevant skills for each mood in an order that most closely fits with evidence-based treatments. The Reading Guides recommend that people read the first four chapters of *MOM2,* then choose a mood to work on and skip ahead to read that mood chapter next: either Chapter 13 (Understanding Your Depression), Chapter 14 (Understanding Your Anxiety), or Chapter 15 (Understanding Your Anger, Guilt, and Shame). Once a client finishes the chosen mood chapter, the Reading Guide for that mood suggests a reading order for learning skills taught in additional *MOM2* chapters.

The first time you follow a specific *MOM2* Reading Guide with a client, it can be helpful to read the corresponding chapters in this clinician's guide, in the order in

Find What You Are Looking for Quickly

We anticipate and hope that you will find it useful to review sections of this clinician's guide over and over again. You can reference information contained in its various chapters whenever it is relevant for a particular therapy session. For ease of finding the information you are looking for more quickly, we include a more detailed table of contents than is contained in most books. Troubleshooting Guide topics are listed at the end of each chapter in the table of contents. We understand that your work day is busy, and we hope that these signposts help you find what you are looking for more quickly.

which you are assigning readings and worksheets to your client. By following the same pathway as your client, you obtain a clearer overview of the relevant *MOM2* skills taught for a particular mood, and you are better able to troubleshoot common difficulties that can arise in therapy. This is likely to be particularly useful if you are relatively new to CBT or *MOM2.* Although following the Reading Guides works well for many clients, you may want to assign the chapter of *MOM2* on goal setting (Chapter 5) nearer the beginning of therapy. Chapter 3 of this clinician's guide, Goal Setting, provides guidance for how to do this.

Certain chapters in *MOM2* will not even apply to some moods. For example, people primarily working on anxiety may never use thought records; thus they can skip Chapters 6–9 of *MOM2,* which teach readers thought record skills. For an explanation of why thought records are less relevant for anxiety disorders, see Chapter 10 of this clinician's guide.

Collaborate on the Decision to use *MOM2*

If you intend to fully integrate *MOM2* into therapy, make sure that your client is interested in the workbook and is able to use it. Most people welcome a workbook if they understand the benefits of using it and if they can set their own learning pace. Sometimes using a workbook will help reduce the cost of therapy by reducing the number of therapy sessions required. In addition to this benefit, *MOM2* reminds people what they are learning in therapy and structures their between-session learning and skills practice. You and your client should discuss how frequently sessions will be scheduled. Meeting weekly for the first two or three weeks is often ideal, because you need to assess your client's problems and determine how to best use the workbook to enhance therapy. During initial therapy sessions, you can help your client set therapy goals (see Chapter 3 of this guide) and review your client's response to the initial chapters of *MOM2.*

If a client responds with interest and successfully completes the first few chapters of *MOM2,* it is sometimes possible to meet less frequently in subsequent weeks when this is necessary for financial or other reasons. This therapy course is illustrated below. As is

true throughout this guide, this case example is based on actual therapy experiences and the treatment course of either single or composite clients. In all case examples, client details have been modified to protect client confidentiality.

Case Example: Pam

Pam, struggling with depression, a husband who drinks excessively, and a variety of family crises, came to therapy requesting help to "cope better." She and her therapist decided after the first meeting that she would benefit from CBT for depression, a local group for partners of persons with alcoholism, support in getting her husband into treatment, and the development of assertion skills so that she could say no to family members who made unreasonable demands of her. Pam had limited financial resources, and her health insurance plan covered only eight therapy sessions. When offered *MOM2* as a core part of therapy, she agreed to give it a try.

After the first session, Pam read and completed Chapters 1 (How *Mind Over Mood* Can Help You), 2 (Understanding Your Problems), and 3 (It's the Thought That Counts). Her therapist reviewed her worksheets in the second session and observed that Pam was able to complete them without difficulty. Much of the second session was spent working on stressful situations in which Pam could not say no to adult family members. Pam and her therapist identified her moods in these situations and the types of thoughts, images and memories that accompanied these moods. Pam agreed to read Chapter 4 (Identifying and Rating Moods) during the following week, and to write down and rate her moods in situations in which she felt her family took advantage of her.

During the third session, her therapist helped Pam (1) develop a list of tactful ways to say no, and (2) identify the thoughts that interfered with her practice of assertion. Pam reported some decrease in depression as a result of feeling less guilty about not meeting everyone's expectations. She also had attended meetings of a group for partners of persons with alcoholism, and she liked the people she met there. Pam agreed to practice saying no during the week; to read the first section of the *MOM2* depression chapter (Chapter 13); and to complete Worksheets 13.1–13.4 to measure her depression and begin to track how her moods might be linked to her activities throughout the day.

In the fourth session, Pam and her therapist reviewed her experiences with saying no to family members, as well as her activities and moods as recorded on her Activity Record (Worksheet 13.4, *MOM2,* pp. 206–207). They completed Worksheet 13.5 (Learning from My Activity Record, p. 208) and Worksheet 13.6 (Activity Schedule, pp. 214–215) in session. Guided by Pam's written observations on the previous week's worksheets, they focused especially on increasing pleasurable activities and activities linked to her values, because she was already doing a lot of accomplishment activities and she was not very prone to avoidance. Since her depression was already improving, as measured on the *Mind Over Mood* Depression Inventory (Worksheet 13.1; *MOM2,* p. 191), and since she could only attend four

more therapy sessions, she and her therapist agreed to schedule her fifth appointment two weeks later.

For this extended time interval until her next appointment, Pam agreed to do the activities written on her Activity Schedule during the first week, and also to call her husband's employee assistance program counselor to find out what treatment options would be available if her husband agreed to get help. During the second week, she agreed to continue any activities that helped her mood, and also to read and complete worksheets in Chapters 6 (Situations, Moods, and Thoughts) and 7 (Automatic Thoughts) of *MOM2.*

When Pam returned two weeks later, her mood was much brighter, and she reported that the workbook was helping her "straighten out her thinking." She commented that she identified with Marissa in *MOM2,* because Marissa also was depressed and, like Pam, had a history of sexual abuse. Pam reported some difficulty in distinguishing between thoughts and moods, although review of her worksheets showed that she only occasionally misidentified them. She and her therapist discussed the differences between thoughts and moods, using Pam's worksheets as examples.

A recurrent thought was identified for situations in which Pam wanted to say no but could not: "They will leave me or hurt me." This belief was examined in the session by completing the last four columns of the 7-Column Thought Record (Worksheet 9.2, *MOM2,* pp. 114–115), which Pam had already begun on Worksheet 7.3 (Identifying Automatic Thoughts, *MOM2,* p. 60). A brief discussion of Pam's history, including the physical and sexual abuse that followed when she tried to assert herself as a child, helped her understand the origins of this belief. She and her therapist then reviewed Pam's current family's (her husband's and adult children's) responses to her infrequent assertiveness. She recalled that although her current family members acted angry when she asserted herself, they usually apologized within a few hours and recently had even told her that she was right to say no. This conceptualization linking her belief, her history, and her current experience was eye-opening to Pam. She left with more assertion plans and a commitment to read Chapter 8 (Where's the Evidence?) of *MOM2.* Her sixth session was scheduled two weeks later because of her therapist's vacation.

The remaining three sessions were scheduled three weeks apart, because Pam found it helpful during the two-week break to have more time to practice the exercises in *MOM2.* She also wanted more time to pursue an alcoholism evaluation with her husband, practice assertiveness, and experiment with solving her problems independently. Although Pam had many problems, the skills taught in *MOM2* and their focused application to her current problems were sufficient to help her make significant progress in brief therapy. By the end of treatment, Pam was able to set appropriate limits on demands made by other family members; she regularly attended meetings for partners of persons with alcoholism; and she no longer took responsibility for her husband's drinking. Her husband entered but then dropped out of treatment. Despite the mixture of improvements and setbacks in her life, Pam's depression and feelings of guilt had decreased. She wrote her therapist a few

months later that she still had many problems, but that she was making slow progress and was continuing to use the *MOM2* workbook.

As illustrated in this case example, the usefulness of *MOM2* as a template for treatment is enhanced when therapists apply the skills taught to clients' therapy goals. Since Pam was able to use the workbook fairly independently, her therapist could accomplish additional tasks during therapy sessions. If Pam had had difficulty learning *MOM2* skills, her therapist would have spent a greater portion of each therapy session directly reviewing information in the *MOM2* workbook, reviewing the exercises Pam completed, and providing additional in-session skills practice.

Pam moved quite quickly through the relevant *MOM2* chapters. The pace for progress through this workbook will vary from client to client. The skills taught in *MOM2* build on each other sequentially, so clients should spend enough time in each chapter to ensure that they can complete the worksheets in that chapter with some ease and confidence. It is therefore important for therapists to review their clients' worksheets. In-session review allows clients the opportunity to tell their therapists what they are learning and to discuss some of the problem situations they faced during the week as described on those worksheets. Review of worksheets also informs therapists how well clients understand and can practice the skills taught in each chapter.

Using *MOM2* as an Adjunct to Therapy

When *MOM2* is used as a therapy adjunct, particular *MOM2* sections, chapters, or worksheets are suggested to clients as needed. Clients can use *MOM2* even during times when you are not working with them or are providing different treatment for them (e.g., crisis or medication management). Sometimes clients need to develop only a few skills taught in *MOM2.* Whenever you are targeting these skills, incorporate the workbook into your therapy. Other circumstances in which *MOM2* is likely to be used as an adjunct to therapy include cases in which you:

- Use a therapy approach other than CBT, and yet consider skills in *MOM2* helpful ones for clients to learn.
- Work in a setting where there is limited or no time for psychotherapy.
- Work in a setting where medication is the sole mode of treatment.
- Are permitted to do only brief crisis-oriented intervention and cannot offer multiple therapy sessions for ongoing difficulties.
- Identify only one or two of the skills in *MOM2* as ones a client needs to learn.

When using *MOM2* as a therapy adjunct, you can enhance its therapeutic value by following a few simple steps:

- Spend time orienting clients to *MOM2.* Describe how and why you think it may be helpful. Advise which chapters may be most useful, and in which order to read them.

• Inform clients that not all skills are easy to apply, and encourage them to complete exercises as many times as necessary to learn the skills in each chapter. Tell them what help is available from you or others if difficulties are encountered.

The case example below illustrates these two points.

Case Example: Carmine

Carmine is a physician in a mental health clinic. He manages medication for a large number of depressed and anxious patients. He offers *MOM2* as an adjunct to medication. Patients interested in using the workbook are told to read specific chapters, following the Reading Guides in Appendix A on pages 456–459 and Guilford's companion website to *MOM2.* Carmine tells his patients:

> "Each chapter has worksheets to complete. The worksheets will help you understand your depression or anxiety better and help you learn skills so you feel better. Most people need to use this book for several months to learn these skills. It is important that you do each exercise as many times as necessary to understand it well. Some exercises you will need to do only once. Other exercises you might have to do five or even ten times before you understand them. Don't hurry through the book: use it as often as you can throughout the week.
>
> "If you try an exercise several times and you still don't understand how to do it, reread the chapter and examples. If it still is confusing to you, we can take five minutes at our next medication checkup to see if I can help you. If I can't help you in that amount of time, I will refer you to a therapist for more help."

• Set reasonable expectations with your client. For instance, do you think *MOM2* will help resolve a client's depression completely, or only moderately help it? Is this a client who will be able to complete most of the chapters in a matter of weeks, or is this client likely to need a week or more for each chapter?

The case example below illustrates this point.

Case Example: Trinity

Trinity works in a crisis clinic. She sees many low-income clients with mood problems and personality disorders who cannot afford as much therapy as would be helpful. She offers these clients *MOM2* and actively promotes its long-term use by setting reasonable expectations for the workbook's helpfulness:

> "This book may help you manage some of the problems in your life. It's not a quick fix, because those don't tend to last. This is a book for you to use day by day, month by month, year after year. It may help you feel better right away, or it may not seem to help much at all. But if you stick with it, you can learn to understand your moods better and learn some ways to feel better. I recommend that you spend a week or more on each chapter until you find a chapter that

really helps. Stick with that chapter for a few weeks, and then move on until you find another helpful chapter.

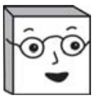
"When you reach the end of the book, go back and reread the chapters that helped you most. Many of the worksheets in this book are repeated at the back of the book, and all of them are available online from the publisher as fillable .pdf forms, so you can load them into a phone or tablet and fill them out in the heat of a situation wherever you are. You can use them as many times as you need to in the years ahead. It will be up to you to read the book slowly and figure out what chapters and exercises are most helpful to you."

- Demonstrate interest in clients' use of *MOM2*. Ask how they like the book if you see them in subsequent weeks. If you are not likely to see them again, you can ask them to contact you in a few weeks with a brief progress report.
- If possible, show clients how *MOM2* applies to their lives before sending it home with them. You might open to the second chapter of *MOM2* and show how their struggles fit within the five-part model for understanding problems depicted in Figure 2.1 there (p. 7), and also describe how this model fits with the type of therapy you offer. Discussion of the book during your meeting provides a bridge between the treatment you offer and *MOM2;* clients can more easily link the approach of the workbook to whatever they have already learned from you.

The case example below illustrates these two points.

Case Example: Bob

Bob has been using a psychodynamic approach to help Melody with her depression. He has recently learned about *MOM2* and decides to add it to her therapy, because Melody is still quite depressed. She is also taking antidepressant medication. Bob tells Melody:



Reminder Box

You can use *MOM2* in different ways:

- As a guide for the entire course of therapy.
- As an adjunct to therapy with a client who is using the manual at home, with or without therapist guidance.
- As a means of teaching discrete skills (integrate specific chapters into therapy).

Again, until you are fully familiar with *MOM2,* review the relevant chapter guides that pertain to the worksheets and chapters you are using with your clients. Your periodic review will help you recall the "best use" for *MOM2.*

"I'd like to give you a book to read and use between our therapy sessions. It describes things you can do to help your depression. Just like we added medication to your therapy, we can add this workbook as well. To show you how therapy, medication, and the workbook fit together, let's look at this model for understanding your depression (*points to Figure 2.1 in MOM2*).

"You'll learn in this book how these five parts of your life fit together. The antidepressant you take is working to improve the physical reactions part of your depression. In therapy, we are working to understand the connections between your past environments and your current moods, behaviors, and thoughts (*points to sections of Figure 2.1*). The book will teach you things you can do to change the negative ways you think about things when you are depressed. Some of the ideas in this book will be like the ones we talk about in therapy, and some may be different. If you have any questions when you read it, we can talk about them in here. Do you have any questions right now?"

HOW *MOM2* SUPPORTS CLIENTS' PROGRESS

MOM2 supports clients' progress in four ways:

1. It teaches skills. *MOM2* teaches skills to manage moods, evaluate behaviors and thoughts, and solve problems. Each chapter includes relevant didactic information, illustrated with examples of how various people might apply this knowledge in common life situations. When clients practice skills until these become second nature, they have a greater chance of being able to take and sustain the steps necessary to improve their lives.

2. It shows clients how to apply skills. *MOM2* worksheets actively enlist clients to apply the skills they are learning to their everyday life experiences. They provide a structured way for clients to continue developing new skills between therapy sessions and after therapy has ended. The worksheets highlight and capture clients' observations and insights. To extract as much learning as possible from clients' efforts, worksheets are reviewed in therapy.

3. It provides feedback. The worksheets provide immediate feedback to a client and therapist about whether the client understands the skills taught and whether these skills help improve target problems. If particular skills are not helpful, the client and therapist can consider whether the skill does not adequately address important aspects of the client's issues, or whether the client is not practicing the skill in the ways intended or at the proper "dose." For example, some of the worksheet exercises require practice several times a week and/or over a number of weeks before they will have an enduring effect on moods.

4. It measures moods. All clients using *MOM2* are encouraged to measure their moods regularly, using the *Mind Over Mood* inventories provided, so that they and their therapists have concrete evidence for whether they are improving or not. Mood measures provided include the *Mind Over Mood* Depression Inventory, the *Mind Over*

Mood Anxiety Inventory, and a general set of scales called Measuring and Tracking My Moods (*MOM2,* pp. 191, 221, and 253). The Measuring and Tracking My Moods scales can be used to assess a variety of distressing or positive moods such as anger, guilt, shame, and happiness, as well as other therapy targets (e.g., stress, pain, conflict). Each of these measures is accompanied by a chart that enables a client to track change over time. Each tracking chart is printed on the *MOM2* page immediately following the mood measure to which it corresponds.

All the mood inventories and other worksheets in *MOM2* are available as downloadable, fillable .pdf forms from the publisher. Purchasers of *MOM2* can download these forms from Guilford's companion website for the workbook (again, see the box at the end of the *MOM2* table of contents) and load these on any electronic device to fill these out as needed. Clinicians are advised to remind clients about potential confidentiality limits if they load and store their worksheets on devices that can be accessed by others. Clients also need to keep in mind that some worksheets are too detailed to fill out easily on small-format electronic devices such as smartphones and are best completed either on a larger electronic device or by using pen/pencil and paper.

Clients' Skill Acquisition and Enduring Change

CBT has been shown to lead to more enduring change than medication does in the treatment of depression and anxiety (Hollon, Stewart, & Strunk, 2006; Steinert, Hofmann, Kruse, & Leichsenring, 2014). It is also considered a leading evidence-based treatment for many disorders (Hofmann, Asnaani, Vonk, Sawyer, & Fange, 2012). People who receive CBT for depression and anxiety report improved quality of life after treatment (Hofmann, Curtiss, Carpenter, & Kind, 2017; Hofmann, Wu, & Boettcher, 2014).

These CBT benefits have been linked to acquisition of mood management skills. Studies demonstrate that clients' understanding of and competence in the use of CBT skills are linked with recovery from depression (Jarrett, Vittengl, Clark, & Thase, 2018). Both qualitative and quantitative practice of CBT skills in "homework" during CBT have been linked to positive therapy outcome (Kazantskis et al., 2016). Furthermore, quality of skill development has been linked to lower rates of relapse (Neimeyer & Feixas, 2016).

The benefits of skill acquisition and their links to enduring change are the primary reasons we wrote both editions of *Mind Over Mood.* Most of the cognitive and behavioral skills that we know help people can be learned through using a workbook. During couple therapy, you may want both partners to learn to identify and test their automatic thoughts when they feel angry, but there may not be enough time in the session to accomplish this. Or you may work in a substance abuse program, and most of your clients cannot easily identify their moods. Or you may want to help clients struggling with procrastination to see the relationship between their current difficulties and underlying assumptions about perfection. Each of these therapy situations requires teaching specific skills that are taught in *MOM2.*

For example, a couple struggling with anger and conflict may already know how to identify moods. Their therapist might recommend that each partner read *MOM2*

Chapters 3 (It's the Thought That Counts), Chapter 6 (Situations, Moods, and Thoughts), and all or portions of Chapter 7 (Automatic Thoughts) over a reasonable time period. Then the partners can be asked to identify one or two automatic thoughts they have when they feel anger toward each other. It will take less therapy time to answer questions about these chapters and review completed exercises than to teach the concepts included in these chapters during therapy sessions. Once the partners become adept at identifying their automatic thoughts during arguments, the couple can read *MOM2* Chapters 8 (Where's the Evidence?), 9 (Alternative or Balanced Thinking), and 10 (New Thoughts, Action Plans, and Acceptance) at a pace matching their mutual skill development. They can practice the skills taught in those chapters inside and outside therapy sessions.

Can using a self-help manual truly replace time spent in therapy and achieve equivalent results? A review of guided self-help in the treatment of depression and anxiety disorders found that guided self-help might actually have a small advantage over face-to-face psychotherapy in the short-run. However, there were no significant differences between the two at follow-up (Cuijpers, Donker, van Straten, Li, & Andersson, 2010). Thus you can use a workbook such as *MOM2* as part of therapy without being concerned that you are delivering suboptimal care, as long as the workbook is used in clinically appropriate ways. Use the decision tree in Figure 1.1 in this chapter, and the principles outlined throughout this clinician's guide, to increase the likelihood that *MOM2* will enhance therapy for your clients.

2

Fundamental Skills

(*MOM2* CHAPTERS 1–4)

When *MOM2* is fully integrated into therapy, clients read Chapters 1 through 4, no matter what mood, behavior, or other goal they are targeting. These four chapters introduce fundamental ideas of CBT theory and practice. Understanding these chapters is easy for most people. They show how a CBT model can be applied to everyday issues. This chapter illustrates how to support your clients' understanding of these first four chapters of *MOM2,* and also how to encourage relevant skills practice. We begin with a demonstration of how you can introduce *MOM2* to your clients.

INTRODUCING *MOM2*

How many psychotherapy books are sitting on your shelf that you have not read? Presumably you bought these books because you thought they would be helpful or interesting. What determines which books you read and use? The first goal in introducing someone to *MOM2* is to increase the likelihood that it will be read and used. It is important to allow time in a therapy session to describe or show the book to your client, give a rationale for its use, discuss your mutual expectations for how it might be helpful, and present clear instructions on how you would like your client to use the book in subsequent weeks. A dialogue illustrating one way to introduce *MOM2* follows. Notice how this therapist used collaboration and guided discovery (principles described more fully in Chapter 14 of this clinician's guide) to increase Kyle's interest in using it.

THERAPIST: You've been very clear in describing your anxiety to me today. Thank you. If I've heard you correctly, you feel anxious all the time.

KYLE: Yes, I can hardly stand it.

THERAPIST: Most people who are anxious want to learn to manage it as quickly as possible. Do you feel that way?

KYLE: Yes!

THERAPIST: Ironically, this means that over the next few weeks, I'm going to ask you to allow yourself to feel anxious instead of trying to get rid of it. When you feel anxious, I'm going to ask you to pay close attention and write down some of the things you notice about it. This will help us understand your anxiety better, so we can set off on the best treatment path.

KYLE: Are you saying I need to feel anxious to learn about it?

THERAPIST: Yes. Does that make sense to you?

KYLE: I think I understand, but I don't like it.

THERAPIST: Being anxious isn't fun. So we better make sure that when you experience anxiety, we learn something that is likely to help you.

KYLE: I'm not sure what I'll learn.

THERAPIST: In the beginning, it would help if you could make some observations about your anxiety. When does it increase or decrease? What goes through your mind when you are anxious? What do you feel physically? This information can help us figure out together what your anxiety is all about and how to best help you.

KYLE: OK. But I'm not exactly sure how to do that.

THERAPIST: There is a lot to learn in the beginning of therapy. So we're going to use a written reminder of what we've talked about, and some written instructions about how to observe your anxiety.

KYLE: OK.

THERAPIST: I'd like to recommend a book called *Mind Over Mood,* which can help you learn about your anxiety and remind you of some of the things we talk about in our appointments.

KYLE: Do I have to read the whole book?

THERAPIST: No. If you like the book, I'll recommend certain chapters that can help us during therapy. You will just read chapters that teach skills to help you with your anxiety.

KYLE: OK.

THERAPIST: My first suggestion would be for you to read the first two chapters—the first 15 pages of the book—before our next appointment, and see if you can fill out Worksheet 2.1, Understanding My Problems (opening the book and pointing to this worksheet on p. 14). You see, there is a Helpful Hints box on this page (points to p. 15) that will help you fill out the worksheet. Then bring the book to therapy next week, so that we can look at the worksheet together. If you have any problems with it, I'll help you next time.

KYLE: OK.

THERAPIST: If you want to do more, you could also read the first six pages of Chapter 14, the anxiety chapter, and fill out the anxiety questionnaire there so we know how anxious you are now. Here it is on page 221. We'll aim to help you become less anxious in the coming weeks. If you fill it out, we'll use this as your starting anxiety score, so we can measure and track how you are doing. Do you think you'll have time to start reading Chapter 14, or do you just want to read Chapters 1 and 2?

KYLE: I might have time.

THERAPIST: You can see how Chapters 1 and 2 go, and then decide if you want to read the first part of Chapter 14. Why don't you circle on the table of contents what you've agreed to do this week so you don't forget?

KYLE: (Circles Chapters 1 and 2, and writes, "If I have time, first six pages," next to Chapter 14.)

THERAPIST: Is there anything that might get in the way of reading these first two chapters this week?

KYLE: No. They don't look too long.

THERAPIST: If you have difficulty, I'll help you next time. But I think you'll find this interesting. I'm certainly curious to learn more about what things are connected to your anxiety. So bring the book back next week, even if you don't complete everything. OK?

KYLE: OK.

Clinical Tip: Introducing *MOM2* to Clients

- Give a rationale for its use.
- Allow time for discussion.
- Link *MOM2* to clients' goals.
- Collaborate on setting expectations for how *MOM2* will be used in therapy.
- Provide clear instructions on how to use it (which pages and worksheets).
- Ask your clients to write down what they agree to do.
- Remind your clients to bring *MOM2* to therapy sessions.
- Review clients' worksheets in therapy sessions.
- Offer to help with difficulties.
- Express interest and curiosity in what your clients will learn.

Kyle's therapist did not hurry the discussion of *MOM2*. She introduced the workbook during the session at a point when he was expressing a need that might be helped by it ("I'm not exactly sure how to do that"). She also gave a rationale for using a workbook (it would "help you learn" between appointments, provide a written reminder of what was discussed in therapy, and teach Kyle how to observe anxiety), as well as clear instructions on what portions of *MOM2* to complete in the following week.

Furthermore, his therapist collaborated with Kyle, asking with each request if he was willing to give it a try, and figuring out with him how much of the book to read and complete. The therapist also asked about roadblocks that might interfere with reading it, and offered to help if Kyle was not able to complete the assignment. Her communications fostered collaboration and implied that using *MOM2* was intended to help Kyle, not to be a burdensome task. Finally, Kyle's therapist signaled that the workbook would play an integral part in the next session ("bring the book back next week"), and she expressed her own interest and curiosity in discovering what he would learn.

As this example illustrates, a few minutes of discussion linking *MOM2* to therapy goals and the learning process can weave this workbook into the fabric of therapy. Clients are more likely to actively use *MOM2* if therapists encourage its use outside the therapy sessions and review what is completed within therapy sessions. Clients with whom we have used the workbook bring it to each session, along with any other therapy notes or journals they keep, and we discuss or review their writings and observations that are pertinent to that week's learning.

Caution: Read Before Use!

Before using *MOM2* with clients, become familiar with its contents. The more thoroughly you know the workbook, the easier it will be to tailor readings and worksheets to particular clients. Weaving *MOM2* into therapy encourages its use at home and provides a bridge toward independent practice of therapy skills learned. Finally, *MOM2* provides many Helpful Hints boxes that you and your clients can use to navigate "stuck" points in therapy sessions.

If you read *MOM2* carefully, you can learn change strategies and paths for client discovery that are new to you and this might help improve the quality of therapy you provide. The following sections help you understand how to use each of the first four chapters of *MOM2* more effectively.

MOM2 CHAPTER 1: HOW *MIND OVER MOOD* CAN HELP YOU

Expectancy plays a large role in the success of psychotherapy and other treatment interventions. The first chapter of *MOM2* is only four pages long, and yet it provides an overview of *MOM2*'s potential benefits and supports readers' expectancies for positive outcomes. You can support positive expectancies for therapy and use of *Mind Over Mood* by making brief, genuine statements such as these:

"The CBT approach used in this book is one of the most successful therapies for the types of issues you are experiencing. That's why I'd like you to try it."

"Many people [or "my clients," if that is true for you] have used this book successfully to learn to manage *XYZ*. If you are willing, we can see if it will help you."

It is important that whatever statements you make are honest. Do not oversell therapy or *MOM2*. Do not say, "I'm sure this will help you quickly." Instead, it is better to say, "I expect that this approach will be helpful. If you are willing, we will give it a try for a few weeks and see if it seems to be helping. Of course, there are no guarantees. If it doesn't help, we will try something else."

MOM2 includes summaries at the end of each chapter. These summaries remind us as therapists of the main learning points we want to make sure our clients understand. For this reason, these summaries are reprinted in the relevant chapters of this clinician's guide. See the *MOM2* Chapter 1 Summary in the box below.

Because there are no worksheets to complete or skills to practice in Chapter 1, most people can also read Chapter 2 in the same week. If you are uncertain about clients' reading ability or motivation, ask them to read Chapter 1, and add that they are welcome to go ahead and read all or part of Chapter 2 if they want. When someone agrees to read Chapter 1 and then does not read it, it can be a sign that this person is reluctant to use a workbook, has difficulty reading, or is ambivalent about therapy or working with you. In this rare instance, the person's thoughts and feelings about therapy and/or using *MOM2* can be explored in the next session.

Chapter 1 Summary

(*MOM2,* pp. 1–4)

- ✓ Cognitive-behavioral therapy (CBT) is a proven, effective therapy for depression, anxiety, anger, and other moods.
- ✓ CBT can also be used to help with eating disorders, alcohol and drug use, stress, low self-esteem, and many other problems.
- ✓ *Mind Over Mood* is designed to teach CBT skills in a step-by-step fashion.
- ✓ Most people find that the more time they spend practicing each skill, the more benefit they get.
- ✓ There are guides throughout the book to help you customize the chapter reading order so you can target the moods that concern you the most.

MOM2 CHAPTER 2: UNDERSTANDING MY PROBLEMS

Four Primary Characters

Four primary characters are followed throughout *MOM2,* and we meet them in Chapter 2: Ben, Linda, Marissa, and Vic. They represent people with well-defined and discrete diagnoses, as well as persons with multiple problems.

- **Ben** was depressed. His depression was of recent onset.
- **Marissa**'s depression was recurrent and sometimes included suicidal thoughts and behaviors.
- **Linda** reported a variety of anxiety-related problems, including panic attacks, worries, and a fear of flying on airplanes.
- **Vic** was recovering from alcoholism. He was experiencing bouts of anxiety, low self-esteem, guilt, and shame, as well as anger outbursts that had begun to strain his relationship with his wife, Judy.

The purpose of including four primary characters throughout the book is to help readers observe a variety of ways the principles and skills taught in *MOM2* can be applied to common issues and life challenges. Most of the skills-building worksheets in *MOM2* are illustrated with examples from one or more of these four characters, to provide readers with concrete examples for how to complete them. Readers can follow the learning progress of these four characters throughout the workbook, and can even learn what happened to them after therapy in the Epilogue of *MOM2.* Readers often identify with one or more of these characters, especially when their presenting issues are similar. However, it is not necessary for people to identify with a single character in *MOM2.* Many secondary characters are introduced in various chapters who illustrate a wide variety of human struggles.

The Five-Part Model

A simple five-part model (Padesky & Mooney, 1990) for describing and understanding difficulties is introduced in Chapter 2. Readers see how the four primary characters in *MOM2* put information from their lives into this model. The fact that four diverse sets of presenting issues can fit this model encourages readers that their own personal issues will fit this model as well. The five-part model is a simple, client-friendly way to begin to draw a descriptive case conceptualization of presenting issues (Kuyken, Padesky, & Dudley, 2009).

One of the common misconceptions about CBT is that it considers thoughts the main starting point for moods and behavior. The five-part model shown in Figure 2.1 (p. 7) of *MOM2* (and presented here, also as Figure 2.1) is a more accurate drawing of CBT theory. It reflects a constant interaction among behavior, thoughts, moods, and physical experience. Changes in any one of these areas can lead to changes in the others. And these four intrapersonal elements are constantly influenced by the environment,

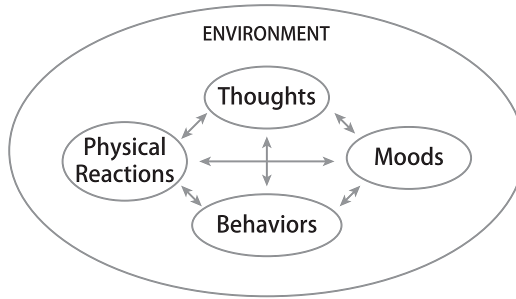


FIGURE 2.1. Five-part model for understanding life experiences. Copyright © 1986 Christine A. Padesky.

which includes situational (e.g., financial difficulties) and interpersonal (e.g., social supports and demands) contexts, as well as the broader environment (e.g., urban setting vs. small town) and a person's cultural factors (e.g., ethnic, racial, LGBTQ+, religious), both current and historical (Padesky & Mooney, 1990). Clients are asked to complete Worksheet 2.1, Understanding My Problems (*MOM2,* p. 14). Remind them that there are guiding questions they can ask themselves in the Helpful Hints box on p. 15 of *MOM2.* When clients have difficulty filling out this worksheet on their own, you can complete it with them in session. The *MOM2* Chapter 2 Summary describes what clients can learn from this exercise.

Rather than just reviewing these summary learning points with each client, it is more memorable to derive these learning points from their worksheet responses, as illustrated in the following dialogue:

THERAPIST: It's interesting to see everything you wrote on this worksheet. Was this difficult to fill out?

JONTELLE: I got stuck a few times, but the Helpful Hints box on the next page helped.

Chapter 2 Summary

(*MOM2,* pp. 5–15)

- ✓ There are five parts to any problem: environment/life situations, physical reactions, moods, behaviors, and thoughts.
- ✓ Each of these five parts interacts with the others.
- ✓ Small changes in any one area can lead to changes in the other areas.
- ✓ Identifying these five parts may give you a new way of understanding your own problems and give you some ideas for how to make positive changes in your life (see Worksheet 2.1, *MOM2,* p. 14).

THERAPIST: I'm glad. Well, you did a good job filling it out. I do notice that the trouble you told me you are having with your daughter is missing from this worksheet. Are things going better there, or did you just forget to put it in?

JONTELLE: Oh. I forgot about that.

THERAPIST: Do you want to add it?

JONTELLE: Yes.

THERAPIST: Where would you put that on the worksheet?

JONTELLE: Under "situations"?

THERAPIST: That makes sense.

JONTELLE: (*Writes the additional information on Worksheet 2.1.*)

Notice that the therapist did not provide more help than necessary and supported the client's correct understanding of the model.

THERAPIST: The chapter said that each of these five parts interacts with the others. Can you give me any examples of how that might work for you?

JONTELLE: Well, I notice I tend to stay home more when I get anxious.

THERAPIST: Let's draw a line between your behavior [staying home] and your mood [anxious], then.

JONTELLE: OK. (*Draws line.*)

THERAPIST: When you stay home more, do you think that this affects any of your thoughts?

JONTELLE: (*Looks at her worksheet.*) I guess that's when I start to think, "I'm weak."

THERAPIST: OK. Let's draw a line, then, between your behavior and your thoughts.

As her therapist and Jontelle worked together and drew lines connecting various parts of the model, Jontelle began to understand what the Chapter 2 Summary means by "Each of these five parts interacts with the others." It was not necessary to make all the connections once she grasped this idea. Next, her therapist linked her five-part model worksheet to treatment options a few minutes later in this session:

THERAPIST: When I see how these parts all interact for you, it helps me understand how you've gotten into such a tough spot with your anxiety. Small changes in one area lead to small changes in other areas, and pretty soon you are really stuck. Does that make sense to you?

JONTELLE: Yes, it really does. I never realized this before. Now I'm really stuck in a mess.

THERAPIST: Actually, I see good news in this picture.

JONTELLE: You do? I don't see it.

THERAPIST: The good news seems to be small changes. If small changes for the worse can lead to such a mess, then small improvements in one area can lead

to small improvements in other areas, and eventually your mess can get solved.

JONTELLE: Do you really think so?

THERAPIST: Yes. If you are willing to work with me, our job will be to figure out what are the smallest changes you can make that will lead to the biggest positive improvement over time.

JONTELLE: How do we do that?

THERAPIST: Take a minute and look at this worksheet. Are there any areas where you think you could make a small positive change? We could start there and see if that small change can help shift some of the other areas as well.

JONTELLE: (*Silent for a minute*) I want to stay home when I'm anxious. But I notice on days when I have to go out, I sometimes feel a little bit better. Maybe I could start by figuring out some easier things to do outside the house when I'm feeling anxious.

THERAPIST: That's an interesting idea. We could experiment with that and see what happens. Do you have any predictions?

Making links between case conceptualization and treatment steps is important in therapy. When clients are invited to collaborate in making connections among different parts of their experience (as Worksheet 2.1 guides them to do), they often begin to think of steps they can take to help themselves. In this way, the problems a client lists on Worksheet 2.1 can be used as a springboard for developing therapy goals and even an initial therapy plan.

Thoughts and behaviors are the two parts of the five-part model that are usually easiest for people to directly change. For these reasons, behaviors and thoughts are often targets of CBT change efforts. Behaviors are generally easier to identify, even though changing them sometimes can prove challenging. Thoughts are often out of people's awareness. Therefore, *MOM2* teaches readers how to become more aware of their thoughts. Even though thoughts are not necessarily the root causes of many issues addressed in therapy, the beliefs people hold can interfere with (e.g., "Why try? It won't make any difference") or support (e.g., "If I take it one step at a time, I can do this") change efforts.

Thoughts often serve a maintenance function for mood and behavioral difficulties, and thus have a strong influence over change efforts. Beliefs people hold can make it difficult for them to change behaviors, even when they see the benefits of doing so. Therefore, the next chapter of *MOM2* teaches people more about the roles thoughts play in their lives.

MOM2 CHAPTER 3: IT'S THE THOUGHT THAT COUNTS

The third chapter of *MOM2* is only eight pages long, and yet it includes a variety of examples that demonstrate why it is so important to learn to identify thoughts. The most

Chapter 3 Summary
(*MOM2,* pp. 16–24)

- ✓ Thoughts help define the moods we experience.
- ✓ Thoughts influence how we behave and what we choose to do and not to do.
- ✓ Thoughts and beliefs affect our physical responses.
- ✓ Life experiences (environment) help determine the attitudes, beliefs, and thoughts that develop in childhood and often persist into adulthood.
- ✓ *Mind Over Mood* helps you look at all the information available; it is not simply positive thinking.
- ✓ While changes in thinking are often central, mood improvement may also require changes in behavior, physical reactions, and home or work situations/environments.

important ideas are highlighted in the Chapter 3 Summary. As noted in this summary, Chapter 3 addresses two misconceptions about CBT that can be addressed early in therapy. The first is a common belief that positive thinking is a solution to life's problems. In fact, positive thinking "is overly simplistic, usually does not lead to lasting change, and can lead us to overlook information that might be important" (*MOM2,* p. 23). A second misunderstanding about CBT is that changing beliefs is the sole focus of the therapy. The final page of Chapter 3 offers a variety of scenarios that demonstrate the equal importance of making changes in thoughts, moods, behaviors, physical responses, and environment/life situations. So, while identifying, testing, and sometimes changing thoughts can help people solve many of life's problems, it is equally important to consider what changes need to be made in all the other areas of the five-part model.

The Thought Connections

Readers of *MOM2* have just one worksheet to complete in the third chapter: Worksheet 3.1, The Thought Connections (*MOM2,* pp. 22–23). Most people find this an easy worksheet to complete, because it offers a concrete scenario about a parent (Sarah) at a school meeting, and then asks readers to imagine what moods, behaviors, and physical reactions are likely to be connected to Sarah's thoughts as described at the top of the worksheet. They simply need to check one or more responses in each of three areas.

This worksheet is designed to encourage readers to apply the ideas in this chapter to a real-life situation. There is no one correct set of answers, because people could imagine responding in a variety of ways to particular thoughts. Instead, therapists can ask clients to say a bit more about why they chose the answers they did, in order to make sure they understand the connections between thoughts and these other parts of

human experience. Alternatively, a therapist can simply ask, "Did this worksheet help you understand how thoughts are linked to moods, behaviors, and physical reactions?" If the client says that it did, the therapist can ask, "Can you give me an example from your own life this week that demonstrates this same connection between thoughts and one of these other areas of your life?"

What Else Therapists Need to Know about Thought Connections

While Chapter 3 provides clients with a simple introduction to the roles thoughts play in people's lives, therapists benefit from a more complete understanding. For example, specific types of thoughts are linked to specific moods. This is called "cognitive specificity." Second, there are three levels of thought commonly addressed in therapy. Therapy proceeds more smoothly when therapists learn to recognize what levels of thought are present, because different therapy tools are used to address each level of thought.

Cognitive Specificity

One of Beck's early contributions to an understanding of the links between thoughts and moods was the idea that each emotional state or mood, regardless of origin, is accompanied by characteristic patterns of thinking (Beck, 1976). Anxiety is accompanied by thoughts of danger and vulnerability; depression by negative thoughts about the self, world, and future; and anger by thoughts of violation and unfairness. Therapy can be hampered if these thoughts are not identified and evaluated. For example, even though increased activity can serve as a powerful antidepressant, many depressed individuals refuse to do activities because of the characteristic thoughts that occur in depression: "It won't help" (hopelessness), "I'm no fun to be around" (self-criticism), and "I won't enjoy myself anyway" (pessimism).

CBT therapists teach clients to identify, evaluate, and change dysfunctional thinking patterns that interfere with improvement in their moods, behaviors, and other aspects of their lives. By understanding cognitive specificity, therapists can make sure that the types of thoughts addressed in therapy are the ones linked to targeted moods. Relevant cognitive changes often also help clients change their environments (e.g., "If I have worth, then maybe I deserve more nurturing relationships") and can be accompanied by neurobiological changes as well.

Three Levels of Thought

Three levels of thought are addressed in CBT: "automatic thoughts," "underlying assumptions," and "core beliefs" (sometimes referred to as "schemas"). Here we offer a succinct primer on these three levels as linked to *MOM2*.

AUTOMATIC THOUGHTS

Automatic thoughts are the moment-to-moment, unplanned thoughts (words, images, and memories) that flow through people's minds throughout the day. These thoughts

are the easiest to change, especially when they are tested within the situations in which they arise. Thus *MOM2* teaches readers to identify automatic thoughts in connection to particular situations. The tool most often used to test automatic thoughts is the thought record (see Figure 6.1 in *MOM2,* pp. 40–41). This 7-Column Thought Record (Padesky, 1983) used in *MOM2* asks people to identify their thoughts (column 3) connected to a strong mood (column 2) they felt in a specific situation (column 1). Then they are asked to look within that situation for evidence that supports (column 4) or doesn't support (column 5) their automatic thoughts. Finally, they are asked to generate an alternative or balanced thought (column 6) that fits the evidence from the situation, and see if this new thought leads to any changes in their mood (column 7). Chapters 4 and 5 of this clinician's guide teach you in depth how to help your clients learn to use 7-Column Thought Records. For a description of how and why this 7-Column Thought Record was developed, see Appendix B.

UNDERLYING ASSUMPTIONS

Underlying assumptions are cross-situational beliefs or rules that guide people's lives; they include "should" statements (e.g., "A mother should always think of her children first") and conditional "If . . . then . . ." beliefs (e.g., "If people get to know me, then they will reject me"). Underlying assumptions are predictive; they guide behaviors and expectations, even though often they are not articulated consciously. The predictive nature of underlying assumptions makes it easier to test them by doing experiments rather than looking for evidence in a single situation. Thus readers of *MOM2* are taught about underlying assumptions in connection with a chapter on testing beliefs with active experiments. Chapter 7 of this clinician's guide provides step-by-step guidance for how to identify underlying assumptions and test these with behavioral experiments.

CORE BELIEFS (SCHEMAS)

Core beliefs or schemas have been described as screens or filters that help process and code information (Beck, Rush, Shaw, & Emery, 1979). In this clinician's guide, we prefer the term "core beliefs" and use it to describe core beliefs about the self, others and the world. Core beliefs are absolute (e.g., "I am strong") and dichotomous (e.g., "I am strong" or "I am weak"). For this reason, they are best examined on a continuum (scale), which can help people see the middle ground between these endpoints. Most life experiences are likely to fall in the middle rather than at the endpoints of a continuum/scale. We include a Rating Behaviors on a Scale Worksheet in *MOM2* (Worksheet 12.8, p. 171), which can be very helpful for clients who tend to judge themselves, others, and life experiences in "all-or-nothing" core belief terms.

Again, core beliefs usually come in pairs/dichotomies (e.g., "People are cruel" or "People are kind"). According to cognitive theory, only one core belief of a pair is activated at a time (see Beck, 1967). When an intense mood is activated, core beliefs associated with that mood are generally the ones activated. Thus people who are depressed are more likely to believe "I'm unlovable" than "I'm lovable." People who are extremely anxious are more likely to believe "This is dangerous" and "I can't cope" than "This is

manageable" and "I can handle this." When these moods lift, then the alternative paired belief is likely to return.

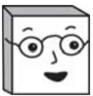
The core belief that is currently active guides people's interpretations of events in their lives. Thus, when people face a life challenge on a day when they feel highly anxious, they are likely to focus on all the problems ("This is dangerous") and their weaknesses ("I can't cope"); as a result, they feel overwhelmed. On a day when they are not feeling anxious, they could face the same life challenge with resignation or even optimism, because different core beliefs would be active: "This is tough," and yet "I can manage and get through it one step at a time." Work with core beliefs is described more fully in Chapter 8 of this clinician's guide.

WHICH LEVEL OF THOUGHT SHOULD BE ADDRESSED IN THERAPY?

We expect maladaptive core beliefs to be active during intense mood states, because the paired core belief connected to that mood will be the one activated. Automatic thoughts, underlying assumptions, and core beliefs are connected with each other. When a particular core belief is activated, automatic thoughts and underlying assumptions related to this core belief are also likely to be activated. For example, the core belief that "People can't be trusted" is likely to be accompanied by underlying assumptions such as "If I get close, then I'll be hurt," and by automatic thoughts such as "She is trying to hurt me."

Even though core beliefs sound really important to address, it is generally advisable for therapists to work with beliefs at the levels of automatic thoughts or underlying assumptions when clients are experiencing intense moods. Why? Automatic thoughts and underlying assumptions can be tested more quickly than core beliefs can. Most of the time, work on automatic thoughts or underlying assumptions will lead to fairly rapid mood improvement, and more adaptive core beliefs will naturally return. Thus it is better to work with automatic thoughts and underlying assumptions earlier in therapy, and only work with core beliefs if these do not naturally shift over time once clients' moods have improved. If therapy does eventually need to focus on direct interventions with core beliefs, these can take a long time to shift (Padesky, 1994).

When the aim of therapy is behavior change, the best level of thought to focus on is usually underlying assumptions. This is because behavioral patterns are guided by



Reminder Box

The majority of the time, therapists will not need to work with core beliefs at all. Even though core beliefs sound really important to address, it is generally advisable for therapists to work with beliefs at the level of automatic thoughts or underlying assumptions when clients are experiencing intense moods. Once clients experience positive shifts in moods and behaviors, more positive core beliefs are likely to reemerge.

underlying assumptions. For example, addictive behaviors are maintained in part by underlying assumptions about urges (e.g., "If I have an urge, then it will go on forever or get worse if I don't satisfy it") and control (e.g., "If I'm tired, then I can't control myself"). Similarly, underlying assumptions are often at the root of behaviors in relationships. For example, the assumption "If we disagree about things, then that means we aren't compatible" can lead to either avoidance of conflict or unwillingness to make a commitment to a highly positive and yet occasionally contentious relationship.

WHEN WOULD A THERAPIST WORK ON CORE BELIEFS?

Core beliefs may not naturally shift as mood improves if the one of these paired beliefs is either weak or missing. This is sometimes the case for people with lifelong chronic mood difficulties or those diagnosed with personality disorders. For these clients, it can be necessary to identify, build, and strengthen more positive core beliefs (Padesky, 1994) by using worksheets from Chapter 12 of *MOM2*. Even so, the processes of building and strengthening more adaptive core beliefs are easier and more likely to be successful when people experience more balanced mood states. Thus therapists are encouraged to follow the Reading Guides for particular moods (see Appendix A, pp. 456–459, or Guilford's companion website to *MOM2*) and help clients develop mood management skills prior to making efforts to build more positive core beliefs.

LEVELS OF THOUGHT: SUMMARY

In summary, there are three interconnected levels of thought. Core beliefs ("I'm unlovable") give birth to underlying assumptions ("If people meet me, then they won't like me"). Together, core beliefs and underlying assumptions determine what types of automatic thoughts occur. For example, in the presence of an activated core belief that "I'm unlovable," and an underlying assumption that "If I'm depressed, then nothing will help me feel better," a more likely automatic thought would be "I won't have any fun at the party," rather than "I'll go to the party and enjoy my friends."

Many cognitive therapy texts label only two levels of thought: automatic thoughts and schemas. In these cases, both underlying assumptions and core beliefs are considered "schemas." We believe that the three-level system is a more helpful way of classifying thoughts, because therapists can differentially choose therapy methods based on the type of thought to be evaluated.

As a reminder:

- Automatic thoughts are best evaluated on thought records (*MOM2* Chapters 6–9; Chapters 4 and 5 of this clinician's guide).
- Underlying assumptions are best tested with behavioral experiments (*MOM2* Chapter 11; Chapter 7 of this guide).
- Core beliefs can be shifted over time by rating experiences on a continuum and by identifying and strengthening more positive core beliefs (*MOM2* Chapter 12; Chapter 8 of this guide).

The chapters noted in this clinician's guide teach these skills in greater depth.

MOM2 CHAPTER 4: IDENTIFYING AND RATING MOODS

THERAPIST: How did you feel when your friend said that to you?

RICK: I don't know. Bad.

THERAPIST: What type of bad? Sad? Mad? Scared?

RICK: I don't know. Just bad.

As shown in the summary box on the facing page, Chapter 4 is designed to help people become more aware of their moods, identify and name a variety of moods, and rate the intensity of those moods. The ability to identify moods is important, especially because different skills are likely to be helpful, depending upon the types of moods someone experiences. Like Rick in the brief dialogue above, some clients cannot identify and label their moods, or they do not have very big mood vocabularies. For these clients, Chapter 4 offers strategies and exercises to help them learn this useful skill.

Identifying Moods

Identification of moods is a particularly important skill, because it ensures that therapists and clients are speaking a common language. Also, at the end of *MOM2* Chapter 4, readers are asked to go to the chapter with the topic most closely matching the mood that distresses them the most: depression (Chapter 13), anxiety (Chapter 14), or anger, guilt, or shame (Chapter 15). So it is important that people spend enough time in Chapter 4 to identify the moods that are most important for them to understand and manage. To help, Worksheet 4.1, Identifying Moods (*MOM2,* p. 28), asks people to identify moods in five separate situations. If people have mood issues, it is likely that the same mood or moods may show up in several of these situations.

Like Rick in the dialogue above, some people identify all their moods in terms of "I feel bad" or "I feel good." These clients need additional help to learn to be more specific in identifying moods. In therapy, we want to help clients begin to replace vague words like "bad" or "numb" or "tense" with more specific mood descriptions like "nervous," "angry," "irritated," "sad," and "disappointed." Chapter 4 of *MOM2* begins with a mood list (*MOM2,* p. 25) they can use to help identify variations in moods. We suggest that clients who are completely unaware of moods pay attention to their physical reactions or situations that they want to avoid. When they notice physical tension, arousal, or times when they feel "bad," they can use these circumstances as opportunities to scan the mood list and see if any of these moods might fit their reactions.

MOM2 Chapter 4 includes suggested exercises clients can do in terms of paying attention to their body tension to see if different moods affect their bodies in different ways. For example, sadness might feel like a complete lack of energy—"Someone pulled a plug and drained me." Anger might be connected to tension in a client's neck or shoulders. Some people find it helpful to actively search their memories for situations

in which they probably felt particular moods in the past. They can then try to recall what these moods felt like. When clients are struggling to identify specific moods, it can be very helpful to do these types of exercises *in session* until they begin to notice the differences between particular moods. It is also helpful to include more enjoyable moods such as happiness or excitement.

Rating Moods

Once people can identify and label moods, they can learn to rate their intensity. The ability to rate moods is an essential skill, because many people come to therapy to learn how to manage distressing moods, and also to increase positive moods. Changes in mood ratings over time is one way to measure whether the skills they are learning and practicing are helping them reach their mood management and improvement goals. One indicator your clients are able to do this is their ability to complete Worksheet 4.2, Identifying and Rating Moods (*MOM2,* p. 30).

While the worksheets in *MOM2* Chapter 4 use generic mood ratings, readers are alerted that there are more specific mood inventories in later chapters. Specifically, there is a *Mind Over Mood* Depression Inventory (Worksheet 13.1 in *MOM2,* p. 191); a *Mind Over Mood* Anxiety Inventory (Worksheet 14.1 in *MOM2,* p. 221); and a set of scales for Measuring and Tracking My Moods (Worksheet 15.1, *MOM2,* p. 253), which can be used to track a variety of moods, including positive moods such as happiness. The use of ongoing mood measurements to track progress is emphasized in the *MOM2* Chapter 4 Summary.

Chapter 4 Summary

(*MOM2,* pp. 25–32)

- ✓ Strong moods signal that something important is happening in your life.
- ✓ Moods can usually be described in one word.
- ✓ Identifying specific moods helps you set goals and track progress.
- ✓ It is important to identify the moods you have in particular situations (Worksheet 4.1, *MOM2,* p. 28).
- ✓ Rating your moods (Worksheet 4.2, *MOM2,* p. 30) allows you to evaluate their strength, track your progress, and evaluate the effectiveness of strategies you are learning.
- ✓ *Mind Over Mood* can be customized to help with the moods that are most distressing to you. After completing this chapter, go to the recommended mood chapter pertaining to that mood. At the end of that chapter, additional chapters and the order in which you should read them are recommended.

If you know early in therapy that certain clients are experiencing depression, anxiety, or another mood, you can ask them to fill out the relevant *Mind Over Mood* inventories or other mood measures before they read Chapter 4 of *MOM2.* In fact, we recommend asking all clients to fill out relevant mood measures at the beginning of therapy. Tracking change on these measures is one of the best ways to get feedback on whether therapy is helping or not. Most CBT therapists ask their clients to fill out a variety of mood measures at intake; then, throughout the course of therapy, they regularly ask them to complete measures pertaining to moods targeted in therapy.

As noted in Chapter 1 of this clinician's guide, your clients can download fillable .pdf versions of the *MOM2* mood measures from Guilford's *MOM2* companion website (again, see the end of the *MOM2* table of contents, p. vi there) and load these onto an electronic device to facilitate easy completion and storage. If you choose to suggest this, remember to advise your clients about potential limits to confidentiality if they load and store their worksheets on devices that can be accessed by others.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTERS 1–4

A variety of dilemmas can arise when you decide to incorporate *MOM2* into therapy. Most of these are variations on potential roadblocks that can occur in therapy even if you are not using a workbook. The most common issues are addressed here.

When Clients Have More Than One Primary Mood

People commonly struggle with more than one mood. Depression is often comorbid with anxiety, guilt, shame, and/or anger, for example. This is actually one of the rationales for why we have covered a variety of moods in *MOM2,* rather than taking the easier course of writing a self-help book for a single mood. It can be encouraging for clients to see that skills they are learning can be helpful for several or even most of their moods. On the other hand, at the end of *MOM2* Chapter 4, we ask people to choose one mood and follow the Reading Guide for that mood (see Appendix A, pp. 456–459, or Guilford's *MOM2* companion website) during the opening weeks and months of using the workbook. If clients are struggling with more than one mood, how do they choose? Some clients have no difficulty choosing the mood they want to tackle first.

When clients are uncertain which mood to choose, ask them to consider the following questions:

1. "Which moods do you experience most intensely? Which moods interfere with your life the most?" (Note: The *MOM2* mood measures can help determine mood intensity.)

> Paul experienced both anger and anxiety. He rated both moods at a level of about 80/100 at their worst. However, his anger was leading to difficulties at work and home that were reaching crisis levels. Thus he decided to target anger first, even though he also wanted help with his anxiety.

2. "Which moods do you find most troubling?" This is often not the same as intensity.

Emma experienced intense anxiety, but she had been experiencing anxiety for many years and was "used to it." When she began to feel depressed, she became very worried and concerned about suicidal thoughts. Thus she reported being more troubled by depression than by anxiety, even though her anxiety scores were higher.

3. "Is one mood primary, in that it probably gives rise to most of your other moods?"

Mahmoud came to therapy to get help with depression, which had become quite severe over the past year. His therapist discovered that Mahmoud also had a long history of social anxiety. Over the past three years, he had increasingly withdrawn from live social interactions. Mahmoud spent more and more time at home and only participated in activities he could do online. As he and his therapist began discussing activities he could do that might help lift his depressed mood, it became clear that Mahmoud's social anxiety was creating a barrier to standard CBT for depression. They agreed that they needed to address his social anxiety first.

4. "Which mood do you want to work on first?"

Occasionally therapists have concerns that their clients are not choosing the "right" mood to work on, or they disagree with the choices their clients make. It is generally better to begin therapy by targeting the goals that are most important to your client, even if you think a different starting point would be better. Clients' perception that their therapists agree with and are working toward client-chosen therapy goals is among the components of a good therapy alliance (Bordin, 1979; Horvath & Greenberg, 1989). For example, if Mahmoud in the example above wanted to work only on his depression, rather than starting with his social anxiety, then his therapist would be better off figuring out ways to modify depression treatment in the early weeks of therapy. If Mahmoud made some progress in reducing his depression, their therapy alliance would be likely to increase (Strunk, Brotman, & DeRubeis, 2010). At this time, his therapist might be able to help Mahmoud consider the pros and cons of addressing his social anxiety as well.

When Clients Have Limited Reading Ability

The first edition of *Mind Over Mood* was rated on a variety of readability scores and given an average reading score rating of age 15 (Martinez, Whitfield, Dafters, & Williams, 2007). When writing the second edition, we aimed to simplify the words used and shorten sentences so that even those adults and older adolescents with lower reading abilities could read and understand it. To date, we are not aware of any analyses of the second edition's reading level, although most adults are capable of reading all of *MOM2.*

Even so, some clients will have limited reading abilities or attention spans. For

example, a client who is severely depressed may find it challenging to read more than a page or two at a time. One way to simplify *MOM2* is to describe the four characters followed in the manual (Ben, Marissa, Linda, and Vic) and ask clients to pick the character who is most like them. A client can then be instructed to follow this one character while reading *MOM2,* and to ignore most of the text related to the other characters.

Suppose that Rita, who is severely depressed, chooses to follow the *MOM2* character Marissa, who was also very depressed. In *MOM2* Chapter 2 (Understanding Your Problems), the therapist crosses out the sections describing Vic and Linda, and asks Rita to read only the opening pages of the chapter (which introduce concepts via Ben, who was also depressed), the section describing Marissa, and the exercise titled Understanding Your Own Problems. Eliminating the sections on Vic and Linda reduces the chapter length almost by half; it also eliminates the discussion of anxiety, which Rita does not need at this time. Her therapist can similarly trim the following chapters to help create a shorter, easier-to-read version of *MOM2.* Rita's therapist should provide guidance on what to read in each chapter, because some important learning points will be missed if *all* references to Vic and Linda are skipped.

Clients who are unable to read and write may not be able to use *MOM2* directly. However, some of these clients may benefit from using an audio reader for *MOM2,* or their therapists can use *MOM2* to guide treatment planning and client exercises. Keep in mind that we ask clients to read and write things down for two reasons: to help clients consolidate skills and to help them remember important learning points. In our experience, clients who do not read or write have often created other ways to remember things. Therapists are encouraged to be curious as to how these clients remember important things, and to incorporate these methods into therapy. For example, clients can benefit from pictorial reminders of what they are learning in therapy. A client keeping a Core Belief Record (Worksheet 12.6, *MOM2,* p. 166) can cut out and save magazine pictures to help remember events that support a new core belief. Clients who can read but cannot write can use a digital recorder to complete *MOM2* exercises. In these ways, therapists can creatively adapt the material in *MOM2* for use with many clients who otherwise might seem poorly suited to benefit from this workbook.

When Clients Don't Do What They Agree to Do

What we ask clients to do in therapy, and how we ask this, will have a big influence on their level of participation. Following a few simple guidelines will greatly increase the likelihood that clients will read and complete *MOM2* exercises and other types of skills practice between appointments.

1. Make Assignments Small

Reading and writing assignments should be workable enough to fit in a client's schedule. For example, a working mother with two small children may have to make an enormous effort to spend even five minutes a day reading or writing. Discuss reasonable expectations with each client. Some clients will commit to spending 15–20 minutes per week on assignments; others may be able to spend as much as an hour per day.

2. Assign Tasks Within the Client's Skill Level

MOM2 is written to help clients develop skills that have been linked with improved mood and more effective problem solving. If therapy moves too quickly through the workbook, clients can begin to feel lost and stop doing assigned readings and worksheets. Clients will have to complete some chapters and worksheets more than once to learn skills. Occasionally chapters presuppose that clients can use the skills taught in earlier chapters. For example, if a client is asked to fill out a complete 7-Column Thought Record (Chapters 8 and 9) before learning to identify hot thoughts (Chapter 7), the client may not be able to complete the assignment. If you follow the Reading Guides on pages 456–459 of Appendix A, you can be assured that skills are being learned in an order that makes sense for a particular mood. It is also wise to assess skills in session via written, role-play, or imagery practice.

3. Make Assignments Relevant and Interesting

Link therapy assignments to clients' goals, and make the assignments as interesting as possible. One way to increase the interest level is to use action phrases like these:

> "Let's see what happens if . . ."
> "Let's plan an experiment for this week . . ."
> "I'm curious what you will notice when . . ."
> "Write down what happens, and we will see what we can learn from it next time."

This type of language is much more engaging than using a phrase like "homework assignment," since very few people get excited about doing homework. People are more likely to feel energized by the idea of doing experiments, investigating, noticing and writing down what they observe, or trying something out to see if it helps.

One study found that clients were more likely to do homework that was directly linked to learning that they found most helpful in a session (Jensen et al., in press). Consider Bill, who wants greater success in his relationships. When his therapist asked him 30 minutes into their meeting what had been most helpful about the therapy session so far, Bill reported he was most interested in what his therapist taught him about automatic thoughts and images, because he realized he had many of these that interfered with his dating efforts. Which of these assignments do you think he will be most likely to complete?

- **a.** "Write down ten automatic thoughts and images this week"
- **b.** "Read *MOM2* Chapter 6."
- **c.** "Imagine that you are preparing to call Pat for a date. Write down three automatic thoughts or images that could stop you from making the call. Pick one of these thoughts or images, read *MOM2* Chapter 6, and see if you can complete the evidence columns of a thought record, using the questions in the Helpful Hints box on page 75 for guidance. Notice if you feel more or less inclined to call Pat after you work on the thought record."

Although the third assignment (c) is more complex, Bill is more likely to complete it, because it is directly relevant to his problem. Also, if calling for dates has been a roadblock for Bill, he will probably be interested to learn more about this experience. The Helpful Hints box on page 75 of *MOM2* can help him begin to resolve his difficulty. Therefore, Bill will benefit more from the third assignment than from either of the first two, which are more rote.

4. Collaborate with Clients in Developing Learning Assignments

Encourage your clients to collaborate with you in selecting and planning therapy assignments. Clients can often figure out what steps need to be taken and how quickly they can take these steps. Part of planning assignments together is discussing whether a client is willing to do particular assignments. Don't ask clients to do things that they are not willing to do, or that you would not be willing to do yourself. Clients are more likely to complete collaboratively designed learning tasks rather than tasks simply assigned by a therapist.

5. Provide a Written Summary and a Clear Rationale for Each Assignment

Often clients are motivated to do therapy exercises, but they forget what to do or why they are doing them. Once you and a client have chosen a learning assignment for the week, write it down. A written summary can include a rationale for the assignment (What is the client going to try to learn? How is this linked to therapy goals?); a specific description of what the client will observe, read, write, or do; and an alternative plan if the original task proves impossible. For example, the alternative learning exercise may be to write down thoughts and moods that interfere with completion of the original assignment.

6. Begin the Assignment during the Session

One of the best ways to make certain a client understands and can complete a learning exercise is to begin it during the therapy session. For example, a client who is asked to write down automatic thoughts related to self-doubt can notice any doubts regarding the ability to complete this assignment. If so, these doubts can be written down as a sample of the type of thoughts that will be recorded. Beginning an assignment in the therapy session increases the client's understanding of what is expected. Furthermore, difficulties that can interfere with completion of the assignment often emerge when the client attempts to begin it (in writing, role play, or imagination) under your guidance. You then can address these roadblocks in advance.

7. Identify and Problem Solve Impediments to the Assignment

It is not enough to clearly assign a therapy task. Ask the client, "What could interfere with completing this exercise?" When asked, clients usually are able to anticipate likely difficulties. Discussing these difficulties ahead of time increases a client's ability to

fulfill learning assignments. For example, if a client says, "I might forget," the two of you can discuss a plan for remembering. If a client says, "I'm not sure I'll have time to complete these observations this week," you can discuss whether to reduce the size of the assignment or how to prioritize observations so that the client can learn the most from whatever time is available for the task.

It is helpful to encourage clients to solve on their own any difficulties they identify. Instead of offering a quick solution ("Maybe you could take 10 minutes during lunch each day"), it is better to ask a client, "How would you like to handle that? What do you think would help?" and then allow a period of silence for the client to think it through. People are more likely to employ strategies they think of themselves than to follow another person's advice. Also, people often devise better solutions for their difficulties than the ones you suggest, given they know themselves and their daily schedules much better than you do.

8. Emphasize Learning, Not a Particular Desired Outcome

A prime goal of therapy is learning. Sometimes people learn more from undesirable outcomes than from successful ones. Clients can become discouraged if a therapist seems to expect particular outcomes that do not occur. Therefore, do not predict what clients will learn from their activities. Instead, be open to whatever learning emerges from experiments, observations, or written exercises.

To set the stage, you might say, "We've talked today about how directly saying what you want could make you feel less burdened by your friends. We won't know if this works until you try it. Do you think it could be worthwhile to try what we practiced today a few times this week?" If the client agrees, you can continue: "When you do this, notice how you feel and how your friends react. That will help us learn if this idea is helpful or not." This instruction keeps the door open to both expected and unexpected results. For example, Marla could discover that her friends become irritated when she expresses her wishes. Although unexpected, this outcome provides important information that could shift your mutual understanding of her issue. Perhaps she feels burdened by friends because they do not respect her feelings, or perhaps she expresses herself in ways that are interpersonally harmful.

It is part of therapists' role to help clients learn *something* from every exercise completed. Therapists should strive to help clients learn from incomplete tasks as well. For example, when a client expressed willingness to read a chapter or complete a worksheet and then did not do it, exploration of this lapse can uncover life events, moods, or beliefs that are interfering with progress. Or the therapist can learn that certain aspects or purposes of an assignment were not clear to the client.

9. Show Interest and Follow Up in the Next Appointment

Ideally, you will be interested in what your clients learn from their activities between sessions. Showing your own enthusiasm encourages clients and so does spending time each session discussing their efforts. How do clients' reading, writing, experiments, or observations contribute to learning or bring them closer to their therapy goals?

When you link clients' learning activities to therapy progress, you encourage clients to continue their efforts.

It is a good therapist practice to write down what each client has agreed to do that week. Reviewing these notes before the next session helps you remember, so you can greet the client with genuine curiosity in the next meeting—for example, "I am really interested to learn how that Action Plan worked with your family this week." Reviewing your clients' between-session learning activities should be part of each session's agenda. For more about agenda setting, see the "Collaboration: Agenda Setting" section of Chapter 14 of this clinician's guide.

10. Learn from Nonadherence

Don't think of clients' nonadherence with learning assignments as "resistance" to therapy. There are usually very good reasons why clients do not complete activities they have agreed to do. Ask your clients why they didn't do what you discussed. Identifying these reasons helps both you and them problem solve impediments to therapy progress. Review the previous nine therapist guidelines to make sure you are doing everything possible to make adherence easy for your client. If you are implementing all of these principles, then examine client factors. Two types of client factors that commonly underlie nonadherence are life factors or problems that need to be solved, and beliefs that interfere with adherence.

LIFE FACTORS OR PROBLEMS TO BE SOLVED

Quite often when clients come to a session without having done a learning assignment, they explain that they forgot or didn't have time to do the assignment. Ask clients to estimate how much time they think an assignment could take. If their estimate is different from yours, review what is expected and begin the assignment in the session, to evaluate the likely time demand. It also can be worthwhile to develop practical, specific strategies to help clients complete assignments. The two most common strategies are scheduling a particular time to do assignments and doing assignments on an as-needed basis.

Some clients find it helpful to schedule a predesignated time to do assignments. If the designated time precedes or follows a daily activity such as brushing teeth, eating dinner, or taking a coffee break, then the daily activity becomes a cue and a reminder to do the assignment. A depressed client who agrees to fill out one thought record at a designated time every day can be asked to mentally review the previous 24 hours and choose the most depressing moment as a focus for that thought record. One disadvantage of designating a time to write out detailed observations such as those required by a thought record is that the memory of the experience may have dimmed by the time the thought record is written.

An alternative to the predetermined time method is the as-needed method. Some clients find it easier to do thought records and other assignments during or immediately following a mood-related experience. They can take *MOM2* with them to work,

carry it with them in their car, keep it available while at home, use a printout of the 7-Column Thought Record, or use the fillable .pdf forms on their electronic devices. For these clients, the cue or reminder to do a thought record is the experience of a particular emotion or behavior. The advantage of the as-needed method is that clients address difficulties immediately, when details of the experience are fresh in their mind. The disadvantage of this method is that events may not occur frequently enough for rapid skill building. To increase the number of situations addressed, clients who experience moods infrequently can use previous experiences for skills practice.

You and your clients can consider a broad spectrum of issues that can interfere with learning activities (e.g., nonsupportive family members, an abusive partner or colleague, or substance misuse). For example, Mary did not complete her written assignments three sessions in a row. During the fourth session, she revealed that she was reluctant to write anything on paper at home, for fear that her physically abusive husband would find it and become enraged. Mary and her therapist decided that it would be safer for her to come to therapy sessions 30 minutes early, do her written assignments in the waiting room, and leave written material with her therapist. In this way, Mary could benefit from written assignments and be assured that her husband would not see what she had written. Of course her therapist also explored with Mary issues related to keeping her safe from abuse.

INTERFERING BELIEFS

Some clients believe that seeing a therapist will lead to improvement if they just show up for every session. They can think of therapy as analogous to seeing a physician and expect that they merely need to attend each appointment, perhaps take some medication, and not do anything else until the next appointment. In CBT, and when using *MOM2,* clients are asked to be much more active and collaborative in their treatment. You can check, especially early in therapy, whether your clients understand that they are required to play an active role. Even if they do, it is helpful before making the first assignment to offer a rationale for between-session efforts. You can assert that what happens between therapy sessions is as important as what happens during them. Clients' adherence with learning assignments has prognostic implications: clients who do assignments tend to get better faster (Kazantzis et al., 2016). This explanation is often sufficient to increase adherence.

When clients routinely do not complete agreed-upon activities, nonadherence becomes a therapy focus. Nonadherence is a valuable opportunity to discover beliefs that need to be addressed before therapy is likely to be beneficial. For example, consider how each of the following beliefs would affect adherence to therapy learning assignments:

> "It's hopeless; nothing I do will make a difference."
> "I won't do it right."
> "I won't do it perfectly."
> "My therapist will criticize me."

"If I show my therapist what I am thinking, she will know I'm crazy."
"If my therapist really cared, he would know how tough it is for me and not ask me to do more."

Therapists can identify beliefs like these that accompany nonadherence and address them by using the methods detailed in *MOM2.* Evaluating these types of beliefs increases the likelihood of changing nonadherence to adherence. In addition, beliefs related to nonadherence sometime mirror underlying assumptions that are contributing to other problems in clients' lives.

3

Goal Setting

(*MOM2* CHAPTER 5)

THERAPIST: What are your goals for therapy?

LAMAR: Mainly, I just want to feel better.

THERAPIST: I can certainly understand that. It sounds like you don't feel very good right now. (*Pause*) If you felt better, what would be different in your life?

LAMAR: I'd wake up feeling happy. I'd probably spend more time with my family and friends. And work on some projects that I've just not felt up to doing.

Once you and your client agree on goals and the road you will take to reach those goals, therapy proceeds more quickly and can be more effective. Goal setting sounds like a dry task, but it includes discussing the client's reasons for wanting change, as well as strengths, values, supports, and motivations. Bringing these factors into your client's awareness can offer hope and jump-start therapy. When you and your client pay attention to early signs of improvement, this also bolsters the client's hope and motivation. Think of goal setting as the musical theme at the start of a good movie: It sets the stage and promises action ahead. Some of the important notes of this musical score are highlighted in the Chapter 5 Summary in *MOM2.*

SETTING GOALS

It might strike some as unusual that we have not put the chapter on goal setting at the beginning of *MOM2,* especially since this is often something discussed in the first therapy session. This goal-setting chapter is the sixth chapter recommended by the Reading Guides for different moods in Appendix A on pages 456–459 and The Guilford Press's *MOM2* companion website (see the box at the end of the *MOM2* table of contents, p. vi there). This placement is designed for people using *MOM2* who are not in therapy.

Early self-help readers of *MOM2* gave us feedback that goal setting was a bit boring to do early on, but that it became more interesting once they got more into the ideas of the book. In therapy, the process of goal setting becomes more interesting because therapists are skilled in helping clients describe specific goals and can offer realistic encouragement that goals are attainable. The possibility or even probability of reaching one's goals is uplifting.

Therapists will often decide to ask clients to read Chapter 5 earlier in therapy than the Reading Guides suggest. This is a chapter that stands on its own and can be read at any time a therapist thinks it would be helpful. This is one of the shortest chapters in *MOM2,* and yet it includes four worksheets people can fill out to increase the likelihood that they will choose goals important to them and ones they are likely to achieve. It begins by simply asking people to make a list of goals they want to achieve, using Worksheet 5.1, Setting Goals (*MOM2,* p. 34). Since *MOM2* is ideally suited to help make changes in mood or behavior, these two types of goals are highlighted in the instructions for this worksheet. Even so, clients can write any types of therapy goals they have.

It is best to describe goals in terms that can be either observed or measured. Mood improvements can be measured on the various mood inventories included in *MOM2.* Try to help your clients describe behavior changes they want to make in terms that can be observed and/or measured. For example, one of the four clients profiled in *MOM2* is Vic, a man recovering from alcoholism who had low self-esteem, anxiety, anger, and relationship problems. Figure 3.1 shows the goals Vic and his therapist specified in the second therapy session. Notice how some of the initial general goals that Vic set for himself were observable and measurable ("Stay sober," "Feel calmer"), and how some might be harder to measure and judge, whether or not they are achieved ("Be a better husband," "Be more successful on my job," "Feel more worthwhile"). This is typical.

Chapter 5 Summary

(*MOM2,* pp. 33–38)

- ✓ Setting personal goals for mood or behavior change helps you know where you are headed and can help you track your progress.
- ✓ People often have mixed feelings about making changes, because there are usually advantages and disadvantages in doing so. Keeping your reasons for change in mind can help you stay motivated.
- ✓ Supportive people in your life, as well as your personal qualities, past experiences, values, strengths, and motivation to learn new skills, can all offer hope that you will reach your goals.
- ✓ It is important to pay attention and notice the early signs of improvement you have checked on Worksheet 5.4 (*MOM2,* p. 37), because positive changes often start small and grow bigger over time.

General goals	Small specific goals
Be a better husband.	Yell less. Don't slam things. Kiss Judy good-bye. Hug Judy when I come home. Come home on time.
Stay sober.	Don't drink. Don't go out with Pete when tired. Call AA sponsor when it's hard. Go to AA meetings when traveling.
Feel calmer.	Figure out what triggers tension. Learn how to relax in tense times.
Be more successful on my job.	Call five customers a day. Get reports in on time. Talk with boss once a week.
Feel more worthwhile.	Stop kicking myself for mistakes. Learn to see my good points. Learn to accept my imperfections.

FIGURE 3.1. Vic's therapy goals. The general goals were the ones Vic recorded on Worksheet 5.1; the specific ones were developed through discussion with his therapist and were attached to this worksheet.

Vic's therapist suggested that they establish "small specific goals" next. This was an attempt to help Vic describe his more ambiguous goals in measurable terms. Vic wrote his more general goals on Worksheet 5.1, and attached his list of more specific goals to this worksheet.

Vic's general goals helped establish areas in his life that needed improvement. His more specific goals itemized observable and measurable changes, so that both Vic and his therapist could regularly monitor whether or not progress was being made. Some of the specific changes Vic and his therapist listed were still not as specific as would be ideal. For example, the steps Vic could begin to take to be a better husband were much clearer than those he could take to feel more worthwhile. But since working on Vic's sense of worth was a goal for later in therapy, his therapist did not think it was necessary to spend additional time clarifying that goal in this second session. Also, some of Vic's specific goals described stopping behaviors ("Yell less"). It can be difficult to stop one behavior without replacing it with another. When it became time to work on particular goals, his therapist helped Vic describe new behaviors he wanted to develop to replace undesirable behaviors ("Discuss problems with Judy at a normal speaking volume. Take a break when I notice my voice begins to increase in volume").

ADVANTAGES AND DISADVANTAGES OF REACHING GOALS

Worksheet 5.2 in Chapter 5, Advantages and Disadvantages of Reaching and Not Reaching My Goals (*MOM2,* p. 35), guides people through a decision-making exercise. In this exercise, people are asked to consider the advantages and disadvantages of both reaching and not reaching their goals. Research shows that asking about both the pros and cons of achieving change can increase someone's persistence and goal commitment (Nenkov & Gollwitzer, 2012). Since most clients and other people using *MOM2* are quite motivated to make changes, this exercise is expected to increase motivation to learn and practice the skills taught.

Important Caution!

For people who have not yet committed to a particular goal, be aware that looking at the advantages and disadvantages of change can *decrease* willingness to change. When people have not yet decided whether they want to make a change, change is more likely to be promoted if therapists use methods drawn from "motivational interviewing," an approach designed to resolve ambivalence toward change (Miller & Rollnick, 2013; Miller & Rose, 2015). For example, when people are still quite ambivalent about making a change, exploring only the positive reasons for change is more effective than asking about both positive and negative aspects of change. Thus Worksheet 5.2, Advantages and Disadvantages of Reaching or Not Reaching My Goals, should be used only for those goals a client clearly and definitely wants to achieve.

WHAT WILL HELP SOMEONE REACH GOALS?

Although goals often seem difficult to achieve, asking people to think about their personal qualities, values, support network, and past experiences of overcoming obstacles can encourage them that positive change is possible. We ask people to think about and make a list of these strengths and experiences on Worksheet 5.3, What Will Help Me Reach My Goals? (*MOM2,* p. 36). Although this is a brief worksheet, it is beneficial for people to spend at least 10–15 minutes thinking about it. Often people can think of only one or two things to write down in the first minute. If they are given more time, a diverse list of positive experiences, strengths, and values will often come to mind. The assets listed on this worksheet provide a wealth of resources to return to in the weeks and months ahead as you help your clients pursue their goals.

If any of your clients find it difficult to identify things to write on this worksheet, you can follow the principles Padesky and Mooney (2012) outline in their model for building a personal model of resilience. These principles encourage a focus on a search for strengths and resilience in everyday experiences linked to a client's positive interests and values. Their idea is that we all show strengths when we are doing something we are highly motivated to do.

For example, Cecelia was living in poverty in government housing, isolated from her family, and without friends; she had been experiencing severe depression for the

past year. She could not identify anything that would help her reach her goal to feel less depressed. Instead, her hopelessness increased when she looked at Worksheet 5.3. Observe how her therapist helped her identify reasons for hope by focusing on a small everyday experience:

CECELIA: I don't have any help. That's why I'm depressed. I don't have money, I haven't been successful in my life, and no one cares about me.

THERAPIST: Let's think a little more about this. (*Pause*) Is there any small thing you look forward to doing each day?

CECELIA: Not really. What do you mean?

THERAPIST: Well, I look forward to a cup of coffee in the morning. I wonder if there is any small moment during the day that you look forward to . . . even a little bit.

CECELIA: No.

THERAPIST: Take just a minute and think about it. It might be a very small thing.

CECELIA: (*After a minute*) Well, there is one thing. (*Pause*) My neighbor has a little girl and a small puppy. Sometimes they go out in the street in the afternoon. I watch them.

THERAPIST: What do you enjoy about watching them?

CECELIA: The little girl is funny. She sometimes just dances around. Sometimes the puppy jumps up and down, and sometimes it runs away from her. They remind me of some of the good times when I was young.

THERAPIST: Do you make a point of looking out for them in the afternoon?

CECELIA: Yes, I do. It is usually about 4:00 when they go out. So I sit by the window then and watch for them.

THERAPIST: What are some of the things that sometimes interfere with your seeing them?

CECELIA: If it's raining, they don't go outside. Well, they take the puppy out, but just for a minute. And some days they just don't go out, or they go out and leave to walk somewhere else.

THERAPIST: On those days they don't go or stay outside, is there anything you do to help remind yourself of how nice that experience of watching them is?

CECELIA: Hmmm. I never thought about it, but I guess I think about that little girl and remember her on those days. Around 4:00.

THERAPIST: So, even though you are very depressed, it sounds like you are still able to enjoy watching that little girl. That lifts your spirits just for a little bit.

CECELIA: Yes.

THERAPIST: And even when she is not there, you have a good imagination and can remember her and enjoy that memory of her.

CECELIA: That's right.

THERAPIST: And seeing her even sparks some good memories from your own childhood.

CECELIA: Yes. Sometimes.

THERAPIST: Let's write these three things down. Take this piece of paper, and write in your own words about your ability to enjoy watching the little girl (*pauses while Cecelia writes*), your imagination and how it can help you remember good things (*pauses while Cecelia writes*), and your own good memories (*pauses while Cecelia writes*).

CECELIA: OK.

THERAPIST: Can you think of any ways these three things might in some small way help you reach your goal to feel less depressed?

CECELIA: Not really.

THERAPIST: Do you think your ability to imagine her and good times, even when they are not there, could help you in any way?

CECELIA: Hmmm. Maybe if I can imagine feeling better, that would help me.

THERAPIST: How do you think it might help?

CECELIA: Well, most of the time, I just think about how I will always be depressed. Maybe if I thought about the possibility of feeling better that would help.

THERAPIST: Yes, I see what you mean. It's hard to try things to help yourself if you are sure you will always be depressed. What can you write on the worksheet to capture this idea?

CECELIA: If I can imagine feeling better, this could help me a little. (*Writes this on Worksheet 5.3.*)

THERAPIST: And is there anything you can take from your own good memories to help you reach your goals?

CECELIA: I was happy sometimes as a child, even though my life was tough. Maybe I could figure out ways to be happy again.

THERAPIST: That's a good idea. And maybe together we can figure out some things for you to do and try that will not only give you hope but also help you actually feel better in the long run.

CECELIA: That would be good.

Cecelia's therapist did a number of things well in this interview. Her therapist asked Cecelia to notice small things, acknowledge a few positive things she was doing, frame hopefulness in her own words, and write down her ideas on the worksheet. If her therapist had pointed out these ideas to Cecelia and told Cecelia what to write down, then Cecelia might have felt less confident in these ideas or might have thought that the therapist was making too much of a small positive experience. By using slow, patient guided discovery in the form of Socratic dialogue, her therapist helped Cecelia discover her own ideas to write on the worksheet. By the end of this interchange, Cecelia appeared to experience a small degree of hope. Therapists not familiar with Socratic dialogue and other methods of guided discovery can read more about them in Padesky (1993a, 2019) and Chapters 7 and 14 of this clinician's guide.

SIGNS OF IMPROVEMENT

At the outset, some goals can seem daunting. Identifying small signs of improvement increases motivation and hope. Why is this so? As an example, think of how much hope you experience for the goal of "feeling happier" compared with the same goal when a signpost you look for along the way is whether you "smile more often." Feeling happier is a bit abstract; people have an easier time imagining smiling more often. The final worksheet in Chapter 5, Worksheet 5.4 (*MOM2,* p. 37), asks readers to identify small signs of improvement. A checklist of some common improvements people notice when their moods improve is included on this worksheet, along with blank lines on which you and your client can write personalized signs you hope to see.

This is not a "write it and forget it" worksheet. Make a note to return to this worksheet every few weeks. It guides you and your clients to make deliberate efforts to look for and notice positive changes. In this way, it can help set up more positive and optimistic expectations. It also helps your clients overcome the pessimism some people feel about making changes or improvements in their life. When people don't believe they can change, they often are not attuned to noticing small positive changes that occur. If you return to this worksheet every few weeks or months and notice that some of the identified signposts are occurring in your client's life, this encourages you both that you are making progress toward important goals.

Use some of the following questions to help your clients determine individualized signposts of change. Choose the questions that seem most helpful for a particular client and goal. For example, if a client has a goal that is vague ("I want to feel better"), questions 4, 6, and 8 in the list below can be particularly helpful in clarifying desired therapy outcomes.

1. "What small steps would show that you are inching toward your goal?"
2. "What do you need to do first before your goal is possible?"
3. "How many weeks or months do you think it will take to reach your goal? What one or two things can you do first?"
4. "What would be the first sign that you are making progress?"
5. "If this was a friend's goal, what would you advise them to do to get started?"
6. "Are there one or two smaller changes that would make you feel better and let you know you are on the right track?"
7. "Can you break your goal into a number of smaller steps?"
8. "Are your goals observable? How will you know if you're making progress? What will be different in your life?"

SETTING GOALS FOR EMOTIONAL CHANGE

Many clients come to therapy with the general goal of wanting to feel less depressed, less anxious, or happier. Examining the intensity of their moods and the types of

experiences that elicit mood reactions can inform their choices for specific, measurable goals and signposts of change. The *Mind Over Mood* Depression Inventory (Worksheet 13.1, p. 191) and the *Mind Over Mood* Anxiety Inventory (Worksheet 14.1, p. 221) assess specific, measurable symptoms of depression and anxiety. These inventories are included in *MOM2* to make it easy for you and a client to establish a baseline mood score, so you both can track changes from session to session and measure progress toward goals for these particular moods.

In addition, these *Mind Over Mood* inventories identify specific symptoms of depression and anxiety that respond to targeted interventions and can be good signposts of change. You can look for changes on specific items of these inventories to see if particular skills practiced by your clients lead to improvements in relevant symptoms. For example, if a client scheduled pleasurable activities during the week, and doing these coincided with a decrease in the client's *Mind Over Mood* Depression Inventory score, discuss whether the client thinks the behavior change was linked to the decrease in depression.

For many people, behavioral activation can lead to these positive changes:

- Improved mood (item 1, *Mind Over Mood* Depression Inventory).
- Increased interest and pleasure in usual activities (item 4).
- Decreased withdrawal from other people (item 5).
- Decrease in finding it harder to do usual things (item 6).

Behavioral activation can also affect other items, such as these:

- Seeing oneself as worthless (item 7).
- Suicidal thoughts (item 9).
- Seeing the future as hopeless (item 14).
- Self-critical thoughts (item 15).
- Tiredness or loss of energy (item 16).
- Change in sleep pattern (item 18).

If changes occur in any of these symptoms, discuss how your client thinks behavioral activation could have helped in the previous week. Identifying specific benefits of skills practice encourages people to incorporate these changes into their lives. Other items on the *Mind Over Mood* Depression Inventory, such as suicidal thoughts, sleep disturbances, and avoidance behavior, can require special attention and planned interventions. By detailing and measuring specific symptoms, you ensure thoroughness and improve the likelihood of positive therapy outcomes.

Many clients have goals related to increasing happiness or a positive sense of well-being. Others want to decrease stress reactions or experience certain emotions more or less frequently. Progress toward all of these types of goals can be tracked with Worksheet 15.1, Measuring and Tracking My Moods (*MOM2,* p. 253), which tracks the frequency, strength, and duration of any mood. As described in greater detail in Chapter 12 of this

Clinical Tip

We recommend that therapists use Worksheet 15.1 with clients to track progress toward goals for positive moods (e.g., happiness) or behaviors (e.g., expressions of affection).

clinician's guide, this generic mood measure can also be used to track other client experiences that are targets of change, such as physical pain or even particular behaviors.

PRIORITIZING GOALS AND TRACKING PROGRESS

Once therapy goals are specified, you and your client can decide how many goals can be accomplished in the time available. If you are doing brief therapy with only a few meetings, one or two goals at most are likely to be achieved. Even if therapy can be extended over a longer time frame, goals must be prioritized so that you and the client can decide what to work on first. In CBT, clients and therapists discuss goals and determine their priorities collaboratively. The following questions are suggested to help your clients choose their highest-priority goals:

1. "Do you need to tackle any of these goals right away to avoid a crisis?"
2. "Which goal would make the most immediate improvement in your life?"
3. "Is there another goal you need to reach first before you can accomplish the goals you named in answer to questions 1 and 2?"
4. "Which of these goals is most important or most meaningful to you?"
5. "Which of these goals would be the easiest to accomplish?"

Questions 1 and 2 help identify urgent goals. Question 3 asks the client to consider whether reaching the urgent goals depends on the accomplishment of another goal. For example, Vic needed to stay sober in order to accomplish his other goals. Whether or not particular goals are urgent, question 4 identifies goals your client is more strongly motivated to achieve. Question 5 considers which goal would be the easiest to achieve. If your client is feeling overwhelmed or hopeless about making change, the easiest goal is sometimes the most manageable starting point. Accomplishing some goal, even an easy one, can increase your client's hope.

Once therapy goals are established and prioritized, you and your client can spend part of each session assessing progress toward goals. As goals are achieved, other goals can emerge as highest priority. If your client is not making progress toward achieving goals, (1) consider breaking specific goals into even smaller steps; (2) search for what is interfering with progress toward goals (e.g., thoughts, emotions, skill deficits, life circumstances); and (3) discuss with your client what could be changed or added to therapy to speed up improvement.

Reminder Box

- Goals help identify what clients want to change, set targets for change, and provide signposts to track progress.
- Break vague general goals into observable and measurable specific goals, so that there will be a clearer roadmap for tracking goal progress.
- Prioritize goals, helping your client decide which goals to work on first.
- Measure and graph mood scores to monitor progress. You can track changes in the frequency, intensity, and duration of moods.
- If a client is not making progress toward goals, consider breaking goals into even smaller steps, problem solve what is interfering with goal progress, or consider changes in the therapy plan.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 5

Although the principles of goal setting are straightforward, this stage of therapy can be much more difficult than it appears. Clients and therapists who do not set goals in other areas of their lives often have difficulty learning to do so in therapy, especially when emotional distress is high. The following clinical examples model therapeutic responses to three common pitfalls in goal setting.

Vague Client Goals or Client Difficulty in Describing Goals

The questions on page 51 can help a client become more specific about vague goals. The following therapy excerpt illustrates this process.

THERAPIST: Judy, you say you want to be a better mother. What do you mean by that?

JUDY: I'm not sure. I just don't think I measure up.

THERAPIST: Can you think of one or two things you would do differently if you were a better mother?

JUDY: (*Pause*) Just make a happier home.

THERAPIST: If a friend told you she wanted to make her home happier, what would you advise her to do?

JUDY: Yell less. And do more things with the kids. Keep things more organized.

THERAPIST: Are there more things?

JUDY: If I made any of those changes, it would be a miracle.

THERAPIST: OK, let's write a list: "Yell less," "Do more things with the kids," "Keep things more organized." Pick one of the things on this list, and let's see if we can get more specific.

JUDY: I don't know which one to pick.

THERAPIST: Pick one that seems important to you. If they're all important, pick any one you like.

JUDY: Keep things more organized.

THERAPIST: What would you need to do to get things more organized at home?

JUDY: I don't know. That's my problem.

THERAPIST: What are the things that let you know you are not organized?

JUDY: I'm late picking up the kids, the house is a mess, I pay my bills late even when I have the money, and there are usually dirty dishes in the sink. Do you want more?

THERAPIST: I get the picture. What would be one or two small changes you could make in the next few weeks that would signal you that you were making progress?

JUDY: I guess if the house was more picked up. And if I was at school when the kids get out.

THERAPIST: Why don't you write those two goals over here under "Keep things more organized"?

Later in this session, Judy and her therapist discussed in detail the changes she needed to make to get her life more organized in the two ways she specified. Clear goals and a plan for achieving them set the stage for Judy either to make desired changes or to discover what thoughts, feelings, and life circumstances were interfering with progress in this area of her life. As this dialogue shows, goal setting requires patience and persistence. When Judy had difficulty being specific, her therapist shifted perspective and asked her to think about a friend. Most people who become lost in their own experience can think more clearly about someone else. Although it takes time to specify goals in this degree of detail, it is easier to achieve specific goals than vague ones. Also, Judy would see her progress in therapy more clearly if she set clear, measurable goals.

Constantly Changing Client Goals

Maintaining focus on the goals a client has chosen is a second common difficulty. Sometimes a change in goals is necessary. For example, Keisha and her therapist established a goal of reducing depression. Once Keisha learned to identify her moods and automatic thoughts, they discovered that she was angry, not depressed. Keisha and her therapist shifted their goals to increasing her awareness of anger and practicing assertion to reflect this change in goals. However, some clients change therapy goals so often that it is not therapeutic, because they don't make progress in any areas of their lives. Observe how Ricardo's therapist discussed the impact on therapy of his constantly shifting goals.

THERAPIST: What do you want to make sure we cover today, Ricardo?

RICARDO: I'd like help figuring out how to meet someone to date.

THERAPIST: Anything else?

RICARDO: No. That's the main thing I want help with.

THERAPIST: Last week we began talking about your plans to change jobs. Should we continue talking about that this week as well?

RICARDO: That's not so much on my mind this week.

THERAPIST: OK. But before we begin talking about dating, I have a concern I'd like to talk over with you, Ricardo.

RICARDO: What's that? Are you upset with me about something?

THERAPIST: No. Do I seem upset?

RICARDO: Not upset exactly. But real serious.

THERAPIST: I guess I do feel serious, because I'm concerned about whether I am helping you as much as I could. Each week, you come here with a different problem. Each of these problems is quite upsetting to you, but we don't seem to stick to any one problem long enough to begin to solve it. Have you noticed that?

RICARDO: Are you saying you want to get rid of me?

THERAPIST: Not at all. But I want to make sure the therapy is helping you as much as possible. I'm worried that if we keep shifting problems, months from now you'll be in the same spot we started. What do you think? Do you think you are making progress?

RICARDO: I'm not sure. I like coming here.

THERAPIST: I'm glad you do. What do you think about my idea of trying to improve how much therapy helps you?

RICARDO: Maybe that's a good idea, but I'm not sure how to make it different.

THERAPIST: One idea I have is to pick one of your problems and talk about it every week, for at least part of the session. What would that be like for you?

RICARDO: It might be hard. If I'm charged up about something, I want to go with that.

THERAPIST: Yes, it might be hard for you. We could talk about whatever has you "charged up" at the beginning of the session, and then switch to talking about the regular problem until it is solved. How would that be?

RICARDO: I'm not sure. Maybe OK. What problem would we work on?

THERAPIST: That would be up to you. I've made a list of all the problems we've talked about so far. Let's take some time today and decide which one of these areas you'd most like to improve.

Ricardo's therapist directly expressed concern and described the possible risks of switching goals each week. Next, rather than demanding a single goal focus, the therapist asked Ricardo questions to discover what his experience had been in therapy. If Ricardo had said that a single session was enough to solve each of the problems

presented to date, the therapist could have agreed to continue this pattern. But Ricardo seemed to affirm the therapist's perception that there had been little therapy progress except for development of a positive therapy relationship.

The therapist then asked Ricardo if he was willing to try a different approach to therapy, and proposed one option. Ricardo noted that it could be difficult for him to stay focused on a single goal, so his therapist proposed a plan for accommodating both Ricardo's style and the therapist's sense of what was likely to be most helpful. As with all changes in therapy, Ricardo and his therapist could treat this change as a behavioral experiment and evaluate its pros and cons in upcoming therapy sessions. If necessary, Ricardo and his therapist could collaborate to make additional adjustments to maximize therapy effectiveness.

Maladaptive Client Goals

In most instances, therapists accept the goals clients choose. However, there are a few circumstances in which this may be countertherapeutic. Two such instances that occur are when clients (1) choose goals they are not likely to achieve through their own efforts, or (2) set goals that actually restate or are likely to maintain their difficulties.

Goals Unlikely to Be Achieved Through Clients' Efforts

Sometimes clients set goals that involve changing other people or altering circumstances in their lives that are not under their control. Goals that involve other people can be achieved if those other people agree to join the client in therapy, and if the therapy contract is changed from individual to couple therapy, family therapy, or therapy with some other relevant group. Even then, it is important to explore what changes the client is willing to make, because changes to improve relationships are rarely one-sided. Other times, clients' goals are under someone else's control. For example, one client wanted her husband to stop drinking. She could certainly consider what steps she can take to ask her husband to consider making this change, but her husband's sobriety was not a goal she could achieve on her own.

In these circumstances, ask your client one or more of the following questions. After each question, there is a sample rationale you can give to your client for asking that question. Even better, create your own explanations, adapting language and metaphors that individualize this discussion.

1. **"Does this goal involve changing something about you?"** Sample rationale:

   "Your goals should not involve changing other people. For example, if you set a goal to have your boyfriend stop criticizing you, this is a goal for his behavior, not your own. You have no direct control over his behavior, although you can tell him how you feel and ask him to stop. If his criticism is a problem for you, your goals might be first to talk with him about it and see if he is willing to change his behavior. If he is unwilling to make a change, you might need to

decide whether to continue the relationship. If you decide to stay in the relationship and he continues to criticize you, you may need to learn to cope with his criticism and continue to talk with him about it."

2. **"Do these goals involve changing things that are in your control?"** Sample rationale:

"It is best to set goals that are in our control. For example, if somebody else decides job promotions where you work, a goal to become manager of your department is not really under your direct control. If you want to be manager, you could set goals such as improving your work performance and meeting with your supervisor to clarify what performance standards you need to achieve to be considered for promotion.

"Also, even perfect efforts don't guarantee a particular outcome, especially when someone else has control over our goal. For example, you can probably find out what expectations your supervisor has for the department manager and you can probably meet them. Hopefully, you will feel a sense of satisfaction as you improve your job performance. However, a manager position may not become available, or someone else in or outside your department may be appointed to the position despite your best efforts."

3. **"Are your goals realistic in the time frame you want?"** Sample rationale:

"Some goals are nearly impossible for anybody to achieve. For example, a goal of being a millionaire by the end of the year if you currently have no savings and a job that barely pays the bills is probably not realistic. Most of us wouldn't set a goal like this, but we often do set therapy goals that are equally unrealistic. For example, some people who are anxious set a goal 'never to feel nervous again.' Since all people feel nervous sometimes in some situations, this is not a realistic goal. It would be more realistic to set goals such as 'to get only as nervous as the average person,' 'to be able to fly in an airplane without having a panic attack,' and 'to get over my fear of public speaking.' These are realistic and achievable goals.

"Similarly, it is unrealistic to stop all negative thoughts. If you want to be less self-critical, for example, you could set goal such as 'to criticize myself less' or 'to give myself as much credit for my successes as I give for my mistakes.' It is unlikely that you will be able to completely stop being self-critical; all of us are self-critical sometimes—and that can even be good for us in small doses."

Goals That Restate or Maintain Difficulties

Sometimes clients set goals that are actually restatements of their difficulties. For example, Claudia described herself in ways that suggested a highly dependent interpersonal style. She was coming to therapy to find out what she was doing wrong in her relationships. According to Claudia, her last four romantic partners had told her she wanted

"too much, too soon." When her therapist began to help her set goals, Claudia said her main goal was to find a partner who "would be there for her 24/7." Upon clarification, Claudia acknowledged that this was a literal goal, not a metaphor for deep caring.

Based on her history and the working case conceptualization, Claudia's therapist hypothesized that Claudia was highly dependent, and that this was why Claudia believed she needed to be cared for 100% of the time by her partner. The therapist recognized that Claudia's goal of receiving constant care was a restatement of her interpersonal difficulties. Observe how Claudia's therapist artfully helped her transform this initial goal into one that aimed toward reductions in dependency, so that Claudia would be able to form a more balanced relationship.

THERAPIST: It sounds like having a partner who is there for you 24/7 would really feel good to you.

CLAUDIA: Yes, that is the kind of person I'm looking for.

THERAPIST: If you could be in a relationship with someone who was there for you 24/7, how would that make your life better?

CLAUDIA: I could relax for once. And feel secure that any problems that came up would be handled by us together.

THERAPIST: Anything else?

CLAUDIA: I would be certain he loved me. If someone is committed to you and willing to always be there, you know he loves you.

THERAPIST: Let's write these things down. (*Writing*) "I want to relax. I want to feel secure we will handle any problems that come up together. I want to be certain he loves me."

CLAUDIA: That looks good.

THERAPIST: I can see how you would really want these things.

CLAUDIA: I'm glad, because that other therapist told me these weren't reasonable.

THERAPIST: I think most people want to be relaxed in their closest love relationship, feel secure that problems can be handled, and be certain their partner loves them.

CLAUDIA: Yes, I agree.

THERAPIST: I want the best for you. And so I have to tell you there is one thing about your goal that worries me.

CLAUDIA: What's that?

THERAPIST: You said you would only feel these things if your partner is there for you 24/7. And you've described to me how distressed you feel when you are alone for any length of time.

CLAUDIA: Yes.

THERAPIST: I understand that. What worries me is that even when people are totally in love, it is sometimes impossible to be together all the time. People have

to go to work, or they have to run errands, or they have other family members who get sick and need their help. It sounds like each of these normal things that are bound to happen would ruin your ability to relax, feel secure in his love, and be confident problems could get handled. And even cause you a lot of distress. So I worry that you can never be happy if someone being there 24/7 is your goal.

CLAUDIA: But that is the only time I feel these things, when we are together.

THERAPIST: I understand. And so I worry about you because, in my experience, it is impossible to have a guarantee that someone will always be there—even if they love you very much.

CLAUDIA: Then I don't know what to do.

THERAPIST: I have an idea. Would you like to hear it?

CLAUDIA: OK.

THERAPIST: What if you were able to relax, feel secure in someone's love, and be confident that problems would get handled, whether your partner was with you or you were alone for a day or longer? What would that be like for you?

CLAUDIA: I'm not sure how that is possible.

THERAPIST: If we imagine it is possible, just for a minute, what would it be like for you to feel those relaxed and secure feelings even when you were alone?

CLAUDIA: That would be good . . . if I was really relaxed and felt secure.

THERAPIST: Let's look at the list we made a little while ago: "I want to relax. I want to feel secure we will handle any problems that come up together. I want to be certain he loves me." If you could experience these things when you were alone just as much as when your partner is with you, wouldn't that be something?

CLAUDIA: Yes. A little hard to imagine, but it would be good.

THERAPIST: What advantages would you have if you experienced these things just as much on your own as when you were with him?

CLAUDIA: I wouldn't have to spend so much time worrying when we are together what will happen if I am alone.

THERAPIST: Would it be like being OK 24/7, because no matter what circumstances came up you could feel secure . . . whether alone or with him?

CLAUDIA: I see what you mean. But how do I feel those things if I am alone?

THERAPIST: That is what we will have to figure out together. But first I want to know if you would be willing to set goals to relax, feel secure about handling problems, and trust in your partner's love both when you are alone and when you are with him.

CLAUDIA: OK. That sounds good—if we can figure out how to do that.

Claudia's therapist followed interview guidelines that can be used with almost any goal a client sets that appears maladaptive. Let's recap the interview steps:

1. Empathize with what your client wants. State that you can understand how this goal would make the client feel good.

2. Ask how life would be better if the client reached this goal. Write down the consequences and meanings that are most important for your client.

3. Ally with your client in the benefits of these consequences and meanings, and acknowledge, if appropriate, how it is understandable that the client would want these things.

4. Express caring and concern (or worry) that your client may not be able to get these things, because, in your experience, the world or other people are not likely to cooperate or be able to fulfill the goal as stated. Express your concern for how distressed your client feels whenever the world or other people let the client down.

5. Propose setting goals for achieving the consequences or meanings of the client's original goal (e.g., relax, feel secure, be able to handle problems) without including the problematic aspects of the original goals.

6. Ask your client about the advantages of achieving the goals as restated. Note that because your client could be ambivalent about these new goals, you will ask about the advantages and *not* the disadvantages of achieving the restated goals. Recall the research on motivational interviewing cited earlier in this chapter, in connection with when and when not to examine the advantages and disadvantages of reaching goals (Miller & Rollnick, 2013; Miller & Rose, 2015).

7. Ask your client, "Are you willing to pursue the goals as we have restated them?" If your client wants to modify these goals in some way, support the client in doing so, as long as maladaptive elements are not reintroduced. If such elements do reappear, then these dialogue steps can be repeated for the newly added elements.

The key to this interview is to be empathic with the valid reasons clients want to achieve the goals they set, even when the stated goals are maladaptive. The consequences and meanings attached to maladaptive goals are usually good goals in and of themselves. Take a therapeutic stance that you are an ally committed to achieving outcomes that are good for your client. The interview outlined above can help you and your client discover these revised goals.

Belief That Change Is Impossible

Therapists sometimes believe that change is impossible or unlikely for some clients, especially those who have chronic, severe, or long-standing difficulties. Because therapists' expectations influence their behavior and therapy outcomes, it is countertherapeutic to believe that a client cannot change. For example, a therapist who believes that a client cannot change may easily give up when a therapy roadblock arises, because the therapist does not really expect to make progress. In contrast, a therapist who believes that change is possible actively problem solves when progress stalls and makes adjustments in the therapy plan until change is achieved. When you catch yourself thinking that change is impossible for a particular client, ask yourself, "What would I do with a

client who did not have this diagnosis/profile if I ran into this difficulty?" or "If change is inevitable, how can I alter the treatment plan to help it come more quickly?"

Some clients are convinced that they cannot change, and therefore that setting a goal is a meaningless task. When they tell you this, here are steps you can take:

1. First, find out if this belief has been reinforced by other mental health professionals with whom they have worked, including you. Many people have been told by well-meaning professionals that their problems are chronic and that the best they can do is to accept their difficulties.

2. Next, discuss your own beliefs about change and possible differences in your treatment approach from past ones, as in the following example.

CARLOS: What's the use? I can't change. I was born this way, and I'll always be this way.

THERAPIST: Where have you gotten the idea you can't change?

CARLOS: It's obvious. I never have changed, even though I've been in therapy for years.

THERAPIST: What have past therapists told you about change?

CARLOS: Some tried to be nice about it, like you. But the more I think about it, Dr. Grayson was right.

THERAPIST: What did Dr. Grayson say?

CARLOS: He said that some people are born with musical talent, and some people aren't. And some people are born with the skills to have an easy time in relationships, and other people aren't. He was very kind about it. He said I was doing my best if I learned to be less angry with people, but I couldn't expect to get along all the time like other people do.

THERAPIST: So he said you could change a little, but not a lot.

CARLOS: Yeah. And I have changed a little. So there's no point in hitting my head against the wall. It just won't get any better than this.

THERAPIST: This is an important idea for us to discuss. How do you suppose Dr. Grayson knew how much you could change?

CARLOS: I guess from his training and experience.

THERAPIST: When did you see him?

CARLOS: A few years ago.

THERAPIST: Did you and he do the same sort of therapy we are doing together?

CARLOS: No, it was different. We mostly talked about things. He didn't give me specific things to try during the week.

THERAPIST: As you probably know from your experience, there are different therapy approaches. Depending on the approaches used, therapists work with problems in different ways.

CARLOS: Yeah.

THERAPIST: In addition, we learn more each year, and new therapy methods are developed and tested, so some things we thought were hard to change five years ago are easier to change now. For example, when I began doing therapy, I didn't have many ideas about how to help people with panic disorder—but now I find I can help these people really easily.

CARLOS: So are you saying Dr. Grayson was wrong?

THERAPIST: I'm not sure. Dr. Grayson may have been right for that time and for the approach he was using.

CARLOS: But do you think I can change?

THERAPIST: Yes, I do. And I think we can come up with things for you to learn and try in between appointments that will help you make the changes you want.

CARLOS: But what if I can't change? What if it's not you or your approach? What if it's me?

THERAPIST: Would you like to change?

CARLOS: Of course. I'm miserable.

THERAPIST: In my experience, if people want to change, we can usually figure out a way, even if it means changing our approach a number of times until we figure out what helps.

CARLOS: I'm sorry, but I'm not sure I believe that.

THERAPIST: You don't have to believe it. The good thing about change is that it is possible, even if you don't believe in it. Many of the people I work with don't believe they can change. All I ask is that you try out the things we think might help and give me honest feedback about how these things make it better or worse for you, so that we can keep adjusting our plan.

CARLOS: I can do that.

THERAPIST: Would you like to give it a try, then?

CARLOS: Yes.

THERAPIST: And I don't want you to just go along with me on faith without change happening. So let's be sure to set some goals, and to measure your moods and review our progress every few weeks, to make sure we are getting somewhere.

In this discussion, Carlos's therapist elicited and addressed his central beliefs about change. It can be important to have an open discussion of beliefs about change, because hopelessness can undermine change efforts. For example, Carlos believed that additional change was not possible for him. Holding this belief, he was likely to interpret setbacks as representative of life's reality for him. He could view any progress as a fortunate but temporary fluke. Carlos's attitudes predisposed him to accept setbacks and mistrust progress.

His therapist did not insist that Carlos share her confidence about the possibility of change. Rather than engage in a battle to convince him that change was possible, she introduced the possibility of change with a plausible rationale. Instead of asking Carlos to believe in her plan, she asked him to participate in it and give her regular and honest feedback to evaluate progress.

Notice that Carlos's therapist did not denigrate his previous therapist, Dr. Grayson, or question Dr. Grayson's therapy methods. Doing so is not helpful unless a prior therapist has been clearly unethical or unprofessional. Even previous therapists who sound inept to you could have been helpful to your client in many ways. There is no therapeutic benefit in undermining someone's positive reactions to a previous therapist. An emphasis on differences among therapy approaches and new developments in psychotherapy can foster a client's hope without detracting from previous therapy experiences.

3. Finally, once your client agrees to try to make changes and help evaluate treatment success, therapy can begin in earnest. Work with your client to set clear and attainable change goals. Large goals (such as establishment of a close friendship) can be broken into attainable initial goals (such as maintaining a conversation). Do not ask dichotomous questions such as "Have you changed?" These are likely to elicit a negative response from clients like Carlos, who hold negative expectations and therefore are more apt to focus on perceived setbacks than progress. Instead, use a continuum or rating scale to measure progress toward goals. A continuum allows people to acknowledge both progress and setbacks, and can prevent them from slipping into all-or-nothing thinking.

Discouragement with Slow Change

When people achieve very slow progress and/or have frequent setbacks, both clients and therapists can become discouraged. Metaphors that incorporate hope can provide encouragement. Charleen, a woman diagnosed with recurrent major depression and borderline personality disorder, was particularly despondent following a suicide attempt and hospitalization (her third hospitalization in a year). Her therapist introduced the metaphor of a spiral staircase to transform her perspective on this setback.

CHARLEEN: Here I am again. I'm so disgusted with myself, and you must be, too. You may as well give up. I'm never going to change.

THERAPIST: (*After a long pause*) I wonder how we'd know if you changed.

CHARLEEN: What?

THERAPIST: Have you ever been on a spiral staircase?

CHARLEEN: Yes.

THERAPIST: When you round the first bend and look out, what do you see?

CHARLEEN: Oh, a tree and a building.

THERAPIST: Now, if you keep going up the staircase and you round the next bend, what do you see?

CHARLEEN: The same tree and building.

THERAPIST: Does it look exactly the same?

CHARLEEN: Yes.

THERAPIST: Are you sure? Would there be any change at all in what you see, no matter how small?

CHARLEEN: Well, maybe a slight difference in perspective. You might see a little higher up the tree or into a window on the building.

THERAPIST: So the view would look essentially the same, with a slight difference in perspective.

CHARLEEN: Yes.

THERAPIST: Do you think you're making progress when you climb a spiral staircase?

CHARLEEN: I see what you're getting at.

THERAPIST: What's that?

CHARLEEN: That you can seem to be in the same place sometimes, even if you are making progress.

THERAPIST: I think so. And maybe the only way to know if you are stuck or making progress is to see if there is any change in perspective. (*Pause*) We have been together in this hospital a number of times now. Is there is any difference between this hospitalization and the past ones to show us that we might be making progress?

CHARLEEN: Well, in the past I always yelled and attacked you when you first showed up. I didn't do that today.

THERAPIST: Why not?

CHARLEEN: I guess I believe now that you put me here because you care, not because you hate me.

THERAPIST: Do you think that's progress?

CHARLEEN: Yes. I suppose so.

THERAPIST: Any other changes in perspective, even small ones, which show we are moving forward?

Metaphors of change like the spiral staircase can help you and your clients maintain hope and commitment to therapy progress, even when maladaptive patterns are repeated over and over again.

4

Thought Records, Part I: Situations, Moods, and Thoughts

(COLUMNS 1–3; *MOM2* CHAPTERS 6–7)

> I've been working on those thought records for so many weeks now, I wasn't sure if all the time was worth it. But last night I went out after group and saw my car was blocked in on both sides by two other cars. They were parked real close, and both of them were over the [parking space] lines, and I thought, "Those ****! They are only thinking about themselves. I should smash in their windows!" Then, just as quickly, I found myself thinking, "Hey, where's the evidence?" And I looked down the line of cars, and I saw that the parking lot was full and those two cars were forced to park over the line by cars next to them. In that nanosecond, I realized that this wasn't the fault of the people next to me. My anger went down, and I caught myself thinking a balanced thought: "Hey, they are OK. It's a tight parking lot, and they didn't mean me any harm." It took me a while to get into my car, but I was so happy because I had an "automatic balanced thought" like you told me I might have someday. I guess I'm making progress.
>
> —*Roberto, in therapy for depression and anger management*

The ability to use a thought record and obtain emotional relief is a skill that has been linked to the reduction of relapse for depression (Neimeyer & Feixas, 2016). In fact, a thought record is a primary tool in depression treatment. Thought records require people to learn skills for identifying and testing their automatic thoughts. These cognitive restructuring skills can seem novel and a bit challenging at first, especially for people who are not introspective or who are currently emotionally overwhelmed. Therefore, *MOM2* devotes four chapters (Chapters 6–9) to illustrative explanations and step-by-step practice of each of the component skills required to complete the 7-Column Thought Record developed by Padesky (1983) and used in this workbook. When you

are working with clients who experience depression, be sure to spend enough time on these *MOM2* chapters for your clients to master using this 7-Column Thought Record. Appendix B (pp. 460–462) describes the development and rationales for elements in the 7-Column Thought Record. This history is especially relevant for therapists who have experience using other thought record forms.

Thought records are also helpful for many additional client issues, as case examples throughout this chapter, the next chapter, and *MOM2* illustrate. Therapists can use thought records with clients struggling with anger, guilt, shame, interpersonal conflict, substance misuse, eating difficulties, parenting issues and psychosis. Plan a minimum of four weeks to help your clients master the cognitive restructuring skills embedded in the 7-Column Thought Record (see Figure 6.1 in *MOM2,* pp, 40–41). Some people need several months to master these skills.

This chapter and the next guide you through the important learning processes and common roadblocks encountered when you begin to teach people to use a 7-Column Thought Record. This chapter shows you how to help clients master the skills required to complete the first three columns of the 7-Column Thought Record, in order to identify the hot thoughts and images linked to mood reactions in particular situations. Chapter 5 shows you how to teach clients to restructure their thoughts and images, using columns 4 through 7 of this thought record.

ARE THOUGHT RECORDS IMPORTANT?

Like Roberto, sometimes people wonder if all the time spent learning to use a thought record is worth it. Metaphors from daily life that underscore the benefits of mastering a challenging tool can be offered. Ask your clients about any skills they currently have that were challenging to learn at first. Consider relevant areas of expertise for each client, such as child care, carpentry, artwork, playing a musical instrument, or working in a trade or business. When people think back on their first encounters with these tasks that they now accomplish with ease, they can often recall challenges that seemed confusing at the time. That is exactly how it is as clients learn to use the 7-Column Thought Record. During the first weeks, they need to think a lot about each of the steps and figure everything out. Over time, clients learn their thinking patterns and develop strategies that allow them to replace fast emotional thinking with the slower thinking required to look at the whole picture and react to events in more balanced ways (Kahneman, 2013).

Intensive practice with 7-Column Thought Records reprograms the brain so that a client can do this process on the fly and often quite quickly, as Roberto experienced in the parking lot. For people who have been plagued with intense emotional reactions and impulsive behaviors for many years, thought records can lead to transformations worth celebrating. Once someone begins to have "automatic balanced thoughts" in response to quick judgments, emotional reasoning, and catastrophizing, they will rarely need to continue to practice the intensive process of writing out 7-Column Thought Records. People who are computer-literate sometimes think of this process as learning to "upload new brain software."

To help you develop your own skills in implementing the 7-Column Thought Record, this chapter and Chapter 5 of this guide illustrate how the component skills of this thought record work and fit together.

THE FLOW OF USING 7-COLUMN THOUGHT RECORDS IN THERAPY

Chapters 6–9 of *MOM2* teach the cognitive restructuring skills required to use the 7-Column Thought Record effectively. When you introduce it into therapy, expect to work with your clients for a number of weeks before they are able to use this thought record independently. It often takes four or more weeks of in-session work before clients are capable of filling out all seven columns of this thought record on their own between sessions.

You and each client will be completing all seven columns of this thought record in session. Clients' learning exercises begin with weekly practice in completing the first three columns of a 7-Column Thought Record for situations in which a target mood was activated or exacerbated, as described in this chapter. They bring these worksheets with the first three columns completed to each therapy session. You will ask a client to choose one of these thought records for you to complete together in session, and, while doing so, focus on boosting the client's skills in effectively using each column. It often takes a few weeks of practice with columns 1–3 before clients can readily identify their hot thoughts.

Once they can identify their hot thoughts in specific situations, ask clients to fill out the first five columns of the 7-Column Thought Record between sessions. The next chapter of this guide (Chapter 5) teaches you methods for helping clients complete columns 4 through 7. The fourth and fifth columns require them to look for evidence in the situation that supports and doesn't support their hot thoughts. In the next session, ask a client to choose one of these thought records begun at home for the two of you to fine-tune and complete together. Once clients can gather evidence that doesn't support their hot thoughts, then they are ready to fill out entire 7-Column Thought Records independently. These can be reviewed and discussed in session to the degree required to consolidate your clients' skills for each of the seven columns and incorporate their thought record discoveries into other therapy discussions.

We recommend that clients spend enough time reading each of the thought record chapters of *MOM2* (Chapters 6–9) to enable them to do the worksheets in that chapter with some ease. A client's skill development should determine the pace of moving through these chapters; no arbitrary time should be allotted for completing each chapter. Whatever pace the client sets, discuss what is learned each week and review completed exercises. Use at least a portion of each therapy session to improve the client's understanding of the steps currently being practiced.

In this clinician's guide, the rest of this chapter and Chapter 5 address "best practices" for teaching clients to use the 7-Column Thought Records. The Troubleshooting Guides at the end of these two chapters illustrate therapeutic responses you can make to common challenges that occur with thought record use.

MOM2 CHAPTER 6: SITUATIONS, MOODS, AND THOUGHTS

The sample blank and completed 7-Column Thought Records at the beginning of Chapter 6 of *MOM2* (pp. 40–43) show readers what a 7-Column Thought Record is, how it is filled out, and what the positive mood benefits of using one can be. As shown in the *MOM2* Chapter 6 Summary, the chapter first provides a rationale for learning to use thought records. It also teaches people the fundamental skills required to complete the first three columns of a 7-Column Thought Record, which differentiate among situations, moods, and thoughts.

The only worksheet in this chapter is Worksheet 6.1, Distinguishing Situations, Moods, and Thoughts (*MOM2,* pp. 47–48). The worksheet provides a list of 33 words and statements; for each one, readers are asked to decide whether it pertains to a situation, mood, or thought. The correct answers are provided on pages 48–49 of *MOM2.* Fill this worksheet out now to see what this experience could be like for your clients. Even if most of the answers seem fairly obvious, you might mislabel one or two of the items. Clients often mislabel a number of items, and these items can be discussed to clarify the differences among situations, moods, and thoughts. Clients need to learn to distinguish among these three separate components; otherwise, a thought record isn't likely to help them. It's not uncommon for people to mix up thoughts and moods. Since we want to help people test their thoughts, these need to be accurately identified. For example, a person who labels "I feel like people don't like me" a mood is unlikely to see this as a thought that can be tested.

When you introduce the 7-Column Thought Record to your clients, do not ask them to fill out an entire thought record on their own the first week. They don't yet have the skills to do so. Instead, either the week before or after a client reads *MOM2* Chapter 6, help them fill out an entire 7-Column Thought Record in session. Because this can take 30–45 minutes, introduce the thought record early in a session, so there

Chapter 6 Summary

(*MOM2,* pp. 39–49)

- ✓ Thought records help develop a set of skills that can improve your moods and relationships and lead to positive changes in your life.
- ✓ The first three columns of a thought record distinguish a situation from the moods, physical reactions, and thoughts you had in the situation.
- ✓ The thought record is a tool that can help you develop new ways of thinking in order to feel better.
- ✓ As is true whenever you develop a new skill, you will need to practice using the thought record until it becomes a reliable tool to help you feel better.

is ample time to complete all seven columns. This will offer your clients direct experience of the positive effects a thought record can have on their moods. Once they have this experience, they are more likely to spend the necessary time practicing the skills required to learn to use thought records independently. Even so, clients will need your help completing each of the thought record columns the first few weeks they fill them out.

After you complete a 7-Column Thought Record with a client in session, ask the client to fill out just the first three columns of the thought record at home. The client can follow the guidance provided in *MOM2* Chapter 6, along with what you have taught in the session. The following sections summarize what you need to know about the best and most effective use of these three columns.

Column 1: Situation

Thought records are most helpful for situations that are highly specific and evoke especially strong moods. Usually a "specific" situation can be described as one that is happening at a particular time, in a particular place, with particular people involved. Thus people are advised to answer "Who? What? When? Where?" when describing situations in column 1 of a 7-Column Thought Record. It is best to describe a situation that is time-limited—generally somewhere between a few seconds and 30 minutes. This will bring significant moods and thoughts into focus. Research estimates that people have tens of thousands of thoughts per day. There are likely to be an unmanageable number of thoughts if a client describes a situation as "All day yesterday."

Sometimes a situation is largely occurring inside a person's head. In this instance, it is acceptable to write in column 1 the general theme of thoughts the person was having, as in this example: "I was sitting in my chair and thinking about all the bills that came that day and wondering how I would be able to pay them." More specific thoughts will be written in the third column of the 7-Column Thought Record, under Automatic Thoughts (Images). In the bill-paying example, specific thoughts and images might include "I'll never be able to pay all these bills. My car will be repossessed. I'll lose my job and have to declare bankruptcy. Image: My car being towed away. Image: Opening up a letter from a collection agency."

Instruct your clients who are learning to use thought records to choose situations in which the primary mood they are working on is activated at an intense level. For example, someone working on depression, may always feel depressed, and yet a thought record will be more helpful for a situation in which the person's depression is rated 60% or higher on a 0–100% scale.

Throughout the early weeks of using thought records, remind your clients to choose situations in which the mood they are targeting in therapy (e.g., depression, anger, or guilt) is activated and also intense. Without these reminders, it is quite common for people to fill out thought records for any time of the week in which they feel distress, even if their mood was not particularly intense or if a different mood from their target mood is activated. Although thought records can be a helpful tool for many moods, clients make better progress when they work on thought records related to the mood that is their current primary focus in therapy. This is because thought records give

Reminder Box

When using thought records, encourage your client to choose specific situations during the week in which the mood you are currently targeting in therapy is intensely activated.

them opportunities to identify and test the central thoughts maintaining that particular mood.

Column 2: Moods

Most clients reading *MOM2* Chapter 6 will have already read Chapter 4, Identifying and Rating Moods. Since this is a skill people are likely to have already acquired, there is not extensive information in Chapter 6 on identifying and rating moods. If some clients still cannot easily identify and rate moods, ask them to review Chapter 4. One of the simplest guidelines offered there to people learning to identify moods is that a mood generally can be described in one word. There is a sample list of moods on page 25 of *MOM2* that can be used as a guide to expand people's mood vocabulary.

When you and your clients begin filling out thought records, keep in mind that people typically experience more than one mood in a given situation. You will notice that thought record examples throughout *MOM2* often have several moods identified and rated for intensity in column 2. Encourage your clients to identify and rate all the moods they experience in a given situation. Recognizing the combination of moods experienced can add depth to your mutual understanding of why particular situations are distressing.

Although people frequently experience multiple moods in given situations, it is usually helpful for them to zero in on a single mood when identifying automatic thoughts and images, because different types of thoughts will accompany each mood. Ask clients to circle the mood listed in column 2 that they most want to understand better or that is most closely connected to their treatment goals. When they get to column 3, they will look for the thoughts connected to this mood.

Rating Physical Experiences, Urges, and Other Targets in Column 2

Your clients can record physical reactions, in addition to moods, in column 2 when this is relevant (see Figure 6.5 in *MOM2*, p. 46). The *MOM2* text suggests that this is helpful if the primary mood being investigated is anxiety. You can choose to add a section to column 2 of a 7-Column Thought Record for other purposes as well. For example, you can add a section to the bottom of column 2 for clients to identify and rate their pain; their urges to misuse alcohol and drugs, binge or purge, or commit self-harm; or other therapy targets that are linked to situations, moods, and thoughts. If you decide

Reminder Box

You can customize a thought record to identify and test thoughts related to physical experiences as well as behaviors or urges. Add items you want your client to identify and rate (e.g., pain, urges to misuse substances) in the lower half of column 2.

to add a section like one of these, ask your clients to rate the intensity of those physical experiences or urges as well.

Column 3: Automatic Thoughts (Images)

This brief section in Chapter 6 introduces the range of cognitive content to be collected in column 3 of a 7-Column Thought Record (*MOM2,* p. 44). Here people write the thoughts, beliefs, images, memories, and meanings that are attached to the situation in column 1 and the moods identified in column 2. Keep in mind that the most important thoughts do not always occur in word form. Thoughts can occur in the forms of imagery, daydreams, and memories and can include a variety of sensory components (sights, smells, sounds, tastes, and kinesthetic experiences). These latter forms of thought can be hand-drawn in column 3 of a 7-Column Thought Record or described in words (e.g., "Image: I see myself lying on the floor, unable to breathe" in Figure 6.5 of *MOM2,* p. 46).

Examples of the first three columns of a 7-Column Thought Record as completed by Marissa, Vic, Linda, and Ben, the four main *MOM2* characters, are shown on pages 45–46 of *MOM2.* Those examples are intended to provide clear illustrations of what is involved in completing these first three columns. Automatic thoughts and images are addressed only briefly at this point in *MOM2,* because Chapter 7 of the workbook discusses these in depth. That chapter guides people to develop and apply these skills to their own situations, moods, and thoughts.

MOM2 CHAPTER 7: AUTOMATIC THOUGHTS

Most people find it relatively easy to identify and describe situations in which particular moods are activated. Identifying and rating moods can be a little more challenging. It often takes even greater amounts of practice for people to become adept at identifying the thoughts and images that accompany their moods. Chapter 7 of *MOM2* is devoted to helping people identify these thoughts and images, and also to helping them determine which thoughts are most closely linked to the moods they are trying to understand and manage (see the Chapter 7 Summary).

Chapter 7 Summary

(*MOM2,* pp. 50–68)

- ✓ Automatic thoughts are thoughts that come into our minds spontaneously throughout the day.
- ✓ Whenever we have strong moods, there are also automatic thoughts present that provide clues to understanding our emotional reactions.
- ✓ Automatic thoughts can be words, images, or memories.
- ✓ To identify automatic thoughts, notice what goes through your mind when you have a strong mood.
- ✓ Specific types of thoughts are linked to each mood. This chapter suggests questions you can ask to identify these mood-specific thoughts.
- ✓ Hot thoughts are automatic thoughts that carry the strongest emotional charge. These are usually the most valuable thoughts to test on a thought record.

Automatic Thoughts

We all have many "automatic thoughts" throughout the day, and these can help us understand our mood reactions to situations. The opening pages of Chapter 7 demonstrate how the *MOM2* character Marissa was only able to make sense of a very puzzling mood reaction by becoming aware of her thoughts (*MOM2,* pp. 50–51). This is followed by an example from Vic's life for which readers are provided with a situation and his mood reactions, and are then asked to imagine what thoughts could help explain his mood (*MOM2,* p. 52). When introducing automatic thoughts to your clients, set up similar personalized examples from their lives. The following dialogue shows how a therapist accomplished this with a teenage client, Kendra.

THERAPIST: Did you have any times this week when your moods flipped really fast from one mood to another?

KENDRA: Yes. I was really excited about the new play and was sure I would get the lead role. Then I saw Mischa walk up to the microphone, and my heart dropped.

THERAPIST: What mood did you have when you saw her at the microphone?

KENDRA: Defeated.

THERAPIST: You thought she would defeat you for the lead role?

KENDRA: Yes, I was sure of it.

THERAPIST: And how did you feel about that?

KENDRA: My mood just crashed.

THERAPIST: When you look at this mood list (*points to mood list on p. 25 of MOM2*), which mood would you say captures best how you felt?

KENDRA: Disappointed . . . times 1,000.

Notice that when Kendra said she felt "defeated," this was more of a thought than a feeling. Her therapist noticed this discrepancy, but, rather than belabor this point with Kendra and risk throwing this discussion off track, the therapist simply reflected, "You thought she would defeat you for the lead role?" When Kendra agreed with this restatement of "defeat" as a thought, her therapist asked, "And how did you feel about that?"

THERAPIST: OK. So you were feeling excited (*writes "Excited" on left side of whiteboard*), and then you saw Mischa at the microphone (*writes "Saw Mischa" to the right of "Excited," and draws two arrows and a box as shown in Figure 4.1*), and then you felt disappointed times 1,000 (*adds "Disappointed × 1,000" as shown in Figure 4.1*).

KENDRA: What's with the box?

THERAPIST: Our moods don't just switch without reason. Just seeing Mischa does not explain your feeling disappointed times 1,000. I bet some other people in the room didn't feel disappointed when they saw Mischa.

KENDRA: No. Some probably felt happy to see her there, because she is a really talented singer. I saw some people look at each other and smile when she walked up.

THERAPIST: So those people could be thinking . . .

KENDRA: "Oh, good! Mischa is going to try out. She's got a great voice."

THERAPIST: And with those thoughts, they would probably feel . . .

KENDRA: Maybe excited?

THERAPIST: That makes sense.

KENDRA: Hmmm.

THERAPIST: What thoughts, images, or memories were you having that we could put in this box to explain why you felt so disappointed to see her?

KENDRA: I knew I wouldn't get the lead if I was up against her. She always defeats me in tryouts. I'm never going to get a lead while she is at my school.

THERAPIST: Here, take this marker and write those thoughts in the box. (*Pauses while*

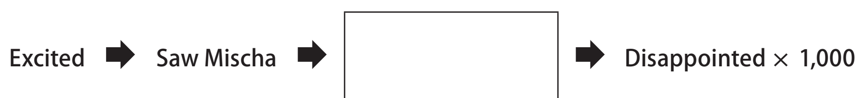


FIGURE 4.1. Therapist's drawing of Kendra's situation with automatic thoughts missing.

Kendra writes) Did you have any images or memories come to mind when you saw her at the microphone?

KENDRA: Yes. I remembered last year's musical, and how I was her understudy and she never got sick once. It's mean to want someone to get sick, but . . . (*shrugs her shoulders*).

THERAPIST: When you imagined her getting sick, did you also imagine what it would be like to be the lead?

KENDRA: Uh-huh. It would feel fantastic.

THERAPIST: So another part of your disappointment was imagining this great experience that you would be missing?

KENDRA: Yes, I think so.

THERAPIST: Why don't you write a few words in the box to describe that image you had?

KENDRA: (*Writes, "Vision of myself singing on stage—it won't happen."*)

THERAPIST: Do these thoughts and your images that you wrote in the box help you understand why you felt disappointed times 1,000?

KENDRA: Absolutely.

THERAPIST: These thoughts and your image are what we call "automatic thoughts." As we go through a day, we have thousands of automatic thoughts. They can be words or memories or images. Sometimes we even hear or smell things.

KENDRA: (*Smiling*) I sing lots of songs in my head.

THERAPIST: This week I'm going to help you learn to notice and pay attention to what comes into your head when you have a strong mood. The automatic thoughts, images, and songs that pop into your head will help us understand your moods better. Chapter 7 in the *Mind Over Mood* book we have been using has some Helpful Hints boxes that can help you remember these ideas. There are also worksheets to help you practice.

KENDRA: OK. Let's do it.

Therapists need to set the stage for clients' learning. To help people become more aware of their automatic thoughts, it is important to identify specific situations in which they experience an intense mood. Kendra was able to identify her thoughts pretty easily, in part because her therapist drew a really clear picture of a specific situation in which she experienced an intense mood shift. If her therapist had been less specific and simply asked, "What are some of the thoughts you have at school when your mood is low?" Kendra might have simply replied, "I don't know."

When clients have difficulty identifying thoughts even for highly specific situations, ask them to use imagery to vividly recreate the situations in their minds. Once a situation is recalled in detail, it is usually much easier to access the automatic thoughts and images connected to it. Kendra seemed to be vividly imagining the tryouts at her school as she spoke, so her therapist did not need to prompt her to use imagery.

Once Kendra went home, she could use the bulleted questions in the Helpful Hints

box on page 54 of *MOM2* to help identify her automatic thoughts and images. These same questions can be used with clients in session to help identify thoughts closely linked to moods. Usually it is helpful to start with the general question "What was going through your mind just before you started to feel this way?" Notice the wording of this question: "What was going through your mind . . . ?" rather than "What were you thinking?" The advantage of the first question is that it is more likely to prompt a search for memories and images than a question about thinking, which most people interpret as thoughts stated in words.

Clients rarely report their imagery to therapists unless directly asked, despite the fact that imagery is commonly experienced in a wide variety of emotions and circumstances (Hackmann & Holmes, 2004; Brewin, Gregory, Lipton, & Burgess, 2010; O'Donnell, Di Simplicio, Brown, Holmes, & Burnett Heyes, 2018). If a client does not spontaneously report any images or memories, follow up at some point with questions such as these: "Did any images or memories come to mind? You know, like mental pictures or sounds?" Research demonstrates that imagery and memories (often experienced in multisensory dimensions) evoke stronger emotion than similar thoughts formulated as words (Holmes & Matthews, 2010). This imagery advantage is just as true for positive moods as for negative ones (Holmes, Lang, & Shah, 2009). This advantage may exist partly because imagery feels more "real" than thoughts framed in words (Matthews, Ridgeway, & Holmes, 2013). Thus imagery often helps people understand the emotional intensity of their responses to situations more fully than verbal thoughts do.

Moods, Automatic Thoughts, and Cognitive Specificity

How do you know if the automatic thoughts and images your client identifies are the most relevant ones? Cognitive specificity theory teaches us that certain types of automatic thoughts and images are linked to particular moods (as briefly mentioned in Chapter 2 of this clinician's guide). If you know what moods your clients experience, cognitive specificity theory helps you know what types of automatic thoughts and images are most likely to be closely associated with them. Alternatively, once you know your clients' automatic thoughts and images, cognitive specificity theory guides you to discern the moods they are likely to be experiencing.

Beck was one of the first to elaborate on the idea that particular moods are accompanied by specific types of thoughts (see, e.g., Beck, 1976, 2005). More than 50 years ago, he noted that depression is characterized by three primary types of thoughts: negative thoughts about the self (self-criticism), the world (pessimism), and the future (hopelessness) (Beck, 1967). He later expanded his observations to note that thoughts connected to anxiety focus on themes of danger/threat and the inability to cope (Beck, 1976; Beck & Emery with Greenberg, 1985).

Thoughts associated with anger are also characterized by themes of threat, because fear and hurt often give rise to anger (Beck, 1988). More specifically, anger is marked by thoughts that others are being unfair, breaking the rules, hurting us, or being disrespectful. At their extreme, thoughts associated with anger can lead to fixed beliefs that demonize the other person or group of people and grow into hate (Beck, 1988, 1999).

Guilt and shame involve similar themes to anger with a twist. When we feel guilt or shame, we point the finger of "rule breaker" or "hurtful person" at ourselves. We experience guilt when we break rules or values that are important to us. If we believe that these violation(s) of our own standards makes us a bad person and/or that others would reject us if they knew what we did, we are likely to experience shame.

Early in therapy, people are more likely to be able to identify moods than thoughts. Thus, when identifying a client's automatic thoughts, you can ask questions that are most likely to elicit the types of thoughts linked to those identified moods. If the thoughts reported don't "match" the mood, you will know that additional moods are present, that the client has misidentified the mood, or that the client has not yet articulated the thoughts connected with the identified mood. As a check on your own ability to match thoughts with moods, fill out Worksheet 7.1 now (*MOM2,* p. 57), and compare your responses to the answer key below on the same page.

Cognitive specificity theory is described in *MOM2* on pages 55–56. Since you want clients to identify the most relevant automatic thoughts and images as quickly as possible, this information helps people know what types of thoughts they are looking for when they experience particular moods. Thus each question listed in Questions to Help Identify Automatic Thoughts (the Helpful Hints box on p. 54 of *MOM2*) is followed by a list of moods for which the question is likely to be particularly pertinent. You can also use these mood-relevant questions to prompt clients to identify automatic thoughts in session.

General Questions to Identify Automatic Thoughts for Any Mood

When you are using the Questions to Help Identify Automatic Thoughts box (*MOM2,* p. 54) with a client, first ask the two general questions for any mood (rephrasing them from the *MOM2* versions that readers ask themselves):

> "What was going through your mind just before you started to feel this way?"
> "What images or memories did you have in this situation?"

Rather than hurrying from one question to the other, give your client some time to think about each one. After asking the first question, you might simply prompt, "And was anything else going through your mind at that time?" When images and memories are identified, take time to get specific details of what was imagined and how different elements of the imagery or memory linked up to their mood.

Next, you can ask one or more of the questions listed in the Helpful Hints box (again, rephrased from the *MOM2* versions readers ask themselves) that are most relevant to the mood you are trying to understand.

Questions to Identify Automatic Thoughts Linked to Depression

The questions listed for depression in this box search for thoughts and images related to Beck's negative cognitive triad (negative thoughts about self, world, and future). In posing these questions to a client, you can ask:

"What does this mean about you? Your life? Your future?"

Allow your client time to think about each of these questions. Often it is helpful to ask questions more than once, or to return to earlier questions if they take on new relevance once thoughts are uncovered. The following dialogue illustrates the first part of this process.

THERAPIST: You said the most depressing thing is that you think you will fail the test on Friday. If you did fail it, what would that say about you?

REBECCA: I'm stupid.

THERAPIST: And, taking this a bit further, if you fail the test, what would that mean for your future?

REBECCA: I won't get into medical school and can't become a physician.

THERAPIST: And if you can't become a physician, what does that say about you or your future?

REBECCA: I'm a failure, and I'll never be happy.

THERAPIST: Do you have any images related to that future?

REBECCA: I see myself as a housewife. I'll have to clean the house all day, and my life won't have any meaning or purpose.

THERAPIST: When you tell me about these thoughts, I can understand why you feel so depressed when you imagine failing Friday's test. To you, it means you are stupid; you won't be able to get into medical school and fulfill your dream of becoming a physician. And that means you will be a failure and unhappy the rest of your life. You imagine your future self as an unhappy housewife with no life purpose. Do I have that right?

REBECCA: Yes. It's really pretty desperate.

Notice that Rebecca's therapist did not jump in to question her predictions about what would happen during Friday's test or the meanings she was attaching to predicted failure on the test. At this point, the therapist was focused on uncovering the automatic thoughts, images, and meanings attached to this event. Later in the session, each of these could be examined. Her therapist could also help Rebecca develop an Action Plan to increase her odds of passing the test. However, it was important for her therapist to identify as many relevant thoughts and images as possible before beginning any interventions. Otherwise, there would be a risk that while one thought was being addressed in session, other important thoughts would be overlooked and later erode the effectiveness of this session.

Questions to Identify Automatic Thoughts Linked to Anxiety

When clients report anxiety, begin by asking questions that capture the catastrophic nature of anxious thoughts that are generally focused on danger, threat, and an inability

to cope. Draw on the anxiety questions in the Helpful Hints box (*MOM2,* p. 54), and begin by asking questions like these:

"What are you afraid might happen?"
"What is the worst that could happen?"

You can prompt for imagery by rephrasing this second question as follows:

"What is the worst you can imagine happening?"

These questions capture the danger/threat aspects of anxiety, but they do not directly address the vulnerability component related to a perception that we cannot cope with danger or bad outcomes. Vulnerability thoughts are often encoded in anxious imagery. Thus you can ask:

"And if that were to happen, how do you imagine yourself coping?"

Get details of any anxious images. This imagery is likely to include exaggerations of danger and underestimations of personal coping ability and help options. For example, one man who felt anxious about asking his supervisor for a salary increase reported an image in which his boss, in his words, "towered over me. His face was beet-red, and he shouted that I was insignificant and had no right to ask for more money. I shrunk into the corner and curled up into a ball and was too embarrassed to return to my desk." This image exaggerated his boss's height, presented a loud and insulting response (which was unlikely, given his boss's typical demeanor), and included a caricature of poor coping. This image nonetheless matched this man's level of anxiety well and served as a potent precipitant for avoidance.

Questions to Identify Automatic Thoughts Linked to Anger

Since thoughts associated with anger usually focus on another person or other people, you can rephrase the questions listed in *MOM2* to identify automatic thoughts associated with anger (p. 54) as follows:

"What does this mean about how the other person(s) feel(s)/think(s) about you?"
"What does this mean about the other person(s) or people in general?"

Using these questions as follow-up to the general question "What was going through your mind just before you started to feel this way?" will usually yield a rich trove of thoughts fueling anger.

For example, Darlene's frequent anger toward her husband, John, was prompted by differences in their values regarding parenting their two young children. When her husband took the children to the park on a Saturday afternoon, she specifically told him not to buy them any "junk food," and he agreed to this as they walked out the door.

When they arrived back, just before dinner, her son's shirt was stained with ice cream. Darlene immediately felt enraged (rating her anger at 100%) and reported the following thoughts: "He didn't follow what I asked. He never listens to me. He gives the children whatever they want. I always have to be the 'bad' parent, and he is the 'good' one." The two questions listed above, regarding what this meant to her about others, helped her uncover additional thoughts: "John doesn't respect me. If he can't agree to parent as a team for a few hours, we will never be on the same page," and "Our children will grow up thinking they can manipulate people to do whatever they want."

Collectively, these thoughts explain the intensity of Darlene's reactions very well. At this point, many clinicians would stop gathering thoughts and begin testing these. However, before stopping the identification of automatic thoughts, it is important to ask a client the second general question: "What images or memories did you have in this situation?" Anger is often greatest when situations remind clients of other times people have hurt or disrespected them. It is also often accompanied by images, which can be accurate or distorted in the same ways as thoughts expressed in words can be.

When clients first learn to identify automatic thoughts and images, it can be more fruitful to ask about images and memories after they identify a number of verbal thoughts. This is because the processes of thought identification bring a situation back to life and makes the scene more vivid in someone's mind. When Darlene's therapist asked about images or memories, she reported the following memory:

> "When I saw the ice cream on DJ's shirt, I flashed on how my dad used to take us out for ice cream when he would visit with us after my parents divorced. He used to tell us to keep it secret from our mother, because she was 'too uptight' to let us enjoy ourselves and she would get mad we were having so much fun."

Bringing this memory into awareness proved pivotal in helping Darlene understand the intensity of her anger toward John. It also helped her and her therapist tease apart which aspects of the current situation warranted anger and should be discussed with John, and which parts of her reaction stemmed from early childhood experiences with her father that might not apply to her husband. These distinctions helped her discuss the situation with John more constructively.

Questions to Identify Automatic Thoughts Linked to Guilt

People generally feel guilt when they believe they have violated rules or values that are important to them. Thus, for a client struggling with guilt, the prime questions included in the Helpful Hints box (*MOM2,* p. 54) related to guilt can be posed as follows:

> "Did you break rules, hurt others, or not do something you should have done?"
> "What do you think about yourself that you did this or believe you did this?"

Answers to the first question reveal situations and thoughts that triggered guilty feelings. The second question helps differentiate between guilt and shame. With guilt, people are more likely to judge themselves situationally: "I made a big mistake. It was

wrong of me to do this. I need to do something to make this right." With shame, people usually report thoughts that describe themselves in terms of stable traits: "I'm clearly a bad person. What kind of person would do something like this? I'm evil/bad/sinful."

As with all moods, it is important to ask these mood-specific questions in the context of the general mood questions described previously. Notice how Xavier's therapist helped him uncover automatic thoughts related to his feelings of guilt following an office meeting,

XAVIER: I felt so guilty after the meeting that I went to my office and avoided seeing anyone the rest of the afternoon.

THERAPIST: What happened in the meeting? Did you do or say something wrong?

XAVIER: I didn't stand up for my team. When the numbers showed our team was lagging, I said that they were not working hard enough and I would talk to them, instead of pointing out the unreasonableness of the deadlines management had set.

THERAPIST: I see. I want to make sure I understand what part of this was connected with feeling guilty. Did your response go against some of your values?

XAVIER: Yes. That's the right way to say it. I want to be a team leader who supports my team. Instead, I sold them out so I would look good in front of the regional manager. Afterwards, I felt miserable.

THERAPIST: What did this behavior say about you? What did you think about yourself after the meeting?

XAVIER: I let myself and my team down. My answers were weak in this meeting. I need to figure out a way to make this right.

THERAPIST: What would you say makes you feel most guilty about what you said and did in the meeting?

XAVIER: The fact that I said something negative about the team when they have been working so hard all year. I wasn't fair to them at all.

THERAPIST: So, if we write down the thoughts connected to your guilt, what would they be?

XAVIER: "I wasn't fair to the team. It was unfair to criticize their work. I was a weak instead of a strong leader."

THERAPIST: Did you have any memories or images connected with these thoughts?

XAVIER: Not really . . . although I always thought I would be a brave leader fighting at the front of the battle alongside my people. I behaved more like a traitor who runs at the first shot.

Xavier was able to identify a clear trigger and thoughts connected to his guilt. Instead of identifying a specific memory, he identified an image of the type of leader he wanted to be, contrasted with an image of how he thought he had behaved. Images can provide rich opportunities for interventions. For example, Xavier could devise a

response for his guilt by imagining what a brave leader would do to rectify the statements he made in the meeting.

Questions to Identify Automatic Thoughts Linked to Shame

The initial mood-specific questions that can reveal automatic thoughts related to shame are the same as those for guilt:

> "Did you break rules, hurt others, or not do something you should have done?"
> "What do you think about yourself that you did this or believe you did this?"

Recall that answers to the second question are likely to describe stable negative traits if the mood experienced is shame—for example, "I'm a bad person [and the fact that I did this proves it]." Whereas guilt can be experienced regardless of whether people believe that others would agree that what they did was wrong, shame is almost always accompanied by this conviction: "If others knew this about me, they would reject me/think very poorly of me/not love me anymore." For this reason, an additional question inquires about other people's opinions:

> "What does this mean about how the other person(s) feel(s)/think(s) about you [if they knew you did this]?"

These thoughts about other people's reactions are often purely assumptions, because the circumstances leading to shame are usually kept secret from others. Nonetheless, thoughts and images about other's reactions have a strong impact on the depth of shame felt.

Using our previous example, we might wonder if Xavier was experiencing shame in addition to guilt after he spoke negatively about his team in the meeting. He seemed to want to keep his actions secret from his team, which could signal some shame. If shame was present, we would expect him to have thoughts about the team's reactions to him. His therapist checked this out:

THERAPIST: I now understand your guilt about what you said in the meeting. I want to ask about something else you said when we started talking about this. You said that you avoided seeing anyone the rest of the afternoon. Who were you avoiding?

XAVIER: Everyone. But mostly I didn't want to talk to my team members. They knew the regional meeting was that afternoon.

THERAPIST: What do you imagine would have happened if you did see them?

XAVIER: Maybe they would ask me what happened in the meeting.

THERAPIST: And if they did ask you about the meeting, what would you have said?

XAVIER: I didn't know what to say. If they knew what I had said, they would feel really betrayed. They would think much less of me.

THERAPIST: And, in a way, that matches up with what you are telling me you think about yourself.

XAVIER: Yes, of course. I am embarrassed about what I did.

THERAPIST: What feeling do you have when you imagine your team finding out what you said, and especially if they then think less of you? How would you feel then?

XAVIER: Ashamed. It wasn't right, and it's not the kind of leader I want to be.

At this point, Xavier was caught up in his internal reactions of guilt about his behavior. It would seem that he was also vulnerable to feeling shame if others were to learn what he said. His avoidance of other people was a clue for his therapist to inquire further and consider whether shame might be an additional mood to address. Interventions that address guilt and shame are detailed in Chapter 12 of this guide.

Identifying Hot Thoughts

The tips in the previous section can guide you and your clients to identify thoughts and images relevant to particular moods. Even so, it is quite common for people to identify thoughts that don't completely explain the intensity of their reactions in given situations. In sessions, review the thoughts you and your client identify, and consider this question: "Do these thoughts explain the intensity of the mood you reported?" If not, it is likely that your client has not yet identified the hot thought (or thoughts) connected to the mood in the situation. "Hot thoughts" are the thoughts that most clearly explain particular emotional reactions and their intensity. The mood ratings in column 2 of the 7-Column Thought Record suggest what intensity of mood the thoughts need to match.

When the thoughts identified for a given situation seem cooler than the mood ratings, review the automatic thoughts identified in column 3 of the 7-Column Thought Record and ask your client, "What was it about this thought that was most distressing for you?" The following dialogue illustrates this process. Danni and her therapist were reviewing her completed Worksheet 7.3 (depicted in Figure 4.2). This worksheet provides just the first three columns of the 7-Column Thought Record.

THERAPIST: Let's look at the worksheet you filled out this week [see Figure 4.2].

DANNI: OK.

THERAPIST: I see you identified a situation in which you felt pretty depressed.

DANNI: Yes, I was feeling a bit better playing with my dog, but then I hurt her, and my depression came crashing down.

THERAPIST: You chose a really good situation for this thought record, then. I asked you to choose a time when your depression was bad or got worse. I see you felt depressed at a level of 80%.

DANNI: Uh-huh.

THERAPIST: Let's look at your automatic thoughts. I see you put a question in the Automatic Thoughts (Images) column, column 3. What do you think would be the most depressing answer to this question?

DANNI: If I did hurt her.

THERAPIST: Sure. I'd feel really bad if I hurt my dog, too. But, just to make sure I understand your reactions, what would be so depressing about hurting your dog? What would that mean to you?

DANNI: I guess that would mean I'm not even good enough to have a dog. I'm a real messed-up person.

WORKSHEET 7.3. Identifying Automatic Thoughts

1. Situation	2. Moods	3. Automatic Thoughts (Images)
Playing with my dog. I tugged too hard and my dog barked at me.	Scared 65% Depressed 80%	Did I hurt her? She seems OK, but I shouldn't play so rough.
Who were you with? What were you doing? When was it? Where were you?	Describe each mood in one word. Rate intensity of mood (0–100%). Circle or mark the mood you want to examine.	What was going through my mind just before I started to feel this way? (General) What images or memories do I have in this situation? (General) What does this mean about me? My life? My future? (Depression) What am I afraid might happen? (Anxiety) What is the worst that could happen? (Anxiety) What does this mean about how the other person(s) feel(s)/think(s) about me? (Anger, Shame) What does this mean about the other person(s) or people in general? (Anger) Did I break rules, hurt others, or not do something I should have done? What do I think about myself that I did this or believe I did this? (Guilt, Shame)

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FIGURE 4.2. Danni's filled-in Worksheet 7.3. As her discussion with her therapist indicated (see text), her identified thoughts were not hot enough.

THERAPIST: Even though she seemed OK, like this other thought below says, do you think you still had thoughts about not being good enough to have a dog and being a messed-up person after this happened?

DANNI: Yes. I felt really bad and thought about all the ways I've messed up this year. I think I was thinking, "I'm not good enough."

THERAPIST: Why don't you add those three thoughts to your thought record: "I might have hurt my dog," "I'm really messed up," and "I'm not good enough to have a dog."

DANNI: (*Writes these three thoughts on the 7-Column Thought Record.*)

THERAPIST: (*Silent while Danni writes, then:*) Before we go on, did you have any images related to these thoughts?

DANNI: Hmmm. I'm not sure. I might have had an image of carrying my dog to the vet. If she was really hurt, I mean.

THERAPIST: Write that image on your thought record. (*Pauses while Danni writes.*) When you look at those five thoughts and that image, which one or ones do you think were connected most strongly with feeling 80% depressed?

DANNI: This thought (*pointing*): "I'm not good enough to have a dog."

THERAPIST: OK. Put a circle around that one, so we know that this was the hot thought. Before we look at the evidence related to that thought, can you tell me what helped us identify this thought?

DANNI: I can't remember.

THERAPIST: That's OK. I think it was when we looked at the question you wrote and asked, "What would be the most depressing answer?" to that question.

DANNI: Oh, right.

THERAPIST: And then, even when we had that answer, I asked, "What would be so depressing about that?" and "What would that mean to you?" Maybe you could write those three questions in your therapy notes. They might help you figure out more hot thoughts this week. (*Pauses while Danni writes, and also reminds Danni what the three questions are.*) And also write a reminder to look for images. Sometimes an image might be the hot thought.

As illustrated in this dialogue, Danni's therapist reviewed what Danni wrote on Worksheet 7.3 (*MOM2,* p. 60) and looked to see if there was a hot thought there. None of the thoughts seemed hot enough to match a depression rating of 80%, and so the therapist asked Danni questions to help her find additional, hotter thoughts. Notice also that at the end of this conversation, the therapist reviewed with Danni the steps they took to identify the hotter automatic thoughts. You can help improve clients' skill from week to week by asking them to reflect on what helped them identify important automatic thoughts, and then directing them to write these ideas and strategies in their therapy notes. Therapy notes can be written in the *MOM2* book itself, in a separate therapy notebook, or in an electronic file that the client reviews periodically.

How Do You Know When You've Found the Hot Thought?

Sometimes you and your client may wonder how you can know when you have found a hot thought, or if you should continue looking for more thoughts. The criteria noted in the adjacent Reminder Box can help you decide. Let's briefly consider each of these three criteria, with a few clinical examples.

IS THE THOUGHT HOT ENOUGH?

The hotness of the thought required depends on the mood rating in column 2 of the thought record. For example, suppose your client identifies this thought: "I messed that up, and it will cause more work for Sharon." Could this be the hot thought for a mood of guilt? If guilt is rated at 20–30%, perhaps it would be. But usually we ask our clients to fill out thought records when moods are much more intense. If your client rated feelings of guilt at 75%, would this same thought seem hot enough? Probably not, because it is not clear why causing more work for Sharon would merit a 75% guilt rating.

To find a hotter thought, ask, "And what makes you feel guilty about causing more work for Sharon?" Your client may reply, "I didn't really put in as much effort as I should have. To save 20 minutes of my time, I took a shortcut, and I've now caused her about 2 hours of work to fix my mistake." Does this thought seem hotter? It certainly explains your client's guilt more clearly. It is easier to understand why these circumstances might lead this client to rate the guilt at 75%. At this point, you can also ask your client about the meaning of these events: "And what do you think it means that your shortcut has caused extra work for Sharon?" This client may answer, "I'm lazy, and someone else is paying the price." This could also be a hot thought. You can ask your client to rate the amount of guilt each thought elicits, to decide which thought is hottest.

DOES THE THOUGHT RELATE TO THE SITUATION IN COLUMN 1?

Sometimes people write thoughts that are judgments of themselves or others, without a clear connection to the situation described on the thought record. When people are evaluating their hot thoughts, they ideally want to look for evidence that comes from the situation listed in column 1. Consider Paul, who was filling out a 7-Column Thought Record for a situation in which he ran his bicycle over a nail and got a flat tire. His mood was anger, rated at 90%. He described his hot thought as "People go out of their way to hurt others." Although this thought seemed quite hot and helped explain an anger response, it was not clear how it related to the nail and his flat tire. Notice how his therapist helped Paul make this link.

PAUL: So my hot thought was "People go out of their way to hurt others."

THERAPIST: That thought certainly fits with anger.

PAUL: Yes.

THERAPIST: I want to be sure I understand what you mean. How does that thought relate to the nail you ran over and your flat tire?

Reminder Box

In order to be a hot thought, a thought (words or image) needs to be:

- Hot enough—does the thought match the intensity of the mood rating?
- Related to the specific situation in column 1 of the thought record.
- Testable (not a fact).

PAUL: Someone clearly put the nail there who was hoping to cause grief for someone else. I'm the poor sucker who hit it and had to pay for a new tire.

THERAPIST: So we should add that thought to column 3: "Someone put the nail there to cause grief for someone else."

PAUL: (*Writes this thought in column 3.*)

THERAPIST: Which do you think is the hottest thought related to the nail in your tire? The general thought about people going out of their way to hurt others, or your more specific thought that someone put this nail there to cause grief for someone else . . . and that someone happened to be you?

PAUL: Definitely the idea that someone put the nail there to cause problems.

THERAPIST: Does that thought explain why you felt anger at a 90% level?

PAUL: Yes.

THERAPIST: Let's circle that thought as your hottest thought, then. Now, let's look for evidence that supports this idea and write it down in column 4.

IS THE THOUGHT TESTABLE, NOT A FACT?

Sometimes people record a thought that describes a distressing event and circle it as their hot thought. For example, Elon listed "Rafael left me" as his hot thought explaining his mood of "depressed 95%." Rafael and Elon had broken up a few months earlier. The fact that his partner left him could not be the hot thought explaining Elon's depression, because this fact does not guarantee any particular emotion. Some people might feel relieved when a partner leaves them; others might feel anxious or angry. When someone writes a fact in column 3 of the 7-Column Thought Record, ask that person about the *meanings* related to this event that fit with this mood. The simplest way to do this is to express empathy and then make a mood-related inquiry, as Elon's therapist did.

ELON: The hot thought is "Rafael left me."

THERAPIST: I can understand how that was very painful for you. (*Pause*) I want to make sure I don't make any assumptions and that I understand fully. What was the most depressing part about him leaving you?

ELON: He was the love of my life. I don't think I will ever be as happy again. In fact, I can't imagine falling in love again.

THERAPIST: And if those things prove to be true, what will this mean for you and the rest of your life?

ELON: (*Eyes filling with tears*) I'll never be happy. The rest of my life is ruined.

THERAPIST: I can see how painful this is for you. Do any images or memories come to mind connected to those thoughts?

ELON: I see myself in a dark house with all the curtains closed. I'm just sitting in a chair staring off into the distance and thinking about him.

THERAPIST: These are some really important thoughts and images. I know they are painful. Even so, it is important to write them on your thought record, so we really capture what is so depressing for you about Rafael leaving. I wrote your thoughts down as you were talking. If I read what you told me, do you think you can write these ideas down in column 3 on your thought record?

ELON: (*Nods his head and picks up the pen.*)

THERAPIST: (*Reading*) "He was the love of my life. I don't think I'll ever be as happy again. I can't imagine falling in love again. I'll never be happy. The rest of my life is ruined." And you had an image of yourself in a dark house, sitting in a chair, curtains closed, staring and thinking about Rafael. (*After Elon finishes writing*) These thoughts really help me understand why you feel so depressed when you think about him leaving you. Which of these thoughts do you think is the hottest for you?

ELON: "I'll never be happy."

THERAPIST: Let's circle that thought. Would you be willing to talk more about that today and see if the evidence mostly supports that idea, or if there is any evidence that suggests you could find a way to be happy again sometime in the future?

ELON: I suppose. But I can't imagine ever feeling happy again.

THERAPIST: I get that. In fact, that thought seems to be really important to understanding your depression. Let's review how we found it. You wrote what I would call a "fact" in column 3: Rafael left you. You had the sense that this was your hot thought, but when a fact is driving your mood, it is helpful to figure out what the *meaning* of this fact is for you. So I asked you, "What's the most depressing part for you about him leaving?" Then you told me all these thoughts that describe what your break-up means to you.

ELON: Uh-huh.

THERAPIST: Before we move on, let's make a note to remind you about this in your *Mind Over Mood* book where it talks about identifying hot thoughts. This can help you next time.

ELON: What should I write?

THERAPIST: How about, "If my thought is a fact, ask, 'What is the most depressing thing about this fact?' " Of course, you would change the question slightly, depending on the mood you were working on. If you are working on anger, you would write, "What makes me so angry about this fact?"

ELON: I see what you mean.

Hot Thoughts: Summary

It takes varying amounts of practice before clients can easily identify their hottest thoughts and images. While your clients work toward mastering the skill of identifying hot thoughts, you want them to practice filling out columns 1–3 of 7-Column Thought Records at home each week, and to continue reviewing Chapter 7 of *MOM2*. In session with each client, review the first three columns of at least one of your client's thought records, and ask questions like this to uncover additional thoughts: "Let me make sure I understand what you mean here. What would be most depressing for you about . . . ?" Ask your client to add these thoughts to the thought record before choosing a hot thought, and then proceed to help your client complete the remaining four columns of the 7-Column Thought Record in session.

Teach your clients to look for hot thoughts that meet the hotness test, pertain to the situation in column 1, and capture the mood-related meaning of facts rather than the facts themselves. Completing thought records in session reinforces the usefulness of this approach, especially if you and your clients complete one or more of the 7-Column Thought Records they've started that address situations or circumstances that are still activating their target moods. Completion of thought records in session can serve to improve clients' moods, and also reinforces the helpfulness of the time they have spent identifying automatic thoughts during the week. The next chapter of this clinician's guide demonstrates how to help clients learn the cognitive restructuring skills required for them to complete the remaining four columns of the 7-Column Thought Record on their own.

Mood Check-Ups

Chapter 7 of *MOM2* ends with a reminder for readers to measure their moods again. This is an opportune point in this clinician's guide to remind you of the importance of asking your clients to fill out mood measures on a regular basis. Generally, measurement weekly or every other week is recommended. People can schedule days in their paper or electronic calendars to complete relevant mood measures. They can do so using whatever measures you suggest. *MOM2* includes the following measures: the *Mind Over Mood* Depression Inventory (Worksheet 13.1, p. 191); the *Mind Over Mood* Anxiety Inventory (Worksheet 14.1, p. 221); and Measuring and Tracking My Moods (Worksheet 15.1, p. 253), which can be used to track a variety of moods including positive moods such as happiness.

The benefits of having clients track their moods include helping clients evaluate

the strength of their moods, allowing them to track their progress, and also measuring the effectiveness of the skills they are practicing. Measuring happiness on a regular basis can be as helpful as measuring moods clients are trying to decrease. By measuring and thinking about happiness, clients often begin to recognize that the moods that trouble them are not constant and do not solely define their experiences. Keep in mind, however, that it can be premature to measure happiness when clients are experiencing severe depression, because they may not experience much happiness until their depression moderates.

Periodic mood measures provide data that are equally valuable for you as a clinician. In addition to tracking progress or lack of progress in therapy, mood measures can let you know what specific symptoms or client experiences are increasing, decreasing, or ongoing. If depression or anxiety disorders are not responding to therapy as expected, it is helpful to see what symptoms are accounting for scores on the depression or anxiety inventories. Targeting these symptoms can lead to more rapid improvement. For example, if a client indicates very poor sleep on a depression measure, targeting sleep in therapy can lead to significant mood improvements (Manber et al., 2011). Chapters 9–13 in this clinician's guide include information about additional important roles that mood measures can play in treatment planning, outcome assessment, and relapse management for specific moods.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTERS 6–7

If You Are More Familiar with a Different Thought Record Format

MOM2 teaches readers how to use a 7-Column Thought Record (Padesky, 1983). There are more than 100 different versions of a thought record in existence, and the relative efficacies of different versions have rarely been studied (Waltman, Frankel, Hall, Williston, & Jager-Hyman, 2019). The 7-Column Thought Record used in *MOM2* has the advantage of guiding clients to weigh evidence before looking for alternative explanations—a process that is linked to greater CBT skill use, compared with methods that only include development of alternative explanations (Jarrett, Vittengl, Clark, & Thase, 2011). Although you can teach clients to use other thought records, some of the potential clinical benefits of using the 7-Column Thought Record are highlighted in Appendix B: A Personal History of the 7-Column Thought Record (pp. 460–462). Compare these benefits with those of the thought record(s) you currently use. Also, a clinical demonstration by Padesky using a 7-Column Thought Record in session is referenced in Appendix C on p. 463 (Padesky, 1996a).

5

Thought Records, Part II: Cognitive Restructuring

(COLUMNS 4–7; *MOM2* CHAPTERS 8–9)

I can figure out my hot thoughts more easily now.
—*Alycia, third week of working on thought records*
—*Naraj, fifth week of working on thought records*

Once people can identify hot thoughts, they are ready to begin to master the skill of looking for evidence that supports and doesn't support these thoughts. This is the primary skill taught in Chapter 8 of *MOM2*. If you are fairly new to using the 7-Column Thought Record in therapy, take a minute before reading this chapter to review the section near the beginning of Chapter 4 titled "The Flow of Using 7-Column Thought Records in Therapy." This will remind you of your roles in the early stages of thought record use. As that section highlights, you need to be ready to help your clients complete all seven columns of this thought record in session for weeks before they are able to do so on their own. This chapter of this clinician's guide shows you how to do that effectively.

MOM2 CHAPTER 8: WHERE'S THE EVIDENCE?

Finding evidence that *supports* hot thoughts is usually easy for people. On the other hand, it can be quite difficult for people to identify evidence that *doesn't support* their hot thoughts, especially at first. It is not unusual for clients to spend a number of weeks mastering the skills of gathering evidence related to hot thoughts. If the number of therapy sessions available is limited, consider meeting less often once clients reach *MOM2* Chapter 8, rather than hurrying forward and skipping the time necessary to develop evidence-collecting skills. Examining the evidence that supports and doesn't support hot thoughts is a process that can help reduce the intensity of distressing moods, as highlighted in the Chapter 8 Summary.

Chapter 8 Summary

(*MOM2,* pp. 69–94)

- ✓ When we have negative automatic thoughts, we usually think mostly about information and experiences that confirm our conclusions.
- ✓ It is helpful to think about your hot thoughts as hypotheses or guesses.
- ✓ Gathering evidence that supports and does not support your hot thoughts can help reduce the intensity of distressing moods.
- ✓ Evidence consists of factual information, not interpretations.
- ✓ Column 5 of the thought record asks you to actively search for information that doesn't support a hot thought.
- ✓ It is important to write down all the evidence that does not support your hot thought.
- ✓ You can ask yourself the specific questions in the Helpful Hints on page 75 of *MOM2* to help you complete column 5 of a thought record.

Facts versus Interpretations

Factual: John told me he did not like my attitude.
Possibly factual: I never get invited to parties.
Interpretation: No one likes me.

The best evidence is based on facts, not on opinions or interpretations. People often have some difficulty telling the difference between factual evidence and opinions/interpretations, especially when they are experiencing strong moods. Take a moment now to fill out Worksheet 8.1, Facts versus Interpretations (*MOM2,* p. 72), and compare your answers to those in the answer key on page 73 of *MOM2.* If you had difficulties with this exercise, read the text that follows on page 73 to review the differences between factual evidence and interpretations. Remember that facts are observations that almost all people viewing a situation are likely to agree on. Whenever possible, help your clients learn to list facts rather than interpretations in the evidence columns of their 7-Column Thought Records.

Column 4: Evidence That Supports the Hot Thought

You may be wondering why the 7-Column Thought Record (Padesky, 1983) asks first for evidence that supports a hot thought. There are three reasons for this. A primary reason is that it can be quite invalidating if someone tells you a hot thought such as

"I'll never be happy again," and you follow this statement up with the question "What evidence doesn't support that?" In therapy, we usually empathize with such a statement (e.g., "That idea is pretty distressing"), and then follow up with an open-ended inquiry such as "Tell me what experiences you have had that lead you to that conclusion." The 7-Column Thought Record allows this same process to happen whether a therapist is present or not by asking for evidence that supports the hot thought.

A second reason for first gathering and writing down the information that *supports* a hot thought is that it records this information so that people can then think about something different. Once they write down the evidence that supports their hot thought, people are more able to consider information that might not support their hot thought. If supportive evidence is not collected first, when nonsupporting evidence is gathered a person is likely to think or say, "Well, yes, there is that, but . . ." and then state the evidence that supports the hot thought. This order diminishes the value of nonsupporting evidence.

Third, CBT is empirical, and it is critical for therapists not to fall into the trap of assuming that every distressing thought is somehow distorted. We need to identify the evidence that supports a hot thought. For example, if Beth has the hot thought "I'm a bad parent," it is important to know what has happened that leads her to this conclusion. There is quite a difference between people who think they are bad parents because they lose patience and yell at their toddlers, and people who pour boiling water over their toddlers' hands to "teach them a lesson." In either case, Beth might be really trying to behave in a way she considers good parenting, and yet she might not know how to handle challenging circumstances. Gathering evidence from your clients' lives that support their hot thoughts can help you decide what types of interventions are needed: testing thoughts, providing parent education, devising Action Plans for managing parenting challenges, setting up behavioral experiments to test the clients' fears, and even contacting social services to report child abuse.

What Types of Evidence, and How Much Evidence, Should Be Listed?

Usually people can quickly list a variety of things that support their hot thoughts. This can be problematic, especially if people scan their entire lives when looking for this evidence. Memory is not an accurate recorder of past experience, and what we recall is influenced in part by whom we tell about our memories (see Stone, Barnier, Sutton, & Hirst, 2013). Thus we might remember things somewhat differently if we tell a therapist about a childhood event than if we talk with a sibling or a stranger. In addition, we have thousands of past memories. The ones that come to mind in a given moment depend partly on our current mood. We are more likely to recall and attend to mood-congruent memories than to mood-incongruent memories (Holland & Kensinger, 2010; Hitchcock, Werner-Seidler, Blackwell, & Dalgleish, 2017). Thus, if we look for evidence across our lifespans that we are "failures," most of us would be able to cite a number of events that support this conclusion, even if we or others generally think that we are successful. If this same question is asked when we are feeling depressed, even more supporting memories of "failure" will come to mind, and fewer memories of "success."

Clinical Tip

When you and a client are looking for evidence that supports a hot thought, look primarily for facts drawn from the specific situation described in column 1 of the 7-Column Thought Record.

When people have had a long history of life difficulties, we can expect that they will have a deep store of memories to support many different types of distressing thoughts. It can actually intensify a current mood state to recall and write down mood-congruent historical life experiences on a thought record. Therefore, rather than teaching clients to write evidence from across their lifespans in column 4, it is much more productive to ask them to only write down evidence obtained from the specific situation described in column 1 of that 7-Column Thought Record. This instruction makes sense, because this thought record is designed to test automatic thoughts and images evoked in a specific situation.

Consider Karla, who was currently experiencing depression. Karla had been sexually molested as a child, was physically abused in her recent marriage, and struggled with prescription pill addiction until she entered a drug addiction program two years ago. She was filling out a 7-Column Thought Record about a recent situation at work in which she thought that a colleague had treated her disrespectfully in a meeting. Her hot thought was "I'm not the sort of person who deserves respect." Left to her own devices, Karla was likely to list her sexual abuse, physical abuse, addiction, and other traumatic and distressing life events as evidence that she did not deserve respect (see Figure 5.1). Instead, Karla's therapist directed her to look for evidence in the situation listed in column 1 of her thought record.

THERAPIST: What evidence can you think of that supports this idea that you are "not the sort of person who deserves respect"?

KARLA: So many people decided they could abuse me, and I didn't stop them.

THERAPIST: I'm sorry, Karla. I wasn't clear with you. I want us to test out this thought in *this situation* on your thought record: "Wednesday, 2 P.M. Meeting at work." What evidence was there in that meeting that you did not deserve respect?

KARLA: I'm not sure what you mean.

THERAPIST: Well, I wasn't there. Did you act in some way that told people you weren't to be respected? Did you say something that made you appear less worthy of respect?

KARLA: Oh, I see what you mean. Well, I think I was talking pretty quietly, so maybe John thought he could just talk over me.

THERAPIST: Write that in column 4: "I was talking pretty quietly." (*Pauses while Karla*

Thought Record

1. Situation Who? What? When? Where?	2. Moods a. What did you feel? b. Rate each mood (0–100%). c. Circle or mark the mood you want to examine.	3. Automatic Thoughts (Images) a. What was going through your mind just before you started to feel this way? Any other thoughts? Images? b. Circle or mark the hot thought.	4. Evidence That Supports the Hot Thought	5. Evidence That Does Not Support the Hot Thought
Wednesday, 2 P.M. Meeting at work. When I started to give a suggestion about the new sales plan, John interrupted me and said, "That won't work," and then talked about his own ideas.	Depressed 80% Hurt 75%	He doesn't like my idea. It probably wasn't a good idea. Interrupting me was disrespectful I'm not the sort of person who deserves respect.	My uncle molested me. My ex-husband hit me and told me I was worthless. I'm an addict and sometimes struggle to stay off drugs. I've messed up a lot in my life.	

FIGURE 5.1. Karla's first five columns of a 7-Column Thought Record with column 4 evidence gathered from her history. Adapted from Padesky (1983). Copyright © 1983 Christine A. Padesky.

writes.) Now that I see what you wrote, I guess I'm not sure how it is that talking quietly means you are less worthy of respect.

KARLA: We had a training meeting at work, and they said you should talk clearly and firmly if you want to be respected.

THERAPIST: Oh. So maybe you could add something to your sentence, like " . . . which is not the best way to get respect, according to our training meeting."

KARLA: OK. (*Writes this idea in her own words on her thought record, as shown in Figure 5.2.*)

THERAPIST: What other evidence is there from the meeting that you did not deserve respect?

KARLA: I'm not a manager, and most of the others in the meeting were managers. Also, John has an MBA, and I just have a two-year degree from the community college.

THERAPIST: OK, write that down in column 4.

Notice that Karla's therapist did not dispute the evidence from the situation that Karla offered. Even though her therapist did not believe that Karla's nonmanagerial status, amount of education, or talking quietly deserved disrespect, her therapist encouraged Karla to write these on her 7-Column Thought Record, because Karla was linking these facts to her being less worthy of respect. Compare Figures 5.1 and 5.2. Recall that in Figure 5.1, Karla was listing events that happened over her lifetime. Figure 5.2 shows what a 7-Column Thought Record looks like when the evidence is drawn from a *specific situation.* Take a moment before reading further, and consider what you notice about each one and what you think the advantages might be for looking for evidence in the situation rather than across one's lifetime.

Looking in the Specific Situation for Facts That Support a Hot Thought

A 7-Column Thought Record is designed to test automatic thoughts and images (column 3) that came into someone's mind in a given situation (recorded in column 1). It is not designed to test whether a particular thought might ever be true in other situations. Therefore, the most pertinent evidence that supports or does not support a hot thought will be found in the situation described on that thought record. One benefit of gathering evidence from a specific situation is that people can more easily detect distortions and generate alternative views of recent, specific events than they can when they scan their entire lives and focus on mood-congruent historical experiences. As discussed in the previous section, when Karla scanned her life looking through the lens of depression, she found lots of evidence fitting with her idea that she was "not the sort of person who deserves respect." However, these past experiences were not pertinent to whether she deserved respect in Wednesday's meeting.

Also, evidence from a recent situation is usually more emotionally manageable than a summary of life's worst moments. Karla's list of past traumas and struggles (Figure 5.1, column 4) might be emotionally overwhelming for her to recall. Writing

Thought Record

1. Situation Who? What? When? Where?	**2. Moods** a. What did you feel? b. Rate each mood (0–100%). c. Circle or mark the mood you want to examine.	**3. Automatic Thoughts (Images)** a. What was going through your mind just before you started to feel this way? Any other thoughts? Images? b. Circle or mark the hot thought.	**4. Evidence That Supports the Hot Thought**	**5. Evidence That Does Not Support the Hot Thought**
Wednesday, 2 P.M. Meeting at work. When I started to give a suggestion about the new sales plan, John interrupted me and said, "That won't work," and then talked about his own ideas.	Depressed 80% Hurt 75%	He doesn't like my idea. It probably wasn't a good idea. Interrupting me was disrespectful I'm not the sort of person who deserves respect.	I was talking pretty quietly, and our training meeting taught us that is not a good way to get respect. I'm not a manager, and most of the others in the meeting were managers. John has an MBA, and I just have a two-year degree from our community college.	

FIGURE 5.2. Karla's first five columns of a 7-Column Thought Record with column 4 evidence gathered from the situation in column 1. Adapted from Padesky (1983). Copyright © 1983 Christine A. Padesky.

these experiences down could strengthen her current depressed mood and negative beliefs about herself. Although her history helps us understand why "disrespected" was a theme for Karla, her traumatic memories and life challenges would take us far afield of her current situation. A thought record is not the ideal tool to address beliefs across the context of a variety of past experiences. It is designed to evaluate automatic thoughts relevant to a single situation.

Even so, it is interesting to note that if Karla's hot thought was not supported by the evidence in her current situation, then this thought record could begin to weaken her conviction that she didn't deserve respect across other present and future situations. On the other hand, if her hot thought that she didn't deserve respect was supported in the current situation, then she and her therapist could create an Action Plan to begin to address the issues uncovered (using Worksheet 10.2, *MOM2,* p. 125). This Action Plan could help Karla in other related situations.

In sum, since Karla wanted help with her current experience of depression, it was best to test her hot thoughts in relation to evidence drawn from her current situations. Whatever she learned from this evidence regarding her hot thoughts could be applied in ways that would have a positive impact on other current and future situations. A focus on historical traumas and difficulties would be unlikely to be the shortest path to mood relief for Karla, unless her primary diagnosis was posttraumatic stress disorder related to these traumas. In that case, a 7-Column Thought Record would probably not have been used, because other methods have been developed that are more effective in the treatment of this disorder (see Ehlers & Clark, 2000; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005).

Generally, we only record evidence from across the lifespan on a 7-Column Thought Record when the situation in column 1 is something like "Sitting in a chair, thinking about my life." Even in that instance, the advantages just described would suggest that there are likely to be benefits in urging someone to look within more recent life experiences rather than more distant ones. These benefits become even clearer in the next section, when we consider the search for evidence that doesn't support a hot thought.

The first four columns of a 7-Column Thought Record require us as users to slow down and document our reactions. Everything recorded in these four columns can happen in a flash. We observe what is happening around us (column 1, Situation). We experience quick emotional responses (column 2, Moods) and thoughts (column 3, Automatic Thoughts (Images)). Our mind selectively focuses on observations that fit with and support our automatic thoughts and our moods (column 4, Evidence That Supports the Hot Thought). The first four columns of a 7-Column Thought Record require us to look closely at these fast responses and describe them in detail. This process of slowing down and elaborating our automatic reactions can be therapeutic in and of itself, because we often don't fully realize why we respond as we do in situations (see Kahneman, 2013).

Column 5: Evidence That Does Not Support the Hot Thought

Beginning with column 5 (Evidence That Does Not Support the Hot Thought), the remaining three columns of the 7-Column Thought Record require people to engage

in even slower, more deliberate thought processes in order to generate responses that don't come as automatically as hot thoughts do. Most people who are in the midst of experiencing intense moods need help to see evidence that does not support their hot thoughts. The Helpful Hints box on page 75 of *MOM2,* Questions to Help Find Evidence That Does Not Support Your Hot Thought, is designed to help people gather this information by shifting the perspective with which they view the situation described in column 1 of the thought record. This Helpful Hints box provides a variety of questions that employ different perspective-switching strategies. Thus, if one or two questions don't prove fruitful for a given person in a given situation, there are many additional questions to ask.

Shifting perspective is the key to identifying information in a given situation that doesn't support hot thoughts. The natural perspective people take when they experience an intense mood is to scan everything around them that fits with this mood. Therefore, when we ask our clients an opening question such as "Was there any evidence in this situation that doesn't support your hot thought?", most clients will fairly quickly respond, "No." It is still useful to ask this opening question, because people who can generate alternative views about situation with minimal prompting are demonstrating greater cognitive flexibility. An ability to shift perspectives easily is a signpost that these people might develop thought record skills more quickly.

Some of the questions offered in the Helpful Hints box shift perspective by asking people to imagine someone else in their place in the same situation:

- If my best friend or someone I loved had this thought, what would I tell them?

Another strategy is to shift selective attention away from mood-congruent information:

- When I am not feeling this way, do I think about this type of situation any differently? How? What factual information do I focus on?
- Are there any small pieces of information that contradict my hot thought that I might be ignoring or discounting as not important?
- Are there any strengths or qualities I have that I am ignoring? What are they? How might they help in this situation?
- Are there any positives in this situation that I am ignoring? Is there any information that suggests there might be a positive outcome in this situation?

Changing time perspective can also shift perspective:

- Five years from now, if I look back at this situation, will I look at it any differently? How? Will I focus on any different part of my experience?

You and your clients can consider a number of different questions in session when you are collaboratively looking for evidence that does not support their hot thoughts. Ask your clients to mark the most helpful questions in the Helpful Hints box as a reminder to ask themselves these questions first when they begin to fill out the evidence

columns of 7-Column Thought Records on their own. Explain to your clients that they don't need to ask themselves all of these questions. They can scan the Helpful Hints box and ask the questions that seem most relevant and helpful for a given thought record. Asking a variety of questions is helpful. When the information that doesn't a support a hot thought comes from several different perspectives, a person is more likely to feel confident that an alternative viewpoint could be valid.

Here are a few guidelines that can help the process proceed more smoothly when you are helping a client gather evidence that doesn't support a hot thought:

1. As guided by the 7-Column Thought Record, take ample opportunity to record all the evidence from within the situation that *supports* the hot thought (column 4) before you seek evidence that *doesn't support* the hot thought (column 5). Rationales for this process have been offered in this chapter's discussion of column 4.

2. Adopt a neutral, collaborative stance of curious inquiry, rather than a dogged pursuit of errors in thinking. For example:

> "OK. We have gathered quite a bit of evidence that supports your hot thought. This helps me understand your reactions much better. Just to be fair, we should also look to see if there was any evidence in this situation that doesn't support your hot thought."

3. It sometimes takes a few minutes to find the first piece of evidence that doesn't support a hot thought. Be patient and stay curious. The second piece of evidence can take nearly as long. Once two pieces of evidence have been found, additional pieces of evidence sometime emerge more quickly.

4. Gather evidence conversationally for a few minutes before asking your clients to begin writing it down on their 7-Column Thought Records. If you ask your clients to write down the first piece of evidence as soon as it is mentioned, this can slow their discovery processes. Waiting until there are two or three pieces of evidence before you ask your clients to write it down maintains the momentum of the search. You can take notes while they speak, to remember things your clients say that might be relevant. Be sure to use your clients' *exact* words in your notes instead of paraphrasing. This way, when you read back the summary of evidence gathered, your clients will recognize what you have written as their own ideas.

5. Look for a *variety* of evidence in the situation. Consider information about your client, the situation itself and circumstances surrounding it, other people in the situation, and invisible factors that might have influenced what happened or was said (e.g., alcohol or drugs consumed, time of day or night, fatigue, work or other life pressures). When a greater variety of evidence can be found that doesn't support the hot thought, alternative perspectives are more likely to be credible to your client.

6. Do not overstate the evidence that clients offer. Again, try to summarize by using their exact words. If you modify their words at all, it is better to understate what they said. A slight understatement leads your client to mentally correct your summary

in a positive direction. A slight overstatement can lead your client to negatively discount the evidence; an overstated summary can serve to weaken the meaning of the evidence.

For example, compare your mental reactions if someone summarizes "I did a pretty good job explaining my feelings" as follows:

"You did a pretty good job explaining your feelings." (Exact words, with only pronoun changes)

"You were very clear in explaining your feelings. (Overstatement)

"You might not have done as well as you hoped, but you tried to explain your feelings." (Slight understatement)

Let's see how Karla's therapist, building on the partially completed thought record shown in Figure 5.2, used these guidelines to advantage in helping Karla look for evidence that didn't support her hot thought: "I'm not the sort of person who deserves respect."

THERAPIST: OK. So we have this evidence in column 4: You were talking pretty quietly, and your training meeting taught you that this is not a good way to get respect; you are not a manager, and most of the others in the meeting were managers; John has an MBA, and you have a two-year degree from our community college.

KARLA: Uh-huh.

THERAPIST: Just to be fair, we should also look in this situation to see if there was any evidence that doesn't support your hot thought.

KARLA: OK.

THERAPIST: Was there anything about you in that meeting that you think did deserve respect?

KARLA: Not that I can think of.

THERAPIST: That other woman in your department who works with you. What is her name?

KARLA: Keysha.

THERAPIST: Keysha. Thanks for reminding me. Does Keysha have an MBA, and is she a manager?

KARLA: No.

THERAPIST: If Keysha had been in the meeting and spoke quietly about something, and John had interrupted her and said, "That won't work," how would you react?

KARLA: I'd be mad and feel sorry for her.

THERAPIST: What would you think about what just happened?

KARLA: I'd think that John was being rude and that it was unfair not to listen to her ideas.

THERAPIST: Would you then think, "Oh, well, Keysha isn't the sort of person who deserves respect"?

KARLA: No, because she is a good worker and her ideas are good. She does deserve respect.

THERAPIST: Why does she deserve respect even though she was speaking quietly, is not a manager, and doesn't have an MBA?

KARLA: Well, anybody who has an idea at least deserves the respect of letting them finish saying their idea before John shoots it down.

THERAPIST: (*Writing this down in his notes*) Any other reasons she deserves respect?

KARLA: She's a human being. And our training said we are supposed to act respectful toward everyone in the company, whether we agree with them or not.

THERAPIST: (*Writing down her words*) Any other reasons she deserves respect?

KARLA: No. That's it.

THERAPIST: So if you were sitting in that meeting, and John interrupted Keysha as she quietly started to present her idea, how do you think you would have felt?

KARLA: Angry. At John.

THERAPIST: And what would you have done or said to express your anger?

KARLA: Probably nothing. Because John doesn't like people to call him out. He gets on his high horse and won't be interrupted.

THERAPIST: I understand. So you wouldn't have said or done anything. What would you have been thinking about Keysha in terms of her being worthy of respect?

KARLA: I would have thought she deserved more respect than John showed her.

THERAPIST: So, if Keysha was there, you would not have spoken out for her. But you would have been thinking, "She deserves respect."

KARLA: Yes.

THERAPIST: Let me read back to you what you have said about Keysha in this same situation. These are your exact words: "John was being rude. It was unfair not to listen to her ideas. She deserves respect because she is a good worker and her ideas are good. Anybody who has an idea at least deserves the respect of letting them finish saying their idea before John shoots it down. She deserves respect because she's a human being. Our training said we are supposed to act respectful toward everyone in the company, whether we agree with them or not."

KARLA: I said all that?

THERAPIST: Yes. I was careful to write down your ideas in your words. Do you think any of these ideas could go in column 5 of your thought record as Evidence That Does Not Support the Hot Thought?

KARLA: (*Examining the written list*) Yes.

Therapist: Take this pen and write down the relevant ideas on your thought record.

Karla: (*Writing*) "John was being rude. It was unfair not to listen to my idea. Anybody who has an idea at least deserves the respect of letting them finish saying their idea before John shoots it down. I deserve respect because I'm a human being. And our training said we are supposed to act respectful toward everyone in the company, whether we agree with them or not."

Therapist: What do you think about this evidence?

Karla: It's true. I didn't think I'd have anything to write here.

Therapist: I notice you didn't write down the idea you got from thinking about Keysha that she deserves respect because "She is a good worker and her ideas are good." What made you decide that this idea did not apply to you?

Karla: I don't know if I'm a good worker or not. And maybe my idea wasn't very good.

Therapist: I'm curious. Why did you get included in this meeting?

Karla: Because I'm the person doing the work on this project.

Therapist: Why do you think they assigned this work to you?

Karla: Because I'm the one who handles all the product supply logistics.

Therapist: Were you put in charge of that just because no one else wanted to do it?

Karla: No. I worked in that department for a few years, and my supervisor thought I could handle the greater responsibility.

Therapist: Do you think your supervisor thought you were a good worker or not?

Karla: You got me there. (*Smiling slightly*) Yeah, he thought I was pretty good.

Therapist: I'm not trying to "get you" or trip you up. I just am not sure that someone who was not a good worker would even get invited to a management meeting.

Karla: I see your point.

Therapist: So could you write something in column 5 about that? Something like "At least one supervisor thought I was a pretty good worker," or whatever you think is fair.

Karla: (*Writing*) "I'm good at managing product supply logistics."

Therapist: OK. Was that what you were talking about in the meeting?

Karla: Yes. Our supply chain and how to fix some of the hold-ups.

Therapist: And I notice you wrote "managing product supply logistics." Are you the manager of that?

Karla: Yes.

Therapist: But you said you were not a manager.

Karla: No, I'm not. The managers are all people in finance and planning. They don't really know how things actually work in our factory. That's why they invited me there.

THERAPIST: But surely John knows about product supply logistics if he has an MBA.

KARLA: No, not really. He thinks he does. But you can't really know what is going on unless you are on the factory floor and watch the line and see where the problems are.

THERAPIST: This is really interesting. I didn't fully understand the situation. Based on what you are telling me, are there any additional reasons you deserved respect in that meeting?

KARLA: Yes. Actually, I was the only one in the meeting who works the factory floor and understands what is going on to speed up and slow down production. And I am the only one who manages the supply chain, which was what I was trying to talk about. Even John doesn't know this area as well as I do. If he hadn't interrupted me, I had a reasonably good idea that could have saved the company money.

THERAPIST: That seems so important. Let's take a moment while you write down those ideas on your thought record.

Figure 5.3 shows Karla's thought record listing all her evidence that didn't support her hot thought. Notice that even more evidence could have been gathered. You might wonder why her therapist asked Karla about whether she would have stood up to John and said something about his being disrespectful toward Keysha. The reason for asking about this was the therapist's guess that thinking it might weaken any assumptions Karla was making about other managers' staying silent after John's interruption (e.g., "They must agree that I don't deserve respect."). However, this line of potential evidence was dropped when her therapist learned more details about Karla's special expertise and what she was speaking about in the meeting. This information Karla offered was even more relevant to her hot thought about whether or not she deserved respect.

Notice that her therapist obtained the second half of the evidence for column 5 very quickly, once she asked Karla about the one bit of evidence regarding Keysha's deserving respect that Karla had not chosen to put on her thought record in regard to herself: "She is a good worker and her ideas are good." If Karla's therapist had not made a written list of Karla's statements about Keysha's deserving respect, the omission of this statement might not have been apparent. Writing down all your clients' ideas and then letting them choose what to write on their thought records is a really good strategy. Once they have done so, stay as curious about what they decide not to write on their thought records as about what they do choose to write.

As recommended earlier, her therapist guided Karla to look for evidence directly related to the situation in column 1 of her 7-Column Thought Record. Guiding a client in this manner provides a search focus that can make filling out a thought record a more time-efficient process compared with looking across the client's entire lifetime for evidence. More importantly, evidence from someone's distant past is not as likely to be as convincing as evidence from a recent situation. Consider the following evidence that might have been derived from Karla's past:

Thought Record

1. Situation Who? What? When? Where?	2. Moods a. What did you feel? b. Rate each mood (0–100%). c. Circle or mark the mood you want to examine.	3. Automatic Thoughts (Images) a. What was going through your mind just before you started to feel this way? Any other thoughts? Images? b. Circle or mark the hot thought.	4. Evidence That Supports the Hot Thought	5. Evidence That Does Not Support the Hot Thought
Wednesday, 2 P.M. Meeting at work. When I started to give a suggestion about the new sales plan, John interrupted me and said, "That won't work," and then talked about his own ideas.	Depressed 80% Hurt 75%	He doesn't like my idea. It probably wasn't a good idea. Interrupting me was disrespectful I'm not the sort of person who deserves respect.	I was talking pretty quietly, and our training meeting taught us that is not a good way to get respect. I'm not a manager, and most of the others in the meeting were managers. John has an MBA, and I just have a two-year degree from our community college.	John was being rude. It was unfair not to listen to my idea. Anybody who has an idea at least deserves the respect of letting them finish saying their idea before John shoots it down. I deserve respect because I'm a human being. Our training said we are supposed to act respectful toward everyone in the company, whether we agree with them or not. I'm good at managing product supply logistics. I was the only one in the meeting who works the factory floor and understands what is going on to speed up and slow down production. I am the only one who manages the supply chain, which was what I was trying to talk about. Even John doesn't know this area as well as me. If he hadn't interrupted me, I had a pretty good idea that could have saved the company money.

FIGURE 5.3. Karla's first five columns of a 7-Column Thought Record with column 5 evidence gathered from the situation in column 1. Adapted from Padesky (1983). Copyright © 1983 Christine A. Padesky.

"My mother used to say that everyone deserves respect."
"My college coach said he respected my effort and hard work."
"My best friend in my 20s said she respected me more than anyone else."

Even though this evidence might be relevant to Karla, compare its power to that of the evidence recorded in column 5 of Figure 5.3. It is easy to imagine Karla responding to historical evidence with the discounting thought "These people all cared about me when I was younger, but their opinions don't really count in terms of Wednesday's meeting."

Gathering Evidence When a Hot Thought Is an Image

Therapists sometimes wonder how to look for evidence when a hot thought is an image. The same processes described in the previous sections work just as well for testing images. Depending upon the nature of the image, there are a number of approaches to take. Here are three common strategies:

1. If the image is about something that did not occur, then consider creating an alternative image that retains some of the elements of the original image, but includes enough changed aspects so that the image is no longer disturbing. For example, one woman was distressed by a recurrent image of a thief breaking into her house and robbing her. In the absence of any intruders, she and her therapist changed this image to one of a friend breaking into her house to deliver a surprise present. Whenever this woman began to think about the first disturbing image, she switched the ending to the image of the friend's playful invasion.

2. Another approach is to test the meaning of an image. For example, the meaning of the woman's image of someone breaking into her house and robbing her might have been that she did not feel safe or that she doubted her ability to protect herself when things went wrong. Gathering evidence to test her beliefs about safety or her capacity to protect herself might lead to balanced or alternative beliefs (e.g., "The evidence shows I am safe at home") and images (e.g., an image of herself successfully defending herself against an intruder). It can also be important to test the meanings people attach to having particular images. For example, sometimes people conclude that they are bad persons because they have had particular images. At other times, people think that having an image means that what they envision is bound to happen. Clients can test beliefs like these either by completing thought records or by using behavioral experiments (see Chapter 7 of this clinician's guide).

3. If an image is a highly distorted representation of a real-life event, work to modify the image and bring it into alignment with what really happened, as demonstrated in the next dialogue. Look for evidence for which portions of the image align closely with real-life events and which portions might be distorted. Testing images will not be as effective if you use purely verbal methods (Pearson, Naselaris, Holmes, & Kosslyn, 2015). Instead, enter into and visualize your client's image during the evidence-gathering process, as the following example with Cliff illustrates.

THERAPIST: So this week you filled out this thought record for a situation in which you felt ashamed. Let's see, in column 1 you wrote, "Tuesday afternoon, I was walking down the street and saw a homeless person. He was shouting at me and the other people walking by, and I shouted back, 'Leave me alone!'" In column 2, your mood was "shame," which you rated at 90%. And in column 3, you identified a variety of automatic thoughts: "I shouldn't have spoken in such a mean voice to him. Any one of us could be homeless some day. He made me uncomfortable and I wanted to get away." You circled your hot thought, which was an image of you "shouting at and kicking the man as he lay defenseless on the ground."

CLIFF: (*Staring into his lap*)

THERAPIST: That sounds like a pretty intense image.

CLIFF: (*Quietly*) Yes.

THERAPIST: Do you still feel shame when you think about that image?

CLIFF: Yes.

THERAPIST: Then this seems like an important thought record to work on today. Is that OK with you?

CLIFF: Yeah. I suppose.

THERAPIST: First, I want to compliment you on doing such a good job filling out these first few columns. You chose a clear situation in which you experienced an intense mood, and you did a really good job of identifying your automatic thoughts and images. I can understand how your hottest thought was this image of you shouting at and kicking the man. And, even though I can see that image is unsettling for you, you were courageous enough to write it down so we can discuss it.

CLIFF: (*Making eye contact for the first time*) It has really bothered me that I could have an image like that. I never thought about myself that way before.

THERAPIST: So is there an additional thought there as well? A thought like "If I can have an image like that, then . . ."?

CLIFF: Then I might be that sort of person.

THERAPIST: OK. Could you write that on your thought record just below the image: "If I can have an image like this, then I might be the sort of person who . . . "

CLIFF: (*Writing*) "If I can have an image like this, then I might be the sort of person who could violently beat up a homeless man."

THERAPIST: Now we have this hot image, and also this hot assumption that having an image like this means you might be the sort of person who could violently beat up a homeless man. Which one do you want to test first?

CLIFF: The image. I can't get it out of my head.

THERAPIST: Fine. Let's start with evidence that supports this image. What happened in the situation that matches up with your image? We can write that information in column 4, Evidence That Supports the Hot Thought.

CLIFF: I yelled at the man to leave me alone.

THERAPIST: OK. Write that down. (*Pauses while Cliff writes.*) Anything else?

CLIFF: Not really.

THERAPIST: Just to be sure we have everything for this column before we move to the next one, tell me a bit more about your image. What did you see, feel, hear, and so forth in your image? Can you slow it down and describe it for me?

CLIFF: I felt really angry and pumped up inside. I can see him huddled on the ground, and I can feel myself kicking him, but he doesn't move, so it is like kicking a 100-pound sack of flour. There is just a dull thud. But I'm pumped up and I'm shouting, "Leave me alone. You are a worthless piece of ★★★★!"

THERAPIST: What else is happening? Are other people around?

CLIFF: No, it's just me and him.

THERAPIST: Are you seeing this from the perspective of your eyes looking out, or from another perspective, like you are an onlooker watching the scene?

CLIFF: That's an interesting question. . . . I guess I am really watching the scene from a few feet away, because I see all of myself.

THERAPIST: What are you wearing?

CLIFF: A blue t-shirt and jeans and black boots.

THERAPIST: Are those the clothes you were wearing that day you saw the homeless man?

CLIFF: No. I was dressed for work, so I had on black pants and a tan shirt. And regular shoes.

THERAPIST: Perhaps you should write that difference down in column 5, Evidence That Does Not Support the Hot Thought. (*Pauses while Cliff writes.*) What other things from your image don't quite fit what was really going on in the situation?

CLIFF: Well, I didn't really kick him. He wasn't huddled on the ground; he was standing up and waving his arms at people and shouting. In the image, I'm the one being aggressive, and he is quiet and limp. In reality, he was being pretty aggressive and lunging at people. I felt a bit threatened, to be honest.

As Cliff and his therapist gathered details comparing his image to what had actually happened, it became clearer that Cliff's image had very little evidence to support it, and lots of evidence that didn't support it. After writing all this evidence down, Cliff wrote down in column 6 the details of a balanced image that fit the actual events more closely:

> "New image: I'm visualizing what actually happened. I'm standing alert. I'm aware he is homeless and upset. My muscles are flexed so I am ready to defend myself or others in case he attacks, and, at the same time, I walk away without attacking him."

Once Cliff wrote down this new image and spent a few minutes imagining it vividly, he reported a reduced shame rating of 65%. Given that Cliff still experienced significant shame, his therapist worked with him to examine his assumptions about the meaning of his original image.

THERAPIST: Even though we can see that the image you circled as your hot thought doesn't relate very closely to what was going on that day, you still feel quite a bit of shame.

CLIFF: Yes, it goes back to this other hot thought (*pointing*): "If I can have an image like this, then I might be the sort of person who could violently beat up a homeless man."

THERAPIST: Shall we test that thought?

CLIFF: Yes, please. I don't understand how I could have imagined this.

THERAPIST: What evidence do you have that supports the idea having an image like this means you are the type of person who can do this?

CLIFF: The image was so real and detailed.

THERAPIST: OK. Write that down in column 4, Evidence That Supports the Hot Thought. (*Pauses while Cliff writes.*) Any other evidence that supports your idea?

CLIFF: I felt really pumped up inside. And I told him to leave me alone in a really strong and mean voice. I can hear my tone, and I think I sounded threatening.

THERAPIST: OK. Write those things down.

CLIFF: (*Writes, then*:) I think that is about it for supporting evidence.

THERAPIST: Can you think of any evidence that doesn't support this hot thought?

CLIFF: I'm not sure.

THERAPIST: Well, let's start with . . . have you ever beaten someone before, like you imagined?

CLIFF: No! Never.

THERAPIST: What does that tell you?

CLIFF: I don't really want to be violent toward him or anyone, really.

THERAPIST: (*Writing down Cliff's words on a notepad*) Have you ever had any other images that seemed real and intense, but they didn't really relate to what was happening or likely to happen in your life?

CLIFF: What do you mean?

THERAPIST: Well, sometimes we see someone attractive and imagine having sex with them, or we imagine yelling and telling off our boss, even though we know we'd probably never do that.

CLIFF: Oh, I see what you mean. Yeah, I've imagined those sorts of things.

THERAPIST: Do you think imagining those sorts of things makes it more likely they will happen?

CLIFF: I wish. (*Laughing*) No, seriously, I get your point. Imagining things doesn't make them come true.

THERAPIST: So why do you think our brains imagine things like that? What's the point?

CLIFF: Well, maybe our brains are imagining what could be. Or fantasizing about what it would like to happen, even if it is not likely.

THERAPIST: What would be the benefit of having a brain that can do that?

CLIFF: Well, I guess imagination helps us see good things, too. And sometimes we might try to make those things happen. That would be good. And other times it might help us blow off steam or imagine revenge so we don't feel so helpless, like with a mean boss.

THERAPIST: Hmmm. Those are interesting ideas. Do you think any of them could apply to this situation and the image you had of beating up the homeless man?

CLIFF: I was feeling threatened. Not just me, but I could see that an old lady walking near me was really scared by him. He was making quite a scene. So maybe my image was like a revenge fantasy. I changed from him being threatening to me, to me threatening him back and shutting him up. Which I wanted to do. Only not in a violent way.

THERAPIST: Does that seem plausible to you? As an explanation for your image?

CLIFF: Yes, it does.

THERAPIST: Why don't you write that down then on your thought record in column 5, Evidence That Does Not Support the Hot Thought? (*Pauses while Cliff writes.*) Can you read to me what you wrote?

CLIFF: (*Reading*) "My image was a revenge fantasy to blow off steam, because the man felt threatening to me. It doesn't mean I wanted to really beat him up."

THERAPIST: Does that seem believable to you?

CLIFF: Yes, it does.

THERAPIST: Earlier you said a few other things. Let me read them to you, and you can decide whether you want to write any of them on your thought record: "I don't really want to be violent toward him or anyone. Imagining things doesn't make them come true. Imagination helps us blow off steam or imagine revenge so we don't feel so helpless."

CLIFF: Yeah, could you read those to me again? I want to write them down.

Cliff's therapist quietly recorded relevant evidence Cliff proposed that did not support his hot thought. His therapist did not ask Cliff to write down this evidence until several ideas had been collected and there was a natural pause in their discussion. This allowed Cliff to actively consider various types of evidence, without interrupting

his flow of thought by having him stop to write. If a client thinks of a single piece of evidence and can't think of a second one after a few minutes of continued discussion, then it can be helpful to write that piece of evidence down. Sometimes seeing evidence in writing sparks further ideas. Figure 5.4 summarizes the work Cliff and his therapist did on the first five columns of his 7-Column Thought Record.

Throughout their discussion, Cliff's therapist asked him how credible and believable various ideas were to him. The more people believe the evidence that *doesn't support* their hot thoughts, the more likely it is that they will believe alternative or balanced thoughts based on this evidence. In turn, higher confidence in alternative or balanced thoughts is associated with a greater reduction in the related moods. After writing down all the evidence shown in Figure 5.4 (pp. 112–113), Cliff wrote these alternative thoughts about his capacity for violence in column 6 of his 7-Column Thought Record:

> "Having a violent image does not mean I am likely to be violent. It's just a way for my brain to help me feel more secure in a situation where I felt helpless. I have never wanted to be violent, and this image won't make me be violent."

He rated his confidence in these thoughts at 90% and rerated his shame at 20%. The next section teaches how to generate these types of alternative or balanced thoughts based on the evidence, and what to do if the evidence supports your client's hot thought.

MOM2 CHAPTER 9: ALTERNATIVE OR BALANCED THINKING

So far we have covered two key steps in cognitive restructuring: identifying hot thoughts linked to a targeted mood (*MOM2* Chapter 7), and looking for evidence that supports and does not support these hot thoughts (*MOM2* Chapter 8). The final step in cognitive restructuring is using the evidence gathered to generate credible alternative or balanced thoughts (*MOM2* Chapter 9). The main ideas we want clients to learn during this final step of cognitive restructuring are found in the Chapter 9 Summary. We address common questions therapists ask about this process in the following sections.

When Do Clients Write an Alternative Thought? When Do Clients Write a Balanced Thought?

The evidence in columns 4 and 5 of the 7-Column Thought Record usually determines whether your clients write an alternative or balanced thought in column 6, Alternative/Balanced Thoughts. Sometimes the evidence gathered naturally leads a client to quite a different conclusion from the original hot thought. This can be because there is very little evidence in the situation that supports the hot thought or because, in the process of gathering evidence, a completely new idea spontaneously occurs to the client. For example, when Cliff gathered evidence regarding his image about violently kicking the homeless man, he realized there was no evidence that he had or would behave violently toward anyone. As shown in Figure 5.4, Cliff wrote the following *alternative* thoughts in column 6 of his 7-Column Thought Record:

"Having a violent image doesn't mean I am likely to be violent. It's just a way for my brain to help me feel more secure in a situation where I felt helpless. I have never wanted to be violent, and this image won't make me be violent."

At other times, there is some factual evidence that supports the hot thought and other factual evidence that does not support the hot thought. In these instances, you will want to help your client write a balanced thought in column 6. A balanced thought should summarize both the supporting evidence and the evidence that does not support the hot thought. You and the client can decide whether it is more helpful to link these

Thought

1. Situation Who? What? When? Where?	**2. Moods** a. What did you feel? b. Rate each mood (0–100%). c. Circle or mark the mood you want to examine.	**3. Automatic Thoughts (Images)** a. What was going through your mind just before you started to feel this way? Any other thoughts? Images? b. Circle or mark the hot thought.
Tuesday afternoon. I was walking down the street and saw a homeless person. He was shouting at me and the other people walking by, and I shouted back, "Leave me alone!"	Shame 90%	I shouldn't have spoken in such a mean voice to him. Any one of us could be homeless someday. He made me uncomfortable and I wanted to get away. Image: Shouting at and kicking the man as he lay defenseless on the ground. If I can have an image like this, then I might be the sort of person who could violently beat up a homeless man.

FIGURE 5.4. Testing Cliff's image and assumption about the image on a 7-Column Thought Record. Adapted from Padesky (1983). Copyright © 1983 Christine A. Padesky.

statements by "and" or "and yet," as demonstrated in the following dialogue between José and his therapist.

JOSÉ: So the two summary statements [for evidence written in columns 4 and 5 of his thought record] would be "I neglect my children in ways that say I am not a good father," and "There is other evidence that I am a good father, especially on weekends and holidays when I have more time."

THERAPIST: OK. Now you want to write both of these summary statements in column 6, because together they make a balanced summary of the evidence.

Record

4. Evidence That Supports the Hot Thought	5. Evidence That Does Not Support the Hot Thought	6. Alternative/ Balanced Thoughts a. Write an alternative or balanced thought. b. Rate how much you believe each thought (0–100%).	7. Rate Moods Now Rerate column 2 moods and any new moods (0–100%).
I yelled at the man to leave me alone. I was really pumped up inside.	The clothes in my image are quite different from the clothes I was wearing. I didn't really kick him. He wasn't huddled on the ground; he was standing up and waving his arms at people and shouting. In the image, I'm the one being aggressive, and he is quiet and limp. In reality, he was being pretty aggressive and lunging at people. I felt threatened.	New image: I'm visualizing what actually happened. I'm standing tall and alert. I'm aware he is homeless and upset. My muscles are flexed so I am ready to defend myself or others in case he attacks, and, at the same time, I walk away without attacking him. 100%	Shame 65%
This image was so real and detailed. I felt really pumped up inside. I told him to leave me alone in a really strong and mean voice. My tone sounded threatening.	My image was a revenge fantasy to blow off steam, because the man felt threatening to me. It doesn't mean I wanted to really beat him up. I don't really want to be violent toward him or anyone. Imagining things doesn't make them come true. Imagination helps us blow off steam or imagine revenge so we don't feel so helpless.	Having a violent image doesn't mean I am likely to be violent. It's just a way for my brain to help me feel more secure in a situation where I felt helpless. I have never wanted to be violent, and this image won't make me be violent. 90%	Shame 20%

José: OK. (*Writes the summary statements in column 6 of his thought record.*)

Therapist: There are two more things we need to do. First, would you like to link the two summary sentences by the word "and" or the words "and yet"?

José: (*Reading the two sentences silently*) If I write "and," they both seem equal. If I write "and yet," it seems like the second one becomes more important.

Therapist: In this situation, which way seems more accurate to you?

José: In this case, I think I want to use "and." The reason is that I really want to change how I am as a father during the week. The "and yet" seems to take the pressure off of that.

Chapter 9 Summary

(*MOM2,* pp. 95–116)

- ✓ Column 6 of the 7-Column Thought Record, "Alternative/Balanced Thoughts," summarizes the important evidence collected and recorded in columns 4 and 5.
- ✓ If the evidence in columns 4 and 5 does not support the original hot thought, write in column 6 an alternative view of the situation that is consistent with the evidence.
- ✓ If the evidence in columns 4 and 5 only partially supports your original hot thought, write a balanced thought in column 6 that summarizes the evidence both supporting and not supporting your original thought.
- ✓ Ask yourself the questions in the Helpful Hints (*MOM2,* p. 100) to help construct an alternative or balanced thought.
- ✓ Alternative or balanced thoughts are not merely positive thinking. Instead, they reflect new ways of thinking about the situation based on all the available evidence written in columns 4 and 5.
- ✓ In column 7 of the 7-Column Thought Record, rerate the intensity of the mood(s) you identified in column 2.
- ✓ The shift in emotional response to a situation is often related to the believability of your alternative or balanced thoughts. This is why we rate how strongly we believe the alternative or balanced thought.
- ✓ If there is no shift in your mood after completing a thought record, use the "Questions to Determine Reason for No Mood Change" (*MOM2,* p. 107) to discover what else you may need to do to feel better.
- ✓ The more thought records you complete, the easier it will become to think more flexibly and begin to consider alternative or balanced explanations for events automatically without writing out the evidence.

THERAPIST: OK. Write "and" between your summary statements. (*Pauses while José writes.*) The second thing you need to do is to rate how much you believe these two summary statements.

JOSÉ: They are right. I guess I believe them 90%.

THERAPIST: Write that number beneath your statements, then.

José chose to link his summary statements of the evidence columns with "and" to construct his balanced thought. He correctly noticed that linking these summaries with the words "and yet" would tilt the balanced thought toward the column 5 evidence that did not support the hot thought. When there is more (or more meaningful) evidence in column 5 than in column 4, you can encourage your clients, if they are willing, to link the evidence summaries with the words "and yet" to capture this imbalance.

If clients have difficulty constructing an alternative/balanced thought, you can propose that they write headlines to capture what story is written in each column. Alternatively, you can ask them to approach the task from a different perspective. For example, how would a friend or other caring person summarize the evidence written in columns 4 and 5? A variety of suggestions to help people generate alternative or balanced thoughts are offered in the Helpful Hints box on page 100 of *MOM2*. Keep in mind that there is no one "right" alternative or balanced thought. You want to encourage your clients to write a summary of the evidence in column 6 that seems fair and reasonable to them.

Is It Necessary to Rate the Belief in Alternative/Balanced Thoughts?

Notice that José's therapist asked him to rate the credibility of his balanced thought. The amount of mood shift someone experiences in the process of using a 7-Column Thought Record often depends on the degree to which the alternative or balanced thought is credible to them. José believed his balanced thought 90%, and it accurately captured all of his evidence, so his therapist knew they did not need to work on it more. Ideally we hope people believe their alternative/balanced thoughts more than 75%—preferably, at least more than 50%. When belief ratings are low, ask your clients to rewrite their alternative/balanced thoughts so that they find these more credible. Work with them to make sure that these rewritten alternative/balanced thoughts do not discount relevant evidence.

When there is solid factual evidence that doesn't support hot thoughts, and yet clients' belief ratings for alternative/balanced thoughts are low, then it can be necessary to gather more evidence to examine whether these alternative or balanced thoughts are supported by other life experiences. Chapter 10 of *MOM2* and the next chapter of this clinician's guide discuss how to gather evidence to strengthen alternative/balanced thoughts. If people consistently reject the credibility of reasonable alternative/balanced thoughts despite the evidence supporting them, it is possible that they are stuck in extreme "all-or-nothing" thinking. Use of a continuum in addition to, or instead of, a 7-Column Thought Record can help break the logjam when you work with clients who rarely believe balanced thoughts because of rigid dichotomous thinking. The last

case example in the Troubleshooting Guide at the end of this chapter shows how to do this.

What If the Evidence Supports the Hot Thought?

Although people often jump to erroneous conclusions when moods are intense, this is not always the case. The purpose of a 7-Column Thought Record is to examine all the evidence and to determine if a hot thought is mostly supported, or if an alternative/balanced thought is a fairer way to view a situation. Sometimes the evidence gathered in columns 4 and 5 mostly or entirely supports the hot thought. 7-Column Thought Records with this outcome are just as helpful as thought records that yield a mood shift because they generate an alternative/balanced thought. Whichever way the evidence points, a 7-Column Thought Record has done its job. When the evidence mostly supports a hot thought, consider addressing the issue with an Action Plan (as described in Chapter 10 of *MOM2*). An Action Plan outlines steps a person can take to improve circumstances related to a hot thought. This plan can be written in the bottom half of column 6 of a 7-Column Thought Record, beneath the alternative/balanced thoughts.

Consider José (from the dialogue in the preceding section of this chapter), whose balanced thought was this: "I neglect my children in ways that say I am not a good father, and there is other evidence that I am a good father, especially on weekends and holidays when I have more time." José's hot thought that he was not a good father was largely supported by evidence drawn from weekdays; he reported that he neglected his children then because he had to work late hours. Before finishing his thought record, his therapist helped him construct an Action Plan to improve his parenting performance on weekdays, since this was José's goal.

THERAPIST: It sounds like you really want to be a better father during the week.

JOSÉ: Yes, I do.

THERAPIST: Let's draw a line under your balanced thought and write "Action Plan" underneath it.

JOSÉ: OK.

THERAPIST: What are two or three things you could do in the coming weeks to be a better father to your children during the week?

JOSÉ: I'm not sure.

THERAPIST: One of the things you said was evidence you neglect them is that you sometimes don't even talk to them for two or three days in a row, because you are not home when they are awake.

JOSÉ: That's right. But my business is so busy now, I'm not sure I could get home.

THERAPIST: Is there any other way you could talk to them?

JOSÉ: Oh . . . I guess I could video chat with them.

THERAPIST: Would you be a better father if you did that?

JOSÉ: Yes, I think so. Because I could ask them about school and kiss them good night.

THERAPIST: How would that make you feel?

JOSÉ: I would feel better if I remembered to do that.

THERAPIST: How do you think your children would feel?

JOSÉ: Good, I think. When I am on a trip and we video chat, they seem excited to talk with me.

THERAPIST: Do you want to write that down under "Action Plan" and try it out?

José and his therapist developed three items for his Action Plan, and wrote this list at the bottom of column 6 of his 7-Column Thought Record. In addition to making a plan to call his children every night about an hour before bedtime, José decided that he would write a note to his children on a whiteboard in their kitchen before leaving for work each morning. He also decided that part of being a good father was showing greater appreciation to his wife for all she did to care for the children in his absence. Rather than being irritable with her when he arrived home tired at the end of a long day, he decided that he would take a deep breath before entering the house, and then give her a hug and express appreciation. He would also listen to her concerns about the children and try to help solve some of their parenting problems. The addition of this Action Plan to the bottom of column 6 of his thought record led to a significant improvement in José's mood. These steps seemed practical and meaningful to him, and boosted his expectancy that he could become a better father.

How Much Mood Change Can Be Expected?

The final step in filling out a 7-Column Thought Record is to rerate the target mood, keeping in mind the evidence that has been gathered and the alternative/balanced thought. This new mood rating is recorded in column 7. Most of the time, completing a 7-Column Thought Record leads to positive mood shifts when the guidelines in *MOM2* and in this and the previous chapters of this clinician's guide are followed. There is likely to be an improvement in mood (as determined by comparing column 7 and column 2 ratings) when the alternative or balanced thought is believed to a high degree. Mood improvements are only expected for the mood(s) most closely connected to the hot thought that is tested. Other moods may not be affected.

The goal of a thought record is not to eliminate moods. Instead, the goal is to modulate mood reactions when these are more extreme than the situation warrants, and/or to identify hot thoughts that require action (e.g., those that are mostly supported by the evidence and therefore highlight a concern that needs to be addressed). Typically, a mood will shift 10–50% when a thought record is completed well. Testing a single hot thought will rarely reduce a mood rating to 0%, because there are usually multiple thoughts and factors related to situational mood responses.

Sometimes therapists wonder whether thought records are worth the effort if

someone's mood only shifts from, for example, 90% to 70% depressed. Actually, that shift in mood is significant. When people are 90% depressed, they can become immobilized, because they perceive things to be quite overwhelming and even hopeless. When their mood improves to 70% depressed, they are still quite depressed, and yet their hopelessness may decrease. If so, they may experience somewhat more energy. Even a relatively small improvement in mood can encourage someone to take steps that lead to bigger changes over time. In addition, the fact that someone's mood has shifted even a tiny bit in response to changes in thinking offers the person hope that learning to evaluate thoughts is a helpful change strategy. People who learn to use 7-Column Thought Records effectively (i.e., who experience mood improvement when using them) begin to develop confidence that they can change their mood by practicing thought record skills. Furthermore, there is evidence that learning to use thought records (of various types) effectively reduces relapse risk, especially for depression (Neimeyer & Feixas, 2016).

When a 7-Column Thought Record is filled out well and you fully expect a client to experience a mood shift, but this does not happen, review the thought record with the client. Consider the Questions to Determine Reason for No Mood Change after Completing a Thought Record on page 107 of *MOM2*. Most of these questions ask you to review the thought record to make sure you have adequately addressed what is required at each step. There are three common reasons why a 7-Column Thought Record that is completed well does not lead to a mood shift:

1. The hot thought is supported. In this case, the mood may not shift until an Action Plan is made and steps are taken to solve issues related to this hot thought.
2. There are additional hot thoughts that need to be tested before an appreciable mood shift will occur.
3. The person doesn't believe the alternative/balanced thoughts even though they fit the evidence. Such a client may need to gather additional evidence that supports the alternative/balanced thoughts. See the "use of imagery" and "all-or-nothing" thinking examples in the Troubleshooting Guide below, as well as Chapters 6 and 7 of this clinician's guide and Chapters 10 and 11 in *MOM2*.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTERS 8–9

If the Hot Thought Is a Core Belief, Treat It as an Automatic Thought

Thought records are designed to test automatic thoughts that occur in specific situations. Therapists often wonder what to do when the hot thoughts identified on thought records are actually core beliefs. Recall that core beliefs are absolute beliefs about the self, others, or the world, such as "I'm worthless" or "People can't be trusted." Core beliefs are commonly activated in situations that evoke strong moods. The key to working with core beliefs circled as hot thoughts on a thought record is to treat each one as an automatic thought. You can treat core beliefs like automatic thoughts when you look

for evidence *in the situation described in column 1 of the 7-Column Thought Record,* rather than looking across the person's lifetime of experience.

For example, if someone's hot thought is "I'm worthless," look in the situation described in column 1 for evidence that supports and does not support this conclusion. Have the client record this situation-specific evidence on the 7-Column Thought Record in the evidence columns (4 and 5). Then construct an alternative or balanced thought in column 6 that takes into account all the evidence from the situation described. If the same hot thought comes up over and over again in various situations (as you would expect if the belief is a core belief), this person has an opportunity to discover that the evidence in particular situations does not usually support this conclusion. In this way, thought records can begin to set the stage to weaken negative core beliefs and construct alternative core beliefs, as discussed in Chapter 8 of this guide.

If There Is Little Engagement with or Impact of Thought Records: Use Imagery

Some people are not very engaged in using thought records, or they fill out thought records but find them only modestly helpful. A common remark made by clients who find that 7-Column Thought Records provide limited benefits is "I see that this evidence [fits with this balanced thought], but I still feel like the hot thought is true." These issues often can be effectively addressed by incorporating imagery throughout the 7-Column Thought Record (Josefowitz, 2017). One clear advantage of including imagery instead of identifying and testing thoughts by using words alone is that imagery is more likely to elicit and involve strong emotional reactions (Holmes & Matthews, 2010), and this can make thought records more engaging.

Josefowitz's article provides detailed and helpful guidance for incorporating imagery into 7-Column Thought Records. To start, she recommends a variety of approaches and questions you can ask to help clients identify images for column 3, Automatic Thoughts (Images). For example, you can ask your clients about general images related to the situation in column 1, images related to a worst-case imagined scenario, images connected to the moods reported in column 2, and images connected to verbal automatic thoughts identified in column 3. Josefowitz further recommends that you explore any images identified by asking for details, inquiring if the image is more like a movie or a still photo, and staying alert to the multisensory nature of imagery (sights, smells, sensations, tastes, and sounds). Connecting images and moods is a revelation for many people. This exercise can seed their awareness and encourage identification of other images in the future.

Quite often, an identified image is chosen as the hot thought. Josefowitz recommends exploring the "encapsulated meaning" of images before examining the evidence. An image such as "I'm in a dark hole" could be linked to meanings related to hopelessness, to a sense of loss, or to confusion about what steps to take in a client's life. Exploring the meanings of images will help you and your clients appreciate the types of evidence that will be most relevant for testing them. Sometimes the meaning of an image may be the thought someone needs to test. Recall Cliff, a client described earlier in this chapter, who identified an assumption about his image: "If I can have an image like this, then I

might be the sort of person who could violently beat up a homeless man." His shame did not appreciably decrease until he tested this meaning associated with his image.

Josefowitz also discusses the role memories can play in testing images and their meanings. Images are sometimes linked to memories. When there are relevant memories, ask the client to recall them vividly and to consider how they relate to the current situation. As discussed throughout Chapter 4 and this chapter, 7-Column Thought Records are designed to look for evidence that is situation-specific. Therefore, you generally only explore memories that spontaneously occurred in the situation described in column 1 of the thought record. Evidence supporting and not supporting a hot thought can be drawn from these memories if it somehow relates to the situation in which the hot thought occurred.

One of the most helpful integrations of imagery with 7-Column Thought Records proposed by Josefowitz is the use of imagery to help column 6 (Alternative/Balanced Thoughts) become more "emotionally real and engaging" (Josefowitz, 2017, pp. 98–99). 7-Column Thought Records become more engaging when you ask your clients to vividly imagine and recall real-life experiences that fit with their alternative or balanced thought. Furthermore, she proposes asking clients to imagine a future situation that would normally trigger the negative hot thought. They can then practice coping with this negative thought in imagery by applying their new balanced or alternative thought to this imagined situation. During this practice imagery, clients are again encouraged to imagine the situation vividly, using all their senses. Check on the tone of voice connected to a client's expression of the alternative or balanced thought in this image, because, as Gilbert (2009) notes, clients often use harsh, critical tones when they try to change thoughts. Encapsulating the balanced or alternative thought in a warm, compassionate voice during imagery rehearsal can increase engagement with a new thought (Josefowitz, 2017).

Imagery rehearsal of alternative and balanced thoughts can begin in the therapy office, and clients can then practice this on a daily basis throughout the week to strengthen the images' memorability and credibility. Balanced or alternative thoughts can be easier to remember and apply in future situations if they are captured in the form of an image, symbol, or metaphor (Padesky & Mooney, 2012). For example, suppose the alternative thought to the image "I'm in a dark hole" turns out to be "When I feel lost, if I give it some time, then I can usually figure out the next step." This alternative thought is complex and may be hard to recall in a situation when the "dark hole" image appears. A client-generated metaphor such as a map or a light (something that can help illuminate the path forward) can prove to be a more effective and memorable alternative to the "dark hole" than a complex sentence. An alternative image can even elaborate on the possibilities. Perhaps the light can be used to find a ladder that helps a client climb out of the hole. Furthermore, rehearsal of this metaphor in imagery can lead to more a nuanced understanding of and conviction in an alternative belief.

If All-or-Nothing Thinking Interferes: Use a Continuum

When clients hold dichotomous beliefs that strongly interfere with their learning thought record skills, a continuum can be a better tool for evaluating hot thoughts

than a 7-Column Thought Record. For example, Pasha had great difficulty testing her automatic thoughts on a thought record, because each hot thought seemed 100% true to her, and no amount of data convinced her that her perceptions of situations were perceptions rather than the truth. Her therapist suggested that Pasha temporarily stop using thought records and instead use a continuum to rate her hot thoughts in situations (as described in Chapter 12 of *MOM2* and Chapter 8 of this clinician's guide). The following dialogue shows how use of a continuum was helpful to Pasha.

THERAPIST: So when Alisha got angry with you, you "knew" she hated you.

PASHA: That's right. And I don't need to deal with that. So I ended our friendship. And that's why I didn't have anything to write in the "Evidence That Does Not Support the Hot Thought" column. It was true.

THERAPIST: Let's take a somewhat different approach to see if we can understand this better. Remember how you learned to rate feelings on a 0–100% scale?

PASHA: Yeah, sure.

THERAPIST: Let's use the 0–100% scale to rate the hot thought "Alisha hates me."

PASHA: OK. It's 100% true.

THERAPIST: (*Drawing a scale*) Here's the line to measure how much someone hates you. Now you put an "X" where you think Alisha's feelings lie. (*Pasha draws an "X" at 100%.*) Let's clarify. Does 100% mean the most anyone can hate you?

PASHA: Yes.

THERAPIST: So you can't imagine anyone hating you as much as you're sure Alisha does?

PASHA: No. That's why I was so upset! After all we've been through together, it made me so mad that she turned on me like that.

THERAPIST: What if someone hated you so much that they physically assaulted you or killed you? Where would that go on this continuum?

PASHA: I guess that would be 100%.

THERAPIST: And Alisha reacted to you that violently?

PASHA: No. Of course not.

THERAPIST: I want to make sure this scale includes all the possible experiences. So let's put violence on the scale and rate it. Have you ever been a victim of this kind of hate?

PASHA: Yes. Once I was beaten up and raped outside school.

THERAPIST: I'm so sorry. (*Pausing*) Where would you put that kind of experience on this hate scale?

PASHA: That would be 100%.

THERAPIST: Any other hate experiences you've had that could go on this scale?

PASHA: My uncle molested me. That wasn't actually as hateful as the school attack. But it sure wasn't loving.

THERAPIST: Where would you put that on this scale?

PASHA: I'd put my uncle at 95%.

THERAPIST: Let's see what other experiences could go on this scale. (*Together, Pasha and her therapist define and rate a variety of hate experiences, from an obscene phone call at 35% to the school assault and rape at 100%.*)

THERAPIST: Now that we've filled in more of this scale, where would you put Alisha when she was angry at you?

PASHA: I guess at about 45%. But I felt so bad.

THERAPIST: Sure you did. It's not easy to have someone we like so much get so angry at us. But it seems important to put her anger in perspective in terms of whether and how much she hated you. What difference does it make to you if her hate level was 45% instead of 100%, as you thought?

PASHA: I feel a little better. And I think maybe I didn't need to stop being friends with her. That makes me feel weird.

In this session, Pasha's therapist replaced the thought record with a continuum to evaluate her beliefs. When clients have strong convictions regarding "all-or-nothing" beliefs and adamantly reject data gathered on a 7-Column Thought Record, a continuum provides a more flexible and user-friendly tool for investigating those beliefs. A continuum allows for incremental belief shifts in response to data, rather than searching for an alternative or balanced thought in response to the evidence columns on a 7-Column Thought Record. Eventually Pasha would benefit from using thought records, but first she needed to develop some flexibility in her thinking. She needed to learn that her thoughts were perceptions, not facts.

6

New Thoughts, Action Plans, and Acceptance

(*MOM2* CHAPTER 10)

I can see that this new idea fits the evidence, but it doesn't *feel* true to me.
—*Charley, reacting to his balanced thought on a 7-Column Thought Record*

But I lost my job, and there aren't many other jobs I can get. How am I supposed to feel good about this?
—*Magda, responding to a therapist's offer to help her feel better*

It's not my thinking. My back pain is terrible. I just can't go on.
—*Roberta, rebuffing her therapist's suggestion to look at the links between her thoughts and pain*

Like Charley, many people identify new thoughts in the Alternative/Balanced Thoughts column of a 7-Column Thought Record and say, "I can see that this fits the evidence, but it doesn't *feel* true to me." Others, like Magda and Roberta, face difficult life circumstances that are not easy to solve or endure. For many people, testing their thoughts on a thought record does not seem like a sufficient intervention when they are dealing with serious life challenges such as unemployment, chronic pain, discrimination, or death of a loved one. Thought records are most helpful when people have automatic thoughts that are likely to be either distorted or missing the whole picture. What do we do when people are accurately viewing a pretty negative picture?

Additional and alternative approaches for these types of issues are offered in Chapter 10 of *MOM2*. As shown in the Chapter 10 Summary, this chapter teaches users of the workbook how to (1) strengthen new, alternative thoughts so they begin to "feel more true"; (2) construct and follow Action Plans to solve challenging problems; and (3) develop greater acceptance for difficulties that are hard to endure, slow to change, or impossible to solve.

Chapter 10 Summary

(*MOM2,* pp. 117–131)

- ✓ Initially, you may not fully believe your balanced or alternative thoughts.
- ✓ You can strengthen new balanced or alternative thoughts by gathering evidence to support them. This is an ongoing process.
- ✓ As your belief in your balanced or alternative thoughts increases, your improved mood will stabilize.
- ✓ Action Plans can help you solve problems that you've identified.
- ✓ Action Plans are specific and include actions to take, a time to begin, possible problems with strategies to overcome them, and a written record of progress.
- ✓ Acceptance of thoughts and moods is sometimes a worthwhile alternative to identifying, evaluating, and changing your thoughts.
- ✓ Developing an attitude of acceptance can help when you are in the midst of life circumstances that can't be changed or are difficult to endure.
- ✓ Three paths to acceptance are observing your thoughts and moods rather than judging them, keeping the big picture in mind, and acting in accord with your values even when you are distressed.

STRENGTHENING NEW THOUGHTS

When new alternative or balanced thoughts fit the evidence of people's lives but do not "feel true" to them, additional work is often required to strengthen these thoughts. The second section of the Troubleshooting Guide at the end of Chapter 5 discusses the use of imagery to increase the credibility of alternative/balanced thoughts. Another approach is to guide clients to pay attention to evidence during the week that supports new alternative or balanced thoughts; Worksheet 10.1, Strengthening New Thoughts (*MOM2,* p. 119), is helpful in this regard. Information recorded on this worksheet can provide a platform for in-session discussion of new thoughts.

Encourage your clients to keep open minds and consider the evidence they gather. This is a more effective approach than trying to "convince" them of a new belief. Noticing life experiences that support a new belief is more convincing than dialogue with a therapist. This process is illustrated in the following therapy excerpt from a session with Charley. Two weeks earlier, Charley had generated an alternative thought on a 7-Column Thought Record: "Some people enjoy being with me." However, he had a hard time believing this, because he had always thought of himself as weird and unlikable. Charley rated his belief in his new thought at only 5%, and so his therapist

asked him to begin filling out Worksheet 10.1, Strengthening New Thoughts, as a learning assignment.

THERAPIST: Did you have any experiences to write down on your worksheet this week?

CHARLEY: Two or three things. I remembered something from last month that seemed to fit. A guy at work asked me to join a project team at work. But I didn't know if it was OK to write that down, since it didn't happen this week.

THERAPIST: Would you have written it down if you were doing this worksheet last month?

CHARLEY: Yeah.

THERAPIST: That seems OK then to me, if it seems OK to you.

CHARLEY: OK. Well that was the first thing. Then the same guy asked me to have lunch with him this week. I don't know if that proves anything about him enjoying being with me, but . . .

THERAPIST: What about your lunch fits with the possibility of him enjoying being with you, and what parts don't fit?

CHARLEY: Well, there were two other guys in the room when he invited me to lunch. So it wasn't like I was the only option.

THERAPIST: Uh-huh.

CHARLEY: And lunch was pretty nice. It turns out he likes old cars too, so we talked about that, and he seemed interested in seeing pictures of the car I'm restoring.

THERAPIST: And what parts of the lunch didn't fit with him enjoying being with you?

CHARLEY: There were a few awkward moments when we first sat down. I don't think either of us knew how to start a conversation that wasn't about work.

THERAPIST: Anything else?

CHARLEY: No. Once we got going, the lunch was pretty good.

THERAPIST: So how much did this lunch fit with the idea that some people enjoy being with you.

CHARLEY: Pretty much. At least he seemed to enjoy talking with me.

THERAPIST: OK. And what was the third thing?

CHARLEY: I was grocery shopping at my usual store, and the usual clerk was there. She looked pretty tired, and I asked her about her day. She said it had been a tough one, but that her spirits lifted a bit when regular customers like me came through her line and showed interest. I guess I never thought about that before—how I could make her feel better. I tried to make her feel better by telling her the store would be closed soon and she could go home. She smiled at me when I left, and it felt like a sort of connection.

THERAPIST: So it seemed like she enjoyed that time with you, just for those few minutes.

CHARLEY: Yeah.

THERAPIST: So you wrote down these three experiences that fit with this idea that some people enjoy you. How did you rerate your confidence in your new thought after you wrote them down?

CHARLEY: It shifted to about 10%.

THERAPIST: OK. Tell me about that.

CHARLEY: Well, they did support that new idea. But I think I need a lot more evidence before it feels solidly true to me.

THERAPIST: That sounds fair. Do you want to continue to fill out this worksheet for a few more weeks?

CHARLEY: I think so. But I don't have any more room to write on it.

THERAPIST: How do you want to handle that?

CHARLEY: I printed this worksheet out. I think I'll just write more ideas on the back of the page for now. That way everything will all be in one place.

THERAPIST: That sounds like a good plan.

His therapist did not press Charley to believe his new belief more than 10%—especially because Charley had noticed relevant experiences, because his confidence in the new belief was increasing (from 5% to 10%), and because he seemed interested in continuing to gather evidence. If Charley had discounted all his recent relevant experiences, then his therapist would have intervened more directly. For example, if Charley had discounted the lunch invitation by saying, "He probably just invited me because I was sitting next to him in the meeting," his therapist could ask about the other people in the room at the time and inquire why Charley thought he was asked instead of the other people. In addition, his therapist could ask Charley questions about their conversation and the tone of their lunch together, gathering enough information to put the experience on a 0–100% continuum of how enjoyable it was. At the end of this discussion, his therapist would ask Charley whether or not his experience at lunch fit or did not fit with his new belief, rating the degree of fit on a continuum if necessary.

Therapists ideally express interest and concern, not a commitment to changing clients' minds. His therapist would accept whatever rating Charley gave his new belief after this discussion. Charley might have to fill out the Strengthening New Thoughts worksheet for a number of weeks before his alternative or balanced thoughts become more credible to him. And his therapist would need to stay open to the possibility that Charley's experiences wouldn't fit with his new belief. In that case, a different alternative belief that better matched Charley's experiences could be created.

ACTION PLANS TO SOLVE PROBLEMS

Negative thoughts are primary features of many moods. However, this does not mean that all negative thoughts are distorted or exaggerated. When most or all of the evidence on a 7-Column Thought Record or other *MOM2* worksheets supports negative beliefs,

then an Action Plan is a helpful tool. Action Plans can be used to solve problems or to plan changes that are likely to lead to life improvements. If most of Charley's experiences fit with his hot thought that people do not enjoy being with him, then his therapist would want to help Charley figure out whether or not this circumstance could be changed. If his therapist thought there were things that Charley could learn to do to increase the likelihood that people would enjoy being with him, then his therapist would be likely to construct an Action Plan with him.

An Action Plan (Worksheet 10.2, *MOM2,* p. 125) asks the person to set a goal (e.g., "Become a more enjoyable person") and identify steps that can be taken to approach that goal. Action Plans require both problem solving and persistent, step-by-step efforts to implement the plans. They can be the focus of many weeks or even months of change efforts. Action Plans are especially helpful when people face difficult life circumstances that require active problem solving. Recall Magda, described at the beginning of this chapter, who had lost her job. The manufacturing company where Magda had worked for the past 15 years had just replaced dozens of jobs with a new robotic assembly line. She was now unemployed in a small town with few job openings for laborers with limited education. More than 30 people from her former company were also newly unemployed, and so there was fierce competition for every available job.

Magda was divorced and lived alone. Her severance pay would only cover six months of rent and expenses. She had come to the local community mental health clinic on the advice of a neighbor who had benefited from free services there in the past. Observe how her therapist redirected Magda to consider actions she could take. Her therapist was aware that Magda's problems were likely to grow exponentially if too much time passed without a plan for solving them.

THERAPIST: Thanks for telling me what happened and how you are feeling right now. Let's figure out what we can do to help you feel better.

MAGDA: But I lost my job, and there aren't many other jobs I can get. How am I supposed to feel good about this?

THERAPIST: I'm sorry. I didn't mean I expect you to feel good about losing your job. That is really tough. And I can understand why you are discouraged about finding a new job.

MAGDA: My old job paid me a decent wage. There aren't any other jobs like that in town . . . at least not for someone who never finished school. How will I pay my rent? How can I afford to eat?

THERAPIST: These are serious problems that need to be solved. Would you be willing to work with me today to begin figuring this out?

MAGDA: Yes. But I can't think of anything that will help.

THERAPIST: That's how it usually is when we are in a really tough spot. Let's start by figuring out your goals. Is your goal to get another job that pays as much as your last one, or would there be some other goal that would help you if we could figure out a way to get there?

MAGDA: Even if I could get a job that paid a little less, I could make it. But the jobs I've seen so far only pay about half of what I used to make, and that's not enough to pay rent and buy food.

THERAPIST: It sounds like you know how much money you need every month to get by.

MAGDA: Yes.

THERAPIST: Should we make that our immediate goal? To have enough money to pay for rent and food and your other expenses?

MAGDA: OK. But I don't know how I'll find a job that will pay that much.

THERAPIST: Let's just write that at the top of this page and mark it "#1 goal."

MAGDA: OK.

THERAPIST: Now, once you have paid for food and rent and other things you need, what would be your next goal in terms of making your life more secure or happy?

MAGDA: To have a job I like and friends to enjoy after work.

THERAPIST: OK. Can I write those down and mark them "#2 goals"?

MAGDA: Yes.

THERAPIST: Let's keep in mind that we need to meet this first goal as soon as possible, and we want to keep in mind your second goals because these are things that will make your life happier.

MAGDA: That's right.

THERAPIST: And just to check, did you like your last job, and do you have friends you enjoy?

MAGDA: I did like my last job, because it paid well and the people I worked with were nice. Some of them are my friends. I don't have many other friends, but my cousin lives in the next town. I spend time with her and her family.

THERAPIST: And are your friends from work also struggling right now?

MAGDA: I've not really seen them much since that last day there. I think Susan is OK, because she is married and her husband is still working. I don't know what Evelyn is doing. She lives alone like me. I saw her at the unemployment office one day, and she seemed worried. She told me Karl got another job right away in construction. And I think some of the other people probably will find work because they know how to do other things.

Magda's therapist did not immediately bring out the Action Plan worksheet. That could have seemed impersonal in these early stages of this session, especially because she was still building a therapy alliance with Magda. However, Magda's therapist had this worksheet in mind when she began to help Magda articulate goals. Naming a goal is the first step in filling out an Action Plan. As information was gathered in relation to her goals, potential actions that Magda might take were beginning to emerge from her narrative. For example, before you read on, can you identify three options Magda

might have for meeting her short-term goal of having enough money to cover her rent, food, and other monthly expenses? Reread the dialogue on the previous pages, and write options that occur to you here:

1. ______________________________
2. ______________________________
3. ______________________________

The reason Magda's therapist asked her to identify "#1" and "#2" goals was that Magda appeared to be on the brink of an economic crisis. She might need to choose an initial solution that was unsatisfactory in the long run. Writing down her secondary goals was a promise to her that anything short of these broader goals would be a temporary solution. For example, she might work at a job she didn't like to meet her first goal, but continue looking for a job she liked better to achieve her second goals. Since her first goal was to achieve minimal financial security, Magda would be more likely to be open to a variety of solutions if these were recast as temporary "fixes" on the road to more permanent solutions that would support her happiness.

As her therapist interviewed Magda about her former job and friends, she learned information that began to suggest short-term options that could help Magda. If she could not find a job that would meet her full economic needs, perhaps Magda could work out a temporary arrangement to share lodging with her friend Evelyn. Alternatively, perhaps Magda could live with her cousin for a while. Since her cousin lived in another town, there might be job possibilities there that neither Magda nor Evelyn knew about. If Magda didn't like these options, she could consider advertising for a roommate or finding a less expensive place to live. Did you think of any of these options, or other ones?

No matter how many options her therapist could imagine, it was better to ask Magda questions to help her arrive at these solutions on her own than it would be to suggest solutions to her. For example, if the therapist suggested that she consider sharing lodging with Evelyn, she might object and say, "I prefer to live alone." Instead, the therapist could ask her, "Is it important to you to continue to live alone until you find a new job, or would you consider living with someone else for a short while to save money?" If Magda was willing to consider a temporary roommate, the therapist could say, "Let's brainstorm all the possibilities so you can see if any of them suit you." This could lead to a list including Evelyn, her cousin, and perhaps other people Magda had not yet mentioned.

Other steps to consider for Magda's Action Plan might include learning how to describe her job skills to a prospective employer, evaluating whether and how to acquire new skills to expand her work options, and even considering relocating to an area with more employment opportunities. These options could be discussed over one or more sessions, and Magda could choose which ones to list on her Action Plan. All options would need to be weighed in light of her ultimate wish to find work she enjoyed and friends with whom to enjoy her life. Her therapist would keep these important goals and values in mind and encourage Magda to choose steps now that could eventually

lead to good work and friends, even if the intermediary steps temporarily fell short of those ultimate goals.

Once her therapist and Magda listed actions she can take on her Action Plan, they would need to agree on a time to begin each step. Sometimes this might be an exact time (e.g., "Monday at 9 A.M."), and sometimes it might be a broader time frame, such as "Tuesday morning" or "When my cousin returns my phone call."

The worksheet also reminds you to ask your clients to identify possible problems that can interfere with carrying out steps on the Action Plan. Your client writes these down in the third column of the Action Plan, brainstorms possible ways to manage these problems, and writes these strategies in the fourth column. Again, it is best when clients figure out their own strategies for managing problems rather than therapists providing solutions. The final column of an Action Plan allows the person to make notes about progress made. Acknowledging interim progress is crucial, especially if change efforts are likely to yield small and incremental results.

ACCEPTANCE

While Chapter 10 of *MOM2* encourages people to make Action Plans to solve problems big and small, it also introduces the concept of developing acceptance for problems that can't be solved or that are likely to last for a long time. Acceptance is a helpful stance when life circumstances cannot be changed. It also can prove invaluable when challenges are likely to change so slowly that they need to be endured for a long time. Magda was close to struggling with poverty or even homelessness if she could not gain financial stability quickly. Other people experience health issues that place real limitations on their lives. The death of someone we love can lead to life alterations that we need to accept.

At the beginning of this chapter, Roberta is quoted as telling her therapist, "My back pain is terrible. I just can't go on." Roberta denied being suicidal, but she was really struggling to cope with pain that followed surgery she needed after an auto accident. Roberta carried out an Action Plan that included working with her physician to get appropriate pain medication and adopting an exercise regimen she had learned in physical therapy. Although Roberta's pain decreased with these efforts, she discovered it was likely that she would have to live with a moderate degree of chronic pain. Roberta spent a lot of time in the next therapy session focused on how unfair it was that she had to cope with this pain when the auto accident was not her fault. Her therapist thought it was appropriate to begin to talk with Roberta about acceptance.

ROBERTA: It's just unfair. Why do I have to deal with this pain the rest of my life when I have always been a good driver and didn't do anything wrong to cause this accident?

THERAPIST: Yes, it certainly does seem unfair.

ROBERTA: I just don't want to be in pain any more (*eyes welling with tears*).

THERAPIST: I can understand that. At the same time, I worry that when you focus on how unfair this is, you may actually be making things worse for yourself.

ROBERTA: What do you mean?

THERAPIST: How does your body react when you say, "It's so unfair. I didn't do anything wrong. I don't want to be in pain any more"?

ROBERTA: I guess tense, tight.

THERAPIST: How does that tension affect your pain?

ROBERTA: I suppose it makes it feel a bit worse.

THERAPIST: Hmmm. What do you think about that?

ROBERTA: Maybe it's not a good idea to be so upset about it. But what can I do?

THERAPIST: How would you like to feel?

ROBERTA: Pain-free.

THERAPIST: And if you were pain-free, how would your body react to that?

ROBERTA: I guess I'd be more relaxed.

THERAPIST: And how would that relaxation affect your pain . . . just the normal pains of everyday living?

ROBERTA: I guess if I was relaxed, then pain might not bother me as much.

THERAPIST: So what if you could learn to stay more relaxed, even when you do have pain? Do you think that might help?

ROBERTA: It might. But I'm not sure how to relax with this pain I'm feeling.

THERAPIST: Sure. (*Pause*) I'm wondering if a first step might be to accept your pain and not focus on its being unfair or too much to take. I wonder how it would affect your experience of the pain if you could do that. What do you think?

ROBERTA: I'm not sure. It might help.

THERAPIST: Would you be willing to do an experiment with this?

ROBERTA: What kind of experiment?

THERAPIST: The *Mind Over Mood* book we have been using has a section titled "Acceptance." It describes three paths to acceptance on page 128. Let's talk about those three paths today and you can decide if you are willing to try one of them as an experiment this week, to see if it helps you deal with your pain.

ROBERTA: OK.

Roberta's therapist briefly introduced her to one possible benefit of learning to accept her pain—greater relaxation, which could help lessen her pain. At the same time, he suggested that they consider three pathways to acceptance, so Roberta could choose the one that made most sense to her and that she would be willing to try as an experiment for one week. The three paths to acceptance described in *MOM2* are (1) a mindfulness approach (observing thoughts and feelings without trying to change them); (2) "big-picture" perspective taking (considering the benefits of acceptance, as well as looking for the good parts within the situation); and (3) focusing on personal values and how these can help with moving forward despite distress or challenges.

Any of these three paths could be helpful for Roberta. She and her therapist

first discussed a mindfulness approach, which would involve Roberta's noticing her pain throughout the day as well as other sensations, thoughts, and moods. With this approach, she would not try to change anything, but just observe her pain and reactions to it, without judging them. Roberta thought that this approach was too difficult for her to try first, and her therapist agreed. Her therapist told her about a mindfulness-based stress reduction class in their town that could help her learn this approach if she later decided to pursue this method.

Second, they considered the big-picture approach. Rebecca was intrigued with the idea of learning to be more relaxed with her pain and trying to find good in it rather than just reasons for distress. She commented to her therapist that the pain had increased her appreciation for one of her coworkers, who was partially paralyzed and sometimes had difficulties navigating their office building. One day after her accident, Roberta slowed down to walk with this woman and had a conversation with her for the first time. She discovered that this woman did not seem bothered by her walking difficulties and had a really good sense of humor. "I guess one good thing about my pain is that I'm more sensitive about other people's pain and difficulties. Maybe that makes me a better person and open to understanding others more."

In the end, Roberta decided that she really wanted to focus on her goals and values in the coming week. This third pathway to acceptance appealed to her, because she realized that she was letting her pain control her life and activities. Even though her physical therapist said it was good for her to walk and be more active, Roberta had withdrawn from many of her friends and from things she enjoyed doing since the accident. She began making a list of her values and goals in the session, and she agreed to add to this list in the coming week as part of completing the Acceptance worksheet (Worksheet 10.3, *MOM2,* p. 129).

Over the next few weeks, Roberta used this exercise as a springboard to resume some of her former activities and to contact friends she had not seen as often since her accident. One friend invited her to the opening of an art gallery show, and Roberta was surprised to learn that her pain receded somewhat when she was engaged in talking with others at this event. She then invited one of her friends to go with her to a movie she wanted to see. The chairs in the theatre were not comfortable and aggravated her pain somewhat. Roberta tried to keep her mind on the pleasure of the movie and on the value she found in spending time with her friend. She suggested a walk after the movie to stretch out her back, and she tried her best to continue appreciating the time spent with her friend, even though she was experiencing aggravated pain. The next week, she reported to her therapist that the evening at the movies would have felt disastrous in the past because of her increased pain. Instead, Roberta was really pleased that her focus on her goals and values throughout the evening had actually allowed her to experience genuine enjoyment, even when she felt greater pain. This was a meaningful experience for her and really underscored the value acceptance could have in her life.

The Acceptance worksheet in *MOM2* can be applied either to life circumstances (health, work, family) that distress people, or to thoughts or moods that recur often and have a negative impact on them. Rather than suggesting a particular path toward acceptance, the worksheet asks readers to try any of the three approaches that they think might be helpful. As with all *MOM2* worksheets, the emphasis is on learning something

useful. After a period of time practicing one or more acceptance strategies, people are encouraged to record what they have learned at the bottom of this worksheet.

In therapy, encourage your clients to choose what type (or types) of acceptance they want to practice. Then assist them in sticking to this method long enough to discover if it helps. Usually several weeks of practicing acceptance will be required before a meaningful impact on mood is achieved. When clients are interested in observing thoughts and feelings without judgment, a mindfulness class can support their practice.

COMBINING ACTION PLANS AND ACCEPTANCE

Chronic Health Problems

Of course, many life issues require both problem solving and acceptance. For example, chronic health problems like Roberta's ongoing pain can require problem solving to make changes that will maintain optimal health, as well as acceptance of health circumstances that are out of one's control. As another example, a person diagnosed with diabetes can use Action Plans to support good health practices and, at the same time, to develop acceptance of the life circumstances related to diabetes that cannot be controlled.

Discrimination and Social Injustice

Issues of discrimination and social injustice also often require extensive exercise of both problem solving and acceptance. For example, transgender adolescents are likely to face bullying and discrimination over most of their lifetimes. These issues are not always easily or safely resolved via problem solving, and yet acceptance of bullying or discrimination also does not seem the best path. Navigating discrimination and social injustice usually involves both Action Plans and acceptance, as explained below.

Action Plan steps can include communicating with others, seeking legal remedies, creating or finding a support network, and even avoiding or hiding one's identity in

Clinical Tip

The Action Plan and Acceptance worksheets in *MOM2* can be used in therapy whenever they seem useful. For example, if a 7-Column Thought Record reveals a genuine problem (e.g., the negative thought "I'm a bad parent" is supported by evidence), an Action Plan can be used to begin to solve the problem (in this case, to help this client become a better parent) even if the client is still practicing thought record skills. Similarly, when chronic difficulties or situations that are unlikely to change are identified in therapy, acceptance practices and the Acceptance worksheet can be introduced alongside other skills practices.

certain situations if this is possible. The choices made depend on each person's goals, life and social circumstances, and current strengths/skills. People's goals and values can act like a compass, guiding them in the general direction they want to proceed. Specific circumstances and personal strengths affect the strategies chosen from moment to moment, the pace of change, and decisions about what steps to take or not to take on a given day.

Acceptance can include recognition that many people are ignorant about, or have learned to hate, people who are different. It can acknowledge that such biases are sometimes slow to change. People who belong to racial, ethnic, or religious minorities; LGBTQ+ persons; people with disabilities; and other socially disadvantaged people (e.g., women and girls in many societies) often find it helpful to pair acceptance with action. For example, you can help your clients develop acceptance that unfairness exists, and at the same time encourage them to participate in personal and social actions to help change a discriminating status quo. Acceptance includes clients' recognizing and expressing righteous anger, taking solace in connections with people who share or understand their circumstances, and adopting a long-term view of social change. All these avenues can be explored and supported in therapy when clients face social discrimination or injustice.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 10

When People Misinterpret Acceptance as Giving Up

Sometimes people misinterpret "acceptance" as giving up and not doing anything. If therapy to date has been very action-oriented, with lots of problem solving and a focus on behavioral and cognitive change, the concept of accepting a serious difficulty can seem quite discrepant to clients. The examples in this chapter illustrate ways to introduce acceptance as another strategy to consider when clients don't have control over a situation. Sometimes introducing the "Serenity Prayer" (or a similar saying that resonates with a client's culture) helps: "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." This often-quoted prayer captures the need to be flexible enough to put effort into changing things that can be changed, and to accept things that cannot be altered.

Of course, when people are highly depressed, anxious, or in the throes of anger, guilt, or shame, they sometimes think that it is hopeless to try to change things even when this is probably not true. Therefore, they may assume that they should just accept low motivation, worry, shame, or the like. It will be up to you as the therapist in these instances to encourage change efforts. For people with long-standing mood issues, acceptance can appear to be the same as times they have given up. This is why it is important to link acceptance efforts with measurement of some type of improvement or progress toward goals. Recall from earlier in this chapter that Roberta linked her acceptance practice to reduction in a focus on her pain. When she noticed that acceptance lowered the extent to which her pain bothered her, it helped her view acceptance as an active therapy method.

When Therapists Are Not Trained in Mindfulness or Acceptance Therapies

Therapists who have received training in mindfulness or acceptance therapies will see many ways to apply these approaches. Therapists who are less familiar with mindfulness or acceptance can experience uncertainty about and/or avoid using the Acceptance worksheet (Worksheet 10.3, *MOM2,* p. 129). We encourage you to use this worksheet when it is relevant. Before doing so with clients, use the worksheet yourself for a personal issue to help you understand the dimensions of its practice. Descriptions that support your use of the Acceptance worksheet are found in *MOM2* on pages 126–129. If one of the three acceptance methods seems confusing or unhelpful to you, try another. Similar advice can be given to people you see in therapy.

Personal experience offers a valuable first step for learning more about both mindfulness and acceptance. People usually learn mindfulness by establishing a daily mindfulness/meditation practice—even if it is just 5 minutes a day. Consider taking a mindfulness class or joining a mindfulness group in your community. Ideally, you will learn from someone who already has experience with this approach. If you experience the benefits of the other two acceptance approaches, you may become interested in learning more about acceptance methods in general. To learn how to incorporate mindfulness or acceptance approaches effectively into therapy, you can attend workshops and read books on acceptance and commitment therapy (Hayes, Follette, & Linehan, 2011; Hayes, Strosahl, & Wilson, 2016; Luona, Hayes, & Walser, 2007), dialectical behavior therapy (Linehan, 1993; Swenson, 2016), and/or mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2018).

7

Underlying Assumptions and Behavioral Experiments

(*MOM2* CHAPTER 11)

> Why do I keep thinking the same thoughts?
>
> I want to change, but I keep doing the same things over and over again.
>
> —*Common client remarks*

Most people are fascinated to learn that (1) we all operate according to rules that run beneath the surface (underlying assumptions); (2) we can identify and test these rules; and (3) we can write new rules to follow in order to make our lives better. Given the appeal of these ideas, identifying underlying assumptions and carrying out behavioral experiments to test them are therapy tasks that most clients embrace with great interest and curiosity.

Underlying assumptions are the "If . . . then . . ." conditional beliefs that guide our automatic thoughts, behaviors, moods, and life choices. They help explain why the same types of automatic thoughts come up over and over again in therapy discussions and on thought records. For example, someone who has frequent has automatic thoughts and images about rejection is likely to have underlying assumptions such as "If I let people down in any way, then they will reject me," and "If someone gets upset or ignores me, then they are rejecting me." Any time one of the circumstances in the "If . . ." part of these assumptions occurs, automatic thoughts related to the "then . . ." part are triggered. Therapy aims to identify and test the underlying assumptions that give rise to recurring automatic thoughts, maintain distressing moods, and trigger relapse.

In addition, whenever your clients are unsuccessful in trying to change their behaviors, you will find underlying assumptions maintaining those behaviors. For example, someone who wants to stop verbally attacking people can have underlying assumptions in place that make this change difficult, such as "If someone shows me

Clinical Tip

Underlying assumptions lead to recurrent automatic thoughts and behaviors. The presence of either of these is a clue that underlying assumptions are present. Behavioral experiments are usually the best method to test existing underlying assumptions and develop new ones. New underlying assumptions help support changes in people's behaviors and automatic thoughts, as well as their moods.

disrespect and I don't push back hard, then I will look weak, and they will take even greater advantage of me." People struggling with addictions hold underlying assumptions about urges (e.g., "If I have an urge, then it will just get worse until I give in to it") and control (e.g., "If I have an urge, then I can't stop myself"). Underlying assumptions also influence behavior by predicting the future (e.g., "If I try something new, then I will fail"). Underlying assumptions offer many rules like these that guide people's behavior cross-situationally.

Chapter 2 of this clinician's guide has described three levels of thought: automatic thoughts, underlying assumptions, and core beliefs. Recall that automatic thoughts and images are the cognitions that spontaneously come into people's minds throughout the day. The first nine chapters of *MOM2* address how to identify moods, behaviors, and automatic thoughts/images, and then how to test the automatic thoughts/images on 7-Column Thought Records. Thought records are not the best method for evaluating underlying assumptions, however, because thought records are designed to test automatic thoughts about the meaning of particular situations, as described in Chapters 4 and 5 of this clinician's guide.

Instead, the best way to test an underlying assumption is to set up a series of experiments to see if its predictions fit what actually happens in life. Just as 7-Column Thought Records help people develop more balanced and alternative thoughts when their automatic thoughts are not supported by the evidence, behavioral experiments help people develop and strengthen new underlying assumptions when the predictions made by their underlying assumptions do not materialize.

Chapter 11 of *MOM2* introduces the concept of underlying assumptions to your clients and teaches them how to use behavioral experiments to test them. Keep in mind the learning points from the Chapter 11 Summary that you want your clients to understand as they work with their underlying assumptions.

WHEN TO WORK WITH UNDERLYING ASSUMPTIONS

Underlying assumptions can be addressed earlier or later in therapy, depending upon the issues discussed. When clients' goals relate to recurrent behaviors (e.g., perfectionism, addictions, procrastination) or interpersonal issues (e.g., conflict avoidance,

Chapter 11 Summary

(*MOM2,* pp. 132–151)

- ✓ Underlying assumptions are "If . . . then . . ." beliefs that guide our behavior and emotional reactions at a deeper level than automatic thoughts do.
- ✓ Underlying assumptions can be identified and tested, just as automatic thoughts can.
- ✓ To identify underlying assumptions, put a behavior or situation that triggers a strong emotion into a sentence that begins with "If . . ."; follow that by "then . . . " and let your mind complete that sentence.
- ✓ Underlying assumptions can be tested by using behavioral experiments.
- ✓ There are many types of behavioral experiments, including doing the "If . . ." part of your assumptions and seeing if the "then . . ." occurs, observing other people to see if the rule applies to them, and trying the opposite behavior and noticing what happens.
- ✓ It is usually necessary to do a number of behavioral experiments in order to fairly test existing assumptions and to develop alternative assumptions that fit your life experiences.
- ✓ Developing new underlying assumptions can lead to meaningful change and greater happiness.

dependency), underlying assumptions are often identified and tested throughout therapy, starting in early sessions. When therapy is focused on moods, underlying assumptions will be addressed early or late, depending on the mood. Mood-related timing choices for work with underlying assumptions are addressed in detail in Chapters 9–12 of this guide. Here is a brief synopsis of what is covered there.

For Depression

In general, depression treatment begins with behavioral activation and then teaches skills for identifying and testing automatic thoughts. Underlying assumptions are addressed later in depression therapy. This order makes sense, because depression is characterized by inertia and moment-to-moment negative automatic thoughts that intrude throughout the day. Once someone learns to manage negative automatic thoughts, depression usually lifts. Underlying assumptions then become important in order to identify beliefs that contribute to vulnerability to future depressive episodes. See Chapter 9 of this guide for more details.

For Anxiety

In contrast, anxiety treatment usually begins with identification of underlying assumptions and does not need to focus to any great extent on directly testing automatic thoughts. This is because anxious thoughts generally occur in the form of underlying assumptions (e.g., "If my heart beats fast, then I will have a heart attack," "If something goes wrong, then I won't be able to cope," or "If I sound foolish, then others will laugh and I will feel humiliated"). As these examples illustrate, the central thoughts in anxiety are usually future-oriented, predictive underlying assumptions. Behavioral experiments are ideal for testing anxiety assumptions, because you and your clients can do a series of experiments to find out if their predictions come true.

Since underlying assumptions constitute the most important level of thought for understanding anxiety, and since behavioral experiments are the prime interventions, identifying underlying assumptions and using behavioral experiments to test them are among the first skills taught in treatment of anxiety disorders. Many of the case examples in Chapter 11 of *MOM2* describe people experiencing anxiety. Chapters 10 and 11 of this guide offer more details about anxiety treatment.

For Anger, Guilt, Shame, and Other Moods

For other moods, such as anger, guilt, and shame, good arguments can be made for either working with automatic thoughts or underlying assumptions first. The Reading Guides for anger, guilt, and shame (available in Appendix A on pp. 456–459 and The Guilford Press's companion website to *MOM2;* see the box at the end of the *MOM2* table of contents, p. vi there) direct readers struggling with these moods to work first on automatic thoughts, using 7-Column Thought Records, *before* turning to underlying assumptions and behavioral experiments. This order makes sense for people who are using *MOM2* for self-help, because it takes them step by step through ways of testing hot thoughts linked to their moods in the moment. Next, they learn to identify and test the underlying assumptions that maintain these moods. This order will often make sense in therapy as well. However, sometimes it becomes clear early in therapy that a person's moods are directly tied to underlying assumptions such as these:

"If someone hurts me, then I have to right to hurt them back."
"If I've done something wrong, then I don't deserve good things in life."

When underlying assumptions are already on the surface, and you can see that these assumptions are central to your clients' struggles, it makes sense to start working with them early in therapy.

For Behavior Change and Interpersonal Relationships

When clients want help with behavior change or interpersonal relationships, you will often work with underlying assumptions early in therapy. This is because behavioral

habits and interpersonal interaction patterns are primarily guided by underlying assumptions, not automatic thoughts. Someone who wants to reduce their alcohol or drug use needs to address underlying assumptions such as these:

"If I use, then I'll feel and perform better."
"If I don't use, then I'll get edgy, and this will continue until I use again."
"If I want to be with my friends, then I have to use drugs and/or drink."

People struggling with eating issues or weight loss often have underlying assumptions such as these:

"If I feel hungry, then I need to eat, or the feeling of hunger will become intolerable."
"If I've gone off my diet, then I might as well binge, because my diet is ruined for today."

Relationship conflicts are born of and maintained by underlying assumptions like these:

"If someone loves me, then he will know what I need and meet those needs."
"If my partner hurts me, then that means she doesn't love me."
"If my partner loves me, then he will do what I want even when we disagree."
"If my partner breaks one of our agreements, then she is completely untrustworthy."

Underlying assumptions like any of these are unlikely to change through talk therapy alone. *Direct experiences* that support or contradict expectations provide the most powerful learning available for deeply held beliefs such as underlying assumptions. Therefore, it is essential to identify underlying assumptions and directly test them, most often by using behavioral experiments.

IDENTIFYING UNDERLYING ASSUMPTIONS

It is quite easy to identify underlying assumptions if you stick to an "If . . . then . . ." format. All you need to do is identify a relevant "If . . ." circumstance, and a person will usually quickly blurt out the "then . . ." ending for this belief. Worksheet 11.1, Identifying Underlying Assumptions (*MOM2,* pp. 140–141), can be used to begin this process. Illustrative examples of how to identify underlying assumptions are included in the following sections.

Mood-Related Underlying Assumptions

For moods, put a situation or circumstance that triggers the mood in the "If . . ." part, add the word "then . . . ," and pause, letting your client fill in the blank. The following brief dialogues illustrate this approach.

THERAPIST 1: Kerry, I've noticed that you tend to feel shame whenever someone criticizes or corrects something you are doing. It is as if you have a belief, "If someone corrects me, then . . ." (*Stops speaking and looks at Kerry expectantly.*)

KERRY: "That proves I'm inadequate."

Identified assumption:

"If someone corrects me, then that proves I'm inadequate."

THERAPIST 2: Raul, we've discussed how you feel especially anxious when you are driving in heavy traffic. I wonder what belief can help us understand this. Perhaps it's something like this: "If I'm driving in heavy traffic, then . . ." (*Stops speaking and looks at Raul with curiosity.*)

RAUL: "Then the risk of an accident goes up."

Identified assumption:

"If I'm driving in heavy traffic, then the risk of an accident goes up."

Behavior-Related Underlying Assumptions

To identify underlying assumptions that maintain behaviors, it is usually helpful to put the frequent behavior in the "If . . ." part first, and to follow with "then what do you hope will happen?" Second, you can put the new desired behavior that is not occurring in the "If . . ." part, and follow with "then what are you afraid might happen?" These two questions help identify underlying assumptions that maintain the current behavior and that make it hard to start a new behavior (Mooney & Padesky, 2000; Padesky & Mooney, 2006). The following dialogue illustrates this process.

THERAPIST 3: Liu, you said you wanted to go out more and meet new people, and we made a step-by-step plan. Yet it seems that every week there are things that interfere with you starting your plan. This makes me think there might be some beliefs that are stopping you from making this change.

LIU: I really do want to meet people. It is just that things come up to interfere.

THERAPIST 3: I believe you. Would you be willing to find out if beliefs are also interfering?

LIU: Sure.

THERAPIST 3: Let's start with this: "If I stay home this week and don't go out to meet people . . . ," then what do you hope will happen?

LIU: "Then I hope that one of these days I'll really feel ready to go out, and it will be easier to meet people when I'm in a more confident mood."

THERAPIST 3: OK, good. And "If I go out to meet people when I don't yet feel ready . . . ," then what are you afraid might happen?

Liu: "I'm afraid I will blow it and do something weird and ruin my chances in that place."

Therapist 3: Let's write those beliefs down. They help me understand why you have been reluctant to leave home.

Identified assumptions:

"If I stay home and don't go out to meet people, then I hope that one of these days I'll really feel ready to go out, and it will be easier to meet people when I'm in a more confident mood."

"If I go out to meet people when I don't yet feel ready, then I'll blow it and do something weird and ruin my chances to meet someone in that place."

BEHAVIORAL EXPERIMENTS

Behavioral experiments are the primary CBT intervention used to test underlying assumptions. There are many types of behavioral experiments, including direct tests of beliefs (e.g., doing the "If . . ." part of an underlying assumption and observing whether the expected "then . . ." part happens or not), making observations of others to see if assumptions correctly apply to them, and conducting surveys to see if assumptions match others' experiences or beliefs (Bennett-Levy et al., 2004). No matter what type of experiment is done, behavioral experiments require people to (1) write down the belief being tested, (2) design experiments that directly test that belief, (3) make written predictions in advance, (4) repeat the experiments a sufficient number of times, (5) record the outcomes of experiments, and (6) compare actual outcomes with predicted outcomes. Depending on what people learn, they either conclude that their experiences fit the original belief, or construct a new belief that fits better with the outcomes of experiments.

Setting Up Effective Behavioral Experiments

Worksheet 11.2, Experiments to Test an Underlying Assumption (*MOM2,* p. 149), provides a structure that can help you and your clients set up and debrief behavioral experiments by using the six steps listed above. The following sections highlight important principles to follow at each step of the process. Keep these principles in mind to ensure that the behavioral experiments you and the clients devise are effective. "Effective" means following good principles of observation and empiricism to test clients' assumptions adequately. It does not mean devising experiments that you hope will lead to a particular outcome. For example, you do not want to set up experiments to prove to a client that "greater activity helps you feel less depressed." Instead, you set up experiments to learn if there is a relationship between activity and mood in order to test the client's belief "If I do more things, it won't matter, because I'll feel just as depressed."

Step 1: Write Down the Assumption You and Your Client Are Testing

Begin by identifying an underlying assumption that you and a client want to test. Use the guidelines presented earlier in this chapter for identifying underlying assumptions. Try to phrase a client's belief as an "If . . . then . . ." prediction, because this format provides an easily testable hypothesis. Many clients often do not initially state their beliefs this way. For example, during activity planning, people experiencing depression often predict that activities will not be "enjoyable" or "worthwhile" and use these predictions to support continued inactivity. As the instructions for identifying underlying assumptions suggest, you can put the behavior that is not occurring in the "If . . ." part of the assumption; follow up with "then what are you afraid might happen?"; and see how your client finishes the sentence. One person said it this way: "Even if I do activities, they won't help me feel any better." This is a good statement of a testable hypothesis.

All of us hold hundreds of underlying assumptions. It can take one or more weeks to conduct enough experiments to test an assumption adequately, so you and your client want to make sure that you choose important assumptions to test. Generally these will be the ones that maintain difficulties or block treatment progress. The *Oxford Guide to Behavioural Experiments in Cognitive Therapy* (Bennett-Levy et al., 2004) offers excellent examples of the types of underlying assumptions that maintain a broad spectrum of mental health issues. Clinical examples in this chapter and others throughout this book also model how to do this. Despite expected themes for underlying assumptions that commonly maintain depression, anxiety, guilt, and so on, be sure to phrase beliefs in your client's own words, because assumptions are often phrased in idiosyncratic ways. Write (or have the client write) the underlying assumption you and the client are currently testing on the top line of Worksheet 11.2, Experiments to Test an Underlying Assumption.

Step 2: Collaboratively Design an Experiment to Test That Belief Directly

Once an important underlying assumption has been identified, collaborate with your client to figure out a good way to test this belief. Sometimes the test will be as straightforward as doing the "If . . ." part of an assumption and seeing if the "then . . ." part follows (Experiment 1, *MOM2,* p. 142). For the belief, "Even if I do activities, they won't help me feel any better," the test could simply be to plan a series of activities and have the client rate mood before and after each activity to find out if any of them lead to mood improvement.

At other times, tests of a belief are a bit trickier to devise. For example, what is a good experiment to test the belief "If I don't worry, then I'll miss something, and bad things will happen"? A direct test appears to be to ask the client not to worry and then wait and see if bad things happen. But this plan leaves a lot to be desired. First, how will the client "not worry"? Second, how long do you and the client have to wait to see to see if "bad things happen"? Third, bad things happen all the time. How will you and your client know if these bad things are consequences of not worrying? As this worry

belief example illustrates, you and your client need to reach agreement on definitions for experiments and their predicted consequences.

This worry belief is a good illustration of why not all beliefs can be tested by doing the "If . . ." part of the belief and seeing if the "then . . ." follows. Chapter 11 of *MOM2* includes two additional types of experiments. One is to have clients observe and see whether their rules apply to others (Experiment 2, *MOM2,* pp. 143–144). This experiment benefits from the tendency we all have to apply underlying assumptions or rules to ourselves that we don't apply to others. Thus an alternative experiment for the worry belief would be for the client to identify several people who don't tend to worry and see if they have more bad things happening in their lives than several people who do worry. Of course, it is always possible that people who experience a series of "bad events" worry more than people who are relatively trouble-free.

A third type of experiment described in Chapter 11 (Experiment 3, *MOM2,* pp. 144–147) is for the client to do the opposite of the usual behavior and see what happens. The example of this type of experiment in *MOM2* illustrates a mother, Gabriela, who practiced not worrying in a situation in which the "bad thing" she expected to happen would happen within the time frame of an evening. Gabriela and her therapist problem-solved how she could reduce her worrying, because it can be very difficult "not to worry." By setting up a very specific plan, Gabriela was able to do an experiment and get a clear outcome within a time frame of a few hours. This was ideal, because with a longer time frame, it could have been difficult to link consequences with the experiment. Of course, unlike the results of Gabriela's experiment (described in Figure 11.4 on p. 147 of *MOM2*), it was always possible that Gabriela's daughter could have something bad happen to her during the evening. In this case, Gabriela and her therapist would need to discuss whether whatever happened would have been prevented if Gabriela had worried more.

Often a series of experiments needs to be designed. This is the case when a belief is complex or broadly applied and needs to be tested in a variety of contexts. For example, if a client has the belief "If I reveal my true feelings, then people won't want to be close to me," this belief can be tested in appropriate ways with family, friends, coworkers, and strangers. There can be a variety of responses with people in each category. In addition, this client can choose to start these experiments with relatively minor revelations (e.g., food preferences) and gradually increase the importance of what is expressed (e.g., ranging from political attitudes to feelings toward a person).

You can expect a series of experiments to lead to more nuanced belief systems. For example, after doing a series of experiments over several months, this client may develop the following new underlying assumptions: "If I reveal my true feelings to strangers, then they are likely to engage with me more if they share my feelings and less and if they don't," "If I reveal minor food preferences, my family members won't pay attention, but friends and coworkers will respect my choices," and "If I reveal more important and intimate feelings, then my family and friends will engage with me more, and some coworkers will distance themselves."

Also plan a series of experiments when the best experiment is too challenging for someone to do at this time. A sequence of experiments can help clients approach a desired ultimate experiment step by step. Doing a series of experiments is a common

approach in the treatment of anxiety disorders when the ultimate goal is exposure to fears that clients are too afraid to approach as their first step. People with a phobic fear often approach a feared situation or object in a graduated fashion, testing relevant underlying assumptions as they proceed. For example, someone with a fear of bridges may have the belief "If I drive over a bridge, then the bridge will collapse, and I will sink underwater and drown." This person's first experiment could be to drive over a bridge as a passenger; the person can then move gradually on to being the driver, first over shorter and then longer bridges, initially with a companion and later alone.

Collaborate with your clients in the design of these experiments, whether you are devising a single experiment or a series of experiments. Here are a few questions you can ask your clients to encourage their participation and also to help them carry out planned experiments.

1. "What types of information or experiences would have the greatest credibility in testing your belief?" Ideally, clients conduct their own observations and experiments. However, in some cases, they can make a case for asking a friend to help them with the experiment. One client was testing the belief "If I don't have a lot of money, no woman will want to date me." He and his therapist decided that the best initial test of this belief would be to conduct a survey and ask women two questions: "What qualities determine whether you will date someone?" and "Would you go out with a man who didn't have a lot of money?" He thought women would be too kind to give him honest answers, so he decided to enlist a female friend to conduct the survey. His therapist asked what types of women she should survey. He asked his friend to interview women between the ages of 20 and 35, because this was the age range of women he wanted to date. She agreed to audio-record their answers (with their permission) so he could hear the tones of their voices, which he thought would help him judge their honesty. She conducted the interviews at a local shopping center.

2. "What problems do you anticipate you could have in carrying out this experiment?" Ask your client to role-play the experiment with you or take a few minutes to fully imagine doing each step of it. During these practices or imaginal rehearsals, clients will often envision problems, roadblocks, moods, and beliefs that could interfere with the experiment. Have the client write each of these down in the third column of the behavioral experiment worksheet (Worksheet 11.2, *MOM2,* p. 149), and then ask the next question.

3. "How can you manage these problems to keep going in the experiment?" It is much better to ask clients to devise their own solutions to potential problems than to propose solutions yourself. When you propose solutions, clients are likely to respond, "Yes, but . . ." and describe the shortcomings of your solution. When your clients think of their own ways to manage difficulties, they are likely to feel empowered and be more likely to carry out these strategies if the problems do occur. Have a client write each solution down in the fourth column of Worksheet 11.2.

4. "What outcomes of this experiment could be particularly difficult for you to manage?" Help clients to imagine worst-case outcomes, because there is no guarantee that experiments will have typical or desirable outcomes. If you and your

clients can anticipate negative outcomes in advance, you can help to prepare clients so that they aren't blindsided by hurtful outcomes. For example, Gina held the underlying assumption "If people disagree with you, then arguments will just become more heated over time, so it is better to avoid conflict." One of her later experiments was to ask her father to come to her wedding, even though her father expressed disapproval that she was in a same-sex relationship. She imagined a worst-case scenario in which her father began an angry tirade against Gina's marrying her partner, Brigitta.

5. "How could you manage that outcome?" Her therapist helped Gina devise several responses she could make to her father if he did become angry, ranging from (a) firm assertion of her love for Brigitta, to (b) inviting her father to express his fears about what Gina's marriage would mean, to (c) exiting the house if her father escalated his attack. After role-playing these options, Gina and her therapist discussed what her father's possible rejection would mean to her and how she could cope if her father did not develop greater acceptance of her marriage to Brigitta over time. With this preparation, she decided to carry out this experiment and see if her communication efforts could make a difference.

Step 3: Make Written Predictions in Advance

Before doing an experiment, ask your client to make written predictions of what will happen if the underlying assumption is correct. Have the client record these predictions in column 2 of Worksheet 11.2 (*MOM2,* p. 149). Predictions should be written down; otherwise, people can shift their predictions after the experiments to fit with what actually happened. For example, a person with a high degree of anxiety related to a bridge phobia is likely to predict before the experiment that "I'm certain the bridge will collapse when I am on it." After driving on the bridge without incident, the person may recall the prediction as "I thought it was likely the bridge would collapse, but it was not a certainty. It didn't collapse this time, but it might collapse next time." When predictions are written down in the person's own handwriting, it is easier to compare outcomes to expectations.

Written predictions should be specific (e.g., "four out of ten times") and consistent with the belief being tested. If predictions do not seem to be "in sync" with the belief, clarify this discrepancy as Gayle's therapist did.

GAYLE: So my prediction is that five out of ten people will give me an odd look if I smile at them.

THERAPIST: OK. That surprises me a bit, because your belief is "If I smile at people, they will give me an odd look, because I have a weird smile." And yet you only think 50% of people will give you an odd look.

GAYLE: That is because I think half of people are skilled at hiding their feelings.

THERAPIST: So what about the 50% who don't give you an odd look?

GAYLE: They will be thinking I look weird, but be too socially skilled to show it.

THERAPIST: So your prediction is that 100% of the people will think you look weird, but only 50% will show it on their faces.

GAYLE: That's right.

THERAPIST: Hmmm. That's a bit tricky. Your prediction assumes that everyone with a blank face is thinking the same thing. Is there any facial expression that wouldn't fit with your belief that people think you have a weird smile?

GAYLE: I don't know. Maybe if they quickly smiled back?

THERAPIST: What do you think? Would that mean they didn't think your smile was weird?

GAYLE: Yes, I think so.

THERAPIST: OK. So how many people out of ten do you think will smile back?

GAYLE: Zero.

THERAPIST: Let's write that down. I'm still wondering about those people who don't show any reaction on their faces. I'm not sure it is fair to assume that they all think your smile is weird. Can you think of any other response a blank face could mean?

GAYLE: Maybe they didn't notice me smiling, or they are deep in thought.

THERAPIST: Yes, those are possibilities. It seems the blank faces are a bit of an unknown. Maybe you could make predictions regarding "odd looks," "smiles," and "unknown reactions."

GAYLE: OK. Out of ten, I predict five odd looks, five unknowns, and zero smiles.

THERAPIST: Let's write those predictions down and clarify how you can increase the odds that people will see you smiling at them. The fewer unknowns we have, the more information we will have to test your belief.

Her therapist did a good job of trying to clarify how Gayle could interpret other people's reactions, given the experiment they were planning. During this discussion, it occurred to her therapist that Gayle's judgments of other people's reactions were based on subjective interpretation. Since Gayle was already convinced that people thought her smile was weird, she was likely to interpret ambiguous faces as either giving her an odd look or masking reactions that reflected their perception of her smile as weird. Thus the planned experiment appeared biased toward confirmation of Gayle's beliefs. Gayle's therapist was wise to ask about what facial expressions could indicate people did not think her smile was weird. *Predictions for experiments need to allow for a belief to be either supported or contradicted.*

After this discussion, her therapist considered that a better experiment would begin with taking a photo of Gayle smiling and putting it in a mix of other photos of people smiling. The actual experiment would be to interview a range of people (without Gayle present) and ask them to choose any photos in which people's smiles looked weird. This experiment removed subjective interpretations of people's responses. It also eliminated Gayle's concern that people were masking their real responses when they were facing her. Of course, Gayle's therapist would need to discuss this idea for an alternative experiment with Gayle and find out whether or not she agreed that this was a more credible experiment and that the results would be meaningful to her.

Step 4: Repeat Experiments a Sufficient Number of Times

Once is not enough. One way to describe the rationale for repeating experiments is to say, "If you do something only one time, you don't know if you are getting the best possible outcome, the worst possible outcome, or a typical outcome. If we do something five times, we have a better idea of what is typical, and if we try it ten times, we can be even more confident in our results." Here is a more concrete example:

> "Suppose you are given a coin, and you are told that one side has a head on it, but you don't know if the other side also has a head on it or has a different image. If you flip the coin just once and it comes up heads, then you don't know what that means. If you flip it twice and it comes up heads both times, you might think that both sides are heads. But this could just be the luck of the toss. To get a true sense of what both sides of the coin look like, you need to toss a coin five or ten times, because just two or three flips can be deceiving. If the same thing happens ten times, then you can be pretty sure that both sides of the coin are heads."

A client is more likely to be willing to do the same experiment multiple times, once the client understands this link between repeated observations and confidence in the meaning of results. Of course, if the results are not what the underlying assumption predicts the first few times, the client's confidence in this assumption can begin to weaken. Or, if the results the first few times match the client's predictions, the client can become reluctant to keep repeating the experiment. Usually, just like a coin toss, the results of experiments are not one-sided. Experiments can turn out as an underlying assumption predicts three times out of ten or six times out of ten. You and your client will then discuss these outcomes to make sense of them, as described in the sections below.

Step 5: Record the Outcomes of the Experiments

You and a client can fill out the first four columns of Worksheet 11.2, Experiments to Test an Underlying Assumption (*MOM2,* p. 149), together in session. Once clients begin doing planned experiments, they can record the outcomes of each experiment in the fifth column of this worksheet. Remind them to review the relevant questions at the bottom of this column, which suggest the types of observations that are helpful for them to record in that column:

What happened (compared to your prediction)?

Actual outcomes need to be compared with the predicted outcomes written in the second column of Worksheet 11.2.

Do the outcomes match what you predicted?

This question is answered only after a number of experiments have been done. You don't want someone to make the coin toss error and jump to a conclusion after just one or two experiments.

Did anything unexpected happen?

Sometimes completely unexpected things happen. For example, a person who expects criticism receives a compliment instead. Since behavioral experiments often involve new behaviors or practicing things that the person has avoided for a long time, there are often outcomes the person did not anticipate. These outcomes can be welcome (e.g., a compliment) or unwelcome (e.g., a friend reacts with anger). If your client writes these down on the worksheet, it reminds you both to discuss these unexpected outcomes and their meanings in the next session.

If things didn't turn out as you wanted, how well did you handle it?

Often underlying assumptions predict that negative outcomes will lead to terrible consequences. For example, anxious assumptions are usually a variation on the theme "If *X* happens or doesn't happen, then bad things will follow." A second assumption is often implied: "And if bad things happen, then it will be disastrous, and I won't be able to cope or mend it in any way."

Asking someone to reflect on unwanted outcomes in terms of how well they coped addresses this second implied assumption. When negative consequences occur during behavioral experiments, and people are able to cope well enough with these experiences, they may actually experience a boost in self-efficacy. This question is designed to capture and record coping strengths, to help mitigate fears that can block behavioral change.

Step 6: Compare Actual Outcomes with Predictions

When experiments begin, it is natural to start comparing outcomes with predictions. As stated in the discussion of step 5 above, it is best to wait until a number of experiments have been completed before drawing any solid conclusions about this comparison.

WHEN OUTCOMES OF EXPERIMENTS DO NOT ENTIRELY SUPPORT THE ORIGINAL BELIEF

Each experiment's outcome will support, not support, or provide mixed support for the underlying assumption tested. When most of the experiments' outcomes do not support the assumption, then you and the client can construct a new assumption that is consistent with the outcomes.

For example, Gerry experienced social anxiety and predicted that people would make demeaning comments if he said something foolish. After doing a number of experiments in which he intentionally said foolish things (e.g., saying he was sure an underdog team would win, asking where he could get a cup of coffee when he was standing in front of a coffee shop), he observed that his best male friends did in fact make demeaning comments about him when he made foolish statements (e.g., "You're so lame!" and expletive-laced insults). However, he noticed that family members, female friends, and members of his work groups did not demean him in these circumstances.

In debriefing these outcomes, Gerry commented that his male friends made demeaning comments about each member of their group at different times, and that

these often seemed like good-natured ridicule rather than expressions of attack. In fact, he did not see any evidence that his friends thought less of him after he said foolish things. Gerry linked his social anxiety fears to the bullying he had endured in middle school. His current experiences were quite different from those, and he was able to see that as a grown man with friends and family who cared about him, the consequences of making mistakes or saying foolish things were not likely to be serious. His new underlying assumption was "If I say foolish things or make mistakes as an adult, any teasing I receive is good-natured and not dangerous." Gerry continued to practice saying and doing foolish things until his fears diminished and he was confident in his new assumption.

WHEN OUTCOMES OF EXPERIMENTS SUPPORT THE ORIGINAL BELIEF

When the underlying assumption you and a client are testing is supported by the outcomes of experiments, you both need to consider the implications of this finding. For example, Malik and his therapist conducted experiments to test out his belief "If I tell others that I am gay, they will reject me." Malik did not want to do experiments with people who knew him, because he thought the risks were too high. Therefore, he and his therapist devised a series of experiments he could do with strangers. First, he set up a new email account with a fake profile. He then logged onto several websites using this email address, which was not associated with any of his regular accounts. He posted in five different discussion groups about various topics without incident, and then posted a new comment in each group that mentioned that he was gay. Each of his messages including a comment that he was gay received a number of hostile responses from other members of these discussion groups. Malik said he would have felt quite threatened if these interchanges had occurred in person. Before continuing with additional experiments, he and his therapist discussed these results.

MALIK: I was really shaken by some of the comments. People are even more hateful than I predicted.

THERAPIST: I'm so sorry this was your experience.

MALIK: Thanks. Now you can understand why I don't want to tell anyone I am gay.

THERAPIST: I do understand why it feels so risky.

MALIK: So what can I do?

THERAPIST: First, I think we should look closely at these first experiments. Do you think that every website discussion group would have the same outcome?

MALIK: What do you mean? All five had the same outcome.

THERAPIST: Well . . . to consider a different type of experiment, if you had posted to a gay discussion group, do you think you would have been attacked?

MALIK: No, of course not. But we are talking about telling my straight friends and family that I am gay. And I think it is too risky.

THERAPIST: Right. I wonder if there are people who live in the middle between those who will attack gays and those who are gay themselves and are accepting?

MALIK: I'm sure there are. But how do you know what someone will say or think if you tell them?

THERAPIST: That is an important question—how you can learn to judge and guess when it will be safe to tell someone you are gay.

MALIK: Yes.

THERAPIST: Perhaps our experiment was not set up in the best way. In reality, you would not be likely to just pick a random group and announce that you were gay, and especially not on social media, where we know people get attacked for almost anything. You would know some people in a group and make some guesses about the safety of it first.

MALIK: Uh-huh.

THERAPIST: Do you think you are likely to come out first to a new group, or to a group where you know most of the people, or to an individual that you knew pretty well?

MALIK: Probably to an individual, not a group. And someone I knew pretty well.

THERAPIST: Did you notice any individuals in the discussion groups you were participating in this past week who you thought seemed likable and friendly?

MALIK: You mean with my new profile and email address?

THERAPIST: Yes.

MALIK: Yeah, there were some posts by a woman called Deja. She seemed very solid and nice.

THERAPIST: Can you write a message to just an individual in that discussion group?

MALIK: Yes, I think so.

THERAPIST: What do you predict would happen if you wrote to Deja and told her how badly you feel about some of the gay-bashing posts you received?

MALIK: I don't know.

THERAPIST: What would your belief we are testing predict?

MALIK: She will reject me. Either not answer or write something negative back.

THERAPIST: I guess if she doesn't answer back, then we won't know if she is out of town, or left the discussion board, or is rejecting you. If she writes something negative, then that will be clear. And, if she were to write something supportive, would that be clear?

MALIK: Yeah.

THERAPIST: In the real world, is Deja the kind of person you might trust to talk to about being gay?

MALIK: I think so. As much as I can tell.

THERAPIST: Sure. It's hard to tell on the Internet. We don't know if others on those

discussion boards have fake profiles like you made. We don't know if the posts they make are representative of how they are with real people in their lives.

MALIK: No, we don't. But I do know that some people are pretty nasty when they learn you are gay. Total picture or not, they hold some hate in their hearts.

THERAPIST: Yes, we certainly know that this is true of some people. What we don't know is whether some straight people would accept you if you told them you are gay.

MALIK: Yeah.

THERAPIST: You said you felt threatened by some of the posts people made, once you said you were gay. Do you think it is possible that some people who might have felt supportive were too intimidated to express their support, because they felt threatened too?

MALIK: I guess that's possible.

THERAPIST: So perhaps an individual conversation might be a safer starting point on the Internet, just like in real life.

MALIK: Maybe.

As his therapist continued debriefing the results of Malik's initial experiments, she considered the implications of what had happened in his online experiments and how this might fit or not fit with other relevant aspects of his concerns about telling others that he was gay. Although the experiments he did had outcomes that matched his predictions, she helped Malik consider features of these experiments that could be changed to explore more meaningfully whether other, more desirable outcomes were possible under different circumstances. As therapy proceeded, she and Malik had opportunities to devise additional experiments to test his underlying assumption. At the same time, his therapist supported Malik's desire to be safe and to learn how to judge when and how he could talk with others about being gay.

When the outcomes of Malik's experiments supported his underlying assumption, this led to discussions regarding what types of experiments he could conduct to mimic his real-life behavior more closely, and what the chances were that these experiments would also support his assumption. His therapist supported Malik's desire to stay safe, and these experiments were designed with safety in mind.

In other cases when the outcomes of experiments support predictions, these findings suggest that the client needs to make some type of change. Another client, Deven, wanted to make friends, and yet he held this assumption: "If I ask someone to do something with me, then they will turn me down, so there is no point in trying." His assumption deterred Deven from taking the initiative in his relationships. He waited for others to invite him to do things. As a result, he had become quite isolated. He and his therapist devised a series of experiments in which he would ask work colleagues and a few seemingly friendly neighbors to do things with him (e.g., walk or bicycle, go to a coffee shop together). In the following week, Deven extended five invitations to various people, and all of them turned him down. When he arrived for the next session, he

was quite discouraged. The following section illustrates how his therapist used Socratic dialogue to debrief his experiments and help Deven find a way forward.

Debrief Behavioral Experiments Using Socratic Dialogue

Whatever the results of behavioral experiments, it is your job as a clinician to help clients learn something valuable from them. Socratic dialogue is the preferred approach for comparing outcomes to predictions, because you want to engage clients in drawing their own conclusions, rather than pointing out what you notice first. The advantage of using Socratic dialogue is that it can increase a client's confidence in any conclusions drawn and can lead to greater change (Padesky, 1993a; Braun, Strunk, Sasso, & Cooper, 2015; Heiniger, Clark, & Egan, 2017). Observe Deven's therapist's use of Socratic dialogue as she interviewed him about his experiments. The steps of Socratic dialogue are summarized at the end of this exchange.

Deven: So now you can believe me. Even when I ask people to do something with me, they say no. So there is no point in trying.

Therapist: That certainly fits with your experiences this week. Could we talk a bit more about what happened?

Deven: Sure.

Therapist: Tell me about the people you asked, what you asked them to do with you, and how they responded.

Deven: I asked Jamal from work to go to see a new movie we were talking about at lunch. That seemed like a natural opportunity, like you and I talked about last time.

Therapist: Yes, well done.

Deven: Well, he said he and his girlfriend had plans to see it. So that was a no. Then I asked this other guy sitting there who was listening to our discussion if he wanted to go to the movie, but he said he didn't like that kind of movie. Another no. The next day I asked my next door neighbor if she wanted to walk with me every morning at 7 a.m. before I go to work, but she just laughed and said, "No way!" That was a big no. Then I asked her to go bicycling with me on the weekend. She said she'd think about it, but she was pretty busy the next few weekends. So that sounded like a no, don't you think?

Therapist: Hard to be sure, but it sounds like it could be a no.

Deven: All right. So then I asked my cousin to go to Mexico with me for vacation next month, but he said he couldn't afford it. He spends lots of money on video games and stuff, so I think he could afford it and just didn't want to go with me.

Therapist: I want to congratulate you on asking people to do things with you five times this week like we discussed. Was this difficult to do?

DEVEN: Not as hard as I thought. But I had begun to hope you might be right and someone might do something with me, so it was hard on me that everyone said no.

THERAPIST: I'm sorry it turned out that way. (*Pause*) At the same time, I'm impressed you stuck with it.

DEVEN: Thanks.

THERAPIST: I see you wrote each of these experiments on your copy of Worksheet 11.2, and in the last column that asks what you learned about your assumption, you wrote, "No one wants to do anything with me."

DEVEN: Uh-huh.

THERAPIST: I wonder if there are some other things we can learn from your experiments.

DEVEN: Like what?

THERAPIST: Well, that conclusion sounds to me like everyone said no to you because of something about you. If that's the case, then maybe we need to talk about what changes you need to make so someone will want to do things with you.

DEVEN: What do you mean?

THERAPIST: I'm not sure. We'll have to figure that out together. Maybe we'll learn something from these experiences that will help us figure it out. But first we should make sure that each of these people said no because of something about you.

DEVEN: What else could it be?

THERAPIST: Let's write down the reasons people told you no.

Over the next few minutes, they discussed each rejection, and Deven wrote the following summary:

> Jamal already had plans to see the movie with his girlfriend.
>
> The other guy doesn't like that kind of movie, and we don't really know each other.
>
> Maybe 7 A.M. is too early for her, or she doesn't like to walk (I don't really know, but she was friendly when I asked, and an observer watching us probably wouldn't think it looked like a rejection).
>
> Truly busy or maybe a solid no, can't be sure.
>
> Mexico trip might not be what my cousin wants to spend money on.

THERAPIST: OK. How many of those times you were told no have to do with you, how many have to do with other people or circumstances, and how many are unknowns?

DEVEN: The movie ones don't seem to have anything to do with me. I'm not really sure about my neighbor or my cousin.

THERAPIST: Hmmm. What do you make of that?

DEVEN: People can say no for reasons that have nothing to do with me.

THERAPIST: (*Writing down what Deven is saying*) That seems important. Anything else?

DEVEN: Well, like we talked about, sometimes the timing of what you ask can make a difference. Some people don't like to walk at 7 A.M. And some people like to plan vacations more than a few weeks in advance.

THERAPIST: (*Writes so Deven can see it, "The timing of what you ask can make a difference."*)

DEVEN: (*Leaning in to look at the summary his therapist is writing*) That's about it.

THERAPIST: How much do you believe these two ideas?

DEVEN: I believe people can say no for reasons that have nothing to do with me about 95%. And I believe the timing can make a difference about 80%.

THERAPIST: Does that affect how certain you are about the conclusion you wrote on your worksheet, "No one wants to do anything with me"?

DEVEN: I guess I can't know that for sure right now, because there were other reasons for the movie, and the timing might have been wrong for one or two of the other things I tried.

THERAPIST: Can you think of a way you could plan some additional experiments and take these new ideas you figured out today into account?

DEVEN: I guess I would need to adjust the timing.

THERAPIST: How could you do that?

DEVEN: Well, instead of asking someone to do something on a particular day, I could ask them if they would like to do it sometime. Then, if they say yes, I could ask them when they would be able to do it with me.

THERAPIST: That sounds like a good idea. Why don't you write that in your therapy notes?

DEVEN: (*After writing his first idea down*) Maybe if they say no or they have other plans, I could ask them, "Do you ever want to do anything with me or not?" Just so I know.

THERAPIST: That would certainly help, you know. However, I think if you said it that strongly to me, I might feel a bit pinned in a corner. Can you think of a way to say it that gives people more of a chance to say yes or no without putting it so strongly?

DEVEN: What about "That's OK if you have other plans this weekend. Do you have another time we could do something, or are you too busy to do things with me all the time?"

THERAPIST: (*Writing down what Deven has asked*) When you say it that way, it would feel easier for me to answer. I'm wondering how you are feeling inside when you ask that.

DEVEN: Nervous. And a little mad if they say they never want to do anything with me.

THERAPIST: Yes, you even sounded a little mad to me when you asked it. Can you think of a way to think about this that makes you feel more relaxed while asking the question?

DEVEN: Ummm . . . I guess it will let me know whether to keep trying with that person or not. And that would save me time.

THERAPIST: Does that feel like a good thing?

DEVEN: Yes.

THERAPIST: I've written here what you asked me. Why don't you look at this and try to ask me again? And keep in mind that either way I answer will be helpful for you.

DEVEN: OK. (*Glancing at the paper*) OK, so you have other plans this weekend. Is there another time you might want to do something, or would you rather we didn't?

THERAPIST: How did you feel asking that?

DEVEN: That felt better. It felt more like I wanted to know one way or the other. But I still feel a bit awkward asking that.

THERAPIST: Can you think of a better way to say it?

DEVEN: Maybe "OK, not this weekend. If you ever want to get together and do something, let me know. Here's my number."

THERAPIST: That sounded more relaxed. How did you feel?

DEVEN: That feels better. I think I sound a little desperate when I ask if they ever want to get together. It sounds more normal to say, "Call me if you want to do something."

THERAPIST: Why don't you write that down so you remember it? (*Waits while Deven writes.*) Is that what you'd like to practice this week?

DEVEN: Yeah.

THERAPIST: So you've come up with two ideas here (*pointing to Deven's handwritten therapy notes*). First, to leave the timing open and ask something like "Would you like to go to a movie sometime?" If they say yes, you can make a plan. If they say they are not sure they have the time, you are going to say something like "If you ever want to get together, call me. Here's my number." Is that right?

DEVEN: Exactly.

THERAPIST: OK. Let's set this new way up as an experiment and make some predictions.

FOUR STAGES OF SOCRATIC DIALOGUE

Deven's therapist systematically helped him unravel the outcomes of his behavioral experiments so he could learn helpful ideas from them. Rather than either pointing out that he might be jumping to conclusions, or suggesting alternative ways of interpreting people's responses to his invitations, she followed the four stages of Socratic dialogue

described by Padesky (1993a). These four stages offer a useful template for debriefing behavioral experiments and other learning assignments your clients do between sessions. Socratic dialogue also provides a framework for testing beliefs in session. Let's recap how each stage occurred in this interview with Deven.

Stage 1. Informational Questions

Deven's therapist began by asking informational questions about what happened in his experiments. Informational questions should be driven by general curiosity and not by an intention to find flaws in the meanings or conclusions someone has made. Ask: "Who? What? Where? When? How long? What did you think/feel/experience? How did others react/look? What did they say?" Ask whatever questions seem relevant, so you can understand what happened and how your client experienced these events. Actively imagine what you client describes, so you can inquire about portions of the experience that the client might not spontaneously think to mention.

The sections of the interview in which Deven's therapist made these inquiries are not shown in the excerpt above. She asked him questions like these: "What was the look on your neighbor's face when you asked her to walk with you at 7 A.M.?" and "If I was watching you two from a distance, would it look to me like you were having a relaxed conversation, or like she was trying to get out of there as fast as possible?" Such questions need to be asked with genuine curiosity and expressions of your desire to fully understand your client's experiences.

Stage 2. Empathic Listening

As clients describe their experiences to you, listen with empathy. Deven's therapist made empathic statements such as "That certainly fits with your experiences this week," and "I'm sorry it turned out that way." She paired these statements with head nods, caring facial expressions, and smiles when smiling seemed appropriate. She also expressed caring later in the interview by giving Deven honest feedback that some of his proposed questions made her feel uncomfortable: "I think if you said it that strongly to me, I might feel a bit pinned in a corner." This gave him a chance to figure out ways

Four Stages of Socratic Dialogue
(Padesky, 1993a)

1. Informational questions
2. Empathic listening
3. Written summary
4. Analytical or synthesizing questions

to express himself that might have better social success. In addition to empathy, make sure your listening is accurate. Practice using a client's exact words when you take notes. Reflect back what clients say in their own words and images instead of paraphrased ones, to make sure you heard these accurately, and also to convey you are listening carefully.

It is not necessary to express empathy in the extreme or for long periods of time, unless emotional awareness is the therapy task of the moment and/or the person you are working with is actively keeping emotions at a distance. Expressions of empathy generally increase the emotion someone feels. If a client is already feeling an intense emotion, such as depression, severe anxiety, or shame, it is more therapeutic to pair a genuinely empathic statement with an action invitation. For example, if someone says, "I'm so desperately in pain I want to kill myself," expressing empathy alone (e.g., "I can hear your desperation. I'm so sorry you feel that way") can seem helpful in the moment. And yet repeated expressions of empathy alone can intensify the responses of a despondent person over time. Adding an action/learning component to your response changes everything: "I can hear your desperation. I'm so sorry you feel that way. Let's see what we can figure out together that might help ease your pain." *Pairing empathy with a commitment to some type of learning or action offers hope,* rather than simply underlining the client's emotional response.

Stage 3. Written Summary

As your clients answer your informational questions and you listen with empathy, keep a written summary of what they tell you, especially information that might help them find a way forward with their struggles. You can summarize clients' reactions, thoughts, observations, insights, or any other information. Again, whatever you record, be sure to use a client's exact words and images in writing the summary. If a client says, "My head was spinning," and you write, "You felt so confused," your summary can lack resonance for your client when you look at it together later. When summaries are written in clients' exact words, they can review and process them immediately without having to compare their experiences to the words written.

Deven's therapist actually asked *him* to write a summary of what they discussed about his various experiments. She took notes during their discussion, writing down his exact words. She read his words back to him as prompts when it came time for Deven to write summary statements. This process resulted in a summary in Deven's own handwriting. Ideas written in a client's own handwriting can seem more credible. Handwriting also provides a visual reminder that these were "my ideas."

Later in the interview, Deven's therapist gave an oral summary from her notes of what Deven had figured out:

> "So you've come up with two ideas here (*pointing to Deven's handwritten summary*). First, to leave the timing open and ask something like 'Would you like to go to a movie sometime?' If they say yes, you can make a plan. If they say they are not sure they have the time, you are going to say something like 'If you ever want to get together, call me. Here's my number.' Is that right?"

Once Deven agreed with this summary, it would be important for him to write it down in his therapy notes (either in the *MOM2* workbook itself or in a paper or electronic record of his sessions). Written summaries increase the likelihood that important ideas will be remembered and acted on in coming weeks.

Stage 4. Analytical or Synthesizing Questions

Written summaries also play an important role during the final stage of the Socratic dialogue process. Ultimately, the purpose of a Socratic dialogue is to help a client figure out new ideas, develop alternative beliefs, or apply what was discussed in the session to help themselves in the coming week(s). This can be hard to do if the details and nuances of a discussion have been forgotten. The written summary is something the client can look at when considering answers to your final questions, which Padesky (1993a) calls "synthesizing" or "analytical" questions.

Synthesizing questions guide clients to fit the information gathered in their summary with the issues being discussed in therapy. Common synthesizing questions include "What do you make of this summary?" and "How does what we have summarized here fit with your original belief?" After they reviewed his written summary of his experiments and the reasons each person said no, Deven's therapist asked him this synthesizing question:

> "Does that affect how certain you are about the conclusion you wrote on your worksheet, 'No one wants to do anything with me'?"

Analytical questions ask people to consider how to use what they have learned and summarized in session to make a helpful plan for the coming week(s). These questions help clients figure out next steps or new ways of thinking. The simplest analytical question is "How can you use these ideas and observations to help yourself this week?" Deven's therapist asked him this analytical question:

> "Can you think of a way you could plan some additional experiments and take these new ideas you figured out today into account?"

Clinical Tip

All four stages in Socratic dialogue are necessary. Without the foundation provided by informational questions, empathic listening, and written summaries, most clients won't find it easy to answer questions like "How does what we talked about today fit with your original beliefs?" or "How can you use what we have discussed this week to help yourself?"

Most therapists are familiar with asking informational questions and listening empathically. Helping your clients to make written summaries of what they have observed and learned, and asking analytical or synthesizing questions to help them apply their learning, are the signature stages of Socratic dialogue. These last two stages are designed to ensure that your clients discover and remember new ideas, and also to help them figure out how to use these ideas to make progress. As noted earlier in this chapter, when we tell our clients what to do, they often say, "Yes, that's a good idea, but . . ." When clients come up with ideas to help themselves, they are more likely to feel empowered and be willing to try those ideas out.

Behavioral Experiments, Socratic Dialogue, and Our "Two Minds"

The processes involved in setting up and conducting behavioral experiments, and then debriefing them with Socratic dialogue, facilitate communication between clients' "two minds." "Two minds" is a shorthand metaphor for the dual-process theory of cognition described by Epstein (1994), Kahneman (2013), and others. Epstein demonstrated in numerous studies that we all make decisions in our lives by using two mental systems: a fast, experiential thinking system that is subject to emotional and intuitive ("felt sense") processing; and a slower, more deliberate, rational thinking system that is capable of considering and weighing evidence.

The first, faster mental system is likely to prevail when the two minds are in conflict. For example, if we meet Barry and we get the impression in our first meeting that Barry is honest and kind (experiential thinking), and later someone tells us that Barry lied and took advantage of someone, most of us will discount the negative information in favor of our "felt sense" that Barry is a good man. We can think, "There is probably a good explanation for what Barry did, because he is honest and kind." It takes considerable mental work to change our minds about Barry, because we have to overcome our tendency to believe what our experiential minds tell us.

Underlying assumptions show characteristics of fast, experiential thinking. Imagine you have a client named Emma, who holds the underlying assumption "If I make a mistake, then people will think less of me." When Emma is in a social situation and makes a mistake, she immediately responds with embarrassment and avoids eye contact with others. She does not contemplate the various aspects of the situation or look to see how others are actually reacting. Instead, she quickly responds and acts as if her assumption is true. There are two ways to address Emma's belief in therapy. One way is to discuss the situation with her and look at the evidence to see if she might have jumped to conclusions. This could be helpful post hoc for this particular situation. However, the next time she makes a mistake, Emma is likely to react according to her original assumption.

A second way to address her belief is to set up a series of behavioral experiments in which you and Emma predict what will happen if her assumption is true and what will happen if it is not true. After Emma does these experiments, you can debrief these together—engaging her slower, analytical mind, and paying particular attention to unexpected results. Over time, if Emma's experience does not match what is predicted by her original underlying assumption, she will develop a new underlying assumption

that is believed by both her experiential and analytical minds. The experiential mind must be convinced that a new underlying assumption is "true" in a felt sense before it will guide her reactions. This is only possible if Emma has "walked" and experienced the assumption in action as much as she has "talked" about it.

Thus one way to understand the power of behavioral experiments for shifting beliefs and supporting behavior change is that they facilitate communication between a client's experiential and analytic minds. The active components of behavioral experiments are necessary to engage and influence a client's experiential mind; the analytic mind is involved when you and the client debrief experiments, extracting as much learning as possible from them (Padesky, 2004a). When you conduct behavioral experiments, make efforts to engage both your client's experiential and analytic minds. Keep in mind that behavioral experiments have the greatest impact when they are collaboratively devised, conducted with genuine curiosity, and debriefed as both you and the client keep an open mind. Although many clients begin this process with skepticism, clinicians increase the credibility of behavioral experiments when they model the qualities of collaboration, curiosity, and open mindedness throughout the process.

DEVELOPING AND STRENGTHENING NEW UNDERLYING ASSUMPTIONS

When behavioral experiments do not support the underlying assumptions you and a client have tested, help your client develop new underlying assumptions. New underlying assumptions often emerge from summary statements that describe what was learned from the experiments. These new assumptions are often more nuanced than the old assumptions. Rather than stating broad undifferentiated rules, new assumptions sometimes lay out a variety of rules that cover various circumstances. For example, after a few weeks of additional experiments, Deven wrote the following assumptions that fit his experiences:

> If I allow flexibility in timing, then some people I invite to do things will agree.
>
> If people don't agree to do things with me, it is often because of factors that have nothing to do with me.
>
> If people agree to do things with me once, then this is a chance to see if we like each other enough to do more things together.
>
> If I do things with others, I don't always want to do things with them again. This does not mean there is anything wrong with them. Not all people are compatible.
>
> Therefore, if other people don't want to do more things with me after the first time, then this does not mean there is anything wrong with me. We are probably just not compatible.

These new assumptions increased Deven's willingness to continue asking people to do things with him. Even after clients develop new underlying assumptions, it is important

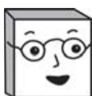
for them to continue doing experiments until they have a high degree of confidence in their new assumptions.

Benefits of New Underlying Assumptions

Many benefits follow the development of new underlying assumptions, because these beliefs guide people's behaviors, emotional responses, and interpersonal interactions. Consider Deven's new underlying assumptions, summarized above. His new assumptions made it possible for him to continue asking people to do things with him even when the majority of times he was told no. They also helped Deven modulate his mood reactions to hearing people say no, and to potential friendship loss when people showed little interest in continuing their interactions with him. His new assumptions helped him approach new people in a more exploratory fashion, because they framed social encounters as "a chance to see if we like each other enough to do more things together." When you focus on the underlying assumptions that maintain clients' distressing moods and behaviors, new assumptions also help build a robust platform for relapse management.

An Alternative Approach: Acting "As If" New Assumptions Are True

Sometimes an alternative approach can be followed for developing new underlying assumptions. Mooney and Padesky (2000) have developed a model for directly constructing and testing new assumptions that sidesteps testing old assumptions. Their approach is designed to elicit client creativity and focus on possibilities rather than



Reminder Box

Underlying assumptions are rules and beliefs that guide people's emotional reactions, behaviors, and interpersonal patterns. As such, they provide a rich lode of beliefs to explore in therapy, especially when your clients experience and want to change persistent reactions or behaviors. Behavioral experiments are the ideal intervention for testing underlying assumptions. Such experiments can yield unexpected findings and reveal new paths for change, especially when they are designed collaboratively and debriefed with curiosity and an open-minded willingness to learn from whatever occurs. Ultimately, identifying new underlying assumptions and conducting ongoing experiments to refine their application can lead to more adaptive ways of living and more positive well-being.

Encourage your clients to continue doing experiments until they have a high degree of confidence in their new underlying assumptions. New assumptions help build a robust platform for relapse management when you focus on the assumptions that maintain distressing moods and behaviors.

existing problems. It includes methods similar to those proposed by George Kelly in the 1950s as part of personal construct theory (Kelly, 1955a/1991a, 1955b/1991b). Mooney and Padesky suggest that when clients are motivated to change behaviors or emotional responses but have difficulty doing so, therapists can begin by identifying the existing underlying assumptions that maintain the clients' current reactions, following the guidelines presented earlier in this chapter.

Next, they propose that therapists help clients identify new emotional and behavioral possibilities they would like to achieve. These new possibilities are elaborated in great detail in their approach. For example, Deven could imagine that he wanted to approach people with a smile and bounce in his step. He would be prompted to notice how this would feel in his body. His imagination could lead him to notice an open feeling in his chest related to new possibilities, and a calm feeling in his stomach linked to feeling secure in his own likability, regardless of someone's responses to him. His therapist would prompt him to recall any memories of feeling this way in the past, and to generate personally meaningful memories that could bring these feelings to the fore quickly when he wanted to recapture them. For example, Deven might recall feeling this way when playing certain video games, and liken this experience to "I'm a lead character with a lot of lives built up, so I will survive no matter what happens."

Then therapists can ask, "What new underlying assumptions would you need to believe in order to make this possible?" If clients have difficulty generating these, Mooney and Padesky (2000) suggest asking them to identify someone they know (in real life or fiction) who lives their lives in the desired ways. A therapist can ask, "What underlying assumptions do you imagine this person must believe in order to respond in those ways?" Following these steps, Mooney and Padesky collaborate with clients to design behavioral experiments that directly evaluate the new underlying assumptions instead of testing the old ones. These experiments are usually designed with the requirement that the clients will act "as if" the new assumptions are true and see what happens (see Padesky, 2004b, for a video demonstration of this approach; see also Appendix C, p. 463). Predictions for these experiments are made from the perspectives of both the old and new assumptions, to see which fit the outcomes of these experiments most closely. The behavioral experiments worksheet (Worksheet 11.2, *MOM2,* p. 149) also can be used to record the outcomes of experiments within this approach.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 11

This Troubleshooting Guide begins with therapist roadblocks, and ends with common client underlying assumptions and helpful behavioral experiments to test them.

Therapist Roadblocks: Underlying Assumptions and Behavioral Experiments

Generally, people are quite interested in carrying out behavioral experiments when the guidelines offered in this chapter are followed. Therefore, when roadblocks arise

regarding underlying assumptions and behavioral experiments, it is sometimes due to some shortcoming in how these are presented and operationalized. The following sections describe a few of the most common difficulties, as well as client clues that these are present.

Therapist Disinterest: Clients React with Disinterest

Any therapy task that is approached academically or intellectually, with little expressed interest on a therapist's part, is likely to fall flat. Therapists' curiosity and animated interest in clients' underlying assumptions are often necessary to spark the clients' interest. Imagine your responses if you are Therapist A's or Therapist B's client.

Therapist A: (*Gives a long explanation of what underlying assumptions are and how they link to automatic thoughts. Then*:) Take your *MOM2* home and try to figure out your underlying assumptions this week, using Worksheet 11.1.

Therapist B: That's really interesting that you have tried to change this behavior. You want to change this behavior, and yet you have not been able to do it. I have a hunch that might help us. Usually when we keep doing the same thing, it is because we are operating according to hidden rules that guide us. If we can figure out what your hidden rules are, maybe we can make a real difference in your life. For example, it's almost like you keep doing the same thing because you have a rule like this: "If I keep doing *X,* then . . ." What do you hope will happen? What's the best you can imagine? And, "If I don't do *X,* then . . ." What are you afraid might happen?

Which therapist captures your interest more? Most people will probably respond with greater interest to Therapist B, who appears energized and curious, links identification of underlying assumptions to figuring out and helping a problem that has been a struggle, and is ready to work actively with them to begin identifying underlying assumptions. Therapists who bring curiosity to every session and set up learning experiences within the session are much more likely to spark interest in their clients than therapists who spend time teaching abstract ideas and then send clients home to figure out the next steps.

Client Disinterest: Are the Identified Underlying Assumptions the Most Important?

If you've expressed curiosity and interest, and yet your clients appear disinterested in either the underlying assumptions you've identified and/or in doing behavioral experiments to test them, then it is possible you are working on assumptions that aren't central to your clients' concerns. For example, Catherine was highly anxious and wanted to feel better. She was also perfectionistic, and her therapist thought Catherine would feel less anxiety if she relaxed her expectations of herself. He helped her identify this underlying

assumption: "If it's not perfect, then I can't be happy with my performance." Catherine showed little interest in devising experiments to test this assumption, telling him, "I don't want to do things in a lesser way."

Her therapist's error was not linking her underlying assumption to Catherine's anxiety, which was her main concern. Once he realized this, he helped Catherine identify this pair of assumptions: "If I focus on perfection, then I feel more anxious and actually perform more badly than I am capable of," and "If I don't focus on perfection and instead focus on doing my best to a good enough quality, then I will feel less anxious and could actually perform better." Catherine was highly intrigued by these ideas and participated actively in designing behavioral experiments to see whether these underlying assumptions fit her experience.

Experiments Not Helpful: Include Both the "If . . ." and "Then . . . "

Sometimes behavioral experiments don't lead to clear or convincing information related to the original underlying assumption. This is usually because the experiments are not set up as a clear test of the assumption. In order to reduce the likelihood of muddled outcomes, it is important to devise experiments that include both the "If . . ." and "then . . ." parts of the belief. For example, imagine that Gia has this underlying assumption: "If something goes wrong, then I won't be able to cope." Which of the following behavioral experiments are adequate tests of this belief?

1. Have Gia survey other people and see how often they are able to cope with things going wrong.
2. Ask Gia to do five things wrong and see if bad things happen.
3. Make a list of things that have gone wrong in Gia's life that she no longer thinks about.
4. Make a list of things that have gone wrong in Gia's life, and ask her to rate how well she coped with each.
5. When things go wrong in the coming week, have Gia rate how confident she is in her coping.
6. Have Gia plan things to go wrong (e.g., ask her to leave an ingredient out of a recipe), and then ask her to rate how well she is able to cope.

Although each of these experiments has interesting aspects, only two of these experiments actually qualify as clear tests of Gia's underlying assumption. Before reading on, see if you can choose the best two experiments.

Our analysis of these experiments is as follows. Experiment 1 is irrelevant as a direct test, because it does not matter how other people cope. Gia may already believe that others cope better than she does. Experiment 2 is also off track, because Gia's belief is not whether bad things happen when she does something wrong; instead, she is concerned with how well she can cope when something goes wrong. Experiment 3 might seem relevant, but it really does not directly test Gia's coping when things go

wrong. Experiment 4 is a potentially helpful experiment, because it both includes the "If . . ." part of Gia's belief (things going wrong) and asks her if the "then . . ." occurred. Examination of various historical circumstances could reveal a variety of useful information. For example, maybe Gia coped well from the start with certain challenging circumstances, or maybe she "fell apart" in the face of some difficulties and was able to cope better over time. Experiment 5 is less helpful, in that we could predict (given her underlying assumption) that her confidence in her coping will be low. What is more important than her confidence in her coping is her actual coping. Thus Experiment 6 is a good experiment, because she is planning ways to make things go wrong and rating how well she is able to cope. This is a direct test of her belief. So Experiments 4 and 6 seem the best ones in this list.

This example with Gia also highlights that we can optimize the usefulness of experiments by defining terms with our clients. We need to know what sort of things qualify as "going wrong" for Gia. It also helps to define what she means by "coping." For example, if Gia drops a pitcher of syrup and it breaks and she cries, and then she cleans up the mess, is that good coping or not? People vary greatly in their definitions of hazards, outcomes, and coping. Sometimes, modifying those definitions leads to new underlying assumptions. If Gia thinks that good coping is devoid of emotional response, she might do a survey with people she considers good copers and find out if any of them express emotion (e.g., tears, swearing) when things go wrong in their lives. If they do, it can be helpful for her to find out their underlying assumptions about emotional reactions or coping and to compare these with her own.

Common Underlying Assumptions and Behavioral Experiments to Test Them

Perfectionistic Beliefs

Beliefs related to perfectionism are among the most common underlying assumptions linked to anxiety, as well as to depression relapse (Bieling & Antony, 2003). Many types of behavioral experiments can test perfectionistic assumptions. You can use any of the three basic types of experiments illustrated in *MOM2* Chapter 11. Consider the perfectionistic belief "If it's not perfect, then it has no value." For Experiment 1 (*MOM2,* pp. 142–143), clients can intentionally do a few small tasks imperfectly and rate whether there is any value in the outcomes. Since perfectionism tends to be "all or nothing," it is worthwhile to rate value on a 0–10 scale.

It is also helpful to ask others to rate the value if clients can identify people whose opinion they respect. The example for Experiment 2 described in Chapter 11 of *MOM2* (pp. 143–145) pertains to perfectionism and provides a template for that type of experiment.

For clients who worry that chaos or disaster will follow imperfection, Experiment 3 in Chapter 11 of *MOM2* (pp. 143–147) is often helpful. For Experiment 3, the client conducts experiments to see if small and then larger versions of imperfection lead to disaster or chaos. It is easier for people who are perfectionistic to do experiments in "small" areas of their lives, where the predicted disasters are less catastrophic. For

example, one woman predicted that if she did not immediately remove laundry from the dryer, her children's clothes would be wrinkled, and then she would need to iron everything. She was surprised that her young sons were delighted when they helped her remove lightly wrinkled clothes from the dryer. They insisted on being allowed to wear them "as is" because they matched their friends' attire. Once small tests of imperfection lead to new learning, clients generally are more willing to do experiments involving higher degrees of imperfection.

There are many additional types of experiments that can be done to test perfectionistic assumptions, such as evaluating them in terms of the advantages and disadvantages of holding perfectionistic versus nonperfectionistic standards. People can survey others about their beliefs, values, and evaluations of situations or even perfectionism itself. You and your clients can construct surveys for trusted others to administer to relevant people (e.g., young single women, middle-aged retirees, refugee children) when your clients are too embarrassed or the risk seems too high for them to do this polling on their own. For an excellent review of creative behavioral experiments, see Bennett-Levy et al. (2004).

Underlying Assumptions about Relationships

For many people, distress is triggered and maintained by underlying assumptions about relationships, such as the following:

"If someone doesn't like me or want to be in a relationship with me, then I am unlovable."
"If I can't be with *X,* then I'm doomed to a lifetime of unhappiness."
"If I'm not attractive in *Y* ways [e.g., beauty, wealth, ability], then no one will want to be with me."

People who hold these types of assumptions can become depressed when they have difficulty making friends or finding a romantic partner, or when a relationship ends. They can become anxious in social situations. Some even feel shame about their perceived deficits. Even minor criticism or not being invited to an event can exacerbate distressed moods when such assumptions are present. People who hold these beliefs sometimes experience an immediate remission of their distress if they meet someone and begin a new relationship. This can be a sign of vulnerability for relapse, because as long as these underlying assumptions are in place, there is a high likelihood of relapse if their new relationship is not long-lasting.

Underlying assumptions about relationships can be tested with behavioral experiments. Sometimes such experiments can appear difficult to do, since the "If . . ." part of these assumptions often has to do with other people's behavior or emotional responses to a client. In these instances, consider perspective-switching experiments. For example, the assumption "If someone doesn't like me or want to be in a relationship with me, then that means I'm unlovable" can be tested by identifying people with whom the client does not want to be in a relationship and seeing if the client judges these people as unlovable. Further discussions can explore why people are attracted to some

people and not to others. Ask your client to think of other people they know who have had relationships end, and to consider whether these people are unlovable. It can also be fruitful for the client (or someone the client trusts) to conduct surveys asking people what qualities they look for in a partner, and whether they would be willing to be friends or partners with someone who lacked some of these qualities. If you are collecting the survey results for your client, it is helpful to audio-record answers from the people you interview. Clients are likely to give greater credibility to opinions they hear spoken aloud.

For assumptions about the impossibility of happiness unless a certain relationship develops or continues, prompt a client to recall times the client felt happy prior to the relationship that is either ending or out of reach. Of course, if an important relationship has recently ended, people need time and support to grieve for their loss. After grieving a while, it will be important for them to resume activities (solo or social) that are likely to boost their mood. This is a good time to resume a focus on their underlying assumptions.

Avoidance of Behavioral Experiments That Feel "Dangerous"

There are many circumstances in which people avoid doing behavioral experiments because the experiments feel "dangerous." For example, people who experience anxiety can sincerely believe that it is dangerous to approach rather than avoid their fears. People diagnosed with personality disorders hold underlying assumptions that are designed to keep them safe and that, at the same time, maintain maladaptive interpersonal strategies. For example, is it adaptive or maladaptive for someone to be suspicious of others, in the context of the conviction "If I'm not always on my guard, then others will use or manipulate me"? Dependent behaviors look like sensible coping strategies when someone believes "I am weak and vulnerable. Others are stronger and can protect me."

Even though behavioral experiments offer ideal methods for testing these types of beliefs, safety-related underlying assumptions often interfere. Gary and his therapist planned a series of behavioral experiments to test a new underlying assumption: "I'm safe even if I express my honest opinions." Gary had decided his first experiment would be to express irritation to his wife, Lin. Gary initially avoided this behavioral experiment, because he felt anxious when he started to think about expressing something that might upset Lin. He still believed, "If I express my honest opinions, then that is dangerous [Lin will become angry, and I can't handle that]." Gary's therapist helped him overcome reluctance to complete this behavioral experiment.

GARY: I didn't really say what I felt this week, like we talked about last week.

THERAPIST: Did you forget to do this or decide not to?

GARY: I sort of decided not to.

THERAPIST: What thoughts and feelings led to that decision?

GARY: Well, I felt scared. I thought it was too risky.

THERAPIST: Give me an example of a time that felt too risky this week.

GARY: I was irritated with Lin on Saturday, and I thought about telling her to back off and leave me alone for a while. But I was afraid she'd get mad and it would be bad for me.

THERAPIST: So what did you do?

GARY: I just worked on my car and turned up the radio so she couldn't talk to me.

THERAPIST: And how did that work out for you?

GARY: I felt mad the whole time and kept yelling at her in my head. Later she came out to talk to me, and I was sort of cold to her, and she got mad.

THERAPIST: So your old behavior strategy didn't really protect you from Lin's anger?

GARY: No.

THERAPIST: And yet saying what you felt in the beginning might have led to Lin's getting angry, too.

GARY: I think so.

THERAPIST: So maybe we need to plan one step beyond this experiment.

GARY: What do you mean?

THERAPIST: Do you think it would help if you had a plan for what to do if Lin gets mad when you tell her how you feel?

GARY: Yeah. I don't really do anything when she gets mad, but maybe walk away or sometimes call her a name and then walk away.

THERAPIST: There's a worksheet in *Mind Over Mood* that could help. Let's find it and give it a try. (*Turns to Worksheet 11.2, Experiments to Test an Underlying Assumption, MOM2, p. 149.*)

GARY: OK.

THERAPIST: Let's write the assumption we're testing at the top of the worksheet.

GARY: (*Writes, "I'm safe even if I tell Lin what I feel."*)

THERAPIST: In the columns, you can write your experiment—that's what you're going to do—your prediction of what will happen, and possible problems that might come up. Let's do that for Saturday, just as an example.

GARY: So for "Experiment," I could write, "Tell Lin to back off."

THERAPIST: That's right. We can role-play later some different ways you could say that to her. And what was your prediction of what would happen if you did this experiment?

GARY: She'd get mad.

THERAPIST: Anything else?

GARY: We'd have a big fight.

THERAPIST: Anything else?

GARY: She'd want to split up.

THERAPIST: Anything else?

GARY: No, that's enough!

THERAPIST: OK, write those three predictions down: "Lin will get mad, we'll have a big fight, and she'll want to split up."

GARY: (*Writing*) This is where I get stuck. I don't know what to write where it says "Strategies to overcome these problems."

THERAPIST: Let's talk about some strategies. I bet you'll have a tough time doing these experiments until you have a plan for how to handle problems that could come up as a result.

GARY: When she gets mad, I just freeze, or else I explode.

THERAPIST: Do you know anyone who handles it well when someone gets mad at them?

GARY: Actually, Lin does pretty good. She makes sales calls, and customers get mad at her all the time.

THERAPIST: What does Lin do to handle it when people get mad at her?

GARY: She listens and says, "I didn't mean to make you mad," and says, "I understand," and says things like "This doesn't seem to be a good time to talk." I don't hear what they are saying because she's on the phone, but that's what I hear her say.

THERAPIST: Do you think any of those comments would help you if Lin gets mad at you?

GARY: Maybe. I could say, "Maybe we should talk later."

THERAPIST: Let's write that down. (*Pauses while Gary writes.*) That might be a useful strategy if your fight seems to be getting out of hand, but I'm not sure that's the best place to start, because it sounds a little like avoiding talking to her about your feelings.

GARY: That's why it seems so good! (*Laughs*) Maybe I could say I don't want her to be mad.

THERAPIST: OK. And what do you want from her?

GARY: I want her to listen and understand why I'm upset.

THERAPIST: Do you think that would be a good thing to say to her? (*Gary nods.*) Why don't you write that down, too?

Gary and his therapist continued brainstorming responses he could make if Lin expressed anger, then strategies for defusing a big fight, and finally things Gary could do to prevent a break-up. Gary wrote down several strategies to overcome each potential problem. After completing the first four columns of Worksheet 11.2, Gary and his therapist role-played various problem situations and his planned responses. At first Gary hesitated to respond to Lin (as role-played by the therapist). His therapist coached Gary through a number of role plays until Gary felt pretty confident that he could be assertive in the face of Lin's anger.

As this example illustrates, common reasons why clients do not follow through on

behavioral experiments include predictions of intense emotions, hopelessness beliefs, negative predictions about outcomes, and inadequate knowledge or skills to respond to problems that might arise. To support your clients so they can successfully complete experiments that address maladaptive assumptions and behavior patterns, (1) identify roadblocks and possible problems; (2) devise strategies for overcoming these; and (3) practice new strategies in sessions until your clients gain skills and the confidence to use them.

8

New Core Beliefs, Gratitude, and Acts of Kindness

(*MOM2* CHAPTER 12)

We need to uncover core beliefs because those are most important.
—*Therapist 1*

Working with core beliefs is optional.
—*Therapist 2*

Which of these therapists is correct? This chapter of the clinician's guide explains why Therapist 2 is correct that most people never need to target core beliefs at all to improve their moods and change their behavior. This idea is emphasized on the opening page of Chapter 12 in *MOM2*:

> Many people notice a big mood improvement once they integrate and apply the skills taught in the mood chapters (Chapters 13–15) and the earlier chapters of this book (Chapters 1–11). . . . If this has been the case for you, this current chapter is optional. Even if you decide you do not need to complete this entire chapter, you may still find it interesting to read and complete the sections later in the chapter on gratitude and acts of kindness . . . because these sections teach ways to boost your positive moods. (p. 152)

Thus the introduction to Chapter 12 encourages most readers to skip the sections on core beliefs and jump ahead to learn more about gratitude and kindness at the end of this chapter.

As you study this clinician's guide to learn best practices for *MOM2*'s use in therapy, you are welcome to follow the same guidelines. If gratitude journals and acts of kindness interest you more than core beliefs do, feel free to move ahead to that section of this chapter now. If you want to learn more about core beliefs and when/how to

Chapter 12 Summary

(*MOM2,* pp. 152–187)

- ✓ If you are still struggling with your moods after practice with thought records (Chapters 6–9), Action Plans (Chapter 10), and behavioral experiments (Chapter 11), then you may need to identify and work with core beliefs.
- ✓ Core beliefs are all-or-nothing statements about ourselves, other people, or the world.
- ✓ Core beliefs are the roots of our underlying assumptions and automatic thoughts.
- ✓ Core beliefs come in pairs. When we have negative core beliefs that are active most of the time, it is helpful to identify and strengthen new positive core beliefs.
- ✓ Core beliefs can be identified either by using the downward arrow technique or by completing the sentences "I am . . . ," "Other people are . . . ," and "The world is . . .".
- ✓ New positive core beliefs can be strengthened by recording experiences that are consistent with the new core belief, rating your confidence in your new belief, rating behaviors linked to the new core beliefs, and conducting behavioral experiments to try out the new belief.
- ✓ Core beliefs shift gradually, but over time they become stronger and more stable, and they exert a powerful influence over the way we think, behave, and feel.
- ✓ Keeping a gratitude journal and expressing gratitude can strengthen our positive core beliefs and lead to greater happiness.
- ✓ Performing acts of kindness can increase our happiness and improve our relationships.

address these in therapy, continue reading the sections immediately following. In either case, first skim the Chapter 12 Summary as a quick overview of all the learning points included in that chapter of *MOM2*.

WHY DOESN'T EVERYONE NEED TO WORK WITH CORE BELIEFS?

Chapter 12 is the only chapter in *MOM2* that addresses core beliefs, and it is the last skills chapter most people are likely to read before they begin working on relapse management (Chapter 16). Like Therapist 1 above, therapists who have been taught that core beliefs are central to our understanding of psychological struggles may be surprised by this reading order. Why are core beliefs not an early intervention target? Why isn't it necessary for everyone to address core beliefs? Consider these three rationales.

1. As described in Chapter 2 of this clinician's guide, three levels of thought are addressed in *MOM2*: automatic thoughts, underlying assumptions, and core beliefs. These three levels of thought are connected to each other. Core beliefs are absolute and dichotomous beliefs (e.g., "People are cruel" or "People are kind"). Underlying assumptions are conditional beliefs linked to these core beliefs (e.g., "If I reveal any weaknesses, then people will [cruelly] take advantage of me," or "If I reveal weaknesses, then people will [kindly] understand"). Automatic thoughts are moment-to-moment thoughts we all have in various situations that reflect these deeper beliefs (e.g., "Customer service will turn me down without a receipt," or "Customer service will probably help me even without a receipt"). Because of the interconnectedness among these three levels, when people learn to identify, test, and change their automatic thoughts and underlying assumptions, their core beliefs usually begin to shift as well.

2. Core beliefs come in pairs. People don't believe either "I'm unlovable" or "I'm lovable." They have the capacity to believe both "I'm unlovable" and "I'm lovable." We can believe both that "People are cruel" and that "People are kind." Generally, only one core belief of these pairs is activated in any moment. When we experience an intense mood, core beliefs congruent with that mood are activated. Thus, when we are depressed, negative core beliefs about ourselves, our lives, and our future are active, and more positive core beliefs lie dormant. When we are anxious, core beliefs linked to danger and personal vulnerability are activated (e.g., "Bad things will happen," "I'm weak; I can't handle this"). When we are angry, core beliefs about unfairness and threat are activated (e.g., "People take advantage of me," "The world is threatening").

Similarly, as moods lift and behavioral improvements are achieved, more positive core beliefs come to the fore, and the negative ones recede. For example, people who believe "I'm a complete failure" when they are depressed will naturally shift to a core belief "I'm as successful as the next person" when their depression remits and they feel happier again. Thus, even without a direct focus on core beliefs, core beliefs naturally shift to the more positive belief of the pair as people improve in therapy.

3. One study showed that when depressed clients did assignments outside of therapy sessions that focused on core beliefs, their depression actually got worse (Hawley et al., 2017). In contrast, when they practiced skills related to behavioral activation (*MOM2* Chapter 13) or completed 7-Column Thought Records (*MOM2* Chapters 6–9), their depression scores significantly improved. This study offers a cautionary note that there may be a danger in focusing on core beliefs when moods are still highly active; early emphasis on these beliefs in therapy can lead symptoms to worsen instead of improve.

For these reasons, Chapter 12 of *MOM2* begins with two pages of encouragement for people to spend the necessary time to fully develop the skills they've learned elsewhere in the workbook before spending any time on core beliefs. Behavioral experiments, 7-Column Thought Records, Action Plans, acceptance, and other mood management tools and skills taught throughout *MOM2* are likely to provide the most rapid path to improvement for most people. Once they have experienced some improvement and feel better, some people will find it helpful or interesting to learn about core beliefs,

especially if some of their struggles have been long-standing and if negative core beliefs continue to be at the forefront even when their mood is improved.

WHO IS LIKELY TO BENEFIT FROM WORK ON CORE BELIEFS?

Anyone whose maladaptive core beliefs persist even after their presenting issues have resolved is a good candidate for work on core beliefs. Persistent maladaptive core beliefs are more likely to be experienced by people who have experienced chronic mood or behavior problems, and also by those who meet criteria for personality disorder diagnoses.

Chronic or Long-Standing Mood Issues

People with chronic histories of depression, anxiety, anger, guilt, and shame often have developed core beliefs that maintain mild to moderate levels of these moods even when their most intense moods lift. When distressing moods are chronic, there are limited times in someone's life when more positive core beliefs are active. Over time, negative core beliefs become more practiced and familiar, and more positive core beliefs are not activated often enough to feel as "true" to the person. Marissa and Vic are the major character case examples in *MOM2* who best fit this pattern. Some of their core beliefs are described on pages 156–157 of *MOM2*.

Chronic or Long-Standing Behavioral Issues

People who have long-standing behavioral issues such as substance misuse, eating disorders, or conflict avoidance can sometimes benefit from a focus on core beliefs after their primary issues improve. Keep in mind that maladaptive behavioral patterns are directly maintained by underlying assumptions (e.g., "If I have an urge to take a drug, then I need to take it or the urge will get worse and overwhelm me," or "If someone mistreats me, then I need to hit back hard or I will look weak"), and so the use of behavioral experiments as described in Chapter 7 of this clinician's guide is the first line of intervention for these issues. However, some people benefit from addressing negative core beliefs even after they develop new underlying assumptions and behaviors. For example, a woman who overcame ten years of bulimic bingeing and purging found that she could not celebrate her success, because negative core beliefs about herself ("I'm bad") and others ("Others will hurt me") still weighed on her every day.

Concurrent Personality Disorder Diagnoses

Nearly half of all people coming to therapy for treatment of depression and anxiety have concurrent personality disorder diagnoses (Morrison, Bradley, & Westen, 2003; Shafran et al., 2009). Despite researchers' expectations, a number of studies have shown that people with concurrent personality disorder diagnoses show improvements in CBT for presenting mood issues and behavioral change goals similar to those achieved by clients

without personality disorder diagnoses (DeRubeis et al., 2005; Dreessen & Arntz, 1998; Dreessen, Hoekstra, & Arntz, 1997; Grilo et al., 2007; Rowe et al., 2008; Weertman, Arntz, Schouten, & Dreessen, 2005). Therefore, it is reasonable to follow the treatment approaches described throughout this clinician's guide even when clients meet criteria for personality disorders. When personality disorder comorbidity is present, the main therapy differences are that progress is sometimes slower, and that it can be necessary to pay extra attention to the therapy relationship. With these clients, therapy is more likely to be successful when therapists notice and attend to therapy ruptures as quickly as possible. As with all clients, clinicians also need to spend as much time on skills as necessary to build proficiency. The Troubleshooting Guide at the end of this chapter includes more specific information about therapy modifications that are sometimes required with clients diagnosed with personality disorders.

Primary Treatment of Personality Disorders

Some clinicians use *MOM2* as part of treatment for a personality disorder diagnosis itself. In this case, therapy is likely to include work with core beliefs. The interpersonal difficulties that characterize personality disorders are often maintained by a few negative core beliefs (Padesky, 1994; Beck, Davis, & Freeman, 2015), along with associated underlying assumptions. Cognitive theory hypothesizes that core beliefs (also known as schemas) are formed in response to developmental circumstances (e.g., growing up experiencing other people as manipulative or harmful) and/or biological influences rather than from gross distortions of experience. Most people develop both positive and negative core beliefs regarding the self (e.g., "I'm competent," "I'm incompetent"), others (e.g., "People can be trusted," "People can't be trusted"), and the world (e.g., "The world is overwhelming," "The world is manageable"). As described previously, these core beliefs are differentially activated according to mood. Various factors in addition to mood can trigger emergence of particular core beliefs, including situational circumstances (e.g., in a dangerous place, core beliefs regarding vulnerability emerge), recent life events (e.g., following trauma, core beliefs related to vulnerability and mistrust can emerge), and even biology (e.g., physiological activation, fatigue, and illness can influence activation of core beliefs).

According to cognitive theory, people who meet criteria for personality disorders often hold negative core beliefs in relevant domains without possessing well-developed paired positive core beliefs (Padesky, 1994; Beck et al., 2015). When one core belief in a pair is missing or weak, people maintain fixed views regardless of mood, circumstance, life events, or biological state. For example, a man diagnosed with dependent personality disorder saw himself as weak even after a personal mastery experience. A woman diagnosed with avoidant personality disorder viewed herself as inadequate even when she was valued as a mother by her children, loved by her husband, and regularly promoted in her job. Although negative core beliefs are not necessarily the cause of personality disorders, they serve a powerful maintenance function (Padesky, 1994).

Negative core beliefs can affect the therapy relationship and lead to relationship difficulties (e.g., "I can't trust anyone. You'll hurt me, too"). Negative core beliefs can

interfere with someone's ability to recognize progress (e.g., "Oh, sure, I was promoted in my job, but that's just because my boss doesn't see how incompetent I really am"), accept positive feedback (e.g., "You have to say that because you're my therapist"), or learn from setbacks (e.g., "Of course it didn't work out. I'm no good. There's no reason to problem-solve and try again").

Beck and his colleagues (2015) specify core beliefs that appear to maintain each of the personality disorders, and they articulate treatment plans for each. Cognitive therapy of personality disorders involves using the therapy relationship as a "schema laboratory" in which a client can safely evaluate maladaptive core beliefs. The developmental origins of core beliefs are explored, so that the client can understand the circumstances under which negative core beliefs can be adaptive and learn to recognize when life circumstances allow alternative core beliefs to be safely held. Their therapy hinges on weakening clients' conviction that negative core beliefs are always true, and constructing/strengthening alternative core beliefs so that clients can perceive and accept positive as well as negative data (Padesky, 1994).

Therapists using this CBT approach for personality disorders will find *MOM2* a compatible and helpful client workbook. Early in this therapy, *MOM2* can help build skills relevant to presenting mood and behavioral issues (e.g., depression, relationship difficulties), as described throughout this clinician's guide. Identifying and testing the underlying assumptions connected to old and new core beliefs can help people diagnosed with personality disorders learn and practice more adaptive interpersonal behavior patterns via behavioral experiments. When it is time to identify negative core beliefs and identify/strengthen more positive core beliefs, the methods described in Chapter 12 of *MOM2* can guide and structure those processes. In general, building and/or strengthening new core beliefs requires a minimum of three to six months and sometimes a year or more. Thus core belief work is generally addressed as part of longer-term therapy.

IDENTIFYING CORE BELIEFS

We all hold many core beliefs. In therapy, you only need to address the core beliefs that contribute to difficulties or make clients vulnerable to relapse. Therefore, once you decide it is necessary and there is enough time to work with a client's core beliefs, the first step is to identify the core beliefs that maintain the client's difficulties. Worksheet 12.1, Identifying Core Beliefs (*MOM2,* p. 159), offers the easiest and most direct way to identify core beliefs. For many clients, this one worksheet is sufficient and leads to identification of the central core beliefs maintaining their difficulties. It asks people to vividly imagine a situation in which a strong mood is present. They then complete these sentences for how they see things when this strong mood is activated: "I am ____________," "Others are ____________," and "The world is ____________."

The key to effective use of this worksheet is to choose a situation and mood central to a client's issues. For example, ask a client who is struggling with chronic mood problems to envision a typical situation in which this mood is strongly activated. Ask someone struggling with bulimia to imagine a recent situation in which the client wanted

to binge or purge. Ask someone diagnosed with a personality disorder to envision an interpersonal situation in which a maladaptive behavior is triggered (e.g., someone with a diagnosis of borderline personality disorder could be asked to envision a situation in which the person has an urge to attack someone else or end a relationship; someone diagnosed with avoidant personality disorder could be asked to complete this worksheet while thinking about a situation that the person wants to withdraw from or avoid).

If this simple worksheet does not successfully identify core beliefs, the next three worksheets employ the "downward arrow" technique to identify core beliefs about the self, other people, and the world (or "my life") (Worksheets 12.2, 12.3, and 12.4, *MOM2,* pp. 160–162). The downward arrow technique consists of asking someone, or having the person ask herself, what an emotionally evocative situations means to her. For each statement about what the situation means in each of these three domains, the person asks, "If this is true, what does this say or mean about [me/other people/the world (or my life)]?" Downward arrow questioning continues until the person arrives at a core belief, which will be either an absolute statement (e.g., "I'm unlovable") or image (e.g., "I'm standing alone on the edge of the world").

Core Beliefs about Self, Others, and the World

These worksheets ask people to identify core beliefs about themselves, others, and the world. It is important to help clients identify all three types of core beliefs, because these cognitive domains interact. As a cluster, these three types of core beliefs help explain emotional, behavioral, and motivational responses better than any single core belief can. For example, imagine that three people each have the core belief "I am weak." The first person holds a core belief about others, "Others will hurt you if they get the chance," and therefore tries to hide personal weakness and adopts an avoidant style for self-protection. The second person's core beliefs about others are "Others are always weaker than I am. They deserve to be taken advantage of." This person is always on the alert for weaker people and takes advantage of them, adopting an antisocial pattern of coping. The third person's core belief about others is "Others will take care of me." This person reveals weaknesses to others readily, in anticipation that it will elicit help and support.

As these three people illustrate, it is always necessary to identify core beliefs about oneself and others in order to fully understand behavioral, mood, and motivational reactions. Core beliefs about the world do not always make a game-changing difference. Even so, you can imagine the difference it makes for the three people in the preceding paragraph if they believe that "The world is manageable" versus "The world is overwhelming." It is best to identify all three types of core beliefs when possible.

When a situation is chosen that is typical of those that trigger a client's issues, core belief identification is often quite easy, as illustrated below for Gary—a client described at the end of Chapter 7 of this guide. As background, Gary had made good progress in therapy for generalized anxiety disorder. Avoidance of challenging situations was a chronic pattern for Gary, however, so his therapist spent considerable time helping Gary use behavioral experiments to test his underlying assumptions related to avoidance. Given the chronicity of Gary's avoidance and anxiety, his therapist thought it would also be wise to identify and test his core beliefs related to the avoidance.

THERAPIST: Gary, you have made terrific progress in therapy so far.

GARY: Yes, I am so grateful to you.

THERAPIST: Actually, it is your hard work that has helped you succeed. You are almost at the end of learning the *Mind Over Mood* skills that will help you going forward. This next chapter addresses core beliefs. (*Talks briefly about core beliefs.*) Let's take a bit of time today to identify your core beliefs, or at least the ones that could trip you up in the future if we don't address them.

GARY: Sure.

THERAPIST: Think of a situation that still triggers a strong desire to avoid, even if you are able to approach it now because of everything you've learned.

GARY: The biggest thing is that I still want to avoid making decisions until I've researched all the things that can go wrong and how to fix them. I'm getting better at making decisions more quickly, but I have to work with myself.

THERAPIST: That sounds like a good area. Is there something you are in the process of making a decision about right now that fits this pattern?

GARY: Yes. I'm trying to decide whether to put solar panels on my house and which company to work with for the installation.

THERAPIST: OK. Let's look at this worksheet in *Mind Over Mood* (*turns to Worksheet 12.1, Identifying Core Beliefs, p. 159*). Think about making that solar installation decision. Allow yourself to feel anxious about the decision you will make. Let me know when you begin to feel pretty anxious.

GARY: (*After about 45 seconds*) OK, I'm anxious now thinking about it.

THERAPIST: How would you rate your anxiety on a 10-point scale, with 10 being the most anxious you have ever felt?

GARY: I'd say an 8.

To ensure that core beliefs are activated, an exercise of this type should not proceed until a client's mood strength is 6 or higher.

THERAPIST: As you imagine yourself making this decision, complete this sentence for how you are seeing yourself in this moment of anxiety: "I am . . ."

GARY: "No good."

THERAPIST: And what would you say about others? "Others are . . ."

GARY: "Critical."

THERAPIST: And how about the world? "The world is . . ."

GARY: "Unpredictable."

THERAPIST: Let's look at these three sentences: "I am no good. People are critical. The world is unpredictable." Do these ideas help us understand your anxiety and reluctance to make a decision?

GARY: Yes. I really don't feel like I have the necessary expertise to make this decision. I'm afraid if I make the wrong decision, then Lin [Gary's wife] will be upset with me. So many things can change over the next ten years that I might make a wrong choice and regret it later.

Using Either the Simple or Downward Arrow Worksheets to Identify Core Beliefs

If Gary was not able to identify his core beliefs by using Worksheet 12.1, then his therapist could use the downward arrow worksheets (Worksheets 12.2–12.4, *MOM2,* pp. 160–162) to accomplish the same task. For each of these worksheets, the situation would be placed on the top line: "I'm anxious making a decision about installation of solar panels on my house." Use of either the simple or downward arrow worksheets would lead to the same or similar core beliefs. For example, Gary might state the core belief "I'm no good" in those or similar words (e.g., "I'm inadequate") or an image (e.g., an image of himself slumped like a rag doll). Whatever form a client's core beliefs take, it is good to ask the client once these are identified, "Do you think these core beliefs fit your emotional experience? And do you think they help explain what is going on when you face your central issue?"

IDENTIFYING NEW CORE BELIEFS

Recall that core beliefs ideally come in pairs (e.g., "People are trustworthy," "People are untrustworthy"). Paired core beliefs allow us to interpret a variety of life experiences flexibly (e.g., "This person is trustworthy, and that person is not") and adjust our reactions to each situation. The core beliefs sections of Chapter 12 in *MOM2* are designed primarily to help people who hold rigid core beliefs. These people often respond inflexibly across situations, because their overdeveloped core beliefs are nearly always active. Most likely, these people either are missing or have weak alternative core beliefs. Therefore, we ask them to identify new core beliefs they would like to have. As described succinctly on pages 163–164 of *MOM2,* building new core beliefs increases cognitive flexibility and also can make it easier to remember positive experiences.

Worksheet 12.5, Identifying New Core Beliefs (*MOM2,* p. 165), asks people to choose a core belief named on any one of the previously filled out worksheets for identifying core beliefs (Worksheets 12.1–12.4). Then they are asked to write a new belief that describes how they would like to think about themselves, others, or the world. This worksheet can be used to identify alternative core beliefs for each core belief previously named.

Be sure your clients state new core beliefs in their own words, using language that has emotional resonance for them. As emphasized in different contexts in previous chapters, don't attempt to rephrase or modify their language. Your words and metaphors may speak eloquently to you but fall flat for your clients. New core beliefs should be highly desirable to people and evoke emotions in the same ways their old core beliefs engender strong emotional reactions. When clients are multilingual, it is often better

to identify core beliefs in the first language they learned to speak or the language that connects most closely with the issue they are addressing in therapy, in order to maximize the emotional meaning of the new core belief. For example, a Syrian man who had immigrated to England was formulating his new core belief for how he would like to think about himself. He used a word in a Syrian dialect of Arabic that evoked many childhood memories and emotions. He explained this word's meaning and taught his therapist to pronounce it correctly, so that it could be used in therapy sessions. His new core belief about other people was an English word, because his negative core belief about others began during work experiences in England when he was speaking English.

It will take several months to strengthen a new core belief, so it is worthwhile to make sure new core beliefs are phrased in ways that fit with clients' aspirations and goals. Sometimes the words or images they want to use change over time, as illustrated in the following dialogue between Gary and his therapist.

THERAPIST: Last week we talked about your negative core belief "I'm no good," and we came up with the alternative belief "I'm good enough." I asked you to think this week about the phrase "I'm good enough," to see if it captures how you'd like to see yourself. Did you do that?

GARY: Yes. It would be nice to see myself that way. But I don't think it's quite right.

THERAPIST: What's not right?

GARY: When I think, "I'm no good," it's not just me I'm thinking about. It's how other people see me.

THERAPIST: So is it more like "Others see I'm no good"?

GARY: No. That's not it, either. I think it's "I'll be punished for my faults."

THERAPIST: I see. That is a different meaning. What would be the alternative to that? How would you like it to be?

GARY: "Safe." (*Pause*) "I'm safe even if others see my faults." (*Shoulders relax, eyes moisten.*)

THERAPIST: How does it feel to say that?

GARY: Good. Scary. I'd feel relief if I could ever believe that.

THERAPIST: Let's each write this down in our notes: "I'm safe even if others see my faults." Think about this idea this week, and see if it seems to capture how you'd like things to be in your life.

In this interchange, his therapist listened carefully and asked questions to help Gary articulate a nuanced version of his negative core belief—one that was out of his awareness before he tried to construct a new core belief. Notice that Gary had moderately strong affect when he stated his new alternative core belief. Core beliefs are closely tied to affect, and clients usually show some emotion when an old or new core belief is named for the first time. Gary's disbelief that his new belief could be true is also a characteristic response to an alternative, more adaptive core belief.

Gary's core belief "I'm safe even if others see my faults" was phrased in a somewhat different format from the core belief statements provided in Chapter 12 of *MOM2*: "I am ___________," "Others are ___________," and "The world is ___________." His new core belief responded to aspects of his old core beliefs about himself ("I am no good") and also about others ("Others will punish me"). You may notice that it was stated in a form that looked almost like an underlying assumption (e.g., "If others see my faults, then I am still safe"). However, the lead phrase "I'm safe" did match the absolute nature of a core belief. "Even if others see my faults" was not a condition for safety (as it would be in an underlying assumption), but a context relevant to Gary's anxiety that reaffirmed the absolute nature of his safety.

Encourage clients to state new core beliefs in the form most meaningful to them. Do not force them to conform to *MOM2*'s or any other template. Core beliefs can take many shapes, including images. For example, one woman had a negative core belief that took the form of an image of a small critical gnome sitting on her shoulder. She worked to develop an alternative, more adaptive image. Her new core belief was a cheerful woman who provided encouragement and a humorous commentary on her efforts throughout the day. Once old and new core beliefs are identified, your clients are ready to use the remaining exercises in Chapter 12 of *MOM2* to work actively on strengthening their confidence in the new core belief(s) they have constructed.

STRENGTHENING NEW CORE BELIEFS

Why do we recommend identifying and strengthening new core beliefs rather than testing existing core beliefs? According to schema theory, people can only perceive what their schemas (core beliefs) prepare them to see. If therapy focuses on testing existing core beliefs in the absence of alternative core beliefs, it will be handicapped by the fact that clients will perceive all their life experiences through the lens of their existing core beliefs. During tests of these core beliefs, life experiences that contradict these beliefs will be discounted, distorted, not noticed, or viewed as exceptions to broader "reality" (Padesky, 1994).

For example, a woman who believes "I'm unlovable" without the companion core belief "I'm lovable" can perceive every human interaction as proof that she is unlovable. Negative responses from others fit her core belief perfectly. When she receives positive reactions from others, she does not notice or distorts them (e.g., "She is so kind to act nice toward me, even though I probably disgust her"), discounts them (e.g., "He probably says this to everyone"), or sees these experiences as exceptions (e.g., "Oh, sure, she likes me now. But when she gets to know the real me, she'll see how unlovable I am"). Once her therapist helps this woman construct the paired core belief "I am lovable," over time she becomes capable of perceiving and remembering both positive and negative responses from others.

New core beliefs need to be strong enough in relation to the original, overdeveloped core beliefs that they can be activated in situations when they are warranted. This is only likely to be the case once people develop a high degree of confidence in the validity of their new core beliefs. Completing Core Belief Records, rating confidence in a

new core belief, rating experiences on a continuum (instead of in all-or-nothing terms), and conducting behavioral experiments are four interventions that help strengthen new core beliefs.

Completing Core Belief Records

Core beliefs shape what we notice, observe, and remember from our experiences. As described previously, it is difficult to perceive and remember information inconsistent with activated core beliefs (Padesky, 1994). Therefore, people are unlikely to see and remember experiences that support new, alternative core beliefs unless they pay particular attention to and actively look for this information. Worksheet 12.6, Core Belief Record: Recording Evidence That Supports a New Core Belief (*MOM2,* p. 166), is designed to help clients notice and record experiences that support new core beliefs.

Core Belief Records are designed to record small daily experiences that support new core beliefs. Helpful Hints to guide people in their search for experiences to record can be found on page 167 of *MOM2.* Ideally, clients will find at least two or three examples per day to write in their Core Belief Records. However, because people cannot easily perceive data that contradict their active core beliefs, at first most will have difficulty carrying out this seemingly simple task. Until their new core beliefs are strengthened, people don't have a lens to detect these data. At the same time, these data are necessary to strengthen new core beliefs. As therapists, we can help our clients develop this lens more quickly when we stay alert in session to detect small experiences in our clients' reports of their week that support new core beliefs. When we bring these events into our clients' awareness, they can begin noting and recording them. Notice how Gary's therapist helped him do this. Figure 8.1 shows the copy of Worksheet 12.6 that Gary completed during and after this session.

THERAPIST: Did you add any items to your Core Belief Record this week?

GARY: No. Nothing happened to write down.

THERAPIST: So you didn't make any mistakes or show any faults this week? It must have been a pretty good week!

GARY: Not really. My truck broke down, and I was late to work. And I was pretty depressed last weekend.

THERAPIST: When those things happened, did you get punished by your boss or by other people around you?

GARY: No, not really.

THERAPIST: What happened?

GARY: Well, I couldn't call in to work because my phone was dead. But when he found out what happened, my boss was pretty understanding. And Lin was pretty nice to me on the weekend. She tried to cheer me up, and she made an excuse for me so I didn't have to go to her mother's house.

THERAPIST: So if you look at your new core belief, "I'm safe even if others see my faults," do you think either or both of these experiences might be small

examples you could write on your worksheet to show that this belief is sometimes true?

GARY: I guess so. But I didn't think those were really related to being safe, though.

THERAPIST: But if you were always punished for your faults, what would have happened these two times?

GARY: My boss could have given me a job warning, and Lin could have gotten mad at me, I guess.

THERAPIST: Yes, those would be punishments of a sort. And they didn't happen.

GARY: No. Both of them were pretty good about my problems.

THERAPIST: Do you think you could write these examples on your worksheet for this week?

WORKSHEET 12.6. Core Belief Record: Recording Evidence That Supports a New Core Belief

New core belief: I'm safe even if others see my faults.

Evidence or experiences that support the new belief:

1. My boss was understanding when I was late because my truck broke down.
2. Lin was nice when I told her about my bad day.
3. My therapist didn't get mad at me for forgetting my worksheet.
4. Jim helped me when I couldn't get the bolt off.
5. I stumbled reading a story and my son didn't seem to mind.
6. Lin and I made up after I got mad and we had a fight.
7. ___
8. ___
9. ___

FIGURE 8.1. Top portion of Gary's Core Belief Record (Worksheet 12.6). From Greenberger and Padesky (2016). Copyright © 2016 Dennis Greenberger and Christine A. Padesky. Adapted by permission.

GARY: Yeah. (*Writes them on his worksheet.*)

THERAPIST: Maybe this week you could think each day what went wrong and notice any way you messed up. Then, if you weren't punished for it, you could write it on the worksheet.

GARY: OK.

THERAPIST: Let's write this plan down on the top of the worksheet page, as a reminder of what types of experience to write down.

His therapist helped Gary look for data that could have been recorded on his Core Belief Record by asking about the types of experiences Gary feared (making a mistake or having some sort of problem). His therapist assumed that Gary would not notice experiences supporting his new core belief. She helped him see that he wasn't punished in two important instances during the week when things went poorly. She asked Gary to write these examples on his worksheet, and then to write reminders on the worksheet to help him notice these types of experiences in the future. She asked Gary to write down ideas for noticing data that supported his new core belief, because she knew that Gary, like most people, would forget information related to a new core belief if he didn't write it down. When Gary could easily add items to Worksheet 12.6 on a daily basis, that would be a sign that his new core belief was gaining strength. Soon after that, he would begin easily perceiving supportive data throughout the week. Most people need to keep a Core Belief Record for about six months before a new belief is firmly established and holds high credibility for them.

Rating Confidence in a New Core Belief on a Scale (Continuum)

Core Belief Records can be combined with continuum ratings to chart progress. For example, Gary kept weekly ratings of his confidence in his new belief, "I'm safe even if others see my faults," on Worksheet 12.7, Rating Confidence in My New Core Belief (*MOM2,* p. 168). When he first identified this new core belief, Gary believed it 0%. After one month of recording evidence on his Core Belief Record that supported this belief, he believed his new core belief 10%. After three months, Gary's rated his confidence that he was safe when his faults were revealed in the 30–40% range on a weekly basis. After six months of recording supportive evidence on his Core Belief Record, his confidence in his new core belief increased to 70% for most of his relationships.

In order to make these confidence ratings, a person has to define a new core belief in practical terms. The following dialogue shows how Gary's therapist used guiding questions to help him generate his own definitions of "faults" and "safety," so that he could define reference points on his continuum ratings.

THERAPIST: Did the phrasing you proposed last session for your new alternative belief, "I'm safe even if others see my faults," fit for you this week?

GARY: That seems like what I'd like. But the more I think about it, the more I'm sure it's impossible.

THERAPIST: What makes it seem impossible to you?

GARY: I've never been safe. At work, at home . . . people clobber me if I screw up.

THERAPIST: Let's make a safety scale on one of these lines on your worksheet. (*Crosses out "Date" and writes "Safety" above it on the top continuum on Worksheet 12.7, MOM2, p. 168.*) Here's a scale for safety from 0% to 100%. On the "New core belief" line, write, "How safe I am when others see my faults." (*Hands Gary the pen so he can write this on the worksheet.*) Where do you generally think of yourself on this scale?

GARY: At 0%.

THERAPIST: Put an X at 0%, Gary, and note that that is where you see yourself.

GARY: (*Puts an X at 0% and writes, "Me."*)

THERAPIST: Now let's make a list of recent times others have seen your faults.

GARY: Last week at work, when my calculator broke and I couldn't figure out the sales tax. Let's see . . . I promised my son I'd fix his toy, but I was too tired and didn't do it. That's all I can think of right now.

THERAPIST: Any times you can think of when I've seen your faults?

GARY: When I first came here, I'd agree to do some work in the book, and then I wouldn't do it.

THERAPIST: So it sounds like when you say "my faults," you mean mistakes you make or times you don't follow through on what you promise, or things you don't know how to do.

GARY: Yeah, that's right.

THERAPIST: What do you mean by "safe"?

GARY: Safe from being hurt.

THERAPIST: Physically hurt? Or emotionally hurt?

GARY: Both. When I was a kid, my dad would beat me up pretty bad when I screwed up. But I feel just as bad if someone makes fun of me or calls me dumb.

THERAPIST: Has that happened to you, too?

GARY: Yeah. In school. And sometimes at work my boss will get mad and call me a "dumb ****."

THERAPIST: So let's write on this scale what safety means for you. At 0%, let's write what no safety would mean. For example, you might get beat up until you're almost dead.

GARY: Yes. Beat up real bad or ridiculed in front of the group. (*Writes these ideas below 0% on the scale.*)

THERAPIST: What would 100% safety look like?

GARY: I'm not sure.

THERAPIST: Well, if 0% is being beaten within an inch of your life, I guess 100% safety would be feeling protected from physical harm.

GARY: Like having a bodyguard.

THERAPIST: Yes. What would be the safest you could imagine?

GARY: Protected by a safety shield, so no one could touch me.

THERAPIST: OK. Write that under 100%. (*Pauses while Gary writes this image down.*) Now what about 100% safe from public shame or criticism? What would that look like?

GARY: If people were patient and encouraged me, instead of making fun of me.

THERAPIST: Write that under 100%, too. (*Pauses while Gary writes.*) On this scale we are making, what would 50% safe look like? Something halfway between these endpoints?

GARY: Physically, I guess being shoved but not hurt. (*Pause*) And I guess someone being critical or upset with me on a one-on-one basis, not in front of a group.

THERAPIST: Write those down under the midpoint of the continuum, where it's labeled 50%. Now let's mark on this scale these three experiences you gave me where others saw your faults. First, you couldn't figure the sales tax at work when your calculator broke. Where would you put your safety then?

GARY: Hmmm. I guess about 25%. My manager made fun of me, but only one other person was there, and he didn't beat me up or anything.

THERAPIST: Put an X at 25% and label it "Sales tax" or something like that, so you know what the X means. (*Pause*) And how about when you didn't fix your son's toy?

GARY: I guess about 80%. He was disappointed, but he wasn't mad at me.

THERAPIST: Put an X at 80% and label it. (*Pause*) How about in here when you didn't do what you said you would in the book?

GARY: Well, you didn't beat me up. (*Laughing*)

THERAPIST: Did you expect me to?

GARY: I sort of did.

THERAPIST: And what did happen?

GARY: You asked me questions and were nice about it. And you helped me be not so afraid of screwing up.

THERAPIST: So where would that go on this scale?

GARY: I think 90% safe.

THERAPIST: Write that down. (*Pause*) Now we've got four X's on this scale—one for where you generally see yourself (0%) when others see your faults, and three for recent events (25%, 80%, 90%). What do you notice when you look at this scale and these marks?

GARY: Where I see myself is different from what has happened lately.

THERAPIST: Good point. What if we put some of your childhood events here, like that time your dad beat you up for making a mistake?

GARY: That would be 0%.

THERAPIST: So do you think as a kid you lived in 0% safety more often?

GARY: Not all the time. But I never knew when my dad would blow up.

THERAPIST: So seeing yourself as 0% safe might have been a good thing to do as a kid. I mean, it might have been better to assume you were never safe and be careful, since you never knew when your dad would blow up.

GARY: Yeah. I think that's true.

THERAPIST: How about today? Do you think it's still better to assume you're never safe?

GARY: (*Pause*) No, I guess not. It looks from this line here that I may be safer than I think.

THERAPIST: And what would be the advantage for you in thinking of yourself as being safer? Why not still think of yourself as only 0% safe?

GARY: Well . . . I could be more relaxed if I felt safer. And maybe I'd face up to people more.

THERAPIST: And how do you think that would help you?

GARY: If I acted stronger, my boss might back off. He doesn't give Pete as hard a time as he gives me.

THERAPIST: That's an interesting idea. It might be good to find out if your boss would back off if you acted stronger. We could practice in here how you might do that. First, though, maybe it would be helpful to keep track on this scale how safe you are this week when others see your faults. It might help to find out more about when you are safe and when you are not. What do you think?

GARY: That makes sense.

Although Worksheet 12.7 asks people to rate confidence in new core beliefs over time, Gary's therapist took the top continuum on this worksheet and used it to help Gary define criteria for safety, in the context of having people see his faults. An early step in building new core beliefs is to clarify and define criteria for core belief concepts. His therapist asked Gary to specify what he meant by "faults" and "safety," and then used the continuum to provide a visual summary of Gary's recent experiences to assess whether these support or contradict his new core belief (see Figure 8.2).

His therapist helped Gary qualitatively define the endpoints and midpoint of a safety continuum. It is important to help someone label the endpoints *in extreme terms,* so that the entirety of human experience is accounted for on the scale. On their own, clients sometimes define continuum endpoints in more moderate terms, thus reducing the value of a scale for measuring change. For example, if Gary defined 0% safety as "Someone is displeased with me," then there would be little room for variability across the scale, and his father's beatings would end up equivalent to his boss's reprimands and his son's disappointment.

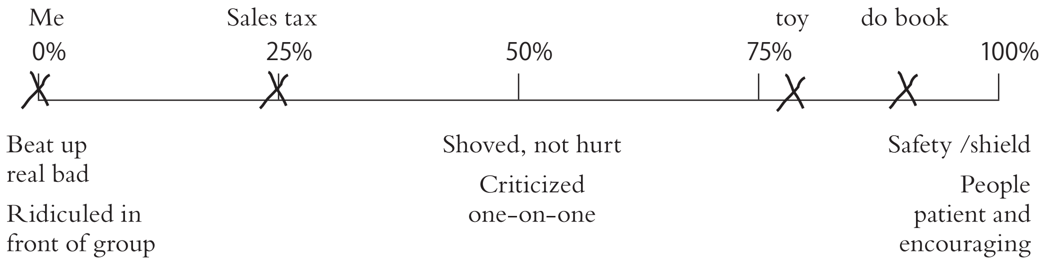
WORKSHEET 12.7. Rating Confidence in My New Core Belief

New core belief: How safe I am when others see my faults

Ratings of confidence in my belief

Safety Criteria:

~~Date:~~



Date:

Date:

FIGURE 8.2. Top portion of Gary's Rating Confidence in My New Core Belief (Worksheet 12.7), with "Date" relabeled "Safety Criteria," defined safety criteria shown below the continuum, and ratings of recent experiences shown above the continuum. From Greenberger and Padesky (2016). Copyright © 2016 Dennis Greenberger and Christine A. Padesky. Adapted by permission.

A scale or continuum is most likely to be therapeutic when it is constructed to rate only the *new* core belief from 0% to 100%, rather than using a broader scale that ranges from 100% belief in the old core belief to 100% belief in the new core belief. The reason for this is that core beliefs shift incrementally. A small shift in the positive direction for a new core belief usually offers more hope to a client than a small shift away from an old core belief. Consider the difference for Gary if a 10% incremental shift in his belief was stated as "I'm 10% safe when others see my faults" (rated on a continuum that just included the new core belief) versus "It's only 90% true that I'll be punished for my mistakes" (rated on a continuum ranging from 100% confidence that the old core belief was true to 100% confidence in his new core belief). A small gain in confidence in a positive idea offers more hope than a small decrease in confidence in a negative idea.

Once continuum endpoints were defined, his therapist asked Gary to place recent

experiences on the scale. After rating several events, she asked Gary to compare the perception (driven by his core belief) that he was 0% safe when faults were revealed to his actual experiences. Note that his therapist did not focus single-mindedly on disproving his core belief, which could put him on the defensive. Instead, she linked Gary's core belief to early developmental experiences and empathically noted the adaptive value of his core belief when he was growing up with a physically abusive father. Once the origins and historical adaptiveness of his old core belief were validated, his therapist asked Gary to consider whether this core belief was always adaptive for him in his current circumstances.

Rating Behaviors on a Scale (Continuum) Instead of in All-or-Nothing Terms

Continuum work is central to core belief change, because core beliefs are dichotomous (e.g., safe versus not safe). Use of a continuum or scale helps people learn to evaluate experiences in more graduated terms. Small changes in belief that can be missed on a thought record can be captured on a continuum. A worksheet titled Rating Behaviors on a Scale (Worksheet 12.8, *MOM2,* p. 171) capitalizes on the weaknesses of dichotomous thinking by encouraging people to rate their own behavior and that of others on a continuum, instead of in all-or-nothing terms. We say "the weaknesses of dichotomous thinking," because most human behavior cannot be described as 0% or 100%. Using a scale to rate behavior undermines the human tendency to discount positive behaviors when negative core beliefs are activated.

For example, Lily was working on a new core belief that she was competent. However, when she reviewed her day, she tended to focus on her errors and mistakes. Her therapist encouraged Lily to rate some of her behaviors on the scales in Worksheet 12.8.

LILY: I was using the new accounting software at work, and I really messed up some of the entries.

THERAPIST: Let's get out the worksheet you are using this month and see how you would rate this experience.

LILY: OK. (*Opens MOM2 to Worksheet 12.8, p. 171.*)

THERAPIST: What can you write on the situation line?

LILY: "Using the new accounting software to enter my expense log."

THERAPIST: OK. (*Waits while Lily writes.*) And we are working on your new core belief of competence, so what behavior do you want to rate?

LILY: I guess "Using the program correctly."

THERAPIST: Write that down for the behavior you are rating.

LILY: OK.

THERAPIST: How long did you work on your expense log?

LILY: Probably about 10 minutes.

THERAPIST: In order to rate your competence fairly, how many entries did you make, and approximately how many errors did you make?

LILY: Oh, I only had about ten entries, and I messed up half of them.

THERAPIST: When you say you "messed them up," did you put them in and then later have someone else find your errors?

LILY: No. I could see I messed them up, because the numbers got put in the wrong places on the report.

THERAPIST: So what did you do?

LILY: I checked my work, and then I went back and corrected my mistakes.

THERAPIST: So do you think the final report was pretty accurate?

LILY: Yes. I think so.

THERAPIST: So how would you rate "Using the program correctly" in the end?

LILY: Well, in the end, the report was correct, but I made some errors along the way.

THERAPIST: So, if you were evaluating a colleague learning this software, and she made some mistakes along the way and noticed them and corrected them so her expense log was completed correctly within 10 minutes, how would you rate her on "Using the program correctly"?

LILY: Hmmm. I see what you mean. I guess I would rate her about 90%. Not perfect, because she made some mistakes, but she found and corrected them right away.

THERAPIST: So you would rate her 90%. How would you rate yourself?

LILY: When we started, I would have rated myself less than 50%, but now that we are talking about it, maybe 90% is about right.

Lily's therapist gathered information about Lily's experience before asking her to rate her behavior. This was important, because Lily was prone to focus on mistakes and not on positive outcomes or things she did correctly. After summarizing what Lily told her, her therapist asked her to imagine and rate a colleague showing the same behavior. This strategy reduced the likelihood that Lily would evaluate her mistakes harshly. People who hold themselves to perfectionistic standards are often much more forgiving of others than they are of themselves.

Since core beliefs change gradually in response to an accumulation of experiences, people usually need to use Core Belief Records, continuum scales, and other core belief change methods for six months or longer before a new core belief is fully developed. Once clients rate their confidence in a core belief as 70% or greater, you can be assured that this new core belief is strong enough to persist. The length of time required to build and strengthen new core beliefs is one of the reasons why core belief work is not recommended early in therapy or as a prime focus of brief therapy. However, people who struggle with chronic negative core beliefs can benefit from using *MOM2* to strengthen new core beliefs, even after therapy has ended.

Conducting Behavioral Experiments to Strengthen New Core Beliefs

Core Belief Records and continuum (scale) ratings are good ways to capture experiences that occur naturally throughout the week and use them to strengthen new core beliefs. Behavioral experiments can speed the process of gaining confidence in new core beliefs, because these can be planned to ensure that they happen frequently. Behavioral experiments that are particularly likely to strengthen new core beliefs include these:

- Planned daily experiments in which people act "as if" a new core belief is true.
- "Stretch" activities in which people try something new, consistent with their new beliefs.
- Approaching rather than avoiding situations people find challenging because of old core beliefs.

All the principles regarding behavioral experiments described in Chapter 7 of this

Behavioral Experiments to Strengthen New Core Beliefs

- Step 1: Write down the new core belief you want to strengthen.
- Step 2: Collaboratively design an experiment to test that belief directly. Ask your client:
  - "What would you be able or likely to do if this core belief was strong?"
  - "What types of experiences would have the greatest credibility?"
  - "What problems do you anticipate in carrying out this experiment?"
  - "How can you manage these problems to keep going in the experiment?"
  - "What outcomes could be particularly difficult for you to manage?'
  - "How could you manage those outcomes?"
- Step 3: Make written predictions in advance (for old and new core beliefs).
- Step 4: Repeat the experiments a sufficient number of times.
- Step 5: Record the outcomes of the experiments. Ask your client:
  - "What happened (compared to your predictions)?"
  - "Do the outcomes match what you predicted?"
  - "Did anything unexpected happen?"
  - "If things didn't turn out as you wanted, how well did you handle it?"
- Step 6: Compare actual outcomes with predictions. Ask your client:
  - "Do these outcomes support my new core beliefs (even partially)?"

clinician's guide can be applied equally well in behavioral experiments designed to strengthen new core beliefs. These principles are summarized in the adjacent box.

Planned Daily Experiments: Acting "As If" a New Core Belief Is True

One fast track to strengthening new core beliefs is for clients to act as if they already believe them to be true. For example, Anaya wanted to believe that she was "lovable." She created a variety of experiments to do during the week in which she would act as if she was lovable. She came up with the ideas for these experiments by thinking about things she would do more often if she thought she was lovable. Her old core belief, "I'm unlovable," predicted a variety of negative responses. Her new core belief predicted positive responses. She and her therapist discussed in advance how she could evaluate responses from others and herself. Here is a sample of the experiments she agreed to try; she agreed to do each experiment more than once:

> Smile at clerks in stores and say "hello."
>
> Treat myself as lovable—for example, plan a relaxing evening with my favorite music, food, and entertainment.
>
> Ask a friend for help with a small problem.
>
> Greet friends with a smile and say, "Hello, I'm glad to be here."
>
> Invite someone to join me for lunch.

Anaya and her therapist kept track of the outcomes of these experiments on Worksheet 12.9, Behavioral Experiments to Strengthen New Core Beliefs (*MOM2,* p. 174). Most people responded positively to Anaya when she behaved in these new ways. This encouraged Anaya to continue experiments in which she acted "as if" she was lovable. Even when she received neutral or negative reactions from others, her therapist was able to help Anaya see that people's reactions were not always due to her (e.g., friends might have their own pressures and might not be able to help her). These experiments boosted Anaya's confidence in her lovability.

"Stretch" Activities to Try Something New

Initially, people find it easier to plan behavioral experiments that involve doing familiar activities with slight changes to reflect a new core belief. However, trying to build and strengthen core beliefs that are genuinely "new" will probably require experiments in which people try out entirely new behaviors or activities. As Anaya continued to carry out her experiments to increase her confidence that she was lovable, her therapist recognized that all of Anaya's experiments were brief, and that most involved positive behaviors Anaya initiated.

Anaya had a history of relationships that ended once disagreements or conflicts arose. Some of these relationships had problems that made them untenable. For example, one of her former friends had frequently lied to her and even stolen some money

from her. Yet other relationships seemed quite good until disagreements surfaced. Anaya withdrew and became silent in the face of conflict. She told her therapist that she had always believed that if she disagreed with someone, then they would think she was unlovable. By never expressing her own feelings and preferences, Anaya often ended up thinking of herself as unlovable even when friendships continued. Anaya would think, "If they knew I didn't share their interests, they wouldn't like me any more."

Her therapist proposed to Anaya that she might need to do some "stretch" experiments that involved disagreement and conflict. At first, these new experiments involved Anaya's expressing her opinions to others. For example, she expressed her preferences for eating at a particular restaurant or watching a particular television show. Next, she experimented with expressing differing opinions from her friends about movies or items in the news. After each experiment, she was asked to identify signs that people still found her "lovable," despite her expressed differences in preference or opinion. Signs of her lovability included invitations to do things together in the future, verbal and nonverbal expressions of warmth or caring, and even caring enough to have a prolonged disagreement with her. Anaya's therapist pointed out that indifference was a better marker of not loving someone than impassioned disagreement. Over time, Anaya experimented with participating in prolonged arguments with close friends and practiced reconciling with them when arguments could not be resolved.

APPROACHING RATHER THAN AVOIDING CHALLENGING SITUATIONS

It is human nature to avoid challenges that our core beliefs tell us might threaten our safety or well-being. For example, people who hold a core belief that others are harshly critical often avoid evaluation situations. People who believe they are incompetent often avoid new tasks or work promotions. Approaching these challenges can help build and strengthen new core beliefs, because there is an opportunity for people to learn either that the risks posed by these challenges are not as great as they feared, or that they have a greater ability to cope and manage challenges than they imagined. Thus, when you identify situations or circumstances relevant to a new core belief that your clients have been avoiding, you can discuss the benefits of approaching these challenges.

Dominic wanted to build and strengthen a new core belief that other people were trustworthy. He recognized that his mistrust of people had prevented him from becoming intimate with anyone. Prior to reaching this point in his therapy, Dominic had kept work colleagues, neighbors, and even family members at a distance by not revealing much information about himself or his interests. For example, no one in his life knew that he had been arrested for driving under the influence of alcohol, and that he was staying sober by attending support groups and individual therapy.

His therapist encouraged Dominic to rate various people he knew on a scale of how trustworthy he thought they could be. Once he had identified three people who were "probably trustworthy" (70% or greater likelihood on his rating scale), his therapist role-played with Dominic how he could ask for their agreement not to reveal certain private information about him to others. If they agreed to keep his information confidential,

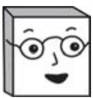
Dominic was willing to conduct experiments in which he told these selected people about his struggles with alcohol. He would observe whether they honored his trust by keeping this information private. This experiment required him to approach and cross boundaries that had limited Dominic's relationships for the past five years. Even so, it would be difficult for him to build confidence in others' trustworthiness until he actually behaved in ways that expanded his previous levels of trust in others.

There is no limit to the number and variety of behavioral experiments that people can do to strengthen new core beliefs. Use Worksheet 12.9, Behavioral Experiments to Strengthen New Core Beliefs (*MOM2,* p. 174), over and over again as new types of experiments are devised. For most people, strengthening new core beliefs involves months of conducting behavioral experiments that involve acting "as if" new core beliefs are true, stretching their comfort zones, and approaching rather than avoiding situations and circumstances relevant to new core beliefs. Results of these experiments that support new core beliefs can be added to the Core Belief Record (Worksheet 12.6, *MOM2,* p. 166). Results of experiments that do not support new core beliefs can be examined in order to evaluate how well clients coped with the outcomes, and also to help them consider what can be learned from these experiences.

WHAT HAPPENS AFTER CORE BELIEF WORK?

At the end of *MOM2* Chapter 12 (p. 186), readers are reminded to complete mood measures relevant to the moods they have been working on. There is a reminder to keep practicing skills learned thus far and to review written exercises when distressing moods or thoughts return. For most people using *MOM2,* Chapter 12 is their final step in skill development. Clients who are completing therapy will now turn to Chapter 16, Maintaining Gains and Experiencing More Happiness, to put a plan in place for using the skills they have learned to manage relapse and continue their positive development after therapy ends.

Those who have completed their work on one mood and now want help with other moods can turn to another *MOM2* mood chapter to learn how to apply the



Reminder Box

An early step in building new core beliefs is to clarify and define criteria for core belief concepts. Completing Core Belief Records, rating confidence in a new core belief, rating experiences on a continuum (instead of in all-or-nothing terms), and conducting behavioral experiments are four interventions that help strengthen new core beliefs. Focus on strengthening new core beliefs rather than testing old core beliefs, because a small gain in confidence in a positive idea offers more hope than a small decrease in confidence in a negative idea.

skills they've already acquired, as well as new skills particular to those moods (Understanding Your Depression, Chapter 13; Understanding Your Anxiety, Chapter 14; or Understanding Your Anger, Guilt, and Shame, Chapter 15). Those progressing to a new mood can follow the Reading Guide for that mood reprinted in Appendix A on pages 456–459 and Guilford's *MOM2* companion website (see the box at the end of the *MOM2* table of contents). Clients who want to address non-mood-related issues in therapy after completing mood work can learn to apply skills taught in *MOM2* to those other issues (e.g., identifying and testing underlying assumptions that maintain behavior or relationship difficulties). When your clients are nearing the end of therapy and are ready to work on skills for managing relapse, they will then turn to Chapter 16 in *MOM2*. Before doing so, consider introducing gratitude and kindness exercises if you have not already done so.

GRATITUDE AND KINDNESS

Gratitude and acts of kindness are evidence-based practices derived from positive psychology research that are demonstrated to increase well-being. "Well-being" is a term used to encompass a variety of human experiences, including positive affect, happiness, and life satisfaction. Gratitude and kindness exercises are included in *MOM2* to boost well-being and happiness, rather than being linked to alleviation of particular distressing moods. We have placed gratitude and kindness in *MOM2* Chapter 12 because we believe that these approaches can help bolster many new core beliefs. However, you can direct a client to read and use only the gratitude and kindness sections of Chapter 12 (*MOM2,* pp. 175–186) whenever you both think these methods could prove beneficial. The following sections highlight evidence-based findings regarding gratitude journals and acts of kindness that many clinicians do not know, and that are important to keep in mind in order to maximize the effectiveness of these tools in therapy.

Gratitude

"Gratitude" is generally defined as appreciation and/or thankfulness. Over the past several decades, numerous studies have suggested that attending to and expressing gratitude can increase well-being, although the mechanisms of change are still not understood (Wood, Froh, & Geraghty, 2010; Krejtz, Nezlek, Michnicka, Holas, & Rusanowska, 2016). Five gratitude worksheets are included in *MOM2* (pp. 176–183). The first three worksheets (Worksheets 12.10, 12.11, and 12.12) are gratitude journals. The fourth worksheet (Worksheet 12.13) summarizes learning from the first three and should be filled out after six weeks of keeping the gratitude journals. The final gratitude worksheet (Worksheet 12.14) encourages expressions of gratitude to others. The first three gratitude worksheets are phrased in ways that allow them to be linked to the development of new core beliefs that some people will be working on in Chapter 12. Even so, all five worksheets can be beneficially used by anyone who wants to cultivate an attitude of gratitude; specific work on new core beliefs is not required.

Clinical Tip

Gratitude and kindness exercises do not need to be tied to strengthening new core beliefs. Clinicians can introduce them at any point in therapy when likely to prove helpful.

Gratitude about the World, Others, and Myself (Worksheets 12.10–12.12)

Worksheets titled Gratitude about the World and my Life, Gratitude about Others, and Gratitude about Myself (Worksheets 12.10–12.12, *MOM2,* pp. 177–179) are designed to be completed simultaneously. Thus these three worksheets have a single set of instructions on page 176 of *MOM2.* When reviewing these instructions, some therapists may be surprised that this gratitude journaling exercise is designed to be completed only *once a week* rather than daily. Most of the research studies on gratitude involve daily gratitude journaling for a two- or three-week time period. However, Lyubomirsky and Layous (2013) have found that the dosage and longevity of gratitude practice can be very important. Findings from their research suggest that weekly gratitude journaling may be more effective than filling out gratitude journals multiple times during a week.

Thus we have decided to direct readers of *MOM2* to complete the gratitude worksheets once a week rather than daily. The hope is that people will complete these worksheets weekly for several months and, if they find this practice helpful, develop a long-term habit of keeping a weekly gratitude journal. It is possible that long-term weekly gratitude journaling may provide more of a boost to well-being than daily journaling, because the effectiveness of gratitude journals can diminish with overuse (Lyubomirsky, Sheldon, & Schkade, 2005).

Writing in depth about one or two things for which people are grateful is likely to boost their well-being more than a long list of items described superficially. Thinking about something in depth is more likely to prompt the emotions and full experience of gratitude. Since people are encouraged on the *MOM2* gratitude worksheets to write in detail about one or two things each week, they will probably not write on each of these three worksheets weekly. Whatever they choose to write about in a given week can be written on the appropriate worksheet, depending upon whether the gratitude relates to life and the world, other people, or oneself.

Notice that the lines on these three worksheets are quite close together. This may lead people to conclude that they should write just a few words instead of many details about a target of gratitude. Encourage your clients to write headline-style descriptions about the topics of their gratitude on these lines, and to make more detailed notes about the reasons for their gratitude in their therapy notebooks, in loose sheets of paper inserted into this section of *MOM2,* or in their electronic therapy notes. In the future, when they want to get a gratitude boost, they can review these detailed notes along with their headline-style lists on these worksheets.

If you notice that a client expresses gratitude over time only in areas pertaining to one or two of the three worksheets, you can consider whether this is appropriate or whether it merits discussion in therapy. For example, Anna easily expressed gratitude toward others and the world, but during the first few weeks of keeping her gratitude journal, she never wrote anything on Worksheet 12.12, Gratitude about Myself. She tended to have low self-esteem, so her therapist encouraged Anna to spend that week's gratitude time thinking and writing about qualities, strengths, values, and good deeds she could record on her Gratitude about Myself worksheet. Another client, Jessica, also did not record gratitude items regarding herself. Since Jessica had positive self-esteem and was more focused in therapy on developing greater compassion and empathy toward others in order to reduce her anger, her therapist did not give her any particular suggestions to increase her use of the Gratitude about Myself worksheet.

When clients are working on strengthening particular core beliefs, a relevant gratitude worksheet can support these efforts. For example, Jamal was working on a new core belief that people were kind. His therapist suggested that he find at least one person or incident per week to write about on Worksheet 12.11, Gratitude about Others, especially ones that related to people being kind. This exercise often dovetailed with behavioral experiments Jamal was doing in which he asked for help from others. The outcomes of these "asking for help" experiments were recorded on Worksheet 12.9, Behavioral Experiments to Strengthen New Core Beliefs (*MOM2,* p. 174). When others were willing to help him, Jamal sometimes wrote more in depth about these experiences in his gratitude journal. Writing in detail about experiences in which others helped him made these events more memorable and meaningful for Jamal, as shown in Figure 8.3.

Learning from My Gratitude Journal (Worksheet 12.13)

The first three gratitude worksheets collectively form a gratitude journal, separating items for gratitude into the categories of world/life, others, and myself. Worksheet 12.13, Learning from My Gratitude Journal (*MOM2,* p. 180), gathers personal observations about the impact and benefits of focusing on gratitude. The impact of gratitude often develops over time, so the instructions at the bottom of page 176 of *MOM2* suggest that people fill out their three gratitude worksheets for at least six weeks before they complete the Learning from My Gratitude Journal worksheet. The questions on this worksheet are self-explanatory and can be filled in either as part of a discussion in therapy and/or as a self-reflection assignment at home. Note that question 7 ("Did keeping this gratitude journal inform my work on strengthening my new core beliefs? If so, how?") will not apply if someone has not been working on strengthening new core beliefs. However, people who are working on new core beliefs often find that their new beliefs are consistent with experiences recorded in their gratitude journals.

"WOULD IT BE HELPFUL FOR ME TO CONTINUE PRACTICING GRATITUDE?"

Question 8 on the Learning from My Gratitude Journal worksheet includes two significant questions: "Would it be helpful for me to continue practicing gratitude? If so, how and why?" The goal of these questions is not to encourage every person to commit to

WORKSHEET 12.11. Gratitude about Others

Things about others (family, friends, coworkers, pets, etc.) that I am grateful for and appreciate:

1. Keisha was very kind to me when I asked for help with my new song.
2.
3.
4.
5.
6.
7.

He added these details in his journal: When I asked Keisha to help me with my new song, I thought she would say no because I've sometimes said mean things about her. But she said yes. I'm grateful she worked with me on it, because she has a great voice and was able to sing it in ways I didn't imagine. She had good ideas about changing up the flow in the middle, which made it a lot better. The whole afternoon was really special. She was very kind to me.

FIGURE 8.3. Jamal's entry in Gratitude about Others (Worksheet 12.11) after his "asking for help" experiment.

an ongoing practice of gratitude. *MOM2* teaches a variety of skills in the hope that all readers will find a few skills that really help them and that they will want to incorporate into their lives. Methods that are helpful for improving well-being and happiness vary greatly from person to person. An individual's decision regarding whether to continue a gratitude journal will rely on whether or not keeping a gratitude journal has proven to be a rewarding activity or not. Lyubomirsky and her colleagues (2005) propose that people are most likely to develop lifelong habits when the activities fit their values and interests. We encourage you to accept your clients' judgments of whether or not to continue gratitude journaling. After six weeks, most people have given gratitude journals a good effort, and they should be able to determine if an ongoing focus on gratitude is something they want to pursue or not.

"IF SO, HOW AND WHY?"

When people decide to continue a practice of keeping gratitude journals, help them consider what frequency and which ways of doing this are likely to be most useful. Some people may simply decide to continue the ongoing weekly use of gratitude worksheets. Others may decide to work on one of these worksheets for a number of weeks and then switch to another. Some people may decide that a monthly gratitude journal is now more useful than a weekly one. Others may decide to make this a family effort and include gratitude discussions at the dinner table once a week. There is no single best way to build and sustain well-being. Yet we know that when people actively engage in making a personal plan for sustained effort, they are more likely to carry it out than when they are following another person's instructions for doing so (Lyubomirsky & Layous, 2013). Therefore, encourage clients to make their own decisions about these issues.

Expressing Gratitude

Once people become more aware of gratitude, it is often a natural step to begin expressing their gratitude to others. Recognizing and paying attention to things that people are grateful for is a cognitive intervention; the expression of gratitude is a behavioral one. Worksheet 12.14, Expressing Gratitude (*MOM2,* p. 183), provides its users a place to record what happens when they express gratitude to others. Gratitude can be expressed to strangers as well as intimate others. Some people choose to express gratitude by writing a grateful letter or email; they can subsequently choose whether or not to actually send it. Or they can write a letter of gratitude to someone who is no longer living or who doesn't even know them. Expressions of gratitude can have positive benefits, whether or not they are actually delivered or receive a response.

Research suggests that this type of exercise is only likely to enhance well-being and happiness if people voluntarily choose to do it because they want to be happier (Lyubomirsky, Dickerhoof, Boehm, & Sheldon, 2011). There may be little benefit in asking someone to express gratitude if they are not interested in doing so, or if they already are quite satisfied with their level of happiness. Therefore, before suggesting the Expressing Gratitude worksheet to your clients, ask them whether or not increasing happiness is a current goal and whether or not they are interested in expressing gratitude.

These gratitude exercises precede the section on acts of kindness in *MOM2* Chapter 12. We recommend introducing gratitude exercises *before* kindness exercises. Participants in a happiness intervention who practiced gratitude before beginning exercises in acts of kindness experienced greater increases in well-being than those who began with acts of kindness (Layous, Lee, Choi, & Lyubormirsky, 2013).

CULTURAL DIFFERENCES IN GRATITUDE PRACTICE

Gratitude is not a panacea. Its meanings and purposes affect its impact. Layous, Lee, Choi, and Lyubomirsky (2013) found cultural differences in the outcomes of gratitude: People from the United States benefited more from expressions of gratitude than did people from South Korea, whereas participants from both cultures experienced similar increases in well-being when performing acts of kindness. The authors of this study speculate that the South Korean participants may have felt indebtedness as well as gratitude when writing a gratitude letter. Their perception of indebtedness could thus have blunted the positive effects of gratitude. Thus keep in mind potential cultural influences on the meaning of gratitude exercises.

Acts of Kindness

Intentional acts of kindness can also increase well-being and happiness. The word "intentional" implies that someone makes a decision to do a particular act of kindness, rather than simply practicing habitual acts of kindness that may not involve effort, thought, or attention to one's behavior. Worksheet 12.15, Acts of Kindness (*MOM2,* p. 185), invites people to practice kindness and record the kind things they do. Usually

people record acts of kindness that require at least a small amount of effort. After several weeks, they are prompted to review their list and reflect on how these kind acts affected their moods and relationships. In addition, those who are working on the development of new core beliefs are asked to consider which of their new core beliefs were active during acts of kindness.

Research suggests that doing five acts of kindness on a single day actually boosts well-being more than doing five acts of kindness spread out over a week does (Lyubomirsky et al., 2005). Thus you can recommend to your clients who want to start this practice that they experiment with choosing a day of the week for extra kindness practices. Clients might plan "Kindness Tuesday" (or whatever day works for them), mark this in their calendars, and try to do as many kind things as possible on this day. Since many acts of kindness are quite small behaviors, it can be easier to notice the impact on mood and relationships when these are practiced within a day's time rather than spread out over a week. Of course, people can be kind every day in addition to doing special kindness exercises. In fact, daily kindness practices are the norm in most people's lives. The idea of this exercise is to do extra acts of kindness, above and beyond what people would usually do.

Applications of Gratitude and Kindness for Clinical Issues

Most of the research on use of gratitude and kindness with clinical populations has been done with people who experience depression. And this research has most often been conducted with people with mild depression symptoms. For people with mild depression, even a week of participation in gratitude or kindness practices can lead to positive boosts in mood that can last months (Seligman, Steen, Park, & Peterson, 2005). One study with severely depressed individuals who were asked to do positive gratitude and kindness activities demonstrated benefits within about two weeks (Seligman, 2002). Thus, even though this research is still in its relative infancy, positive activities such as gratitude and acts of kindness show promise in helping lift depression (Layous, Chancellor, Lyubomirsky, Wang & Doraiswamy, 2011).

A meta-analysis of 25 research studies that used positive psychology interventions with depressed individuals (Sin & Lyubomirsky, 2009) found that those with depression diagnoses did benefit from a wide variety of positive psychology interventions. In addition, their analyses revealed that those who *chose* to participate in these types of activities had greater improvement than those *assigned* to participate; that older clients improved more than younger clients; and that these practices were more effective when used in individual compared with group therapy.

Your choices of whether and when to introduce clients to this section of *MOM2* should be based on clinical judgments of when your clients have the energy, willingness, and social context for these practices. For some clients, keeping a gratitude journal can be part of an activity schedule early in therapy for depression (see *MOM2* Chapter 13, and also Chapter 9 in this clinician's guide). For other clients, introduction to these practices can come late in therapy as a prelude to relapse management. Whenever you decide to introduce these types of exercises, give your clients the *choice* of whether or not to practice gratitude and kindness.

Kerr, O'Donovan, and Pepping (2014) conducted an intriguing study in which they examined the efficacy of two-week gratitude and kindness interventions with people of all diagnoses on a waiting list for outpatient psychotherapy. Unfortunately, half of the people who entered this study dropped out, and those who dropped out scored higher on measures of distress than the group that completed the study. Those who remained in the study and who were able to complete a gratitude journal received benefits from it in terms of higher optimism, lower anxiety, and greater connectedness to other people, compared with a control group. Those who completed the kindness intervention also had significant increases in optimism and connectedness to others.

However, the results of the kindness interventions were overall more mixed, because many of the participants did not conduct the acts of kindness as prescribed. The researchers speculated that when people are in a high degree of distress, it can be more difficult to offer help to others. Thus it is possible that gratitude is acceptable as an intervention early in therapy for a wide range of clients, and that acts of kindness could be better suited to use with individuals who are less distressed.

Finally, except for lowering anxiety, the gratitude and kindness exercises did not have an impact on either positive or negative affect (e.g., sadness) for people in the Kerr et al. (2014) study. Thus, while gratitude and kindness exercises can increase well-being, optimism, and a sense of connection with others, they are not substitutes for the primary mood management skills taught in *MOM2*. Similarly, gratitude and kindness exercises could help strengthen some positive core beliefs. However, these exercises are meant to *supplement,* not *replace,* the primary core belief interventions described in the earlier sections of this chapter.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 12

Therapy When Concurrent Personality Disorders Are Present

As described earlier in this chapter, research suggests that people with concurrent personality disorder diagnoses generally can do just as well in CBT for presenting mood and behavioral issues as clients without personality disorder diagnoses. Sometimes, however, therapy modifications are needed to increase the odds of this improvement. The following suggestions can be implemented when clients with personality disorders are not progressing as well as expected in therapy.

Therapy Pace

Some clients require adjustments in the pace of progressing through *MOM2.* People diagnosed with avoidant personality disorder prefer not to think about painful thoughts and emotions, so *MOM2* can become a symbol of what is "unpleasant" about therapy to them. When this is the case, consider suggesting timed assignments in the workbook followed by pleasant or distracting activities. For example, you could recommend that your clients focus on reading or completing exercises in *MOM2* 15 minutes before their children arrive home from school. As clients with avoidant diagnoses become more

familiar with skills related to experiencing and managing emotions, they will be more willing to use *MOM2* for longer periods of time.

In contrast, some clients with borderline personality disorder benefit most if they use the manual several times a day. Clients who experience frequent mood swings can use Chapter 4 of *MOM2* to identify and rate their moods, and later chapters of the book to help modulate them. Some clients with borderline personality disorder diagnoses need to follow a slower pace through the workbook, spending several weeks on chapters that teach skills they particularly need. Encourage these clients to take as much time as necessary to master component skills.

Repetition Needs

Many clients can read *MOM2* and add to their skill repertoire chapter by chapter, with little need to refer to earlier worksheets or summaries. Others may require frequent repetition of skills to master them. All clients with personality disorders (as well as those with other chronic issues) need repetition once they begin the core belief work described in Chapter 12 of *MOM2*. Repetition is necessary to promote development of new core beliefs, because core beliefs generally develop and strengthen quite slowly.

In addition, since core beliefs are connected to automatic thoughts and underlying assumptions, people with personality disorder diagnoses can also require more repetition with earlier chapters of *MOM2*. For example, someone diagnosed with major depression and no personality disorder may recover completely after learning behavioral activation strategies, completing 15–20 thought records, and conducting five or six behavioral experiments. For this person, *MOM2* skills practice restores the more balanced thinking style characteristic of the person's functioning before becoming depressed. In comparison, someone diagnosed with both major depression and borderline personality disorder could learn the skills in the manual in a comparable period of time and experience a lifting of the major depression. Yet this person may not experience a stable restoration of balanced thinking, because, in many domains of the client's life, negative core beliefs are activated whether depression is present or not. This client will benefit from ongoing repetition of *MOM2* worksheets along with ongoing core belief efforts, as outlined earlier in this chapter of the clinician's guide.

Personality Disorders, Therapy Relationship, and Reactions to *MOM2*

Core beliefs central to personality disorder diagnoses are often interpersonal and can be expected to be expressed clearly in the therapy relationship. People diagnosed with avoidant personality disorder believe that their therapists see them as inferior and inadequate; people diagnosed with obsessive–compulsive personality disorder try to do every therapy task perfectly and are loath to depend on their therapists for help; clients diagnosed with narcissistic personality disorder constantly scan for indications that their therapists think they are special or just "routine" clients, and demand special attention when they feel vulnerable.

Clients with these differing personality styles respond quite differently to use of a

therapy workbook. And in different ways, the therapy relationship can be used to foster the use of *MOM2* with each. For example, extra reassurance, therapist support, and behavioral experiments in self-revelation will help those with an avoidant style engage in therapy and use of *MOM2*. Clients diagnosed with obsessive–compulsive personality disorder are usually eager to use a workbook, although they will criticize limitations or errors they find in it. With these clients, *MOM2* worksheets can provide a forum for testing beliefs such as "Unless I do things perfectly, they have no value," and "I am fully responsible for everything." For example, one therapist asked a client with this diagnosis to complete some of the worksheets partially or imperfectly, to see if they still had learning value.

The combination of a positive and collaborative therapy alliance in sessions with *MOM2* use outside of sessions provides substantial support for clients while they learn skills to help themselves. For clients with obsessive–compulsive personality disorder, and also those with dependent personality disorder, use of *MOM2* provides an experience on the midpoint of a continuum ranging from complete self-reliance to complete dependence on others. This balance of help and independence appeals to most clients with obsessive–compulsive personality diagnoses and can help them begin relinquishing a need to be in complete control of the therapy. For clients with dependent diagnoses, use of *MOM2* provides an opportunity to experiment with greater independence and learn that they can handle some of life's challenges without the assistance of others.

Clients diagnosed with narcissistic personality disorder can balk at the use of a standardized therapy workbook like *MOM2*. A core belief for these clients is "I am worthless," with an accompanying underlying assumption: "If I am treated specially, then I am not worthless." Introduction of a therapy workbook can trigger underlying assumptions connected to their worthlessness core belief (i.e., "If this is a standard therapy workbook, then I am not being treated as special"). The sense of worthlessness often engenders depressed mood and triggers classic narcissistic coping behaviors: (1) making demeaning statements about the therapist ("You must be new at this if you have to use a book"); (2) assertions of specialness ("I always get personal service, and if you expect me to follow a program like a trained seal, I'll take my business elsewhere"); and (3) appealing to the therapist's own narcissism ("I'm sure I could learn this better and faster from you than from a book. Why don't we just talk this through like two intelligent people?").

Responses such as these provide opportunities to identify emotions linked to core beliefs about worthlessness. As the therapist, you can do this by deflecting attack and empathically searching for the emotions connected to these responses. Possible responses that can help identify these clients' underlying emotions connected to the cognitive theme of worthlessness include (1) "I wonder if the idea of using a book like this triggers some feelings in you?" or "You must feel somewhat disappointed that I think a book like this would help you, given the depth of your feelings"; (2) "Introducing this book seems to make you feel as if I don't see you as very special. Does that make you feel anything besides anger?"; and (3) "What would it be like for you to read and learn from a book, without the attention you receive from me when we meet face to face?" Note that each of these responses asks a person to focus on emotions, especially the types of

emotions someone diagnosed with narcissistic personality disorder wishes to avoid, such as depression and loneliness.

These examples illustrate how use of *MOM2* can trigger relationship issues in therapy. People diagnosed with personality disorders sometimes produce these signature responses to *MOM2,* predicted by the core beliefs central to each disorder. For example, relative to other clients, those with dependent personality disorder request much more help to complete *MOM2* exercises and seek reassurance that this workbook is not a replacement for therapist assistance. These responses to *MOM2* highlight relationship issues early in therapy, so you can begin to respond therapeutically to them early on. For more specific guidelines for how to use the therapy relationship to help clients with personality disorders, see Beck et al. (2015).

9

Depression and Behavioral Activation

(*MOM2* CHAPTER 13)

Makayla had struggled with low mood on and off for the past five years, since she lost a job she really enjoyed. She had been employed occasionally since then, but each job seemed mostly a path to a paycheck. Over the past five months, Makayla had experienced increased insomnia, as well as worsening of her mood; she had also begun neglecting daily tasks, so her apartment was becoming more and more cluttered and dirty. When she came home at night, she looked at her apartment and had images that she was living in a dirty cave. Her self-confidence was eroding, and she was beginning to think that her life would never get better.

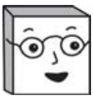
Makayla's story is not unusual. Depression is the leading cause of disability worldwide, and yet fewer than half of all people who are depressed receive one of the known effective therapies that could help (World Health Organization, 2018). *MOM2* helps bridge this gap, whether it is used for self-help or in therapy, because it teaches skills shown to be effective in reducing depression and relapse. *MOM2* Chapter 13, Understanding Your Depression, shows readers how to measure and track depression symptoms, offers exercises designed to help readers learn what types of activities can reduce depressed mood, and illustrates the types of thoughts associated with depression. As shown in the Chapter 13 Summary, this chapter of *MOM2* also helps people understand depression, its common symptoms, and treatments.

By following the guidelines in this chapter of this clinician's guide, you can learn more effective ways to help your depressed clients acquire core antidepressant skills. The Troubleshooting Guide at the end of this chapter highlights strategies to manage common difficulties encountered during therapy for depression.

Chapter 13 Summary

(*MOM2*, pp. 188–218)

- ✓ Depression does not just describe a mood; it also involves changes in thinking, behavior, and physical functioning.
- ✓ The *Mind Over Mood* Depression Inventory (Worksheet 13.1, *MOM2,* p. 191) can be used to rate depression symptoms. Weekly scores on the inventory can be charted on Worksheet 13.2 (*MOM2,* p. 192) to track changes in your depression as you master *Mind Over Mood* skills.
- ✓ There are many effective treatments for depression, including CBT, improving your relationships, and medication.
- ✓ People who learn the skills taught in *Mind Over Mood* have lower rates of relapse for depression than those treated with medication alone.
- ✓ When we are depressed, we tend to have negative thoughts about ourselves, our experiences, and the future.
- ✓ CBT for depression helps us learn new ways of thinking and behaving in order to improve our moods in a lasting way.
- ✓ Tracking and analyzing your activities and moods on an Activity Record can help you discover the connections between behavior and depression (Worksheets 13.4, *MOM2,* pp. 206–207, and Worksheet 13.5, *MOM2,* p. 208).
- ✓ An Activity Schedule (Worksheet 13.6, *MOM2,* pp. 214–215) can be used to plan activities that are pleasurable, accomplish something, help you overcome avoidance, and/or fit with your values. Using an Activity Schedule in this way for several weeks is likely to boost your mood.



Reminder Box

People generally read the first four chapters of *MOM2* and then choose a relevant mood to work on in depth. The first four chapters of *MOM2* teach core ideas about the links among thoughts, moods, behaviors, physical reactions, and life/environmental factors. Those who choose to work on depression are then directed to read Chapter 13, Understanding Your Depression (*MOM2,* pp. 188–218).

DEPRESSION GUIDE FOR CLINICIANS: THE FLOW OF THERAPY

When people who come to therapy are depressed, they usually have quite low energy and are pessimistic that therapy can help. Therefore, our initial interventions should be simple enough that even a highly depressed person can do them and, at the same time, have a good chance of boosting mood in the first few weeks of therapy. This is the reason we usually start treatment for depression by targeting small changes in people's behavior that are likely to boost mood. These interventions are part of a treatment approach called "behavioral activation," which is the primary skill addressed in *MOM2* Chapter 13.

Once your clients experience a mood boost from using behavioral activation, they are ready to learn additional skills. We recommend that clients consult the Depression Reading Guide (available on p. 456 in Appendix A here and online at The Guilford Press's *MOM2* companion website; see the box at the end of the *MOM2* table of contents, p. vi there), which directs them to read the remaining chapters of *MOM2* in an order that fits with evidence-based practice guidelines for depression. The next chapter recommended is Chapter 5, Setting Personal Goals and Noticing Improvement. Many therapists will have already assigned this chapter earlier in therapy. If your clients have already set goals, this is a good time to see what improvements they notice after their behavioral activation efforts, by reviewing their responses on Worksheet 5.4, Signs of Improvement (*MOM2,* p. 37). Also, review their score sheet for the *Mind Over Mood* Depression Inventory (Worksheet 13.2, *MOM2,* p. 192), to see how much their scores on this inventory (discussed in detail in the next section) have changed since therapy began. Noticing and appreciating signs of improvement will reinforce clients' efforts and boost their confidence that your treatment plan is effective.

Table 9.1, the Depression Guide for Clinicians, links the *MOM2* chapters as listed in the Depression Reading Guide (see p. 456) with chapters in this clinician's guide. As you can see there, once goals are set and/or signs of improvement reviewed, you can begin teaching your clients how to use 7-Column Thought Records to test the negative thoughts that characterize depression. While your clients are reading the thought record chapters in *MOM2,* you can read Chapters 4 and 5 of this clinician's guide for illustrations of how best to help them acquire skills taught in those chapters. If therapy time is limited, behavioral activation and thought records are the prime skills to teach people who feel depressed. If there is more time available after these skills are learned, consider helping clients identify and test any underlying assumptions that make them vulnerable to relapse. These often include perfectionistic beliefs or beliefs about relationships.

If there is additional therapy time, clients can learn whichever of the additional *MOM2* skills seem most likely to be helpful for them: problem solving, acceptance, mindfulness, and building new core beliefs, as well as the practices of gratitude and kindness. Whichever *MOM2* skills chapters you decide to use with your clients, you can read the companion chapters in this clinician's guide, using Table 9.1 as your chapter link reference. Before therapy ends, allow time to work with your clients to build a relapse management plan that incorporates whatever antidepressant skills they have learned into their life after therapy ends. This often includes a posttherapy plan to boost their happiness and sense of well-being.

TABLE 9.1. Depression Guide for Clinicians: *MOM2* Chapters (in Order Recommended by Depression Reading Guide) and Corresponding Clinician's Guide Chapters

MOM2 chapters	Purpose	Clinician's guide chapters
1–4	Introduction to *MOM2* and five-part model.	2
13	Learn more about depression. Increase types of activity to improve mood.	9
5	Set goals. Identify personal signs of improvement.	3
6–9	Use 7-Column Thought Records to identify and test negative thoughts. Generate alternatives.	4–5
10	Strengthen alternative thoughts. Use Action Plans to solve problems. For problems that can't be solved, develop acceptance.	6
11	Use behavioral experiments to test negative underlying assumptions, address perfectionism. Develop new assumptions.	7
12	Develop new core beliefs. Gratitude and acts of kindness.	8
14	Learn more about anxiety, if relevant.	10–11
15	Learn more about anger, guilt, or shame, if relevant.	12
16	Make a plan to continue to feel better over time (relapse management).	13

MEASURING DEPRESSION AND TRACKING IMPROVEMENT

In the beginning of *MOM2* Chapter 13, as part of understanding depression, readers complete the *Mind Over Mood* Depression Inventory (referred to in this discussion as *MOM*-D; Worksheet 13.1, *MOM2,* p. 191). The *MOM*-D helps people identify the symptoms they currently experience and establishes a baseline depression score. In order to track the impact on their mood of skills learned and practiced, readers are advised to fill out the *MOM*-D weekly and graph their scores on Worksheet 13.2 (*MOM2,* p. 192). We expect their scores on the *MOM*-D to drop as clients learn and practice relevant skills.

We encourage you to ask *all* clients (regardless of diagnosis) to complete the *MOM*-D or some other depression measure at intake, to screen for depression symptoms and also establish a baseline depression score. At the beginning of treatment, we recommend that clients who experience depression complete the *MOM*-D weekly. Once depression remits, monthly ratings are recommended to provide early warning of any return of depression symptoms. An increase in depression scores can indicate the

need to implement a relapse management plan (see *MOM2* Chapter 16, and Chapter 13 of this clinician's guide).

The *MOM*-D can be filled out on a paper copy of Worksheet 13.1 or a fillable .pdf version, which can be downloaded into a smartphone or other electronic device (available from Guilford's *MOM2* companion website; see the box at the end of the *MOM2* table of contents, p. vi). The .pdf version is self-scoring; a total score is generated at the bottom of the form as symptoms are rated. To track changes in depression scores over time, you or your client can record scores on Worksheet 13.2 (also on a paper copy from *MOM2,* p. 192, or on a .pdf version available from Guilford's companion website). A graph of depression scores provides visible evidence of improvement or lack of improvement to both of you, thus indicating whether therapy is helping or needs to be modified in some way. If your client has difficulty graphing depression scores, you can help by completing the graph when you meet.

Sometimes clients become discouraged after about six weeks of skills practice. They still feel depressed, even if they have been practicing new skills. When this occurs, look at their graphed *MOM*-D scores to see if they have improved somewhat. Most people experiencing depression identify with either Marissa or Ben, main characters described throughout *MOM2* who each reported depression. People can see in the Epilogue of *MOM2* that Marissa's and Ben's depression scores did not improve steadily (Figures E.1 and E.2, *MOM2,* pp. 293–294), and that both were still quite depressed in the sixth week of therapy. Consider showing these graphs to clients who become demoralized by their own persistent depression scores. These two graphs are included in *MOM2* to help normalize score fluctuation patterns that people experience. You can read a bit more about the origins of these graphs in the discussion of the *MOM2* Epilogue in Chapter 13 of this clinician's guide. Of course, ongoing high scores on the *MOM*-D indicate that you should consider whether or not treatment is targeting central issues or needs modification.

In addition to total score, pay attention to item scores on the *MOM*-D. Consider Manya, who rated item 18 ("Change in sleep pattern—difficulty sleeping or sleeping more or less than usual") a 3, and rated most other items 0–2. Discussion of Manya's sleep revealed that she had been experiencing insomnia for some time. When insomnia is present, research shows that a specialized form of CBT for insomnia can have a rapid and positive impact on depression as well (Manber et al., 2011). Since insomnia can be a precursor of depression and may persist after recovery, target it early in treatment when this is a primary depression symptom (Baglioni et al., 2011).

Looking for patterns among the highest-scored items on the *MOM*-D can be illuminating. Observations of these patterns can provide a rationale to clients for why various treatment approaches are being suggested. For example, you can highlight your clients' scores on items of the *MOM*-D that reflect symptoms often linked to decreases in activities during depression (items 4, 5, 6, 8, 9, and 16). When behavioral activation is implemented, track changes in scores on these items. When cognitive restructuring is started, pay particular attention to the impact of these skills on scores for the items that capture negative thinking (items 7, 13, 14, and 15). As therapy progresses, if scores on any items are not improving, consider adding interventions to address those symptoms specifically.

BEHAVIORAL ACTIVATION

At the same time your clients begin to measure and track their depression symptoms, you can ask them to complete an Activity Record (Worksheet 13.4, *MOM2,* pp. 206–207). People are more likely to complete an Activity Record if you begin filling it out with them collaboratively in session and if you make it easy to do. For example, help them fill it out for the past four hours. Encourage them to write just two or three words to describe what they were doing, and to rate their depression for each hour. Once you do this, a dialogue like the following exchange between Pat and her therapist can encourage them to fill it out during the week.

THERAPIST: Was it easy or difficult to fill this out?

PAT: Not bad.

THERAPIST: How much time do you think it took to fill in these four hours?

PAT: About three minutes, maybe.

THERAPIST: Since you could remember back the past few hours, you don't really need to fill out this form each hour of the day. Maybe at lunchtime you could fill it out for the morning; at dinnertime you could fill it out for the afternoon; and before you go to bed, you could fill out the evening hours. Would that be easier for you?

PAT: Yes. So I just need to fill it out three times a day?

THERAPIST: It seems that this would work for you. That might take about ten minutes per day. I know that this might seem like a lot of time. But, if you can do that, then the next time we meet, we will be able to figure out what types of steps we should take to help your depression improve as quickly as possible. The time you spend this week will help us save time next week and get you feeling better faster. Does that sounds like something you would be willing to do?

PAT: I think so.

THERAPIST: What do you think might get in the way?

Asking someone what might interfere with completing an Activity Record allows you to anticipate and solve problems in advance. For any potential roadblocks mentioned, ask, "How would you like to handle that?" Asking them to problem-solve difficulties (rather than suggesting solutions) encourages engagement and increases their commitment to doing the task. Linking the Activity Record to learning information that can speed improvement is likely to be a motivating rationale, as most depressed people want to feel better as fast as possible. It is also helpful to set up all at-home learning assignments as "no-fail," as seen in the following therapist statement:

"It's possible that you might forget to fill out this Activity Record some day this week. If you do, don't make up information. It is important that you only record the hours you can remember, so we get good information about your activities

> and moods. The next time you remember to do it, just fill out the last few hours you can remember. And don't worry; we can learn a lot even if you only partially complete the Activity Record. Of course, the more you remember to fill in, the easier it will be to learn things that will help you feel better. But even if you just fill in a day or two, we will learn some helpful things."

Anticipating difficulties or incomplete learning assignments, and telling your clients that these will not derail therapy, are important messages. Without these messages, some people will skip therapy sessions or drop out when they do not complete learning assignments (thinking that they have let you down or are "failures" as clients).

After clients complete all or part of an Activity Record, it is important to ensure that they learn something valuable from their efforts. This is often one of the first learning assignments depressed clients complete in therapy. If their efforts lead to positive learning, they are much more likely to complete future learning assignments. To guide learning, ask the questions on Worksheet 13.5, Learning from My Activity Record (*MOM2,* p. 208). One person might learn that certain types of activities improve her mood and others do not. Someone else might learn that activities boost his mood more than he predicted. Another person might experience no mood boost at all from activities.

Most people discover that they feel less depressed when they are more active, especially when they do pleasurable activities or accomplish something. Also identify activities or tasks that a person is avoiding. Things we avoid create drag on our mood ("I'm enjoying watching this soccer match, but I should be working on repairing my fence"). According to research, the three best types of mood-boosting activities are pleasurable activities, accomplishments, and tackling avoided tasks (see Martell, Dimidjian, & Herman-Dunn, 2010). Within these categories, any activities linked to someone's personal values are more likely to lift mood than activities done just to fill time. For example, Willem valued relationships and discovered that walking with someone else was more uplifting than walking alone. Whenever possible, he planned walks with other people rather than solitary strolls. And when he did walk by himself, he greeted other people he encountered with a smile. Sometimes these interactions resulted in brief conversations, which often provided an added mood boost.

When clients do not get any mood improvement from activities, you can explore what happens during these activities to "spoil" a possible mood boost. Is a person ruminating during activities? If so, activity experiments can be planned to compare mindful, in-the-moment activities with activities accompanied by rumination. Some people don't experience mood improvements when they do pleasurable activities, because they are unable to experience pleasure even during highly enjoyable activities. One potential response to this circumstance is described in the Troubleshooting Guide at the end of this chapter (see the "Inability to Feel Pleasure" section).

Use what you learn from the Activity Record and the Learning from My Activity Record worksheets (*MOM2,* pp. 205–208) to help clients plan activities they can do in the following week to try to boost their mood. Rather than simply assigning activities to a client, it is more engaging (once the Activity Record has been completed) to ask, "How could you use what you learned to help yourself this week?" and "What ideas

do you have for how you could increase these types of activities that helped you feel a bit better?"

An Activity Scheduling exercise on page 213 of *MOM2* helps organize your clients' brainstorming. This exercise asks them to identify activities they could do in each of four categories. The first three categories are ones that behavioral activation researchers have found are likely to improve mood: pleasure, accomplishment, and approaching activities that have been avoided (Martell et al., 2010). We've added a fourth category, "Activities that fit with my values," to make sure that people include activities along highly valued dimensions such as relationships with other people, work accomplishments, helping their community, and spiritual development. Identifying several activities in each of these categories broadens people's thinking and encourages them to begin a diverse range of activities, so they are more likely to benefit from some of them.

In the beginning, many people who are depressed will need help from their therapist to plan activities. A weekly Activity Schedule (Worksheet 13.6, *MOM2,* pp. 214–215) can be used to write a plan for the upcoming week. When you and a client are writing activities on the Activity Schedule, work with your client to be specific. Try to think of how to make activities more engaging. For example, instead of simply writing "Walk the dog," the client might write, "Walk the dog in the park" if this location is likely to be more enjoyable. Ask questions about the client's neighborhood and community to assess safety and learn about social opportunities. Often different activities will be available in the daytime than at night, or only in good weather. It can be helpful to discuss and write down alternative activities when planned activities are vulnerable to factors outside a client's control. Each of these steps can be done collaboratively, but make sure you let your clients take the lead when choosing activities and deciding where to put them on the Activity Schedule. People are more likely to follow through on plans that they devise themselves. Also, your clients know their own life circumstances better than you do, and they may have ideas that would never occur to you. For example, Willem knew a coffee shop near his home that had good WiFi, and he suggested he do some of his computer work there so he could be around people instead of working alone.

Whenever depressed persons are tempted simply to "do nothing" for long periods of time, the Activity Schedule provides a plan for their activities. Clients are encouraged to follow their Activity Schedule as an experiment to see if certain types of activity improve their mood. Remind them that they can substitute more preferable activities that arise. For example, the Activity Schedule says, "Take a walk," but the person notices a neighbor outside and decides it would be more enjoyable to talk with the neighbor instead. This is fine, as long as the alternative activities do not constitute avoidance.

Review the results of a client's behavioral activation in each session. Notice what activities led to improved mood and ask, "How can you use this information to help yourself this week?" When activities do not improve mood, use curiosity to help your client figure out whether this is an anomaly, or whether these activities should be changed in some way or even dropped from the Activity Schedule. Sometimes activities that are not in and of themselves enjoyable (e.g., washing dishes) can be made more so by adding music or the participation of family members or friends.

As they near the end of *MOM2* Chapter 13, readers are advised to continue to

focus on activity scheduling for several weeks until their scores on the *MOM*-D begin to drop. We advise you to encourage behavioral activation until meaningful shifts in mood occur. For people whose initial scores on the *MOM*-D are in the mid-30s, for example, it is best to stay focused on increasing meaningful activities until *MOM*-D scores drop at least into the mid-20s. Having a meaningful mood drop after behavioral activation is likely to increase your clients' confidence that further skills acquisition will be beneficial.

Sticking to behavioral activation skills for a number of weeks before moving on to cognitive skills has three advantages:

1. A sustained focus on activity scheduling and on learning what shifts in mood come from different types of activities increases the likelihood that clients will be able to really understand and incorporate principles of behavioral activation into their lives.
2. Cognitive skills are easier to learn and master when depression scores are lower, because cognitive flexibility increases as depression decreases.
3. When an initial treatment intervention is successful in reducing depressed mood, it gives your client hope.

Once your client begins to experience improved mood through behavioral activation, you can consider teaching antidepressant cognitive skills, which begin with the 7-Column Thought Record chapters in *MOM2* (Chapters 6–9).

THOUGHTS AND DEPRESSION

Although most people think of depression as a mood problem, it is just as much a thinking problem. Beck (1967) coined the term "negative cognitive triad" as a succinct description of the thinking style that characterizes depression. When depressed, people have negative thoughts about themselves (self-criticism), their life experiences (pessimism), and their future (hopelessness). This negative cognitive triad doesn't necessarily precede or cause depression, but once depression is present, these types of thoughts occur and maintain depression. For example, people who feel depressed may think, "My life's a mess" (negative thought about a life experience), "It's all my fault" (negative thought about the self), and "It will never get any better" (negative thought about the future). Such thoughts inhibit people from doing the very things that could help them feel better.

Even though *MOM2* Chapter 13 primarily teaches skills related to behavioral activation, it also introduces people to Beck's three categories of negative thoughts and asks readers to write down some of the thoughts they have had in each area. Worksheet 13.3, Identifying Cognitive Aspects of Depression (*MOM2,* p. 197), asks people to place a check mark next to common negative thoughts they have had and to identify whether these are negative thoughts about themselves, their life experiences, or their future. The answer key to this worksheet is on the following page (*MOM2,* p. 198). You can expect

these types of thoughts to permeate therapy, especially in the early weeks when depression is worse. The following sections illustrate some of the ways cognitive approaches are used to address these types of thought early in therapy before thought records are introduced.

"I Can't Do This" (Negative Thoughts about Oneself)

One of the consequences of negative thoughts about oneself is that tasks can seem difficult and overwhelming. If people don't perceive themselves as capable, even small tasks seem doomed to failure. Some depressed people look at *MOM2* and want to put it aside because it looks like too much to read and understand. They may think that the worksheets and exercises are too complicated, or that they are too stupid or inept to complete them. When these thoughts are expressed, thank your clients for telling you their reactions.

THERAPIST: When you looked at the Activity Record, your shoulders slumped. What went through your mind?

CLAIRE: I just can't do this. It's too much.

THERAPIST: Thank you for letting me know that. Let's see if it is too much. If it is, we can break it into smaller pieces.

CLAIRE: Maybe I could do a small bit. The whole page just looks too hard.

THERAPIST: Well, let's try a bit of it together and see how it goes.

CLAIRE: OK.

THERAPIST: Let's take this morning as an example. Right now it is 10:40 A.M. What could you write as a brief description of what you are doing between 10:00 and 11:00 on Wednesday?

CLAIRE: "I'm at therapy with Christine"?

THERAPIST: Good. Take this pen and write this in that 10–11 A.M. Wednesday block. (*Pauses while Claire writes, "therapy with Christine"*) Now, how depressed are you feeling from 0 to 100, where 0 is not at all depressed and 100 is the most you have ever felt?

CLAIRE: About 80, I guess.

THERAPIST: OK. Write 80 in the box under "therapy with Christine."

CLAIRE: OK.

THERAPIST: Now what were you doing from 9 to 10 this morning?

CLAIRE: Driving here and getting a coffee.

THERAPIST: OK. Write that in the 9–10 A.M. Wednesday block, and then rate how depressed you felt when doing that. (*Pauses while Claire writes.*) What rating did you give it?

CLAIRE: About a 90. (*Therapist and Claire work together to fill out the remaining morning hours.*)

THERAPIST: Now that you have given this a try, how easy or difficult do you think it will be to fill out this Activity Record this week?

CLAIRE: It seems a little easier than I thought it would be.

THERAPIST: If you are willing to give it a try, let's talk about how to handle it if you forget to do it, or what to do if you get stuck at any point during the week.

As this example shows, depressed clients often feel more capable and less overwhelmed when they actually do something than when they think about doing something. To test beliefs that an assignment will be too difficult, begin all assignments in your therapy sessions. Clients who are so depressed that they think reading is too difficult can even practice by reading one paragraph in your office.

An additional benefit of beginning therapy assignments in the office is that you can assess whether an assignment is truly too large or difficult for a client. If it is, break it into smaller pieces, or devise a different assignment. For example, if your client has difficulty completing an Activity Record, suggest filling it out for only one or two days. You can even get an activity sample if the client can complete the Activity Record one weekday morning, one weekday afternoon, one weekday evening, and a few hours on the weekend.

Pessimism (Negative Thoughts about Life Experiences)

Given the likelihood of pessimism, you can expect people working on depression to be skeptical that *MOM2* or any other treatment procedure will be helpful. You lose credibility with a depressed person if you guarantee that therapy will help. The following dialogue from an earlier session with Claire illustrates one way to discuss pessimism regarding therapy.

THERAPIST: (*After presenting MOM2 and describing its proposed use in therapy*) How does this sound to you? Would you be willing to give this book a try?

CLAIRE: I don't know. It seems like a lot of work.

THERAPIST: It will involve some work on your part. Of course, if I could guarantee your work will help you feel better, I'm sure you'd give a try. But we can't be sure it will help you. What do you think are the odds that it will help?

CLAIRE: I doubt it will. I've been depressed a long time, and nothing helps me.

THERAPIST: So what's the use of putting out the energy to do this if it won't help, right?

CLAIRE: Right.

THERAPIST: I'm glad you let me know you are not very optimistic. Fortunately, if this book is going to help you, it will help even if you don't believe in it. And if it isn't going to help you, we can find that out in just a few weeks of trying it. What do you think about trying this book for a few weeks? Then, based on your experience with it, we can decide if it is helpful for you or not. If it's not helpful, we can stop using it.

CLAIRE: Just for two weeks?

THERAPIST: How about for three weeks? So you give it a fair try.

CLAIRE: OK. I can do that.

Notice that her therapist did not try to convince Claire that *MOM2* would help. Instead, her therapist agreed that it did not seem worthwhile to spend energy on something that wouldn't help. At the same time, her therapist maintained a sense of optimism by proposing to Claire that she give the workbook a try for three weeks, to evaluate whether or not she would be able to use it and find benefit. She assured Claire that they wouldn't continue use of the workbook if it was not helpful. It is generally better to provide experiences for people to evaluate than to enter into prolonged debates about the benefits of each treatment step. People who are depressed often cannot imagine feeling better, and so discussions designed to convince them otherwise are doomed to fail and may even harm the therapy alliance. Instead, begin exercises and therapy steps in the office, and write down what activities or readings they have agreed to do between appointments, so they can easily remember which ones to do and how to do them.

Hopelessness (Negative Thoughts about the Future)

A third common cognitive feature of depression is hopelessness. Hopelessness is important to monitor during depression treatment, not only because it can derail skills practice, but also because it is a good predictor of suicide. Reduce hopelessness whenever possible. How do you do this when hopelessness can interfere with someone's treatment adherence? One approach is to ask your clients regularly about hopelessness and acknowledge its credibility to them. At the same time, tell them that you do not find their problems hopeless. Furthermore, try to provide concrete evidence that expectations of doom do not mean that doom is certain. One way to do this is to create hope even in the face of negative reactions to *MOM2* or other aspects of treatment. Notice how Claire's therapist did this in her second therapy session.

THERAPIST: I notice you completed the Understanding My Problems worksheet (*MOM2,* p. 14). What did you learn by doing this?

CLAIRE: I've got lots of problems. I may as well give up.

THERAPIST: Let's see. Yes, you do have lots of problems. Would solving even one of these problems help?

CLAIRE: No. I'd have to solve them all.

THERAPIST: That's a pretty tough order.

CLAIRE: So you agree. It's hopeless.

THERAPIST: Well, if I had to solve them all at once, I'd feel pretty overwhelmed. But I bet if I could solve half of them, the other half would be easier to handle.

CLAIRE: Maybe. But how could I solve even half of them?

THERAPIST: Well, you've got me there. That's tough. Whenever I look at more than one problem at a time, they seem pretty tough to solve.

CLAIRE: So you're saying I have to look at one at a time.

THERAPIST: Well, if we look at one of these problems by itself, I bet we can solve it. If we knock them off one at a time, in a while your life would be better.

CLAIRE: How can you fix me getting laid off from my job?

THERAPIST: Oh, I'm guessing we can somehow fix the problems connected to that if we work together. But before getting into the details, let's decide if that's the best place to start. First, are you willing to give my idea a try—solve one problem at a time?

CLAIRE: Yeah. For a bit.

THERAPIST: OK. Let's look at your list here. Why don't you pick the problem we should solve first? Which one could we solve to help you right now?

Her therapist simultaneously acknowledged Claire's hopelessness and provided an alternative viewpoint. By using guided discovery (described in more detail in Chapter 13 of this guide), her therapist helped Claire see the advantages of tackling one problem at a time. Making progress in solving one problem would provide more hope to Claire than hours of discussion about hope. You can counteract hopelessness with positive problem solving and action. There is a possibility that clients who perceive their future as hopeless will see a glimmer of hope if they experience some progress and relief from suffering. If hopelessness is not addressed in a meaningful way, people can become suicidal. For a thorough discussion of the assessment and treatment of suicidal clients, we recommend books by Wenzel, Brown, and Beck (2009) and Jobes (2016).

THE EVIDENCE BASE FOR *MOM2*'S APPROACH TO DEPRESSION

MOM2 Chapter 13 includes a brief summary of evidence-based treatments for depression, written in a manner easily understood by general readers (pp. 198–201). The important take-away message for readers is that there are many effective treatments for depression, and if one doesn't work, they can try another. This hopeful message is one you can offer your clients. There is growing evidence that a broad variety of treatment approaches are helpful for depression. As clinicians, we want to be aware of this literature, and also cognizant that the very best depression treatments are those that also provide a buffer against relapse. A succinct summary of the research regarding effective psychotherapy for depression is offered here.

Many Effective Therapies for Depression

The three evidence-based therapies for depression with the largest amount of research support were developed in the 1960s and 1970s. Aaron T. Beck articulated a new theory of depression in the 1960s that linked emotional, behavioral, neurobiological, and

motivational aspects of depression to cognition (Beck, 1967). Over the next decade, Beck and his colleagues developed cognitive therapy (CT) for depression (Beck et al., 1979). Meanwhile, Peter Lewinsohn and his colleagues at the University of Oregon were developing the first version of behavioral activation (BA) therapy for depression (Lewinsohn, 1974), which was later elaborated by Martell, Addis, and Jacobson (2001) and Martell et al. (2010). Interpersonal therapy (IPT) for depression was also developed in the 1970s, and many studies demonstrated its effectiveness (DiMascio et al., 1979; Weissman et al., 1979). IPT targets the acute symptoms of depression by treating interpersonal relations: grief, role disputes, role transitions, or interpersonal deficits that are associated with a current episode of depression (Weissman & Klerman, 1990).

All three of these forms of psychotherapy were empirically derived. That is, BA, CT, and IPT all have their origins in observations and theories about what maintains depression (reduction in rewarding behaviors in the case of BA, negative thoughts and distorted thinking processes for CT, and interpersonal stress and life events for IPT). Perhaps because there have not been widespread established training programs in the approach, IPT has never been as widely practiced as the other two therapies, despite good research outcomes. BA and CT became the most widely researched forms of psychotherapy for depression in the final decades of the 20th century and opening decades of the 21st century. These therapies each have extensive research support and directly address the behavioral, the cognitive, and often even the interpersonal maintenance factors considered central to depression (Hofmann & Asmundson, 2017). The primary antidepressant skills taught in *MOM2* are drawn mostly from these three therapies.

In recent decades, many other types of psychotherapy have provided evidence of their effectiveness in the treatment of depression. Short-term psychodynamic psychotherapy, problem-solving therapy, nondirective supportive treatment, and social skills training have all been examined in at least five randomized controlled research trials. Meta-analyses of outcome studies for these therapies, as well as BA and CT, suggest that there are no large differences in efficacy among these major psychotherapies for mild to moderate depression (Cuijpers, van Sraten, Andersson, & van Oppen, 2008). Newer therapies such as acceptance and commitment therapy also have evidence of their effectiveness in the treatment of depression from a small but growing number of studies. The cognitive-behavioral analysis system of psychotherapy, which emphasizes interpersonal problem solving, has been developed for chronic depression and has proven effectiveness in a number of studies (see Wiersma et al., 2014). For treatment of more severe depressions, some randomized controlled studies show greater benefit for one therapy over another—usually IPT, BA, or CT (Dimidjian et al., 2006; Luty et al., 2007).

Choosing Treatments That Reduce Relapse

With so many different types of psychotherapy demonstrating efficacy, can therapists simply choose any of these therapies with confidence that they are doing evidence-based treatment for depression? The answer to this question is a qualified "yes" if a therapist is only trying to help a client recover from a current episode of depression and a therapy is chosen that matches the client's preferences. However, depression is a

diagnosis with very high rates of relapse. It is estimated that 50–60% of people who recover from depression will have additional episodes. For those who have experienced two episodes of depression, the risk of recurrence goes up to 80%. "On average, individuals with a history of depression will have five to nine separate depressive episodes in their lifetime" (Burcusa & Iacono, 2007, p. 959).

Therapists are advised to take a long-term view in depression treatment. Prevention of future episodes is just as important as treatment of a current depressive episode. To date, BA and CT have the most extensive research demonstrating their relapse advantage over medication treatments for depression (Hollon et al., 2006; Dobson et al., 2008). Together, BA and CT form the CBT approach to depression presented in *MOM2.* Although research supports BA and CT over medication, there have not been enough studies comparing CBT to other psychotherapy treatments to know for sure whether CBT has a relapse advantage over them.

Bockting, Hollon, Jarrett, Kuyken, and Dobson (2015) provide a comprehensive review of evidence-based approaches for major depressive disorder across the lifespan, using a conceptual framework based on acute treatment, continuation treatment, and prevention strategies for clients in remission. Importantly, they highlight the best interventions for people at greatest risk for relapse. Relapse risk is highest for those people with unstable remission, more previous episodes of depression, and early age of first onset. Their guidelines can be used to help tailor effective use of *MOM2* for depressed clients at different stages of treatment.

Here is a concise summary of Bockting et al.'s (2015) conclusions, derived from their review of randomized controlled trials and meta-analyses:

1. Use of CBT during the acute treatment for depression was more likely to have enduring effects (lower likelihood of relapse) than treatment with antidepressant medications in one meta-analysis; the respective relapse percentages were 39% versus 61% over 68 weeks (Vittengl, Clark, & Jarrett, 2007). In another meta-analysis, clients who responded to CBT were no more likely to relapse than those kept on continuation antidepressant medications (Cuijpers et al., 2013).

2. Even though CBT may prevent relapse for some clients, the rate of overall relapse for CBT remains unacceptably high; it was 29% within the first year and 54% within two years in the Vittengl et al. (2007) meta-analysis. This relapse rate was significantly reduced (to as low as 10% the first year and 36% over 2 years) by continuation-phase cognitive therapy (Jarrett et al., 1998, 2001; Jarrett, Vittengl, & Clark, 2008). Continuation-phase CT generally consists of ten therapy sessions during the eight months following the end of CBT for acute depression. It focuses on helping clients maintain their practice of CBT skills to target residual depression symptoms.

3. Once a client is in remission (two months or longer without significant symptoms), there is some evidence that prevention interventions such as mindfulness-based cognitive therapy (MBCT; Teasdale et al., 2000), well-being cognitive therapy (Fava et al., 2004), and preventive cognitive therapy (Bockting et al., 2005) are beneficial. MBCT has been demonstrated to reduce relapse risk *only* for clients with three or more

previous episodes of major depressive disorder. However, there is encouraging evidence that these interventions might be viable alternatives to maintenance on antidepressant medications for clients who have experienced multiple prior episodes of depression. Relapse rates for an MBCT group that tapered medication usage were 47% over 15 months, compared with a 60% relapse rate for those who continued medication (Segal et al., 2010).

4. Those at higher risk for relapse and recurrence of depression are clients with more residual depression symptoms at the end of therapy, highly fluctuating depression scores on self-report measures near the end of therapy, early age of onset (age 18 or earlier), and/or multiple prior episodes of depression. Thus interventions designed to reduce relapse and recurrence, such as continuation-phase CT and MBCT, are most useful when applied with these higher-risk clients. Antidepressant medications are not very effective as continuation therapy for individuals who have experienced recurrent depressions (Kaymaz, van Os, Loonen, & Nolen, 2008).

The Influence of This Research on *MOM2*

When we wrote *MOM2,* we wanted it to reflect best practices in evidence-based treatments for depression and the other moods addressed. Given the preponderance of evidence summarized above, we chose to emphasize behavioral activation and thought record skills in *MOM2.* These two approaches provide both short-term effectiveness and relapse management advantages for depression treatment. We also included skills such as acceptance and mindfulness, derived from therapies that currently show evidence of effectiveness in either depression treatment or relapse prevention. Finally, in anticipation that depressed individuals would also want to increase happiness, we included skills derived from positive psychology, specifically gratitude and kindness exercises.

Thus, to alleviate depression, *MOM2* places primary emphases on behavioral activation and effective use of thought records for cognitive restructuring. Skills such as acceptance, mindfulness, gratitude, and the like are typically introduced after these two skill sets have been practiced for some time. The first of the two core antidepressant skills, behavioral activation, is introduced and taught in *MOM2* Chapter 13.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 13

Reluctance to Do Activities

Some people are reluctant to do planned activities, especially during the early stages of behavioral activation. When people report that they have not done activities, a spirit of friendly curiosity is the best therapeutic stance. Ask if they were willing to do the activities when they agreed to them. Some people are overly compliant and may verbally agree to things they really don't intend to do. In these instances, thank them for their honesty, and ask them to tell you in the future if they don't think they want to or can do the learning exercises you discuss: "This is your therapy, and I don't want you to

agree to do things you aren't willing to try. We can always figure out an alternative if something doesn't suit you."

More commonly, people don't try activities for one of these reasons: They are experiencing inertia; the activities seem overwhelming; or they are pessimistic that planned activities will improve mood. Rather than trying to convince someone to increase activities, identify which of these three reasons is the roadblock, and set up a behavioral experiment to help overcome this hurdle. Say, "I imagine there were good reasons you didn't do the activities this week. When you thought about doing them, what got in the way?" Here are three types of behavioral experiments that can help clients overcome each of these potential roadblocks to activity.

Inertia Interferes

Many years ago, Padesky (1986) introduced a "five-minute rule" to help people who are depressed overcome inertia. People are told that they only need to do activities for five minutes to get full credit for doing them. At the end of five minutes, they can stop doing the activity or continue, as they wish. Here is an example: "If you are scheduled to wash the dishes, set a timer for five minutes. Fill the sink with soap and water and begin washing. When your timer goes off, you can simply stop if you want and leave the rest of the dishes there. Then you can record on your activity schedule that you washed the dishes." People who are depressed find it much easier to begin a task if they only need to do it for five minutes. Because inertia often carries them forward even when the timer goes off, they often end up doing an activity more than five minutes. This leads to a double boost in mood, because they have "completed the activity for 5 minutes" and then done "extra credit." It is important to set up the five-minute rule in good faith. It is not a "trick" to get clients to do more. It is designed to foster *some* activity rather than none. If clients learn that activities are easier to continue than they expected once they start them, this is a bonus.

Tasks Appear Overwhelming

When people feel overwhelmed by an activity, the best antidote is to simplify the activity. If a walk to the park is too far, a person can walk to the end of the block and back. Walking with someone else or a pet may make a walk easier. Putting activities in order from easiest to more difficult can also help. For example, find out which of the following morning activities are easiest or most rewarding for someone: showering, getting dressed, making coffee, or telephoning a friend. If making and drinking coffee and talking to the friend are more pleasurable than showering and dressing, it might be easier to make coffee and call the friend before getting ready for the rest of the day. Of course, someone else may prefer showering and dressing first, in order to use making coffee and talking with a friend as rewards. Ask your clients to experiment and see what works best for them. For quite complex tasks, it may be necessary to work together in session to figure out how to divide the task into small steps that will lead to meaningful progress. The idea is to plan steps that seem less overwhelming in order to help overcome avoidance.

Clients Are Pessimistic

It is difficult to convince someone who is pessimistic that things can be better using discussion only. Positive and meaningful experiences are much more likely to increase hope. Therefore, often the best response to pessimism about change is to set up small experiments to test pessimistic predictions. Real-time recording of the outcomes of a series of experiments is important, because otherwise the person can reject positive experiences as simply "a fluke" or can distort what happened.

For example, Elias believed that there was no point in leaving his apartment and interacting with other people: "If I go out, I won't feel better; I'll just feel worse." In order to test this underlying assumption, he and his therapist used Worksheet 11.2 (Experiments to Test an Underlying Assumption, *MOM2,* p. 149). In the "Outcome of experiment" column, they added the instruction to rate his mood before leaving the apartment and just after talking with someone else. They set up three experiments for the first week, writing in the names of specific people in the neighborhood with whom Elias would talk. As guided by the worksheet, they anticipated problems that might interfere and strategies for overcoming these. These were brief, planned interactions with a local convenience store clerk Elias liked, with children who played in the street after school, and with a neighbor who walked on a regular schedule. Much to his surprise, Elias's mood improved slightly after each encounter. He continued this experiment for another week before agreeing to leave the apartment each day for longer and longer periods of time.

Inability to Feel Pleasure

Some people diagnosed with depression report an almost complete lack of pleasure or responsiveness to activities they expect to be pleasurable. These people often describe a flat emotional experience to most of their life experiences, including therapy. The inability to experience pleasure is addressed briefly on pages 216–217 of *MOM2.* As recommended there, it may take a few weeks of intentional practice for people to begin to experience small amounts of pleasure. It is best to begin these activities in the therapy session, as the following excerpt illustrates.

THERAPIST: So you never experience any pleasure?

CARL: No.

THERAPIST: Let's do an experiment together. Stand up and walk over here with me. Let's look at this poster on my wall.

CARL: I don't get any pleasure from looking at it.

THERAPIST: That's fine. Can you tell me one color in this poster that you prefer more than other colors?

CARL: I'm not sure.

THERAPIST: Just look a bit and tell me one color that appeals to you, even a little bit.

CARL: I think this green here.

THERAPIST: OK. Look at that green, and just allow yourself to appreciate that color for a bit.

CARL: I still don't experience pleasure.

THERAPIST: I'm not expecting that. However, the first step to being able to experience pleasure is to begin to learn what you like and pay attention to those things. Let's open the window for a moment and listen to the sounds outside my office. I'd like you to listen for a while and then tell me a sound that you prefer over the other sounds.

CARL: (*After about one minute*) I hear a ball bouncing at the park.

THERAPIST: Oh? Yes, I hear it too. Let's just listen to that ball bounce for a bit. (*A moment of silence passes.*) Now let's walk around the office and touch different textures. For example, the couch and the pillows are made of different fabrics. Touch different objects in my office and find one you like.

CARL: (*After touching five or six objects*) I like this vase. It's cool to touch.

THERAPIST: Good. It's a good sign that you are able to find things you like. Colors, sounds, things you touch. This can be the beginning of learning to experience pleasure. This week I propose you go for a walk once a day. During this walk, I'd like you to find one sight, one sound, one smell, and one touch that you prefer or even like. The touch can be something you touch with your hands, or it could be the feeling of the wind or sun on your face. Do you understand what I'm asking you to do?

CARL: Yes. And do you think I'll experience pleasure doing this?

THERAPIST: I'm not sure. We'll find out together. I don't want you to focus on pleasure just right now. Just tune in and notice what sensory experiences you prefer. Once you learn this, you will be able to take additional steps that might lead to experiences of pleasure. Would you be willing to do this?

CARL: Yes.

THERAPIST: Let's write down a summary of what you are going to do this week, and we can write what you preferred in my office, so you have a sample of what you are going to write. Maybe you can write this in your therapy notebook, and I will write it in my notes as well.

Once clients become aware of sensory preferences, the next step is for them to spend extra time focusing on these experiences. Even 30 seconds of focusing can begin to sow the seeds of pleasure. In addition to sights, sounds, touches, and smells, people can focus on tastes they prefer when eating. As they begin to do this, their daily activities can begin to incorporate the idea of savoring small experiences. This can include focusing on these experiences or even intensifying them by moving closer or making other adjustments to increase awareness and the potency of the experience. For example, Carl walked to the park and enjoyed the sounds of a soccer match up close. This could eventually lead to greater engagement, such as speaking to some of the people watching or playing soccer.

Usually several weeks of these types of exercises will begin to lead to small experiences of pleasure or enjoyment. This may come about because the clients are now actively looking for and savoring positive experiences. Also, mindful focusing on sensory experience can help reduce the negative ruminations that often interfere with positive experiences. Do not put the focus in early weeks on ratings of pleasure, because looking for pleasure can actually dampen the positive aspects of these experiences. People experiencing depression are likely to discount small positive experiences if they don't reach the threshold of pleasure, and this can prematurely convince them they are incapable of experiencing pleasure.

Extremely Low Activity Levels

Some people have very low activity levels when they are depressed. This is especially likely to be true for those with severe levels of depression. These individuals may lie in bed or sit in front of a TV for hours with little energy or motivation to do much else. When people are at such a low level of functioning, we recommend your therapy be more behavioral than cognitive. Focus on the behavioral activation exercises discussed in *MOM2* Chapter 13. You can help energize severely depressed clients by constructing very small behavioral experiments following the principles outlined in *MOM2* Chapter 11, Underlying Assumptions and Behavioral Experiments, and as described in Chapter 7 of this clinician's guide.

For example, Petra announced, "When I feel really depressed, I can't take a walk or do anything but sit in a chair." Her therapist decided to help test this belief in a series of small-step experiments in the office. First, her therapist helped Petra stand and walk a few feet from her chair. Following this experiment, Petra and her therapist discussed its meaning.

THERAPIST: You told me you didn't think you could walk over to the desk. Are you surprised you did it?

PETRA: Yes.

THERAPIST: What are you feeling right now?

PETRA: Nothing.

THERAPIST: Do you think you could do it again?

PETRA: I suppose so.

THERAPIST: I wonder what else you could do if we tried it out?

PETRA: I don't know.

As you can see, Petra remained fairly nonresponsive. Notice that her therapist kept questions and statements brief and simple, to increase the likelihood that Petra would understand what was said. Her therapist's questions introduced possibilities that might become meaningful to Petra at some point. It is important to take a gentle and yet firm approach to help someone who is this depressed to increase activities in small but meaningful ways. Discovering positive interests from their past can be a guide to the types

of activities that will be most meaningful and motivating for them. For example, Petra enjoyed music. She might be motivated to get out of her chair to put on some music. If she did this, she might be able to use the energy of the music to fuel other activities. When depression lessens, clients with low activity levels are ready to benefit from cognitive interventions in addition to behavioral activation.

Discriminating among Sadness, Grief, and Depression

People who have experienced recurrent depression, or who experience a mixture of grief and depression, often have difficulty discriminating among depression, grief, and sadness. Some people falsely believe that they need to rid themselves of all sadness, or they will be susceptible to a return bout of depression. Help your clients understand that sadness and grief are normal, healthy emotions that are part of the human experience. These emotions reflect what we value in life and validate our love for people we have lost.

One way to teach discrimination between depression and sadness or grief is to review the cognitive features of depression described on pages 194–198 *of MOM2* Chapter 13. Thoughts such as "I miss him," "My life is empty now that she is gone," and "I wish this had never happened" signal sadness or grief because they focus on what has been lost. In contrast, depressed thoughts are self-critical ("It's my fault; I'm no good"), pessimistic ("No one cares for me"), and hopeless about the future ("Things will never get better; nothing will work out for me"). The content of thoughts is often the best way to determine if emotional reactions are part of healthy grieving, everyday sadness, or potentially devastating depression. Sadness and depression often feel similar physiologically and emotionally. You can consider the length of time these feelings last, how deeply clients feel them, and whether or not these are responses to a recent event or loss. Generally sadness resolves in a few hours or days, whereas depression is only diagnosed after two weeks or more of persistent low mood. Although people experience and express grief in a wide variety of ways, most return to healthy levels of functioning by the second year of bereavement (Bonanno & Kaltman, 2001).

10

Understanding Anxiety and Treatment Principles

(*MOM2* CHAPTER 14)

ANXIETY

THERAPIST: Thanks for telling me a bit about your history and current struggles, Lucas. As I understand it, you have been feeling pretty stressed and anxious since you lost your job three months ago. This has gotten worse over time, because you have had difficulty finding a new job that earns as much as your old one. So that I can make sure we stay on track, what would you say are your goals for therapy right now?

LUCAS: I want to get rid of this anxiety. And I want to know what ideas you have for how I can get a good job again.

Like Lucas, people who experience anxiety commonly seek therapy with a primary goal to eliminate anxiety. Sometimes anxious clients appear impatient, as if they are thinking, "I've already been here 30 minutes and I still feel anxious. Can't you help me?" Thus health care providers can feel pressured to provide quick relief in the very first session. Perhaps this is one reason why antianxiety medications and training in relaxation methods are two of the most common interventions clinicians offer to people seeking treatment for anxiety. This is unfortunate. Even though these approaches offer short-term relief, each can interfere with long-term positive treatment outcomes for anxiety disorders (see Foa, Franklin, & Moser, 2002).

MOM2 Chapter 14, Understanding Your Anxiety, lays the groundwork for you and your clients to follow a different, more effective treatment path. As shown in the Chapter 14 Summary, it helps your clients recognize common anxiety symptoms, understand the role that avoidance and safety behaviors play in maintaining anxiety, appreciate the importance of identifying anxious thoughts and images, and practice skills that can help them face their fears.

Chapter 14 Summary

(*MOM2,* pp. 219–252)

- ✓ Common types of anxiety include phobias, social anxiety, panic disorder, posttraumatic stress disorder, health worries, and generalized anxiety disorder.
- ✓ Anxiety symptoms include a wide range of physical reactions; moods that range from nervousness to panic; avoidance of situations or feelings; and worries about danger, as well as thoughts about not being able to cope.
- ✓ Common behaviors when we are anxious are avoidance and safety behaviors. These types of behaviors reduce our anxiety in the short term, but make our anxiety worse over time.
- ✓ Anxious thoughts include overestimations of danger, along with underestimations of our ability to cope with the threats we anticipate.
- ✓ Thoughts that accompany anxiety often begin with "What if . . . ?" and contain the theme that "Something terrible is going to happen, and I won't be able to cope."
- ✓ Our anxious thoughts often occur as images. It is important to identify these images so we can respond to them in helpful ways.
- ✓ Different types of anxiety are characterized by different thoughts, depending on the type of dangers anticipated.
- ✓ One of the best ways to overcome anxiety is to face our fears through exposure to what scares us. A Fear Ladder is often used to help us face our fears one step at a time at a pace we can tolerate.
- ✓ Many skills can help us manage anxiety as we face our fears, including mindfulness and acceptance, breathing, progressive muscle relaxation, imagery, and changing our anxious thoughts.
- ✓ Medication may be helpful to some people in the short term, but it does not lead to enduring improvement in anxiety for most people.
- ✓ Changing our thoughts is an important way to achieve enduring improvement from anxiety.
- ✓ *Mind Over Mood* chapters can be customized and read in various orders, to help you learn *Mind Over Mood* skills for various purposes. Figure 14.6 describes a helpful chapter reading order for anxiety.

ANXIETY GUIDE FOR CLINICIANS: THE FLOW OF THERAPY

Clients who are anxious want fast relief, and we want to help them as quickly as possible. However, compassion for clients with anxiety disorders requires resisting our natural therapist impulses to help people feel comfortable throughout therapy. Many therapy methods that have proven long-term effectiveness for reducing anxiety actually lead to increases in anxiety in the short run. Instead of steady comfort, we aim to offer clients like Lucas confidence that we can understand their anxiety, we have a plan for helping them, we will be with them each step of the way, the most effective steps in therapy are ones that are likely to increase their anxiety temporarily, and we will only ask clients to take those steps that have a proven track record of reducing anxiety in the long run.

To provide enduring help for our clients, we need to help them discover what is triggering their anxiety. In early sessions, we help them identify the thoughts and images that evoke anxiety in particular situations. We also identify the ways in which our clients avoid triggers for their anxiety and practice safety behaviors, because avoidance and safety behaviors undermine the effectiveness of anxiety interventions.

Anxiety is maintained by underlying assumptions, so we help clients uncover the "If . . . then . . ." conditional rules that are currently operating (e.g., "If something bad happens, then I can't cope"). These assumptions are tested with behavioral experiments. Sometimes behavioral experiments are exposure-based: Clients stay in situations long enough to find out whether the feared consequences occur. Other behavioral experiments directly test anxious assumptions. For example, a client who believes, "If I make a mistake, then others will think poorly of me," could intentionally make mistakes and then interview trusted others to find out what impact this has on their impression of them. We encourage our clients to do a sufficient number of behavioral experiments until they develop new assumptions that allow them to approach situations with less fear and manage any anxiety they do feel. Throughout the course of therapy, we encourage curiosity rather than self-criticism. We guide our clients to approach rather than avoid what they fear.

This chapter of this clinician's guide offers numerous therapist–client dialogues that illustrate anxiety treatment principles, to guide your implementation of these therapy steps. The *MOM2* anxiety chapter that clients read (Chapter 14) describes many of these same treatment principles, so they will understand why you are helping them approach rather than avoid what they fear, identify anxious thoughts and images, and participate in exposure exercises and behavioral experiments to test their fears.

At the end of *MOM2* Chapter 14, readers are shown a figure that tells them which chapters to read next to learn the skills most important in anxiety treatment (Figure 14.6, *MOM2,* p. 250). This figure is the same as the Anxiety Reading Guide (reprinted on p. 457 of Appendix A here), which directs them to read the remaining chapters of *MOM2* in an order that fits with evidence-based practice guidelines for anxiety. The Anxiety Guide for Clinicians (see Table 10.1) links the *MOM2* chapters as listed in the Anxiety Reading Guide with chapters in this clinician's guide. In the following sections we offer a few observations about the particular ways anxiety can affect your clients' use of these *MOM2* chapters.

TABLE 10.1. Anxiety Guide for Clinicians: *MOM2* Chapters (in Order Recommended by Anxiety Reading Guide) and Corresponding Clinician's Guide Chapters

MOM2 chapters	Purpose	Clinician's guide chapters
1–4	Introduction to MOM2 and five-part model.	2
14	Learn more about anxiety and treatment principles. Make a Fear Ladder.	10–11
5	Set goals. Identify personal signs of improvement.	3
11	Use behavioral experiments to test underlying assumptions as you move up your Fear Ladder.	7
10	Strengthen alternative thoughts. Use Action Plans to solve problems. For problems that can't be solved, develop acceptance.	6
13	Learn more about depression, if relevant.	9
15	Learn more about anger, guilt, or shame, if relevant.	12
6–9 and 12	To help with other mood and life issues once anxiety improves.	4–5 and 8
16	Make a plan to continue to feel better over time (relapse management).	13

1. After people complete *MOM2* Chapter 14, the Anxiety Reading Guide directs clients to proceed to Setting Personal Goals and Noticing Improvement (*MOM2* Chapter 5). You may have already assigned this goal-setting chapter earlier in therapy; if your clients have already set goals, this is a good time to review them. *Make sure your clients' goals emphasize managing and approaching anxiety, rather than eliminating it or avoiding situations that evoke it.* Periodically over the course of therapy, review their responses on the Signs of Improvement worksheet (Worksheet 5.4, *MOM2,* p. 37). Also, review their score sheet for the *Mind Over Mood* Anxiety Inventory (Worksheet 14.2, *MOM2,* p. 222) to see how much their anxiety scores on this inventory (discussed in detail in a later section) have changed since therapy began. Noticing and appreciating signs of improvement will reinforce clients' efforts and boost their confidence that your treatment plan is effective. Once goals are set and/or signs of improvement are reviewed, you and your clients will begin identifying their underlying assumptions and testing these with behavioral experiments (*MOM2* Chapter 11). Use Chapter 7 of this clinician's guide to learn more about identifying underlying assumptions and constructing behavioral experiments, *which together constitute the primary focus of anxiety treatment.* Additional information about the common underlying assumptions linked to particular types of anxiety disorders, and suggestions for how to tailor behavioral experiments for each disorder, are provided in Chapter 11 of this clinician's guide.

2. Anxiety treatments also include Action Plans to solve problems and acceptance exercises, as described in *MOM2* Chapter 10. Table 10.1 notes that these skills are elaborated in Chapter 6 of this clinician's guide. Clinicians can move back and forth between *MOM2* Chapters 10 and 11 as needed throughout anxiety treatment, as long as behavioral experiments remain the primary intervention.

If there is additional therapy time, people can learn whichever of the additional MOM2 skills seem most likely to be helpful. For example, if there is comorbid depression, they can read Understanding My Depression (*MOM2* Chapter 13) to rate this mood and begin practicing behavioral activation and then proceed to learn effective use of 7-Column Thought Records (*MOM2* Chapters 6–9). Before therapy ends, allow time to help clients build a relapse management plan and a posttherapy plan to boost their happiness and positive sense of well-being. Chapter 16 of *MOM2* guides those efforts, which are described in greater detail in Chapter 13 of this clinician's guide.

THERAPIST CONFIDENCE IN ANXIETY TREATMENT

How can you develop the confidence to convey a nuanced message of compassion to clients experiencing anxiety: "I want you to feel better quickly, and to do that, you will need to feel more anxiety now"? Knowledge and experience are necessary. Your *knowledge* can be fueled by the information and guidelines offered in this chapter and the next (Chapter 11), as referenced in Table 10.2. Your therapy *experience* is enhanced when you apply these anxiety treatment principles and protocols under the guidance of supervisors or consultant therapists who are skilled in the application of these effective anxiety treatments.

We recommend that you read this chapter of the clinician's guide (Chapter 10) jointly with the next (Chapter 11) to learn best practices for effective use of *MOM2* in anxiety treatment. The present chapter (10) highlights information taught in *MOM2*

TABLE 10.2. Content and Purpose of Clinician's Guide Anxiety Chapters (Chapters 10 and 11)

Clinician's guide anxiety chapters	Purpose
Understanding Anxiety (10)	• Illustrates anxiety treatment principles to guide treatment decisions. • Highlights use of information taught in *MOM2* Chapter 14 (Understanding Your Anxiety), consistent with these treatment principles.
Common Anxiety Disorders (11)	• Offers treatment-planning context. • Highlights the differential application of anxiety treatment principles and *MOM2* methods with particular anxiety diagnoses. • Cautions regarding use with related disorders (OCD and PTSD).

Chapter 14, along with anxiety treatment principles to guide its best use. You learn how to foster curiosity in your clients who, like Lucas, want to eliminate anxiety. Curiosity is often the key that encourages clients to approach rather than avoid their anxiety. Illustrative case examples demonstrate the central role that imagery and underlying assumptions play in triggering and maintaining anxiety responses. And you learn how to discern whether teaching your clients' anxiety management methods like controlled breathing are likely to assist or interfere with positive therapy outcomes.

The next chapter (11) puts these ideas into a treatment-planning context by highlighting how to differentially apply *MOM2* with particular anxiety diagnoses, as well as cautions regarding related disorders such as obsessive–compulsive disorder (OCD) and posttraumatic stress disorder (PTSD). There you learn how and why the same anxiety interventions that provide effective help for one client can actually interfere with successful outcomes for another client. For this reason, before initiating a treatment plan, it is crucial first to identify the triggers, maintenance factors, and type(s) of anxiety someone experiences (e.g., generalized anxiety disorder [GAD], panic disorder, social anxiety). Chapter 11 illustrates how to accomplish each of these tasks.

ANXIETY TREATMENT: GUIDING PRINCIPLES

Many people experience multiple types of anxiety. They can hold anxious assumptions that do not neatly fit into a single diagnosis or match any one anxiety type. Sometimes standard treatment protocols for anxiety do not work as intended. These are some of the reasons why a full understanding of transdiagnostic principles in anxiety treatment is needed. Such principles will help you make decisions about what treatment interventions to try first, discern whether clients' responses to anxiety are good coping or safety behaviors, and guide modifications to standard anxiety treatment protocols when we encounter roadblocks to recovery.

Five important principles of anxiety treatment to guide your decision making are illustrated throughout this chapter:

1. Welcome anxiety: Evoke curiosity instead of self-criticism.
2. Measure anxiety and track improvement.
3. Approach anxiety instead of allowing avoidance and safety behaviors.
4. Therapy goal: Manage anxiety, don't eliminate it.
5. Identify and test the central beliefs in anxiety.

1. Welcome Anxiety: Evoke Curiosity Instead of Self-Criticism

Unlike depression, which people usually experience 24/7 for a number of weeks or months, anxiety is a mood that can be experienced intermittently. Some people only experience anxiety in particular situations; others experience low levels of anxiety much of the time, with periods of heightened anxiety throughout the week. Therapists

Clinical Tip

- When people are self-critical, they ask, "What's wrong with me?" Self-criticism is judgmental and is often accompanied by avoidance.
- Therapy efforts are designed to evoke nonjudgmental observation paired with curiosity: "What is happening? What might be causing this?" Curiosity is often associated with approach and an attitude of investigation.

cannot rely on clients' experiencing anxiety in the therapy office. Some clients who struggle with anxiety feel quite calm when sitting with their therapists.

In order to work effectively with anxiety, we therapists need to bring it into the room during therapy sessions so we can learn its triggers, identify and test maintaining thoughts and behaviors, and evaluate the benefits of the treatment interventions. To accomplish these tasks, we need to welcome anxiety even when our clients do not. We welcome anxiety when we approach it instead of avoiding it, when we use experiential methods (e.g., imagery, role plays, behavioral experiments) to evoke anxiety in session, and when we express curiosity about our clients' anxiety experiences rather than trying to dampen them down. By using a "Welcome anxiety" approach, we model an eagerness to learn more about our clients' anxiety, and offer encouragement that they will eventually learn to welcome anxiety as well.

The opening pages of *MOM2* Chapter 14 begin by describing a variety of things that can prompt anxiety (bottom of p. 219), and then ask readers to reflect on their own experiences with anxiety and write whether their anxiety is fairly constant or sparked by particular situations (top of p. 220). This simple introduction to anxiety prompts people to begin observing their anxiety, and, at the same time, to consider what their own personal anxiety triggers could be. In these ways, this reflection exercise is an invitation for readers to welcome anxiety by making observations and becoming more curious about it. Curiosity is an important antidote to the self-criticism that is a common feature of anxiety. Rather than noting, "I'm anxious," and asking, "What's wrong with me?", we want to guide our clients to begin to observe, "I'm anxious"—and then to ask with genuine curiosity, "What could be triggering this?" or "What just went through my mind? Did I have any images or memories?"

2. Measure Anxiety and Track Improvement

Another way to spark clients' curiosity is to ask them to measure and track their anxiety symptoms. Doing so assists them in figuring out when and why anxiety increases or decreases, and also helps them track the impact of skills they learn and practice. When people experience anxiety, they are often more aware of physical symptoms than of any other component (e.g., thoughts, behaviors). Thus many physical symptoms are rated

on Worksheet 14.1, the *Mind Over Mood* Anxiety Inventory (referred to in this discussion as *MOM*-A; *MOM2,* p. 221). Readers are advised to fill out the *MOM*-A weekly and graph their scores on Worksheet 14.2 (*MOM2,* p. 222).

Some clients may prefer a fillable .pdf version of the *MOM*-A, which can be downloaded into a smartphone or another electronic device and is available on The Guilford Press's *MOM2* companion website (again, see the box at the end of the *MOM2* table of contents). The .pdf version is self-scoring; a total score is generated at the bottom of the form as items are rated. Clients can graph their total score each week on Worksheet 14.2 (also on a paper copy from *MOM2,* p. 222, or in a .pdf version available on Guilford's companion website) to track changes in anxiety symptoms over time. A graph of anxiety scores provides visible evidence to both you and your clients of improvement or lack of improvement, thus indicating whether therapy is helping or needs to be modified in some way. When clients have difficulty or express uncertainty about graphing anxiety scores, collaborate with them and complete their graphs in session. Staying curious about what this experience is like for your clients will help you identify and address any issues contributing to avoidance or confusion about these worksheets.

You are encouraged to ask *all* clients (regardless of diagnosis) to complete the *MOM*-A or some other anxiety measure at intake, to screen for anxiety symptoms and also to establish a baseline anxiety symptom score. In the beginning of treatment, we recommend that the *MOM*-A be used weekly by people who experience anxiety. Once someone has significantly improved, monthly or quarterly ratings are still helpful to ensure that improvements are maintained or warn if anxiety symptoms are returning. Recurrence of higher anxiety scores after therapy ends can signal the need to implement a relapse management plan (see *MOM2* Chapter 16, and Chapter 13 of this clinician's guide).

Anxiety scores often *increase* early in treatment, unlike depression scores, which frequently begin dropping soon after therapy begins. Why would anxiety scores increase during the early weeks of therapy? Before entering therapy, most people avoid circumstances in which they feel anxious. Effective anxiety treatments ask people to think more about their anxiety, make observations about anxious thoughts and images, and approach (rather than avoid) situations in which they feel anxious. As treatment begins and people stop avoiding anxiety-provoking situations, their anxiety will temporarily increase. Such increases can be discussed with clients as positive signs that they are facing their anxiety more often—a first step for learning more about it. Fortunately, most types of anxiety respond to treatment within a short period of time. Thus anxiety scores can be expected to drop as soon as clients begin testing the assumptions that maintain their anxiety and developing confidence in alternative, less anxiety-provoking beliefs.

By graphing weekly anxiety scores on *MOM2*'s Worksheet 14.2, clients can observe increases and decreases in anxiety as therapy proceeds. Observing patterns of change in anxiety scores helps determine when to continue or change treatment plans. Of course, many treatment steps will lead to a temporary increase in anxiety; weekly fluctuations in scores are not as significant as trends sustained over several weeks or more. If someone has persistent high scores on the *MOM*-A as therapy proceeds, consider whether your therapy is adequately targeting central anxiety issues or needs to be modified.

3. Approach Anxiety Instead of Allowing Avoidance and Safety Behaviors

"Approach anxiety" could be the mantra of effective therapy. Convincing clients to approach their fears requires overcoming the most common behavioral responses to anxiety: avoidance and safety behaviors. It makes sense that people avoid circumstances triggering anxiety, because anxiety can be uncomfortable. And when it is impossible to avoid anxiety, people practice safety behaviors in an effort to reduce perceived dangers or threats. Safety behaviors are sometimes clearly observable (e.g., leaving home only if with a friend); others can be quite subtle (e.g., carrying an antianxiety pill in a pocket). They can also be cognitive (e.g., planning a response in advance to every possible outcome in order to avoid the "danger" of uncertainty).

After learning about common anxiety symptoms and rating these on the *MOM*-A, readers of *MOM2* are asked to identify situations in their lives that they avoid, along with some of their personal safety behaviors. Some avoidance and safety behaviors are easy for people to identify. Others may be outside of their awareness or may be embarrassing in some way; if they are embarrassing, people can be reluctant to reveal them. Be on the alert for subtle forms of avoidance and safety behaviors that your clients have not yet disclosed. This is important, because continuation of avoidance and safety behaviors will undermine positive therapy outcomes. Effective therapy for anxiety disorders always entails exposure to fears without the use of safety behaviors.

Staying alert to factors that can reduce the effectiveness of exposure is an important therapist task (see Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). For example, Kyra had a fear of collapsing and dying when she became light-headed. She told her therapist that she avoided elevators and heights because she had felt light-headed in these situations in the past. She also identified a safety behavior: She ate light meals throughout the day so that she would not become light-headed from hunger. Her therapist and Kyra did experiments in session in which she hyperventilated, bringing on sensations of light-headedness, so Kyra could test her assumption that light-headedness would lead to collapse and death. Kyra's therapist did not realize that at the end of each experiment, Kyra thought, "I'm glad I'm sitting down. If I stood up right now, I might collapse and die." Sitting during these in-session experiments served as a subtle and unidentified safety behavior. When it came time to ask Kyra to practice hyperventilation at home between sessions, she did so while lying on a floor mat. When she practiced hyperventilation in an elevator, she leaned against the wall to ensure stability. As long as Kyra continued to engage in these safety behaviors during her experiments, she was maintaining her belief that it was potentially dangerous to become light-headed.

Kyra's therapist could have avoided failing to identify these safety behaviors by regularly asking her after each experiment, "Did you do anything to avoid collapsing, or did anything in this experiment prevent you from collapsing?" This question might have prompted Kyra to tell her therapist about her beliefs in the benefits of sitting while doing the experiments. Similarly, the therapist could have asked this question regarding at-home experiments.

Be on the alert for a variety of subtle safety behaviors, such as doing experiments only for a brief period of time so that anxiety does not become too great, only doing

Clinical Tip

To identify subtle safety behaviors, always ask, "Is there something about how you did this experiment that you think helped keep you safe from what you feared might happen?"

experiments when alone or with someone else, or avoiding experiments in particular locations or at certain times of the day or night. Get as many details as possible about how, when, where, with whom, and for what length of time people do experiments. And always ask, "Is there something about how you did this experiment that you think helped keep you safe from what you feared might happen?"

Safety behaviors are designed to help prevent the occurrence of one or more feared outcomes. Often they can even appear to therapists to be aspects of good coping. For example, it might appear to be a good idea for someone experiencing social anxiety to take a friend to a social gathering. Table 10.3 summarizes the differences between safety and coping behaviors, as well as the consequences of avoidance versus approach. Judging whether a client's behavior is a safety behavior or a good coping practice usually requires finding out its purpose, which is either to eliminate danger or to increase the client's ability to stay in anxiety-provoking situations. Also, it is important to understand the long-term impact of the strategy on anxiety: Does it maintain or decrease anxiety over time?

We advise actively exploring these aspects of clients' coping behaviors, to determine whether or not they are actually safety behaviors in disguise. In the example above, if the person experiencing social anxiety would not attend the social event without the friend, perhaps taking the friend along is good coping in the short run until the person feels confident enough to go alone. However, if the person relies on the friend to create positive social interactions during the event, and hangs back acting merely as an observer, then taking the friend along is most likely filling the role of a safety behavior.

TABLE 10.3. **Safety Behaviors versus Coping Behaviors; Avoidance versus Approach**

Safety behaviors	Coping behaviors
Designed to eliminate danger.	Designed to help us approach, stay in, and manage situations that frighten us.
Maintain or increase anxiety.	Lead to a decrease in anxiety over time.
Avoidance	**Approach**
Short-term: Decrease in anxiety.	Short-term: Increase in anxiety.
Long-term: Increase in anxiety.	Long-term: Decrease in anxiety.

4. Therapy Goal: Manage Anxiety, Don't Eliminate It

Avoidance and safety behaviors aim to eliminate anxiety. Effective therapy relies on a different goal: to approach and learn to manage anxiety. Because it is in our clients' best interest to stop avoidance and safety behaviors, we want to demonstrate that these actually interfere with their ability to manage anxiety. Introduce this theme at the beginning of therapy. Discussions about the necessity of experiencing anxiety in order to understand it better are a good starting point. Consider the snippet of dialogue between Lucas and his therapist that opened this chapter. We repeat those statements here, along with the following discussion, which helped Lucas understand one disadvantage of getting rid of anxiety.

THERAPIST: Thanks for telling me a bit about your history and current struggles, Lucas. As I understand it, you have been feeling pretty stressed and anxious since you lost your job three months ago. This has gotten worse over time, because you have had difficulty finding a new job that earns as much as your old one. So that I can make sure we stay on track, what would you say are your goals for therapy right now?

LUCAS: I want to get rid of this anxiety. And I want to know what ideas you have for how I can get a good job again.

THERAPIST: (*Writing down what Lucas has said*) OK. I do have a bit of concern about this goal of getting rid of your anxiety. Do you mean never feel anxious again?

LUCAS: That would be great!

THERAPIST: (*Smiling*) I can imagine why you would think that. Feeling anxious is often no fun. However, anxiety signals to us that we might be in danger. (*Pause*) Do you have a smoke alarm in your apartment?

LUCAS: Yes.

THERAPIST: Does it ever go off when there is not a fire?

LUCAS: Sure. When I barbecue and leave the door open, the smoke sets it off.

THERAPIST: That's annoying. Do you think it would make sense to disconnect the smoke alarm so you don't have to ever experience this again?

LUCAS: Yeah, I sure do. But if I disconnect it, I am not protected in case there is a fire. So, if it goes off when we're barbecuing, I just turn on fans to push the smoke out of the house until the alarm stops ringing.

THERAPIST: So you don't disconnect it, because you know it's a false alarm. If we could stop you from ever feeling anxious again, that would be like totally disconnecting your smoke alarm. That would mean you might not know if there was danger you needed to handle. Instead of doing that, I think it would be better if we set a goal for you to figure out quickly when your anxiety alarm goes off what is setting it off, and then learn to handle that so the alarm turns off as fast as possible. Sort of like knowing it's a false alarm, so

you just turn on the fans and push the smoke out. What do you think about that idea?

LUCAS: I can see how that makes sense . . . as long as I can turn off the anxiety faster.

Anxious clients like Lucas often want to set a therapy goal to eliminate anxiety. This goal is not therapeutic, however, because it implies that it is desirable (and possible) to avoid all anxiety. Also, a client who wants to eliminate anxiety will often balk at necessary therapeutic interventions that inevitably lead to temporary increases in anxiety. Since it is impossible to eliminate anxiety, a client who maintains this goal will view therapy as a failure when anxiety reappears. The belief that anxiety is "bad" should therefore be identified and evaluated early in therapy. Similarly, when clients cling to avoidance and safety behaviors, we encourage directly exploring the advantages and disadvantages of these strategies. Observe how Lucas's therapist did this a few sessions later.

THERAPIST: Were you able to make that list of job skills this week, Lucas?

LUCAS: Uh . . . I really didn't finish it.

THERAPIST: Did you bring a summary of the ideas you have so far?

LUCAS: No. I didn't really write anything down, because I get really upset when I think about doing a different kind of work than before.

THERAPIST: When you say "upset," what were some of your moods?

LUCAS: Mostly anxious. I don't really think I'll succeed at doing different kinds of work.

THERAPIST: How much time did you spend thinking about work this week?

LUCAS: It was in the back of my mind a lot. But whenever I sat down to do what we talked about, I felt too wound up, so I played video games to get my head focused.

THERAPIST: How long would you guess you played video games?

LUCAS: Probably a few hours a day. Maybe more.

THERAPIST: So the video games helped you avoid thinking about work, and you did that so you wouldn't feel so anxious and your head would feel more focused?

LUCAS: Yeah. That's right. I know I probably shouldn't have done that, but I was just so wound up, I needed to clear my head.

THERAPIST: Did that help then?

LUCAS: Some. I felt more relaxed when I was playing a game.

THERAPIST: I can see why you wanted to do it then. As you played your games over the week, did you notice your anxiety going down? When you weren't playing the games, I mean?

LUCAS: No. Not really.

THERAPIST: Did you feel less wound up and more focused when you thought about work?

LUCAS: No.

THERAPIST: So the video games gave you relief from anxiety while you played them. But when you stopped playing them, your anxiety was right back where you started.

LUCAS: I guess so. To be honest, I think my anxiety is worse now than after I last saw you.

THERAPIST: Why do you think that is?

LUCAS: Time keeps going. And every week I'm out of work, my money situation gets worse.

THERAPIST: So playing video games helps you avoid anxiety in the short run, but in the long run, doing that instead of working on your job search makes you feel worse?

LUCAS: Yeah, I see that.

THERAPIST: What do you think would lower your anxiety in the long run?

LUCAS: If I got a job. But I feel too anxious to work on that.

THERAPIST: That sounds like a challenge we should try to address today. Maybe you and I can do some experiments and find out what strategies might help you stick with thinking about things that might lead to job possibilities, even when you are anxious.

LUCAS: OK. But I'd rather not feel anxious.

THERAPIST: Of course. Can you think of a way to work on getting a job without feeling any anxiety?

LUCAS: Not really. I get anxious thinking about it even a little.

THERAPIST: So you learned this week that doing things to distract from your anxiety doesn't help in the long run, because you are avoiding thinking about your job. Let's try the approach of living with your anxiety while we work on a job plan, and see how that affects your anxiety in the long run. Even if we can predict that it might make you pretty uncomfortable in the short run.

LUCAS: OK.

THERAPIST: First, let's write down what we just discussed. Where do you want to put it?

LUCAS: In my phone notes.

THERAPIST: OK. (*Waits while Lucas gets out his phone.*) There are two ideas we've discussed. First, if you do things to distract yourself from your anxiety, they help you feel better in the short run, but . . . (*Pause*)

LUCAS: . . . they don't really help me feel less anxious later. Sometimes my anxiety even gets worse.

THERAPIST: OK. Write that in your notes. (*Pauses while Lucas types.*) And the second idea is about sitting with your anxiety and what that might do—in the short run and the long run.

LUCAS: If I keep working on my job even when I am anxious, I might feel worse right then, but maybe it will help me more over time?

THERAPIST: OK. Write that down. (*Pause*) How much do you believe those two statements?

LUCAS: I believe the first one 95%. The second one, maybe 10%.

THERAPIST: Those seem like reasonable ratings. You've had a lot of experience with the first idea, so you believe it a lot. You need more experience with the second idea—of working even when you feel anxious—before you will be able to find out if that idea is also true for you.

LUCAS: Yes.

THERAPIST: OK. Let's do an experiment right now by getting out that job skills worksheet we started last week. We'll rate your anxiety as you work on it, and I'll ask you to let me know next week what the long-term effects were. Of course, you'll need to practice working on the job search even when you are anxious a number of times this week, so we can gather enough information to know if this helps in the long run.

Notice how Lucas's therapist patiently gathered information about the short-term and long-term impact of his avoidance. She proposed an alternative strategy of sticking with tasks even when he felt anxious, and asserted that this approach would most likely feel worse in the short run. She asked Lucas to rate his confidence that this new approach would have a better long-term outcome. As expected, Lucas did not have a high degree of positive expectation for the benefits of sticking with tasks even when he was anxious. However, Lucas expressed a strong sense of conviction (95%) that avoidance, although providing short-term relief, would not have long-term benefits. This discussion set the stage for Lucas and his therapist to track the impact of sticking with job search tasks even when he was feeling anxious. Her hope was that Lucas would now have greater awareness of the pitfalls of playing video games and engaging in other avoidance tasks. Although she did not expect or insist that he stop these avoidance activities, she anticipated that this discussion would lead him to persist longer with job search activities for portions of the coming week.

5. Identify and Test the Central Beliefs in Anxiety

Overcoming avoidance, eliminating safety behaviors, and facilitating relevant exposure to fears are the main behavioral tasks in CBT for anxiety disorders. The main cognitive tasks are to identify and test the central beliefs that maintain anxiety. How can you know whether a belief is central? As shown in the adjacent box, central fears in anxiety incorporate themes of danger/threat and coping/resources; they often take the form of images; and they are more likely to be underlying assumptions than automatic

thoughts. Furthermore, each of the common anxiety disorders is maintained by characteristic beliefs.

When people are anxious, they tend to overestimate danger and threat. At the same time, they underestimate their ability to cope and the resources that can help them when they encounter those dangers and threats. Overestimation of danger/threat and underestimation of coping ability/resources are the two cognitive themes that characterize anxiety. Thoughts associated with anxiety will incorporate these themes. Furthermore, the hottest anxious thoughts often take the form of images:

> "In my mind I saw a car flipped, and my daughter was hanging upside down and covered in blood. I even could smell gasoline and hear sirens." (Reported by a father who worried about his daughter's driving, even though she was a good driver and had never been in an accident.)
>
> "I am lying in a casket in the hole, and I can hear the dirt being shoveled on top. I feel the casket shift with each dirt clod falling, but I can't open my mouth and scream." (Reported by a woman with a fear of being buried alive.)

When stated in words, central anxiety-related beliefs are more likely to be stated as underlying assumptions than as automatic thoughts. This is because predictive, "If . . . then . . ." assumptions evoke anxiety across a number of situations and maintain it over time:

> "If *X* happens, then catastrophe *Y* will follow."
> "If *X* happens, then I can't cope."

Specific anxiety disorders are characterized by signature versions of the generic underlying assumptions above. For example, social anxiety is maintained by underlying assumptions such as "If someone criticizes me, then I will feel humiliated, and I can't handle that." The following sections unpack these characteristics of anxiety beliefs in greater detail.

Characteristics of Central Beliefs in Anxiety

- Two themes predominate in anxious beliefs: overestimation of danger/threat and underestimation of coping/resources.
- The hottest anxious thoughts often occur as images (visual, auditory, or involving other senses).
- Underlying assumptions (cross-situational, predictive beliefs) are more important for maintenance of anxiety than automatic thoughts (situation-specific thoughts).
- Common anxiety disorders are maintained by characteristic underlying assumptions.

Overestimation of Danger/Threat and Underestimation of Coping/Resources

When people are anxious, their thoughts tend to be focused on perceived dangers and threats. However, danger alone is not enough to evoke anxiety. People only feel anxious if they doubt their ability to cope with the danger and threats that are present. In fact, many people seek out situations that appear dangerous, and yet, if they believe they have the skill or stamina to cope with these threats, they may experience thrill rather than anxiety. People who seek adventure sports such as rock climbing, skydiving, or bungee jumping fall into this category of experiencing thrill rather than anxiety in the face of these potential dangers. This also holds true for people who stand up to speak in front of a group when there is a risk of criticism or rejection. If people are confident that they can handle criticism or rejection, they often feel energized instead of anxious when they get up to speak. In contrast, even a small danger or threat can evoke anxiety if people lack confidence in their ability to cope with it. Someone who believes they cannot handle any level of rejection or criticism might feel anxious even at the thought of expressing a preference for one restaurant over another to work colleagues.

This interaction between perceived danger and perceived ability to cope suggests that anxiety treatment can target either of these types of beliefs. We predict that anxiety will decrease as perceived danger decreases. Likewise, we predict that anxiety will decrease when people increase their confidence in the belief that they can cope with whatever level of danger they might face or when they become aware of resources that can help them cope. Consider someone who is anxious before speaking at a public event where they will reveal they are transgender. ("They," "them," and "their" are used in this example to reflect this person's pronoun preferences.) They know they are expected to answer questions from the audience about their transgender experiences. We would expect each of the following occurrences to reduce their anxiety:

1. They learn that only a handful of people will be present, and that the people who are attending are also from the LGBTQ+ community (thus decreasing perceived danger).
2. They practice their speech a number of times and plan a few responses to expected negative comments. With each practice session, their confidence grows (thus increasing perceived ability to cope).
3. They learn that there will be three other people on stage with them to field questions, and they do not have to answer all the questions asked (thus increasing perceived help resources).

EXPOSURE AND DANGER/COPING BELIEFS

Most evidence-based treatments for anxiety include exposure to whatever is feared. It is easy to see that exposure to fears provides opportunities to address both danger and coping beliefs. When people who fear dogs spend more time in the presence of dogs, they have an opportunity to learn that the feared dangers do not occur most of the time. They also have an opportunity to learn and practice ways to cope with and handle

dogs. In addition, when they practice being around dogs (exposure) with other people present, they have an opportunity to observe how other people handle dogs, and can learn that some people are quite good resources for helping manage dog encounters. For example, walking down the street and passing dogs on leashes with their owners is an opportunity to learn that some dogs are friendly (nondangerous in that moment), that unfriendly dogs can be given a wide berth (good coping), and that dog owners usually restrain their dogs from harming others (good resources).

IS IT BETTER TO FOCUS ON DANGER OR COPING?

While it is true that either decreasing danger beliefs or increasing confidence in coping can lower anxiety, sometimes one approach is more effective than another. For particular types of anxiety and related disorders, we highlight which type(s) of beliefs are most effective to target in Chapter 11 of this clinician's guide. For example, evidence-based treatment for panic disorder uses behavioral experiments primarily to test "danger" beliefs, because these are central to maintaining that type of anxiety. In contrast, GAD is more effectively treated with a central emphasis on increasing people's confidence in their ability to cope with danger, as well as their awareness of resources that can help. The probable reasons for these differences in treatment focus are elaborated in Chapter 11.

Look for Imagery

When people are anxious, they almost always have images that can help you understand their anxiety. Usually these images capture both the danger and coping themes outlined above. If images are not identified, both you and your clients may have a hard time understanding the intensity of the anxiety they experience. Imagery is often related to culture, reflects deeply held beliefs, and can be linked to highly emotional life experiences. For example, Jin-qua reported frequent panic attacks. When his heart beat fast, he thought he was dying of a heart attack. He and his therapist conducted experiments to test his belief that a rapid heart rate meant that he was having a heart attack, but Jin-qua did not experience the same speed of improvement as his therapist's other clients with panic disorder did.

During one session, his therapist asked Jin-qua if he had any images connected to his rapid heart rate beside his image of a heart attack. Jin-qua began shaking before slowly replying, "When I was younger, I encouraged my wife to get an abortion, because we could not have a child at that time. When my heart beats fast, I know it is my dead baby girl. I feel her spirit swirling around me, and I know she is making me die as punishment." His image of his dead daughter and his belief that spirits could cause one to die were primary causes of his panic. It was not simply that Jin-qua thought he was having a heart attack; he feared that his heart attack was being caused by his dead baby, and that it was impossible to fight a spirit who wanted to harm him.

As Jin-qua's potent image illustrates, it is not always the case that images are experienced visually. They can include smells, sounds, visual images, tastes, kinesthetic sensations, or what can be framed by some people as a "felt sense." The physical "reality" of

images can make these seem more real than verbally stated thoughts. It is always important to teach clients about images, and to ask them to stay curious and try to be aware of them when anxiety is present. Clients sometimes avoid reporting images, especially because anxious images can be disturbing or violent, or can seem "crazy." It is helpful to normalize images in an early session when you are encouraging clients to notice their thoughts connected to anxiety, as Jin-qua's therapist did.

THERAPIST: This week I'd like you to notice what thoughts come into your mind when you are anxious, just like we did in session today. You can record them on this worksheet. (*Indicates Worksheet 14.3, Identifying Thoughts Associated with Anxiety, MOM2, p. 232.*)

JIN-QUA: OK.

THERAPIST: Your thoughts will probably include images, and these are important to notice and write down so you don't forget them. Just like we have dreams when we are sleeping and we often forget them after we wake up, we have images when we are awake, and yet we can forget them if we don't make a point to write them down.

JIN-QUA: So are images daydreams?

THERAPIST: In a way. They can be a quick flash or longer, like a part of a movie with sound and pictures. Images might be things you see or hear or taste or smell. They can also be a "funny feeling" or a body temperature or sensation, like something crawling on your neck. Look for anything that makes you feel nervous or anxious.

JIN-QUA: Like my daughter's spirit?

THERAPIST: Yes. Is that more like a quick flash or a movie?

JIN-QUA: She is just on the edge of my body. It can last a long time, but I don't exactly see her. I feel her presence, and it is like having lightning in the room.

THERAPIST: Good observation. When you feel her presence, see what you can remember about your experience. For example, write in your notes, "She feels like lightning in the room." That might be important. (*Pauses while Jin-qua writes.*)

JIN-QUA: Do you think this means I am crazy?

THERAPIST: Having experiences like you are having are quite common when we are anxious. We can even have images that are violent or that somehow disgust us, and we might hesitate to mention them. But it is important to tell me. For example, sometimes people have images of being attacked or attacking someone else. Other images can seem really crazy, because things might fly through the air or disappear or look bizarre or sound scary. Or we might hear voices when no one is there. All these experiences can happen when we are anxious. Please tell me about them, because they provide important clues for how to help you.

Jin-Qua: And that doesn't mean I'm crazy?

Therapist: No, it doesn't mean that. Actually, if we know about whatever images you have, we can work together to understand them. The more we learn about your images, the more we will learn how to manage your anxiety.

Jin-qua's therapist encouraged him to notice and record images during the week by giving him many examples of different types of images and normalizing their co-occurrence with anxiety. Like many people, Jin-qua worried that his images might signal he was "crazy." Therapists sometimes will need to make a differential diagnosis between an anxiety disorder and psychosis, but the presence of disturbing imagery alone is not a diagnostic indicator of psychosis. In fact, disturbing images are more common than not in anxiety disorders and related disorders like PTSD (Ji, Heyes, MacLeod, & Holmes, 2016).

It is interesting to note that anxiety can trigger verbal hallucinations (i.e., hearing voices) in both clinical and nonclinical populations (Ratcliffe & Wilkinson, 2016). Thus, unless there are other indications that clients are experiencing psychosis, you can assure anxious clients that their imagery is not a sign of being "crazy." Most clinicians who work with psychosis are not inclined to label the images, hallucinations, and delusions experienced during psychosis as "crazy." Instead, they provide useful information about those clients' state of mind, emotional state, and belief system. Of course, if Jin-qua's diagnosis was OCD and his thought "I'm crazy" was an obsessive rumination, then his therapist would avoid offering reassurance that he was not "crazy," because reassurance can actually function as a maintenance factor for OCD (Kobori & Salkovskis, 2013).

USE OF IMAGERY WHEN THERE IS DIFFICULTY IDENTIFYING ANXIOUS THOUGHTS

Anxious clients sometimes cannot identify the content of their thoughts when they are in the midst of experiencing anxiety. For example, when you ask, "What was going through your mind just before you quickly left the shopping mall?" an anxious client might reply, "I don't know. I just felt really bad and had to get out of there." There are several ways to help anxious clients identify thoughts when these seem inaccessible. Working with imagery often proves to be a direct route to such thoughts.

As already stated, when people are anxious, they avoid. Avoidance can be cognitive as well as behavioral; many anxious thoughts are pushed out of the mind as soon as they occur. Therefore, clients literally can have trouble accessing thoughts that can provide the key to understanding their anxiety. One way to deal with cognitive avoidance is to bring anxiety into the therapy session and stay alert to the momentary, fleeting thoughts that accompany or precede it. Using imagery, most clients can reexperience any anxiety-related event, as illustrated here.

Therapist: What was going through your mind just before you quickly left the shopping mall?

Mariana: I don't know. I just felt really bad and had to get out of there.

THERAPIST: Let's see if we can recapture your thoughts by returning to the shopping mall right now. I'd like you to imagine yourself at the shopping mall just as it was yesterday. Take a few minutes and see if you can vividly recall the scene—sights, sounds, smells, and what you were feeling inside.

MARIANA: (*Closes eyes for a minute.*) OK.

THERAPIST: Describe to me what is going on.

MARIANA: I'm holding a heavy shopping bag, and my daughter is tugging on my arm. There are people rushing everywhere, and I can't decide where I need to go next.

THERAPIST: What are you feeling?

MARIANA: I'm hot, and my mind seems all confused. I can't quite figure out where I am. All the stores look strange to me.

THERAPIST: What's going through your mind?

MARIANA: I don't know. My mind seems odd. I think I'm losing it.

THERAPIST: You think you're losing your mind?

MARIANA: Yes. I feel like I'm going crazy. Who will take care of my daughter?

THERAPIST: Do you have any mental images of this?

MARIANA: I see my mother with her hair all tangled and her eyes wild, like she got when she was drunk when I was a kid. I think I look like that to my daughter.

THERAPIST: How does that image make you feel?

MARIANA: (*Breathing rapidly*) Very anxious. I've got to stop now. (*Opens eyes in fear.*)

THERAPIST: How similar was your experience today to what you felt yesterday?

MARIANA: That's exactly how I felt. I had forgotten about that picture of my mother. I do get scared that I look like that to my daughter when I get anxious.

This session excerpt illustrates how imagery can help a client recapture anxious feelings and the accompanying thoughts. It also provides another demonstration of why it is important to help clients experience anxiety within the therapy hour in order to identify and test anxious thoughts. In addition, this example highlights the importance of asking about images when someone is anxious. In this illustration, Mariana had a thought ("I'm going crazy") that helped explain her anxiety. However, her image of her mother with wild eyes and tangled hair, and the meanings associated with that image, proved to be a much more vivid trigger for her anxiety.

IDENTIFYING AND TESTING IMAGES

Worksheet 14.3, Identifying Thoughts Associated with Anxiety (*MOM2,* p. 232), prompts people to look for images in order to be able to list them in the Automatic Thoughts (Images) column when they are trying to understand their anxiety reactions. Just like Mariana experienced, images sometimes capture memories. *Identifying*

images and memories should be emphasized for anxious clients, most of whom will have images during their peak feelings of anxiety. Images can be tested similarly to word thoughts. For example, Mariana could be given a mirror in session when she became highly anxious and had an image of herself looking like her mother. Or she could take a "selfie" with her phone when the image came into her mind during the week. Mariana's therapist could help her compare her actual appearance with the image of herself in her mind and her memory of her mother. Finally, her childhood emotional and cognitive reactions to her mother when she was drunk could be explored and related to Mariana's current fears regarding the impact of her anxiety on her daughter.

Central Thoughts Are Likely to Be Underlying Assumptions

Unfortunately, work with automatic thoughts only brings temporary relief for anxiety. Although necessary to identify, just looking at automatic thoughts (images) is not the ultimate focus of our treatment. This is because automatic thoughts do not constitute the central level of belief that maintains anxiety disorders. If our focus remains only on testing automatic thoughts, anxiety treatment can end up as a never-ending task.

Consider Talika, who was diagnosed with GAD. Throughout the day, her automatic thoughts linked to GAD typically took the form of ruminative worries, often stated as questions. These were two examples:

Question: "What if I say the wrong thing to my daughter?"
Answer that contributed the most to her anxiety: "I will hurt her and damage our relationship forever."

Question: "What is the right thing to say to her?"
Answer that contributed the most to her anxiety: "I don't know the right thing to say."

In addition, Talika experienced images that related to catastrophic outcomes:

"I see my daughter in 20 years with her arms crossed. She is grimacing and blocking my access to visit my grandchildren."

In working with GAD, many therapists identify and test automatic thoughts and images like these. Why would this not be enough in Talika's case? These clearly contributed to Talika's daily anxiety, but work with automatic thoughts would only bring her temporary relief. For instance, suppose her therapist were to help Talika develop an alternative or more balanced thought for her worries above, such as "Saying one wrong thing is not likely to hurt our relationship forever," and develop a new image of a friendly future visit with her daughter. Talika would probably feel less anxiety about this particular situation. And yet tomorrow she would begin a new string of worries: "What if the doctor finds something wrong with me when I see her next week?" "What if my car breaks down when we are on vacation?" "What if my paycheck arrives late and I can't pay the electric bill?"

The focus of therapy in cases like Talika's needs to shift to identifying the central beliefs maintaining anxiety. Central anxiety beliefs occur in the form of underlying assumptions, which, again, are usually stated as "If . . . then . . ." beliefs:

"If *X* happens, then *Y* catastrophe will follow."
"If *X* happens, then I can't cope."

Thus effective CBT approaches for anxiety disorders identify central underlying assumptions and test these with behavioral experiments (see Chapter 7 of this clinician's guide for a review of underlying assumptions and behavioral experiments). In order to identify the central underlying assumptions for a particular anxiety disorder, therapists need to identify general, cross-situational underlying assumptions, not assumptions about a particular situation. What could be Talika's central underlying assumption? It could be something like this:

"If I say the wrong thing, then it will ruin my relationship with my daughter forever."

But this assumption is about a particular situation. To identify central underlying assumptions, therapists need to seek *general* rules that apply across many anxiety situations, as Talika's therapist did here.

THERAPIST: We've discussed a number of your worries today and last week. It seems to me that these worries might be linked in some way. It is almost like you have a general rule: "If something can go wrong . . ."

TALIKA: "Then it will!"

THERAPIST: Yes. Murphy's Law. And yet Murphy's Law doesn't explain your anxiety. You could expect things to go wrong and feel calm and ready. But you feel anxious. Help me understand that. What fuels your anxiety? "If something goes wrong . . ."

TALIKA: "Then it will be a disaster." Things will go from bad to worse, and I don't handle problems well!

Talika's central underlying assumptions thus appeared to be "If something goes wrong, then it will be a disaster," and "If bad things happen, then I won't be able to handle it." If she and her therapist could test these assumptions and develop alternative assumptions—ones that would build Talika's confidence that not all her problems would become disasters, and that she could cope with problems (and even disasters) when they occurred—then her daily worries would not lead to severe anxiety.

BEHAVIORAL EXPERIMENTS, NOT THOUGHT RECORDS

Some clinicians are surprised to learn that thought records are not recommended as a necessary CBT intervention for anxiety. People who experience anxiety can certainly

be taught to use 7-Column Thought Records and receive some benefit from them. But a thought record is not the "best tool in the box" for anxiety (Padesky, 2013). Thought records are designed to test automatic thoughts. As just described, although people who experience anxiety certainly have automatic thoughts and images ("I look foolish," "an image of my face looking beet-red"), the beliefs that maintain anxiety disorders are underlying assumptions ("If I look unusual in any way, then people will think less of me and reject me"). This level of belief is best tested with behavioral experiments.

This is why the Anxiety Reading Guide (see p. 457 in Appendix A) suggests that readers proceed to the *MOM2* chapter on underlying assumptions and behavioral experiments (Chapter 11) as soon as they have read the anxiety chapter (Chapter 14) and the goal-setting chapter (Chapter 5). Again, therapists who are not very familiar with underlying assumptions and behavioral experiments can review Chapter 7 of this clinician's guide. *MOM2* readers working on anxiety can skip the 7-Column Thought Record chapters (Chapters 6–9) entirely, unless they target an additional mood, such as depression, later.

IMAGERY AND UNDERLYING ASSUMPTIONS

How do we reconcile the statement that underlying assumptions are the most important level of thought for understanding anxiety with the observation that the hottest thoughts linked to anxiety often take the form of imagery? Anxious images can be frightening on their own. Even so, the underlying assumptions connected to them can ratchet up their potential for fueling anxiety. Recall the example earlier in this chapter, in which Mariana reported high levels of anxiety in response to a memory and image of her mother being drunk. This image probably evoked anxiety on its own, because it recalled a situation that was frightening to Mariana as a child. It became even more anxiety-provoking, however, in the context of two of Mariana's underlying assumptions: "When [if] I feel really anxious, then I look just like my mother to my daughter," and "If I frighten her like my mother did me, then I will harm her like my mother did me." There can also be assumptions about imagery that feed anxiety reactions, such as "If my image is this vivid, then this means it is real [or will happen]."

UNDERLYING ASSUMPTIONS FOR COMMON ANXIETY DISORDERS

Each of the anxiety disorders has characteristic underlying assumptions associated with it, as summarized in Table 10.4. Notice that each of these refers to some perceived danger/threat in the "If . . ." part of the assumption and a catastrophic outcome or inability to cope in the "then . . ." part of the assumption. As these assumptions demonstrate, anxiety is often a future-focused mood. Thus people who are anxious appear not to benefit as much from reviewing past and present experiences in which their anxious predictions didn't come true as they do from making future predictions and doing experiments to see if these come true. People who are anxious believe this: "Even if I experienced my feared event today and nothing went wrong, tomorrow something bad could happen, and then I won't be able to cope or survive."

Given the types of underlying assumptions that maintain anxiety disorders, it is

TABLE 10.4. Common Underlying Assumptions in Anxiety Disorders

Common adult anxiety disorders	Common underlying assumption
Generalized anxiety disorder (GAD)	"If something bad happens, then it will be a disaster and I won't be able to cope."
Panic disorder	"If I experience *X* sensation, then I am dying or going crazy [it is catastrophic]."
Specific phobia	"If I'm in *X* situation, a specific thing I fear will happen and I won't be able to cope."
Social anxiety disorder	"If someone criticizes or rejects me, then I feel humiliated, fall apart, and can't cope."
Agoraphobia	"If I am away from my safe place/safe people and something bad happens, then I can't cope."

usually not enough to evaluate the probability that feared dangers will occur. Typically, it is necessary to address clients' beliefs both about dangers/threats and about their ability to cope with these danger/threats. In CBT for anxiety, danger and coping beliefs are often tested simultaneously in the context of behavioral experiments that require people to face their fears and practice coping with them. The cognitive goal is to increase people's confidence in a new underlying assumption, such as "If and when bad things happen, then I can figure out a way to cope."

UNDERSTANDING ANXIETY: *MOM2* CHAPTER 14 SKILLS AND WORKSHEETS

Either imaginal or *in vivo* exposure to fears is necessary for successful anxiety treatment. However, when people are anxious, they strongly want to avoid feelings of anxiety. Chapter 14 of *MOM2* introduces a variety of tools and skills designed to help people face feared situations and tolerate anxiety, so they can stay in these situations long enough to learn to cope with whatever dangers exist. Keep in mind that all of these interventions can also be used for avoidance; thus it is important to ensure that each one is being used to approach and manage anxiety, rather than serving as a safety behavior or avoidance strategy.

Fear Ladder: Approaching or Avoiding?

When people exhibit a high degree of avoidance, a Fear Ladder—that is, a hierarchy of situations progressing from those that trigger low anxiety to those that trigger high anxiety—can make approaching fears seem more manageable. Worksheets 14.4, Making a Fear Ladder (*MOM2,* p. 238), and 14.5, My Fear Ladder (*MOM2,* p. 239), help readers construct a hierarchy of feared situations by listing situations they avoid,

rating the anxiety evoked by each, and finally ordering these on a pictorial Fear Ladder. The idea is that people will then approach these situations, beginning with whatever rung on the ladder feels as if it could be achieved and yet still provide a mastery experience, and progressing up the ladder as quickly as possible. The first step that will elicit a sense of success or mastery may be on a middle rung of the Fear Ladder; it does not need to be the lowest rung. Fear Ladders are particularly helpful when there is a high degree of observable avoidance. They are less helpful if anxiety is largely characterized by worry, as is common in GAD.

MOM2 emphasizes that a person should stay on each rung of a Fear Ladder long enough to experience anxiety and develop tolerance for it. Once anxiety on one rung can be tolerated, then the person should move up to the next rung. If anxiety is higher than the person believes is manageable, then rungs can be broken into smaller increments. Also, when necessary, each rung of the Fear Ladder can be approached in imagination before *in vivo* practice. A Fear Ladder is a useful tool for anxiety self-help, because it helps people feel in control of exposure and provides a clear plan for taking steps to face anxiety.

However, we encourage therapists to support clients in more rapid exposure to their fears than people often select on their own. Someone working on a spider phobia via self-help, for example, might make a large number of closely spaced rungs on a Fear Ladder (look at a still photo of a small spider, look at a still photo of a medium-sized spider, look at a still photo of a large spider, look at a video of a spider on the Internet from a great distance for a few moments, etc.) and schedule exposure only once a week, so it could take the person months to overcome this fear. If the same person is in therapy, their therapist can provide encouragement through a series of photo and video exposures in a single session. Alternatively, a therapist can bring a live spider into therapy in a jar and encourage a client with spider phobia within that session to look at the spider (at a distance and then up close), touch it, and eventually allow it to crawl up the therapist's and then the client's arm. Thus therapist-directed treatment of phobias can often be accomplished in a few sessions or even a single session, rather than the months that may be required for self-help.

A Cautionary Note about Fear Ladders

With this example in mind, therapists who choose to use Fear Ladders as part of therapy are cautioned that this tool can actually slow therapy down if it sets a pace of exposure so slow that a therapist and client are colluding in subtle avoidance. In fact, some of the most successful CBT approaches do not include hierarchical exposure at all. Instead, research supports the efficacy of therapies that emphasize direct tests of the central beliefs maintaining an anxiety disorder, beginning in early therapy sessions. Examples of successful treatments not employing hierarchical exposure include those for panic disorder (Clark et al., 1994), social anxiety (Clark et al., 2006), and PTSD (Ehlers et al., 2013, 2014). And, as stated earlier, Fear Ladders often do not serve a useful function in treatment for GAD. Therefore, while therapists can choose to use a Fear Ladders in therapy, they do not constitute a necessary part of treatment for most anxious clients.

Clinical Tip

Directly test the central beliefs maintaining anxiety disorders as early as possible in therapy. It is not always necessary to do hierarchical exposure. Use your positive therapy alliance to encourage your clients to engage in exposure exercises as fully, quickly, and intensely as they can manage.

Increasing Anxiety Tolerance

Whether therapy entails graduated exposure to feared situations, or experiments designed as direct tests of the central beliefs maintaining anxiety, people need to develop tolerance for anxiety in order to participate actively in treatment. Frequently, people will tolerate anxiety simply in the context of reminders that it is helpful to stay in anxious situations long enough to make observations and test out beliefs. Since a client's initial anxiety observations and experiments are usually done during the therapy hour, the therapist is present to encourage anxiety tolerance. This practice can serve as a model for experiences that will take place outside the office.

For the many people using *MOM2* who are working with their anxiety in a self-help context, Chapter 14, Understanding My Anxiety, includes information about a variety of approaches that can help people manage and tolerate their anxiety responses: mindfulness and acceptance approaches, breathing techniques, progressive muscle relaxation, and imagery. These methods can be used to help people stay longer in situations linked to anxiety, so they can test their anxious beliefs and develop greater confidence in their coping abilities. Mindfulness and acceptance help increase people's awareness of their anxiety without trying to change the experience. Breathing techniques, progressive muscle relaxation, and imagery are often used to reduce the levels of anxiety experienced, and they therefore carry a risk of functioning as safety behaviors, which can slow positive treatment response. The following sections provide guidelines therapists can follow to determine if these three types of interventions are serving a therapeutic purpose or primarily functioning as safety behaviors and therefore are contraindicated.

Mindfulness and Acceptance

"Mindfulness" and "acceptance" are terms that can describe methods for keeping someone aware of what they are experiencing when anxious. Rather than focusing on reduction of anxiety, these approaches focus on self-observation, living fully in the present moment, behaving according to one's values and acceptance of emotions, thoughts, and experiences. Although the two therapies that emphasize these practices (mindfulness-based cognitive therapy, or MBCT; acceptance and commitment therapy, or ACT) are sometimes considered quite different from other CBT approaches, Arch and Craske (2008) have helpfully written about the many similarities between these therapies and

the more classically behavioral and cognitive variants of CBT for anxiety. In practice, therapists often combine mindfulness and acceptance practices with other CBT anxiety approaches that ask people to observe their anxious thoughts and images, approach situations that were previously avoided, and test out beliefs that fuel anxiety.

There is evidence that MBCT and ACT can provide effective primary treatments for clients with GAD (Roemer, Orsillo, & Salters-Pedneault, 2008), social anxiety (Kocovski, Fleming, Hawley, Huta, & Antony, 2013), mixed samples of anxiety disorders (Arch et al., 2012, 2013), and health worries (McManus, Surawy, Muse, Vazquez-Montes, & Williams, 2012). While demonstrating that these can be effective treatments, many of these studies compared groups receiving MBCT and ACT to nontreatment control groups. Thus the relative strengths of MBCT, ACT, and classic CBT as applied to anxiety disorders are not fully known at this time. Depending on their clients and their own conceptualizations, therapists using *MOM2* in treatment can choose how much emphasis to put on each set of skills. *MOM2* offers greater emphasis on use of exposure and behavioral experiments to test anxious underlying assumptions, as this is the primary focus of therapies whose evidence base is strongest in terms of treatment efficacy.

Breathing

Many therapists are familiar with controlled breathing methods (also called diaphragmatic breathing) in the form in which they are taught on page 243 of *Mind Over Mood*. When initially practiced several times a day, most people learn to reduce their stress and arousal using this breathing method. Within anxiety treatment, controlled breathing, once mastered, can evolve into a useful therapy intervention or can end up functioning primarily as a safety behavior. The section of *MOM2* Chapter 14 that introduces controlled breathing is titled "Managing Your Anxiety." If someone uses controlled breathing every time they begin to feel anxious, then controlled breathing is not being used to manage anxiety. Instead, it is being used to avoid anxiety. Therapists who routinely teach anxious clients to use breathing methods are inadvertently teaching a safety behavior to many of them. The opening section in the Troubleshooting Guide of this chapter ("Therapist Fears") reviews some of the research that investigates the negative impacts of common therapist beliefs about anxiety and relaxation on anxiety treatment and outcomes.

Use of breathing to reduce anxiety is included in *MOM2* to assist people embarking on a self-help program who might not otherwise approach situations in which they feel anxious. By offering this anxiety management method, we hope that more people using *MOM2* as a self-help tool will do the exposure practice and experiments necessary to test their anxious fears. In this way, we hope breathing is used to increase anxiety tolerance and the length of exposure experiments, not to avoid anxiety.

People working with a therapist don't necessarily need to learn controlled breathing. When exposure to anxiety-provoking situations begins in the therapy office, and the therapist guides a client's attention to relevant information, the client is often able to test maladaptive anxiety beliefs in just a few sessions. Anxiety usually rapidly decreases in effective therapy. For these reasons, controlled breathing is only recommended as

part of therapy when its use will actually increase someone's ability to stay in anxiety-provoking situations longer, so that the person can learn to both tolerate anxiety and test out the beliefs that maintain it.

Progressive Muscle Relaxation

"Progressive muscle relaxation" is a core skill of applied relaxation therapy, which was developed by Öst (1987). This treatment approach is an evidence-supported treatment for GAD, specific phobias, social anxiety disorder, and panic disorder (Montero-Marin, Garcia-Compayo, López-Montoyo, & Zabaleta-del-Olmo, 2018). Progressive muscle relaxation is used to help people learn to recognize physical tension and practice relaxation, initially within a cycle of tension (tightening muscle groups) and relaxation (relaxing these same muscle groups). After a week or more of daily practice, people learn to relax muscle groups without tensing them first. Once a state of relaxation is easily attained, it is helpful to pair the state of relaxation with a cue word such as "relax," repeating this cue word with each exhalation of breath. This creates a conditioned response in which the cue word alone can later be used to induce relaxation.

The idea behind Öst's approach is that a state of muscle relaxation is incompatible with anxiety and tension. When people practice progressive muscle relaxation on a regular basis, it becomes easier and easier for them to relax in real-life situations. Therapists can support this skill generalization by asking clients to practice relaxing particular muscle groups while doing everyday activities (standing, walking, working at a desk, cooking, etc.). The desired goal of applied relaxation is for people to achieve rapid relaxation as a portable skill. "Therapists ask clients to take a deep breath, think the word 'relaxing' while exhaling (cue-controlled relaxation), while also scanning the body for spots of tension and releasing that tension (differential relaxation) as they engage in daily activities" (Hayes-Skelton, Roemer, Orsillo, & Borkovec, 2014, pp. 294–295). Once clients can employ rapid relaxation during nonstressful activities, they are asked to practice it during anxiety-provoking situations.

As is apparent from the description above, successful use of applied relaxation requires weeks of graduated practice; the hard work typically pays off, however, and it can prove to be a powerful intervention. In particular, it is an ideal treatment for people who have a high degree of physical tension associated with anxiety, and also for people who might be difficult to engage in more cognitive interventions. Keep in mind that the goal of applied relaxation is for people to intentionally approach situations that evoke anxiety and then to stay in them for a long time. Mastering relaxation skills helps people overcome avoidance and tolerate anxiety, because they have gained confidence that they can restore and experience relaxation. Spending longer intervals of time in situations that used to be avoided (either in imagination or *in vivo*) allows for new learning. People sometimes learn that these situations are less dangerous than feared, that they can cope with the challenges inherent in these situations, and that it is possible to stay in them even while experiencing anxiety (Arch & Craske, 2008). The benefits of applied relaxation can be enhanced if there is repeated in-session practice of early detection of anxiety cues (Hayes-Skelton et al., 2013), as illustrated in the dialogue that follows.

Therapist: OK, Julie, I want you to imagine again that you are sitting in class waiting for your turn to give your speech. Last time, you noticed your anxiety begin to spike when the person speaking before you was near the end of his speech. Slow things down this time, and see if you can notice any earlier signs of anxiety.

Julie: OK. (*Eyes closed, imagining*) When he walks up front, he looks out at everyone and smiles. He looks so relaxed, and I think, "I won't look so relaxed. I'll look nervous." My stomach starts to tighten then. My SUDS [subjective units of distress score] is about 5 out of 10.

Therapist: Good. Focus on that moment. and do your relaxation. Let me know when your stomach relaxes and your SUDS drops to 2 or less.

Julie: (*After about 45 seconds*) My SUDS is about 1 or 2 now. My stomach is relaxed.

Therapist: Good. Let's imagine the scene again and see if you can notice any earlier cues of anxiety.

Notice that Julie's therapist instructed her to look actively for early cues of anxiety and to practice her relaxation skills for each one identified. He encouraged her to return to the scene over and over again and search for even earlier cues. Her response in this particular excerpt was consistent with cognitive aspects of social anxiety; "I won't look so relaxed. I'll look nervous" is typical of the self-focused attention in social anxiety that can be effectively tested by behavioral experiments and video feedback (McManus et al., 2009). However, Julie's therapist continued the focus on relaxation, because that was the skill set she was currently mastering. Future sessions could focus on testing central assumptions that maintain social anxiety with behavioral experiments, as described in the section on social anxiety in Chapter 11 of this clinician's guide.

As emphasized here, applied relaxation can be a powerful tool both for managing anxiety and for increasing tolerance of it. Once relaxation skills are attained, they are intended to be used within anxiety-provoking situations that were previously avoided. Applied relaxation is not meant to be used as a safety behavior to avoid feelings of anxiety. Instead, it includes recognition of anxiety cues and experiences, toleration of anxiety when it occurs, and employment of skills to stay in anxiety-provoking situations as long as necessary to learn more about them and successfully navigate them to their full completion. Thus the goal was for Julie to use relaxation to engage fully in delivering her speech in class and manage her anxiety throughout.

Imagery

Imagery is another portable skill that can help people stay in anxiety-provoking situations and tolerate anxiety for longer periods of time. Many people think of calming imagery as ideal for coping with anxiety: lying on a tropical beach or relaxing in a favorite spot. However, in situations when someone is likely to have high physiological arousal (e.g., facing a challenging situation like a job interview, or coping with fears like terror of a barking dog), it is more helpful to evoke imagery linked to feelings and

memories of mastery. Observe how Gizem and her therapist developed a mastery image that she could practice and carry with her into a challenging conversation with her work supervisor.

Gizem: I still think I will be too anxious to have this conversation with my supervisor. If he becomes even a little upset with me, I think I will burst into tears.

Therapist: Let's see if we can develop another skill to help you in that situation. You know how we have used imagination in here to help identify your anxiety triggers and thoughts?

Gizem: Uh-huh. (*Nods head.)*

Therapist: Let's see how you can use your imagination to help manage your anxiety with your supervisor.

Gizem: OK.

Therapist: Think about some time in your life when you generally feel quite confident and capable of handling challenges. Maybe there are things you do in which you work through challenges with confidence. Or maybe you can think of a situation where people around you are unhappy and yet you are able to manage it.

Gizem: (*Thinking for a minute*) The best example might be when my family is on a long trip, and the children are fussing and my husband is irritable and everyone is hungry.

Therapist: That sounds like quite a challenge! How do you handle that?

Gizem: I speak very quietly and talk about how good dinner will be when we arrive, and tell them I really appreciate everyone doing their best to make this time before we get there easy for everyone. Then I ask everyone to talk about one thing they liked best about our trip. That shifts the mood a lot.

Therapist: You sound very skillful in managing that situation. What makes it possible for you to stay calm and redirect the mood when everyone else is so agitated?

Gizem: I know my family. Each one of them is a good person. They only get troublesome when they are uncomfortable or unhappy. So I try to make the situation more comfortable for everyone.

Therapist: If you were going to describe to a friend what you did in this scene you just told me about, what do you think were the main important things? For example, you said you spoke "quietly." Do you think a quiet voice is helpful?

Gizem: Yes. In a loud, complaining situation, sometimes it is the quiet voice that gains respect. And I also reminded everyone that there is something good ahead and something good that has already come. Thinking about good things puts people in a better mood.

Therapist: (*Showing Gizem what she has written*) I'm making a list of your ideas. "Quiet

voice gains respect. Reminding them about good things ahead and in the past." Anything else?

GIZEM: Yes. Reminding them that they are good and that I appreciate them.

THERAPIST: (*Handing the pen and paper to Gizem*) Why don't you add that to the list? (*Pauses while Gizem writes.*) You sound so calm in your image. Do you feel calm?

GIZEM: Yes, I do.

THERAPIST: What helps you feel calm?

GIZEM: I am their mother and wife. They respect me. I know I can handle this situation. I know that they want to feel better and that I can help them do that.

THERAPIST: This "knowing" you can help them. How does that feel in your body?

GIZEM: My heart feels full. I see what is really going on in my inner eye. And I hear their struggles rather than their complaints. It is all inside my chest and head with a fullness of knowing.

THERAPIST: Can you close your eyes right now and feel that fullness of knowing?

GIZEM: (*Closing her eyes and speaking more quietly now*) Yes.

THERAPIST: Sit with that image and knowing for a moment. (*Gizem sits quietly.*) When you are ready, open your eyes. (*Gizem opens her eyes.*) What might be different if you entered your supervisor's office, feeling what you are feeling right now, imagining your fullness of knowing . . . you can see what is really going on in your inner eye and hear your supervisor's struggles rather than his complaints?

GIZEM: I would feel more in control. Calmer.

THERAPIST: Imagine that for a moment. (*Pauses for 30 seconds.*) What difference might that make?

GIZEM: I could listen to him and not cry. I could tell him my own thinking as an equal.

THERAPIST: Imagine doing that. (*Pauses for a minute while Gizem imagines this scene.*) Can you imagine it?

GIZEM: Yes, I can. It is better.

THERAPIST: Let's look at the list of things you did with your family. Would any of these ideas help with your supervisor?

GIZEM: I could remind him about the good things we have accomplished so far, and express my confidence that there are good things ahead. And thank him for his support of me.

THERAPIST: And if he gets upset with you at any point? How would you hear his struggles in addition to his complaints?

GIZEM: I could think about the pressures he is under from his manager. He is a

good man, but I know he gets really worried about being criticized or missing the goals set for him by his manager.

THERAPIST: Keeping that in mind, what difference would it make?

GIZEM: Oh, it would help me feel less sensitive to his criticism. I would hear his worries rather than his complaints.

THERAPIST: It strikes me as quite beautiful that you are able to do that. Let's talk about how you can practice getting into this state of "imagining your fullness of knowing . . . you can see what is really going on in your inner eye and hear your supervisor's struggles rather than his complaints." What imagery would help you get to that feeling state? Would it be best to start with imaging your family on the trip, or something else?

GIZEM: Yes. I think starting with my family would help. Maybe once I get that feeling, I could shift to thinking about my supervisor in that way.

THERAPIST: That sounds like a good plan. Let's write down what will help you remember the important parts for your practice this week. Then we can then imagine what might interfere with doing this practice and how you would like to handle any obstacles that come up.

Gizem's therapist began by asking her to recall a time when she felt more competent at handling obstacles. Notice that the therapist included in her prompts the idea that it might be a situation in which "people around . . . are unhappy and you are able to manage them and get things going smoothly." While it is not strictly necessary for clients to recall past situations with direct parallels to the one facing them in therapy, Gizem did have such a memory, and it proved especially helpful. If she had chosen something quite different, such as repairing a clock that frequently broke, then the therapist could have still gone through the same steps and then applied the ideas gathered in a metaphorical way to the situation with her supervisor. For example, if Gizem described relying on past experiences to fix a clock, this might metaphorically link up to feeling confident that she could listen to her supervisor and draw on her past experience with him to respond in a useful way.

Once Gizem chose a situation in which she felt confident, her therapist asked about challenges in that situation and how she handled those challenges. She engaged Gizem by asking her to write out a list of the strategies she used. Next, her therapist asked how she felt in her body when using these strategies. This led to a description of Gizem's "felt sense" of knowing, seeing, and hearing in a different way. Other clients might describe more physical descriptors (relaxed shoulders, etc.). It is helpful to flesh out a client's image and get body sensations, sights, sounds, smells, and any other sensory descriptors that help make the image more vivid and real for the person. The more multidimensional a coping image is, the more easily the person will be able to practice the image in the coming week(s) and use it to evoke feelings of confidence when entering and staying in situations that trigger anxiety.

Finally, Gizem's therapist asked her how she could use this image to help her in the actual situation in which she was talking with her supervisor. Gizem had a number

of ideas about this, which were later incorporated into her imagery practice during the week. In this instance, the imagery she practiced in regard to managing her family was directly linked to strategies she could use to navigate the discussion with her supervisor. However, keep in mind that the goal is for clients to use their imagery to help elicit feelings of confidence in the face of interpersonal adversity, not to prevent adversity. Her therapist asked Gizem how her imagery could help if her supervisor became upset with her. Staying in this situation and coping with her supervisor's potential criticism were the ultimate goals for Gizem as she practiced using imagery to help her tolerate anxiety and challenging circumstances. This imagery model illustrated with Gizem is based on Padesky and Mooney's (2012) strengths-based CBT model for building personal resilience, which can be a helpful adjunct in the treatment of anxiety.

Safety Behavior or Good Coping?

The final worksheet in Chapter 14 of *MOM2* is designed to help evaluate whether regular practice of one or more of the "Managing Your Anxiety" methods reduces anxiety and tension. Worksheet 14.6, Ratings for My Relaxation Methods (*MOM2,* p. 246), invites readers to rate their anxiety/tension before and after practicing any of these methods (mindfulness and acceptance, breathing, progressive muscle relaxation, or imagery). Although the title of the worksheet calls all of these "relaxation methods," you can clarify with clients who are using mindfulness and/or acceptance methods that these are actually awareness methods, not relaxation methods. This worksheet can be used to rate anxiety or tension before and after mindfulness and acceptance practices; just make sure you have the client label them as awareness methods. Unless you and a client have a rationale that favors practicing one method over another, encourage your clients to practice the methods they find appealing to see which ones work for them. Use of any of these methods will become more effective with practice over time. Remind clients that a single practice session is not likely to give a good indication of its ultimate helpfulness.

As discussed in the upcoming chapter (Chapter 11) in this clinician's guide, many of the treatment protocols for particular anxiety disorders do not require relaxation practice at all. Thus this section of the *MOM2* anxiety chapter (Chapter 14) can be considered optional unless you think clients will benefit from overall tension reduction, or unless you plan to include mindfulness and acceptance methods in therapy. If you do decide to include any of the three relaxation methods (breathing, progressive muscle relaxation, or imagery) as part of anxiety treatment, stay alert to the tendency for effective relaxation methods to evolve into unhelpful safety behaviors, particularly when people have beliefs that anxiety or its symptoms are themselves dangerous. For example, in the treatment of panic disorder (as explored in the next chapter), relaxation methods can interfere with treatment response if they effectively reduce the frequency of trigger sensations (e.g., rapid heart rate, light-headedness) and thus help clients avoid those sensations.

Remember the principle offered to readers in *MOM2* (p. 227): "Safety behaviors are designed to eliminate danger; coping behaviors are designed to help us approach, stay in, and manage situations that frighten us." When someone considers anxiety and

its symptoms dangerous, then relaxation methods are often practiced as safety behaviors in an attempt to reduce anxiety and stay comfortable. On the other hand, the relaxation methods taught in *MOM2* can also be part of good coping, but only to the extent that they help people approach and stay in situations that evoke anxiety. Whether relaxation practice is a safety behavior or good coping can only be determined by discussing its meaning and purpose with your client, as illustrated below. Charlotte was in therapy for treatment of her social anxiety.

CHARLOTTE: I am so happy that I was able to attend a party this week and not feel so anxious.

THERAPIST: That sounds like progress. What do you think helped you feel less anxious?

CHARLOTTE: Well, I practiced my relaxation exercises before I went into the party, and then I kept using them whenever my anxiety started to get worse. It worked really well.

THERAPIST: Help me understand in a bit more detail. So before you went into the party, what did you do?

CHARLOTTE: I sat in my car for about 10 minutes and practiced my breathing, and I also did a muscle relaxation check. I did this until I felt really relaxed.

THERAPIST: Then what happened?

CHARLOTTE: I went into the party and started feeling anxious right away, so I found a quiet room and did breathing again until I felt calmer. My anxiety went from about an 8 out of 10, down to a 3. Then I went back into the party room and sort of hung out watching people. I was so proud that I felt pretty relaxed. I kept doing my breathing even while I stood there.

THERAPIST: Did you interact with people at the party?

CHARLOTTE: Not a whole lot. Mostly I watched people and practiced my breathing.

THERAPIST: What do you think would have happened if you had talked with people for a while, even if you did get anxious?

CHARLOTTE: I think they would have seen I was anxious, and then I would have gotten more anxious, and I probably would have had to leave the party.

THERAPIST: Hmmm. So it sounds like the breathing successfully helped you stay less anxious at the party, but it doesn't sound like it helped you interact with other people.

CHARLOTTE: Yeah, but I stayed at the party for more than an hour. That's a big improvement!

THERAPIST: I can see how it feels that way. It is good that you went to the party and stayed there. At the same time, it seems like you only stayed there because your anxiety was low, and you didn't risk talking much to other people in case your anxiety would go up and they would see you were anxious. If your fear was just being at a party, then this would be a

success. But do you remember what the fear was that we identified last week?

CHARLOTTE: Yeah. My fear is that if I look anxious, then other people will think less of me and reject me.

THERAPIST: So do you think your breathing practice and hanging on the edge of the party helped you test that fear, or did it act more like a safety behavior keeping you away from what scares you?

CHARLOTTE: I see what you mean. I guess it was more of a safety behavior. And here I thought I had made a real breakthrough.

THERAPIST: Well, being at a party for an hour is a record for you this year (*smiling*). I wonder how you might build on this experience to have an even bigger breakthrough.

CHARLOTTE: I suppose I need to go to a party and talk to people more.

THERAPIST: Yes. And if you are anxious and look anxious when you talk with them, that will be even better. Can you think why I might say that?

CHARLOTTE: Because then I will be testing my biggest fear?

THERAPIST: Yes. Exactly. Maybe we can practice that situation today in some role plays and figure out some more experiments you can do this week.

In this session, when her therapist gathered more information, it quickly became apparent that Charlotte had used relaxation methods as a safety behavior to feel calmer and prevent others from seeing her look anxious. If Charlotte had instead described using relaxation to get up her courage to enter the party and, once there, to enter conversations and remain in these even after feeling anxious, then the relaxation practice would have looked more like good coping. Therapists need to ask lots of questions to learn about the function and meaning of relaxation methods before it is possible to know whether these are supporting therapy progress (good coping) or interfering with treatment success (serving as safety behaviors).

Changing Anxious Thoughts and Images

One section of *MOM2* Chapter 14 introduces readers to the concept that changing thoughts and images can be an important part of enduring improvements in anxiety (Hollon et al., 2006). This brief summary (*MOM2,* pp. 247–248) alerts readers and therapists alike that behavioral experiments are the interventions of choice to test beliefs related to anxiety. As a reminder, this is because the central thoughts in anxiety disorders tend to take the form of predictive underlying assumptions. These pages of *MOM2* also reiterate that anxious thoughts often come in the form of images, while noting that imagery can also be tested with behavioral experiments. In the next chapter of this clinician's guide, we describe treatment approaches for each of several common anxiety disorders, and we illustrate the use of behavioral experiments to test underlying assumptions and images.

Medication

Many people turn to medication for anxiety management. We take the opportunity in *MOM2* to increase readers' awareness of the association between reliance on anxiety medications and high rates of relapse, as well as the various risks for building tolerance and addiction. If medication is used at all, it should only be considered a short-term approach to anxiety management. The most serious risks arise with long-term use of tranquilizers, which can lead to addiction, tolerance effects, and rebound anxiety when these medications are eventually withdrawn. Also, reliance on any type of medication that dampens anxiety responses can interfere with skills practice and reduce positive outcomes from CBT (Foa et al., 2002). Therefore, it is usually desirable to work with prescribing physicians to help clients taper off anxiety medications as soon as possible after therapy begins. The exception to this recommendation is in the treatment of clients who experience anxiety so debilitating that it is difficult for them to participate in therapy. These clients can benefit from short-term use of medication until they learn various skills they can use to manage anxiety unassisted.

Some people balk at the idea of reducing medication, even when their prescribing physicians and therapists agree that it is safe and desirable to do so. Others don't mind reducing medication but are unwilling to stop taking it completely, clinging to a tiny partial dose as insurance against the return of full-blown anxiety. In such cases, actively inquire about beliefs pertaining to the necessity of medication. These beliefs are usually rooted in a conviction that anxiety itself is dangerous and uncontrollable, and that medication is required to block anxiety because other treatments will be ineffective. These beliefs, if untested, can undermine these clients' motivation to practice and rely on skills learned in therapy.

To shift beliefs about medication, it is usually necessary to combine psychoeducational information with behavioral experiments. Ideally, prescribing physicians corroborate information given by therapists regarding the safety of managing anxiety without medication. When a prescribing physician believes that pharmacological treatment is necessary for anxiety, a therapist can offer research reprints regarding medication interference with positive treatment outcomes (see Foa et al., 2002), information about CBT procedures, and CBT outcome studies (including lower relapse rates compared with medication; Hollon et al., 2006). Physicians can be invited to do a behavioral experiment in which they agree to taper the medication to see whether CBT can be effective on its own.

The following excerpt illustrates how one therapist used guided discovery combined with psychoeducation to convey information about the use of medication. Employing guided discovery reduces the likelihood that a client will respond, "Yes, but . . ." to information related to medication reduction, as demonstrated in this exchange between Kai and his therapist.

THERAPIST: You have been unwilling to experiment with going into a meeting without taking a small dose of Xanax. I'd like to discuss that decision today.

KAI: I know you don't want me to take the medication. But I don't think it hurts anything, and it helps me not avoid the meetings, like I used to.

THERAPIST: That's the advantage of the medication. Can you think of any disadvantages?

KAI: No.

THERAPIST: What do you think would happen if you didn't take the medication?

KAI: I'd probably get panicky and leave the meeting.

THERAPIST: What would be an alternative to leaving if you became panicky?

KAI: Well, I suppose I could try those breathing exercises, and I could also identify and test my thoughts.

THERAPIST: How confident are you that these strategies would work as well as the medication?

KAI: If I'm honest with you, not very confident.

THERAPIST: That's what I thought. What would it take for you to become confident?

KAI: I guess I'd have to try them out without medication and see if they work. But it's just too risky to try that at a meeting where I could make a fool of myself in front of customers.

THERAPIST: Suppose you had a friend whom you wanted to encourage to stop taking medication. What would you advise him in this situation?

KAI: (*Smiling*) You're tricking me.

THERAPIST: I don't mean to trick you. It just seems that you can think of only one way to handle this for yourself. I thought maybe you could get more ideas if we shifted the focus off you.

KAI: Well, I might tell my friend to try not taking the medication before a meeting that is less pressured. In some meetings I don't have to say much. Or I could take the medication with me and only take it if my anxiety gets bad and the other techniques don't work.

THERAPIST: Those are two good ideas you could try out. How long would it take the medication to work if you did take it as a last-minute backup?

KAI: Usually I feel better within a few minutes.

THERAPIST: Really?

KAI: You seem surprised.

THERAPIST: I am. Xanax usually takes at least 15 or 20 minutes to take effect. Do you really feel better within a few minutes of taking it?

KAI: Yes, I do.

THERAPIST: Then how would you explain that? Why do you think you feel calmer in a few minutes if the medication takes 15 to 20 minutes to have a physiological effect?

KAI: Maybe because I feel reassured that help is on the way.

THERAPIST: So your confidence in the Xanax might help you even before the medication does?

KAI: Yes, that makes sense.

THERAPIST: Does it also make sense then that increasing your confidence in the methods you've been learning in *Mind Over Mood* might help make these methods more helpful, too?

KAI: Yes, I suppose it might.

THERAPIST: Perhaps it's time to do some experiments to find out if you can be as confident in these other methods as you are in the medication. Which experiment would you be willing to try first?

KAI: Maybe to not take the medication at a less pressured meeting, but to still carry the medication with me in case my anxiety gets too bad.

THERAPIST: That seems like a good place to start. Let's review and practice what you'll do instead of taking medication. Also, we should make some back-up plans so you don't take the medication at the slightest hint of anxiety.

KAI: (*Laughing*) Yes, I might want to do that!

It often takes a number of weeks before someone who firmly believes in medication develops confidence that other methods can be as effective. Therefore, it is a good idea to identify beliefs about medication early in therapy, so you can devise experiments to test them as soon as your client learns other anxiety management strategies. People who have been on medication long enough to experience withdrawal effects when the medication is reduced should be warned of the probability of temporarily increased anxiety. Withdrawal anxiety can be reframed as an opportunity to practice tolerating anxiety when the cause of the anxiety (in this case, physiological withdrawal) cannot be changed. Of course, any reduction in prescribed medication should only occur under the supervision of a physician who can prescribe a safe tapering protocol and monitor any adverse effects.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 14

Therapist Fears

As described throughout this chapter, avoidance is a hallmark of anxiety. Therapist fears also fuel avoidance and form one of the primary roadblocks to successful anxiety treatment. As is evident in this chapter and the next, evidence-based treatment for anxiety involves encouraging clients to face their fears. In the process, they sometimes experience significant anxiety in sessions and outside of sessions. Many therapists have difficulty encouraging exposure when their clients begin to feel anxious because of their own beliefs, which may include these:

"My clients can't tolerate exposure. It will be too distressing to them."

"What if I ask a client to do this and then something bad happens? I will be responsible and could face punitive legal or professional actions."

"If I encourage my clients to experience anxiety, then it will be intolerable for them. They might fall apart, decompensate, drop out of therapy, or tell others I am a terrible therapist."

"If I ask my clients to do this, maybe their fears will come true and they will be in danger."
"If I have to expose my clients to their fears in session, then I can't do it, because I have the same fears."
"It is insensitive or maybe even unethical to make clients uncomfortable in therapy. My job is to keep them comfortable and feeling safe."

Therapists' reluctance to focus on exposure to fears can be harmful for their clients, because exposure is an empirically supported, guiding principle of efficacious anxiety treatment (Lohr, Lilienfeld, & Rosen, 2012). Therapist fears about exposure create a barrier for treatment access for clients who want to receive CBT for anxiety (Gunter & Whittal, 2010). Unfortunately, therapists' negative beliefs about exposure are common and lead to cautious delivery of exposure therapies (Deacon et al., 2013). Cautious implementation of exposure can dampen its effects and can even convey nonverbally to clients that there is significant risk involved in facing their fears. In our experience in our own treatment centers, therapists who have the greatest success in treating anxiety disorders do the following:

1. Welcome anxiety, conveying a fearless calm and curiosity about anxiety and what will be learned in exposure exercises.
2. Participate collaboratively in these exercises.
3. Encourage clients to continue instead of stopping exposure when anxiety becomes more intense (e.g., "You are doing really well. Let's stick with it a little longer and see what we can learn").
4. Explore every aspect of exposure experiences during and after they occur, in order to make sure clients learn something useful and valuable about their anxiety from each exposure exercise.

Our observations fit with the empirical findings of a study in which undergraduates were given information about exposure therapy that supported either positive or negative beliefs, and were then told to conduct an exposure session with a confederate (Farrell, Deacon, Kemp, Dixon, & Sy, 2013). Those who held more negative beliefs about exposure therapy experienced greater anxiety when delivering it, created less ambitious exposure hierarchies, selected less anxiety-provoking tasks at each level of exposure, and tried to minimize anxiety during exposure through reassurance of safety and use of controlled breathing. In contrast, those given positive beliefs about the benefits of exposure were less anxious themselves during exposure tasks, selected higher-anxiety exposure tasks, and were more likely to encourage a focus on the exposure to anxiety triggers.

Interestingly, this same study showed that therapists with greater empathy for clients showed greater caution when delivering exposure therapy, regardless of whether overall beliefs about exposure were positive or negative. Since it is desirable that therapists have empathy for their anxious clients, and many of us therapists hold fears that exposure therapy might be too risky, how do we deal with our own fears that can derail

effective therapy for anxiety disorders? One solution is to use *MOM2* exercises to test beliefs that can interfere with following the anxiety treatment guidance offered in this chapter and the next:

1. Identify your own beliefs and images regarding anxiety treatments. Ask yourself these questions: "What's the worst that could happen? What images or memories do I have? Is this really the worst, or do I have additional fears as well?" Write down all your anxious thoughts and images. Try to write your thoughts in the form of underlying assumptions (e.g., "If I don't teach controlled breathing, then my clients will suffer needlessly"). For each belief, write an alternative, nonanxious assumption that you can use for comparison's sake and that reflects the information provided in this chapter (e.g., "If I don't teach controlled breathing, then my clients will be able to test their beliefs about the dangers and their coping ability more quickly. Their suffering from anxiety might actually decrease more quickly through exposure than by means of controlled breathing exercises").

2. Plan behavioral experiments with yourself and/or your clients to test and compare your actual experience with these beliefs. Do a number of experiments, and write your results from each on Worksheet 11.2, Experiments to Test an Underlying Assumption (*MOM2,* p. 149). Make sure you don't incorporate avoidance and safety behaviors into your experiments. It can be helpful to review your outcomes with a supervisor, consultant, or colleague who is experienced and successful in delivering anxiety treatments, to get input on whether you are conducting your experiments in optimal ways. This person can also help you debrief your experiences to maximize learning from them.

3. If the results of your experiments are consistent with your anxious beliefs, it might help to go over your experiences with an anxiety expert, to help you see if there is something about your experiments or clientele that might account for this finding. Similarly, be skeptical if the results of your experiments contradict your anxious beliefs. Conduct more experiments until you have enough data to be confident that you do not need to feel anxious about using these therapy methods.

Continual awareness of our own beliefs and how these affect our therapy practices is an important part of improving our overall effectiveness as therapists. The exercise above can be used to evaluate any beliefs you hold that might be diminishing your therapy quality. For example, if you consistently end sessions late, you can use this approach to identify underlying assumptions that maintain this issue (e.g., "If someone is distressed, then it is dangerous to end the session, even if time is up") and test these beliefs with behavioral experiments. Behavioral experiments are especially helpful when you are learning new therapy approaches, including methods or philosophies that might contradict your existing therapy practices. It is wise to test such new approaches systematically and evaluate their benefit in your own practice. It is also beneficial to apply therapy methods to yourself, so you can learn more about what is involved when you use these approaches with clients.

Helping Clients Approach Their Fear of Death

Sometimes people's worst fear is that they will die (as a result of anxiety or from circumstances that frighten them). Therapists can feel stuck as to how to test such a prediction, and also how to help a client approach and manage anxiety regarding death. As with all anxious fears, the first step is to help the person identify what the fear is actually about. Fearing one's own death may not really be as specific as it sounds. Therapists should inquire to get more details about this fear and any associated images. It can sound a bit harsh simply to ask, "And what would be the worst thing about dying?", even though this is an important question to ask. Observe how Brian's therapist asked this question in a context that made it seem quite natural.

BRIAN: I'm afraid of a plane crash because my wife and I will die!

THERAPIST: OK, if a plane you are on crashes, there is certainly a chance that you might die. There are many reasons why people are afraid of dying. I want to make sure I don't make any assumptions and misunderstand your fear. What would be the worst thing about dying for you?

BRIAN: I think the big thing is that if we die, we won't be able to provide for our children and ensure a good life for them.

THERAPIST: So it is not the moment of death you fear as much as what comes afterward for your children?

BRIAN: Yes.

THERAPIST: Do you have any worst-case scenario images of what your children's future might look like if you die?

BRIAN: Hmmm. I really have two worst-case scenarios. One is that they will be sent to an orphanage and be neglected there. The other is that my sister Gwen, who is really controlling, will swoop in and take them to live with her. She is so mean that they would be better off in that bad orphanage.

THERAPIST: Thank you for those details. Now I understand your fear of death much better. Let me get a bit more detail from you about both of those images, and then we will see what we can do to address your fears.

Brian's answers guided his therapist to explore with Brian what he could be doing in the here and now to reduce the perceived dangers that would accompany his and his wife's deaths. He and his wife could make a plan for their children's care in the event of their death, and take whatever legal and financial steps were available to them to assure that their children's future would be the best possible. They might need to ask friends or other relatives they trusted (rather than Brian's sister Gwen!) to agree to be named as legal guardians to their children in the event of their deaths while the children were still young. As is apparent, approaching a fear of death does not mean actually needing to approach death. People need to approach and learn to cope with the aspects of death that are most frightening to them.

Brian's fears concerned his children. Others fear death because they imagine it

will be very painful. Such fears can be addressed by exploring what pain management resources will be available to them and what pain management skills they can develop to increase their confidence that they can cope with whatever pain is involved (e.g., mindfulness, acceptance, self-hypnosis, imagery strategies). Notice that the focus is on coping with death and fears associated with it, not on reducing the fear that death could come. The reality is that death will come for us all, so we each must learn to face our fears about it.

Some people fear death because they have beliefs and images about what happens after death. One woman feared that she would still be alive and stuck alone in her casket underground. In this case it was not death itself, but life in a casket underground that frightened her. Therefore, her therapist encouraged her to investigate burial methods in her country until she was certain that this danger could not happen where she lived, due to legally regulated practices of embalming. One man feared going to hell as his biggest danger. His imagery of hell was not fire and brimstone, but an eternity all alone. His therapist directed him to use imagery and figure out how he could cope with an eternity in the hell he imagined. Although this intervention might seem challenging, after much contemplation the man did develop several strategies he thought would help him cope in hell (e.g., listen to favorite music in his mind, create movie scripts). Once his confidence in his coping plan reached 80%, his fear of death dissipated.

Avoidance of Therapy Procedures

People experiencing anxiety often want to avoid therapy procedures, especially since these procedures often lead to a temporary increase in anxiety. Clients may not want to recall images, approach feared situations, or write down their anxious thoughts and images. It is our role as therapists to shepherd our clients through these experiences without creating an antagonistic struggle. If we take small steps, teach coping skills along the way, and adeptly test anxiety-related beliefs, even those who experience high levels of anxiety can overcome avoidance. Lupe's therapist struck a good balance of those strategies in one key session.

THERAPIST: Since you had trouble figuring out what was going through your mind when you were anxious this week, let's use imagery to recapture that anxiety in our session today, and maybe we can figure out the thoughts together.

LUPE: No, I don't want to do that today.

THERAPIST: Why not?

LUPE: I'm not having a good day. I don't think I'd handle getting anxious very well.

THERAPIST: What do you think would happen?

LUPE: I'd probably start shaking all over and couldn't stop.

THERAPIST: Do you have a mental picture of yourself doing that?

LUPE: Yes. (*Shakes head.*) I don't want to think about it.

THERAPIST: Well, we have a bit of a dilemma, then. You see, in order for us to understand and help you learn to handle your anxiety, we need to have you experience it.

LUPE: I know. But let's do it another day.

THERAPIST: That would be one approach. Although if you're already feeling bad today, then this might be a good day to start.

LUPE: Maybe. But I know I can't handle it.

THERAPIST: Would you be willing to take a tiny, tiny step to test that idea?

LUPE: What do you mean?

THERAPIST: Well, for example, do you think you could handle thinking about what makes you anxious for about 30 seconds? After 30 seconds I'll help you reduce your anxiety. We can talk about other things, or do relaxation, or do whatever it takes to help you feel better. Do you think you would start shaking uncontrollably after 30 seconds?

LUPE: I might. I'm not sure.

THERAPIST: Would you be willing to try? I absolutely promise to help you feel less anxious after that time period.

LUPE: All right.

THERAPIST: Just think about what happened on Friday when you felt so anxious. Let your mind recall it really clearly for 30 seconds. I'll watch the time and interrupt you after 30 seconds. (*Lupe closes her eyes and imagines for 30 seconds.*) Stop! OK, let's talk about television for a bit. Do you have a favorite show? Tell me about it. (*Lupe talks with her therapist for a few minutes about a favorite television episode.*) Let's stop our conversation about this show now, so I can do a check with you. How are you feeling right now?

LUPE: Pretty good. Not too anxious.

THERAPIST: If you were going to rate your anxiety from 0, none at all, to 10, the worst ever, how anxious would you say you feel right now?

LUPE: Maybe a 3.

THERAPIST: How did you feel after 30 seconds of thinking about Friday?

LUPE: I was starting to get anxious. Maybe a 5.

THERAPIST: How close were you to shaking uncontrollably?

LUPE: I guess not very close.

THERAPIST: So do you think our plan worked OK? Were you able to feel anxious and then feel better again?

LUPE: Yes, it was better than I expected.

THERAPIST: Maybe we can help you with your anxiety in small steps like this. For instance, we could try 60 seconds of thinking about what makes you anxious, and then help you relax. If that goes all right, we could try two minutes. In two minutes, we could probably learn some important

information about your anxiety without you taking too big a risk. What do you think?

LUPE: I could try that. As long as I can stop if it gets too much.

THERAPIST: That's a deal. We can do a lot of small experiments with brief anxiety until you become more confident. Of course, eventually we'll want to test the idea that you will shake uncontrollably if you really let your anxiety loose, but we can increase your confidence in handling small and medium amounts of anxiety before we tackle that.

LUPE: You really think this is necessary for me to feel better?

THERAPIST: I really do. Ready to try one minute?

LUPE: I guess so, if you think it will help.

Notice how Lupe's therapist gently pushed her to test her belief that she would shake uncontrollably if she was exposed to anxious thoughts. It was important for her therapist to balance respect for Lupe's fear with the knowledge that continued avoidance would only fuel her anxiety. It is much better to take small steps forward in anxiety treatment than to stop progress because a client is unwilling to take a bigger step. At the same time, it was important for Lupe's therapist to follow through as quickly as possible to create an opportunity for Lupe to delve deeply into her anxiety and "really let her anxiety loose." Otherwise, her therapist might end up inadvertently colluding with Lupe to avoid the levels of anxiety that frightened her the most, and this could derail a positive and enduring treatment outcome.

11

Adapting *MOM2* to Common Anxiety and Related Disorders

> I'm afraid of flying. I try to avoid it whenever I can.
>
> —*Bianca*
>
> I'm afraid of flying. Sometimes I have to fly for business, and I try anything to get out of taking a flight.
>
> —*Ji-ho*
>
> I'm afraid of flying. I always drive even if it takes a few more days.
>
> —*DeShawn*

Each of these three people had developed a fear of flying, and their observable behaviors were similar: They tried to avoid flying in airplanes. And yet the best treatment for each of these people would be different. How could this possibly be? And how can therapists decide what the best treatment strategies will be for given clients? This chapter provides a brief sketch of important ideas to know about the most common types of anxiety disorders, along with treatment protocols designed for each.

Effective anxiety treatment requires an understanding of the similarities and differences among various anxiety diagnoses. Treatment planning is much easier if you are able to diagnose what type of anxiety someone is experiencing. To do this, knowing the triggers for fears is usually not enough. You also need to understand what it is about that trigger that frightens someone. For example, Bianca, Ji-ho, and DeShawn each had anxiety triggered by flying on an airplane. However, in their initial interviews, their therapists discovered that these three individuals had markedly different beliefs and images when on airplanes. These variations in beliefs and images led to a different diagnosis for each person, as follows:

- Bianca feared that an airplane could not possibly stay airborne during turbulence and would crash. She had vivid imagery of what it would be like during a plane crash. Her therapist diagnosed a specific phobia of flying.

- Ji-ho was uncomfortable around strangers and usually left situations once his anxiety reached moderate levels. When buckled into his seat on an airplane, he began to get anxious. Since he could not hide his anxiety from others by using his usual exit strategy, he began to fear that neighboring passengers would notice his anxiety and think less of him. His subsequent anxiety reached a crescendo in midflight. Vivid imagery centered on distortions of his physical appearance when he was anxious and sounds that he assumed indicated other people's disapproval of him. Ji-ho's therapist diagnosed social anxiety.
- DeShawn had read on the Internet that oxygen gets depleted on airplanes during flight. When he boarded a plane, he monitored his breathing. Whenever he felt any shortness of breath during flight, he began to think that there was not enough oxygen on the plane and he was about to suffocate and die. His imagery included a scene in which he gasped for air and died, collapsed on the floor. His therapist decided that DeShawn met criteria for panic disorder.

Even though these three people all experienced the same emotion (anxiety) and showed the same behavior (avoidance of flying), the treatment would be quite different for each person, because each met criteria for a different anxiety disorder based on the thoughts and images they had when flying.

Targeting the central beliefs that maintain a person's anxiety disorder can speed treatment response and improve the odds of a successful therapy outcome. For example:

- Bianca would benefit from learning about flight dynamics, and her therapy would involve frequent exposure to flying (either in imagination or *in vivo*), along with practice of anxiety tolerance and coping skills.
- Ji-ho was likely to benefit most from testing his beliefs that his anxiety was visible to others and that others disapproved of his anxiety responses. He could also learn to defend himself assertively if someone else did express disapproval.
- DeShawn was likely to benefit from induction of shortness of breath both in and out of therapy sessions. Breathing experiments would enable him to test his catastrophic assumptions about sensations related to shortness of breath, and to develop alternative, nondangerous explanations for changes in his breathing.

Clinical Tip

Assessment and diagnosis are important, because there are different treatment approaches for each type of anxiety disorder, matched to the types of beliefs that maintain it. Identifying and targeting the central beliefs maintaining a particular anxiety disorder can speed treatment response and improve the odds of a successful therapy outcome.

Importantly, each of these three treatment approaches was unlikely to prove helpful for the other two people. Thus it is imperative for therapists to attain some skill in differential diagnosis and knowledge of treatment protocols designed for each type of anxiety. Since their therapists had this knowledge, Bianca, Ji-ho, and DeShawn would all reach their goal to travel on airplanes.

COMMON ELEMENTS IN CBT PROTOCOLS FOR ANXIETY DISORDERS

In the following sections, we offer brief guidelines for using *MOM2* in treating the most common anxiety disorders seen by most clinicians: generalized anxiety disorder (GAD), panic disorder, specific phobia, agoraphobia, and social anxiety. Specialized CBT protocols have been developed for each of these anxiety disorders. These treatment protocols have several elements in common: (1) identification of maintaining beliefs (usually underlying assumptions and imagery), (2) behavioral experiments designed to test these central beliefs, and (3) exposure to feared situations and stimuli. Detailed treatment protocols for specific anxiety disorders are provided online by Division 12 of the American Psychological Association (*www.div12.org/psychological-treatments*). For an overview of the theoretical underpinnings and empirical evidence supporting CBT approaches for anxiety, see Clark and Beck (2011).

We conclude this chapter with mentions of two disorders formerly classified as anxiety disorders but now assigned to their own diagnostic categories: obsessive–compulsive disorder (OCD) and posttraumatic stress disorder (PTSD). Although specialized treatment protocols have been developed for both OCD and PTSD, we do not recommend *MOM2* as the primary treatment manual for either of these disorders. Nevertheless, selected *MOM2* skills and worksheets can be useful for both, especially in cases where clients have comorbid diagnoses.

USING *MOM2* IN TREATMENT OF GAD: THE WORRY DISORDER

GAD is characterized by worry. While almost everyone worries sometimes, people diagnosed with GAD worry throughout each day about a wide variety of concerns. As is characteristic of all anxiety, two types of thoughts predominate in GAD: overestimations of dangers/threats and underestimations of coping ability/help resources. Worries are varied and often take the form of "What if . . . ?" questions: "What if my child has difficulties? What if I make a mistake? What if our money runs low? What if I can't do something [that is required of me]?" The nature of these worries in GAD is that these persons think about "bad things" that could happen, vividly imagine catastrophic possibilities, and rarely consider anything they can do to cope or to access any help available should the worst actually happen.

In contrast, people who do not experience GAD will often worry about a variety of things that could go wrong, assess the likelihood of each, and put effort into planning how to manage and cope with the most likely possibilities. The difference between these two mindsets is often in the degree of confidence in one's ability to cope

with dangers and life difficulties. Thus we recommend that therapy for GAD focus on boosting confidence in coping, rather than on minimizing assessment of danger. Both strategies can reduce anxiety; however, a focus on coping has the added advantage of reducing the perceived danger of consequences when things going wrong. "If something bad happens, then I will be able to cope with it" is a more resilient stance than "If I think something bad is going to happen, then I might be overestimating it."

There are many different evidence-based CBT approaches for GAD, such as Beck's general cognitive model for anxiety, which emphasizes correcting cognitive distortions regarding overestimations of danger and underestimations of coping and resources (Clark & Beck, 2011); Dugas's treatment model, which works on enhancing the ability to tolerate uncertainty (Dugas & Ladouceur, 2000; Hebert & Dugas, 2019); Wells's focus on testing metacognitions about worry (Wells, 2009); and Riskind and colleagues' treatment, which targets reductions of dysfunctional "looming vulnerability" appraisals (Katz, Rector, & Riskind, 2017). This variety of evidence-based treatments can be a bit confusing for therapists: Is it better to focus on cognitive distortions, metacognitions about worry, or tolerance of uncertainty? There have not really been enough comparative outcome studies to recommend one approach over another. Fortunately, the skills taught in *MOM2* are compatible with each of these approaches.

Whichever evidence-based treatment for GAD is followed, a common error therapists make is to focus on the specifics of clients' worries and try to convince their clients that this particular danger they fear is not likely to come true or that they can cope with it. For instance, a client worries, "What if I can't do this new job?", and the therapist begins a series of investigations and questions along the lines of "Let's look at the evidence. When have you thought this in the past and did this come true? What does the new job require? What skills do you already have that could help? What training is available? What would you tell a friend?" The problem with this therapy approach is that, even if the client by the end of this session is less concerned about being able to do the new job, the client has not learned anything to help with future worries. And dozens if not hundreds of additional worries are likely to arise in the weeks ahead.

A better therapy approach is to do the following:

1. Demonstrate how anxiety operates and how worries are fueled by anxiety.
2. Identify the underlying assumptions that lie beneath worries.
3. Devise behavioral experiments to test these underlying assumptions.
4. Identify alternative assumptions that promote less worry and anxiety.
5. Devise behavioral experiments to test the utility of alternative assumptions.

As described in Chapter 10, a focus on underlying assumptions is a more fruitful treatment focus, because this is the level of thought that maintains anxiety in GAD. Greater awareness of underlying assumptions and development of new underlying assumptions can help the person deal more effectively with worry and anxiety whenever they are activated. *MOM2* can help with each of these five treatment steps, as described more fully here.

1. Demonstrate How Anxiety Operates and How Worries Are Fueled by Anxiety

Chapter 14 of *MOM2,* Understanding My Anxiety, effectively educates people about anxiety and how it operates. As described in Chapter 10 of this clinician's guide, Worksheet 14.1, the *Mind Over Mood* Anxiety Inventory (*MOM*-A), is used to measure baseline anxiety; changes in anxiety over time can be tracked on Worksheet 14.2, *Mind Over Mood* Anxiety Inventory Scores (*MOM2,* pp. 221–222). Filling out the *MOM*-A sensitizes people to physical and other cues of anxiety. By filling this out, they are approaching and thinking about their anxiety rather than avoiding it.

You can expect people with GAD to record many worries in column 3, the Automatic Thoughts (Images) column, when identifying their thoughts associated with anxiety (Worksheet 14.3, *MOM2,* p. 232). Automatic thoughts are likely to be written as worry questions—for example, "What if *X* happens?" or "How will I handle *Y*?" When people write these kinds of questions in column 3, teach them to ask themselves, "What is the answer that makes me most anxious?" Encourage them to identify specific anxious fears in imagery as well as in words, as in this dialogue between Reuben and his therapist.

THERAPIST: I notice in column 3 you identified some questions in your thoughts. Like this one: "What if something bad happens?"

REUBEN: Uh-huh.

THERAPIST: It's best if you can take a moment to figure out what exactly you were worrying about. For example, what bad things were you imagining, and what made you anxious about that?

REUBEN: I guess there are a lot of bad things I can imagine. Like I could mess up and then get in trouble for it and lose my job. Stuff like that.

THERAPIST: Let's list these worries. (*Writes*: *"Mess up. Get in trouble. Lose my job."*) Anything else?

REUBEN: That's enough!

THERAPIST: I'm just checking. When you thought, "What if something bad happens?", was anything else on your mind? What were you imagining as the worst thing?

REUBEN: The worst thing?

THERAPIST: Yes.

REUBEN: I guess facing my father.

THERAPIST: What do you mean?

REUBEN: If I lose my job, then I have to tell him, and he will be so disappointed in me.

THERAPIST: Did you imagine talking to him when you were worrying about this?

REUBEN: Yeah.

THERAPIST: What did you imagine?

REUBEN: He was in the kitchen, and I walked in and told him I lost my job. He was sad, and his eyes looked disappointed. Then he shook his head and turned away from me.

THERAPIST: Did he say anything to you?

REUBEN: No. He was silent. And I knew he thought less of me and I would never have his respect again.

THERAPIST: Wow. And that's an upsetting thing for you.

REUBEN: Yeah. I've worked so hard to redeem myself in his eyes. I don't want to ever lose his respect again.

THERAPIST: And in this long string of events from messing up to losing your job and your father's respect, did you have any thoughts or images about you doing anything to cope or handle these things?

REUBEN: Not really. It just seemed like one bad thing would follow the other.

THERAPIST: So we've unpacked your worry, "What if something bad happens?" As it turns out, anxiety put a lot of scary thoughts in your mind about bad things happening. (*Reading from the written list*:) You'd mess up at work, get in trouble, lose your job, then have to tell your father, and then he would be disappointed, turn away from you, think less of you, and you would never have his respect again. And you didn't really think about doing anything along the way to help yourself or turn things around. Does that capture what was going through your mind?

REUBEN: It does. Really well.

THERAPIST: Do you think these details are more helpful in understanding your anxiety than the general worry, "What if something bad happens?"

REUBEN: Yeah, for sure.

THERAPIST: Then let's write down some questions you can ask yourself next time you think, "What if something bad happens?" that will help you get to these specifics.

After writing down questions Reuben could ask himself to identify specific worries (e.g., "What's the worst that might happen?", "Do I see myself coping in any way?", and "Am I having any images about this?"), his therapist linked Reuben's anxious thoughts and imagery with the model of anxiety described in *MOM2* Chapter 14.

THERAPIST: Remember how the anxiety chapter you read in *Mind Over Mood* said we have lots of thoughts about danger when we are anxious, and we also tend to believe we can't cope with dangers that might happen?

REUBEN: Yeah. We talked about that last week, too.

THERAPIST: After you thought, "What if something bad happens?", you had lots of thoughts and images. Did these have anything to do with danger or coping?

REUBEN: Yeah. All these thoughts are about danger in a way.

THERAPIST: How is that?

REUBEN: Well, if I mess up in my new job, then that would be a danger, and it could lead to getting in trouble, which is like a danger, and losing my job would definitely be a danger, and so would losing my dad's respect.

THERAPIST: And what did you think about coping with these dangers?

REUBEN: I didn't really think about that at all.

THERAPIST: Does that fit with what we talked about with anxiety?

REUBEN: Yes. I didn't even think that I could do something to handle these situations.

THERAPIST: So when you get anxious and worry, you think about lots of dangers, but you don't think much at all about coping.

REUBEN: That's right.

THERAPIST: How do you think things would go if you did think about coping instead of just danger? Like, for instance, if you thought about how you could handle it at the beginning . . . when you messed up.

REUBEN: If I think about coping with messing up by fixing it or talking to my supervisor, then I might feel less anxious about losing my job.

THERAPIST: So it sounds like anxiety really boosts your worries by keeping a spotlight on the dangers and keeping coping out of your mind.

REUBEN: You got that right.

This interview provided a good foundation for Reuben's therapist to ask him to capture more anxious thoughts and images associated with worries to bring to the next session. In addition, he asked Reuben to identify each thought and image as either a "danger" or a "coping" thought.

Once Reuben saw that he was primarily focusing on danger when he worried, his therapist proposed that Reuben begin to follow his "What if . . . ?" worries with "Then what can I do?" problem solving to shift his thinking to coping. As a first step in his worry management, his therapist asked him to write down a specific danger worry when Reuben found himself worrying about something. Next, Reuben was to ask himself, "Then what can I do?" and rate (on a 0–100% scale) how likely he thought it would be that those actions would solve the problem if it actually happened. His therapist asked him to continue considering additional actions he could take or help he could get from others until Reuben was fairly confident that his coping plan would help him successfully manage the danger that worried him. By getting Reuben to increase his focus on and confidence in his ability to cope with potential dangers, his therapist hoped to reduce Reuben's anxiety.

Like Reuben, many people with GAD worry about particular activities but do not always avoid them. Thus people with GAD may not need to read about or complete a Fear Ladder (Worksheets 14.4 and 14.5, *MOM2,* pp. 238–239) in therapy. Similarly, if people with GAD are only occasionally anxious during each week, then they may not need to practice particular relaxation methods as described in the final sections of *MOM2* Chapter 14. However, when people diagnosed with GAD experience high

levels of anxiety most hours of the week, some type of relaxation practice can be helpful until they learn other worry and anxiety management skills.

2. Identify the Underlying Assumptions That Lie Beneath Worries

What types of underlying assumptions maintain worries? The most generic underlying assumption for GAD can be stated as "If something bad happens, then I can't cope." Most people with GAD hold this assumption. There are many additional common assumptions that maintain worry, such as "If I worry, then I can prevent bad things from happening," and "If I don't worry, then I'll be blindsided, and it will be worse." Perfectionism is a common feature of GAD, maintained by assumptions such as "If it's not perfect, then bad things will happen [and then I can't cope]," and "If I make things perfect, then I can prevent bad things from happening." Assumptions related to uncertainty are also common: "If things are uncertain, then I should figure out all the possibilities for what might happen so I am prepared," "If I think long enough (worry) about things that are uncertain, then I can figure out what is likely to happen," and "If something unexpected happens, then I won't be prepared, and the consequences will be even worse."

Of course, each person will have individualized versions of these types of underlying assumptions. Reuben and his therapist identified some of his underlying assumptions in his subsequent session.

THERAPIST: I've been thinking about your worries this week.

REUBEN: I hope they are not contagious!

THERAPIST: (*Laughing*) No, not at all. I think your worries might have some assumptions underneath them, though.

REUBEN: Assumptions? What do you mean?

THERAPIST: We usually have some good reasons for worrying, and I bet you and I could figure out your good reasons. For example, you might assume, "If I worry about making mistakes, then . . ." (*Pause*)

REUBEN: Then I'll be more careful and not make them.

THERAPIST: Right. That's what I mean by an assumption. Let's write that down. (*Asks Reuben to write: "If I worry about making mistakes, then I'll be more careful and not make them."*)

Using the methods described in Chapter 7 of this clinician's guide, Reuben's therapist helped him identify the following underlying assumptions:

"If I worry about making mistakes, then I'll be more careful and not make them."

"If I make a mistake or something goes wrong, a whole series of negative events will follow."

"If a negative chain of events starts, then I won't know what to do and will just have to watch my life fall apart."

"If my life falls apart, then there is no way to recover."

These underlying assumptions helped Reuben understand why he felt so anxious about making mistakes or imagining things that could go "wrong."

3. Devise Behavioral Experiments to Test Underlying Assumptions

Once you and your client identify underlying assumptions, you can devise behavioral experiments to test them, as described in Chapter 7 of this clinician's guide. Reuben and his therapist used a variety of methods to test his assumptions. They did one experiment in their therapy session that involved playing a game in which careful attention was needed to remove sticks from a structure made from wooden pieces. If the wrong wooden piece was pulled, the entire structure collapsed. They played this game under two conditions: one in which Reuben worried about which stick to pull for a minute or more before each action, and the other in which he looked at the structure and made a "best guess," making a choice within 15 seconds. Reuben predicted he would have better outcomes when he worried more, because this would help him make better decisions. In fact, his performance under both conditions was similar, and sometimes he was able to remove more sticks under the "best-guess" condition. In debriefing this experiment, his therapist also asked Reuben to reflect on his anxiety and enjoyment under each condition. Reuben noticed that his anxiety was lower and enjoyment higher under the "best-guess" circumstances than under the "worry" condition. This experiment was one of several that led Reuben to conclude that worry did not necessarily help him prevent mistakes.

To test his second assumption, "If I make a mistake or something goes wrong, a whole series of negative events will follow," the therapist and Reuben reviewed Reuben's past mistakes at work and in his personal life, both big and small. Some of these mistakes did lead to a whole series of negative events, but only when Reuben made the same mistake over and over again (e.g., when he took some money from his father's wallet as a boy and kept doing this until he was caught). Reuben kept a log of mistakes he made during the week to see if these generally started a cascade of negative events, as his assumption predicted they would. They did not. He observed that he generally took action to correct his mistakes since he had become a young adult, and he acknowledged that these responses were really helping him make positive progress in his life.

4. Identify Alternative Assumptions That Promote Less Worry and Anxiety

After a number of experiments were completed, Reuben began to consider alternative underlying assumptions. Based on his experiences, the following assumptions seemed more accurate to him:

> "If I worry, it won't necessarily help, and it almost always makes me feel anxious."
> "If I make a mistake or something goes wrong, then I can usually figure out something to do to make it right."

"If a negative chain of events starts, then I can do something about it; I don't have to watch my life fall apart."
"Even if my life falls apart, then there is always a way to recover."

Although these assumptions were an improvement over his initial assumptions, his therapist wanted to help Reuben develop assumptions that were more assertive about his ability to cope and not focused so closely on "not worrying" or "making mistakes and making it right."

Focus on Coping

His therapist addressed a focus on coping with Reuben in the next therapy session.

THERAPIST: Last week we wrote out some assumptions about worry and mistakes that fit better with your experiences than the assumptions you started with. Did you have time to review and think about those new assumptions this week?

REUBEN: Yes, I did. These assumptions help me feel better.

THERAPIST: And do you still think they match your experiences well?

REUBEN: I do.

THERAPIST: I was thinking that today we could come up with some additional assumptions about coping and tolerating uncertainty, and test these assumptions in the weeks ahead, so you'll feel even better. Would that be OK?

REUBEN: Sure.

THERAPIST: What would you say is a good assumption for you now about the risk that bad things will happen and your ability to cope with these things? Put it in an "If . . . then . . ." statement like we have been doing.

REUBEN: I would say that "If bad things happen, then I can probably cope with it."

THERAPIST: How does it feel to say that?

REUBEN: True. But also a little scary.

THERAPIST: Try saying it again. But this time, take out the word "probably" and see how that feels.

REUBEN: If bad things happen, then I will cope with it somehow.

Clinical Tip

A focus on coping has the added advantage of reducing the perceived danger of consequences when things going wrong. "If something bad happens, then I will be able to cope with it" is a more resilient stance than "If I think something bad is going to happen, then I might be overestimating it."

THERAPIST: How does that feel to you?

REUBEN: I'm not completely sure that is true. But it feels better.

THERAPIST: Good. Let's try one other change. Since we know bad things do happen to everyone in life, try saying, "When bad things happen, I will cope somehow."

[Note that the therapist shifts language from "If" to "When" to make the statement stronger.]

REUBEN: When bad things happen, I will cope somehow. (*Pause*) Actually, I would like to say, "When bad things happen, I'll find a way to cope." That makes me feel much better and stronger.

THERAPIST: Good. Let's write that down. (*Pauses while Reuben writes his statement down.*) How much do you believe that?

REUBEN: Not entirely. But I'm getting there.

THERAPIST: I think we need to do some experiments to test it out.

REUBEN: OK.

After additional discussion, Reuben left this session with a list of new underlying assumptions that asserted his coping abilities more directly:

"When bad things happen, I'll find a way to cope."
"When the future is uncertain, that is OK, because no matter what happens I'll keep working toward my goals."
"When I have confidence I can cope with things, then I don't need to worry so much. I can take life as it comes."

These final underlying assumptions demonstrate that Reuben had moved from worrying about what would follow "if" bad things happened to asserting that "when" bad things happened, he would cope. When people have confidence in their coping abilities, they do not need to worry as much about potential dangers and mishaps.

5. Devise Behavioral Experiments to Test the Utility of Alternative Assumptions

The final stage of Reuben's therapy involved conducting behavioral experiments to test his new alternative underlying assumptions. Many of the experiments he used to test his initial GAD assumptions were similar to Experiment 1 in *MOM2* Chapter 11: Does "Then . . ." Always Follow "If . . . ?" (p. 142). However, testing his new assumptions often required him to use Experiment 3 in this same chapter, Do the Opposite and See What Happens (*MOM2,* pp. 144–146). In this case, Reuben did the opposite of what was suggested by his original GAD assumptions. For example, instead of trying to prevent bad things from happening, Reuben looked forward to bad things happening as opportunities to test his abilities to cope.

Instead of using worry to figure out potential outcomes and prevent uncertainty,

Reuben and his therapist devised a series of experiments to seek out uncertainty. These experiments embracing uncertainty began in session with his therapist. Instead of planning carefully what he would discuss and bringing a written list to each session, Reuben agreed to react more spontaneously. His original assumption, "If I make a mistake or something goes wrong, a whole series of negative events will follow," predicted that this more open-ended approach to his sessions would lead to poorer outcomes. His new assumptions—"When the future is uncertain, that is OK, because no matter what happens I'll keep working toward my goals," and "When I have confidence I can cope with things, then I don't need to worry so much. I can take life as it comes"—predicted that sessions could still be productive even without extensive planning on his part, and that if they were not productive, Reuben would be able to take corrective steps when necessary. Reuben discovered that when he did less planning of session content, unexpected discoveries were more likely to occur. A few sessions seemed less productive to him, although he thought this was OK, given that he continued to make progress.

Experiments with uncertainty outside of session were even more convincing to Reuben. He and his therapist devised a series of experiments that would heighten uncertainty and give him an opportunity to face the unknown. For example, one day he agreed to travel to a new part of his city to eat lunch and spend a few hours. Usually Reuben would research an adventure like this in advance to make sure he planned activities he was likely to enjoy, use the GPS on his mobile phone to guide his travel, and check restaurant ratings with an app before choosing a place to eat. For his experiment, Reuben agreed to forgo all these digital aids and set out without a plan; he even agreed to turn off his phone during the experiment, so that he would not be tempted to use it for safety behaviors.

The entire day was filled with uncertainties. At first, Reuben felt somewhat anxious and uneasy. He jotted down observations about his reactions and fears. During the first hour, he discovered that he was paying greater attention to his surroundings than he normally would. Initially he was screening them for danger. After a short while, however, he noticed that he was looking at the new neighborhood with curiosity and interest. He chatted with people in some shops and began to enjoy himself. By the time he headed home at the end of the afternoon, Reuben was pleased that he felt much more confident in his ability to manage uncertainties.

When debriefing this experiment, Reuben's therapist was careful not simply to notice what had gone well (addressing overestimations of danger). Instead, his therapist focused primarily on a discussion of experiences that had felt like challenges or dangers at the time, so that Reuben could assess how well he had coped with these. Reuben realized he had successfully managed a number of "bad things" happening, such as riding the wrong bus for a mile before he realized he was going in the wrong direction, choosing a restaurant that was a bit more expensive than he wanted, and encountering a homeless man who followed him for a few steps begging for money. Reuben concluded that his new belief, "When I have confidence I can cope with things, then I don't need to worry so much. I can take life as it comes," opened up whole new possibilities for his life. Even though there were risks involved in facing uncertainty, Reuben thought these risks were greatly outweighed by the greater freedom in his life that this assumption

TABLE 11.1. GAD Treatment Tasks Linked to *MOM2* Worksheets and Readings

GAD: Therapy task	*MOM2* worksheets and readings
Track anxiety mood scores every week on the *Mind Over Mood* Anxiety Inventory (*MOM*-A)	Worksheet 14.1, p. 221; graph scores on Worksheet 14.2, p. 222
Demonstrate how anxiety operates and fuels worries	pp. 219–232
Identify anxious thoughts/images	Worksheet 14.3, p. 232
Anxiety management strategies (only if necessary, due to high levels of anxiety throughout day)	pp. 243–245 Worksheet 14.6, p. 246
Identify maintaining underlying assumptions (using client's own language, include assumptions such as "If bad things happen, then I can't cope")	Worksheet 11.1, pp. 140–141
Devise behavioral experiments to test underlying assumptions; construct alternative underlying assumptions emphasizing coping; devise additional behavioral experiments to test new assumptions	Worksheet 11.2, p. 149
Address "What if . . . ?" worries by responding with "Then what . . ." coping plans	pp. 229–230
Consider turning an Action Plan worksheet into a coping plan for a specific danger	Worksheet 10.2, p. 125
Develop acceptance of life's uncertainties	Worksheet 10.3, p. 129

allowed. Reuben gradually developed acceptance of the uncertainties of life, supported by his new underlying assumption.

This encapsulated summary of Reuben's therapy illustrates one way a therapist might use *MOM2* in the treatment of GAD. Although Reuben's therapist did not explicitly use the Acceptance worksheet from *MOM2* (Worksheet 10.3, p. 129), many other therapists might choose to do so when working with clients who have GAD. Therapists are encouraged to adapt *MOM2* to particular clients' needs and to introduce skills in an order that makes best sense for each client. The main skills taught in *MOM2* that therapists will often emphasize in GAD treatment are summarized in Table 11.1, with links to specific *MOM2* worksheets and readings.

USING *MOM2* IN TREATMENT OF PANIC DISORDER

Hundreds of research studies (Clark et al., 1997; Ohst & Tuschen-Caffier, 2018; Teachman, Marker, & Clerkin, 2010) support the cognitive theory of panic disorder, which states that panic attacks in this disorder result from the catastrophic misinterpretation of internal sensations (physical or mental). These misinterpretations are "catastrophic" in the sense that people with panic disorder believe their sensations mean they are

currently dying, either physically or mentally (e.g., having a heart attack, permanently losing their minds). People with panic disorder enter a vicious cycle in which sensations are followed by anxious thoughts about the sensations that lead to anxiety, then by more sensations, and finally by catastrophic misinterpretations about the sensations, which lead to panic (as shown in Figure 11.1). Furthermore, people with panic disorder usually avoid activities or experiences associated with their feared sensations and engage in safety behaviors, which unfortunately prevent them from learning that their sensations are not actually dangerous. For example, a woman who believed that a rapid heart rate signaled an oncoming heart attack avoided walking up stairs because this exercise caused her heart rate to increase.

A very specific and highly successful treatment protocol for panic disorder has been developed by Barlow (2002) and Clark (1986; Clark et al., 1999), based on this cognitive model. This treatment approach can be effective with 75–90% of clients within 5–20 sessions, with less than 10% relapse after one year's follow-up (Clark et al., 1994).

Briefly, CBT for panic disorder involves the following:

1. Identify the catastrophic misinterpretations (fears) linked to sensations.
2. Induce sensations to demonstrate the vicious cycle, testing catastrophic danger beliefs, and identifying alternative (noncatastrophic) explanations for sensations.
3. Devise behavioral experiments to decrease avoidance and safety behaviors during sensation inductions, so that clients can discover that feared catastrophes won't happen even when sensations are very intense.
4. Devise further behavioral experiments to see whether catastrophic or

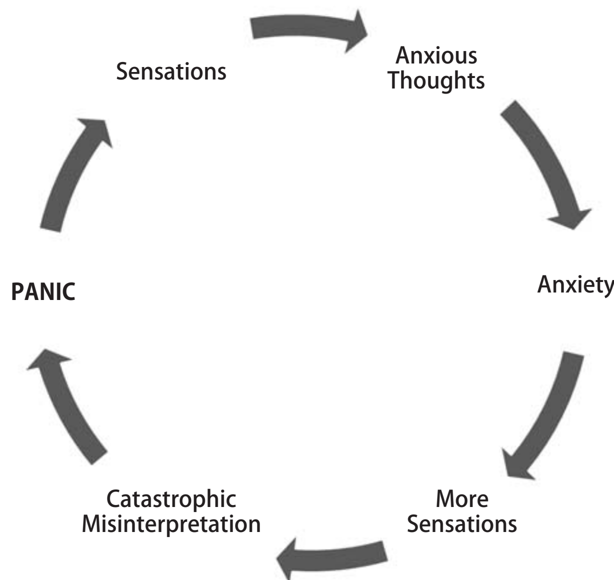


FIGURE 11.1. Vicious cycle in panic disorder.

noncatastrophic explanations provide a better understanding of the sensations experienced.

Padesky (1993b; see also Appendix C, p. 463) provides a video demonstration of the first three steps of this protocol, modeling how these first three steps can begin in a single session.

For example, Manuel avoided becoming overheated because he held this catastrophic underlying assumption: "If I sweat, then that means I will suffocate, collapse, and die." This belief began after he learned that a family member had begun to sweat a few minutes before fatally collapsing. To test this catastrophic misinterpretation of sweating, he and his therapist wore winter coats in a warm room and moved briskly to induce sweating. His catastrophic fear dissipated when he discovered that even intense sweating did not lead him to suffocate or collapse. His therapist helped Manuel develop an alternative explanation that sweating occurred when he was overheated as a way for his body to cool itself, but it did not mean that he was suffocating or dying.

Clients with any type of severe anxiety can experience panic attacks. A common therapist error is using CBT for panic disorder with clients who experience panic attacks but do not have panic disorder. The treatment described here should be applied only when panic attacks are not symptomatic of another anxiety diagnosis—that is, when at least some panic attacks occur "out of the blue" in response to fears about physical or mental sensations, rather than in response to a feared situation. Because the treatment of panic disorder is very specific, often only one or two underlying assumptions about one or more sensations need to be tested. For this reason, clients who are in treatment for panic disorder may need to read only a few chapters or sections of *MOM2.* The following case description illustrates this abbreviated treatment model.

During the intake session, the therapist assessed Roger, a 46-year-old welder, and determined that he met criteria for panic disorder. Roger's therapist asked him to read Chapter 1 and pages 219–235 in Chapter 14 of *MOM2,* and to complete the *MOM*-A (Worksheet 14.1, *MOM2,* p. 221) before the next session.

1. Identify Catastrophic Misinterpretations

In the second session, the therapist interviewed Roger about a severe panic attack he had the previous week, using questions suggested by Clark (1988), which quickly pinpointed Roger's sensations and the catastrophic misinterpretations about these sensations that triggered his panic attack.

THERAPIST: When your panic was at its worst, what sensations did you experience?

ROGER: I couldn't get my breath. My heart was pounding.

THERAPIST: Anything else?

ROGER: I was hot and sweaty. I felt as if I would pass out.

THERAPIST: Anything else?

ROGER: No.

THERAPIST: And when you couldn't get your breath, your heart was pounding, you felt hot and sweaty, and felt as if you would pass out, what went through your mind?

ROGER: I don't know. My head was swimming.

THERAPIST: What was the worst thing you imagined might happen?

ROGER: I thought I was having a heart attack.

THERAPIST: Did you have any images of yourself having a heart attack?

ROGER: Yes, I did. I saw myself on the ground, and I was white and my eyes were closed, and the paramedics were coming.

THERAPIST: In this image, what had happened?

ROGER: I had a heart attack. And I thought I was dead.

THERAPIST: And when you had that image, how did that make you feel?

ROGER: Scared.

THERAPIST: How do you think this scared feeling affected your breathing, heart rate, and sweating?

ROGER: (*Pausing*) Well, when I'm scared, I guess my heart beats faster, and sometimes I sweat more then. I'm not sure about my breathing.

THERAPIST: Those are interesting observations. We'll have to pay attention to your breathing when you get scared and see what we can learn about that. For now, let's draw a picture of what we have discovered about your panic so far. (*Draws a diagram as shown in Figure 11.2, using Roger's own words and reported experiences.*)

ROGER: Yes. That's what happened.

THERAPIST: And what do you do to keep yourself from dying when you can't get your breath and your heart is pounding and you feel hot and sweaty, like you are going to pass out?

ROGER: I usually find a place to sit down. And I try to breathe slowly and loosen my shirt and take off my shoes, so I cool down more quickly.

By the end of this second session, Roger and his therapist had a clearer idea of the links among his physical sensations, his catastrophic thoughts about these sensations ("I'm having a heart attack," an image of lying dead on the floor), and his panic attacks. They also discussed how his safety behaviors (sitting down, breathing slowly, loosening his shirt, and taking off his shoes) prevented him from learning if his sensations were really as dangerous as he imagined. That is, each time this happened and he did not die of a heart attack, Roger told himself, "If I had not sat down and cooled down quickly, then I probably would have had a heart attack." His therapist suggested that Roger fill out Worksheet 14.3, Identifying Thoughts Associated with Anxiety (*MOM2,* p. 232), each time he had a panic attack in the coming week, and also that he record any safety behaviors that he used to prevent either panic attacks or the heart attack he feared would happen.

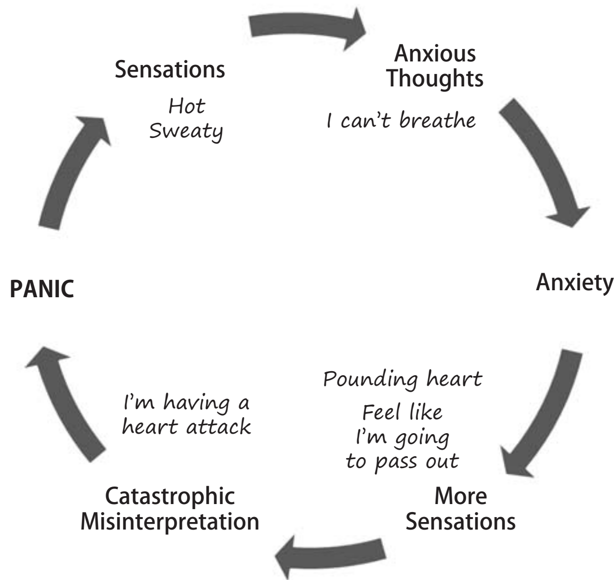


FIGURE 11.2. Roger's vicious cycle leading to panic.

2. Induce and Identify Noncatastrophic Explanations for Sensations

In Session 3, Roger and his therapist induced the sensations that frightened him, and then began to look for alternative explanations for them. (Note: All clients presenting with symptoms of anxiety should have a medical exam to rule out a physical cause for their symptoms. Roger had been examined by his general physician and a cardiologist, neither of whom found evidence that he had a heart problem.) Ideally, a therapist should choose inductions that are a close match to the circumstances leading to a client's sensations in everyday life. Roger's recent panic attacks had occurred when he was exercising or moving rapidly, when he was anxious, and whenever he began thinking about having panic attacks. Therefore, his therapist chose to use three induction methods with him in this session: running in place (to simulate exercise), hyperventilating (because he noticed that Roger breathed quite shallowly in session when he became anxious), and imagining his most recent panic attack as well as his image of lying on the ground dead.

These three induction experiments allowed Roger to observe that exercise, changes in breathing, and anxious mental imagery could bring on the sensations he assumed were indicators of a heart attack. These became noncatastrophic explanations for his "spontaneous" sensations during the week, as his therapist summarized with Roger midway through this session.

THERAPIST: I'll write these two ideas on the board here, and you write them in your therapy notebook. Let's call your original belief Theory 1, and this second belief we are developing today Theory 2.

ROGER: OK.

THERAPIST: (*Writing*) Theory 1 is "When I have these symptoms, it is a sign that I am having a heart attack and dying." Theory 2 is "These symptoms are not dangerous and can be caused by a number of things, like exercise, anxiety, and even images in my head related to other panic attacks."

ROGER: (*Writing*) OK.

THERAPIST: Based on your experiences here today, how much do you believe Theory 1 right now and how much do you believe Theory 2?

ROGER: I must admit I still believe Theory 1 could be true . . . maybe about 50%. I believe Theory 2 can also be true. Actually 100% for that one, because I experienced that today.

By the end of this first sensation induction session (the third therapy session), Roger was only 50% certain that breathlessness, a racing heart, sweating, and light-headedness were dangerous, and he acknowledged that the noncatastrophic explanations for his symptoms were highly credible. In *MOM2,* Linda is the primary client who experienced panic disorder. Roger's therapist asked him to read the section that describes the behavioral experiments Linda conducted in her therapy to test her catastrophic fears and reduce her avoidance and safety behaviors (*MOM2,* pp. 134–137). He asked Roger to compare his experiences in this third session with Linda's experiences. Roger also agreed to consider and write down possible noncatastrophic explanations for any panic-related sensations he experienced during the coming week.

In Session 4, Roger and his therapist discussed noncatastrophic explanations for sensations that occurred "spontaneously" during the week, and continued to induce sensations to compare the credibility of Theory 1 and Theory 2. Roger reported a steady decline in his scores on the *MOM*-A and a decrease in panic attacks from daily to only two times in the preceding week. He still found his Theory 1 (that symptoms were dangerous and meant he was having a heart attack) about 30% credible, especially when he was not with his therapist doing inductions and experienced these symptoms in daily life. They discovered that Roger always sat down when he experienced sensations during the week (a safety behavior).

3. Devise Behavioral Experiments to Decrease Avoidance and Safety Behaviors

During the fourth session, they conducted an experiment in which Roger stayed standing after they induced intense sensations. Roger's therapist helped him devise an experiment to do in the coming week to stop his safety behavior (of sitting down during sensations), so that he could continue to evaluate Theory 1 more closely. They described this experiment on Worksheet 11.2, Experiments to Test an Underlying Assumption (*MOM2,* p. 149), as shown in Figure 11.3. Roger agreed to do this experiment at least twice in the coming week, and to complete the last two columns of the worksheet after each experiment.

Roger conducted this experiment twice during the week. His belief in Theory 1

WORKSHEET 11.2. Experiments to Test an Underlying Assumption

ASSUMPTION TESTED		Theory 1: If I experience breathlessness, a racing heart, sweating, or light-headedness, then it means I'm having a heart attack.			
Experiment	**Predictions**	**Possible problems**	**Strategies to overcome these problems**	**Outcome of experiment**	**What have I learned from this experiment about this assumption?**
Sit in a chair and imagine having a heart attack. Focus on any physical symptoms I start to experience, and vividly imagine a heart attack. Once symptoms get going, stand up and don't lean on anything. Look at my watch and time how long they persist. Stay standing as long as I have symptoms, especially if I feel faint or light-headed.	Theory 1 predicts that if I start to have symptoms and don't stay seated, then they will continue to get worse, and I will have a heart attack. Theory 2 predicts that my imagination will cause symptoms, but these are not dangerous, and walking around or standing won't be dangerous.	I won't get symptoms from imagining a heart attack. If my symptoms get too bad, I will get afraid and want to sit down before the end of the experiment.	I will hyperventilate for 2 or more minutes while continuing to imagine having a heart attack. Get out index card reminder: (1) Doctor says my heart is fine. (2) I've done this in therapy and symptoms go up and then come down. (3) The only way to test my fear is to be tough and stay standing. (4) Theory 2 says these symptoms aren't dangerous and has proven true so far. Stick with it!	What happened (compared to your predictions)? Do the outcomes match what you predicted? Did anything unexpected happen? If things didn't turn out as you wanted, how well did you handle it?	

FIGURE 11.3. Roger's behavioral experiments testing Theory 1 without safety behaviors, as described on *MOM2* Worksheet 11.2, Experiments to Test an Underlying Assumption.

dropped to about 15%, and he reported consistently high confidence (about 80%) in Theory 2, even when he was experiencing symptoms of anxiety.

4. Devise Further Behavioral Experiments

In the next three sessions, Roger and his therapist continued to review and evaluate his experiments inside and outside sessions. They identified a few additional safety behaviors that Roger was using for "heart attack prevention," such as reductions in his gym workout routine. Roger conducted additional experiments in which he dropped these safety behaviors to actively test whether he could bring on a heart attack through exercise.

By the end of therapy, Roger reported 100% certainty that his sensations were not dangerous and could be explained by changes in breathing, anxiety, or imagination, and also sometimes caffeine intake. He had not experienced a panic attack for two weeks and was no longer using his safety behaviors or avoiding exercise. Roger's therapist advised him to bring on the sensations that had worried him (via imagination, exercise, or hyperventilation) at least once a week in the upcoming months, to bolster and maintain his confidence that they were not dangerous. He also agreed to review his worksheets from *MOM2* periodically.

TABLE 11.2. Panic Disorder Treatment Tasks Linked to *MOM2* Worksheets and Readings

Panic disorder: Therapy task	*MOM2* worksheets and reading links
Track anxiety mood scores each week on the *MOM*-A	Worksheet 14.1, p. 221; graph scores on Worksheet 14.2, p. 222
Identify sensations that trigger panic and linked catastrophic thoughts and images[a]	Worksheet 14.3, p. 232
Identify safety behaviors used to prevent panic attacks and feared catastrophic outcomes	Exercise, *MOM2,* p. 228
Induce sensations in office, and develop a noncatastrophic Theory 2 to explain symptoms	Although it is not necessary, you can use the bottom of Worksheet 11.2, *MOM2,* p. 149
Devise behavioral experiments to test Theory 1 underlying assumptions about the danger of feared sensations, and compare with Theory 2 underlying assumptions (e.g., that sensations are not dangerous)	Worksheet 11.2, p. 149
Carry out additional behavioral experiments in and out of sessions as long as necessary, until all safety behaviors are dropped and Theory 2 is credible to the person even in the presence of intense sensations	Worksheet 11.2, p. 149

[a]Use the panic disorder treatment protocol only if the identified thoughts and images relate to dying, either physically or mentally. If thoughts during panic attacks relate to something else, use the protocol for that type of anxiety (e.g., if thoughts relate to fear of criticism or social judgment, consider a diagnosis of social anxiety instead of panic disorder).

Unlike the treatment protocol for GAD, which focuses on increasing confidence in coping, the treatment protocol for panic disorder is tightly focused on testing "catastrophic danger" beliefs via exposure to sensations. Due to the highly specific and narrowly drawn beliefs that maintain panic, it is often not necessary for clients to read extensive sections from *MOM2*. Table 11.2 summarizes the main skills taught in *MOM2* that therapists often emphasize in the treatment of panic disorder, with links to specific *MOM2* worksheets and readings.

USING *MOM2* IN THE TREATMENT OF SPECIFIC PHOBIA

People can have specific phobias about dozens of different things, ranging from creatures (snakes or spiders) to environments (heights or closed spaces) to situations (flying on an airplane, riding in a bus) and to blood or injury. Evidence-based treatments for specific phobias include a variety of CBT approaches, which generally include exposure (*in vivo* and/or imaginal) and sometimes cognitive restructuring. Treatment of phobias tends to be straightforward, has good outcome, and often only requires a few sessions. Sometimes a single lengthy individual or group treatment session (two to three hours) is sufficient (Öst, Salkovskis, & Hellstrom, 1991; Öst, 1996; Zlomke & Davis, 2008).

The most effective treatment for a specific phobia (e.g., a snake phobia) generally involves identifying the central fears driving it (e.g., "Image of a snake flying through the air and biting me; then I am collapsed on the ground and not breathing any more") and then gradually exposing the person to the feared situation or thing (in this case, snakes) until anxiety decreases and the person is confident about being able to cope (e.g., staying in close proximity to the snake if it is nonpoisonous; slowly moving away if the snake is poisonous) with their fears (Choy, Fyer, & Lipsitz, 2007). The exception to this rule is blood–injection–injury phobia, which is characterized by a rapid drop in blood pressure in the presence of blood or injury or when receiving injections. The most effective treatment for blood–injection–injury phobia is applied tension (teaching people to raise their blood pressure temporarily), a very brief and effective treatment developed by Öst and Sterner (1987).

The most challenging step in treating a specific phobia can be uncovering the central fears related to the phobia. These fears are often in the form of images. As is true for other anxiety disorders, one of the best questions to identify central fears related to a specific phobia is "What is the worst thing that could happen?" You can ask this question over and over again (e.g., "And if that happens, what is the worst thing that could happen next?") to uncover the most feared aspects of a phobic stimulus. Once a central fear is uncovered, to identify related images, ask, "Do you have any images of what that might look, feel, or sound like?" Often these images reveal additional aspects that the person fears, as shown in this interview with Bianca (one of the three persons described at the start of this chapter as afraid of flying).

THERAPIST: So when you fly, you start to worry that the plane will crash. If there is any turbulence, that makes you start to think about how the plane could pull

apart and dive to the ground. Do you have images of what that might look, feel, or sound like?"

BIANCA: Yes. I imagine the window in my row being pulled out of the plane, like what happened in that plane accident a few years ago. I can hear the wind rushing and feel it pulling me toward the window. And the whole plane is starting to rattle really loudly, and my stomach drops because we are starting to dive toward the ground. I see the ground coming at us really fast! It's totally frightening.

THERAPIST: Those images are *very* scary. They help me understand how frightening this is for you.

Bianca and her therapist recorded all her identified thoughts and images on Worksheet 14.3, Identifying Thoughts Associated with Anxiety (*MOM2,* p. 232). Next, it is critically important for clients with specific phobias to approach and cope with their fears, either in actuality or (if necessary) in imagery. Since Bianca's fear of a plane crash was not something that she was likely to experience in actuality, imagery was used to expose her to her fears. Fortunately, imaginal exposure and cognitive restructuring can be just as effective as *in vivo* exposure (Hunt et al., 2006). Prior to exposure, people who experience disabling levels of anxiety can benefit from learning relaxation skills to reduce their anxiety to tolerable levels during exposure (*MOM2,* pp. 243–246).

Recall that anxiety can be reduced by correcting either overestimations of danger or underestimations of coping and help resources. Since Bianca appeared to be greatly overestimating the chances of a plane crash, it might seem that the best approach for her therapy would be exploring and examining her assumptions that (1) planes crash frequently and (2) turbulence means a crash is imminent. Helping her gather corrective information about the risks of flying and turbulence could certainly be an important part of her therapy. However, like many people, Bianca told her therapist, "Even if the odds of my dying are one in a million, if I'm the one, that is 100% death for me."

When a feared outcome is possible (e.g., "My plane could crash," "The snake could bite me"), it is helpful, before or during exposure, to have clients imagine and practice ways that they can cope with feared outcomes, in addition to helping them focus on more likely outcomes. When phobic fears are very unlikely or even impossible (e.g., "This small garden snake will eat me whole"), then it is usually sufficient to test the reality of the situation through prolonged, graduated exposure.

Although it is not necessary, you can have a client fill out a Fear Ladder (Worksheets 14.4 and 14.5, *MOM2,* pp. 238–239) to track exposure progress. Rungs on a Fear Ladder for phobia would be marked with increasing proximity or intensity of exposure to one's fear. For example, a small garden snake can be brought into a session, and a person with snake phobia can observe it in a container, first at a distance and then up close. Next the snake can be released into the room and observed slithering on the ground, first at a distance and then up close. You might model putting a hand close to the snake, so both of you can observe the snake's natural behavior when encountering a human. In time, your client will also be encouraged to get close to the snake, and

even to touch it and allow the snake to crawl on a foot or arm. Subsequent sessions can include exposure to larger snakes (in a zoo, via Internet videos, or in imagery if larger snakes are not practically available for use in your office). Such exposure should happen gradually and at a pace set by your client (although you can encourage moving to the next rung on the Fear Ladder whenever it seems that the person is coping pretty well with the current level of exposure and the anxiety rating is 20–30 on a 100-point scale).

Generally, phobia treatments encourage "exposure beyond the goal," which means exposing people to a stronger experience of their feared situation (e.g., more intense, longer, or closer) than their therapy goal would require. If the client with snake phobia, for example, has a goal of simply walking in the garden when a garden snake is present, then "exposure beyond the goal" would suggest a therapy target goal of touching or holding a snake similar to or larger than those found in the garden. The rationale for exposure beyond the goal is that people often experience a decline in their exposure tolerance after therapy has ended. A person who becomes comfortable with touching or holding a snake is always more likely to feel comfortable seeing a snake in the garden than one who has merely achieved comfort with seeing a snake at a distance. Of course, asking the client to continue the exposure to snakes after therapy has ended can also help maintain positive treatment outcomes.

When people's phobic fears have some likelihood of occurring (such as a snake phobia in locations where snakes can be dangerous or even lethal), it is important to combine exposure with coping training. Bianca feared a plane crash. Even though this was not likely, it certainly could occur. Therefore, her therapist encouraged her to develop an Action Plan (Worksheet 10.2, *MOM2,* p. 125) to increase her survival chances if she were ever in a plane that was crashing (e.g., wearing her seatbelt throughout the flight, wearing flat or low-heeled shoes when she flew, and counting the number of rows between her seat and the exit in case she needed to exit the plane in the dark). Bianca was surprised to learn that the odds of surviving a plane crash were as high as 95%, and even in the most serious accidents, the odds of survival were 55% (BBC News, 2018). This information motivated her to learn more about what to do in various crash situations, such as how to exit a plane that crashed over water or in the midst of a fire.

Bianca and her therapist also explored her biggest fears about dying, just in case she was in a plane crash and did not survive. She mostly feared that her young children would be abandoned. One of her therapy assignments was to choose guardians who were willing to take care of her children in the event of her death, and to draw up the proper legal documents to make sure that this matter would be handled if she did die. These various coping plans reduced her anxiety. She rehearsed these plans during repeated imaginal exposure to plane turbulence and crashes until she could imagine these events with minimal anxiety. Finally, Bianca's therapist asked her to read about acceptance and complete the Acceptance worksheet (Worksheet 10.3, *MOM2,* p. 129) prior to a planned flight. This helped her practice ways to achieve greater acceptance of the risks of flying and to put those risks in perspective with her life goals and values.

Table 11.3 summarizes a number of *MOM2* worksheets and readings that can help organize effective treatment for specific phobia.

TABLE 11.3. Specific Phobia Treatment Tasks Linked to *MOM2* Worksheets and Readings

Specific phobia: Therapy task	*MOM2* worksheets and readings
Track anxiety mood scores each week on the *MOM*-A	Worksheet 14.1, p. 221; graph scores on Worksheet 14.2, p. 222
Identify anxious thoughts/images	Worksheet 14.3, p. 232
Anxiety management strategies (only if necessary, due to high levels of anxiety that might prevent participation in exposure exercises)	pp. 243–245 Worksheet 14.6, p. 246
If helpful, use a written Fear Ladder to support and track exposure progress	Worksheets 14.4 and 14.5, pp. 238–239
Devise behavioral experiments centered on exposure (*in vivo* and imaginal) to fears, and write down new learning that occurs; carry out additional exposure experiments as necessary to test any residual assumptions	Worksheet 11.2, p. 149
Use Action Plans to devise coping plans for feared outcomes that might occur	Worksheet 10.2, p. 125
Develop acceptance of life's uncertainties and risks	Worksheet 10.3, p. 129

USING *MOM2* IN THE TREATMENT OF AGORAPHOBIA

People diagnosed with agoraphobia avoid places or situations that might cause them to panic or feel trapped, helpless, or embarrassed. They will typically identify one or more "safe people" who know about their anxiety. They may only venture out of their homes or other familiar surroundings when accompanied by a "safe person." They also sometimes navigate the world in ways that maintain a proximity to safety and help. For example, a former client was able to drive alone, but she took circuitous routes, so that she was never more than five minutes from a hospital in case she needed emergency help related to panic attacks. When someone experiences panic disorder as well as agoraphobia, the panic disorder is usually addressed first and the agoraphobic avoidance second.

Agoraphobia can be treated with the same guidelines used for specific phobias as summarized in Table 11.3. Most specific phobias, except for certain situational phobias (e.g., fear of flying), have an age of onset in childhood. Agoraphobia has an average onset in the middle to late 20s (de Lijster et al., 2016). When your client's "safe person" is a family member, family or couple therapy may be helpful to identify beliefs in the family system that support agoraphobia (Barlow, O'Brien, & Last, 1984; Daiuto, Baucom, Epstein, & Dutton, 1998). Family members can use 7-Column Thought Records (worksheets in *MOM2* Chapters 6–9) and behavioral experiments (Worksheet 11.2, *MOM2,* p. 149) to help evaluate their own beliefs that interfere with an

agoraphobic family member's progress. Family or couple Action Plans (Worksheet 10.2, *MOM2,* p. 125) can be devised, so that everyone has a role to play in helping the person with agoraphobia overcome it. For example, instead of running errands for the person with agoraphobia or accompanying the person on trips, family members can express encouragement and confidence that the person with agoraphobia can complete the steps required alone.

USING *MOM2* IN THE TREATMENT OF SOCIAL ANXIETY

Social anxiety is a type of phobia (in fact, it used to be called "social phobia") in which people fear criticism and rejection from others. In a summary of the various cognitive theories of social anxiety, Hofmann (2007) identified three types of belief that can maintain it: (1) beliefs about social situations (e.g., unrealistic expectations for social performance, and the social costs of a subpar performance); (2) beliefs about oneself (e.g., negative self-perceptions, perceived poor social skills); and (3) beliefs about emotions (e.g., a belief that one has little control over one's emotions).

Social anxiety beliefs do not generally change on their own in response to benign social situations. Instead, these beliefs are fortified over time as a result of four processes identified by Clark and Wells (1995):

1. In social situations, people with social anxiety focus on themselves instead of others. This self-monitoring is intense and focuses on physical symptoms, internal arousal, and images of how they appear to others—images that are often distorted and extremely negative.
2. People who experience social anxiety use safety behaviors to reduce the risk of criticism and rejection (e.g., avoiding eye contact, deflecting attention from themselves by asking questions). These prevent them from learning whether feared outcomes would occur if they fully participated in social interactions.
3. Given their levels of anxiety, people with social anxiety actually do sometimes exhibit odd behaviors (e.g., staring at another person's shoes during a conversation) or perform at a lower skill level than they are capable of. When such things happen, they overestimate the negative impact of these on their social relationships.
4. Before and after social events, people with social anxiety focus in detail on negative aspects of the situation, negative images of themselves, and predictions of negative consequences for their perceived poor performance.

The two CBT approaches developed for social anxiety that have the greatest empirical evidence to support them are those developed by Clark et al. (2003) and a group therapy model developed by Heimberg and Becker (2002), which is based on Beck et al.'s (1985) anxiety theory as applied to social anxiety (Rapee & Heimberg, 1997). As might be expected, there is considerable overlap between these treatment models (Wong & Rapee, 2016). However, Clark's group has added a number of innovations

in the form of creative behavioral experiments that add video (and still photo) feedback to compare with negative self-perceptions (Warnock-Parkes et al., 2017); experiential exercises to demonstrate the adverse effects of self-focused attention and safety behaviors; and surveys and observations of other people's reactions to social mistakes, awkwardness, or embarrassing situations. Clark's group specifically does not use Fear Ladders, thought records of any kind, rehearsal of what to say in social situations, or other social skills training, since their empirical findings demonstrate that these are not necessary with social anxiety (Leigh & Clark, 2018).

Testing Social Anxiety "Danger" Beliefs

A primary aspect of these CBT approaches for social anxiety is testing "danger" beliefs about the negative consequences of social mistakes and nervousness. As described previously, when socially anxious, people tend to focus their attention on themselves instead of others. Therefore, one danger they predict is that their internal experience of anxiety is a close match to what others observe, even though this is frequently wrong. This observation has led to clinical interventions focused on teaching people to focus their attention externally in social situations, which seems to be effective in lowering social anxiety (Mörtberg, Hoffart, Boecking, & Clark, 2015). A mismatch between internal experience and what is observable to others can also be assessed by video-recording an interview and comparing the person's internal picture of how this looked with the person's actual appearance on the video. A study of this approach found that 98% of clients with social anxiety who viewed videos of their social interactions reported that they came across more favorably than they had predicted (Warnock-Parkes et al., 2017).

Another common "danger" belief is that odd or embarrassing behavior will be judged extremely negatively by others and result in rejection. Such beliefs can be tested by entering social situations with the person and modeling the odd or embarrassing behavior, so that the person can focus on others and see how they react. For example, one therapist helped his client test negative beliefs about sweating by spraying water all over his shirt near his armpits and on his back, so it looked as if he was sweating profusely. Then they entered a store, and the therapist engaged a clerk in conversation while his client observed the clerk and other people's reactions. The therapist even commented on how sweaty he was, and the client observed the clerk smile and comment, "Yes, I'm glad I'm not moving around outside today."

An *in vivo* observational experiment like this one requires a therapist to ask for predictions in advance of what the person expects responses to be (based on their social anxiety beliefs). Not only is this an important part of doing all behavioral experiments, but it also helps cue the therapist to beliefs that may need to be tested during the experiment. For example, if the client in the example just given had predicted that the clerk would be polite when the "sweating" therapist was present but would mock the therapist once they leave the situation, then the client could be instructed to stay in the situation a few minutes longer to observe what happened once the therapist left the store.

Underlying assumptions that maintain social anxiety make ideal predictions for these types of behavioral experiments. These can be identified by using Worksheet 11.1, Identifying Underlying Assumptions (*MOM2,* pp. 140–141). Put each concern in the

"If . . ." part of the assumption, and ask the client to fill out the "then . . ." consequence. Here are some typical client concerns about embarrassing aspects of personal appearance or behavior:

"If I blush, then people will know I'm anxious and think I'm weak."
"If I struggle with what to say, then people will think I'm stupid."

Underlying assumptions that maintain avoidance and safety behaviors can be identified on this same worksheet by putting either avoidance or a safety behavior in the "If . . ." section of the assumption and asking the person to complete the "then . . ." portion of the sentence. Here are some examples of each:

"If I stay home from the party, then I won't make a fool of myself."
"If I avoid eye contact, then people won't talk to me and find out I am a loser."

Once these underlying assumptions are identified, they can be tested by using Worksheet 11.2, Experiments to Test an Underlying Assumption (*MOM2,* p. 149). The underlying assumption and behavioral experiments worksheets will be the primary worksheets from *MOM2* used in the treatment of social anxiety, along with the *MOM*-A (Worksheet 14.1, *MOM2,* p. 221) and its score sheet (Worksheet 14.2, *MOM2,* p. 222).

Increasing Confidence in Coping

Even though many of the beliefs in social anxiety are overestimations of the danger inherent in social interactions, it is important not to ignore the possibility that some people might actually be critical or rejecting toward someone who is socially anxious. Most people who are socially anxious report a history of being criticized or bullied (Fung & Alden, 2017). Even if most of the time people behave more benignly than someone with social anxiety expects, there is always the possibility that a person will respond in a critical, cruel, or even violent manner. In modern-day life, we can all observe the quick criticism, trolling, and bullying that occur on the Internet in response to people's appearance, beliefs, and behavior. These same reactions can happen in daily discourse. People of marginalized groups (e.g., immigrants, racial or religious minorities, people who identify as or are perceived to be LGBTQ+, homeless and other economically disadvantaged people, intellectually and physically challenged persons) are frequent targets of social rejection, criticism, and censure from strangers, as well as people with whom they need to interact in daily life.

Assertive Defense of the Self

The fact that some people may be critical or rejecting is one reason Padesky advocates teaching clients with social anxiety to cope with criticism and rejection in her approach to social anxiety treatment, which she refers to as Assertive Defense of the Self (Padesky, 1997, 2008a, 2008b; see also Padesky [2008] in Appendix C on p. 463). Her approach is extrapolated from the CBT protocol for specific phobia described earlier in this

chapter. She reasons that since successful phobia treatment always entails either *in vivo* or imaginal exposure to what is feared, then social anxiety treatment should center on exposure to criticism and rejection, since these are what people with social anxiety fear. Thus clients with social anxiety who fear rejection and criticism should be exposed to them and be taught to cope with them. Her idea is that if people feel confident they can handle criticism and rejection, then they won't fear these things so much, and their social anxiety will decrease.

There are three main stages to Padesky's Assertive Defense of the Self treatment protocol:

1. Identify clients' predictions of all the criticisms they anticipate and/or reasons they might be rejected, and help them develop assertive responses to each.
2. Conduct role-play practice of assertive defense in each session. This practice entails brief role plays followed by debriefing and therapist coaching (with increases in the levels of criticism and rejection practiced over time).
3. Have clients practice between sessions by imagining that others are being critical of them, so they can rehearse imaginal assertive defense responses. If people "get lucky" and actually encounter criticism or rejection, then they can practice assertive defense *in vivo* if it is safe to do so. Safety is an important consideration in real-world practice of Assertive Defense of the Self, because some situations (e.g., domestic violence, social encounters involving weapons or aggressive people, some employment or housing situations, some encounters with law enforcement) can escalate and become truly dangerous if someone is assertive. Fortunately, role-play practice in therapy and imaginal Assertive Defense of the Self are sufficient for most people to develop and strengthen their confidence that they can cope with criticism and rejection, to a degree that they are able to recover from social anxiety.

1. Identify Predicted Criticisms and Develop Assertive Responses

Excerpts from Ted's sessions with his therapist, combined with summaries of his therapy over time, illustrate these three components of Assertive Defense of the Self.

TED: I just can't go to that meeting. I'll be too anxious.

THERAPIST: What is the worst thing that might happen if you go?

TED: They'll see what a poor job I'm doing.

THERAPIST: Let's make a list of all the negative things they might think of you, and then we can practice how you might cope with these criticisms if they occur.

TED: (*Lists six different feared criticisms over the next five minutes of discussion.*)

THERAPIST: Now let's take each of these criticisms and see how you could respond if someone at the meeting actually said this or thought this about you. Which one would you like to start with?

TED: "You're stupid because you didn't use charts."

THERAPIST: OK. Let's come up with what I call an Assertive Defense of the Self. When someone says you are stupid, you can make three different responses. On the one hand, you can be aggressive and attack the other person, saying something like "You're stupider than me! Your charts make no sense!" (*Smiles after saying this, and Ted laughs.*) At the other end of the spectrum (*stretching out arms to indicate a continuum, and marking one endpoint in the air by moving a hand*), you can just take it to heart when someone calls you stupid. You can hang your head and say, "You're right. I'm really stupid and messed up," and feel really bad. (*Ted nods his head.*) Right here in the middle between attacking the other person and attacking yourself is what we call "assertion." An assertive response accepts any truth to the criticism, but at the same time stands up for you. For example, you might say something like this: "I can see how that seemed stupid to you, but actually I have some good ideas. I guess that didn't come across to you." You are not attacking the other person, but you also aren't attacking yourself . . . in fact, you are standing up for yourself. Does that make sense?

TED: Yes. I think I understand.

THERAPIST: So if you present your report in the meeting, and someone says, "You're stupid because you didn't use charts," what could you say back? What would be an assertive response?

TED: I'm not sure.

THERAPIST: Is it true that you didn't use charts?

TED: Yeah. I don't know how to use that chart program.

THERAPIST: OK. So start with accepting what is true; then say "but . . ." and stand up for yourself. "Yes, it's true I didn't use charts, but . . ."—what could you say?

TED: "It's true I didn't use charts, but if you listened to what I said, you would hear that I included all the same information."

THERAPIST: That sounds good. Is that true?

TED: Yes. I do cover the same information in my reports.

THERAPIST: How do you feel when you say that?

TED: Less stupid, for sure.

THERAPIST: Great. Let's write that down on this piece of paper across from the criticism "You're stupid because you didn't use charts."

Ted and his therapist then developed assertive responses for each of the six criticisms he feared, using Ted's words and ideas for each. These were written down on a piece of paper in two columns: the first labeled "Criticisms," and the second labeled "Assertive Defense Responses." His therapist made two copies of this page, so they would each have one in front of them that could serve as a script for their role plays, as shown in Table 11.4.

TABLE 11.4. Ted's Assertive Defense Script for Social Anxiety

Criticisms	Assertive defense responses
You're stupid because you didn't use charts.	It's true I didn't use charts, but if you listened to what I said, you would hear that I included all the same information.
You're stupid—you stumble over your words.	I'm not stupid. I just get tongue-tied in groups. One on one, I can explain my ideas better.
Your numbers aren't good enough. You shouldn't be team leader.	Our team numbers aren't the best, but they are improving. Numbers don't tell the whole story. I have many good qualities that make me a good team leader.
You look anxious. That shows you are in over your head.	I do get anxious when I speak in groups. Lots of people have anxiety about speaking in front of groups. But that doesn't mean I'm in over my head.
Your hands are shaking. You're weak.	My hands are shaking a bit. I'm nervous, not weak.
You don't have a business degree.	That's true. I do have 10 years of experience, though, and must be doing well enough that they made me team leader.

2. Role-Play Practice of Assertive Defense with Coaching

Once they created assertive defense responses to each criticism he feared, Ted and his therapist began role-play dialogues using this script. First, his therapist said a single criticism in a fairly flat tone. Ted practiced his assertive defense response. After each interchange, his therapist coached him to adopt a strong tone of voice, use assertive body language, and speak as if he really believed that response. As Ted became more confident, his therapist used a more critical tone and body language to increase the challenge. His therapist checked in each time to see how Ted felt while assertively defending himself, and to identify any other reactions that seemed important.

TED: (*Role-playing*) I'm not stupid. I just get tongue-tied in groups. One on one, I can express my ideas better.

THERAPIST: How did you feel saying that this time?

TED: A bit better. It feels more believable. At the same time, when I say, "I get tongue-tied in groups," it feels a bit like I'm putting myself down.

THERAPIST: What would be better for you?

TED: Maybe if I said something like "I don't have a lot of experience speaking in groups."

THERAPIST: Let's try that. Ready? (*Ted nods; therapist shifts to role-play mode.*) You're stupid—you stumble over your words.

TED: Just because I don't have a lot of experience speaking in groups doesn't make me stupid. One on one, I express myself just fine.

THERAPIST: (*Pausing a moment to let Ted feel the impact of his revised defense*) What was that like for you?

TED: Better. I felt stronger and more confident that time.

THERAPIST: You sounded much more confident and assertive. (*Ted smiles.*) Let's write that down in the script since you like it better. (*Pauses while Ted writes.*) Ready to try that again and maybe mix it up with some of the other criticisms?

In the first role-playing session, Ted and his therapist practiced single criticisms and assertive defense responses. They completed as many as 20 role-play interchanges, along with feedback. As Ted became more adept at making assertive defense responses using a confident tone of voice and good eye contact, his therapist began to string various criticisms together in a sequence, to extend the length and intensity of criticism exposure. That is, each time Ted assertively defended himself against one criticism, his therapist followed up with another. As Ted's assertive defense responses become more fluid, his therapist introduced new types of criticisms as a challenge for Ted, so he would develop confidence he could spontaneously defend himself against unexpected criticism. These extended role plays sometimes lasted one to three minutes, and each debriefing typically lasted two to five minutes. Thus it was possible to do five to eight extended assertive defense role-play practices in a single session. After each one, his therapist debriefed Ted's reactions and (when necessary) coached him or inquired what changes he could make to increase his confidence in his assertive defense response.

Over time, Ted reported that he felt less hurt by criticisms, and that he even began to feel annoyed in the role plays with someone who would be so critical. This transition from a stance of humiliation and defeat in the face of criticism to one of assertive defense and evaluating criticism as "a problem in the critic, not me," is typical and generally occurs over several weeks of assertive defense practice. *This is an example of a therapeutic process in which behavioral changes lead to cognitive changes.* Assertive defense practice led to helpful positive shifts in Ted's "danger" beliefs ("Criticism can be tough, but it doesn't have to be catastrophic") and his "coping" beliefs ("I can stand up for myself in the face of criticism. If I'm anxious, it is not a character flaw. Anyone who goes on and on criticizing me about my anxiety has their own problems, and I don't need to take those on board").

3. Practice Assertive Defense between Sessions

For between-session practice, Ted's therapist encouraged him to imagine others being critical so he could practice imaginal Assertive Defense of the Self. They discussed how it would be "lucky" if Ted actually was criticized, because he could see in session that massed practice of assertive defense helped him feel better quite quickly. They discussed

that it was actually a problem that some people might not express criticism aloud, because this did not give Ted an opportunity to practice and stand up for himself. After a few weeks of imaginal practice combined with role-play practice in session, Ted felt ready to conduct behavioral experiments in which he actively evoked critical comments so he could practice assertive defense aloud.

Some of these experiments were done with his brother because Ted predicted that his brother could be counted on to make critical remarks. Others were done with strangers in relatively safe settings, such as a home improvement store and a bookstore. Ted did one experiment several times in which he paid for items by slowly counting out lots of small coins. He turned to the person behind him and said, "I hope you're not in a hurry." If the person looked annoyed or made an irritable comment, then Ted smiled and said, "I know I'm taking a lot of time here, but it's important to me to make sure I get it right and spend this cash." Unlike behavioral experiments designed to test overestimations of danger, Ted's predictions for these experiments were not about whether others would be annoyed and express criticism, but instead about how well he would be able to cope with any criticism he encountered.

Social Anxiety: Better to Test Danger Beliefs, Develop Coping Skills, or Both?

Padesky's Assertive Defense of the Self approach is evidence-based, in that it is derived from established phobia treatment principles for applying coping skills in the context of *in vivo* and imaginal exposure to fears. However, most of the research on social anxiety has emphasized protocols that test beliefs and behaviors (e.g., self-focus) related to the overestimation of danger. We hope that future research will test the comparative efficacy of these two social anxiety treatment approaches. It remains to be seen if one approach is more effective or enduring than the other, or if the combination of testing overestimations of danger and practicing assertive defense coping is better than either alone. In the meantime, therapists can become familiar with both approaches and try the other when one approach is not effective. In either case, *MOM2* can be used to measure and track changes in anxiety levels as therapy proceeds (the *MOM*-A and its score sheet, Worksheets 14.1 and 14.2, *MOM2,* pp. 221–222); to identify central underlying assumptions (Worksheet 11.1, *MOM2,* pp. 140–141); and, finally, to set up well-crafted behavioral experiments and capture insights garnered from these experiments (Worksheet 11.2, *MOM2,* pp. 148–149). All these potential uses of *MOM2* for social anxiety are summarized in Table 11.5.

RELATED DISORDERS: OCD AND PTSD

Although once considered anxiety disorders, obsessive–compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) have now been separately classified: OCD is now one of the obsessive–compulsive and related disorders, and PTSD is considered a trauma- and stressor-related disorder (American Psychiatric Association, 2013). Although no longer classified as anxiety disorders, both OCD and PTSD often have

TABLE 11.5. Social Anxiety Treatment Tasks Linked to *MOM2* Worksheets and Readings

Social anxiety: Therapy task	*MOM2* worksheets and readings
Track anxiety mood scores once a week on the *MOM*-A	Worksheet 14.1, p. 221; graph scores on Worksheet 14.2, p. 222
Identify anxious thoughts/images	Worksheet 14.3, p. 232
Anxiety management strategies (only if necessary, due to high levels of anxiety that might prevent participation in exposure exercises)	pp. 241–245 Worksheet 14.6, p. 246
Devise behavioral experiments centered on exposure (*in vivo* and imaginal) to fears, and write down new learning and insights that occur; carry out additional exposure experiments as necessary to test out any residual assumptions	Worksheet 11.2, p. 149
Use Action Plans to devise coping plans for feared outcomes that might occur	Worksheet 10.2, p. 125
Develop acceptance of life's uncertainties and risks	Worksheet 10.3, p. 129

anxiety as an associated mood. There are well-developed specialized treatments for these disorders, but these treatments center on procedures not emphasized in *MOM2.* For this reason, *MOM2* is *not* recommended as a primary treatment manual for these issues.

However, therapists who frequently use *MOM2* may choose to copy particular worksheets for use with these clients, or ask people struggling with these issues to read particular pages or chapters. Furthermore, many people experiencing OCD or PTSD have comorbid diagnoses such as depression, which might make *MOM2* relevant for their therapy. A few examples of these potential applications of *MOM2* with OCD and PTSD are briefly addressed here.

Obsessive–Compulsive Disorder

There are several very informative books on the treatment of OCD for both therapists (see Sookman, 2016; Wilhelm & Steketee, 2006) and clients (see Veale & Willson, 2009; Winston & Seif, 2017). Most effective treatments for OCD rely on exposure (to obsessive thoughts, contamination fears, and other triggers) and response prevention (e.g., stopping behavioral rituals, such as handwashing, and mental compulsions, such as "thought-undoing rituals," until anxiety decreases). However, some cases of OCD can be treated primarily with cognitive methods (Wilhelm & Steketee, 2006). Since treatment of OCD can be quite complex, we urge you to read these or similar texts before attempting to treat OCD for the first time. Once you are familiar with CBT for OCD,

you can consider if and how *MOM2* can be a helpful adjunct to your therapy plan. For example, completion of an Activity Record (Worksheet 13.4, *MOM2,* pp. 206–207) might help you and a client identify precipitants and the frequency and duration of either obsessional thinking or compulsive behavior.

There are no empirical data to suggest that using thought records to test OCD thoughts (e.g., "Touching a doorknob will give me cancer") will improve treatment outcome. Instead, as is the case for anxiety disorders, underlying assumptions are the most important level of thought to identify and address in OCD treatment. Worksheet 11.1 (*MOM2,* pp. 140–141) can be used to identify and record key underlying assumptions. Some common underlying assumptions in OCD pertain to an overestimation of responsibility (e.g., "If my mother gets ill, it's my fault"). Some therapists might think it would be helpful to use a responsibility pie (see Worksheet 15.7, *MOM2,* p. 274) to test responsibility beliefs in OCD. Instead, the more typical, empirically tested approach would purely involve exposure to thoughts of responsibility (e.g., "If my mother gets ill, it's my fault") accompanied by response prevention.

Posttraumatic Stress Disorder

Two of the therapies for PTSD with the greatest empirical support that are also compatible with ideas taught in *MOM2* are cognitive therapy for PTSD, developed by Ehlers and Clark (Ehlers et al., 2005, 2013), and cognitive processing therapy, developed by Resick and her colleagues (Resick & Schnicke, 1992; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick, Monson, & Chard, 2017). These are both intensive therapies with a direct focus on trauma memories and restructuring cognitive appraisals of traumatic events. There is empirical support for the assumption incorporated in each therapy that cognitive change precedes symptom change in trauma-focused CBT (Kleim et al., 2013).

We recommend reading the primary source material cited here, in order to develop a clear understanding of the conceptual foundations and treatment processes involved, before treating people who experience PTSD. In addition to these materials suitable for therapist education about PTSD treatment, an Internet treatment program has been developed based on evidence-based treatment principles (Wild et al., 2016), and a self-help program is being evaluated by the Ehlers and Clark group (Nollett et al., 2018). Current research has also explored the potential benefits of intensive treatment for PTSD in which session frequency is increased. Ehlers et al. (2014) found that a full course of CBT for PTSD delivered over 7–10 days was as effective as the same treatment delivered in a weekly format over several months. There is evidence that fewer days between sessions leads to greater symptom improvement (Gutner, Suvak, Sloan, & Resick, 2016). Importantly, briefer treatment may involve less overall distress for people experiencing PTSD, especially when treatment is focused on the types of effective interventions employed by the authors cited here.

Regardless of the type or number of traumas a person has survived, an important part of recovery is learning to create constructive personal meanings from traumatic experiences and apply these to one's view of oneself, others, and the world. *MOM2* teaches skills that can facilitate this process for many people. However, treatment of

PTSD involves much more than learning the mood management skills taught in *MOM2*. The timing of PTSD treatment (McNally, Bryant, & Ehlers, 2003), and specialized methods used are important for therapists to fully understand in order to ensure the best treatment outcomes. Thus we recommend use of *MOM2* only as an adjunct to the more comprehensive treatments referenced here.

TROUBLESHOOTING GUIDE: COMMON ANXIETY DISORDERS

Multiple Anxiety Problems

Many people come to therapy with multiple anxiety problems. One person may experience panic disorder as well as social anxiety. Another may have a long history of GAD, yet enter therapy for help with a specific phobia. How do you know what treatment protocol to follow? One strategy is to define the different problems and ask your clients which one they would like to tackle first. When their answer is not clear-cut, use the methods designed to help prioritize therapy goals, as described in Chapter 3 of this clinician's guide. Although you may need to address anxiety concerns sequentially for some people, the skills acquired and learning developed during the treatment of one anxiety issue will often inform and speed progress in the treatment of subsequent anxiety diagnoses. Another strategy is to see if there is a central theme that links comorbid anxiety disorders. Identification of overlapping themes or underdeveloped skills can sometimes lead to an individualized treatment plan that meets most or all of the person's treatment needs, as illustrated in the case of Monique.

Monique was diagnosed with GAD, which was compounded by social anxiety and a recent onset of panic attacks. In her first therapy session, Monique described herself as a perfectionist. Her father had been very punitive when she was a child, and she had struggled to do things perfectly to avoid her father's criticism and punishment. She worried a lot about making mistakes. Throughout her life, Monique experienced intense anxiety whenever she was in a social situation and could not be sure that everyone in the room approved of her.

Monique's anxiety intensified after she moved to a new city. She was afraid that her new neighbors and other people would notice her anxiety and think she was crazy. These thoughts were followed by an increase in anxiety levels and depersonalization experiences, which Monique interpreted as evidence that she was in fact going crazy. Each time she thought she was going crazy, she experienced a panic attack. Monique described herself as "caught in a storm" of anxiety.

Although Monique was experiencing three problems—GAD, panic disorder, and social anxiety—all three were linked to her fear of criticism. Her therapist therefore decided to help Monique learn to cope with criticism better, so that it didn't frighten her so much. The first week, her therapist suggested that Monique read *MOM2* Chapters 1, How *Mind Over Mood* Can Help You, and 14, Understanding Your Anxiety. In addition, he asked her to fill out Worksheet 14.3, Identifying Thoughts Associated with Anxiety (*MOM2,* p. 232), for two situations in which she experienced higher levels of anxiety during the week. He wanted to test his hypothesis that fear of criticism would be a part of most of Monique's anxiety experiences.

She returned to the next session with two worksheet examples. Both situations involved other people, and her thoughts focused on either worries or certainty that others would be critical and reject her in some way. Since managing worries about criticism and rejection are central to social anxiety treatment, her therapist drew heavily on that treatment model. For example, Monique practiced Assertive Defense of the Self, in which she role-played defending her anxiety to a stranger who acted in accordance with her worst-case scenario. After a number of role plays over the course of two sessions, she was finally able to defend herself against the type of stranger criticism she worried about, as demonstrated in the following exchange.

THERAPIST: (*Role-playing a critical stranger*) You look like you're going crazy.

MONIQUE: Actually, I'm just feeling anxious.

THERAPIST: Well, it seems pretty crazy to be anxious just walking down the street.

MONIQUE: Maybe you don't feel anxious here. Different people feel anxious in different situations.

THERAPIST: You look odd. I think maybe I should call an ambulance.

MONIQUE: Just leave me alone. I'm OK. I'll feel better if you leave.

THERAPIST: I don't like how you look. You stay here, and I'll call 911.

MONIQUE: You have no right to meddle in someone else's life. Just go away!

In role-play exercises such as this, Monique learned to speak up for herself, defending her anxiety and other aspects of her behavior that others might criticize. She was surprised that after repeated role plays, she became angry with her imagined critics. If they did say the things she worried about, she now perceived their reactions to her as generally unwarranted. By developing confidence that she could cope with potential criticism, she decreased her anxiety. She became less fearful of strangers and experienced depersonalization less often. Defending her anxiety led Monique to become confident that she was not going crazy, and her panic also subsided. By pinpointing the central theme connecting all her anxiety problems, Monique and her therapist were able to help her understand and successfully treat most of her anxiety in a few months, using the skills taught in *MOM2*.

12

Anger, Guilt, and Shame

(*MOM2* CHAPTER 15)

Rosa: When are you going to fix the gutters on the roof? You said you would do it today, and it's already the middle of the afternoon.

Gabriel: Why are you always complaining? Don't I keep a roof over your head?

Rosa: Yes. But I want to make sure that roof doesn't leak in the rain this week.

Gabriel: Don't talk to me like that! Look at this mess in the house! This looks like a pigsty!

Rosa: And whose mess is it? Am I your housekeeper or your wife?

Later that evening:

Rosa: Thank you for fixing the gutters. I really appreciate it.

Gabriel: Thanks. I'm so sorry I yelled at you. I feel really bad about it. Especially because I promised I wouldn't do that any more.

Rosa: It's OK. I yelled too.

Gabriel: Yes, but it's my fault we fought. I'm a terrible husband.

All couples fight sometimes. Both Gabriel and Rosa expressed anger toward the other in the afternoon. While Rosa appeared to feel happier later, Gabriel experienced guilt about his anger ("I feel really bad about it . . . I promised I wouldn't do that any more") and later, shame ("Yes, but it's my fault . . . I'm a terrible husband"). Anger, guilt, and shame are sometimes linked, as this dialogue shows. These are three moods that often hang in the balance when people consider their values concerning what behaviors, thoughts, or feelings are "right" and good. In fact, the experience and expression of

these moods are aspects of normal human experience and can be constructive. When others harm us, anger can motivate us to take self-protective action, and also to express our upset to alert others that rights or agreements have been violated. When we harm others, guilt can motivate us to make amends and change our behavior. When we have violated our most important moral codes, shame can be appropriate. Each of these emotions has its place in our emotional palette.

Guilt and shame are usually in evidence at a very young age. A study of toddlers who were led to believe they broke an adult's toy found that all of them showed signs of either guilt or shame (Drummond, Hammond, Satlof-Bedrick, Waugh, & Brownell, 2017). Their experience of guilt led to prosocial behaviors such as telling the adult they broke the toy and attempting to repair it. Subsequently in this study, the children who experienced guilt were more likely to help an adult in emotional distress than were the children who experienced shame. Shame was marked more often by social withdrawal and thus appeared to have fewer benefits than guilt.

WHEN DO THESE MOODS BECOME PROBLEMS?

When do anger, guilt, and shame become problems? Each of these emotions can be a cause for concern or become problematic if (1) they are absent, (2) they occur so often (frequency) that they are counterproductive or disabling, (3) they are experienced out of proportion to the circumstances (in strength and/or duration), or (4) they are expressed in ways that harm relationships.

The idea that an absent mood can be a problem is new to our discussions. It would be rare for someone to feel concern for someone who has never experienced depression. However, someone who never experiences or expresses anger is either extremely fortunate in life or possibly someone who is vulnerable to abuse, because they do not recognize when people are hurting or taking advantage of them. In traditions that strive for tolerance and acceptance of life's difficulties or disappointments, such as Buddhist philosophy, even spiritual leaders experience anger. The Dalai Lama has been quoted as saying: "You never stop getting angry about small things. In my case, it's when my staff do something carelessly, then my voice goes high. But after a few minutes, it passes" (Eleftheriou-Smith, 2015). A life without any guilt or shame is more likely to indicate someone who lacks self-awareness or a sense of empathy for others than someone who is leading a saintly existence. In fact, the complete absence of guilt is so unusual that it is one of the diagnostic criteria for antisocial personality disorder (American Psychiatric Association, 2013).

The learning points emphasized in *MOM2* Chapter 15, Understanding Your Anger, Guilt, and Shame, are shown in the Chapter 15 Summary box. This *MOM2* chapter helps people understand the causes and characteristics of these emotions, along with methods designed to help each. This clinician's guide chapter offers a cognitive-behavioral profile for each of the three emotions and shows you how to use *MOM2* Chapter 15 to help your clients who experience these emotions too much or too little.

Chapter 15 Summary

(*MOM2,* pp. 252–279)

- ✓ As you practice *Mind Over Mood* skills, Worksheets 15.1 (MOM2, p. 253) and 15.2 (MOM2, p. 254) help you rate and track your progress in the frequency, strength, and duration of your moods.
- ✓ Anger is characterized by muscle tension, increased heart rate, increased blood pressure, and defensiveness or attack.
- ✓ When we are angry, our thoughts focus on our perceptions that other people are hurting us, threatening us, breaking the rules, or being unfair.
- ✓ Anger can range from mild irritation to rage. How angry we feel is influenced by our interpretation of the meaning of events, our expectations for other people, and whether or not we thought the other persons' behavior was intentional or not.
- ✓ Methods that are effective in controlling anger include testing angry thoughts, using imagery to anticipate and prepare for events in which you are at high risk for anger, recognizing the early warning signs of anger, timeouts, assertion, forgiveness, and couple or family therapy.
- ✓ We feel guilty when we believe that we have done something wrong or not lived up to the standards we have set for ourselves.
- ✓ Guilt is often accompanied by thoughts containing the words "should" or "ought."
- ✓ Shame involves the perception that we have done something wrong, that we need to keep it a secret, and that what we have done means something terrible about us.
- ✓ Guilt and shame can be lessened or eliminated by assessing the seriousness of your actions, weighing personal responsibility, making reparations for any harm you caused, breaking the silence surrounding shame, and self-forgiveness.

MEASURING AND TRACKING MOODS IN THREE DIMENSIONS

Anger, guilt, and shame do not have well-established measures in the way that depression and anxiety do. And yet, throughout this text, we emphasize how important it is to regularly measure and track changes in moods. Changes on mood measures provide meaningful feedback to clients and their therapists as to whether interventions are helping or not. When we wrote *MOM2,* we decided to create a measure that could track changes in anger, guilt, and shame. Our own experience with clients suggested that improvements in these three moods could occur in any of three dimensions: frequency, strength (i.e., intensity), and duration. We constructed a new mood measure, Measuring

and Tracking My Moods (Worksheet 15.1, *MOM2,* p. 253), which asks people to reflect on the past week and rate their target mood on these three dimensions.

To deepen your understanding of the utility of this process, take a moment right now and complete this worksheet for any mood you experienced this week. When you finish, read on.

Our new mood measure has a number of clinical benefits, due to its flexibility:

1. **It can be used to rate a variety of therapy targets.** These include not only distressing moods such as anger, guilt, and shame, but more desirable moods such as happiness. This worksheet can also be used to rate other therapy change targets, such as pain, stress, urges to use alcohol/drugs, or resilience.

2. **Therapists and clients can set goals for any or all three dimensions.** For example, Shannon did not feel guilty very often (frequency), but when she did, she would feel it intensely (strength = 80 or greater on the 0–100 scale in Worksheet 15.1) for a week or more (duration) and would have a hard time coming out of her "guilt stupor." Her therapy goal was not to change the frequency of her guilt; instead Shannon wanted to reduce the strength and duration of her guilt. Mick did not feel guilt strongly, but he felt guilty about many little things every day. He set a therapy goal of reducing the frequency of his guilt.

3. **Improvement is often noticed more quickly when each dimension is rated.** People who are working to reduce anger are sensitized to notice how often (frequency) they feel anger during the week. Progress may seem elusive if they are only noting anger frequency. However, the strength or duration of anger experienced sometimes shifts in the early weeks of anger management. Therefore, rating therapy targets on three dimensions increases the likelihood that small changes will be noticed and recorded.

We encourage therapists to collaborate with clients and explore a variety of ways to use the generic scales in Measuring and Tracking My Moods (Worksheet 15.1, *MOM2,* p. 253). Some people find it more helpful to rate and track only one or two dimensions. Others use this worksheet to rate behaviors, urges, physical pain, or other non-mood-related targets. Many people are interested in using this worksheet to measure and track happiness, well-being, gratitude, resilience, or other positive qualities. There is a recommendation at the end of various *MOM2* chapters to rate happiness, for example, and Worksheet 15.1 is ideal for doing this. Many people find it interesting to observe that happiness is a mood that rarely has a long duration; the frequency and strength of happiness are often the dimensions that they can change more easily.

However your clients decide to use the Measuring and Tracking My Moods worksheet, changes in scores week by week can be recorded on the Mood Scores Chart (Worksheet 15.2, *MOM2,* p. 254). The instructions for this worksheet advise that people complete different copies of this chart for each therapy target they are tracking (e.g., one chart for tracking happiness and another for tracking guilt). Some people prefer to use different colors on Worksheet 15.2 to track frequency, strength, and duration of their target, so that it is easy to see how these go up and down separately or in

unison. Fillable .pdf versions of Worksheets 15.1 and 15.2 can be downloaded from The Guilford Press's *MOM2* companion website (for the exact URL see the box at the end of the *MOM2* table of contents, p. vi there) into a phone or other electronic device. If clients need help graphing their scores, you can complete the graph when you meet. After learning to rate and track anger, guilt, or shame on these worksheets, people can skip to the sections in Chapter 15 that apply to the moods they want to focus on in therapy.

ANGER

Anger Guide for Clinicians: The Flow of Therapy

Anger is often not identified as a presenting issue that brings clients to therapy. It can emerge in midtherapy as an issue during couple therapy or in the process of working on other interpersonal therapy goals. When issues related to anger are identified, you and your client need to decide what priority it should take and when to work on it in therapy. If your client has already learned other skills, consider if any of these can now be applied to understanding and managing anger.

The best way to help clients understand anger is to identify situations that trigger it, along with the automatic thoughts, images, and memories that accompany it. Case examples throughout this section of this chapter show how to do this. One possible impediment is that anger responses can happen so quickly that clients often need to learn skills to slow down anger in order to understand it better. *MOM2* Chapter 15 teaches a variety of skills for doing this: use of anticipatory imagery, recognizing early warning signs of anger, taking a timeout, and assertion.

As a therapist, you will need to maintain a close alliance with your clients who are exploring anger. This sometimes means finding the right balance between validating their perspective that gives rise to anger, and gradually helping them consider alternative views that others may hold of these same situations. This balance is necessary to find the evidence that both supports and does not support anger-related thoughts. When anger is not supported by the evidence, it can be critical to uncover the underlying assumptions that spark anger and to test these with behavioral experiments. When anger is supported by the evidence, assertive communication and Action Plans can help your clients try to resolve the injustice or hurt they have experienced. In time, some clients may choose to forgive those who have harmed them. Forgiveness can be a complex therapeutic process; it is described in more detail later in this chapter.

Many of these anger interventions are highlighted, along with worksheets to practice them, in Chapter 15 of *MOM2*. On page 458 in Appendix A here and on Guilford's *MOM2* companion website (see the box at the end of the *MOM2* table of contents), there is also an Anger Reading Guide that tells people which chapters to read next to learn various skills that can help in anger expression and management. The Anger Guide for Clinicians (see Table 12.1) links the MOM2 chapters from the Reading Guide with chapters in this clinician's guide. Most of these chapters are already familiar to you. However, when anger is the therapy focus, there are a few variations in their use:

TABLE 12.1. Anger Guide for Clinicians: *MOM2* Chapters (in Order Recommended by Anger Reading Guide) and Corresponding Clinician's Guide Chapters

MOM2 chapters	Purpose	Clinician's guide chapters
1–4	Introduction to *MOM2.*	2
15	Learn more about anger and effective methods to understand and express or manage it.	12
5	Set goals. Identify personal signs of improvement.	3
6–9	Use 7-Column Thought Records to identify and test thoughts related to anger.	4–5
10	Strengthen alternative thoughts. Use Action Plans to solve problems. For problems that can't be solved, develop acceptance.	6
11	Use behavioral experiments to test assumptions associated with anger and develop new assumptions.	7
12	Develop new core beliefs. Practice gratitude and acts of kindness.	8
13	Learn more about depression, if relevant.	9
14	Learn more about anxiety, if relevant.	10–11
16	Help make a plan to continue to feel better over time (relapse management).	13

1. After clients have completed the anger exercises in *MOM2* Chapter 15, the Anger Reading Guide directs clients to read Setting Personal Goals and Noticing Improvement (Chapter 5). This chapter may have already been completed for other presenting issues. Help clients set goals related to anger. Make sure their goals are for changes they can make *themselves,* and are not simply focused on how they would like *others* to change.

2. Your clients are likely to use the *MOM2* 7-Column Thought Record chapters (Chapters 6–9) to learn how to identify, test, and restructure thoughts and images associated with anger. You can introduce consideration of others' perspectives when this evidence does not support their hot thoughts associated with anger.

3. Identify the personal rules that spark recurrent anger by helping your clients look for their underlying assumptions in situations that evoke it (*MOM2* Chapter 11). Behavioral experiments designed to test old or develop new underlying assumptions can be devised as described in Chapter 7 of this clinician's guide.

4. There are many reasons for anger, ranging from abuse to social injustice to misunderstandings to misperceptions of others' good intentions. Depending on the circumstances that fit your clients' anger, any or all of the following *MOM2* skills can

be helpful: problem solving, acceptance, building new core beliefs, and practicing gratitude and kindness. When anger is comorbid with other moods, employ the relevant mood chapters. As with all moods, make sure you allow time before therapy ends to help your clients construct a relapse management plan. Such a plan can help incorporate anger management skills practice into their lives. This can also be a time to make a posttherapy plan to boost happiness and a positive sense of well-being.

Forming an Alliance and Rating Anger

Brendon was a university student, living with his parents and siblings; he met criteria for borderline personality disorder. One of his main symptoms was intense and frequent anger. When his anger was triggered, he would rage and shout at his family members (high frequency, high strength, and duration of zero to four hours). When he began measuring and tracking his anger on Worksheet 15.1 at the beginning of therapy, Brendon's therapist asked him which dimension he thought would be easiest to change first.

THERAPIST: When I look at your worksheet, I see you marked frequency at 70, strength at 100, and duration at 30. Which of these three things do you think would be easiest to shift a little bit?

BRENDON: I guess strength, because it is the highest.

THERAPIST: Hmmm. That's an idea. I wonder, though, how long it takes for you to go from 0 to 100 in the strength of your anger. What was your experience this week?

BRENDON: When I walked in my room and found my sister looking at my things, I immediately was angry 100%. She has no right to do that! (*Raising his voice*)

THERAPIST: I can see how just thinking about it now gets you going.

BRENDON: Of course! Wouldn't that make you furious?

THERAPIST: I can see how that didn't seem right. It seems, when things aren't right, your anger shoots from 0 to 100 very fast.

BRENDON: Uh-huh.

THERAPIST: I think it can be hard to change our fast reactions in the beginning. I wonder if either the frequency or the duration your anger lasts might be easier to change in the beginning.

BRENDON: Well, each time I get angry, it is pretty fast. So frequency might be another fast thing. Maybe I could shorten the duration.

THERAPIST: That might work. This week, when your anger was at its highest after you found out about your sister being in your room, how long did it last?

BRENDON: It lasted about four hours—until she apologized and my father said I could put a lock on my door.

THERAPIST: Would there have been any benefit for you if your anger didn't last as long?

BRENDON: Yes. I was so wound up I couldn't study. I had a term paper due the next day,

and it really messed that up, and the teaching assistant told me I couldn't hand in any more late papers or I would flunk the class.

THERAPIST: So the long duration of your anger really gets in the way of your doing things that are important to you.

BRENDON: Yes.

THERAPIST: That sounds like a good place to start, then. Let's begin working on figuring out ways to reduce the length of time that you feel angry, so it doesn't disrupt your life so much.

BRENDON: That would be good.

Notice that Brendon's therapist did not push Brendon to look at the benefits for his family members or others if he could reduce the duration of his anger, even though this was likely to be an additional benefit. This was the second session, and his therapist was still building an alliance with Brendon. As described below, anger is a mood fueled by thoughts of being harmed, threatened or taken advantage of by other people. In addition, people who meet criteria for borderline personality disorder commonly have a belief that others will hurt them. Thus, his therapist emphasized her concern for the impact his anger had on Brendon, to communicate that she was his ally. The impact of his anger on others will be addressed later in therapy with him, once a good alliance is formed and he is able to consider this.

Anger is one of the few emotions in which the accompanying thoughts are more about another person than about oneself. Therefore, angry thoughts often begin with the word "you" when a person is speaking to someone, and "he" or "she" or "they" or "it" when the person is thinking about other people or circumstances connected to their anger:

"You are being unreasonable."
"You are taking advantage of me."
"He/She/They are bad/hurtful/disappointing because . . ."
"It is a not fair because . . ."

When assumptions of fairness or justice are violated, anyone is likely to feel angry. As described to readers in *MOM2* Chapter 15, anger is linked to thoughts that others are threatening, damaging, or hurting them or their rights. Since angry thoughts are about someone else, people sometimes don't think they should have to investigate their thoughts or attempt to modify their reactions. There can be a perception that someone else is the problem and that the person(s) doing the damage should make the changes. Sometimes this is the case. Therefore, when addressing anger, we help our clients identify situations (triggers) as well as the thoughts and images linked to feelings of anger.

Identifying Thoughts, Images, and Memories Linked to Anger

The Understanding Anger, Guilt, and Shame Worksheet can be used to identify the situation (trigger), thoughts, and images connected with anger (Worksheet 15.3,

MOM2, p. 257). The directions to this worksheet remind readers that memories are another type of thought or image that can be recorded. Sometimes aspects of an event evoke memories of other incidents, and then anger quickly escalates to a degree that seems out of proportion to the current situation. For example, a homeless man became enraged when a passer-by said, "Get a job," because this had been said to him hundreds of times that month. He was hurt and angry that no one appreciated that he was working part-time and looking for a second job, and still could not afford to pay rent. A woman who was being sexually harassed in her job slapped a man who leaned into her on a bus because she perceived that he was trying to have sexual contact. He seemed startled and shouted at her, "What did you do that for?" In both of these situations, the harm done probably was not as great as the anger felt and expressed. And yet knowing each person's prior experiences and memories helps us understand and empathize with their reactions. When memories are evoked, these should be recorded in the Automatic Thoughts (Images) column of Worksheet 15.3.

Ask your clients to identify their thoughts, images, and memories associated with anger for several situations. Then they can read the pages in *MOM2* (pp. 257–258) that describe the nature of people's thoughts when they feel anger. These pages can be used as a guide for ways to talk with clients about the roles the following factors play in determining when and to what degree they feel angry in a given situation: (1) beliefs about fairness, (2) interpretation of the intent and reasonableness of others' behaviors, and (3) the clients' own expectations. In fact, asking people to read these few paragraphs and link them to particular angry thoughts that they recorded on Worksheet 15.3 can be a useful exercise in session.

Considering Your Client's Perspective First

Helping clients recognize that their thoughts, interpretations, expectations, and intentions in a situation could be different from another person's is often necessary before they will be willing to learn to test their thoughts linked to anger. In time, they will need to recognize that others can hold different perspectives from their own and that these might be valid for that other person, even when they conflict with beliefs and values that clients hold dear. However, it is not necessarily helpful initially, when clients are still angry, to ask them to look at the situation from the perspective of the other person(s) toward whom they are angry. Consider the differences between these two versions of a dialogue with Brendon, the university student you read about earlier who was angry that his sister entered his room and looked at his things. In the first (hypothetical) dialogue below, his therapist noticed an alternative explanation for Brendon's sister's behavior and chose to ask about that as a first step toward testing his thoughts.

BRENDON: So my thoughts when I found out my sister had been in my room were that she was snooping on me or looking for money. I remembered her telling my parents one time that I had called my friends to go to a party I wasn't supposed to go to. She listened outside my door and tattled on me, and I got in a lot of trouble. She's just a busybody and looking for ways to get my parents mad at me. She even told them she was just in my room

because she needed an eraser and knew I had one in my desk, but I know that wasn't it.

THERAPIST: If she was just looking for an eraser, would that affect how you felt?

BRENDON: You are just like my parents! Taking her side!

In this version, when his therapist began with the other person's perspective, Brendon became even angrier, and their budding therapy alliance was damaged. In the second version of this interview (the one that actually happened), his therapist attended to Brendon's perspective and empathized with his anger before addressing any alternative explanations for his sister's behavior.

BRENDON: So my thoughts when I found out my sister had been in my room were that she was snooping on me or looking for money. I remembered her telling my parents one time that I had called my friends to go to a party I wasn't supposed to go to. She listened outside my door and told on me, and I got in a lot of trouble. She's just a busybody and looking for ways to get my parents mad at me. She even told them she was just in my room because she needed an eraser and knew I had one in my desk, but I know that wasn't it.

THERAPIST: So you have a history of your sister betraying your secrets to your parents?

BRENDON: Yes.

THERAPIST: When did this situation you remember happen?

BRENDON: I guess about three years ago. Before I started going to college.

THERAPIST: And has she continued this type of spying on you and reporting to your parents?

BRENDON: I'm not sure. I hadn't noticed anything this year until she went into my room.

THERAPIST: And I can understand how that seemed to be a real violation of your privacy.

BRENDON: Yes, it was.

THERAPIST: So your sister said she was just looking for an eraser in your desk. What did it look like she was doing when you walked in?

BRENDON: Well, she did have my desk drawer open, and she was looking at things there.

THERAPIST: Is that where you keep your money or secrets you don't want your parents to know about?

BRENDON: Luckily, no.

THERAPIST: What is in your desk drawer that might have interested her?

BRENDON: Just some pens and paper and my checkbook. I guess she could have been looking at that.

THERAPIST: Is that what you saw?

Brendon: No. She was just looking in the drawer.

Therapist: So one possibility is that she was looking in the drawer for secrets of some kind, and fortunately you didn't have anything there she could find to get you in trouble. The other possibility is that she was looking for an eraser, like she said. It's hard to know which is true.

Brendon: Yeah, I guess.

Therapist: I can understand how, in the moment, her behavior looked really suspicious and you thought the worst . . . that she was looking for money or something to get you in trouble. When you look back at the situation now, what odds would you give that idea or her explanation that she was looking for an eraser?

Brendon: I'm not sure. Maybe 50–50.

Therapist: OK. So if she was snooping or looking for money, she was violating your privacy. Since that is what you thought was going on, you felt angry. If it turned out you thought she was just looking for an eraser, would you have felt any differently?

Brendon: I still wouldn't like it, because she should ask me before going into my room. But I wouldn't have felt quite as angry.

In this second version of this interview, his therapist explored the reasons for Brendon's anger first and looked for corroborating evidence. Only after this was done did his therapist ask Brendon to rate the likelihood of both his perspective and his sister's. Since his therapist expressed empathy and understanding toward Brendon's anger, Brendon did not need to keep asserting it. He was able to consider an alternative perspective, at least partially.

Asking people like Brendon who experience frequent and intense anger to examine and test their angry thoughts is likely to be more successful if the reason for doing this is framed in empathy for the impact anger has on them, rather than initially focusing on the impact it has on others. This is because when people are in the midst of anger, they see others as the perpetrators of wrong and themselves as the victims. As you can imagine, Brendon would feel more understood if his therapist said,

> "I'm concerned, Brendon, that this frequent anger you experience is really taking a toll on your life. You've told me that it disrupts your ability to focus at school, it poisons your moods when go home, and it even makes it hard to sleep sometimes. I'd like to help you figure out ways to reduce the strength of your anger and the length of time it lasts, so you can feel better more often during the week."

than if his therapist said,

> "I'm concerned, Brendon, that this frequent anger you experience is really taking a toll on your life. You've told me you are often angry at home. I imagine this is hurting your relationships with your family. And if you get angry with friends, it

will hurt your friendships, too. I'd like to help you figure out ways to reduce the strength of your anger and the length of time it lasts, so you can feel better more often and have better relationships."

Thought Records, Action Plans, and Behavioral Experiments

Once people are willing to consider other perspectives and test out their thoughts in anger situations, thought records are excellent tools for this task. 7-Column Thought Records are ideal for testing situation-specific thoughts, like those for Brendon's situation above (*MOM2* Chapters 6–9). They help people learn to look in situations for evidence that supports and doesn't support their anger-related conclusions about other people.

When Anger Is Supported by the Evidence: Action Plans

When clients' anger is supported by the evidence on 7-Column Thought Records, make an Action Plan to figure out how best to address the concerns giving rise to anger (*MOM2* Chapter 10, pp. 121–125). Action Plans can include communicating what is hurtful, working out compromises for relationship differences, and steps for making changes in your clients' behaviors or supporting changes in others' behaviors. When people in your clients' lives regularly behave in ways that evoke anger, help your clients decide whether it is best to try to change their behaviors, end the relationships, or develop greater acceptance of the offending behaviors. If acceptance is the goal, use the section of *MOM2* Chapter 10 that addresses this (pp. 126–129).

When Anger Is Not Completely Supported by the Evidence: Behavioral Experiments

When clients frequently experience anger that is not supported by the evidence in situations, identifying and testing their underlying assumptions related to anger is a better approach than relying on thought records to test each specific automatic thought. Common assumptions in close romantic relationships that spark recurrent anger are explored in depth in Aaron T. Beck's classic book *Love Is Never Enough* (Beck, 1988). These assumptions include beliefs such as "If someone loves me, then they will never hurt me," "If someone loves me, then they will give me what I want," and "If we disagree about things, then that means we are not compatible." Chapter 11 of *MOM2,* Underlying Assumptions and Behavioral Experiments (pp. 132–151), is ideal for helping people identify the underlying assumptions beneath their anger. That same chapter shows how to create behavioral experiments to test underlying assumptions, as described in Chapter 7 of this clinician's guide.

Slowing Down an Anger Response

Anger is often a fast response, as described by Brendon earlier in this chapter. This can make it difficult for people to use thought records or behavioral experiments (especially

early in therapy), because anger is triggered so quickly, even before they have time to identify their thoughts, images, or memories. Thus Chapter 15 of *MOM2* recommends four strategies people can use to slow down anger responses: anticipatory imagery, recognizing early warning signs of anger, taking a timeout, and assertion. People who learn and practice these strategies have greater opportunities to detect their anger triggers and choose adaptive responses. Practicing these methods for slowing down anger responses can make it easier for clients to benefit from cognitive interventions such as 7-Column Thought Records (to examine evidence regarding their automatic thoughts) and behavioral experiments (to test underlying assumptions).

Anticipatory Imagery

When people are aware of upcoming situations that are likely to trigger anger, anticipatory imagery helps them practice responses to those situations in advance. For example, Melanie's ex-husband, Mark, had custody of their children every other weekend. He often texted at the time he was supposed to arrive to pick up the children to tell her he would be late, sometimes by several hours. In addition, he often returned the children to her at a different time than they had previously agreed on. These changes in the timing of his visits with the children were extremely frustrating for Melanie, because she often had to change her plans to be with the children longer or sooner than agreed upon. Also, she knew the uncertainty about pick-up and drop-off times was unsettling for her young children, especially because Melanie and Mark often argued angrily when he showed up late or returned early with the children. Melanie told Mark during their child custody mediation meetings that she thought it was a necessity to stick to the agreed-upon schedules. However, Mark was lackadaisical about time in most areas of his life. Sometimes she suspected that he changed the times partly to irritate or hurt her because he was still angry about their divorce.

Melanie was committed to handling this issue without exploding in anger, or at least to limiting her angry exchanges with Mark to times when the children were not present. Therefore, she imagined ways she would like to handle it when Mark arrived late to get the children. She and her therapist role-played what she imagined saying the next time Mark was late. Melanie wanted feedback on whether her words or tone sounded too confrontational.

THERAPIST: OK. So I'm Mark and I'm showing up an hour late on Saturday.

MELANIE: Hi, Mark.

THERAPIST: (*As Mark*) Hi. I'm here to get the kids.

MELANIE: They are all ready. Actually, they have been ready for an hour, since you are late.

THERAPIST: Let's stop for a moment. How did you feel saying that?

MELANIE: A little bit snappy. Did I sound angry?

THERAPIST: Yes, a little. Let's go back to how you imagined this. Can you remember the words you described to capture how you wanted to come across?

MELANIE: Calm and strong. Good-hearted.

THERAPIST: What does your calm, strong, good-hearted mother-self want to say?

MELANIE: Just that they are ready. I can take up the timing issue with him later, when it is just the two of us on the phone.

THERAPIST: OK. Let's try that again. I'm Mark, and I'm showing up an hour late on Saturday.

MELANIE: Hi, Mark. Glad you made it. (*Smiling*) Did you run into traffic?

THERAPIST: (*As Mark*) No, not really. I just got busy at the car wash and lost track of time.

MELANIE: Well, the kids are ready. I hope you have a good weekend together.

THERAPIST: Let's stop there. How did you feel saying that?

MELANIE: Actually, pretty good. Knowing that I can talk to Mark later, and that right now I want to show the kids I am calm and strong and good-hearted, made it easier to take it easy on him.

THERAPIST: You sounded really calm and strong and good-hearted. I'd like you to be quiet for a moment. Really capture how this feels inside, so you can recapture this internal feeling if Mark is late on Saturday.

Using imagery to anticipate and plan for events that evoke anger is likely to be more effective when people take the time to imagine the entire scene and practice the responses they want to make. The more challenging the situation, the more often people need to rehearse it in role plays or imagery. As therapists, we want to follow in the footsteps of Melanie's therapist, who asked her what kind of person she wanted to be in the interactions with Mark and how this fit with her goals and values. Melanie would not have been so willing to change her behavior toward Mark if she did not have a goal to make these encounters less stressful for her children. She told her therapist that she valued being calm, strong and good-hearted as a mother.

Melanie wanted to work out timing issues with Mark when the children weren't present. In the past, she and Mark had both begun to attack each other when "discussing" his changes to the agreed-upon timing for getting and leaving the children at her home. Their interactions over this issue mimicked the types of arguments they had had in their final year of marriage, and Melanie could see that angry fights weren't likely to lead to a good resolution. She and her therapist explored ways to communicate with Mark more effectively about the ways his erratic timing was affecting both his relationship with the children and their relationship as parents. Once she settled on a strategy for these discussions with Mark, Melanie practiced them in role plays with her therapist and also in imagery, until she was more confident that she could communicate in the ways she wanted. Prior to her discussion with Mark, Melanie and her therapist also practiced the other three methods of slowing anger down, so that she would be more prepared to manage any anger provoked.

Recognizing Early Warning Signs of Anger

Once Melanie began imagining upcoming discussions with Mark, she became aware of her "early warning signs" that she was going to "lose it" (i.e., start shouting at him). She and her therapist discussed that there was nothing wrong with feeling anger at some of the things Mark said and did. Yet Melanie recognized that once she started shouting at him, neither of them really heard anything the other said. She wanted to learn to handle this situation without shouting. Melanie recognized four early warning signs: when she caught herself mentally crafting mean things to say, when she puffed up her chest, when she began holding her breath, and when she had a mental image of slapping him. She agreed with her therapist that when these signs occurred, she would be better off taking a timeout until she knew she could talk more calmly and stay focused on her goal of reaching an agreement they could both endorse.

Timeouts

As described in *MOM2,* timeouts provide opportunities to "regroup, strategize, relax or simply rest" (p. 261). They are not about avoiding the situation that evokes anger, but more about helping a person face a situation "best foot forward." A timeout entails literally leaving a situation in which a person feels angry. When the situation is interpersonal, it is helpful to tell the other person, "I may want to take a timeout," along with the rationale and good intentions for doing so. This was how Melanie alerted Mark in a telephone conversation that she might take timeouts during their discussions.

Melanie: I'd like to talk with you about sticking to the times we agreed upon for when you pick up or drop off the kids.

Mark: Not again! Can't you just let it go?

Melanie: I agree that I don't want to keep arguing and shouting about this. In fact, I want to have a different conversation with you about it, and I'm committed to staying calm in our discussion.

Mark: (*Somewhat sarcastically*) Really? You think you can do that?

Melanie: Actually, I think I can do that if I take a timeout when I start getting too agitated.

Mark: A timeout? Like we give to Justin?

Melanie: Sort of. Yes. If I notice I'm starting to wind up too much, I'd like to tell you I need a break for a few minutes. I'll tell you if I need it and how long a break I want. Then I'll ask you to agree to hang up the phone for a while until I settle myself down, and then I'll call you back.

Mark: I have to wait for you to call me back?

Melanie: Yes. But I'll try to let you know if I think it will be just a few minutes or

an hour, or if I want to stop our conversation until the next day. How will that be for you?

MARK: I guess all right.

MELANIE: And if you start getting really angry, you can ask for a break too. Just let me know how long a break you think you will need, so I'll know whether to wait by the phone or go do something else.

Melanie and Mark agreed to try out this approach for their discussions. They both discovered that the timeouts were welcome, even though it was somewhat difficult to stop their conversations when things became heated. Each of them felt an urgency to say more when their anger intensified. However, over time, they experienced smoother conversations after these timeouts, because each of them was able to listen better once they took a pause to calm down. Melanie explained to Mark that she used her timeouts to calm herself, to remind herself that they both wanted to be good parents, and to think about how to say things to him in ways that didn't attack him. Hearing her explanation of how she spent her timeouts made Mark more receptive to using them himself. He told her he would also try to use the timeouts to think of ways to work things out, rather than stewing about what made him so angry.

There is no need for people to announce explicitly that they are taking a timeout if this does not seem helpful or appropriate to the situation and relationship. Instead, they can always say that they need to take a break for a few minutes (e.g., to take a phone call, or for some other personal reason). Or they can say, "I'd like to think about what you've told me. Let's talk again in a few minutes/tomorrow to consider what the best resolution will be." When people get angry outside of an interpersonal situation (e.g., alone in a car in traffic, at home thinking about a situation that evokes anger), taking a timeout can involve doing a variety of activities to reduce the intensity of anger, such as playing music, exercising, or even filling out a thought record about the situation. Remember, timeouts are designed to reduce arousal so that people can return with a fresh perspective to whatever made them angry in the first place. Timeouts are intended to help clients effectively resolve important issues, not avoid them.

Assertion

Resolving issues that elicit anger often requires skillful assertion. Many people misunderstand anger management; they think that it is all about keeping quiet and letting other people have their way. When her therapist first suggested that Melanie could work on not getting angry during parenting discussions with Mark, Melanie actually thought that this meant she was going to have to agree with whatever he said. Those who hold this misunderstanding can be reluctant to manage their anger. Melanie learned that overcoming her anger required expressing her thoughts and values in ways that respected both Mark and her, not unquestioningly accepting his actions and decisions. Therapists who are not already familiar with the principles of assertion are encouraged to review pages 261–263 of *MOM2* now. Melanie used the four strategies of assertive responses (described in *MOM2* on page 262) to frame her message to Mark as follows:

1. **Use "I" statements.**

   "I know it might be difficult, Mark, and yet I would like you to think about this from my perspective just for a few minutes. Then I will listen to your perspective and really try to hear what you want to say."

2. **Acknowledge any truth in someone's complaints about you, and at the same time stand up for your own rights.**

   "I know I have been harsh with you in the past about showing up late or bringing the children home early. That was not the best way for me to approach this issue. At the same time, I want you to know that it really does mess things up in my life when the timing for our child care is changed at the last minute."

3. **Make clear, simple statements of your wants and needs, rather than expecting other people to read your mind or anticipate what you want.**

   "I would like you to call me at least two hours in advance if you want to change the times you will pick up or drop off the children. And if the new time you propose doesn't work with my plans, or if you can't reach me, I want you to work out an alternative arrangement in your life instead of relying on me to change my schedule."

4. Focus on the process of assertion rather than results. Melanie found it very liberating to speak to Mark in this way. She knew he was consistently late for most things in his life. However, speaking assertively and explaining the situation from her perspective helped her feel less powerless in the face of his inattention to time. Mark told her he didn't think he could be relied on to pay attention to the time consistently. She calmly replied that she understood paying attention to time was not his style, but that he needed to figure out a solution, because she was quite serious that the current system was not fair to her or the children. She asked him to think about it for a week and see if he could think of a fairer way to handle things.

Assertion does not guarantee that the other person will respond in the hoped-for way, or that two people in conflict will reach a quick resolution to the conflict. However, when people learn to be assertive, they greatly increase their chances of reaching an acceptable solution to an interpersonal disagreement. The four assertion strategies listed above guide people to clearly state solutions that would meet their needs, and help them to say fewer things that are likely to trigger anger in others.

You can help your clients construct assertive communication statements and then role-play these in the context of various responses another person might make. These role plays provide a safe environment for your clients to prepare their own responses to another person's reactions to their statements of hurt and anger. In addition, these role plays can detect if someone is prone to offering "cheap forgiveness" in response to a "cheap apology," as demonstrated in this session that occurred a few weeks later in Melanie's therapy.

MELANIE: (*Role-playing using her prepared statements*) Mark, I feel taken advantage of when you continue to show up late to get the children or call me to drop them off early. I'm really angry about this.

THERAPIST: (*Role-playing as Mark*) I wish you weren't so angry. You know this is not personal to you. I just can never seem to be on time to anything. And today there really was heavier traffic than usual, so that is why I'm late. I tried to be on time. I'm really sorry.

MELANIE: I'm glad to know you're sorry. Yes, I know it is not personal. I guess I can forgive you this time. But I don't want it to happen again.

THERAPIST: Let's stop the role play here. How are you feeling, Melanie?

MELANIE: A bit confused. He doesn't usually apologize; he just makes excuses. I guess if he apologizes, I should accept that apology and forgive him. But I don't really feel happy about that.

THERAPIST: So you believe, "If someone apologizes, then I need to accept it." Is that right?

MELANIE: Well, sort of. It seems kind of mean to stay angry if he seems genuinely apologetic.

THERAPIST: Is your anger just about him being late today?

MELANIE: No. I'm angry because it is the 100th time or more that he has been late.

THERAPIST: Is it possible, then, that an apology for one time does not make up for the other 99+ times?

MELANIE: That's right. Even if he apologized all 100 times, it still seems unfair that he keeps doing it.

THERAPIST: So what is it that Mark would need to do or say that would help you genuinely forgive him and feel less angry?

MELANIE: He would need to stop being late. Make some changes that show he is really changing. Even show up early and sit in his car outside the house until it is time.

THERAPIST: Let's do the role play again, and you try expressing this to Mark, and let's see how that affects your feelings.

MELANIE: OK. (*Role-playing and reading her initial statement*) Mark, I feel taken advantage of when you continue to show up late to get the children or call me to drop them off early. I'm really angry about this.

THERAPIST: (*Role-playing as Mark*) Oh, don't be angry. You know this is not personal to you. I just can never seem to be on time to anything. And today there really was heavier traffic than usual, so that is why I'm late. I tried to be on time. I'm really sorry. Please forgive me.

MELANIE: I would like to believe you and forgive you and not feel angry about this any more. In order to do that, though, I would need to see some real signs of change. For example, if you left your office even earlier, so you got here early and sat in your car out front until it was time, then I would know you are really trying.

THERAPIST: (*Role-playing as Mark*) But you know I can't leave work early on Friday. And traffic is extra heavy then. I can't predict how long it will take.

MELANIE: Then maybe we should change the time you are scheduled to be here. What time would we need to make it so you could guarantee being here on time?

THERAPIST: (*Role-playing as Mark*) Uh . . . maybe it would need to be a half hour later?

MELANIE: We can try that for one month. If you are on time every week, then that new time will be acceptable to me.

THERAPIST: (*Role-playing as Mark*) Will you stop being angry and forgive me then?

MELANIE: I'm not sure how long it will take for me to stop being angry and forgive you about this. But I do know if you start being on time and keep it up for a while, so I begin to trust that the change is real on your part, then I will feel a lot better and probably be able to put the past in the past.

THERAPIST: Let's end the role play here. How did you feel this time?

MELANIE: A lot better. I was being more true to my feelings and not just reacting to his.

THERAPIST: Good. Let's talk more about what made the positive difference for you, and also role-play some other possible reactions Mark might have, so you can figure out how to handle those in ways that are true to your feelings.

As shown in this dialogue, role plays are invaluable for clarifying the nuances of assertive expressions of anger. They can prepare people emotionally, cognitively, and behaviorally to express hurt and anger to another person in ways that stay close to their values and best intentions. For more in-depth information about how to process hurts and betrayals in close relationships, see two excellent books written by Janis Abrahms Spring: *After the Affair* (Spring with Spring, 2012) and *How Can I Forgive You?* (Spring with Spring, 2005). Common beliefs and assumptions that can derail assertion are listed on page 263 of *MOM2*. Clients can be asked to rate how strongly they believe any of these or related underlying assumptions. When clients hold any of these beliefs strongly, it may be necessary to test them by using behavioral experiments as described in Chapter 7 of this clinician's guide.

Forgiving Others

People who hurt others often apologize and ask for forgiveness. If an apology seems sincere and appropriate to the level of injury, an injured person often has little difficulty offering forgiveness in return. The anger people feel is often reduced when they offer forgiveness to other people who have hurt them. This makes forgiveness appear to be a worthwhile anger management step. However, in *MOM2* we take the perspective that forgiveness is one path to help let go of anger and resentment, but it is not a necessary path for everyone. Why not? In this section, we discuss why forgiveness is a choice and one that is not suitable for every person or therapy circumstance.

Forgiveness discussions are easier in the context of a safe, trusting relationship. As

a therapist, you can help create such an environment by not pushing clients to forgive and by only exploring forgiveness when a client seems ready and willing to do so. Trust is deepened when you first take the time to explore, listen, witness, and understand the pain someone has experienced. After doing this in therapy, you can discuss whether the person wants to consider forgiveness and, if so, the benefits they might experience if they are able to forgive.

There are six aspects of forgiveness to discuss with your clients:

1. Forgiveness is a choice. A person can get over anger without choosing to forgive.
2. Ask what forgiveness means to your clients, and clarify any misunderstandings.
3. Forgiveness does not require forgetting or excusing what was done, or reconciling with someone who has caused harm.
4. Clarify the purposes of forgiveness. One positive purpose of forgiveness is to reduce anger and resentment that is interfering with a client's life or values.
5. Timing matters. It is therapeutic to work on forgiveness only after clients have taken the time to experience and process their reactions to whatever deep hurts fuel their anger.
6. Forgiveness takes time; only initiate this work in therapy if you have enough time.

A more detailed description of these and other guidelines for working on forgiveness in therapy is offered by Freedman and Zarifkar (2016). Here are some highlights.

Forgiveness Is a Choice

When clients choose to work on forgiveness, it is important to clarify their purposes for it. Some clients choose to work on forgiveness because they believe the popular myth that forgiveness is a necessary step to overcome anger. A primary purpose of forgiveness in psychotherapy is to be able to reduce anger and/or resentments that have been felt and processed, and yet *still* interfere with someone's life and/or values. You can explain to clients that when past or present hurts bother them less and less over time and life goes on, forgiving people who have hurt them in the past is not a necessary life task. For example, a woman may choose not to forgive a relative who sexually abused her as a child, but she may still be able to let go of resentment over time and move forward in her life believing, "This was not right, and yet it does not define who I am or who I want to be." It is entirely possible for people to let go of anger and resentment without forgiving the persons who harmed them.

Ask What Forgiveness Means, and Clarify Misunderstandings

When forgiveness is discussed in therapy, ask clients what they think forgiveness means. Many people's beliefs about forgiveness are fueled by religious beliefs, because many religions teach about forgiveness. To the extent that religious traditions provide models

for how to forgive, religious teachings can facilitate a willingness to try to forgive. At the same time, if people feel a religious imperative to forgive, they sometimes offer premature or "cheap forgiveness." That is, they mouth the sentiment "I forgive you," without doing the hard work required to offer deeply considered forgiveness.

Forgiveness Does Not Require Forgetting, Excusing, or Reconciling

Many people mistakenly believe that forgiveness involves forgetting or excusing the harm that was done or reconciling with the person who caused the harm (Freedman & Chang, 2010). In fact, forgiveness does not require forgetting or excusing what was done, or even reconciling with the other person.

Clarify the Purposes of Forgiveness

Forgiveness can be a path people forge in order to break free of resentments and ongoing anger. Enright (2001) was one of the first psychologists to propose that forgiveness can be a moral choice in which people decide to give forgiveness as a gift to someone, whether the other person deserves it or not. They can do this work individually without ever communicating with the person who caused the harm.

Timing Matters

Consider the timing of forgiveness work. Working on forgiveness before clients have actually felt and processed the pain of what happened is premature. Thus offering forgiveness is rarely beneficial in the immediate aftermath of deep hurt. Similarly, it is usually premature to help clients consider forgiveness toward someone who is abusing them and continues to do so. In fact, a person who forgives a currently physically abusive partner is more likely to return to or remain in that abusive relationship (Katz, Street, & Arias, 1997). Self-forgiveness may be more important than forgiveness of others for people who have experienced domestic violence, at least in terms of reducing suicide risk (Chang, Kahle, Yu, & Hirsch, 2014). Self-forgiveness is addressed later in this chapter.

Forgiveness Takes Time

Forgiveness is a complex issue that involves emotional, cognitive, and behavioral awareness and change. As we have made clear throughout this clinician's guide, shifts in each of these domains can take time, especially when issues are long-standing. Working toward forgiveness can take a significant amount of time—often months rather than weeks. A study by Luskin (1999) reported that after six 90-minute forgiveness training sessions, only 34% of participants felt greater forgiveness toward their offenders, only 27% had a decrease in physical stress, only 15% experienced less emotional stress, and just 13% experienced a reduction in long-term anger.

Forgiveness programs that show the best outcomes generally take 12 weeks or longer (Baskin & Enright, 2004). Thus, when anger is a prime target, forgiveness would

rarely be an early task in therapy. Generally it is more beneficial to work with people early in therapy to understand and manage their anger in the here and now. When people see that their reactions to current hurts might be magnified by past harm, it can be beneficial to help them learn to evaluate everyday transgressions on their own merit. If only brief therapy is planned, working toward forgiveness of past hurts is usually not even a practical therapy goal.

Writing a Forgiveness Letter

Direct and assertive conversations often lead to forgiveness within current relationships. A forgiveness letter can structure this process for past hurts. Unlike most of the exercises in *MOM2, the forgiveness letter is optional.* Point this out to your clients, and do not pressure them into working on a forgiveness letter unless this process is consistent with their goals and the timing is appropriate according to the criteria listed above. Unless a client wants and chooses to try to forgive, do not begin working on a forgiveness letter. Otherwise, your actions can represent a lack of understanding and compassion.

Despite its name, a forgiveness letter is *not* designed to be given to someone else. It is a private place to gather thoughts about a particular other person (or persons or group) who caused harm and to describe the impact of that harm. A forgiveness letter can be an ideal method for processing hurt and anger when it is not possible or desirable to express reactions in person. For example, the offender may be dead, may still be dangerous or violent, may be in a role (e.g., a boss) in which direct discussion can be too difficult or risky, or may simply be someone with whom your client does not want to talk directly. Worksheet 15.4, Writing a Forgiveness Letter (*MOM2,* p. 265), provides a balanced template for addressing many of the issues described in the previous section as important for developing forgiveness. Thus you can use this worksheet to guide forgiveness therapy work with clients. Each section of the worksheet can be a theme in one or more therapy sessions.

Unlike most other worksheets in *MOM2,* Writing a Forgiveness Letter is likely to be filled out over a number of weeks, because each item requires quite a bit of thought and emotional processing. Sometimes this worksheet is filled out as the culmination of time and energy devoted to examining injuries experienced in a particular relationship. Worksheet 15.4 requires people to specify what was done to them and the impact this has had on their lives, both in the past and the present. Next, people are asked to consider what benefits could come into their lives if they are able to forgive the person(s) who harmed them. The next part of the worksheet asks people to try to develop a compassionate understanding of the person(s) who hurt them. This is a turning point of the worksheet and a step that can be challenging for many people, particularly if the hurt was extremely damaging (e.g., murder, sexual assault, torture, betrayal leading to severe losses). The following dialogue shows Marie grappling with developing a compassionate view of the man who had shot and killed her brother ten years earlier.

MARIE: I don't know if I can have compassion for what he did.

THERAPIST: I understand. That is a big step—and one you may not be able to take. But

compassion is not the first step. Let's begin by talking about the man who shot your brother. Would that be OK with you? (*Marie nods.*) What have you learned about him? From the trial, for example.

MARIE: He was driving up and down our street with a gun. He was high on drugs. He told the judge his girlfriend had broken up with him that night.

THERAPIST: So what do you think was his mood and physical state?

MARIE: He was upset and angry. But my brother had nothing to do with his problems.

THERAPIST: Of course not. It makes no sense to us that he shot your brother. Do you think it made any sense to him that night? Taking into account his state of mind, his being upset and angry, and being on drugs?

MARIE: Maybe he just wanted to hurt someone else, like he was hurting.

THERAPIST: Perhaps. Is there anything else you know about him that would fit with this idea?

Clearly, this discussion was a delicate one. Marie's therapist was being careful to support her emotionally and not to push her too quickly as she began thinking about her brother's murderer and his probable state of mind and emotions that night. This was not a search for the truth, because it was impossible to know the truth surrounding her brother's murder. Instead, Marie was trying to figure out some way to understand how this man could have killed her brother. From this understanding, some compassion for him might emerge.

Understanding and compassion do not necessarily imply developing a kind view toward the person(s) who caused harm. Sometimes understanding can mean acknowledging that a person was cruel or heartless and felt little empathy for others. Understanding could mean acknowledging that a person addicted to drugs or alcohol was unable to think of anyone else when the person was desperate for a fix. In turn, compassion can be based solely on the fact that an offender is a human being and that the person working on forgiveness values human life. Compassion can include feeling sorrow that someone was too selfish and cruel to be able to experience true connection or love with another human being. And sometimes thinking about an offender can lead to an understanding of the offender's behavior that grows into a broad and deeply felt compassion for this person.

Thinking about the other person is a central part of the process, because forgiveness is interpersonal, even when it is developed in a letter that will never be sent to anyone. After developing some level of compassion for someone else, a client may be able to contemplate how the client might forgive the other person for what was done. Understanding another person's circumstances is often a necessary prerequisite for true compassion. Marie needed to spend a few weeks thinking about her brother's killer and trying to understand his actions before she was able to think of him as a three-dimensional person, instead of just a hand at the other end of a gun.

She remembered more details from his trial and recalled that he had been raised by an abusive father and left home at age 15. Marie considered that he must have hurt a lot

growing up and might have been desperate for love. This led her to consider that the break-up from his girlfriend might have been even more devastating for him than this would be for most people. She also recognized that drugs and alcohol can cloud people's judgment and lead them to act impulsively. She recalled that the man who killed her brother was soft-spoken at his trial and did not look around the courtroom. She speculated that he might never have intentionally set out to kill someone that night, as she had previously believed. Along with consideration of these possibilities, Marie began to develop some compassion for her brother's killer. She eventually wrote the following on her Writing a Forgiveness Letter worksheet (*MOM2,* p. 265) in response to item 6, regarding how she would want to be viewed by someone she had hurt:

> I hope that this man is able to recognize the irreparable hurt he has caused and that, over time, he finds a way to redeem himself by becoming a better man, even while living the rest of his life in prison.

The final items on the Writing a Forgiveness Letter ask people to describe how they can forgive someone for what they have done and what qualities they possess that will help them take this step. Marie wrote:

> I can forgive you by thinking of all the pressures and pain you felt that clouded your judgment and choices that night. Once you feel the pain of what you have done to me and everyone who loved Jim, then I truly hope you dedicate yourself to living a better life, so you can feel redemption and get relief from your pain.

The qualities she described in herself that would allow her to move forward were these:

> When I wish that for you, then I can also wish for me that I am lifted out of my pain by embracing and living my life to the fullest. I have a good sense of humor and a willingness to help others. These qualities have helped me build close relationships with many people. I am going to appreciate those relationships and know that Jim would want me to be happy. I will hold in my heart the memory of him laughing at me on the phone with my girlfriends because he said I was going to be voted "most likely to keep a conversation going forever." My conversations and relationships give my life purpose and will help me move forward.

Rating Anger Management Strategies

A number of anger management strategies have been proposed: identifying and testing anger thoughts and images, use of anticipatory imagery, recognizing early warning signs of anger, timeouts, assertion, and forgiveness. In order to measure and compare their personal effectiveness, we encourage people to rate their anger before and after they use any of these strategies. This is done on Worksheet 15.5, Ratings for My Anger Management Strategies (*MOM2,* p. 266). With the exception of forgiveness, which

is a longer process, most of these methods can be used a number of times in a fairly short time period. Encourage your clients to practice each of these briefer strategies a number of times before drawing conclusions about their helpfulness. They can keep a record of the results on Worksheet 15.5. Any observations that particular methods are effective anger management aids can increase motivation to use these methods in the future.

Anger as an Issue in Couple or Family Therapy

The same strategies described in this chapter for individual anger therapy can also be incorporated into couple or family therapy when anger is a central issue. As we describe in Chapter 14 of this clinician's guide, couple or family therapy can be ideal for resolving interpersonal difficulties when these primarily occur in family relationships. Couple or family therapy can provide a rich environment for practicing most of the skills taught so far in this chapter, especially testing thoughts that fuel anger, methods for slowing down anger responses, and even forgiveness. In addition, these therapies often include communication training; a focus on increasing positive behaviors in relationships; and exploration of their underlying assumptions about close relationships that fuel hurt, anger, and conflict.

GUILT AND SHAME

Guilt and shame are emotional responses we all can experience when we have "done something wrong." It does not matter if what we did violates social norms of right and wrong. The important criterion is whether we violated our own personal values of right and wrong. For example, political activists can feel guilty if they obey a law that they believe fosters injustice. The difference between these two emotions is that shame imposes the extra weight of believing that whatever we did means we are "bad" persons in some way. Frequently, shame is accompanied by beliefs that others would think less of us if they knew what we did. Therefore, through action or inaction, we often hide information about what we did from others when we feel shame.

Measuring and Tracking Guilt and Shame

When clients record a high frequency of guilt or shame on Worksheet 15.1, Measuring and Tracking My Moods (*MOM2,* p. 253), inquire about the nature of their experiences that evoke these moods. For anger ratings, high frequency scores are likely to indicate multiple situations that evoke it. However, frequent experiences of guilt and shame can reflect either multiple situations triggering these emotions or frequent rumination about one or more previous events. When guilt and shame are mostly experienced about past events, these will be the primary focus of therapy exercises. As with anger, clients can set goals to reduce the frequency, strength, or duration of guilt and shame.

Guilt or Shame Guide for Clinicians: The Flow of Therapy

Clients commonly come to therapy for other reasons; feelings of guilt and shame are disclosed after therapy is already underway. The secretiveness that usually accompanies shame almost guarantees that this emotion won't be revealed until a positive therapy alliance has been developed and time-tested. Thus the methods used in therapy to address guilt and shame depend, in part, on what your clients have already learned. When clients do come to therapy specifically to work on guilt or shame, you can begin using the specific guilt and shame skills taught in *MOM2* Chapter 15 early in therapy. When guilt and shame are secondary to other therapy issues, talk with your clients about their goals and priorities, and collaboratively decide when to address these moods.

Fortunately, the worksheets introduced in Chapter 15 for directly addressing guilt and shame can be used at any point in therapy. Specifically, the sections that follow show you how to help clients assess the seriousness of their actions, weigh their personal responsibility, make reparations when they have hurt someone, break the silence regarding what they did, and find a path to self-forgiveness when necessary.

Exercises in *MOM2* that address guilt and shame can be used for either emotion. People who are hypersensitive to feeling guilt or shame for minor transgressions can especially benefit from using Worksheets 15.6 and 15.7, Rating the Seriousness of My Actions and Using a Responsibility Pie for Guilt or Shame (*MOM2,* pp. 271, 274). When people have in fact harmed others, Worksheet 15.8, Making Reparations for Hurting Someone (*MOM2,* p. 275), can play an important role in resolving these emotions. People who experience shame can experience a great deal of difficulty with self-forgiveness, and yet the Forgiving Myself exercise (Worksheet 15.9, *MOM2,* pp. 277–278), might be among the most important for them. "Breaking the silence" and telling trusted others what they did that causes shame can facilitate this self-forgiveness (*MOM2,* pp. 276–277). Below, we explore in greater detail each of these processes and worksheets designed to address guilt and shame.

In addition to the guilt and shame exercises in Chapter 15, the Guilt or Shame Reading Guide on page 459 of Appendix A here and on Guilford's *MOM2* companion website (see the box at the end of the *MOM2* table of contents) directs readers to other *MOM2* chapters that are helpful for working with these moods. Table 12.2, the Guilt or Shame Guide for Clinicians, links chapters in this clinician's guide with the *MOM2* chapters from this Reading Guide. After clients complete the guilt and shame exercises in *MOM2* Chapter 15, the Reading Guide suggests that readers move on to Chapter 5, Setting Personal Goals and Noticing Improvement. Even though other therapy goals have most likely been set, this can be a time to set goals related to guilt or shame.

Your clients are likely to use the *MOM2* thought record chapters (*MOM2* Chapters 6–9; see Chapters 4 and 5 of this clinician's guide) to learn how to identify, test, and restructure thoughts and images associated with guilt or shame. As shown in Table 12.2, many of the skills taught throughout *MOM2* can be applied to guilt and shame: problem solving, acceptance, identifying and testing underlying assumptions, building new core beliefs, and practices of gratitude and kindness. When guilt or shame is comorbid with other moods, employ the relevant mood chapters. As with all moods, help your

TABLE 12.2. Guilt or Shame Guide for Clinicians: *MOM2* Chapters (in Order Recommended by Guilt or Shame Reading Guide) and Corresponding Clinician's Guide Chapters

MOM2 chapters	Purpose	Clinician's guide chapters
1–4	Introduction to *MOM2*.	2
15	Learn more about guilt/shame and effective methods to express and/or reduce them.	12
5	Set goals. Identify personal signs of improvement.	3
6–9	Use 7-Column Thought Records to identify and test thoughts related to guilt or shame.	4–5
10	Strengthen alternative thoughts. Use Action Plans to solve problems. For problems that can't be solved, develop acceptance.	6
11	Use behavioral experiments to test assumptions associated with guilt or shame and develop new assumptions.	7
12	Develop new core beliefs. Practice gratitude and acts of kindness.	8
13	Learn about depression, if relevant.	9
14	Learn about anxiety, if relevant.	10–11
16	Help make a plan to continue to feel better over time (relapse management).	13

clients construct a relapse management plan before therapy ends, so they will incorporate guilt and shame management skills into their lives. This can also be a time to make a posttherapy plan to boost happiness and a positive sense of well-being.

Understanding Guilt and Shame

Worksheet 15.3, Understanding Anger, Guilt, and Shame (*MOM2,* p. 257), is used to identify the automatic thoughts and images that accompany guilt and shame. Expected cognitive themes include thoughts and images related to having done something that is wrong or has hurt other people. When shame is a primary mood, hot thoughts are also likely to include negative judgments about oneself and expectations of disapproval or rejection if other people learn what happened. You can zero in on the theme that is central for each particular person by asking clients to circle the hottest thought or image among all those identified.

If the person you are working with has already learned to use 7-Column Thought Records, the questions in the Helpful Hints box on page 270 of *MOM2* Chapter 15 are well suited to help look for evidence that does not support the hot thoughts fueling guilt or shame. These questions shift or broaden the perspective used to evaluate actions or

events that give rise to guilt or shame. For example, since people who are guilt-prone often hold themselves to higher standards than they hold other people, the questions include "How serious would I consider the experience if my best friend did this instead of me?" Other questions include the concepts of reparation (e.g., "Did any damage occur? If so, can it be corrected? If so, how long will this take?"). When feeling guilt or shame, people often take responsibility for unforeseen consequences or apply adult knowledge to childhood events. In those circumstances, apt questions are "Did I know ahead of time the meaning or consequences or my actions (or thoughts)? Based on what I knew at the time, do my current judgments apply?"

Most people struggling with guilt or shame find the exercises from Chapter 15 of *MOM2* more helpful than thought records as initial interventions. Once these perspective-shifting skills have been practiced for a number of weeks, 7-Column Thought Records can be a fruitful next step, especially for testing thoughts and images evoked in current situations that are related to guilt and shame.

Assessing the Seriousness of Actions

When people feel guilt or shame in situations that most people consider quite minor, ask them to put their transgressions on a continuum of possible human behavior. Worksheet 15.6, Rating the Seriousness of My Actions (*MOM2,* p. 271). is designed for this purpose. Fill out the continuum at the top of this worksheet with your client in session. This top continuum scale is used to measure all future transgressions. Thus it is important to ensure that the rating of 100 ("Most serious wrong action") is assigned to truly heinous behavior, and that appropriate benchmarks are assigned to minor, medium, and serious actions. This process is illustrated in the following dialogue.

THERAPIST: (*Pointing to the top of Worksheet 15.6*) Here is a scale we are going to use to rate the seriousness of actions. We need to figure out some guidelines for this scale. So let's start by defining the most serious wrong action that any human being can do. There's a lot of bad stuff that has happened in the world. What would you say is the worst?

CAL: Do you mean something like murder?

THERAPIST: That could be it. Or do you think mass murder would be worse than a single murder?

CAL: I guess genocide would be even worse than mass murder.

THERAPIST: Yes. Shall we put that at 100?

CAL: Yes.

THERAPIST: Why don't you write that on your worksheet? (*Pauses while Cal writes "Genocide" above 100 on the scale.*) Now we need to figure out some markers for minor, medium, and serious actions. Where would you put murder?

CAL: I think above 90.

THERAPIST: So what action might you put around 75, which is serious but not that serious?

CAL: Hurting a friend's feelings.

THERAPIST: I've got an idea. Let's make a list of various actions, and then we can decide where they go on the scale. Let's begin by writing "Hurting a friend's feelings."

CAL: Shall I write that down? (*Therapist nods and hands Cal a notepad; Cal starts a list.*) Another thing would be lying. (*Therapist nods, and Cal writes "Lying" on the list.*) And breaking a promise.

THERAPIST: Sure, write that down on the list. (*Pauses while Cal writes.*) We need to make sure we get some pretty serious things for the top part of the scale. What are pretty serious things beside murder that some people do?

CAL: Robbery, rape, stealing a car, selling porn, molesting children. Oh, and hacking websites and stealing people's identities.

THERAPIST: Good ideas. Let's write them on the list.

Note that Cal suggested rating "hurting a friend's feelings" at 75, as a serious action among all possible human actions. It is important that the continuum at the top of Worksheet 15.6 not be limited to actions people like Cal are likely to take. Rather than contradict Cal, his therapist welcomed his idea and suggested he put it on a list before placing it on the worksheet continuum. As Cal began to add items to his list, the therapist noticed that Cal was mostly listing the types of transgressions that he himself tended to feel guilty about (hurting a friend's feelings, lying, breaking a promise). This is quite common. Even so, it is necessary to have a wider range of transgressions on the continuum, so that relatively minor personal actions do not end up being rated nearly as seriously as actions such as murder. This was why his therapist pushed Cal to consider and list a wide variety of "bad actions," and prompted him to think about "pretty serious things beside murder that some people do."

THERAPIST: There are quite a few things on our list now, Cal. Looking at all of them, what do you think is the most serious on our list?

CAL: Molesting children.

THERAPIST: Where do you think we should put this on the worksheet scale?

CAL: I think it is close to murder. Maybe 90.

THERAPIST: OK. Is there anything on your list that is seriously bad but maybe would go below 90? What should we put at a 75 rating of seriousness?

CAL: Hmmm, rape would be really high also. Maybe selling porn would be a 75.

THERAPIST: Would you feel OK writing that on your worksheet?

CAL: I'm not sure. My kids might see this and wonder if I'm selling porn.

THERAPIST: Good point. How do you want to handle that?

CAL: Maybe I could just write "Selling P."

THERAPIST: That's fine. We both know what that means, but other people who could see your worksheet won't know what it means. (*Pauses while Cal writes on*

the worksheet.) And which of the actions on your list might then be less serious than selling porn, but still medium serious and meriting a score of 50?

CAL: I guess robbery or stealing a car.

THERAPIST: Write those above 50 on the scale. (*Pause*) And what would you say from your list is more minor on your scale? Something that is wrong, but maybe only a 25?

CAL: Lying would be about a 25 on this scale.

THERAPIST: OK, write that down. (*Pause*) Let me clarify for a moment. Do you think all lies are equal? For example, would lying and saying you weren't hungry when someone offers food you don't like be equal to lying and telling a friend you were alone when you were really on a date with his ex-girlfriend?

CAL: No, those wouldn't be the same. Lying about the date would be much worse than lying about not being hungry.

THERAPIST: What makes lying about the date worse?

CAL: It is lying to a friend, and the lie could really hurt their feelings.

THERAPIST: So, perhaps instead of just putting "Lying" above 25, you should write "Lying to a friend about something that might hurt them." Or maybe "Lying/hurt friend," for short. What do you think?

CAL: Yes, that would be better.

As is clear from this example, clients' perceptions of the seriousness of their own actions can begin to shift as you help them devise relevant examples for different points on the scale. Working on his own, Cal was prone to put his actions in the middle to upper ranges of the scale. His therapist helped him use Worksheet 15.6 to put his actions in the context of the entire range of human behavior (see Figure 12.1). This is not meant to minimize the importance of being honest with friends or doing one's best to avoid hurting people's feelings. However, lower seriousness ratings can reduce emotional arousal, making it easier for people to figure out appropriate responses and reparations for these types of actions.

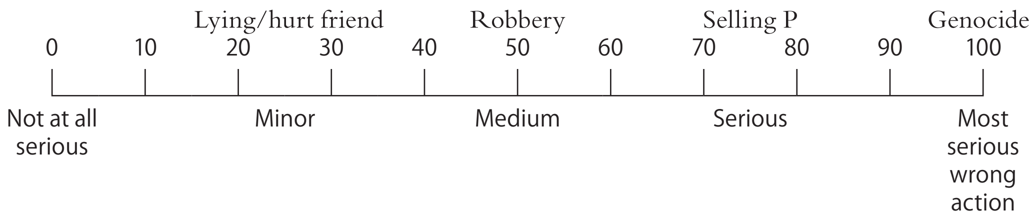
The next step was for Cal to list a minor personal example and his personal worst action, and then rate the seriousness of these on the scale they had just constructed. His therapist guided these steps as follows:

THERAPIST: OK. Now that we have marked different points on this scale, let's see how it can help us rate the seriousness of your actions. Underneath where it says "My personal examples," let's write a sample of a minor thing you do that makes you feel a little bit guilty.

CAL: I guess that would be telling those white lies we just talked about. Like when I say my friend looks good even when it is not their best look. But I don't want to hurt their feelings.

THERAPIST: So write "White lies" there (*pointing to correct place on Worksheet 15.6*). How would you rate the seriousness of that on this scale?

WORKSHEET 15.6. Rating the Seriousness of My Actions



My personal examples:

Minor personal example: White lies Rating I give this: 5

Personal worst action: Cheating on my wife Rating I give this: 65

Action I am rating: ____________________

Rating I give this:

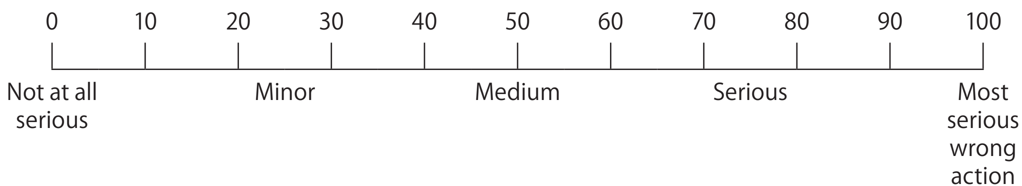


FIGURE 12.1. Kyle's personal anchors for rating the seriousness of his actions, as shown on the top portion of Worksheet 15.6. From Greenberger and Padesky (2016). Copyright © 2016 Dennis Greenberger and Christine A. Padesky. Adapted by permission.

CAL: Maybe a 5 out of 100. (*He writes "5" next to "Rating I give this" on the worksheet.*)

THERAPIST: And what would be the worst action you have ever committed in your life?

CAL: Cheating on my wife.

THERAPIST: Where would you put that on this scale?

CAL: At about 65.

THERAPIST: Worse than robbery or stealing a car?

CAL: Yes. Because this wasn't a crime against a stranger. I hurt someone I loved the most and robbed her of trust.

THERAPIST: OK. That makes sense. Why don't you write your rating of 65 next to "Cheating on my wife"?

His therapist could understand how cheating on his wife violated Cal's values to such a degree that it could be rated as more serious than robbery or car theft, because "this wasn't a crime against a stranger." Cal's score of 65 also provided a highly memorable

and relevant marker against which he could calibrate his other actions in weeks ahead. Cal typically felt guilty about fairly minor things. His betrayal of his wife was much more serious than these and put them in perspective. Once Cal completed these tasks at the top of Worksheet 15.6, he could use the scales lower on the worksheet (and on additional copies or .pdf versions of this worksheet) to rate subsequent actions that evoked guilt or shame. Over time, he was likely to see that many of his actions provoking high levels of guilt were actually quite minor. And, as the next exercise demonstrates, sometimes the outcomes of our actions are not even fully our responsibility.

Using a Responsibility Pie to Weigh Personal Responsibility

People who feel a high degree of guilt or shame sometimes overestimate their personal responsibility for undesirable events or outcomes. When this appears to be the case, therapists can use Worksheet 15.7, Using a Responsibility Pie for Guilt or Shame (*MOM2,* p. 274), to help estimate how much responsibility someone holds for a particular outcome. Similarly, the Using a Responsibility Pie worksheet can be used when someone underestimates and minimizes their responsibility for something. The steps to take in using a responsibility pie with clients are described below. Its more common use is with people who overestimate their responsibility for unwanted outcomes. For people who do not accept enough responsibility for their actions, see the example in the Troubleshooting Guide at the end of this chapter.

People who are guilt-prone tend to take a high degree of responsibility for many things that are multidetermined, even for some outcomes that may be entirely out of their control. For example, how often have you heard people say, "If I had just left the house ten minutes earlier, I could have prevented *X,*" or "It's my fault that my daughter used drugs; I should have been more vigilant." Helping people recalibrate the degree of responsibility they take for events can play an important role in reducing guilt and shame. If they adjust their responsibility from 80% to 50%, for example, they are less likely to feel the entire weight of an unwanted outcome. If they decide that they were less than 50% responsible, there is often additional relief in recognizing that they might not have had the power to change the outcome.

MOM2 gives two examples of completing a responsibility pie. First, Marissa completed a responsibility pie to evaluate her responsibility for being sexually molested by her father (*MOM2,* Figure 15.3, p. 272). As is true for many survivors of sexual, physical, or emotional abuse, Marissa began by assigning most of the responsibility for this abuse to herself. Through the use of a responsibility pie, she was able to reduce her own responsibility to about 10%. The text accompanying this figure states that her therapist eventually helped her see that she did not hold any of the responsibility for her molestation. A second example of using a responsibility pie is given for Vic (*MOM2,* Figure 15.4, p. 273). In this instance, Vic ended up taking more than 50% of the responsibility for his angry outburst at his wife. Vic's example can assure readers that the purpose of using a responsibility pie is not to minimize guilt when it is warranted. In Vic's case, he did hold most of the responsibility for his actions; once he was able to recognize this, the guilt he felt motivated him to make changes in how he managed his anger.

Carefully follow the directions in the Exercise box above Worksheet 15.7 (*MOM2,* p. 274) when you are working with clients who tend to overestimate their responsibility. Once they choose situations for which they take a high degree of responsibility, identify a minimum of four to five people or circumstances that could have contributed to the outcome (more, if possible). Clients often need help identifying other people and circumstances that possibly share a portion of the responsibility. Ask them about other people involved; aspects of the event (e.g., time of day, local context, weather, noise, number of simultaneous demands); internal factors that could affect each person's reactions (fatigue, alcohol/drugs, routine habits, expectations); and other factors that could bear some responsibility for what occurred (e.g., personal history, people who were not physically present but who might have played a role, cultural norms, social biases/discrimination).

It is extremely important for people to put themselves *last* on the list. This is because the next step will be to assign slices of the pie to each identified person or factor that could have contributed to the outcome. If people rate themselves first, they often give themselves a huge slice of the responsibility pie and then divide up the remaining portion of the pie among the other factors. Asking people to rate the other factors first leaves the whole pie available for assignment. Often, by the time they reach the end of the process, only a small slice remains for their own responsibility. This can have a startlingly positive impact. Of course, sometimes at this stage, people decide to reduce the size of other slices to give themselves a larger slice. This is fine—especially because, in most instances, their slice will still be less than 50% of the pie unless they do hold more of the responsibility. The dialogue below shows how Tanya's therapist worked with her on adjusting slices of the pie regarding her responsibility for an argument she had had the previous Saturday night with her husband, Aaron.

THERAPIST: It looks like only about 10% of the pie is still left for your responsibility.

TANYA: That's not right. My piece should be bigger.

THERAPIST: OK. Then which of the other pieces do you think should be smaller?

TANYA: Maybe the fact that Aaron was tired. Maybe he had a right to yell at me and would have done it even if he wasn't tired.

THERAPIST: So what do you want to do? You've got Aaron yelling at 40% and him being tired at 20%.

TANYA: Maybe I'll reduce his responsibility for yelling to 30% and him being tired to 5%. And I'll leave our money problems at 30%.

THERAPIST: That would give him about one-third of the responsibility for your fight, when you add him being tired to him starting to yell soon after your conversation started. Earlier, you said you thought his yelling was the biggest part of what made the fight get so bad for you both.

TANYA: That's right. OK. Maybe I'll keep his yelling at 40%, but put his being tired at 5%. Lots of times he is tired and he doesn't yell at me.

THERAPIST: OK. So why don't you erase the lines around "Tired" to make that a smaller piece? What does that leave for you?

TANYA: About 25% of the responsibility.

THERAPIST: Does that sound about right? Leaving 40% for Aaron, plus 5% for him being tired and about 25% for you?

TANYA: Yes. I think that is about right.

THERAPIST: Item 4 at the bottom of the worksheet asks you about how this responsibility pie affects your feelings of guilt.

TANYA: It helps me see it wasn't totally my fault, even though that is what Aaron told me when he was shouting at me. So I feel less guilty.

THERAPIST: Item 4 also asks if there is some action you could take to make amends for the part you are responsible for.

TANYA: I could apologize for Aaron for what I did that got him mad.

THERAPIST: And what difference does it make for your apology if you feel 25% responsible for the fight versus 100% responsible?

TANYA: I don't think I'll put myself down so much when I apologize. Instead of saying, "I know, I'm a terrible person," I can say something like "I'm sorry I said those things that hurt your feelings. I didn't mean to hurt you. Let's work this out together."

THERAPIST: What difference does that make in how you feel and how you think Aaron will react?

TANYA: I will feel more on an equal footing with him, and that will help me not accept all the blame and figure out a solution that asks both of us to handle things differently.

THERAPIST: How do you predict Aaron will react to that new approach?

TANYA: Actually, I think he will like it. He sometimes gets upset at me when I say, "Oh, I'm such a pathetic human being," because he says that makes it harder for him to talk to me about the things that bother him.

Tanya's therapist stayed neutral regarding her reassignment of responsibility pie slice sizes. However, when Tanya tried to shrink the size of the pie slice assigned to Aaron's yelling, her therapist reminded Tanya of what she had said earlier—that Aaron's yelling deserved the largest slice of the pie. This reminder helped Tanya adjust the pie slices to sizes that fit her current assessment of the factors contributing to their fight. The final item (4) on Worksheet 15.7 asks people to write about the impact of the responsibility pie on their feelings of guilt and shame. Also, item 4 asks how people can make amends for their part of the responsibility. These impacts of the responsibility pie on Tanya were clarified when her therapist asked her what difference taking 25% of the responsibility, compared with taking 100% responsibility (as she did in the beginning), would make when she approached her husband to apologize for her role in their fight. Tanya's answer revealed a further benefit of appropriately sharing responsibility for interpersonal events. When people accept only part of the responsibility, they are able to look for more balanced solutions to problems.

Making Reparations for Hurting Someone

Guilt and shame often revolve around hurting someone else. With minor hurts, people may simply need to apologize and learn to trust others' acceptance of their apologies. Sometimes, even when others no longer hold a grudge, people need to forgive themselves for the hurts they caused (as discussed later in this chapter). However, simply apologizing may not be sufficient when others have been hurt in serious ways, or when more minor injuries have been repeated time and time again. In these circumstances, making amends or reparations can be an important step toward repairing relationships and resolving guilt or shame.

There are multiple stages involved in making an honest effort toward reparations. Worksheet 15.8, Making Reparations for Hurting Someone (*MOM2,* p. 275), provides a step-by-step guide through this process. This reparations worksheet can be filled out in therapy session(s) or as an at-home exercise. The first few items are often relatively easy for people to complete: listing whom they have hurt, what they did that was hurtful, and why it was wrong (relative to their own values). People can have more difficulty figuring out what to do to make amends to the person(s) who were hurt.

Recall an example from earlier in this chapter: Melanie asked her ex-husband, Mark (who was frequently late to pick up their children), to arrive early to ensure that he would not be late. This is an example of "direct amends," in which someone takes some action that is directly related to the hurt. Sometimes, however, direct amends are impossible. This may be because the event was a one-time thing that cannot be undone (e.g., missing someone's wedding), or because a person who was hurt has died or is no longer willing to speak with the person who did the harm. How can reparations be made in these types of circumstances? Looking at the meaning of the hurt and considering surrogate people to whom amends can be made is sometimes a good strategy, as illustrated in the following case example.

Indirect Amends

Constantine was a dispatch officer who answered emergency calls. One day, two calls came in at the same time, and emergency teams were already overloaded from responding to other calls. Constantine was trained to make rapid decisions to determine which call responses to delay in times of necessity. Following protocol, he marked one call he received "urgent" and the other "as soon as possible." Unfortunately, the call marked "as soon as possible" turned out to be an escalating incident of domestic violence that led to the death of a woman and her two children before emergency workers arrived at the scene. This case received wide coverage in the news media. Relatives of the dead woman and children expressed anger regarding the slow emergency response. Even though Constantine was not named in the press, and an administrative review found that he had done everything according to department procedures, he felt extremely guilty and responsible for those three deaths.

How could Constantine possibly make reparations to this dead woman and her children, or to her relatives? His department's legal team forbade him to have any

contact with members of the family; in any case, there was nothing he could really say to them that would ease their grief. After several months, Constantine sought therapy. His therapist encouraged Constantine to talk about his grief for these dead people. During this process, they began to explore his guilt. Constantine agreed that he had "done the right things" according to procedures. He also completed a responsibility pie. Although he could see that their murderer was entitled to nearly all the responsibility for the deaths, Constantine's guilt remained acutely high.

His therapist thought that Constantine would benefit from making reparations. Constantine liked the idea of doing something to atone for his role in the deaths, but he could not think of any meaningful way to do so. His therapist explored the possibilities with him in this way:

THERAPIST: Let's summarize what your role was in these deaths, as you see it.

CONSTANTINE: I did not hear how serious the situation was.

THERAPIST: How often do you think this happens with domestic violence?

CONSTANTINE: I don't know. I would imagine it happens a lot.

THERAPIST: Yes. I think so. Perhaps that gives us some avenues for how you could make amends.

CONSTANTINE: What do you mean?

THERAPIST: I don't have a specific idea. But we do know that this family was one of many in our city who suffer from domestic violence. Would it be meaningful to you to make a difference for another family, since you can't undo what happened to this family?

CONSTANTINE: Maybe. What do you have in mind?

THERAPIST: I'm not sure. Something to do with hearing now how serious their situation was. I don't know exactly how you could honor their memory in a way that could feel reparative for you.

CONSTANTINE: (*Quietly thinking*) I think if I could help another family—another woman with children—it would be meaningful. But I don't know how to do that.

THERAPIST: If we could identify a family, what are your thoughts about how you could help them?

CONSTANTINE: The newspaper said the main reason women don't leave abusive spouses is because they don't have enough money to survive—pay rent and things like that. Maybe I could give money to a woman so she could afford to get into a safer place.

THERAPIST: If you did that, what would that mean to you in terms of your guilt?

CONSTANTINE: It would help, because I would be taking someone else's situation seriously and helping them.

During this discussion, Constantine's therapist weighed the practicalities and risks of his idea. She was aware that there are many complications involved in giving support to a particular family. She also knew that many women return to an abusive relationship after a time away, and imagined that this could cause difficulty for Constantine if this happened to a family he was supporting. At the same time, she respected Constantine's wish to help another family and believed this could make a significant difference for his recovery.

With these issues in mind, she educated Constantine about the systems already in place in their community (shelters for those being abused, social services available, etc.). She asked him if he would feel comfortable finding out from a shelter or social worker how much economic support a mother with two children would need to escape from a violent home situation. Then she suggested that he might pledge as much of this funding as practical for him to a program that could put this money to work for a family on his behalf. This plan made sense to Constantine, and he began to feel some hope that these actions might prove a meaningful way to make amends for the inadvertent outcome of his actions.

Some therapists might think it unreasonable for Constantine to feel a need to make amends at all. He could not have known that the family would be killed. Even if he had prioritized the call, there was no guarantee that the emergency team would have arrived on time. And even if the woman and children had survived that day, there was no guarantee that they might not have been killed another day. If Constantine agreed with these ideas, then he might make amends simply by offering a sincere apology in an imaginal conversation with the dead woman and her children. In this particular case, Constantine was more profoundly shaken by these deaths than a sincere apology could assuage. All of the points made above were discussed with him, without appreciable impact on his guilt. Making indirect but concrete amends in supporting another family felt much more appropriate to him. He eventually made a donation to a local shelter for abused women and children. He continued doing so for a number of years, even after he had paid the cost of one "escape" from a violent home.

Asking for Forgiveness

The final section of Making Reparations for Hurting Someone (Worksheet 15.8, *MOM2,* p. 275) is filled out after people have listed whom they hurt, what they did that was hurtful, why it was wrong (according to their own values), and what they plan to do to make amends. This section is written in the form of a script that a person can say, read, or imagine communicating to the person(s) involved. It summarizes all the information written on the rest of the worksheet and links the amends made to a desire to communicate "how truly sorry I am, and I hope you can forgive me in time." The final phrase, "I hope you can forgive me in time," is intended to communicate to a person making reparations that forgiveness is not guaranteed, even when the person is truly sorry. Even when forgiveness is offered, this sometimes only occurs after amends are carried out and the sincerity of an apology (through actions as well as words) is observed by the offended person over time. Given its structure and content, Worksheet 15.8 is

also ideal for use in couple therapy when one or both partners are making amends for past or present hurts, even when guilt and shame are not primary moods.

Survivor's Guilt or Shame as an Exception

While making reparations seems like a good idea whenever a person feels guilt or shame, it may not be one in the case of survivor's guilt or shame. Murray (2018, 2019) proposed a model for understanding survivor's guilt and shame following a traumatic event in which others die and a person survives. Her model suggests that the survivor's guilt and shame usually follow an appraisal that an "unjust inequity" has occurred. In this circumstance, Murray (2019) suggests that attempts to make reparations will actually maintain guilt and shame, because it is impossible to rebalance such an inequity. Instead, she suggests it may be better to focus on testing beliefs that survival is determined by fairness and equity. Once a client accepts the idea that survival is often not fair or equitable, Murray suggests a worthwhile therapy focus is exploring how to live a good life posttrauma.

Breaking the Silence Surrounding Shame or Guilt

Keeping secrets is bad for our mental and physical health (Larson, Chastain, Hoyt, & Ayzenberg, 2015). When a secret is the source of shame or guilt, most mental health professionals believe it is beneficial for the person keeping it to break the silence and share this secret with one or more trusted people (Brown, 2006; Baumann & Hill, 2016). There is some empirical evidence to support this (see Slepian, Masicampo, & Ambady, 2013). People are more likely to confide secrets to people who are perceived as compassionate and assertive, and less likely to disclose secrets to people perceived as enthusiastic and polite (Slepian & Kirby, 2018). When people are confident in their communication skills, they are more likely to directly confide a secret; when less confident, they are more likely to use indirect methods to reveal the secret (such as making incremental disclosures via text or email), or to reveal it only if they are trapped into doing so (e.g., during an argument) (Afifi & Steuber, 2009).

As might be expected, many people disclose secrets to their therapists. At the same time, more than half of clients in one study reported keeping secrets from their therapists (Baumann & Hill, 2016). Shame or embarrassment was the most common reason given for keeping a secret from a therapist. People fear that telling their secret will lead to criticism or rejection; this fear exists in therapy as well as in the broader world. Clients in this same study reported that they disclosed secrets when they trusted their therapists and when they believed they would benefit from sharing the secrets. For example, most of these clients said they would be more likely to reveal a secret if they thought that hiding it would prevent them from making progress in therapy. They also said they would be more likely to reveal a secret if a therapist asked directly about it. No matter how early or late in a course of therapy secrets are told, sessions in which disclosures are made are characterized by heightened emotional experiences—ranging from shame to vulnerability, anxiety, sometimes relief, and a sense of greater authenticity and intimacy with the therapist.

Helping People Reveal Secrets in Therapy Sessions

These empirical findings provide guidance for ways to help therapy clients break the silence and disclose secrets connected to shame or guilt. First, it is not sufficient to ask only at intake about common secretive events, such as childhood abuse, rape, infidelity, alcohol/drug use, and suicide attempts. Many people will falsely deny these types of experiences to someone they do not yet know or trust. Once some degree of trust has been attained, directly asking about these areas again can make it easier for clients to disclose these types of experiences. Being compassionate and directly assertive in communications with clients throughout therapy will increase their willingness to disclose a secret when it is relevant.

You can also lay groundwork for clients to recognize the benefits of revealing a secret connected to the emotions of shame or guilt. *MOM2* (pp. 276–277) provides a brief description of the benefits that can result from breaking the silence around secrets. Consider asking clients who are thinking about revealing something about themselves to read this section of the workbook, so you can discuss these ideas in session. For clients who experience shame, ask how much time they spend thinking about the secret and what emotions they feel when doing so. Recent research suggests that when secrets are accompanied by shame, people's minds tend to wander a lot to thinking about the secret (Slepian, Kirby, & Kalokerinos, 2019). Jeff's therapist actually helped him notice this effect by reviewing Jeff's own experiences before mentioning the research.

THERAPIST: Jeff, this secret you've mentioned—how often during the past week would you say you thought about it?

JEFF: Almost every day, I guess.

THERAPIST: Once a day, or many times a day?

JEFF: Probably one to three times a day.

THERAPIST: And each time you think about it, how long would you say you spent thinking about it . . . on average?

JEFF: Probably five or ten minutes, sometimes a little longer.

THERAPIST: So it sounds like you spent at least an hour or two in total thinking about it this week.

JEFF: Yes, I would say so.

THERAPIST: Was this week typical?

JEFF: I guess it was. Sometimes I think about it a little bit more, sometimes a little less.

THERAPIST: Can you tell me something you did in that past that other people might keep secret, but you have not? For example, some people hide the fact that they drink or got drunk, or they hide drug use or flunking out of school, or even something goofy about themselves. Other people might tell their friends about these same sorts of things and have their experiences out in the open. Have you told anything like that to others that you could have kept secret?

JEFF: I did get drunk quite a bit when I was younger. I've told my partner and other people about this.

THERAPIST: OK. Can you see how some people could be ashamed of getting drunk, and they could decide to keep this a secret from their partner or friends?

JEFF: I suppose so.

THERAPIST: How much time did you spend this past week thinking about getting drunk when you were younger?

JEFF: None. I didn't think about it at all.

THERAPIST: If this was a secret, how much time do you think you might have thought about it?

JEFF: Hmmm. I see what you mean. I might have thought about it if it was a secret . . . like when we were out with friends having a beer.

THERAPIST: Research actually shows that we think more about something when it is a secret, especially the secrets we feel ashamed about. Once these are brought out in the open, we think less about them.

JEFF: Really?

THERAPIST: Yes. Would that be a benefit for you? To spend less time every week thinking about your secret?

JEFF: Yes, it would.

His therapist used Jeff's actual experiences to bring this first cost of his secret into Jeff's awareness. He followed this a few minutes later by exploring the potential costs for Jeff's therapy progress if he continued to keep his secret:

THERAPIST: We've been working on your shame these past few weeks. On your Rating the Seriousness of My Actions worksheet [Worksheet 15.6, MOM2, p. 271], we put an X for your secret next to "Personal worst action." You made a responsibility pie for your secret at home, and you said it only helped you a little, so I don't know if I could help you with that a bit more or not. Sometimes I think you might not be making as much progress as you could in therapy, because this secret keeps me from being able to help you to my full abilities. What do you think?

JEFF: I have thought about that.

THERAPIST: What are your thoughts?

JEFF: I think if you knew about it, you might be able to help me more. But I'm not sure if I'm ready to tell you.

THERAPIST: What is the worst you can imagine happening if you do?

JEFF: You might find me disgusting. And maybe you wouldn't be able to help me.

THERAPIST: And what is the best that might happen?

JEFF: You might be able to help me feel better. And maybe you won't be disgusted. And I might feel better about myself if I told you.

Notice that Jeff's therapist didn't make promises or offer immediate reassurance to Jeff. At this stage, his therapist was focused on helping Jeff weigh the costs and benefits of revealing his secret. As Jeff imagined various responses his therapist could make after learning his secret, his readiness to tell his therapist or someone else increased. This example demonstrates that good ways to address clients' concerns regarding secrets are to remain honest and to avoid making predictions. For example, Jeff's therapist might say,

> "Since I don't know what your secret is, I can't 100% predict my responses to it. However, maybe my responses to other things you've told me will give you some sense of how I am likely to respond. And I can promise you that if I react with disgust to whatever you tell me, I will work through my reactions on my own time and do my best to continue to help you."

Another way to lay the groundwork for helping clients reveal a shame-related secret is to check on the clients' confidence in their ability to communicate it. Recall the suggestion in the research described above that people who are not confident in their ability to talk about a secret have an easier time revealing information incrementally or indirectly. Thus some people find it easier to reveal their secret in small steps. For example, they might start by telling you how old they were when the information they are hiding occurred, or first telling you a general theme (e.g., "something I did," "something someone did to me," "something I found out"). With each small revelation, they can gauge your reaction. You can also ask them in advance of each revelation to predict what might occur, and then check to see whether their predictions come true or not.

Telling Secrets to Trustworthy People Outside Therapy

It is not always necessary for people who feel shame to disclose their secrets in therapy, although this is often a first step. Usually it will be most therapeutic for clients to reveal their secrets to one or more trusted persons outside therapy. This is because therapists' compassionate, accepting responses to secrets are easily dismissed in terms such as these: "You are paid and trained to be accepting; other people wouldn't feel the same way." The same steps for helping clients reveal secrets to a therapist can be used to prepare them to reveal secrets to trustworthy people outside of therapy. These steps include identifying:

1. The potential benefits of telling someone the secret.
2. People who are likely to respond in a compassionate and honest way.
3. Communication steps that will help the person reveal the secret.
4. Predictions of best- and worst-case scenarios, with coping plans in place.

POTENTIAL BENEFITS OF TELLING SOMEONE A SECRET

It definitely is easier to help clients figure out the potential benefits of revealing their secret to someone else if, as a therapist, you already know the secret. If you don't know the secret, you can still ask questions to prompt clients to consider the costs and benefits of telling another person whom they trust. Benefits can extend beyond relief and the possibility of experiencing acceptance from someone who knows "everything." For example, if clients cut themselves and are suicidal, letting trusted people know this can help set up a stronger and more knowledgeable network for support in times of crisis. If someone who has been raped is having a traumatic response to that assault, and is currently having sexual difficulties with a partner, telling that partner about the rape might help put current difficulties in context and also provide better pathways for resolving sexual difficulties.

IDENTIFYING COMPASSIONATE AND HONEST PEOPLE TO TELL

Clients can tell secrets to people who are not always the obvious choices. Consider a client who feels tremendous shame about being unfaithful to a spouse in the past. If the client is no longer being unfaithful, is the spouse the best person to tell? It can depend on the goals for revealing this secret. If the infidelity has changed the relationship in some way that has been destabilizing since that time, it may be important to reveal the infidelity to the partner, so that both can understand what happened and rebuild trust. However, if the relationship is now going well and the purpose of telling the partner about infidelity is mainly to remove guilt, it may be more productive to tell a therapist or a confessor of some sort (e.g., a member of the clergy, or a family member or friend who will not feel compromised by learning this secret). Talking with someone other than the spouse could still fulfill the goals of revealing to someone else what led to the affair, describing what the impact has been on each of them and on their relationship, and acknowledging the shame and other emotions the person has experienced.

Thus, when clients decide to tell a secret, therapists can serve an important role in helping them evaluate who would be the best person(s) to tell. Usually clients want to choose people whose opinions they respect, who are capable of listening to their story, who are likely to hear their secret with some compassion, and also who can and are willing to keep a secret. It might seem ironic to tell a secret to someone capable of keeping a secret. However, most people don't feel prepared to tell a secret to the whole world, and many secrets do not need to be made public. Thus it makes more sense for clients to tell a secret to someone who is likely to respect their privacy than to tell it to someone known to talk freely about everyone's lives. For these reasons, some clients choose to tell a secret first to a friend rather than a family member.

Secrets can even be shared with strangers to good effect. Sometimes people share secrets with people they meet when traveling away from their usual home area, with telephone counselors working in a crisis call center, or with people with whom they strike up conversations in the course of daily activities. Many people disclose secrets for the first time in forums and online chat rooms. To the extent that people in these settings respond with human kindness, these experiences of sharing secrets can provide many of

the same benefits of talking in person with a therapist, friend, or family member. The only difference is that there may not be the benefits of experiencing acceptance over time in an ongoing relationship.

COMMUNICATION STEPS FOR REVEALING A SECRET

Some people don't need any particular coaching for telling a secret. Once they decide to take this step, they feel confident they can do so. Even so, it can be helpful to ask clients to use imagery to consider how they want this interaction to occur. Alternatively, you might role-play such a conversation with a client in session, to give the person a chance to experience and problem-solve any unanticipated awkwardness or difficulties. It can be helpful to begin a conversation by explaining the reasons a secret was hidden for so long. For example, perhaps there were social risks or the possibility of family censure, as is often the case with revealing LGBTQ+ identity. Some people wait to reveal this identity until one or more disapproving family members have died.

Discussing the time, place, and circumstances for revealing a secret can be as important as considering the person to tell and what to say. Some people choose a situation in which a lot of alcohol is consumed, which is probably not best. Generally, encourage a client to allow ample time to talk about the issue revealed, answer any questions, and discuss any concerns about the other person telling or not telling the secret to others.

PREDICTIONS OF BEST- AND WORST-CASE SCENARIOS, WITH COPING PLANS

Finally, when people are anxious about revealing a secret to a trustworthy person, it can help to make an Action Plan (Worksheet 10.2, *MOM2,* p. 125) for imagined worst-case scenarios. Ask your clients to predict the best and worst outcomes they can imagine for telling the secret. For worst-case scenarios, consider what actions they could take to cope with unwanted responses or outcomes. For example, if the person they tell reacts in a critical or rejecting way, how can they handle it? What might they say or do? How can they accept this reaction? The Acceptance worksheet (Worksheet 10.3, *MOM2,* p. 129) can guide consideration of whether facing rejection is tolerable in light of the goals or values that led to the decision to tell the secret.

It can also be helpful to think about outcomes within a longer time frame than the immediate conversation in which a secret is revealed. Some secrets, such as a history of drug or alcohol use, prior marriages, or LGBTQ+ issues, may be startling or surprising to other people. This surprise factor can at times make it difficult for people to initially express acceptance toward a secret, especially if it turns their views upside down or challenges their values. However, someone who cares about the person revealing the secret might be able to accept unwelcome news or even celebrate it over time. For example, Zoe's therapist helped her cope with the possibility that her parents could reject her when she told them she was lesbian and had moved in with her partner.

THERAPIST: So your worst-case scenario is that your parents will cry and reject you and tell you never to come home again. That's tough. No wonder you have been afraid to tell them about yourself and your relationship with Kylie.

ZOE: Yes. I don't know how I would cope with that reaction.

THERAPIST: Maybe it would help to talk about a timeline for your parents' acceptance.

ZOE: What do you mean?

THERAPIST: When you first thought that you might be lesbian, did you celebrate that idea beginning on the first day?

ZOE: No. Actually, I was bothered by the idea at first and tried to push it out of my mind.

THERAPIST: And how did you get to the point where you could accept being lesbian and even be joyous that you are? Even to today, when you are crazy in love and looking forward to getting married to Kylie next year?

ZOE: I went back and forth on the idea. But I also read about it and met with some other women at the drop-in clinic who were either lesbian or thinking about it. I guess the more I learned about it, the more comfortable I became. And then, when I met Kylie, I didn't have any doubts that being lesbian was how I would be happiest.

THERAPIST: What was the time frame for this change of heart from being bothered by the idea of being lesbian to embracing your identity as a lesbian with a happy future?

ZOE: All in all, about ten months. Pretty fast, actually.

THERAPIST: (*Smiling*) Yes, that is pretty fast. If we had frozen your reaction on the first day and said, "That's it. You are bothered by the idea of being lesbian, so don't think about it any more," would that have been fair to you?

ZOE: No, not at all. I needed time.

THERAPIST: So how much time would you be willing to give your parents to go through their own process of accepting who you are? Do you think it is fair to take their first reaction, freeze that in time, and say that's where it has to remain?

ZOE: Hmmm. I see what you mean. Maybe at first they will be rejecting, but maybe over time they will change their minds, like I did.

THERAPIST: Yes. And you already know some of the things you did that helped you change your mind.

ZOE: Like learning more about it.

THERAPIST: Yes. And you might be able to help them with that when they are ready. And I can also give you some information about the group PFLAG which has information for family members of people who are LGBTQ+ and meetings they can attend (*https://pflag.org*). Sometimes it helps parents if they can talk about their reactions with other parents who have been through or are going through this same process. Also, there is the website of the It Gets Better Project, which is full of personal stories of people's coming out (*https://itgetsbetter.org*).

ZOE: Like I talked with other women at the clinic even before I was sure I was lesbian.

THERAPIST: That's right.

Helping people recall their own trajectory for dealing with their emotional responses to whatever a secret entails can offer hope. Even if others have initial negative reactions to a revelation, these may change over time. There are usually things a person can do or say to help others develop greater understanding and acceptance of the issues surrounding a secret. This may involve multiple conversations about the revealed secret and what this means to the person telling it. It can entail giving these other people information about the issue for them to read and digest later. Thus part of reducing shame can be helping persons with secrets change their stance from passive penitents to active advocates for their better selves.

Self-Forgiveness

Self-forgiveness is often an important step in overcoming shame and boosting overall mental health (Peterson et al., 2017). Achieving this step can be challenging; self-forgiveness is observed to be even harder than forgiving others (Krentzman, Webb, Jester, & Harris, 2018). A point made in the earlier discussion about forgiving others is relevant to self-forgiveness as well: It is not something that needs to apply to everyone. For example, if people feel shame for something that is not their responsibility (e.g., being sexually assaulted), then therapy should focus on eliminating their sense of responsibility rather than on self-forgiveness, because they did nothing wrong. If people are still hurting others in ongoing ways, then self-forgiveness is premature; a focus on ending the hurtful behaviors is more appropriate. It is even possible that promoting self-forgiveness for self-injurious behaviors can decrease motivation for stopping those behaviors, as has been found for problem gambling (Squires, Sztainert, Gillen, Caouette, & Wohl, 2012) and smoking (Wohl & Thompson, 2011).

Fortunately, when it is an appropriate therapy goal and clients are ready for it, the various tools provided in *MOM2* Chapter 15 can collectively support a path to self-forgiveness. Here we offer a brief synopsis of how these *MOM2* interventions can be paired with a four-part therapy approach for self-forgiveness: (1) taking responsibility, (2) experiencing remorse, (3) restoration or reparative behaviors, and (4) renewal of self-compassion (Cornish & Wade, 2014). Generally, people need to take all four of these steps before they can experience genuine self-forgiveness for something they did that violated their personal values.

Taking Responsibility

Worksheets discussed earlier in this chapter can support people in taking responsibility for things they have done that violate their values. Scale ratings from the Rating the Seriousness of My Actions worksheet (Worksheet 15.6, *MOM2,* p. 271) highlights more serious actions that could be considered for forgiveness. The Using a Responsibility Pie

for Guilt or Shame worksheet (Worksheet 15.7, *MOM2,* p. 274) reveals the portions of an action for which someone is responsible. Keep in mind that a responsibility pie can also be used to help someone begin to take at least partial responsibility for events or outcomes, instead of solely blaming others.

Experiencing Remorse

People who experience shame often appear to experience a great deal of remorse. However, unlike guilt (which is characterized by remorse about what one did), the emotion of shame is often tied up in a focus on *being* bad, rather than *doing* bad things and causing harm to others. Thus work on shame and remorse requires a distinction between one's actions and one's innate worth as a human being. Cornish and Wade (2014) suggest one way to do this: a two-chair method in which a client holds a dialogue between the client's self-condemning side and the part that believes the client is worth forgiving. One way to know that this work has been successful is that the client will be more able to focus on the harm caused rather than on self-reproach, and will show interest in reparative behaviors rather than self-castigation.

Restorative and Reparative Behaviors

An earlier section of this chapter has described the use of Worksheet 15.8, Making Reparations for Hurting Someone (*MOM2,* p. 275). This worksheet can be an important precursor to self-forgiveness when one or more specific others have been harmed. As described in that section, people can first make an apology and then either make direct or indirect reparations for the harm caused. When the people who were harmed are no longer living, or if contact is not acceptable to or beneficial for them, apologies can be expressed through two-chair role plays and imaginal conversations. Two-chair dialogues can be especially emotionally powerful and can also aid in perspective taking. For example, a client can take the chair of the person receiving the apology and experience the other's compassion, forgiveness, or lingering resentment. These "responses from the person harmed" can then be addressed by the client (who caused the harm) from the other chair.

Renewal of Self-Compassion

Once clients are ready for self-forgiveness and these other steps have been taken, the Forgiving Myself worksheet (Worksheet 15.9, *MOM2,* p. 278) can complete the process by promoting self-compassion. This exercise reminds people that forgiveness does not mean forgetting or condoning harmful actions. In fact, completion of the worksheet requires describing what one has done, the impact this had had on oneself and others, how it continues to have an effect, and how life might be better if self-forgiveness is granted. The remaining items in the worksheet suggest perspective-shifting steps that can promote self-compassion.

Encourage your clients to spend time on each self-compassion question, rather than

answering them all quickly. For example, people are asked how they would think about someone else who did the same thing, to identify any positive aspects of themselves and their lives that they ignore when feeling guilt or shame, and to write compassionately about how they can understand their actions and forgive themselves for what they have done. Finally, the exercise asks them to reflect on the qualities they have that can help them move forward. Each of these perspective-shifting steps can be explored in therapy sessions and as reflection exercises outside therapy.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTER 15

People Who Blame Others Instead of Feeling Guilt or Shame

Sometimes people underestimate their own responsibility for unwanted outcomes and unfairly assign blame to others. The Using a Responsibility Pie for Guilt or Shame worksheet (Worksheet 15.7) can be used to help these people assume a larger share of the guilt. In working as a therapist with such a client, you will want to put the person first on the list in item 2, instead of last. This makes the entire pie available for consideration of self-responsibility. Also, in this instance you will not work as hard to get a large number of other factors to consider for responsibility; even two or three people or factors are sufficient if this is all the person can think of without prompting. Without these two modifications, people who are prone to excuse their own role in difficulties will easily assign most or all of the responsibility pie to other people and factors before they rate their own responsibility.

It does not ultimately matter if clients fairly take responsibility, as long as they give themselves some of the responsibility rather than none. It is a step forward when someone who normally takes zero responsibility for difficulties accepts even 20% responsibility. Notice how Arno's therapist helped him assign a slice of the pie to himself as they did this work.

THERAPIST: So that is how a responsibility pie works. Let's start for this situation of your losing your job. How much of this would you say was your responsibility? That is, how much do you think your behavior or work style led your boss to let you go?

ARNO: Zero, really. My boss had it in for me since day one.

THERAPIST: Let me make sure I understand what zero means. Would you say every day you worked really hard, did everything your boss asked, showed up on time, and all the other things an employee is supposed to do?

ARNO: In the beginning, sure. But once I could see she didn't like me, I didn't do those things as much. Who would?

THERAPIST: So what are some of the things you did after the beginning that she was able to use as reasons to let you go?

ARNO: When she talked to me with disrespect, I gave her disrespect back. Just to

let her know I wasn't a pushover. And sometimes when she asked me to work overtime, and I knew she was putting more work on me than the others, I told her to shove it.

THERAPIST: Did she list these things in your notice of dismissal?

ARNO: Yes, and she also said some other things, some of which were true and some which were complete lies.

THERAPIST: If you just take the things she said that were true, how much responsibility would you put on this pie for you losing your job to the things you did or didn't do?

ARNO: No more than 20%. The rest was her. And even my 20% wouldn't be there if I had a different boss. That's why I said at first it was all her.

THERAPIST: OK, 20% was your behavior, and that might not be how you would have been with a different boss. Is that right?

ARNO: Yeah.

THERAPIST: Why don't you draw a piece that is about 20% of the total pie?

Arno was someone who was not prone to experiencing guilt. He was generally able to excuse his own behavior and assign blame to others for what went wrong in his life. As a consequence, he had lost many jobs and relationships because he was not open to recognizing his role in difficulties. In the excerpt above from an early therapy session, Arno's therapist managed to maintain a therapy alliance with him and, at the same time, to shift Arno's perspective slightly as to whether or not his own behavior contributed to his difficulties. It was important that his therapist used Arno's own words and frame of reference while working on the responsibility pie for the first time (e.g., "So what are some of the things you did after the beginning that she was able to use as reasons to let you go?"). This shared frame of reference helped Arno acknowledge a small amount of responsibility, which his therapist could later try to expand.

Arno's therapist also wanted to offer a compassionate perspective on the benefits for Arno if he took some responsibility for his difficulties. Arno felt upset with his therapist in a session a few weeks later, and his therapist used this occasion to make this additional point:

ARNO: You keep talking about my responsibility, when others are really to blame for making my life so difficult.

THERAPIST: Yes, I know it is difficult that others seem to constantly be causing trouble for you. If we just talked about them, how would that be for you?

ARNO: Much better. Because then I would know you were on my side.

THERAPIST: I am on your side, Arno. (*Pause*) Let me ask you, if people never caused any problems in your life, how would your life be?

ARNO: Perfect.

THERAPIST: And how would you feel?

ARNO: Relaxed, happy.

THERAPIST: That's a goal I share with you. I would like you to be relaxed and happy. But I'm worried about you.

ARNO: What do you mean?

THERAPIST: I'm worried because right now it only seems you can be relaxed and happy if everyone else stops making your life difficult.

ARNO: That's right.

THERAPIST: I can see how that seems to be the very best solution. My worry is that I don't think everyone in the world will change so they never cause you any problems. And I worry about how angry and stressed you get when people let you down.

ARNO: Uh-huh.

THERAPIST: That's why I keep looking for some bit of responsibility for you. Because if you could take hold of those bits, I hope you could feel relaxed and happy even when people try to make life difficult for you, because you will have some areas you can control. You could learn to make your own happiness, no matter what things people do to you. Do you see what I mean?

ARNO: I think so. Maybe.

When clients like Arno externalize their difficulties, you do not need to disprove the belief that others are the problem. Instead, *find a way to enlist their interest in working on managing their reactions to others.* One way to accomplish this is to express concern for the toll interpersonal problems take on them. Ask how they would feel if these problems were eliminated. Whatever positive states they describe (e.g., Arno said he would be relaxed and happy) can become therapy goals. Indeed, make it a particular therapy goal for these clients to learn how to experience these more positive feelings *in the face of interpersonal difficulties.* Other people cause difficulties in all our lives. Happiness, relaxation, and contentment are more attainable if we learn how to achieve these in the face of life's difficulties, rather than trying to eliminate life's problems.

13

Relapse Management and Happiness

(*MOM2* CHAPTER 16 AND EPILOGUE)

I'm feeling a lot less anxious. How do I know this will last?
—*Client 1 near end of therapy*

What can I do to make sure I don't get depressed again?
—*Client 2 near end of therapy*

I'm starting to feel happier. Will this continue?
—*Client 3 near end of therapy*

Clients want the improvements they experience in therapy to last. Even more, people usually hope that therapy will help them achieve greater happiness. What can we do as therapists to give our clients the best chance for having positive changes endure after therapy? No matter what issues were addressed in therapy, this chapter shows you what to do in the final weeks to boost your clients' chances for continuing their therapy gains and achieving a greater sense of positive well-being after therapy ends. A section at the end of this chapter shows how you can even weave the Epilogue of *MOM2* (pp. 292–296) into these discussions.

In general, for widely studied mood disorders such as depression and anxiety, CBT approaches that teach the skills emphasized in *MOM2* have some of the best rates of positive and enduring change (Hollon et al., 2006). Therefore, continued practice of *MOM2* skills can provide a solid foundation for maintaining therapy gains and expanding positive mood states. And yet no therapy can guarantee that people will not relapse. In fact, some presenting issues, like depression, have very high rates of relapse even after people receive the best evidence-based therapies (Burcusa & Iacono, 2007; Vittengl et al., 2007). People coming to therapy for anxiety disorders fare better; the majority of people successfully treated for the various anxiety disorders do not relapse during post-treatment follow-up studies (Hollon et al., 2006).

MOM2 Chapter 16, Maintaining Your Gains and Experiencing More Happiness, can play a central role in reducing relapse and improving your clients' posttherapy well-being. It walks clients through the process of choosing *MOM2* skills to continue practicing after therapy ends. There is also a guided exercise that shows them how to make a written relapse risk reduction plan. The Chapter 16 Summary reviews the benefits of ongoing skills practice, as well as posttherapy steps any client can take to reduce relapse.

Chapter 16 Summary

(*MOM2,* pp. 280–291)

✓ Learning *Mind Over Mood* skills progresses through three stages: conscious and deliberate practice; being able to use skills in your head with conscious effort; and finally having new behaviors and thinking processes occur automatically, without planning or effort.

✓ People tend to stop using skills once their moods improve, and yet it is better to continue practicing them until their use becomes automatic.

✓ Everyone can expect normal mood fluctuations. It is important to recognize when these begin to become a "relapse" – that is, when moods become more severe, last too long, occur too frequently, or begin to have negative effects on your life or relationships.

✓ The *Mind Over Mood* Skills Checklist (Worksheet 16.1, *MOM2,* pp. 282–285) highlights what skills you have used, how often they help you, whether you still use them, and how often you plan to use them in the future.

✓ The *Mind Over Mood* Skills Checklist also helps you understand that the improvements you have made are the results of your efforts and the skills you have built.

✓ To reduce your risk of relapse, it is helpful to identify your high-risk situations, learn your warning signs, and make a plan of action based on the skills you now possess.

✓ It is helpful to practice your relapse risk reduction plan in imagination when you are feeling well, to test how confident you are that it will help you if you need it.

✓ Even after you finish reading *Mind Over Mood,* keep the book somewhere you will see it, so you can remember what you have learned and continue to practice the skills that help you feel better.

✓ The same activities and skills that lift you out of depression, anxiety, anger, guilt, and shame can also help lift you into positive mood states once you feel better.

SKILLS PRACTICE AND RELAPSE MANAGEMENT

Evidence suggests that people who master and continue to use skills such as those taught in *MOM2* are less likely to relapse than people who do not learn or continue to practice mood management methods (Jarrett et al., 2018; Neimeyer & Feixas, 2016). As described in the *MOM2* Chapter 16 Summary, *MOM2* skills mastery often occurs in three stages: (1) At first, people need conscious and deliberate written practice; (2) over time, skills can be used mentally without writing things down, if people make a conscious effort to do so; and (3) eventually new behaviors and cognitive skills become automatic and do not require planning or effort. A review of where clients are on this continuum of skills mastery can serve as motivation for them to continue skills practice after therapy ends.

Monica had recently been feeling less depressed after increasing her activities and learning to use 7-Column Thought Records. In the second to last therapy session, her therapist raised this issue of practicing skills until they became automatic.

THERAPIST: When you think about your own progress in using activities and thought records to help your depression, where do you think you are at this point with each of them? Do you have to write them out to get benefits? Do you find if you make a conscious effort, you can sometimes figure it out in your head? Or are you using them more or less automatically without thinking about them or writing them down?

MONICA: I can talk myself into doing activities when I don't feel like it by reminding myself of the benefits. I still need to write out thought records, although I told you about that one time I thought of a balanced thought without even writing out a thought record.

THERAPIST: So it sounds like you might not need to write out an Activity Schedule, but you still need to consciously remind yourself about the importance of doing things when you mood and energy are low. What do you think will be the best way to do that after therapy ends?

MONICA: I put a note in my phone that comes up three times a day. It says, "Are you doing anything to help yourself?" That seems to work to keep this on my mind.

THERAPIST: That's a great idea. Will you keep that note in your phone even after therapy ends?

MONICA: Yes, because it really helps.

THERAPIST: Good. The other thing that has really helped your depression is doing thought records. It seems like you still get the best benefits from writing them out, but you had that one experience that suggests you might get to the next stage of being able to do them in your head without writing them out.

MONICA: Yes, that was pretty amazing when it happened.

THERAPIST: It will be even more amazing when that happens regularly. Many people stop filling out thought records when therapy ends, because they don't

have a therapist nudging them to do them any more. (*Smiling*) How will you handle this?

MONICA: I don't know. I have to admit, your nudging and pushing me helps me stick to it.

THERAPIST: What would it be like for you to get to the point where most of the time when you had negative thoughts, you automatically asked yourself, "What's the evidence?" and were able to pretty quickly think about evidence and come up with a balanced or alternative thought?

MONICA: That would be amazing.

THERAPIST: How many more weeks do you think you might have to write out thought records before you got to the point where you could start to do them in your head?

MONICA: I don't know. What do you think?

THERAPIST: You've been using them for eight weeks now. The last two weeks, you've been able to get benefit from them without much help from me. I'm guessing if you wrote one or two out every week for another two or three months, you would get to the point where you could mostly do them in your head. Would you be willing to stick to it that long, or as long as it took to get to that "in your head" skill level?

MONICA: I think so.

THERAPIST: What might be the benefits of your doing that?

MONICA: Like you say, I could get my skills up to the point where I didn't have to write them out.

THERAPIST: Yes. And, of course, if you ever get stuck in a negative place, you could write them out again. When I first got to the point where I could fill out all seven columns of a thought record in my head, I still wrote one down on paper every once in a while—when I got really stuck on a negative thought. The first year, I did this maybe once every month or two. The next year, just a few times. Now I hardly ever have to write them out.

MONICA: So you have used thought records too?

THERAPIST: Yes. They really help me think in balanced ways when my mood gets down. I use all the skills I teach in therapy. They really help.

MONICA: I never thought about you using these skills too. So how do you remember to practice them?

THERAPIST: I've got it easy, because I use them every day in therapy with people, and that keeps them fresh in my mind. How do you think you could keep thought record practice fresh in your mind?

MONICA: Maybe I could use a phone reminder, just like I do for activity planning.

Monica's therapist helped her consider a plan to continue her skills practice after therapy ended. They talked about concrete plans to keep these exercises in her mind throughout the week. And her therapist explicitly suggested that Monica practice skills

in writing until she was able to use them successfully without writing them down. Even once she reached this level of skill development, her therapist acknowledged that occasionally she might still need to write things down to get full benefit.

Notice that one of the advantages for you as a therapist of using these skills in your own life is that this allows discussions of how you have used these skills helpfully across your lifetime. An appropriately timed self-disclosure can model for clients that these are not simply skills people use when in therapy; these are skills that can help them each day, for the rest of their lives.

REVIEWING AND RATING *MOM2* SKILLS

Monica and her therapist established clearly that activity scheduling and 7-Column Thought Records were two primary skills she wanted to continue to practice after therapy ended. How do you and your clients figure out what ongoing skills practice is likely to be worthwhile? Chapter 16 offers an extensive *Mind Over Mood* Skills Checklist (Worksheet 16.1, *MOM2,* pp. 282–285) that people can use to recall and rate the usefulness of skills taught in *MOM2.* This worksheet is divided into core skills that are used with a variety of moods (e.g., "Identify moods," "Set goals," "Identify underlying 'If . . . Then . . .' assumptions," "Practice gratitude by using a gratitude journal") and skills taught in the three mood chapters (Chapters 13–15) that are specific to working with depression, anxiety, anger, guilt, and shame. Ask your clients to rate on Worksheet 16.1, with the 0–3 scale provided, any skills they used during therapy and the perceived helpfulness of each. Next, they can rate how often they still use each skill and how often they plan to use this skill in the future.

Clients are encouraged to rate each of these items, because if a skill has only been used sometimes (a score of 1) and is rated as not at all helpful (a score of 0), this could indicate either that the skill is not helpful for them or that they need more practice with it until its effectiveness can be assessed. However, if a skill has been used frequently (a score of 2) and is rated as not at all helpful (a score of 0), then this skill is probably not helpful for this client. If someone finds it daunting to make all these ratings, then it can be sufficient just to use checkmarks for the skills used, still used, and planned for future use.

In all cases, encourage your clients to rate on the 0–3 scale the helpfulness of each skill used, because this information is used to help determine which skills to emphasize as part of relapse management. Make sure you review the columns with helpfulness ratings and future use plans in a therapy session, even if clients fill out Worksheet 16.1 at home. Also, ask clients to circle or mark in some way any skills that have already become automatic for them. Linking these acquired skills to progress made in therapy is another way to reinforce the lasting benefits of skills practice.

REDUCING THE LIKELIHOOD OF RELAPSE

Relapse management planning is an important final stage of evidence-based therapy practice. As described in Chapter 16 of *MOM2,* people can take three steps to reduce

the likelihood and severity of relapse: (1) identify high-risk situations, (2) identify early warning signs, and (3) prepare a plan of action. The final session(s) of therapy can be devoted to these steps. Your clients will leave therapy with a written relapse management plan that summarizes your discussions if they complete Worksheet 16.2, My Plan to Reduce Relapse Risk (*MOM2,* p. 288). Each of these three steps is summarized in the following sections, as are the benefits of imaginal practice of a relapse management plan.

Identify High-Risk Situations

To figure out what future situations could entail a high relapse risk for a given client, consider the predisposing situation or other factors that brought the person to therapy in the first place. Someone who enters therapy because of becoming depressed after a relationship break-up is likely to list "relationship break-up" as a future high-risk situations. The reasons a relationship break-up was especially hard for this person will provide clues for additional high-risk situations. For example, perhaps the break-up created a crisis in part because the person did not have the financial means to live alone. In that case, financial setbacks such as losing a job or interpersonal difficulties with a roommate would also be listed as future high-risk situations.

Usually people have a variety of ideas for what types of situations could be high-risk ones for them. These can include stressful life events (both positive and negative), relationship changes, work, parenting challenges, illness, or even expected mood fluctuations. Situations that occurred frequently in thought records, behavioral experiments, or Action Plans are also good candidates to consider. Ask your client to write these high-risk situations in the first section of Worksheet 16.2.

Identify Early Warning Signs

"Early warning signs" are indicators that moods, thoughts, and behaviors are beginning to revert to patterns that are potentially problematic. Review of exercises your client has completed in *MOM2* during therapy will bring a number of early warning signs into your and your client's awareness. Ask your client to write these down on Worksheet 16.2. For example, some of the changes listed on Worksheet 2.1, Understanding My Problems (*MOM2,* p. 14), can be clues to early warning signs. If "staying home alone" was listed on that worksheet, then avoiding people or spending more than two days at home alone could be early warning signs of a troublesome pattern. Discuss with your client which experiences recorded on that worksheet could be future early warning signs. Common early warning signs of mood difficulties include behavior changes (e.g., avoidance, social withdrawal, overactivity, risk taking, substance misuse), troubling thoughts (e.g., self-criticism, worries, hopelessness), and physical changes (e.g., sleep changes, appetite shifts, tension, fatigue).

An advantage of completing mood ratings throughout therapy is that these same ratings can be used as early warning signs of possible relapse. Clients who have been regularly using the *Mind Over Mood* mood inventories (Worksheet 13.1, the Depression Inventory, p. 191; Worksheet 14.1, the Anxiety Inventory, p. 221; or Worksheet 15.1,

Measuring and Tracking My Moods, p. 253) will have a good idea of their progress and can also estimate what scores on these worksheets might signal a return to unwanted mood states. If Worksheet 15.1 has been used to track frequency, strength, or duration of moods, determine with your client which dimension(s) are the most likely early warning signs of relapse and what ratings would trigger concern.

In general, if scores have been stable and low for the depression and anxiety inventories in the final weeks of therapy, any rise in scores of 5–10 points can be used as an early warning sign. If scores continue to fluctuate on either of these inventories, even as therapy is coming to an end, this can be a sign of heightened relapse risk (Vittengl et al., 2007). In this instance, it is recommended that therapy continue (even on a monthly basis) until mood scores are low (ideally, scores less than 6) and stable. If this is not possible, you and your client should make a concrete plan for continued skill development and practice after therapy, using *MOM2* or other resources as a guide.

Prepare a Plan of Action

Once high-risk situations and early warning signs are described on Worksheet 16.2, My Plan to Reduce Relapse Risk (*MOM2,* p. 288), it is time to make a plan of action. The plan of action describes what steps your clients will take and what skills they plan to practice when early warning signs begin to appear (item 3 on the worksheet). This plan of action is ideally written in simple language with clear steps. To help someone make this plan, review the skills from the *Mind Over Mood* Skills Checklist (Worksheet 16.1, *MOM2,* pp. 282–285). What skills have proven particularly helpful for this client? Which skills do you and the client think would be best to use if a relapse risk arises?

Be sure to scan the entire checklist, not just skills listed in a particular mood chapter. For example, although clients who notice their anger and irritability signals rising dangerously are likely to benefit from practicing the skills listed in the Anger Skills section of Worksheet 16.1 (p. 284), they might also find 7-Column Thought Records (pp. 282–283), expressing gratitude (p. 283), and use of a responsibility pie (p. 285) helpful. Finally, think about the most useful ways to practice chosen skills. Which skills are most helpful as "quick responses" when warning signs begin, and which skills can be practiced regularly to maintain stability of gains over time?

Engage in Imaginal Coping Practice with the Plan of Action

Ideally, it will be months or even years before your clients face a risk of relapse. What is the likelihood that they will even remember their plan of action at that future time? One way to increase the likelihood that a plan of action will stay fresh in someone's mind is to rehearse its use in imagination. Therefore, spend a bit of time in the final session(s) asking your clients to imagine one or more high-risk situations accompanied by a number of their early warning signs of relapse. Let them vividly imagine this possibility until they begin to capture likely thoughts, emotions, and motivational changes.

At this point, ask the clients to vividly imagine taking each step of their plan of action. Ask them to notice barriers to action, as well as how these action steps affect their thoughts, moods, behaviors, and physical responses. Once clients have completed

this imaginal exercise (which usually takes 10–20 minutes), ask how confident they are that Worksheet 16.2, My Plan to Reduce Relapse Risk, will be sufficient to help them feel better again once they begin to relapse. Low to medium confidence in a plan is a sign that further coping skills or resources need to be added.

Imaginal rehearsal of an action plan for managing high-risk situations can also be employed to encourage people to continue skills practice after therapy ends. In the following final therapy session, Bridgette's therapist used a metaphor to drive this point home.

THERAPIST: How confident are you now in your plan of action to reduce relapse?

BRIDGETTE: Very confident. I know how to use these skills if I need to in the future.

THERAPIST: I'm glad. It may be like riding a bicycle. Once you know how, you never forget. Or do you think it will be more like speaking a foreign language? If years go by and you don't practice, it is easy to get rusty and forget a new language.

BRIDGETTE: Hmmm. I'm not sure.

THERAPIST: Which is more difficult? Riding a bike or speaking a foreign language?

BRIDGETTE: I would say a foreign language. It is more complicated.

THERAPIST: And which do you think these skills are more like? Simple, like riding a bicycle, or a bit more complicated, like speaking a foreign language?

BRIDGETTE: More like a foreign language I think. With a bicycle, you do the same things over and over again. But these skills were a bit trickier to learn.

THERAPIST: So what do you think would be a good way to make sure you don't get rusty in speaking this new skills language you have learned?

BRIDGETTE: I should probably practice them periodically so I don't forget.

THERAPIST: What would be the best and most practical way for you to remember to do that?

The metaphors of riding a bicycle and speaking a foreign language illustrate that *skill complexity* influences how often a person needs to practice a skill to maintain it. When Bridgette was asked to think about the *MOM2* skills while they were fresh in her mind, she recognized that she would benefit from continuing to practice them. One of the final goals of therapy is to help your clients recognize the importance of lifelong skills practice and motivate them to continue using skills learned after therapy has ended. As described in the next section, *MOM2* can serve as a useful posttherapy guide to support these efforts.

USING *MOM2* AS A POSTTHERAPY GUIDE

MOM2 provides a helpful reference and posttherapy guide for continued learning. Although *MOM2* does not address every problem for which people seek therapy, it

does teach "common denominator" skills that can help people solve a wide range of problems. It helps people understand problems, identify moods, identify thoughts and assumptions, gather data that do and do not support automatic thoughts, generate alternative views, develop Action Plans/coping strategies, plan and carry out behavioral experiments to test assumptions, make behavioral changes, guide acceptance/gratitude/kindness exercises, and evaluate core beliefs.

People can use *MOM2* after therapy in a variety of ways, depending on their skill strengths and deficits. Those who have used the workbook with good success in therapy are often inclined to work with it independently after therapy ends. When skills are still being developed at the end of therapy, *MOM2* can guide continued practice until these are mastered. Sometimes one presenting issue or mood has been successfully addressed in therapy, but others remain when therapy must end. Clients can apply *MOM2* skills they have learned to these additional issues, or can learn additional skills from other chapters of the workbook after therapy. To encourage this ongoing use, we suggest that clients set *MOM2* in a place or location where they are likely to see it periodically.

Some clients enter therapy multiple times and/or make limited progress in therapy. Arlene used *MOM2* in a variety of ways over years of treatment. Due to the mental health services available in her area and her limited finances, she could only receive a maximum of 12 therapy sessions per calendar year. With her first therapist, she used *MOM2* to help identify moods and link them to behaviors, thoughts, situations, and physical experiences. Later she attended a *MOM2*-based therapy group recommended by her therapist. In this group, Arlene learned to use 7-Column Thought Records to evaluate her reactions to people and situations. These skills helped attenuate her moods somewhat.

Arlene's overall functioning fluctuated, depending on the number and intensity of stressors in her life. *MOM2* was most helpful to her when she was functioning relatively well. The skills she learned helped her function better more often than not. During periods of poor functioning, Arlene often forgot or chose not to use *MOM2*. She would occasionally sink into a vegetative depression or enter periods of enraged hostility. When Arlene attended therapy during these times, her therapist was able to help her achieve emotional balance within a few days. If her 12 therapy sessions for the year were already completed, Arlene sometimes suffered for weeks at a time. After noting this pattern, she and her therapist decided that her third year of therapy would consist of crisis-only sessions to reduce the length of these periods of low functioning. Arlene agreed to use *MOM2* as a first resort in times of trouble. If she was not able to use the workbook and achieve emotional stability within a few days, she would call her therapist for an appointment. Over time, *MOM2* became a stabilizing resource for Arlene.

ENHANCING HAPPINESS AND POSITIVE EXPERIENCES WITH *MOM2*

Most people are introduced to *MOM2* at a time when they want to manage disruptive moods, make changes in their behavior or relationships, or stop maladaptive life patterns. The skills taught in *MOM2* can help people reach all these types of goals. Once these original therapy goals are achieved, people often have new goals that are more

positive and aspirational. People can want to experience a better sense of well-being, sustain efforts to reach new positive goals, or establish better relationships. Fortunately, the skills taught in *MOM2* can help people achieve these positive goals as well.

Some *MOM2* skills are drawn from positive psychology and are designed to have positive effects on well-being. Keeping a gratitude journal, expressing gratitude to others, and performing acts of kindness (*MOM2,* pp. 175–185) are three practices that are likely to enhance well-being and happiness when incorporated into therapy as described in Chapter 8 of this clinician's guide. Similarly, acceptance and mindfulness are methods that, with sustained practice, can lead to a greater sense of positive well-being (*MOM2,* pp. 126–129, 241–242). The frequency, strength, and duration of positive well-being, happiness, and other positive qualities (e.g., resilience, courage, kindness) can be rated on Worksheet 15.1, even though that worksheet is more narrowly titled Measuring and Tracking My Moods (*MOM2,* p. 253). These ratings can be used to track positive progress over time.

Steps toward positive change can be outlined on Action Plans (*MOM2* Chapter 10). Behavioral experiments (*MOM2* Chapter 11) can be designed either to try out new ways of being or to test assumptions that interfere with reaching positive goals. Happiness and well-being can be boosted when clients learn to savor small positive experiences (*MOM2,* p. 217) and to engage in activities that are pleasurable, accomplish things important to them, and fit with their values and positive aspirations (*MOM2,* pp. 210–217). All these *MOM2* skills designed to improve positive well-being can be introduced at any time throughout therapy, as appropriate.

MOM2 EPILOGUE: FOR READERS AND THERAPISTS

Instead of a Troubleshooting Guide, we end this chapter with recommendations for ways to use the Epilogue of *MOM2* (pp. 292–296) to encourage clients to continue their skills practice and also to address the hopelessness many clients with depression experience early in therapy. Originally we wrote the Epilogue because our clients and readers of early drafts regularly asked us what happened to the main characters followed in the book: Ben, Marissa, Linda, and Vic. When we reminded them that these were not actual people, they would frequently say, "Yes, I know. But what happened to them?" People were genuinely interested and curious to know the rest of the story about these characters' lives, even though they knew these people were fictional composites of clients we have seen in therapy. We realized that their questions about Ben, Marissa, Linda, and Vic were also a way of asking, "What can I expect?" and "How much can these skills help me?" Therefore, we wrote *MOM2's* Epilogue to tell a bit about these characters' future stories and to offer realistic hope to readers who identify with them.

The Epilogue also became an opportunity to embed additional information therapists could find helpful. We have provided graphs of Ben's and Marissa's weekly depression scores (*MOM2,* Figures E.1 and E.2, pp. 293 and 294). These graphs show two quite different patterns of improvement in CBT for depression. Ben's graph actually mimicked average scores in an early research trial of CBT for depression. Thus it models a common change trajectory in successful CBT. Figure E.1 looks quite perfect in its

positive and rapid treatment outcome when viewed as a whole. However, if you cover up the weeks of the chart after the first six, you can see that Ben's positive outcome did not look certain in the early weeks of therapy.

We sometimes show Figure E.1, Ben's weekly depression scores, to depressed clients who express hopelessness in the fourth to sixth week of therapy, especially if they are engaged in learning skills and seem poised to improve over time. At this point in therapy, they have been working hard for a number of weeks and yet are usually still quite depressed. While covering the remaining weeks with a piece of paper, we show them the first number of weeks of the chart that match their time in therapy (not counting the intake interview). We ask how Ben's scores compare with theirs and whether it looks to them as if Ben was improving. Ben was a pessimist in the early stages of his therapy (and the early chapters of *MOM2*), so we sometimes ask them to guess what Ben thought and felt about his progress at this point in his therapy.

Then we remove the paper and show them the rest of Ben's chart. This prompts a discussion of why observable changes in depression can take some time. In fact, noticeable changes in depression scores generally do not begin to appear until after six to eight weeks of CBT. This seems to match the amount of time it requires for people to begin effective use of the skills of behavioral activation and/or 7-Column Thought Records. Fortunately, once improvements begin, depression scores can show steady gains in most weeks.

Not everyone will experience improvement in their depression as rapid as Ben's. We thought it important to include a different recovery picture that occurred over a much longer time frame, so that readers who were slower to respond to treatment would not see themselves as failures. Marissa's depression scores graph in Figure E.2 resembles score patterns obtained by people we have treated who met criteria for both major recurrent depression and borderline personality disorder. Even nine months into Marissa's CBT skills practice, she experienced levels of depression that were too high for her to be considered in remission. Even so, the description of Marissa's life in the Epilogue demonstrates that her lower levels of peak depression made a big difference for her. She would need to continue her skills practice until her scores were reliably below 6, and she was headed in that direction.

Most of your clients will have a depression score graph that is somewhere in between the graph shown for Ben and the one shown for Marissa. Use these graphs in the Epilogue to give people hope. If they stick to their *MOM2* skills practice over time, they can experience improvement in their depression and positive life changes as well.

The Epilogue's description of Linda's life after therapy is consistent with the positive and enduring outcomes that can be expected for most people who receive CBT for panic disorder and phobias. It also fits with her presentation throughout *MOM2* as someone who was relatively confident and successful in other areas of her life. The *MOM2* skills she learned generalized to other areas of her life (e.g., managing work pressures), which is consistent with what we have observed in people who have successful anxiety treatment outcomes.

The Epilogue's summary of Vic's future life story is more complicated than Linda's. This is fitting, given his ongoing struggles to stay sober, work on his marriage, and manage anger, depression, and anxiety. His story offered an ideal opportunity for us

to flag the importance of Worksheet 16.2, My Plan to Reduce Relapse Risk (*MOM2,* p. 288), which is the last worksheet most people fill out before reading the Epilogue. Like those of the three other main characters, Vic's future would look brighter if he continued to practice the skills he found most helpful during therapy. This message is underscored in the final paragraph of *MOM2*:

> Chapter 1 of *Mind Over Mood* described how an oyster turns an irritant into a valuable pearl. Our hope is that *Mind Over Mood* has helped you learn new skills to . . . transform future irritants into valuable pearls. (*MOM2,* p. 296)

In the same way, we hope that this step-by-step clinician's guide helps you learn and master new therapy skills. By doing so, you can use *MOM2* to help transform challenges in your daily therapy practice into learning opportunities for you and your clients. Section II (the final two chapters of this book) offers additional information about using *MOM2* in individual, couple, and group therapy.

Section II

Mind Over Mood in Context

14

CBT Principles in Individual and Couple Therapy

THERAPIST: I'm going to ask each of you to read a few chapters from this book, *Mind Over Mood,* to learn some skills that might help you during your fights.

CESAR: Do we read it together?

THERAPIST: Sometimes you might want to do that. Other times you will do the exercises individually, and we will discuss what you learned in session.

SHAINA: Can this book also help me with my depression?

THERAPIST: Yes, it can. I'll recommend the best sections for you to use for depression, if you want to use it for that as well.

The final two chapters of this clinician's guide put the second edition of *Mind Over Mood* into a fuller CBT context. Many therapists and clients see self-help books and individual or couple therapy as existing at the opposite ends of a continuum. When troubles are mild, they think that a self-help book is sufficient. When difficulties are serious, they assume that the attention of an individual or couple therapist is required. *MOM2* is a self-help book that can also be a full-fledged therapy workbook, teaching the same evidence-based skills taught in CBT. Throughout this clinician's guide, we have tried to demonstrate how the full potential of *MOM2* is revealed when it is put in the hands of a skillful and knowledgeable therapist, capable of individualizing and adapting its use for clients seeking help.

The first 13 chapters of this clinician's guide show how, when, and why to use specific *MOM2* chapters in therapy. Here in Chapter 14, we highlight CBT principles and processes that can guide effective use of *MOM2* in both individual and couple therapy. We address a number of issues not explored elsewhere in this book, such as case conceptualization, collaboration, and the role of empiricism in CBT. At the end of this chapter, before the Troubleshooting Guide, we briefly outline ways *MOM2* can be used in treatment for substance misuse and abuse; we do this to provide a sample of the

creative ways clinicians can apply *MOM2* in therapy for issues other than moods. Finally, in Chapter 15, we demonstrate how to integrate *MOM2* into CBT group therapy.

THE GREAT VARIETY OF CBT APPROACHES: A "MANY THERAPIES" VIEW

You will see many different faces of therapy from hour to hour if you observe a skilled CBT therapist over the course of a day. In the first hour, this therapist works on a 7-Column Thought Record with a client who feels depressed. In the next appointment, she and her client are hyperventilating together and running in place to induce feared sensations related to panic disorder. In the third hour, she conducts a role play in which she criticizes her client who experiences social anxiety, in order to create an opportunity to practice Assertive Defense of the Self (Padesky, 2008a, 2008b). In the last appointment before lunch, she is working with a couple on communication and anger management skills. In her afternoon appointments, this same therapist may teach mindfulness meditation, drive in a car with a client (to test fears related to the client's driving phobia), introduce exercises that cultivate acceptance, and review gratitude diaries.

What you are unlikely to see is a therapist who sits in her chair all day long listening and talking to clients without doing any of these other activities. CBT is filled with interactive writing, behavioral experiments, role plays, written exercises, and imagery exercises both inside and outside the therapy office. One reason for this variety of therapy methods is that CBT is an "evidence-based therapy" approach. That is, therapists strive to use whatever therapy methods are most effective for particular issues according to empirical studies. As illustrated throughout Section I of this clinician's guide, therapists are taught to use different methods with depression, each of the anxiety disorders, anger, guilt, shame, eating disorders, psychosis, substance misuse, relationship difficulties, pain management, and so on. There are specific, and usually research-tested, CBT methods for nearly every issue experienced by people who walk into a clinician's office. The skills taught in *MOM2* are likely to be helpful for most of these clients.

Given the variety of approaches a CBT therapist can use, you might wonder: Does "CBT" refer to one therapy or many different therapies? The answer to this question is even more complicated than the Section I chapters suggest. There are sometimes multiple evidence-based CBT approaches for a given disorder. For example, as we have noted in Chapter 11 of this guide, there are four different CBT theories that help explain GAD: Beck's general model of GAD as a disorder characterized by overestimation of danger and underestimation of coping and resources (Clark & Beck, 2011); Dugas's theory that GAD results from intolerance of uncertainty (Dugas & Ladouceur, 2000; Hebert & Dugas, 2019); Wells's metacognitive theory, which proposes that beliefs about worry are key (Wells, 2009); and Riskind's model of "looming vulnerability" appraisals in GAD (Katz et al., 2017). Each of these theories has a research evidence base to support it and a therapy approach derived from the theory, which has proven effectiveness in research trials. Therapists can review the evidence, choose a model for GAD that makes most sense to them, and follow that approach with confidence that they are following an evidence-based treatment. Therefore, clients seeking CBT for GAD may

receive somewhat different explanations and treatments for their difficulties, depending upon which CBT therapist they choose.

There are more than 25 named versions of CBT currently practiced throughout the world. Thus it can seem most appropriate to say that CBT is many therapies, not one. Given the diversity and complexity of the field, many CBT therapists become specialists in one or two CBT approaches and use these with the majority of their clients. Others learn a variety of CBT approaches and apply them as suited to particular clients. This is not a complete list, but here are some of the forms of CBT with which you may be familiar:

- Acceptance and commitment therapy
- Applied relaxation
- Behavior therapy
- Behavior analytic therapy
- Cognitive therapy
- Cognitive processing therapy
- Cognitive behavioral analysis system of psychotherapy
- Compassion-focused therapy
- Dialectical behavior therapy
- Exposure and response prevention
- Exposure therapy
- Eye movement desensitization and reprocessing
- Functional analytic psychotherapy
- Integrative behavioral couple therapy
- Metacognitive therapy
- Mindfulness-based cognitive therapy
- Narrative therapy
- Problem-solving therapy
- Rational–emotive behavior therapy
- Schema-focused therapy
- Strengths-based CBT
- Stress inoculation training

The advantage of all these forms of CBT is that, with greater specificity in our clinical methods, we are better able to help many more individuals in therapy today than we could 40, 30, 20, or even 10 years ago. These advances were made possible in part because the field of CBT has been committed to empirically testing theories and practices, in order to create evolving forms of evidence-based psychotherapy. In recent decades, most other schools of psychotherapy have also begun to measure what works and for whom.

What Is Evidence-Based Therapy?

An evidence-based therapy, as noted above, is one that has demonstrated effectiveness for particular clinical issues. Research to evaluate the effectiveness of a type of therapy can begin with laboratory tests of its theory and/or data collection in a single case study or for a small group of clients. Psychotherapy approaches that show promise in these smaller studies are eventually evaluated in larger randomized controlled trials (RCTs). Initially, these RCTs often compare a new treatment to a waiting-list control group. The strongest tests of therapy effectiveness compare a new treatment with existing evidence-based therapies, examining both treatment outcomes and relapse rates. Over time, meta-analytic studies pool a number of these research studies together to provide an even better understanding of how likely a particular therapy is to be effective and whether it is more or less effective than other therapies.

A review of more than 100 meta-analyses (Hofmann et al., 2012) found that CBT has demonstrated effectiveness for the following: anger control issues and aggression; depression and dysthymia; various anxiety disorders (GAD, panic disorder, social anxiety, and specific phobias); OCD; PTSD; body dysmorphic disorder; psychosis; delaying relapse in bipolar disorder; reducing recidivism rates for criminal offenders; anxiety and stress related to some medical conditions; bulimia nervosa; chronic fatigue, chronic pain, and fibromyalgia; insomnia; smoking cessation relapse; problem gambling; cannabis dependence; and stress management. Many other applications of CBT have not yet been as adequately studied, so they cannot be subjected to meta-analysis.

The Continuing Evolution of CBT Approaches

As successful therapies emerged, researchers and clinicians turned their attention to people who did not benefit from then-current approaches and to the prevention of relapse for problems that were likely to reoccur. A focus on relapse and clients whose experiences were chronic or nonresponsive to standard treatments led to experimentation with additional variations in methods, some of which are described in various chapters of this clinician's guide. As CBT spread across the globe and into various types of community settings, cultural adaptations were made for specific client populations (see, e.g., Iwamasa & Hays, 2019). In sum, many different CBT approaches have emerged in the field's quest to find effective therapies for every mental health condition, and to modify therapy methods as necessary to help as many people as possible.

COMMON PRINCIPLES OF CBT: A "ONE THERAPY" VIEW

For many clinicians, the "many therapies" view just described is overwhelming, because it offers too many choices for them to feel confident that they are choosing the best approach for a given client. As a response to feeling overwhelmed, some therapists throw out other things they know and get rigidly stuck in one model, instead of benefiting from the flexibility of clinical practice that a diverse clientele requires. Other

therapists simply throw up their hands and reject CBT entirely, because it all just seems like too much to learn.

As an antidote to these scenarios, we favor a "one therapy" view, which acknowledges the diversity in CBT practice methods available and yet focuses on the common principles of CBT that tie all these approaches together. A "one therapy" view of CBT encourages therapists to use a variety of therapy methods to suit clients' needs, as long as these have some clear purpose consistent with CBT principles and with evidence-based theories and practices. Therapy methods can include classic CBT methods (e.g., written exercises, or experiential methods such as role playing, imagery, exposure, or behavioral experiments), as well as methods drawn from "other" therapies, such as hypnosis, body awareness exercises, dream work, drawing, and music.

We consider the following four principles central to the "one therapy" view of CBT:

1. Use CBT-based case conceptualizations for understanding presenting issues.
2. Create and maintain a collaborative therapy relationship.
3. Be guided by empiricism.
4. Emphasize skill acquisition and aim to achieve enduring improvements in people's lives.

There are a number of clinical advantages to viewing CBT as one therapy. In addition to providing the flexibility of drawing from a wide variety of clinical methods, it offers an integrative framework for thinking about the field, which encourages an even-handed consideration of different CBT approaches. "Even-handed" in this context does not mean that each CBT approach is considered equal to all the others for any given client. Instead, evaluation of whether a given CBT approach can be helpful for a particular client is based on an individualized conceptualization, collaborative decision making, and empirical evidence. Emphases on client skill acquisition and enduring improvements maintain a therapy focus on client needs, goals, and strengths throughout therapy. The following sections elaborate on these four common principles of CBT and summarize ways that *MOM2* and this clinician's guide can assist you in following them with people you see in individual and couple therapy.

Principle 1: Use CBT-Based Case Conceptualizations

CBT case conceptualizations link behavior, cognition (which encompasses all types of thoughts, including images and memories), emotions, physical experience, and environmental context. Many therapists are taught to construct case conceptualizations on their own between sessions, based on information gathered about each client. There is actually little empirical evidence that this is the best way to formulate a case conceptualization, or even that therapists given the same information about a client will formulate what is going on in the same way (see Kuyken, Fothergill, Musa, & Chadwick, 2005). A case conceptualization that cannot achieve reliability among a

group of therapists cannot be considered valid. Therefore, we propose an alternative to clinician-constructed case conceptualizations. We favor constructing individualized case conceptualizations collaboratively with clients in session, because this is the only way to make sure that you and your clients reach a shared understanding of their presenting issues.

The Five-Part Model (Descriptive Case Conceptualization)

Kuyken et al. (2009) offer a detailed model to guide CBT case conceptualization. They propose that there is no such thing as a single case conceptualization for a given person. Instead, there are three levels of case conceptualization that can be developed over time in psychotherapy: "descriptive," "cross-sectional," and "longitudinal." From their perspective, the five-part model (Padesky & Mooney, 1990) as presented in *MOM2* is an example of descriptive case conceptualization, which is an appropriate starting point for clients' understanding. This level of conceptualization establishes links among different aspects of personal experience (thoughts, behaviors, emotions, and physical reactions) and life circumstances or situations (environment). It is a useful level of conceptualization to help people understand their presenting issues within a psychosocial frame. Chapter 2 of this clinician's guide details how the case conceptualization worksheet in *MOM2* based on the five-part model (Worksheet 2.1, Understanding My Problems, *MOM2,* p. 14) can serve as a starting point for developing an individualized conceptualization of a client's presenting issues.

Box, Arrow In, Arrow Out (Cross-Sectional Case Conceptualization)

Kuyken et al.'s (2009) second level, cross-sectional case conceptualization, is also commonly used in CBT. Cross-sectional conceptualizations entail identifying triggers and maintenance factors for presenting issues. Padesky (2020) describes a simple approach for collaboratively developing this type of conceptualization with clients; she calls this approach "Box, Arrow In, Arrow Out." It is demonstrated in this session with Susan, who struggled with anxiety when she had a long list of undone tasks.

THERAPIST: Let's see if we can come up with a model to help us understand your anxiety. I'm going to propose we use a model I call "Box, Arrow In, Arrow Out." I'm going to draw a box here with an arrow going into it and another arrow coming out of it.

SUSAN: OK.

THERAPIST: This is where I need your help. We want to write something on this box that describes what you struggle with the most.

SUSAN: That would be anxiety.

THERAPIST: OK. Take this marker and write "Anxiety" on the box. (*Pauses while Susan does so.*) Now I'm going to write the word "Triggers" at the top of the space on the left side of this page [see Figure 14.1], and "Responses" at the top of the space on the right side of this page.

Susan: Uh-huh.

Therapist: Here's the marker, Susan. Write down on this left side some of the situations and experiences that trigger your anxiety.

Susan: Do you mean things like work pressures and having to do a lot of things in one day?

Therapist: Sure. And any other triggers you can think of, too.

Susan: (*After writing the first two triggers*) What other sort of things should I write?

Therapist: I'm not sure. It might be things you think to yourself, or a physical state like feeling tired. Or even other moods. Anything, really, that triggers you to start feeling anxious.

Susan: Oh, I see. Well (*writing*), I would say thinking about my "to do" list.

Therapist: What sort of thoughts or images specifically come into your mind and trigger your anxiety?

Susan: I see myself trying to climb a mountain of paper, and when I take a step forward, my feet just sink in and I slide backward.

Therapist: That's a powerful image. Why not write down a reminder of that image?

Susan: (*Writes: " 'Mountain of paper' image."*)

Therapist: Any other triggers you can think of?

Susan: Not really.

Therapist: OK. Those are your "Arrow In" triggers. Let's look at "Arrow Out." This would be what you tend to do when you get anxious about these things.

Susan: I guess I avoid them. I watch TV or read messages on my phone. Sometimes I call a friend and talk for a while.

Therapist: Write those things on the "Responses" side. (*Pauses while Susan writes as shown in Figure 14.1.*) When you avoid, as you call it, and watch TV or read phone messages or call a friend, what happens to your anxiety?

Susan: For a while it goes down. Then when I remember everything I have to do, it skyrockets.

Therapist: OK. So, would you say your current responses help you feel more or less anxious . . . in the long run?

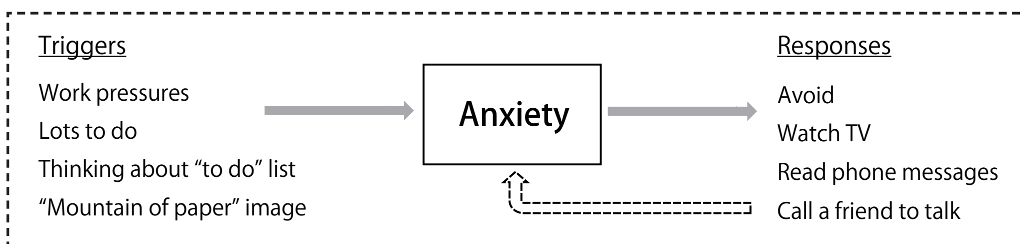


FIGURE 14.1. Susan's anxiety conceptualization, using Box, Arrow In, Arrow Out.

SUSAN: More anxious, definitely.

THERAPIST: Let's draw an arrow, then, from your responses back to anxiety.

SUSAN: Shall I do it?

THERAPIST: Sure. (*Susan draws this arrow, shown as the dashed arrow in Figure 14.1.*) It looks like you are currently stuck in a loop here that keeps bringing you back to anxiety.

SUSAN: Yes, I see that. What can I do?

As shown in this interchange, the Box, Arrow In, Arrow Out method is an easy way for people to conceptualize their current presenting issues. It advances understanding beyond the five-part model, because it is not purely descriptive of "what is." This second level of conceptualization begins to specify when a problem is likely to occur (triggers) and what maintains the problem (responses a person makes that actually increase or maintain either the triggers or the presenting issue in the box). In fact, this level of conceptualization often helps people vividly see how their current responses are not really helpful in the long run. Thus, after looking at their own written model, people often become more amenable to trying something different.

Kuyken et al. (2009) also advocate finding people's strengths, so that these can be incorporated into each level of case conceptualization. One way to identify strengths is to ask people to tell you about areas of their lives that are going well—hobbies and activities they enjoy or look forward to during the day. During her intake interview, Susan's therapist learned that she was an avid gardener. Drawing on principles from Padesky and Mooney's (2012; see also Padesky [2015] in Appendix C on p. 463) strengths-based CBT model for building resilience, her therapist decided to explore Susan's gardening experiences to see if they could provide inspiration to answer Susan's question: "What can I do [to lower anxiety]?" Her therapist interviewed Susan about her gardening, to help her discover potential alternative responses to anxiety.

THERAPIST: It looks like we need to figure out something different you can do that takes you away from this cycle of pressure, anxiety, avoidance, anxiety.

SUSAN: What would that be?

THERAPIST: I need your help to figure that out. Let's take another area of your life where you don't feel anxiety, and see if we can get some ideas.

SUSAN: What do you mean?

THERAPIST: You told me when we first met that you are an avid gardener.

SUSAN: (*Smiling*) Yes, I love to garden.

THERAPIST: (*Smiling back*) Good for you. (*Engages Susan in a several-minute discussion of what type of garden she plants and what she loves about gardening.*) That sounds really terrific. I don't know a lot about gardening, but I would imagine that at the beginning of spring and summer, there are a lot of tasks that have to be done all at once to get your garden ready.

SUSAN: Yes. It can be daunting, especially the first time. But I know what to do, and I just tell myself to take things one at a time.

THERAPIST: And do you feel anxious when you start?

SUSAN: No, I feel ready to tackle it, because I know how nice it will be when summer comes and we have fresh fruits and vegetables.

THERAPIST: (*Continues to interview Susan about challenges she faces in starting and tending her garden, and takes notes on each of her coping strategies. Then shows Susan a written summary of this conversation.*) I've written down all the things you've told me that seem to take the anxiety out of gardening for you: You tell yourself, "Take things one at a time"; you think about how nice getting to your goal will feel—in this case, the fresh fruits and vegetables you can harvest; you identify problems and either get help from an expert or look things up on the Internet; you do a little bit every day so you don't get too far behind; and you share the work with other family members.

SUSAN: Yes, I do all those things.

THERAPIST: I wonder if any of those responses to preparing your garden might be ones we could try as new responses to your anxiety when you look at the number of tasks on your "to do" list?

SUSAN: Hmmm, that's an interesting idea.

THERAPIST: Look at this list for a few minutes and tell me what ideas occur to you.

The five-part model (*MOM2* Chapter 2) and Box, Arrow In, Arrow Out are two easy types of case conceptualizations that you can construct collaboratively with clients in session. For most issues that bring people to therapy, one or both of these methods will provide a sufficient framework for understanding issues. Conceptualizations like these also help people understand a rationale for the treatment steps that follow. For example, clients are prompted to consider:

"If these five parts of my experience are connected [five-part model], then making changes in any of these five parts might be helpful."

"If my current responses are really making the problem in the box worse [Box, Arrow In, Arrow Out], then maybe I should experiment with some different responses."

Experienced CBT therapists will notice that these conceptualizations do not involve core beliefs. In the Kuyken et al. (2009) model, core beliefs only appear in the third level of case conceptualization: longitudinal case conceptualizations. This level of conceptualization is only recommended later in therapy if clients have chronic difficulties that have not responded favorably to therapy, including the types of skills and interventions taught in *MOM2*. Fortunately, these will be a relatively small proportion of people seen in therapy. As described in Chapter 8 of this clinician's guide, even people with personality disorders and other chronic issues can experience a positive treatment

response to CBT focused on depression, anxiety, and other mood-related disorders. If one of your clients is ready to work on core beliefs after these other issues have been addressed, you can turn to Chapter 8 in this clinician's guide for more information on how to identify and strengthen new core beliefs, using Chapter 12 of *MOM2,* Core Beliefs. For more information on incorporating core beliefs into longitudinal case conceptualizations, see Kuyken et al. (2009).

Incorporating Cultural Issues into Case Conceptualizations

It is always important to incorporate cultural factors into case conceptualizations. Many therapists think of cultural factors as part of the environment in the five-part model, although thoughts, emotions, behaviors, and physical reactions also can each have a cultural component. To learn about the roles clients' cultural backgrounds play in relation to presenting issues, it is necessary to ask directly, expressing interest and curiosity. It can be easy for us as therapists to forget that every single person has both cultural similarities to and cultural differences from us. We can make errors in judgment by assuming that someone who comes from a similar background to ours has had the same cultural experiences as ours. Conversely, we can err when we assume that we cannot understand the experiences of someone whose cultural background is quite different from our own. Four steps we can take to actively incorporate clients' cultures into therapy are described here: "Discuss, incorporate, read, and consult."

DISCUSS CULTURE WITH CLIENTS

A starting point for learning about clients' culture can be to ask them in the opening sessions to tell you about the culture or cultures in which they grew up and currently live, especially in terms of how they think these cultures might have an influence on the issues that bring them to therapy. Let them know that "culture" is a broad term that can include race, ethnic heritage, dimensions of gender identity and expression, religious background, sexual identities and orientations, urban–rural experiences, socioeconomic status, political beliefs, living with disabilities, and many other factors. It is helpful to recognize that none of these dimensions of culture are binary, and that none of them exist independently of each other. For example, consider these two therapist queries:

> "Would you say growing up you thought of yourself as male, female, neither, both, or something else?"

> "Thank you for telling me some things about your culture growing up. To recap, your family is from Haiti; you grew up in New York City in a mostly Puerto Rican neighborhood; and you and your family are Roman Catholic and respect your *vodoun* family spirits. You were raised with the belief that as a man you would be entitled to respect, and yet as you grew older you experienced a lot of disrespect, because white Americans you met at school and work just saw 'another black man' and expected you to accept second-class status. Could you describe for me and your wife if and how you think these life experiences might be linked to the anger you feel when she says things that seem to put you down?"

The first of these questions was asked of a young client who arrived in therapy dressed unconventionally. The phrasing of the therapist's question about gender identity communicated the acceptability of a nonbinary response. Human qualities do not necessarily fit into binary boxes (i.e., male or female), and some people reject categories such as gender completely. Adopting more fluid and inclusive language can be an important part of establishing and maintaining a positive therapy alliance with people who do not view their own experiences as binary.

The second therapist query followed a summary of what the husband in a couple had said about his cultural experiences. It asked him to consider whether and how his intersecting cultural experiences were affecting the anger he experienced in certain interactions with his wife. Thinking in terms of "intersectionality" (Carbado, Crenshaw, Mays, & Tomlinson, 2013) of cultural experience, as this therapist did, better captures someone's cultural context and leads to a more individualized view of culture than thinking of people as a part of a single category or group. For example, a 30-year-old African American lesbian living in a rural setting in Iowa and working as an electrician has a very different cultural experience from that of a 30-year-old African American lesbian living in San Francisco and working as an attorney.

We encourage openly discussing culture with your clients. It is helpful to honestly convey both your knowledge and your lack of understanding of a particular culture. Encourage your clients to give you feedback if a case conceptualization or therapy plan violates their cultural norms or ignores important cultural meanings. Sometimes educating a therapist about their culture helps people clarify beliefs and values that they may have followed for years but never articulated. However, it is not professionally responsible for any therapist to rely solely on clients for cultural education. Clients may not be aware of or able to articulate cultural beliefs, behaviors, and emotional responses. Furthermore, clients have limited therapy time, and therapists' cultural education should account for only a small allotment of the time available. The case example of Chapman ("Refusal to Discuss Cultural Background") in this chapter's Troubleshooting Guide illustrates the harm clients can experience when a therapist relies too heavily on them as the sole source of cultural education.

One way to stay alert to cultural influences in each session is to listen carefully to client statements for signposts of culture. For example, a Japanese American client could say, "When I made this decision, I disappointed my parents," and look either ashamed or defiant. This statement, combined with an emotional response of shame, could signal a client who accepts certain aspects of Japanese cultural values (e.g., deference to parental wishes); a defiant emotional response might signal someone who was raised with these values and yet is actively rebelling against them, or who sees these values as harmful.

INCORPORATE RELEVANT CULTURAL INFORMATION INTO THE CONCEPTUALIZATION AND TREATMENT PLAN

Next, consider ways in which someone's intersecting cultural backgrounds influence the conceptualization of this client's problems and the treatment plan. Therapists can err by either ignoring culture or overestimating cultural influence on problems. Therapists who do not even notice a client's race, or do not inquire about religious beliefs, sexual

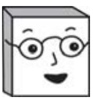
orientation, or gender identity, are guilty of the first error. The second error was made by a therapist who said, "Poor people won't use *MOM2* because they are not motivated to change." Robinson, Cross-Denny, Lee, Werkmeister Rozas, and Yamada (2016) describe a useful training exercise, along with reading assignments, that can be used in graduate programs or postgraduate group training programs to heighten awareness of cultural intersectionality.

READ BOOKS AND ARTICLES ABOUT CLIENTS' CULTURES

Therapists have a responsibility to educate themselves regarding various cultures, in order to become better listeners and better understand the context of their clients' experiences. As a starting point, we recommend the textbook *Culturally Responsive Cognitive Behavior Therapy*: *Practice and Supervision* (Iwamasa & Hays, 2019). In addition, many journal articles accessible on the Internet discuss adaptations of CBT developed for particular cultural groups around the world.

CONSULT WITH COLLEAGUES WHO HAVE CULTURAL EXPERTISE

It is helpful to consult with colleagues regarding cultures that are new to you, either personally or as a therapist. For example, one of us consulted with a psychologist who was a practicing member of the Church of Jesus Christ of Latter-Day Saints (informally known as the Mormons), to better understand the roles that religious and community culture could play in the etiology and treatment of depression for a Mormon client. Some professional groups have Internet discussion forums, and therapists can post questions there to find information and resources or seek consultation about cultural issues. Internet searches can often locate professionals who could offer consultation regarding particular cultural factors in therapy.



Reminder Box

To increase cultural awareness and incorporate it into every phase of therapy, do the following:

1. Discuss culture with clients. Listen carefully and ask questions to understand the influence of each client's cultural background. Seek feedback on your own and your clients' cultural assumptions about therapy and its procedures.
2. Incorporate relevant cultural information into conceptualization and treatment planning.
3. Read books and articles about clients' cultures.
4. Consult with colleagues who have cultural expertise.

The two editions of *Mind Over Mood* have been translated into several dozen languages and used by people from many different cultures around the world. Unfortunately, most of the research published on its effectiveness to date has been done in North America with the first edition of the book. The only study of which we are aware that focused specifically on the first edition's use with a particular cultural group demonstrated its effectiveness in group therapy for depressed members of an LGBT community (Ross, Doctor, Dimito, Kuehl, & Armstrong, 2007). We welcome readers to conduct additional research on the effectiveness of *MOM2,* including examinations of its cultural strengths and weaknesses.

Case Conceptualization with Couples

Case conceptualization for couples' issues usually involves identifying the expectations and underlying assumptions that both support a couple's strengths and underlie hurt, anger, and other relationship issues. The five-part model (Figure 2.1, *MOM2,* p. 7) and the Understanding My Problems worksheet (Worksheet 2.1, *MOM2,* p. 14) are designed to help individuals find links among thoughts, moods, behaviors, physical reactions, and the environment. Some couples therapists choose to have each member of a couple complete a five-part model and then discuss similarities and differences.

An additional conceptualization model for couples is the Box, Arrow In, Arrow Out method described earlier in this chapter. Here is an example of its use with a couple struggling with conflicting underlying assumptions.

Jayda and Wanda sought therapy when they began to experience increased conflict in their relationship three years after their marriage. Their frequent arguments were fueled by Jayda's underlying assumption ("If Wanda loves me, she'll know [and do] what I want and anticipate my needs") and Wanda's underlying assumption ("If people love each other, then they don't criticize or fight"). A pattern of conflict developed:

1. Jayda felt hurt when Wanda did not anticipate her unspoken needs.
2. Jayda expressed this hurt by making small critical comments to Wanda.
3. Wanda interpreted Jayda's criticism as a sign that Jayda didn't love her any more.
4. Wanda withdrew from Jayda, feeling certain that the relationship was ending.
5. Jayda became angrier as Wanda's attention toward her decreased, until she finally exploded in anger.
6. Wanda cried in response to Jayda's anger, saying that she still loved Jayda and didn't want to break up.
7. Jayda was puzzled, saying that she loved Wanda and only wanted Wanda to remain connected and involved.
8. Wanda felt relieved that Jayda still loved her and paid Jayda increased positive attention during the ensuing days.
9. The relationship conflict was resolved until the next time these issues surfaced.

Jayda and Wanda's relationship pattern was captured in an interlocking pair of Box, Arrow In, Arrow Out diagrams, as shown in Figure 14.2. This conceptualization, developed in session collaboratively with Jayda and Wanda, helped each of them see how their respective triggers for hurt made sense in the context of their underlying assumptions. They could also see how each of their responses to feeling hurt contributed to a cycle of conflict and ongoing pain in their relationship. This conceptualization helped this couple move forward and consider alternative responses toward each other when they felt hurt.

Their therapist prompted Jayda and Wanda to consider what information supported or did not support their underlying assumptions by assigning them to each consider at least five relevant questions from the Helpful Hints box on page 75 of *MOM2,* Questions to Help Find Evidence That Does Not Support Your Hot Thought. Even though these questions are designed to help test automatic thoughts on 7-Column Thought Records, their therapist correctly recognized that some of these same questions could be used to evaluate this couple's underlying assumptions. In doing this exercise, Jayda realized that as much as she loved Wanda, she often did not have a clue about what would please Wanda in a given moment. Jayda interviewed friends and discovered that they also frequently misunderstood their partners' needs when these needs were not explicitly expressed. When Jayda reported this insight in their next therapy session,

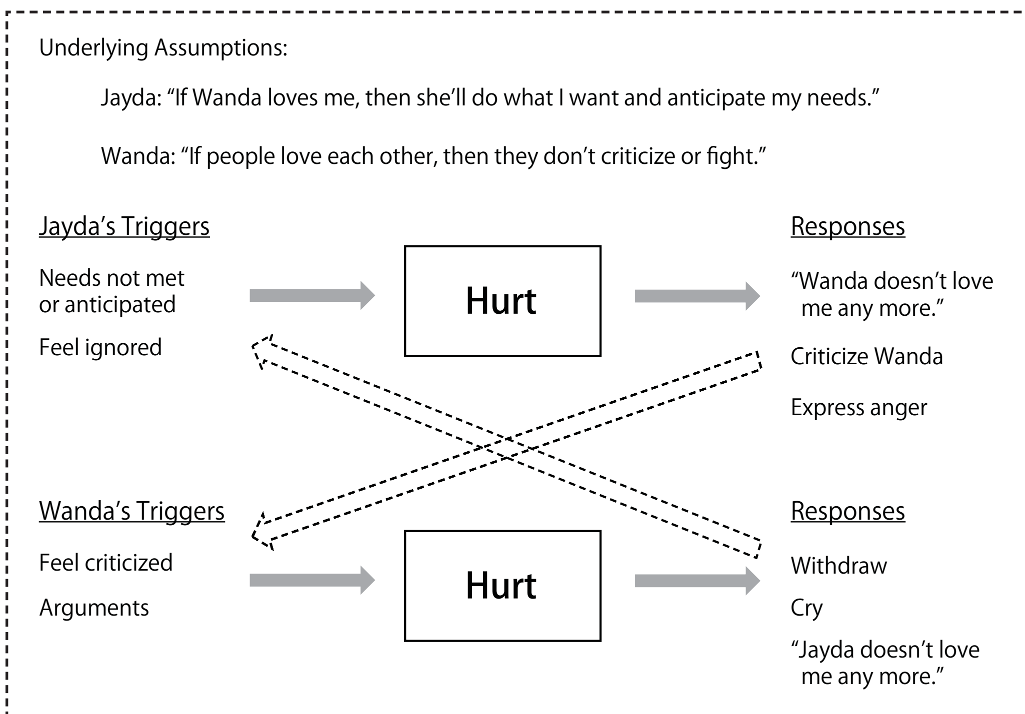


FIGURE 14.2. Jayda and Wanda's conflict conceptualization, using Box, Arrow In, Arrow Out.

Wanda was greatly relieved and helped Jayda understand that her love was deep but not omniscient.

In turn, Wanda examined her own underlying assumption: "If people love each other, then they don't criticize or fight." She interviewed friends in good relationships and discovered that they all fought with and criticized their partners sometimes. She worked on developing an alternative underlying assumption: "If people fight and criticize sometimes, then that is normal and will either blow over or can be an opportunity to make a relationship better." To test this new perspective, Wanda tried to argue constructively with Jayda instead of withdrawing when they had disagreements. When conflicts were expressed in session, their therapist coached Wanda to stay active by listening to Jayda's concerns and expressing her own. In time, Wanda and Jayda each developed more adaptive underlying assumptions that supported a greater understanding of each other's reactions and better conflict resolution. The new beliefs and skills gained in therapy and supported by *MOM2* helped them restore a mutually loving relationship.

Principle 2: Create and Maintain a Collaborative Therapy Relationship

A positive therapist–client relationship is a critically important foundation for successful therapy (Kazantzis, Dattilio, & Dobson, 2017). Clients are most likely to discuss their problems honestly and openly within a relationship that seems safe and trustworthy. CBT therapists are encouraged to be warm, empathic, and genuine with their clients—qualities basic to any good therapeutic relationship. Therapists' straightforward curiosity about clients' experiences, thoughts, and feelings, and the efforts therapists make to devise brief and effective therapy plans, can help build a positive therapy alliance. In this spirit, we recommend that therapists introduce *MOM2* to clients when it can serve as an aid to support their progress, not as a therapist convenience.

CBT adds "collaborative" to the list of qualities important in a therapy relationship. Collaboration requires an active stance on the part of both therapists and clients to work together as a team. Case examples and dialogues throughout this clinician's guide illustrate the many ways that therapists and their clients collaborate in CBT. The language and format of *MOM2* are also designed to evoke a collaborative spirit of inquiry. Since many clients enter therapy expecting to play a more passive role (e.g., "Tell me what to do"), therapists often need to socialize clients to expectations for collaboration. Here is one way a therapist could invite a client to participate actively in therapy:

> "Although I know general strategies to help people with a lot of different issues, you hold all the information about your personal experiences. You are the only one who can observe and describe your thoughts, moods, behaviors, and physical reactions from moment to moment. Your experiences and observations will help us learn how best to apply the things we both know to help you improve your life and reach your therapy goals. By working together as a team, we can figure out what small changes will lead to the biggest improvements in your life."

As described in the following sections, collaboration also means that CBT therapists respect and encourage full client participation by asking them to (1) make observations and practice skills between sessions; (2) participate in setting the agenda for each session, so that the therapist does not control the topics discussed or time allotted to each; (3) give feedback to the therapist each session; and (4) ask questions to learn as much as possible, so they can make informed choices and decisions throughout therapy.

Collaboration: Observations and Skills Practice between Sessions

Clients' active participation in making observations and in practicing skills between sessions is necessary for positive outcomes in CBT. Learning and change are unlikely to occur without this type of engagement. Suggestions for encouraging clients' participation in practice between sessions are offered in the Troubleshooting Guide at the end of Chapter 2 of this clinician's guide.

In addition, clients are encouraged to keep notes of what they learn and practice as therapy proceeds. These notes can be kept in a client's copy of *MOM2* (in the margins of relevant chapters), and/or in a therapy notebook (either paper or electronic). When the client has helpful insights during therapy sessions, the therapist can prompt, "That seems like an important idea. Why don't you write that in your therapy notes, and I will write it in mine?" These notes provide a record of the client's learning and can be reviewed over time to consolidate new ideas. Therapy notes also provide a good summary for the person to use for posttherapy relapse management and to guide further progress.

Collaboration: Agenda Setting

CBT sessions usually begin with a brief discussion about what topics a client and therapist want to be sure to address in that session. CBT manuals refer to this as "setting a session agenda," although more common language can be used with clients, such as "Let's make a plan for today's session." Inviting clients to state at the beginning of the session what they want to be sure to discuss during the session ensures a more equal power relationship in therapy. Why is this? Clients often don't want to begin talking about the most important or difficult topics in the opening minutes of therapy. If a session begins without setting a mutual agenda, a therapist can inadvertently end up controlling what is discussed by virtue of what the therapist reflects upon or asks about during a client's opening remarks.

Consider someone who begins a session musing, "It's been a tough week. My boss has been putting a lot of pressure on me, and the timing couldn't be worse. I've been feeling a bit more depressed, and my family has been visiting, so I feel pressured from all sides." One therapist might follow up with inquiries about the family visit, another with inquiries about work pressures, and still another with discussion of depression and "feeling pressured from all sides." Whichever direction the therapist follows, there will surely be enough content to fill the session. Maybe all these topics will be explored over the course of the session. And yet there is no way of knowing if these are even the topics the client most wants to discuss.

Most people will follow their therapist's lead throughout a therapy session, assuming, "If my therapist is interested in this topic, it must be important." The following dialogue demonstrates the importance of collaboration and setting a session agenda.

THERAPIST: How are you doing today?

CHRIS: It's been a tough week. My boss has been putting a lot of pressure on me, and the timing couldn't be worse. I've been feeling a bit more depressed, and my family has been visiting, so I feel pressured from all sides.

THERAPIST: That does sound tough. So there are extra work pressures; you are feeling more depressed; and your family has been visiting, which also is pressuring you. Are these the things you want to talk about today?

CHRIS: Yes and no. I guess I want you to know this is a tough time for me. I felt I was starting to make some progress on managing my depression, and it bothers me that as soon as my life gets more pressured, it seems like what I've learned isn't helping any more. I'm wondering if that is a bad sign. It also is important to me because I really want to look for a new job. I'm getting a bit worried about how I'll handle the pressure, because I know I feel more pressured when I'm doing new things because I want to do them well, and I might not be able to.

THERAPIST: OK. I think I understand. Let's write some notes about what you want to be sure to talk about today. One of the things has to do with using the skills you've been learning when you feel pressured.

CHRIS: Yes (*writing*). And the second thing is talking about how I can handle the pressures of a new job (*writing*). And I really do want to know if this is normal or if it's a bad sign that my depression is coming back (*writing*). Oh, and I went to the doctor, and she said my thyroid test was a bit low. I want to tell you about the new medication I'm taking (*writing*).

THERAPIST: I'd like to hear about that. (*Pause*) We also need to review the *Mind Over Mood* worksheets you did this week to manage your depression, and the ways in which these helped or didn't help.

CHRIS: (*Writing*)

THERAPIST: Anything else?

CHRIS: No.

THERAPIST: What order makes most sense to you to discuss these things?

CHRIS: I can tell you about the doctor real quickly. Then I guess it makes sense to talk about what I tried this week that didn't work, so you can let me know if this is normal or a problem.

THERAPIST: Good idea. Then maybe we can talk about what might help you more when you feel pressured.

CHRIS: I'd like that. And then, last, we could talk about how to do these things in a new job.

THERAPIST: About how much time do you think we should spend on each thing?

CHRIS: About two or three minutes on the doctor (*writes "2–3" next to "doctor"*); maybe five minutes on what I tried this week and whether it is normal (*writing "5" next to this item*); then most of the time on what I can do when I feel pressured (*writing "30"*); and five minutes at the end (*writing "5"*) about how to use these ideas in a new job.

THERAPIST: It might take more than five minutes to review the worksheets and strategies you tried this week and discuss whether your experiences are typical. Do you think we could plan 10–15 minutes on that? Leaving as much time as possible for exploring additional things you can do?

CHRIS: Yes, OK. (*Changes "5" after "what I tried this week and whether it is normal" to "15," and changes "30" after "what I can do when I feel pressure" to "20."*)

By collaborating early in the session to set the direction for what would be discussed, the therapist and Chris could begin discussing what was most important to Chris more quickly. Sometimes during agenda setting, clients add completely different items from the ones they mention in their opening statements ("Oh, I don't really need to talk about that. What I really want to discuss today is . . ."). When clients are invited to help plan sessions, they get used to doing so and often put more thought into preparing for each one. If there are more topics flagged for discussion than there is likely to be time for, therapists can ask clients to choose which topics are most important to them. Also, therapists know the relative importance their clients place on each topic, given the timings suggested.

Therapists who are not familiar with setting a therapy agenda sometimes hold underlying assumptions that can interfere with this process. For example, some therapists believe, "If we set an agenda, then we are less likely to uncover deep emotional issues," or "If we set an agenda, then therapy will be too structured and not allow time to follow up on important issues that emerge." These concerns are not likely to materialize as long as a session is managed collaboratively from start to finish. Clients often explore deep emotional content more quickly when they can choose when to discuss topics that elicit it. If one topic leads to unanticipated complexity or emotions that are important to explore, the therapist can point this out: "It seems there are deeper issues here than we can explore in the 15 minutes we planned. Do you want to drop some of the other topics and spend more time on this? Or would you rather come back to this another time?"

Collaboration includes therapist input as well. If therapists believe that clients are avoiding certain issues, this can be explored as part of agenda setting. For example, "You said when you first came here that one of the issues you struggled with at work was sexual harassment. I notice you never put that on the agenda. Is there a reason you are not focusing on that, or is there something I'm doing that makes you unsure about talking about this with me?" Also, as shown in the dialogue above between Chris and his therapist, therapists can negotiate different timing allocations when clients' own time estimations seem unrealistic.

Collaboration: Feedback

Therapists demonstrate respect for their clients and a true commitment to collaboration when they allow time in each session for feedback. As with all interventions, it is helpful to give a rationale for seeking feedback, such as this: "Every session I will ask you to tell me what has been helpful, and also what has not been helpful. I know it can feel awkward to discuss things you don't find helpful or things you dislike about me or therapy, but I promise to consider your feelings and reactions in order to make therapy as helpful for you as possible." When clients do give negative feedback, it is important for therapists to consider issues from their clients' point of view rather than becoming defensive. An open and accepting response to a client's criticism is illustrated in the dialogue with Roy in the Troubleshooting Guide at the end of this chapter.

Collaboration: Client Questions and Informed Decision Making

As therapists, we serve our clients best when we give clear information about and rationales for the treatment approaches that will be employed and are likely to help. Part of this process is asking clients for informed consent to treatment at the beginning of therapy. Informed consent involves telling someone about the treatment(s) we offer, potential risks and benefits, and alternative treatment approaches that have equivalent or better empirical support. This step is also a reminder to us not to accept every person into our therapy caseloads. For example, if the evidence suggests that someone is likely to get the best treatment response from an approach that we cannot competently offer, then we should facilitate a referral to a therapist who can deliver that treatment.

Best practices in CBT entail informing clients throughout therapy about the benefits and risks of therapy procedures. This information should be offered in language that each client can comprehend. So, for example, a therapist could say to an adult with average intellectual ability who is a school teacher:

> "Research suggests that the activities we do can have an impact on our mood. This Activity Record [*MOM2,* pp. 206–207] will help us learn whether or not the things you do during the day affect your mood. It will take you about 15 minutes a day to keep this record. The benefit of spending that time is that it will help us learn a lot about what types of activities are most likely to help improve your mood going forward. Let's start it together now to see how this works and what questions you have."

Now consider a young adult who lives in a supervised group home and works as a dishwasher in a restaurant. He has borderline intellectual functioning and a limited ability to use number ratings. A therapist could help him begin an Activity Record by saying this:

> "Let's look at these drawings of five faces. Some are sad and some are happy and one is in between. Which face shows how you feel when you play with your dog?

Which face shows how you feel when your roommate is mad at you? You can use these faces to tell me when you feel happy or sad. I'm going to send you home with this page of faces. When you feel happy or sad this week, write a word or two about what you are doing under the face that shows how you feel. Let's do it together now to see how this works and what questions you have."

An important part of this process is remaining open to clients' questions so that they really understand the rationale for treatment steps. People often have many questions about therapy approaches:

"Is exposure to my fears really necessary?"
"Can't I just do a thought record in my head?"
"Wouldn't medication work just as well?"
"How long will this take?"

We have included summaries of research findings throughout this clinician's guide to help you understand the empirical basis for most of the methods included in *MOM2.* We hope that this information will help you to answer these types of questions. Be grateful when clients ask questions like these, because it indicates that your clients are engaged in therapy. When you answer their questions (or propose that you both look for the information), you are supporting their informed decision making.

Principle 3: Be Guided by Empiricism

What does it mean to say that CBT is guided by empiricism? "Empiricism" refers to three aspects of CBT:

1. CBT is an empirically derived therapy, which means it emerged from theoretical models that have been empirically tested. Once theories are supported by research, therapy methods are developed consistent with them. These therapy approaches are also evaluated and then modified, based on studies of their effectiveness (see Padesky & Beck, 2003). A common misperception of CBT is that it is a static form of therapy. In fact, CBT constantly evolves. Empirically derived therapies are data-based; as new data emerge, therapies are modified to accommodate new findings. *MOM2* can be considered an evidence-based workbook, because each of the skills taught in *MOM2* is derived from theories and research that have an evidence base supporting them.

2. CBT therapists are empirically minded. When possible, CBT therapists choose therapy interventions that are empirically supported. One of the advantages of using *MOM2* in therapy is that the methods are empirically supported and the worksheets follow evidence-based guidelines for their use. However, the fact that a therapy method is evidence-based for a particular mood does not mean that it is evidence-based for every client issue. For instance, behavioral activation (see *MOM2* Chapter 13, Understanding Your Depression) has a strong evidence base for helping with depressed mood, but it does not have an evidence base for helping with shame.

Thus therapists are not being empirically minded if they choose a particular intervention (e.g., thought records, mindfulness) and use it with every client. It is unlikely a single intervention will have an evidence base for every issue. The Reading Guides for depression, anxiety, anger, guilt, and shame on pages 456–459 of Appendix A and on The Guilford Press's *MOM2* companion website (see the box at the end of the *MOM2* table of contents, p. vi there) steer readers and therapists to evidence-based skills for each. These Reading Guides also advise people to learn skills in an order that matches existing evidence-based treatments. For many people, learning skills in the recommended order supports enduring change.

3. Therapy methods themselves are empirical. Therapy methods used in CBT rely on client observations, timely recordings of clients' experiences, and active tests of clients' beliefs and behaviors. These are all data-based therapy methods. For example, it is more helpful for therapists to guide clients to examine the evidence in their lives so that together they can consider what beliefs fit their experiences best, rather than trying to convince clients that a particular thought or assumption is erroneous (Padesky, 1993a). Worksheets in *MOM2* can be used to record observations and structure experiments clients carry out as they examine new and old behaviors and beliefs. Finally, therapists and clients assess what skills are making a difference, and whether therapy is leading to the types of changes clients want, by measuring and tracking moods as therapy proceeds.

A central tenet of empirically based therapy is that therapists stay open and flexible in their selection of approaches. As described earlier in this chapter, CBT therapists strive to have knowledge of various empirically supported treatment methods and know when to use these within an individualized case conceptualization. Targets of change (e.g., moods, behaviors, thoughts, physical symptoms) are measured regularly, and if improvement is not occurring at an expected pace, therapy is modified in ways consistent with empirically supported treatment principles.

For example, if a client's social anxiety is not improving after several weeks of practicing social anxiety interventions (as described in Chapter 11 of this clinician's guide), the therapist and client consider what therapy changes to make. If the social anxiety is so high that the client has a hard time focusing during social interactions, they might decide to make the social situations less intense. They would not create a treatment plan that encourages avoidance, because research demonstrates that avoidance makes anxiety worse. If the client has been practicing skills in situations that barely elicit anxiety, they will likely decide that the client needs to practice skills in more challenging situations in order to get a positive treatment effect.

Evidence-based therapy approaches are not wedded to step-by-step, "one size fits all" methods. Often clients require a "mix and match" approach, especially when there are comorbid conditions. Consider Pauline, who came to therapy wanting to learn mindfulness and acceptance approaches to help manage her anxiety. She was also severely depressed and struggled with frequent negative thoughts, which she had a hard time managing during mindfulness practice. As described in Chapter 9 of this guide, research suggests that mindfulness and acceptance would be more helpful to Pauline

Reminder Box

For each topic addressed in this clinician's guide, relevant chapters describe/include:

- Evidence-based treatment principles and how these are incorporated into *MOM2.*
- Empirically supported treatment methods with reference to *MOM2* worksheets.
- Troubleshooting Guides for common roadblocks and challenges.

once her depression began to lift. *MOM2* could help Pauline if she followed the Depression Reading Guide (see p. 456 in Appendix A) and learned to practice behavioral activation and use 7-Column Thought Records to manage her negative thoughts related to depression prior to a focus on anxiety. When Pauline discovered a lot of evidence supporting one of her distressing hot thoughts, she could switch to using the Acceptance worksheet (Worksheet 10.3, *MOM2,* p. 129) and an Action Plan (Worksheet 10.2, *MOM2,* p. 125), rather than continuing with thought records only.

Principle 4: Emphasize Skill Acquisition and Enduring Improvements

Anyone who has read this far in this clinician's guide is well aware of the emphasis CBT and *MOM2* place on clients' skill acquisition. An emphasis on skill development is supported by a growing evidence base linking clients' skills competence and practice to positive therapy outcomes and enduring improvements (i.e., lower relapse rates), at least for depression. For example, Neimeyer, Kazantzis, Kassler, Baker, and Fletcher (2008) found that both cognitive therapy skills practice via homework (quantity) and the mastery of those skills demonstrated by that homework (quality) were both linked to positive treatment outcomes for depression. Clients' understanding and competence in the use of CBT skills are mediators of depression recovery (Jarrett et al., 2018). Clients who scored higher on the Skills of Cognitive Therapy measure (Jarrett et al., 2011) had a greater reduction in depression symptoms in both cognitive therapy (acute treatment phase) and continuation cognitive therapy (employed after a course of CBT with clients determined to be at higher risk for relapse).

MOM2 specifically teaches the behavioral and cognitive skills measured on the Skills of Cognitive Therapy measure. Thus, to the degree that *MOM2* helps readers master these skills, we would hypothesize that it can be an important tool in attaining positive and enduring outcomes in depression treatment. Preliminary support for this hypothesis was obtained in a study investigating the impact of different types of skills practice on the alleviation of depression symptoms. The study examined the outcomes of a 14-week group therapy for depression based on the first edition of *Mind Over*

Mood (Hawley et al., 2017). Both behavioral activation and cognitive restructuring (e.g., 7-Column Thought Records) practice outside of group sessions were correlated with significant reduction in depression symptoms. At-home skills practice that focused on core beliefs was associated with significant increases in depression symptoms. These findings suggest that, at least in the acute treatment of depression, it is more beneficial to focus on behavior activation and cognitive restructuring than on core beliefs. The Hawley et al. (2017) study supported our decision to reduce the emphasis on core belief work in *MOM2*.

Skill Acquisition in Couple Therapy

CBT with couples emphasizes relationship skills, in addition to many of the same skills taught in individual therapy. In a nutshell, CBT with couples commonly addresses some or all of these nine skills: (1) conceptualization of couples' problems, (2) crisis management when necessary (e.g., when anger leads to physical violence), (3) positive interactive behaviors, (4) identifying and testing automatic thoughts and underlying assumptions, (5) communications skills, (6) identifying and expressing issues underlying anger, (7) problem resolution strategies, (8) core belief work (when necessary), and (9) relapse management (Dattilio & Padesky, 1990, pp. 76–77).

Nearly every chapter of *MOM2* teaches skills that can be helpful during one or more of these stages of couple therapy, as shown in Table 14.1. Anger, guilt, and shame are common moods reported during relationship difficulties, and *MOM2* Chapter 15 provides couples with a concise overview of these moods and exercises to guide work with them. When automatic thoughts add to relationship distress because these interfere

TABLE 14.1. Couple Therapy: Potential Uses for *MOM2* Chapters

Couple therapy skills	*MOM2* chapters
Identify contributing and maintaining factors inside and outside the relationship	2. Understanding Your Problems
Link thoughts and moods	3. It's the Thought That Counts
Identify and rate moods	4. Identifying and Rating Moods
Set goals; identify signs of improvement	5. Setting Goals and Noticing Improvement
Identify and test automatic thoughts	6–9. Thought record chapters
Develop mutual problem-solving plans; foster greater acceptance of partners' characteristics that are unlikely to change	10. New Thoughts, Action Plans, and Acceptance
Identify and test underlying assumptions	11. Underlying Assumptions and Behavioral Experiments
Develop new core beliefs; introduce gratitude and acts of kindness	12. Core Beliefs
Manage anger, guilt, and shame	15. Understanding Anger, Guilt, and Shame

with good communication practices, fuel anger, and block positive interactions, the thought record chapters of *MOM2* (Chapters 6–9) can help each member of the couple identify and test automatic thoughts. When members of a couple need to solve problems and/or develop greater acceptance for each other's idiosyncrasies that are unlikely to change, they can turn to the chapter that teaches use of Action Plans and acceptance (*MOM2* Chapter 10).

A couple can learn many of these *MOM2* skills outside the therapy hour, freeing their therapist to spend more session time on the resolution of relationship difficulties. Many relationship difficulties stem from dysfunctional underlying assumptions, as shown in the example with Jayda and Wanda in the discussion of CBT case conceptualization earlier in this chapter. Chapter 11 of *MOM2* supports the work being done in therapy sessions by showing couples how to identify their underlying assumptions and test them with behavioral experiments.

Therapists who want to learn more about CBT with couples can read Dattilio (2010), which describes CBT for couples and families in greater depth than space allows here. An additional resource for couples is *Love Is Never Enough* (Beck, 1988). Case examples in Beck's book show readers how to evaluate and modify common thoughts that maintain relationship conflict and misunderstandings.

METHODS OF GUIDED DISCOVERY IN CBT

So far we have discussed the roles of case conceptualization, collaboration, empiricism, and client skill acquisition in CBT. If you combine the principles of collaboration and empiricism, you have a rationale for using methods referred to as "guided discovery." Guided discovery includes a variety of methods designed to help people test and evaluate the credibility and/or usefulness of their thoughts, assumptions, and behaviors:

- Discussion-based methods (e.g., Socratic dialogue)
- Written methods (e.g., 7-Column Thought Records and other exercises included in *MOM2*)
- Cognitive methods (e.g., imaginal experiments)
- Behavioral methods (e.g., role plays, behavioral experiments)

Guided discovery helps people focus on relevant parts of their experience in order to avoid global judgments and learn to construct more balanced views (Beck et al., 1979).

Guided Discovery Embedded in *MOM2*

MOM2 is written in the style of guided discovery. Each chapter provides exercises and worksheets to prompt active observations, and asks questions to guide readers' discovery of key principles. Worksheets help clients summarize the information they have discovered and ask them questions to guide the application of what was learned to their own issues. Therapists can pattern their own questioning in therapy sessions on the types of

questions provided in *MOM2*. For example, *MOM2* contains questions to help readers uncover automatic thoughts (p. 54), find information that doesn't support a distressing belief (p. 75), and learn from behavioral experiments (p. 148).

Good questioning strategies are only one aspect of guided discovery. Behavioral experiments, role plays, written observations, and other empirical methods are used to evaluate beliefs, behaviors, moods, and plans for change. *MOM2* worksheets and text also encourage clients to actively test beliefs, consider alternative interpretations for events, experiment with new behaviors, and record observations that can support change. The four clients described in *MOM2* illustrate important aspects of guided discovery by expressing skepticism (Ben in the opening pages of Chapter 2), struggling with data that are hard to accept (Marissa in Chapter 8), and conducting experiments to try to change both emotional reactions and behavior (Linda and others in Chapter 11). Thus the commitment to curiosity and exploration that a CBT therapist establishes in therapy sessions is supported by the use of *MOM2* at home.

Even the decision whether or not to use *MOM2* can be made via guided discovery. Discuss with a client the pros and cons of adding this workbook to the therapy, and propose its experimental use for a few weeks to see how it helps or hinders therapy progress. You can experiment with different approaches for workbook use. For example, you could work together on *MOM2* worksheets in two sessions, and your client could work alone on worksheets between two subsequent sessions. Then you could discuss and evaluate whether and how much guidance from you as the therapist is necessary to maximize your client's learning. More ways to introduce *MOM2* collaboratively into therapy are discussed in Chapter 2 of this clinician's guide.

Socratic Dialogue: Four Steps

Therapists often use Socratic dialogue to help clients evaluate their thoughts and make other discoveries in therapy (Padesky, 1993a, 2019; Overholser, 2018). In Socratic dialogue, a CBT therapist asks a series of questions to help clients discover their own alternative meanings, rather than directly pointing out information that contradicts maladaptive beliefs. Padesky (1993a, 1996; see also Padesky [1996] in Appendix C, p. 463) has outlined a four-step model for Socratic dialogue:

1. Ask a series of questions to uncover relevant information outside a client's current awareness.
2. Listen empathically and make accurate reflections.
3. Summarize the information gathered, in the client's own words.
4. Ask synthesizing and analytical questions to prompt the client to apply the summarized information to the original belief and/or change efforts.

Initial informational questions should be driven by curiosity, not the intention to prove someone wrong. Empathic listening includes hearing what someone says, as well as staying alert to what information could be missing. Summaries are a central part of the process and work best when written down, so both the therapist and client can

see the information and further process it. A written summary provides a resource of information to help the client answer both synthesizing questions (e.g., "How does this information fit with your belief?") and analytical ones (e.g., "What do you make of this information? How could these ideas help you this week?"). Therapists can master the art of Socratic dialogue with practice.

For example, imagine a person who says, "I'm a complete failure." If you say to this person, "Wait a minute. You are successful in work, you have three children who love you, and your life is generally good. How is that a failure?", the person is likely to respond, "You don't understand . . ." or "Yes, but . . ." Directly offering an alternative viewpoint to a distressed person is rarely helpful. Even if someone accepts your alternative view, the person has not learned anything to help deal with these types of thoughts when they occur in the future. The following dialogue between a therapist and Mateo, a social worker struggling with depression, illustrates the four-step Socratic dialogue process.

MATEO: I'm a complete failure.

THERAPIST: How long have you been feeling this way?

MATEO: Just a few months. But I see now it has always been true.

THERAPIST: What makes you think you're a failure?

MATEO: I haven't accomplished anything of lasting value.

THERAPIST: I see. No wonder you're discouraged. I'm a bit confused about something, though.

MATEO: What's that?

THERAPIST: Do you think any of the social work you've done over the past ten years has lasting value—for you or for someone else?

MATEO: Well, I don't know . . . I suppose some of the people our agency helps have benefited.

THERAPIST: Has your work contributed in any way to these benefits?

MATEO: Yes. I have helped a number of people over the years. Others I've not been able to help.

THERAPIST: So you've helped some people, not others.

MATEO: Yes.

THERAPIST: How about at home? Have you contributed anything to your family of value to you or to them?

MATEO: My kids seem happy with me. I think I've been a good parent. But I can see lots of ways I could be a better parent.

THERAPIST: If you want, we can talk about that next. But, first, let's write down some of these experiences you've had. (*Reviews what Mateo has said, and pauses while he writes these observations down.*) I'm wondering how the people you've helped at work and the good things you've done as a parent fit with the idea that you haven't accomplished anything of value.

MATEO: (*Quietly*) They don't, really. I guess I have done some things that are good. But when I get down, all I can see is the fly in the ointment.

THERAPIST: OK. That's helpful to know. Let's talk about the fly in the ointment that's bothering you right now. And let's also keep in mind your observation that you've done some good things in your life, even if they are hard to remember when you feel down.

As this dialogue shows, sometimes a few minutes of questioning can help someone recall experiences linked to an alternative perspective. Once clients are prompted to recall actual life experiences, they are more likely to find alternative perspectives more credible, because these are based on information they suggested. When beliefs and behaviors are more firmly entrenched, a mix of active tests (e.g., behavioral experiments, role plays, imagery exercises) with Socratic dialogue (used to extract learning from them) may be required before shifts in perspective are likely.

For more information about Socratic dialogue, see Padesky (1993a, 1996, 2019), Kennerley et al. (2017), and Padesky and Kennerley (2020). More information about this four-step process and additional clinical examples can be found in Chapter 7 of this clinician's guide.

CREATIVE APPLICATIONS OF *MOM2*: SUBSTANCE MISUSE AND ABUSE

Over the years, therapists have used *MOM2* with a diversity of client issues that go beyond the original mood focus of this workbook. Due to space limitations, we only briefly highlight here a few of the ways *MOM2* is employed by therapists and treatment programs to address substance misuse and abuse. Consider this a sample of the dozens of creative ways in which therapists integrate *MOM2* into therapy. For a more complete description of CBT for substance misuse, see Mitcheson et al. (2010).

Permission-Giving Beliefs

CBT can help people reduce the frequency and severity of alcohol or other substance misuse and abuse by uncovering, examining, and altering the thoughts and assumptions that accompany urges to use. For example, thoughts such as "I need this drug to ease my pain," "I'll be more sociable if I drink some alcohol," or "I won't be able to cope if I don't use" commonly accompany the urge to drink or use drugs. Substance misuse is often accompanied by permission-giving beliefs, which can be identified as underlying assumptions (e.g., "If I've had a really tough day, then I deserve a drink," "If my pain is at such a high level, then I need to take this drug").

These thoughts can be identified, tested, and eventually replaced with alternative thoughts using the skills taught either in *MOM2*'s 7-Column Thought Record chapters (Chapters 6–9) and/or Chapter 11, Underlying Assumptions and Behavioral Experiments. It is often helpful to collaborate with clients in setting up behavioral experiments

to evaluate these beliefs, rather than simply arguing against drug or alcohol use, as illustrated in the following example.

Behavioral Experiments to Test Benefits of Drug Use

Geoff, a 21-year-old mechanic, entered therapy at the insistence of his parents, who were concerned about his depression. At intake, Geoff revealed that he was using cocaine nearly daily to cope with "bum moods." While Geoff was willing to undergo treatment for depression, he did not want to discuss his cocaine habit because "it's not harmful; it's one of the few things that makes me feel better." When his therapist suggested that the cocaine might actually be contributing to his depression, Geoff reiterated that cocaine was not a problem for him and he didn't want to talk about it any more.

Geoff's therapist asked him to read *MOM2* Chapter 1, How *Mind Over Mood* Can Help You, and Chapter 13, Understanding Your Depression, to learn more about depression. Geoff agreed to complete an Activity Record (Worksheet 13.4, MOM2, pp. 206–207) to track his depressed mood. Since Geoff felt that cocaine was an important "mood booster" for him, his therapist suggested that he also mark his cocaine use on the worksheet. The Activity Record Geoff brought to the next appointment revealed several patterns. First, although Geoff was depressed throughout the week, his mood ratings fluctuated considerably. Moreover, contrary to Geoff's belief, cocaine use was not always followed by improved mood. Even when his mood did improve after snorting cocaine, Geoff noticed that his depression always worsened several hours later.

Although one week of data did not shift Geoff's beliefs or willingness to stop using cocaine, his therapist persisted in using guided discovery to increase Geoff's awareness of some of the negative costs of cocaine use. After four weeks of therapy, Geoff was willing to begin doing experiments in which he reduced his cocaine use when he felt depressed. He identified and tested his beliefs associated with both depression and drug use. A month later, he began experimenting with prolonged abstinence from cocaine and enjoyed a noticeable decrease in depression. Eventually, Geoff stopped using cocaine entirely. He also reduced his binge drinking to consuming at most two or three beers on weekends, with a commitment to himself not to drink at all when he was depressed or upset.

Mood Management

Clients with substance misuse problems often avoid or struggle with moods. The basic information in *MOM2* Chapter 4, Identifying and Rating Moods, is important for them to learn early in therapy. Once people can identify and rate moods, they can learn to understand the triggers for these moods and new strategies for coping with them. One complicating factor can be that some people misuse alcohol and drugs in order to numb their moods, and these people often are not very motivated to change their behavior. The worksheet in *MOM2* Chapter 5, Advantages and Disadvantages of Reaching and Not Reaching My Goals, can be used as part of motivational interviewing (Miller & Rollnick, 2013) to identify the costs and benefits of using drugs and alcohol and alternatives to their use. Before introducing this worksheet, review the section on its use in

Chapter 3 of this clinician's guide that cautions it is better to only look at the advantages of change when people are not yet committed to a particular goal.

MOM2 can be used as described throughout this clinician's guide to help people with substance misuse problems alleviate associated mood difficulties. *MOM2* is well suited to addressing moods that commonly accompany substance misuse: depression, anxiety, anger, guilt, and shame. The medication sections in the depression and anxiety chapters (*MOM2* Chapters 13 and 14) address addiction risk, a common concern of clients recovering from chemical dependency.

Life and Relationship Problems

Some people who struggle with addiction live with chronic pain, physical disabilities, and other life problems. Others face relationship difficulties or social disadvantages (e.g., racial discrimination or high community unemployment rates) that seem impossible to resolve. The problem-solving strategies described in *MOM2* Chapter 10 (New Thoughts, Action Plans, and Acceptance) can help clients develop responses for coping with these types of difficult life circumstances. The acceptance exercises in the same chapter can help people manage chronic difficulties that may not change or that may change quite slowly.

As an example, Jim was addicted to fentanyl. He was unemployed and lived alone in a run-down apartment building in a very poor neighborhood. Jim had fewer internal and external resources than Geoff, the employed mechanic who abused cocaine. His therapist became a steady resource for Jim, helping him to come up with a small-steps plan for improvement. The first step was attending a community-based medical detoxification program. The second was finding safe and drug-free housing. Over time, his therapist helped Jim enter a support group and find and maintain a job. Each of these changes triggered both adaptive and maladaptive moods and beliefs. They identified and tested Jim's beliefs that interfered with his progress, using both 7-Column Thought Records and behavioral experiments as taught in *MOM2*.

MOM2 Compatibility with Treatment Programs

MOM2 is compatible with many 12-step programs, including Alcoholics Anonymous (AA), Narcotics Anonymous, and Al-Anon, as well as with Rational Recovery, SMART Recovery, and other programs specializing in alcohol and drug dependency treatment. Treatment programs offering group therapy can use *MOM2,* following the group therapy principles outlined in Chapter 15 of this clinician's guide. Facilitators of 12-step programs can select particular chapters from *MOM2* to help their members successfully complete steps and avoid common pitfalls.

For example, the fourth step of an AA program asks members to "make a searching and fearless moral inventory," and the fifth step directs members to admit wrongs to "God, to ourselves, and to another human being" (Alcoholics Anonymous, 1976, p. 59). Some AA members respond to these steps in exaggerated ways and blame themselves totally for every misfortune in life. Extreme self-blame can lead to overwhelming feelings of hopelessness and self-reproach. which in turn can increase a member's risk

for renewed substance abuse. Program members can work constructively with their guilt and shame by using exercises drawn from *MOM2* Chapter 15, Understanding Your Anger, Guilt, and Shame. For example, Using a Responsibility Pie for Guilt or Shame (Worksheet 15.7, *MOM2,* p. 274) can help AA members acknowledge responsibility without assigning excessive self-blame. This method is particularly helpful for people who are prone to accepting excessive blame and responsibility for their problems, while ignoring other contributing factors. Worksheet 15.8, Making Reparations for Hurting Someone (*MOM2,* p. 275), provides a template for working through the fifth step of an AA program.

Managing Relapse

Relapse management is an important part of any substance abuse treatment program. *MOM2* Chapter 16, Maintaining Your Gains and Experiencing More Happiness, can be a particularly helpful resource for this portion of treatment. In addition to reviewing skills learned in therapy, this chapter includes My Plan to Reduce Relapse Risk (Worksheet 16.2, *MOM2,* p. 288). This worksheet can be used to identify high-risk situations for substance misuse, early warning signs of risk, and a plan of action to avoid relapse.

Many people struggling with substance misuse or addiction identify with Vic, the client recovering from alcoholism who is one of the four main characters described throughout *MOM2.* They can read in detail in Chapters 8 and 9 of *MOM2* how Vic used *MOM2*'s worksheets to prevent a drinking relapse during a period of intense anger with his wife, Judy. Chapter 10 (New Thoughts, Action Plans, and Acceptance) shows how Vic set up an Action Plan to cope with his anger and improve his relationship with Judy, while maintaining his sobriety.

TROUBLESHOOTING GUIDE: USE OF CBT PRINCIPLES

This chapter reviews CBT principles and how these are embedded within and can be enhanced by use of *MOM2.* Below are a few examples of difficulties encountered in therapy that these CBT principles and/or *MOM2* can help resolve.

Refusal to Discuss Cultural Background

The section of this chapter on CBT case conceptualization has described the importance of inquiring about and incorporating relevant aspects of clients' culture. While most clients are willing to describe their cultural backgrounds, some may be guarded or even angry if you raise this issue. When this occurs, examine the manner in which you made your inquiry. Was there anything condescending or judgmental in your tone or language? Consider the difference between "Tell me what it was like growing up black in St. Louis in the 1950s," and "Do you think you're feeling this way because you're an African American?" The first request is a request to understand the client's background, including race. The second question could be heard as belittling a client's reactions or emotions as racial stereotypes.

Second, consider the nature of your relationship with the client. Once a trusting

relationship is established, most clients are comfortable discussing their background and culture. Refusal to discuss culture could indicate that someone does not yet feel safe in your therapy relationship. If you have a seemingly good therapy relationship, but the client responds angrily when you ask about culture, it is important to discover the meaning the question has for the client. Perhaps the person worries that discussion of culture will create distance in your relationship by accentuating differences between the two of you or by activating prejudices you might hold.

Clients also can balk at discussing culture if they find your questions naïve or they feel irritated that you are not as knowledgeable as they thought you were. The following dialogue illustrates this circumstance and one possible therapeutic response.

CHAPMAN: My childhood? Just another boy growing up black in St. Louis.

THERAPIST: What was it like growing up black in St. Louis in the 1950s?

CHAPMAN: (*Angrily*) I'm not going to talk to you about that!

THERAPIST: You seem angry. Did my question offend you in some way?

CHAPMAN: No. But I'm sick and tired of having to educate white therapists about the black experience. What do you think it was like?

THERAPIST: I imagine it was tough. I can even guess some of the experiences you might have had. But I don't want to assume anything, because I know different people have different experiences, and I want to make sure I accurately understood yours.

CHAPMAN: (*In a sarcastic tone*) Yeah, I'm sure.

THERAPIST: You say you're tired of educating white therapists. Have you had to do that a lot?

CHAPMAN: Yes. Once I spent seven weeks telling a student therapist at a clinic about what it was like for me, and then she just left because her time was up. She hadn't even told me that she was only going to be there a few months. I spent all my time helping her and didn't get any help back.

THERAPIST: That would make me angry, too. What have been your other therapy experiences?

CHAPMAN: Another therapist felt he knew all about the black experience from some course he had taken in college. He actually corrected me on my understanding of civil rights progress. And the last therapist kept asking over and over again, "What's that like as a black man?" Like that was all I was to her—black.

THERAPIST: I understand now why you are angry. You don't want to spend your time educating me or listening to my prejudices or feeling like I'm seeing you as black only.

CHAPMAN: That's right.

THERAPIST: Well, I don't want to do any of those things, either. At the same time, I do like to ask all my clients what it was like for them when they were growing up. I bet your past experiences affect your feelings, beliefs, and reactions

to things that happen today. I might misunderstand if you don't tell me anything about it. How could we work this out?

CHAPMAN: I don't mind telling you about my life. I just don't want a bunch of white guilt or overreaction.

THERAPIST: Give me an example of what you mean.

CHAPMAN: I went through some violent, awful stuff in St. Louis and watched my family go through worse. But we have come to terms with this. I don't want to help you come to terms with it. That is your own work to do. Not here.

THERAPIST: So when you tell me these things, would you prefer I not express sympathy—just listen and ask about your reactions and how you handled them?

CHAPMAN: Exactly right.

THERAPIST: So let me summarize my understanding. We'll talk about your past, but only if it's linked to your current problems and can help you, not for my education or curiosity. When you tell me things, I will not express a lot of sorrow or sympathy, because you've worked these things through and my sympathy will seem like "white guilt" to you.

CHAPMAN: You got it.

THERAPIST: Two more questions. I usually do feel and express sorrow when I hear painful things people have experienced. So will you understand if I look sorrowful that this is my reaction and I will deal with it—you don't have to?

CHAPMAN: Fair enough.

THERAPIST: Second, how will I know if you do want support in looking at your feelings and reactions to events in your life? Last week you told me you sometimes want to avoid feelings, and when I pushed you, you discovered it helps to sort them out.

CHAPMAN: That's true. Well, you can ask me if I'm avoiding or if it's really all right to move on to something else. I'll be honest with you.

THERAPIST: OK. Let's try this out today. It helps me to know where you stand and why. I'll check the next few sessions to see how you feel I'm doing in following the guidelines we've come up with. And if I step on your toes, you let me know.

CHAPMAN: Oh, I will! (*Laughing*)

THERAPIST: (*Laughing*) I'm sure you will. (*Pause*) Now, how about telling me what it was like growing up black in St. Louis in the 1950s? Tell me whatever parts you think are relevant to the anxiety you are feeling now.

Chapman's therapist asked for and listened carefully to the reasons for his anger. Relevant events and his reactions were identified and summarized. The therapist explained clearly her views of why knowing his history was important for therapy. Next, she collaborated with Chapman to devise a plan for discussing his background in

ways that could help rather than harm him and the therapy relationship. Finally, they agreed to evaluate their plan over time. She indicated that Chapman was welcome to give her negative feedback if she did not help him in the ways they discussed. Working collaboratively, they resolved the potential roadblock for this session and planned steps for resolving future roadblocks that could arise.

Therapy Ruptures

Perceived Violations of Trust or Respect

Client progress is likely to suffer if actual or perceived violations of trust or respect disrupt the therapy relationship. This is another reason for us as therapists to ask regularly for feedback about how our clients are reacting to therapy procedures and how we come across in therapy. Clients become more comfortable stating these types of concerns when they are asked for feedback in each session. Receiving regular client feedback makes it possible to discuss hidden ruptures in the therapy alliance, so these can be mutually resolved as soon as possible.

As an example, when asked to give feedback in his fourth session, Roy said he thought his therapist was trying to hurry him out the door at the end of each appointment. His therapist respectfully collaborated with Roy to understand and solve this problem.

THERAPIST: We have only five minutes left today, so let me get some feedback from you on how the therapy is going for you so far and any reactions you might have.

ROY: Well, it's going pretty OK.

THERAPIST: You say that with some hesitation. Is there something that could be better for you?

ROY: Yes. It's this endpoint every week. I don't like the idea that you watch the clock. It's like you want to hurry me out of here.

THERAPIST: What exactly do I do that gives you that impression?

ROY: Well, you always tell me when there are a few minutes left. And I always leave between ten and five minutes before the hour is up. I thought therapy was supposed to be an hour.

THERAPIST: And so you figure that means I am hurrying you out faster than usual.

ROY: Yeah.

THERAPIST: And how does that feel to you?

ROY: It seems like I'm unimportant to you.

THERAPIST: Does that make you feel sad? Or angry? Or something else?

ROY: A little angry. I want to have my full amount of time.

THERAPIST: I'm very glad you're bringing this up. Do you have more to say about what this means to you, or would you like to hear what it means to me?

ROY: I would like to know how you feel.

THERAPIST: First, I'm not aware of feelings that I want to hurry you out of here. However, it's always possible that I am feeling pressured to hurry sometimes. If I ever do hurry, I don't think that this has to do with you personally.

ROY: But you seem so aware of the time.

THERAPIST: Does it seem that way to you the entire session, or just at the end?

ROY: Not in the beginning or middle. Just at the end when you get me to leave early.

THERAPIST: This is where I have done a poor job of communicating to you, Roy. You see, I try to end all my appointments ten minutes before the hour. I use the time after you leave and before my next appointment to make notes on what we talked about, and to write myself reminders of what topics I think it is important for us to discuss in the next session. Before we meet, I read those notes and try to get myself ready to continue our work together. So, while we only meet for 50 minutes, I spend about an hour on each session.

ROY: I wondered how you remembered so much about me.

THERAPIST: Just like I ask you to write things down between sessions, I need to do that too. I should have explained this to you clearly in our first meeting, so you knew to expect that we would be together only 50 minutes of the hour. I'm sorry.

ROY: Well, I feel better knowing you do this with everyone.

THERAPIST: I do. But I wonder if the way I tell you there is only five minutes left also makes it harder for you in some way.

ROY: Yes. I think I know why you do it. But it surprises me sometimes, because some weeks the time goes so quickly.

THERAPIST: What would it be like for you if I didn't say, "Five minutes left"?

ROY: (*Pause*) It would be worse for me if the end of the session came and I wasn't expecting it.

THERAPIST: I do let you know, so we can cover whatever else is important to you to discuss. But maybe there's a better way for me to signal you.

ROY: I have a setting on my phone to make it beep at a certain time every hour. Maybe I could set it to go off at 5:45, and then we'd know.

THERAPIST: That's a great idea. Would you be willing to do that?

ROY: Yes. And then I'd feel a little more in control of our time.

THERAPIST: Let's try that next week. Let's also both think more about this discussion to see if there is more to say. I'm going to make a note that you feel better when you are in control of the time.

ROY: OK.

THERAPIST: Before you leave, how are you feeling right now about our relationship and what we've just discussed?

ROY: Better. I was nervous bringing this up, but I'm glad I did.

THERAPIST: I am, too. Please bring up any other concerns you have, so we can have a chance to work them out together.

ROY: OK. I will.

In their discussion, his therapist truly collaborated with Roy to explore his concerns. She asked him to describe his thoughts and feelings about session endings, and she also discussed her own thoughts and feelings. She took responsibility for her inadequate communication about session time, rather than viewing the issue as "all about Roy." Once the situation was mutually understood, they discussed mutually agreeable solutions. If Roy had not suggested his phone alarm, the therapist could have offered to place a clock in the therapy room, so they could both keep track of the time. Some clients express a preference for their therapist to note the session time left with ten minutes remaining instead of five. Collaboration implies mutual problem solving rather than one-sided decision making. For example, the therapist would not accept a request from Roy for sessions to last until he felt ready to end.

Ruptures Due to Client or Therapist Issues

The dialogue between Roy and his therapist above describes a therapy rupture that resulted from a misunderstanding about therapy structure. A more serious type of rupture can occur when clients do not feel safe in the therapy relationship. One man completed all therapy learning assignments but did not experience improvement in his anxiety, because he did not feel safe telling his therapist his central fear: that he could be gay. This type of rupture can result from either client issues (e.g., internalized homophobia) or therapist issues (e.g., a therapist who expresses conscious or unconscious bias against gay people on intake forms and in the language used during therapy). For more information on the importance of the therapeutic relationship and processes for maintaining good relationships with clients, read Beck et al. (2015) and Kazantzis et al. (2017).

Sometimes disruptions in the therapy relationship occur because of therapists' beliefs, expectations, or emotional reactions to clients. For example, sometimes therapists have difficulty maintaining empathic rapport with clients who describe struggles that closely parallel therapists' own current life experiences. One therapist, whose husband had recently announced that he was divorcing her, sought supervision when she found it difficult to focus on the concerns of a male client who was considering divorce. *MOM2* provides a structured approach for therapists to identify and evaluate their own interfering thoughts and moods during therapy sessions. They can complete thought records, Action Plans, behavioral experiments, and other exercises to understand and resolve their own problems. These can be reviewed with a colleague, a supervisor, or a therapist's own therapist, or they can be kept private.

When Clients Don't Improve

Although CBT helps most people feel better, some clients do not improve even though they have shown good treatment adherence. If you are using *MOM2* with a client who is not improving, consider the following factors to identify changes in your therapy that might lead to better outcomes.

Conceptualization and Diagnosis

Two common reasons why clients do not improve are that a therapist has not conceptualized the problem in a helpful way or has not made an accurate or complete diagnosis. For example, Mary experienced intense anxiety whenever she had flashbacks of being raped. Although she acknowledged her history of being raped during her intake interview, she did not mention it again in discussions of her current anxiety. Her therapist did not make a link between her prior rape and her current anxiety, because the sexual assault had happened ten years earlier, and Mary had subsequently experienced a number of years with low levels of anxiety. Her therapist taught Mary controlled breathing to manage her anxiety, because he conceptualized Mary's anxiety as linked to general stress and poor relaxation skills. Mary did not improve because her anxiety was related to the trauma, not to poor relaxation skills.

Many cases of faulty conceptualization are not as clear-cut as Mary's anxiety. Most clients have multiple problems, and a conceptualization needs to consider which problems are primary and whether one conceptualization can explain them all.

Accurate diagnosis is also important, especially since CBT has specific treatment plans for many different diagnoses, as outlined in Chapters 9 through 12 of this clinician's guide. If a client is diagnosed with panic disorder when the client really suffers from social anxiety, the treatment plan for panic disorder will not be helpful. Therefore, the first questions a therapist should consider when a client is not improving are these:

1. Have I identified all the correct diagnoses?
2. Are we conceptualizing problems in a way that makes sense to both of us?
3. Is the treatment plan directly addressing the central and maintaining factors?

Adjunctive Treatments

Sometimes an adjunctive treatment is necessary to facilitate improvement. Some clients who experience severe distress benefit more from therapy if they are also taking medication. People with agoraphobia may improve partially and then stop improving unless couple or family therapy is added to address beliefs and behavioral patterns in the family system that support agoraphobic avoidance.

Therapist Experience

No therapist is skilled in the treatment of every problem. A client's presenting issues may be in areas in which the therapist is relatively inexperienced. Inexperience can be addressed by reading more about the evidence-based treatment being delivered and obtaining supervision or consultation from a therapist with relevant expertise. Relevant chapters in this clinician's guide and the references cited in each can be a good place to start. Also, sometimes the best therapy intervention is a referral to a therapist with greater expertise.

15

MOM2-Based Group Therapy

THERAPIST 1: (*On the telephone*) It sounds like Ruby would be a good fit for a social anxiety group we are offering in our clinic. What do you think?

THERAPIST 2: Oh. I was hoping you could see her in individual therapy. I'm not sure she would want to go to a group. Can't you see her in individual therapy?

Many therapists and individuals seeking therapy consider group therapy a "second-best" option. This is unfortunate, because there is ample evidence that group therapy can be effective for many people (Söchting, 2014). In addition, group therapy offers some advantages over individual therapy—including opportunities for social support and learning from others, lower cost, benefits of helping others who are struggling with similar issues, and more optimal use of therapist resources.

All the CBT principles offered in this clinician's guide apply equally well to cognitive-behavioral group therapy (CBGT). The same active, directive, skill-building and problem-focused approaches used in individual and couple CBT are used with groups. CBGT begins with socialization to group therapy, emphasizes skill building, and concludes with relapse management planning. A CBGT therapist can use *MOM2* to help structure group sessions and between-session learning experiences, as demonstrated throughout this chapter.

This chapter has three main goals:

1. To describe how *MOM2,* CBT, and CBGT can be integrated in order to utilize the strengths of each.
2. To illustrate how therapists can use *MOM2* as a group therapy manual when conducting disorder-specific, protocol-based treatment groups for mood disorders.
3. To demonstrate how therapists can creatively customize *MOM2* group therapy modules to address common problems experienced by the client populations they serve.

STRUCTURE OF *MOM2*-BASED CBGT

CBGT incorporates structure both within and between sessions. Within each group, there is a general structure: Group members construct an agenda that includes review of that week's learning exercises; time is allocated to consolidate skills already learned and to introduce new skills; learning assignments are developed for the coming week; and members give feedback. The sessions are structured in a sequential way to build skills. The next learning assignment after each session is usually based on the skill that has just been introduced.

Therapists can use *MOM2* to help build clients' skills within sessions and as a resource for between-session assignments. Learning assignments often consist of *MOM2* readings and worksheets related to group topics and targeting development of evidence-based skills. Group therapists using *MOM2* can assign sections to read each week, following the Reading Guides for particular moods (available here on pp. 456–459 in Appendix A and The Guilford Press's *MOM2* companion website; see the box at the end of the *MOM2* table of contents, p. vi there), treatment protocols described in this clinician's guide, or a modular format to address specific issues.

The remainder of this chapter provides (1) details for a 17-session protocol-based group for depression (15 group sessions, 1 pregroup individual session, 1 postgroup individual session); (2) a briefer description of a 5-session group module to address perfectionism; and (3) a Troubleshooting Guide that addresses common challenges faced by group therapists. Each group session described includes recommended *MOM2* assignments. Typically, CBGT sessions are 90–120 minutes long, and groups consist of five to ten members.

PROTOCOL-BASED *MOM2* DEPRESSION GROUP

Pregroup Individual Session

Multiple therapy tasks are kept in mind during the pregroup individual session: establishing rapport; assessing the client and reaching at least a provisional diagnosis; developing a preliminary case conceptualization; clarifying the client's motivation and goals for the group; and an introduction to the group format. This is a screening session that includes consideration of the person's current problems, history, previous diagnoses, level of functioning, severity of impairment, expectations, and other factors to determine suitability for the therapy group. The pregroup individual session is also an opportunity for the prospective group member to ask questions about the group, the therapist, and the group process.

If the person is a good match for the group and chooses to participate, individual expectations and therapy goals are discussed. Guidelines in Chapter 3 of this clinician's guide are followed to help set reasonable goals that can be accomplished in the group. Observable and measurable goals are set whenever possible, so that the person can gauge progress. The therapist can introduce *MOM2* and describe how the book will be used to structure group sessions and between-session learning assignments. The first learning assignment is given in the pregroup individual session, to socialize members to

Depression Group Suggested Agenda: Pregroup Individual Session

- Assess diagnosis and severity; determine client's appropriateness for the group.
- Discuss client's motivation and goals.
- Orient client to *MOM2* and the group.
- Introduce *MOM2*—chapter topics, worksheets, mood inventories.
- Review five-part cognitive model from *MOM2* (Figure 2.1, p. 7).
- Learning assignments: Consider reading and worksheets in Chapters 1 and 2; fill out relevant mood inventories (particularly Worksheet 13.1) to establish baseline scores.
- Establish rapport; plant seeds of optimism.

an expectation for active learning outside the group. The first learning assignment is usually to read the first two chapters of *MOM2,* complete Worksheet 2.1 as well as the *Mind Over Mood* Depression Inventory (*MOM*-D; Worksheet 13.1, *MOM2,* p. 191) and record this baseline score on Worksheet 13.2 (*MOM2,* p. 192).

Group Session 1

Members are encouraged to introduce themselves and, if they are willing, to describe their individual goals at the beginning of the first session. Introductions in group therapy are different from social introductions, in that the emphasis is on shared learning goals. The therapist leading the group models this type of introduction by saying something like this:

> "My name is *X,* and I'm your group therapist. I've been helping people with depression for ten years and I'm looking forward to leading this group. This is the first depression group I've led using the *Mind Over Mood* book. I hope each of you will feel a lot better by the end of this group, because you are going to be learning several effective antidepressant skills. Perhaps each of you can give your first name and say something about how and why you are in this group, what you hope to learn, and even your personal goals for the group if you want to share them."

These introductions are the first steps toward building group cohesiveness.

Socialization to CBGT

Following introductions, the group therapist describes the format, expectations, and guidelines for CBGT. The therapist has a plan for the structure and sequence of skills

Depression Group Suggested Agenda: Session 1

- Ask members to briefly introduce themselves, describe their goals, and indicate why they joined the group .
- Describe CBGT, discuss how group will operate, and review confidentiality.
- Collaborate with members to set session agenda.
- Orient members to *MOM2* and discuss how it will be used in the group.
- Review *MOM2* Chapter 2 and Worksheet 2.1; discuss how the five-part model is manifested in members' lives (refer to the Helpful Hints box on p, 15 to address any difficulties encountered in filling out Worksheet 2.1).
- Ask group for examples of the thought connection to draw out principles from *MOM2* Chapter 3.
- Practice identification and rating of moods (*MOM2* Chapter 4).
- Learning assignments: Read and complete all worksheets in *MOM2* Chapters 3 and 4; complete Worksheets 13.1 and 13.2 and any other relevant mood measure(s) prior to the next session.
- Elicit and give feedback.

taught in the group. Even so, each group is unique, because it is based on members' personal experiences and the group processes that unfold. The following sample introduction can be used, with ample opportunity allowed for discussion of each point.

> "We ask you to agree to follow several group guidelines. First, everything group members say is kept confidential. This means that you shouldn't tell your friends or family, or post on social media, anything you hear or learn about other group members. It is very important not to identify any other group members by name. Everyone here has a right to privacy and confidentiality, and nothing said in group sessions should ever leave the group. This rule helps make this group a safe place for you to talk about your lives and experiences. It is important for everyone to know that what they talk about here will be kept confidential. Does that make sense? Do you each agree to keep what is said here confidential?
>
> "Each session follows a regular pattern. At the beginning, we will plan our agenda for the session. Please think about what you want to talk about and add to this agenda at the beginning of each session. We will discuss agenda items in ways that help everyone in the group learn something useful. So we may not always cover your individual issue as thoroughly as you might want. Instead, we will link the issues you put on the agenda with skills everyone is learning. Hopefully, this means that everyone will learn something new and make progress each week. In each group session, we'll review your learning experiences from the past week,

introduce and practice skills, and figure out a new learning assignment for everyone to do between sessions to build new skills and bring you closer to your goals.

"One of the goals of cognitive-behavioral group therapy is for each of you to learn new antidepressant skills and methods for solving your problems. Each week you will learn something new to try out between group sessions to see if it can help you. The more effort that you devote to practicing skills between sessions, the more you are likely to benefit."

Setting the Session Agenda

Following discussion of the group format, members are encouraged to help construct the agenda for the first group session.

THERAPIST: Does anyone have anything you want to put on our agenda to talk about today?

EVA: I've been so depressed and tired lately that I'm just not sure I have the energy to participate in this group. I just don't feel like doing anything. It all seems so overwhelming to me right now.

THERAPIST: I'm sorry to hear that you feel so depressed and tired. It sounds like you are in a bad place. Eva, would you be willing to tell us more about how you are feeling?

EVA: This is the most depressed I have felt in a long time. It seems like it has been going on forever, and I just don't think I will ever get out of the hole I'm in.

JAMES: I have felt that way before. It feels like one long, dark tunnel with no end in sight.

THERAPIST: It sounds like both of you understand how this can feel. Is anyone else in the group feeling that way now, or have you been in that dark of a place in the past?

MARIA: I have been there. I'm not at my lowest point right now, but I can totally relate to what Eva is saying. I'm pretty down at the moment.

THERAPIST: It sounds like one agenda item for today is to continue this discussion. Let's put on the agenda what Eva, James, and Maria are talking about—feeling depressed and overwhelmed, and thinking that you don't even have the energy to participate in the group and that you will never get better. Does anyone else have anything they want to be sure that we talk about today?

Review of Initial Reactions to and Progress in *MOM2*

The therapist will add discussion of the learning assignment given to the group members in their pregroup individual sessions (the *MOM2* readings and exercises) to the agenda if the members don't do so themselves. To help group members begin to understand their problems from a CBT perspective, the group leader can draw the five-part model

(Figure 2.1, *MOM2,* p. 7) on a whiteboard and ask group members to describe how their experiences fit or don't fit with this model. A simple exercise like this encourages members to begin talking and participating in the group. Here is how the therapist in the vignette just presented used Eva's agenda item as a prompt to spark group discussion of the five-part model:

THERAPIST: Eva, would it be OK with you if we talked more about your feeling depressed and overwhelmed, and see how your moods might fit with this five-part model from the *Mind Over Mood* book?

EVA: Sure.

THERAPIST: OK. Let me stand up at the whiteboard here and see if we can understand your situation in terms of these five parts of the model. (*Interviews Eva and James to review what was said earlier, and writes their comments on the drawing of the model, as shown in Figure 15.1.*) Even without knowing what things are going on in the environment of Eva's and James's lives, I'm curious about what connections, if any, people in the group see among these four parts of their experience.

In whatever interaction follows, the therapist can emphasize the interconnection among thoughts, moods, behavior, and physical functioning, and can introduce the idea that changes in any one of these areas are likely to result in changes in the other areas. These ideas can provide a basis for encouraging members to participate actively in the group, as Eva's and James's group therapist did:

"Eva and James, I appreciate your breaking the ice in the group and sharing your experiences. I know that you are feeling overwhelmed right now and feel like you may never get better. Even though you don't have a lot of energy, would you be willing to put as much effort as you can into the group for the next few weeks to see if we can begin to help you to feel better?"

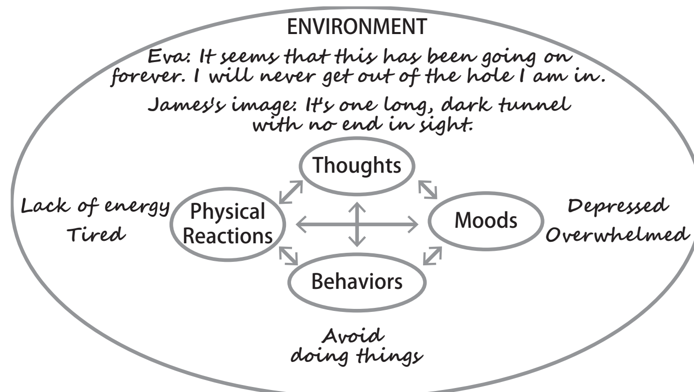


FIGURE 15.1. Eva's and James's experiences as written on the drawing of the five-part model in the first group therapy session. Copyright © 1986 Christine A. Padesky.

Other group members can offer personal examples of the five-part model from their own lives and discuss the responses they wrote down on Worksheet 2.1, Understanding My Problems (*MOM2,* p. 14) prior to this first group session. The therapist uses this discussion to find similarities in group members' experiences and link these commonalities to common features of depression (e.g., avoidance; inactivity; negative views of self, world, and future) that they will learn more about in Chapter 13 of *MOM2,* Understanding Your Depression.

Encapsulated Learning Summaries

A summary of individually significant learning points can also be written on the whiteboard. Group members can write down important ideas they want to remember in either their copies of *MOM2,* a therapy notebook, or an electronic record. If group members want to take photos of the whiteboard with their phones, there should be no information written there that will violate group members' privacy. It is respectful to ask if everyone in the group is comfortable with the idea and willing to allow the whiteboard to be photographed. If so, guidelines for use of these photos should be developed. For example, it would violate the group's privacy if someone posted such a photo on social media.

Learning Assignments between Sessions

A common assignment after the first group session is to read Chapters 3 and 4 of *MOM2.* These chapters provide information and practice regarding connections between the five parts of the cognitive model and guidance on how to identify and rate moods. Group members are encouraged to complete all worksheets in assigned chapters. Clients are more likely to complete learning assignments when these assignments consolidate learning that was started in session and are discussed with curiosity and interest in the next session (as described in the Troubleshooting Guide at the end of Chapter 2 of this clinician's guide). Therefore, the skills described in Chapters 3 and 4 of *MOM2* are introduced in Group Session 1, practiced at home after that session, and then reviewed in Session 2. This same pattern of introducing and practicing skills in a group session, assigning more practice at home, and reviewing members' practice experiences in the next session is followed each week of the group.

Feedback

The final minutes of each group session are spent eliciting feedback from group members. This feedback should include both what was helpful about that session and what could be improved. The therapist can say: "This is the time to let me know if I am doing anything that makes the group a negative or positive experience for you. I welcome all your feedback, because it is important to me that this is a beneficial group experience for each of you." Encourage group members to give feedback on pacing, time management, the group leader's demeanor, and any other relevant group processes.

Group Session 2

The second group session begins with a mood check, agenda setting, and reviewing the between-session learning assignments. It is best to review learning assignments near the beginning of each session, to gauge the members' skill development and to emphasize the importance of completing between-session assignments. For example, in this second session, the review can help clients better understand the connections between thoughts and the other four elements of the five-part model. This session is an opportunity to further develop group cohesion and to deepen the sense of trust, openness, and safety.

Focal points for this session are Worksheets 4.1, Identifying Moods (*MOM2,* p. 28), and 4.2, Identifying and Rating Moods (*MOM2,* p. 30). These worksheets ask clients to view their moods as connected to, but not the same as, situations. Group members can talk about times in the past week they experienced depression and the situations in which this occurred. The following vignette from a second group therapy session demonstrates this.

THERAPIST: Luiza, you mentioned that you wanted to talk about being depressed at a graduation party that you went to this weekend. Can you tell us more about that?

LUIZA: Sure. My nephew graduated from high school last week, and our family had a party for him this weekend. I was sitting alone in the backyard watching everyone talking so easily and enjoying themselves. I felt so removed from the celebration and so depressed and alone. My cousin sat down next to me and tried to talk with me, but I don't think it went very well. I had a hard time finding the right words to say, and then he left and got involved in talking to someone else.

MARY: That happens to me also. I can be in a room full of people and just feel so alone. I get overwhelmed, and then if someone tries to talk to me I get so nervous that I can't respond. I know just how you felt, Luiza.

Depression Group Suggested Agenda: Session 2

- Mood check, agenda setting.
- Review learning assignments: Worksheets from *MOM2* Chapters 3 and 4, and relevant mood inventories.
- More practice in identifying and rating moods.
- Introduction to *MOM2* Chapter 13 and activity recording (Worksheet 13.4).
- Learning assignments: Read *MOM2* Chapter 13 (through p. 211), and complete all worksheets.
- Elicit and give feedback.

THERAPIST: It sounds like it's painful for both of you to be around so many people and feel so alone. You both have described your experiences well. Would it be OK with you both to put these experiences on the whiteboard as an example of identifying moods?

LUIZA: Sure.

MARY: Yes.

THERAPIST: (*Writes their examples on the whiteboard, as shown in Figure 15.2.*) Thank you for sharing these experiences. These are both excellent examples. We can talk more about these experiences in a moment. Before we do, though, I want to write on the whiteboard how these experiences look on Worksheet 4.1, which you filled out at home this week. The Situation lines are for simply describing who, what, when, and where: who you were with, what you were doing, where you were at the time, and when it was. The Moods lines are for describing your mood, usually in one word. There can be more than one mood in any situation, but each one can generally be described in one word. Luiza identified that she felt depressed; Mary said that she felt overwhelmed and anxious. I am using Luiza's and Mary's experiences as examples because they are such good descriptions, and because I want to make sure that everyone understands how to complete Worksheets 4.1 and 4.2. Are there any questions about the worksheet so far? OK, Luiza, before we talk more about your experience at the graduation party, can you rate how depressed you felt at the party, using the 0–100 scale from Worksheet 4.2?

Skills being developed in this group session are the abilities to describe situations in which moods occur and then identify, label, and rate those moods. These are the skills needed to complete an Activity Record, which is the next learning assignment. Identifying situations and moods and rating moods are also skills required to fill out two of the first three columns of a thought record: Situation, Moods, and Automatic

WORKSHEET 4.1

Luiza's

Situation: Sitting in backyard at graduation party. First alone. Then with cousin.

Moods: Depressed.

Mary's

Situation: In a room full of people.

Moods: Overwhelmed. Anxious.

FIGURE 15.2. Luiza's and Mary's examples of situations and moods for Worksheet 4.1 discussion. From Greenberger and Padesky (2016). Copyright © 2016 Dennis Greenberger and Christine A. Padesky. Adapted by permission.

Thoughts (Images). Although the thought record is not introduced until a later group session, group members will have had quite a bit of practice with these two necessary skills by the time it is taught. Mood ratings will also help group members evaluate in the coming weeks whether or not behavioral interventions are effective.

The stages and skill development levels of the group members determine how agenda items are used. In the second or third group meeting, agenda items are used as examples to distinguish between situations and moods, and to help members develop the skills of accurately describing and rating moods. In later sessions, these same types of agenda items provide opportunities to look for evidence that does or does not support hot thoughts, and to construct alternative or balanced thoughts. In still more advanced sessions, agenda items are used to identify underlying assumptions, to develop alternative assumptions, and to devise behavioral experiments and Action Plans.

Group Session 3

When people are depressed, they tend to have less energy, to feel less motivation, and to do fewer activities that give them a sense of accomplishment, joy, or meaning. A primary purpose of the third group session is to introduce behavioral activation as described in *MOM2* Chapter 13. Exercises in this group give members the opportunity to discover whether or not there is a connection between their activities and their moods. Behavioral activation is an important antidepressant skill and will be emphasized over at least two or three group sessions.

Group members have tracked their activities during the past week and simultaneously recorded their levels of depression on an Activity Record (Worksheet 13.4, *MOM2,* pp. 206–207). Activities and moods recorded on that worksheet are analyzed to look for patterns, with the aid of the prompting questions on the Learning from My Activity Record worksheet (Worksheet 13.5, *MOM2,* p. 208). Did group members' moods change during the week? If so, what were they doing when they felt better? What were they doing when they felt more depressed? Were there certain times of the

Depression Group Suggested Agenda: Session 3

- Mood check, agenda setting.
- Review learning assignments.
- Introduction to activity scheduling: Complete Activity Scheduling exercise (*MOM2,* p. 213) in this session; have group members begin filling out Worksheet 13.6 with personalized activities.
- Learning assignments: Use Worksheet 13.6 for week's activity scheduling; finish reading *MOM2* Chapter 13.
- Elicit and give feedback.

day or the week when they felt better or worse? Based on their answers to these questions, what activities can they plan the following week to help them to feel better?

The following vignette illustrates a portion of this third CBGT session.

Therapist: Marta, would you be willing to share some of your responses to Worksheet 13.5—the one that asks questions about your Activity Record?

Marta: I guess I can do that. What do you want to know?

Therapist: Well, to start, I'm curious overall about whether filling out this worksheet provided any insights into the connection between what you do and how you feel.

Marta: I guess it did. I realized that when I lie around in bed all day, which is what I normally do on weekends, I feel more depressed. Especially at the end of the day—I'm so disappointed in myself because I haven't done anything. I feel ashamed of myself when this happens. If I am able to force myself to get up and shower and get out of the house, I tend to feel a little better—not much, but a little bit.

Philomena: I noticed almost the same thing on my worksheet. The less I do, the worse I feel.

Salvador: Same with me. I also noticed that when my grandkids are around, I perk up a little bit. They are able to put a little bit of a smile on my face. The time of the week when I felt best was when I was with them.

Therapist: So, for all three of you, it sounds like there is a connection between what you do and how you feel. Overall, the more you do, the better you feel. And for Salvador, doing certain meaningful things, like spending time with your grandchildren, is one key to feeling better.

Encapsulated summaries of what group members have learned from their Activity Records can be written on the whiteboard and in members' notes. Generally, people observe that they feel less depressed when they do more. Also, activities linked to pleasure, accomplishment, overcoming avoidance, and members' personal values tend to provide the most reliable mood boosts. Once these learning points are derived from group members' experiences during the past week, there is a smooth transition to filling out the Activity Scheduling exercise (*MOM2,* p. 213). This exercise can be completed in session. The group can brainstorm ideas, and group members make their individual lists in each of the four areas in that exercise. Next, group members can figure out the best ways to add these activities to their copies of the Activity Schedule (Worksheet 13.6, *MOM2,* pp. 214–215), which is the primary learning exercise for the coming week.

Group Session 4

Activity scheduling has been addressed in Group Session 3, and this skill is further developed in Session 4. The therapist will attend to both the successes and challenges

group members report regarding that week's attempts to increase activities. Do group members notice patterns among everyone's experiences? For example, can they provide examples related to these questions?

> "Did doing more activities seem to help more than doing fewer activities?"
> "Did more meaningful activities help more than doing less meaningful activities?"
> "Did it matter if activities were consistent with values?"
> "Did any of the four types of activities help more than other types?"
> "Did highly enjoyable activities help more than less enjoyable activities?"
> "Were any activities avoided that could be beneficial to do?"

Quite commonly, some members report that they did not do the scheduled activities, either because they didn't have the motivation or energy to get started or they did not believe that the exercise would be helpful. The barriers these group members encountered during the week should be identified, both so they feel less alone with these struggles and so the group can help problem-solve ways for them to do more activities in the coming weeks. These were the goals in this portion of a fourth group session:

MANNY: I just couldn't get going with this exercise. I marked down what I wanted to do, but I did so little. I just didn't feel like doing anything.

JANIS: I felt the same way most of the week. I just didn't feel like doing anything. I just didn't think that I could do it, or that it would be worth the effort to get myself out of the house. I will say, though, that I noticed that getting dressed and getting some errands done made me feel pretty good—momentarily.

THERAPIST: Manny and Janis, I'm so sorry. It sounds like you both had a difficult time this week. Janis, can you say how you got past not feeling like doing anything on the day you did get dressed and did some errands? Maybe that would help Manny.

JANIS: I'm not sure I know. Maybe what got me going was just how awful it feels to lie around the house. In the last group session, Maria said she was surprised that she felt more motivated after she started doing something,

Depression Group Suggested Agenda: Session 4

- Mood check, agenda setting.
- Review learning assignments.
- Troubleshoot barriers to doing activities.
- Learning assignment: Continue with activity scheduling (Worksheet 13.6).
- Elicit and give feedback.

even though she wasn't motivated before she began. With that in mind, I guess I was willing to try.

KATERINA: Manny, I sometimes feel the same way as you. I know how awful that is for me, and my heart goes out to you. I also know that what Janis is saying works for me too. I had a hard time getting started with this assignment and getting out of my own way. Once I was able to stop thinking and get moving, I felt a little better.

THERAPIST: I'd like to take a moment to summarize. All three of you, and maybe others in the group, at some point felt like not doing anything—or you thought that even if you did do something, it would not be worthwhile or helpful. At that moment you were feeling awful, and that was a hurdle that was difficult to get over. Janis was able to get moving because she remembered how awful it felt to just lie around the house, and she recalled that Maria said her motivation came after she did something, not before. Katerina got moving when she somehow got "out of her own way" and stopped thinking and started doing things. Manny, do you think any of these ideas can help you when you look at your scheduled activities this coming week?

Therapeutic responses to these issues of inertia, pessimism, and feeling overwhelmed when thinking about activities have been presented in the Troubleshooting Guide at the end of Chapter 8 of this clinician's guide. Interventions recommended there (e.g., the five-minute rule, simplifying activities, behavioral experiments) can be introduced in this fourth group session as ideas to try when members have trouble doing activities.

Group Session 5

Because behavioral activation is an important skill in depression treatment, the fifth group session continues to focus on activity scheduling. This session consolidates group members' learning regarding behavioral activation, addresses questions, and troubleshoots barriers that members may still experience. If group members are managing to be more active and experiencing mood improvement, this session can also introduce the thought record, which is the focus of the next few group sessions.

This is the last group session with a primary focus on behavioral activation; future sessions emphasize cognitive skills. Therefore, this session can be considered a bridge between behavioral and cognitive interventions. The group therapist can create a natural segue between behavior and cognition by identifying and addressing thoughts and images that interfere with behavioral activation. The following dialogue illustrates one way this can occur.

THERAPIST: Clem, last week you were having some difficulty getting the behavioral activation exercises started. I'm curious: How did you do with them this week?

CLEM: I did a little better, but honestly I didn't do a whole lot different, and mostly I just had a hard time getting started.

Depression Group Suggested Agenda: Session 5

- Mood check, agenda setting.
- Review learning assignment: Worksheet 13.6.
- Review members' goals.
- Introduce thought records (first three columns).
- Learning assignments: Read *MOM2* Chapters 5 and 6 and complete all worksheets; continue activity scheduling.
- Elicit and give feedback.

THERAPIST: I'm sorry to hear that. Let's see if we can figure out what interfered with your getting going. Would that be OK with you?

CLEM: I guess so.

THERAPIST: Can you remember any moment this past week when you were close to doing something that may have given you a sense of accomplishment or pleasure, but you decided not to do that activity?

CLEM: I think so. I used to play in a co-ed recreational soccer league on Friday nights. Friday I thought about going, and I actually had marked it down on the exercise in *Mind Over Mood* where we were supposed to identify things that we wanted to do. I intended to go play, but I never made it there. I just didn't get it together.

THERAPIST: That's a good example. Can I ask you a few questions about what happened in the 30 or 60 minutes prior to deciding not to go play soccer?

CLEM: Sure. I guess so.

THERAPIST: (*Stands at whiteboard and draws the first three columns of a thought record.*) Clem, when did you decide not to play soccer that night?

CLEM: I don't know exactly when. But the game starts at 7:00, and people start arriving at 6:30 to warm up a little bit. I would have needed to leave the house at 6:15 to get there in time. When I looked at the clock at 6:45, I knew it was too late to go. I just resigned myself to staying home again. I did not feel good about it, and it made me feel even more depressed than normal.

THERAPIST: OK. So in column 1, I am going to write "Friday night about 6:45 P.M., thinking about going to play in the soccer game." In column 2, I am going to write "Depressed" as the mood. How would you rate your depression on a 0–100% scale?

CLEM: I think about 90%.

THERAPIST: So you were really feeling quite depressed. I'm glad we are looking at this situation. Let me ask a few more questions. As you were considering going to play, what kind of thoughts or images did you have about going?

CLEM: What do you mean?

THERAPIST: Well, for me, when I am thinking about doing something, I often have an idea of how I think it will go. Sometimes I have an active imagination and will imagine in great detail how I think the evening will play out. At other times I just have a momentary prediction or idea of what I think will happen. As you considered going to play soccer, did you have any thoughts about what would happen?

CLEM: Oh. I thought that it was going to be cold. Sometimes too many people show up to play, and not everyone gets to play the whole time. I saw myself standing on the sidelines, being cold and watching other people play for most of the night.

THERAPIST: That's so good that you are that aware of what you were thinking. I am going to write those thoughts down in column 3 on the whiteboard. Anything else go through your mind as you were thinking about playing soccer?

CLEM: The other thing that went through my mind is how awkward I feel when people invite me to go for a beer after the game. I'm always uncomfortable in social situations with new people, and I feel like I'm in a situation where it is difficult to say no, but I'm setting myself up for a more uncomfortable situation if I say yes. It's a "lose/lose" situation for me at that point.

THERAPIST: It sounds like you had a number of negative thoughts about that night, and I can understand now why you were hesitant to go. I also think there is a lot we can learn from that moment. I'm going to fill in column 3 with the thoughts that you identified, and then we as a group can talk about this. [See Figure 15.3.]

By introducing the first three columns of a thought record with a focus on the thoughts and images that interfered with Clem's going to play soccer, his therapist combined a familiar experience (behavioral activation) with a new skill (thought record) and provided a natural bridge to the cognitive portion of this CBGT depression group. After the group's discussion, this therapist provided an encapsulated summary:

> "Thanks to Clem, we learned some really important things tonight. We've seen how doing activities can lift our mood. But it looks like we also need to pay attention to the thoughts and images that stop us from doing activities. And Sophia pointed out that the benefit of activities can be spoiled if we think negative thoughts while we do them."

The fifth group session is a good time to ensure that group members are tracking their progress toward therapy goals. Members can review their mood progress with

1. Situation **Who?** **What?** **When?** **Where?**	**2. Moods** **a. What did you feel?** **b. Rate each mood (0–100%).**	**3. Automatic Thoughts (Images)** **a. What was going through your mind just before you started to feel this way? Any other thoughts? Images?** **b. Circle or mark the hot thought.**
Friday night about 6:45 P.M., thinking about going to play in the soccer game.	Depressed 90%	Image: I saw myself standing on the sidelines, being cold and watching other people play for much of the night. I will feel awkward if I get invited to go for a beer after the game. I'm always uncomfortable in social situations with new people, and I feel like I'm in a situation where it is difficult to say no, but I'm setting myself up for a more uncomfortable situation if I say yes. It's "lose/lose" for me.

FIGURE 15.3. Introduction to first three columns of a thought record, using Clem's situation.

the group leader by looking at charts of their weekly scores on the *Mind Over Mood* Depression Inventory (Worksheets 13.1 and 13.2, *MOM2,* pp. 191–192). Also, it is worth spending some time focusing the group's attention on Signs of Improvement (Worksheet 5.4, *MOM2,* p. 37). These signs are often overlooked by people who are depressed, because they are likely to pay more attention to what is not going well and how badly they feel.

Although Group Session 5 includes a goal review and could introduce the 7-Column Thought Record, remind group members that activity scheduling does not end when new skills are learned. The purpose of activity scheduling/behavioral activation is to develop new habits to support doing activities that can have a positive impact on mood, especially when feeling depressed. Ideally, activity scheduling continues until depression lifts and mood-boosting activities become routine.

Group Session 6

As part of their learning assignment during the past week, group members have read Chapter 6 of *MOM2*. That chapter teaches how to distinguish among situations, moods, and thoughts, which are recorded in the first three columns of a 7-Column Thought Record. The sixth group session introduces the 7-Column Thought Record if this was not already done in the previous session. Learning to use a 7-Column Thought Record is the second antidepressant skill taught and is the primary focus of the next few groups. It is an important skill, because thought records help group members identify and test the negative automatic thoughts that are pervasive in depression.

The next several group sessions focus on mastering the components of 7-Column Thought Records, so that members will develop the skills necessary for their effective

use. This group structure follows the approach detailed in Chapter 4 of this clinician's guide. Therapists who are not fully familiar with teaching people how to use 7-Column Thought Records can review that chapter. Here is a recap of the basic prompting questions for the first three columns of a thought record:

Situation (column 1): "Who were you with? What were you doing? Where were you? When was it [time frame of 30 minutes or less]?"
Moods (column 2): "Describe each mood in one word (for instance, 'depressed,' 'afraid'). Rate on a 0–100% scale."
Automatic Thoughts (Images) (column 3): "What was going through your mind just before you started to feel this way?"

The following example illustrates how to link the first three columns of a thought record with group members' agenda items.

THERAPIST: Clem and Sophia, when we set the agenda, you both indicated that you wanted to talk about difficult experiences this week. Would it be OK with you if we talked about what happened and write on the whiteboard what your experiences would look like in the first three sections of the thought record?

CLEM: Sure.

SOPHIA: Yes.

THERAPIST: As we are doing this, I'd like other group members to ask the prompting questions we just discussed to help us figure out what to write in each column. I will draw the first three columns of a 7-Column Thought Record on the whiteboard. Look at Worksheet 7.2 on page 58 of *Mind Over Mood* to see the questions we want to ask ourselves. Ask Clem and

Depression Group Suggested Agenda: Session 6

- Mood check, agenda setting.
- Review learning assignments.
- Discuss progress toward individual goals.
- Discuss and practice first three columns of thought records (*MOM2* Chapter 7). Use group members' examples to help fine-tune skills involved in completing the first three columns.
- Learning assignments: Read *MOM2* Chapter 7 and complete all worksheets; continue activity scheduling and weekly mood ratings.
- Elicit and give feedback.

Sophia these questions, so we can accurately fill out this thought record. (*Draws the first three columns of a thought record.*) OK, Clem, would you mind going first? Can you describe for us what was upsetting for you this week?

CLEM: So I was really down over the weekend. I didn't have anything to do, no one called me, and I basically sat around the house all weekend by myself. It was depressing.

THERAPIST: It sounds like a difficult weekend for you, Clem. Thanks for talking about it with the group. Starting with column 1 on the whiteboard, who has a question for Clem that would help us to fill out this thought record? As we are doing this, let's keep in mind that this is an exercise that can help us feel better.

LINH: You said we want to narrow the situation down to 30 minutes or less. So I guess the question would be "Was there a time over the weekend when you were most depressed?" Is that right?

THERAPIST: That's an excellent question, Linh. In the Situation column, we want to focus on a time frame of between a few seconds and 30 minutes. So you are right to ask Clem, "When over the weekend were you most depressed?"

CLEM: I guess that would have been about 7:00 on Saturday night. I realized that no one had called me to get together, and I was going to be spending yet another evening by myself. I guess I was hoping that I would get a call to do something with my friends.

DYLAN: Maybe another question is "What was going through your mind just before you started feeling this way?"

CLEM: I'm not sure, exactly. I was just very down. Feeling sorry for myself. Feeling like no one likes me or wants to be with me or makes any effort to get together with me. I feel like such a loser.

LINH: Is it important to rate how strong your mood was?

THERAPIST: Yes. Clem, on a 0 to 100 scale, how depressed were you feeling in this situation?

CLEM: I was feeling pretty bad. I guess I would rate my level of depression at about a 90. It was bad but I have felt worse.

THERAPIST: Clem, I'm so sorry you had such a tough time Saturday night. I am going to summarize on the whiteboard, in these columns, what you just described. What do you think goes in column 2 here? Column 3? (*Gets input from various group members and summarizes Clem's description on the whiteboard, as shown in Figure 15.4.*) Clem, I wonder if you could hold on to all that for right now. We are going to return to you and figure out what to do with what you described. First, let's see if we can similarly summarize Sophia's experience. (*Clem nods.*) Sophia, can you tell us more about the experience you wanted to talk about?

SOPHIA: Sure. My situation is almost the opposite of what Clem described. I have been very depressed lately, and I just don't have the energy that I used to

have. On Thursday night at dinner my husband told me that he wanted to invite people to our home over the weekend, and the thought of that was just overwhelming to me. I was so stressed out that I burst into tears when he suggested it.

LINH: I know exactly how you feel, Sophia. When I am really down, I just want to be left alone. I can't handle any extra request—I am barely able to hang on and put one foot in front of another.

DYLAN: So, if we ask the questions on the whiteboard, I guess I want to ask, "What went through your mind when you felt overwhelmed? Did any words or images go through your mind?"

SOPHIA: I guess I just thought that there is no way I can entertain a house full of people this weekend. I'm depressed, I'm tired, I can barely get through my day, and there is no way I can handle a group of friends and family being here when I am feeling this way. I just can't do it. I was feeling overwhelmed and stressed. I'd rate those about a 95.

THERAPIST: I can see how that would be overwhelming. It feels like you are hanging on by a thread, and then you have this extra burden that is looming in front of you. I get it. Let's see if we can summarize this in the same way that we did for Clem. (*Invites group members to summarize what goes in each of the first three columns on the thought record for Sophia's experience, as shown in Figure 15.4.*)

The remainder of this group session was devoted to further processing Clem's and Sophia's experiences, beginning with identifying the "hot thought" for each. It is ideal to complete all columns of a 7-Column Thought Record for at least one hot thought, so group members can see the benefits of learning to use this tool. Group members

1. Situation	2. Moods	3. Automatic Thoughts (Images)
Clem: Saturday night, 7:00 P.M. Alone at home.	**Clem:** Depressed 90%	**Clem:** No one likes me. No one wants to be with me. No one makes any effort to be with me. I'm a loser.
Sophia: Thursday, eating dinner with husband. He tells me that he wants to invite people to our home this weekend.	**Sophia:** Overwhelmed, stressed out 95%	**Sophia:** I cannot entertain a house full of people. I can barely get through my day. There is no way I can handle a group of friends and family being here when I am feeling this way. I just can't do it.

FIGURE 15.4. First three columns of a thought record (as given in Worksheet 7.2), using Clem's and Sophia's agenda items.

will read and complete worksheets in *MOM2* Chapter 7 for their next learning assignment, which gives them additional experience with filling out the first three columns of a thought record. Since this is a depression group, the therapist will remind group members to choose situations for their thought records in which the primary mood is depression.

Group Session 7

Group therapists need to be flexible in pacing group content, so that members have sufficient time to develop skills before moving on to the next topic. Some depression groups will be able to begin looking for evidence in Group Session 7; other groups may need to spend another session focused on identifying automatic thoughts or images and determining the hot thought. The best way to determine the proper pace is to notice how well group members are able to complete the worksheets assigned for the past week. If most group members did a reasonably good job of filling out the first three columns of a thought record, then it is OK to proceed to teaching about the evidence columns (4 and 5). If most group members struggled with filling out the first three columns of a thought record on the worksheets in Chapter 7 of *MOM2,* then this seventh group session can focus again on practicing the skills involved in the first three columns.

The group in the example below struggled with filling out the first three columns of a thought record. Notice how their therapist slowed the pace and reviewed these skills with them.

THERAPIST: Daniel, you put on the agenda that you wanted to talk about lunch with your former coworker. Can you tell us about that?

DANIEL: I guess so. It was really a hard day for me. I was half looking forward to meeting with her and half dreading it. After our lunch, I couldn't stop thinking about how sorry she must feel for me. I used to be her manager and so on top of things and in charge. I felt totally depressed driving home from lunch. I was dwelling on how I am so much less than I once was. I know she thinks less of me because of it.

Depression Group Suggested Agenda: Session 7

- Mood check, agenda setting.
- Review learning assignments.
- Introduce *MOM2* Chapter 8. Practice looking for evidence, using examples from Worksheets 7.3 and 7.4 completed by group members this week.
- Learning assignment: Read *MOM2* Chapter 8 and complete all worksheets.
- Elicit and give feedback.

THERAPIST: It does sound like a difficult day.

BELINDA: I have had similar experiences. It feels like people look at me differently since I've been depressed. Fewer people want to be around me, and when I am with other people, I can't wait for our time together to be over.

THERAPIST: How many of you have had experiences like Daniel and Belinda? (*Four other group members raise their hands.*) Since this is a common experience for many of you, maybe it is a good situation to use to clarify things that were confusing to you this week about filling out the first three columns of a thought record. Daniel, can we use your lunch with your coworker to practice filling out the first three columns of a thought record?

DANIEL: Sure.

THERAPIST: Good, thank you. (*Draws the first three columns of a thought record on the whiteboard.*) As Daniel talks more about his experience, I'll ask the group to look at the questions at the bottom of the columns on page 58 of *Mind Over Mood.* We'll fill out these first three columns as a group. I'll start out asking a question or two, but maybe the rest of you can listen carefully to Daniel and ask some of the other questions on that page. So, Daniel, I know from what you told me so far that you had lunch with a coworker, and as you were driving home you felt really depressed. How should I write this in the Situation column?

DANIEL: How about "Alone, in the car, driving home after having lunch with Ellen."

BELINDA: Would "Depressed" go in the Moods column?

THERAPIST: Thanks, Belinda. Daniel, that is the word that you used. Do you think that word most accurately describes how you were feeling as you were driving home?

DANIEL: Yeah.

THERAPIST: OK, let's write "Depressed" in column 2.

SADIE: It says here that we are supposed to rate the intensity of the mood. Is that really necessary?

THERAPIST: Good question, Sadie. Yes, rate each mood in this column. One of the reasons this is important is that you will rerate your mood after we complete the thought record. This second rating will help you determine if a shift in your thinking results in an improvement in your mood. Daniel, if 100% is the most depressed you ever felt and 0% is not depressed at all, how depressed were you as you were driving home from lunch?

DANIEL: 100% is the most depressed I have ever been?

THERAPIST: Yes.

DANIEL: I don't know. I guess about 75%.

THERAPIST: OK, I will mark that down here. (*Writes 75% next to "Depression" in column 2.*)

PETER: According to the book, in the Helpful Hints box, it looks like the next question would be "What was going through your mind just before you started to feel this way?" I am confused, though, about the general and the specific questions. Can you explain that?

THERAPIST: Sure. All of the questions in the Helpful Hints box on page 54 are designed to help you learn to identify your automatic thoughts. The two general questions can be asked by anyone for any mood or situation, and can even be helpful when you have a lot of moods or are not sure what you are feeling. The two general questions are a good place to start. The mood-specific questions are helpful if you know what you are feeling. These specific questions are designed to hone in on the thoughts that are connected to your mood. So Peter is correct that the next question for Daniel would be "What was going through your mind just before you started to feel depressed?"

DANIEL: I'm not sure. I guess it is along the lines of what I said before. I was thinking that Ellen was feeling sorry for me and was wondering how I had fallen so far from when we worked together. And you know what? I agree with her. I am so much less than I used to be.

SADIE: I know exactly how you feel, Daniel. It's like you took the words right out of my head.

THERAPIST: Given what Daniel just said, who in the group can say what goes in Column 3—the Automatic Thoughts (Images) column?

SADIE: Would his thought be the idea that the woman he was having lunch with was feeling sorry for him, or would it be thinking that he is less than he used to be?

THERAPIST: Both. And excellent. I am going to write both of those thoughts on the whiteboard in column 3.

PETER: If we have identified the thoughts, do we need to even ask the specific questions? In that Helpful Hints box, it says that if you are depressed, you also ask yourself, "What does this mean about me? My life? My future?"

THERAPIST: Let's see what happens if we do. Peter, can you ask Daniel that question?

PETER: OK. Daniel, what would it mean about you if Ellen was feeling sorry for you?

DANIEL: Sometimes I'm afraid that I am a total failure—just a loser. Maybe it means that.

THERAPIST: It looks like asking that specific question can help us identify even more thoughts than the general questions revealed. I'll write those thoughts down. Who wants to ask Daniel another part of the specific depression question?

By having the group members practice the first three columns of a thought record again in this seventh group session, their therapist was able to answer members' questions

and clarify points that they did not fully understand the previous week. If there was time in this session, the group could also identify Daniel's hot thought and help him look for evidence that supported and didn't support it, using questions in the Helpful Hints box on page 75 in Chapter 8 of *MOM2*. If there was time to take this step, the learning assignment could include reading Chapter 8 next week. Otherwise, this group could take another week to complete more copies of Worksheet 7.4—filling out the first three columns of a thought record and identifying the hot thought. This extra week could help the members consolidate these skills before they moved to the evidence columns.

Group Session 8

The eighth group session focuses on skills related to:

1. Understanding the difference between facts and interpretations.
2. Making effective use of questions (Helpful Hints Box, *MOM2*, p. 75) to find evidence that supports and does not support hot thoughts.

One advantage of completing the evidence columns (4 and 5) of a thought record in a group is that people generally evaluate other people's beliefs with greater flexibility than they do their own. As the group works together to gather evidence to test one group member's hot thought, the entire group can become more skilled in learning to ask helpful questions and learning to distinguish between facts and interpretations.

Observe how this group therapist helps the group begin to develop evidence search skills in their eighth group session.

THERAPIST: David, earlier we identified your hot thought that people in this group can't be trusted. Would you mind if we used this thought to help us learn how to gather evidence that supports and does not support a hot thought?

DAVID: OK.

THERAPIST: Good. Who in the group has an idea of what question to ask to start us out?

Depression Group Suggested Agenda: Session 8

- Mood check, agenda setting.
- Review learning assignments.
- Review and fine-tune group members' thought records with extra practice, looking for evidence using the questions in the Helpful Hints box on *MOM2* page 75.
- Learning assignment: Continue practice with Worksheet 8.2.
- Elicit and give feedback.

PADMA: In the book, the chapter is called Where's the Evidence? So maybe the first question is "Where's the evidence that we can't be trusted?"

THERAPIST: Excellent question, Padma. That's good.

DAVID: If I understand "evidence" correctly, I have lost my job twice, my father abandoned me, and everyone I have ever been close to has eventually hurt me.

THERAPIST: That history helps us understand experiences you have had that might make you think people in general can't be trusted. Actually, though, it will be more helpful if we look for evidence from the situation in column 1 that supports your hot thought. That's an important clarification for everyone. Try to look in the specific situation where the thought came up. For example, David, your father and your employers hurt you, but they might or might not be just like the people in this group. The situation you are thinking about is the last group meeting, when we were talking about trust. Was there any evidence in last week's session, during that discussion, that people here can't be trusted?

DAVID: No, I can't think of any. But give people enough time, and eventually they will hurt you.

THERAPIST: I can understand, based on your past experiences, why you might think this, David. Even so, look at the Facts versus Interpretations worksheet you filled out this week on page 72 of *Mind Over Mood*. Do you think this idea that the people in this group will eventually hurt you is a fact that everyone here would agree on, or an interpretation based on your experience that others might disagree with?

DAVID: Technically, it is probably an interpretation, but I still believe it.

THERAPIST: OK. Let's write it down in column 4 and put "my interpretation" in parentheses after it. Were there any facts from last week's group or other group experiences that also support your hot thought that people in this group can't be trusted? Everyone is welcome to offer any facts that we can write down in column 4.

DAVID: I think Emmie said she showed a thought record to her husband, and that makes me wonder if she tells him about things being discussed here.

THERAPIST: Good. What part of that would be the fact?

DAVID: "Emmie showed a thought record to her husband."

THERAPIST: Let's write that down in column 4, and we can check out with Emmie in a bit whether she discusses things with her husband that are said in the group. (*Writes what David has said in column 4.*) Anything else? (*Group members shake heads no.*)

THERAPIST: Based on what you all have been reading and practicing, who has an idea of what the next step would be here?

LUCIANA: Would we want to look for evidence that does not support the hot thought?

THERAPIST: How would we do that, Luciana?

LUCIANA: It looks like we ask this question: "Is there any evidence that suggests that the thought 'Others can't be trusted' is not 100% true or accurate?"

THERAPIST: OK. David?

DAVID: No, I can't think of any. Like I said, though, I believe if you give people enough time, they will hurt you.

THERAPIST: Who in the group has a suggestion for David for how to look for evidence that does not support his thought "Others can't be trusted"?

VICTORIA: David, have you ever trusted anyone who has not hurt you?

DAVID: No.

EMMIE: What about us, David? Has anyone in this group hurt you?

DAVID: Like I said, Emmie said she showed a thought record to her husband, and we weren't supposed to talk about the group at home.

EMMIE: I didn't talk to my husband about the group, David. I showed him my own thought record, and we talked about some of my feelings and thoughts.

THERAPIST: That's an important clarification, Emmie. Of course, any of you can talk about your own worksheets with someone you trust. David, what do you think about what Emmie has said?

DAVID: That sounds OK. I wondered about what you told him. But if you didn't talk about anyone but yourself, then I guess that's OK.

VICTORIA: Has anyone in the group ever done anything untrustworthy toward you?

DAVID: Not that I know of. Not yet, anyway.

THERAPIST: Have people in the group done anything that suggests that you can trust them?

DAVID: Well, people seemed concerned. No one has laughed at me. I guess that no one has said anything that was hurtful.

THERAPIST: What does it mean to you that people in the group have not said or done anything hurtful?

DAVID: I know what you want me to say. You want me to say that I am wrong and that people can be trusted.

THERAPIST: No, I'm not trying to prove you wrong. I'm not invested in your saying one thing or another. You have some good evidence to support the idea that people can be hurtful. At this point, I'm just curious about what it means that no one in the group has said or done anything hurtful.

DAVID: Maybe people in this group are different. Maybe this group is not the real world.

EMMIE: David, do you believe me and trust me?

DAVID: I guess so. We haven't known each other that long.

EMMIE: What could I do to get you to trust me even more?

David: I need to think about that. It may take some time.

Emmie: I agree. It does take time to build trust.

In this interaction, group members asked questions to address the issue of trust in David's life and in the group. Given its inflexibility across situations, it appeared that David's hot thought, "People in this group can't be trusted," was probably linked to a core belief that people can't be trusted. The group's therapist kept the group on track with thought record work by treating this thought as an automatic thought tied to the specific situation described in column 1 of David's thought record. By looking for evidence in the situation from column 1, David was able to stay more in the here and now, and to begin considering relevant evidence that didn't support his hot thought. This would have been more difficult if the group had drifted to a focus on his past life experiences.

As this exchange was occurring, the therapist drew the first five columns of a thought record on the whiteboard with information taken from this interchange, as shown in Figure 15.5. The therapist allowed the group members to interact and question each other as much as was warranted to support skill building.

Group Session 9

While group members continue to practice looking for evidence that supports and does not support their hot thoughts, the ninth group session introduces the concept of constructing alternative/balanced thoughts, based on the evidence gathered. This session thus introduces the final 7-Column Thought Record skills. CBGT therapists will focus on:

1. Helping group members develop their abilities to objectively analyze evidence that both supports and does not support an automatic thought.
2. Clarifying the difference between alternative and balanced thoughts.
3. Helping group members learn to generate personally meaningful alternative or balanced thoughts (column 6), based on evidence gathered in columns 4 and 5.
4. Emphasizing the importance of rerating moods (column 7) to complete a 7-Column Thought Record.

Continuing with David's thought record begun in Session 8, the following vignette illustrates how to develop these skills in Session 9.

Therapist: David, looking at the whiteboard and based on the evidence that you gathered in columns 4 and 5 [see Figure 15.5], what would be an alternative or balanced way of thinking about the trustworthiness of other people in this group?

David: I don't know—maybe that "Everyone is trustworthy"?

Padma: Oh, I'm not sure that works well. To me, that seems as problematic as not trusting anyone.

Thought Record

1. Situation Who? What? When? Where?	2. Moods a. What did you feel? b. Rate each mood (0–100%).	3. Automatic Thoughts (Images) a. What was going through your mind just before you started to feel this way? Any other thoughts? Images? b. Circle or mark the hot thought.	4. Evidence That Supports the Hot Thought	5. Evidence That Does Not Support the Hot Thought
In group, Thursday, 7:30 P.M. Talking about trust.	Sad 90%	People in this group can't be trusted.	Give people enough time, and eventually they will hurt you. (My interpretation, based on past experience.) Emmie showed a thought record to her husband.	I trust people in the group to some degree. No one in the group has done anything untrustworthy. Emmie says she just showed her own thought record to her husband. No one in the group has done anything hurtful. People in the group seemed concerned. No one in the group has laughed at me.

FIGURE 15.5. First five columns of a thought record, as used to look for evidence that did and did not support David's hot thought about trusting people in the group.

Depression Group Suggested Agenda: Session 9

- Mood check, agenda setting.
- Review learning assignment: Worksheet 8.2 (looking for evidence).
- Introduction to alternative or balanced thinking: Group exercise completing Worksheet 9.1.
- Learning assignments: Read *MOM2* Chapter 9 and complete all worksheets; for Worksheet 9.2, use tips from Reminder Box on page 99 and Helpful Hints box on page 100; complete at least two more thought records.
- Elicit and give feedback.

VICTORIA: I agree. It just doesn't seem it should be all or nothing.

THERAPIST: You bring up some good points. This is the importance of genuinely attending to all the evidence that was gathered in columns 4 and 5. David listed some important evidence in column 4. As we construct an alternative or balanced thought, we need to take the information in both of those columns into account.

LUCIANA: Is this where we decide between a balanced and an alternative thought?

THERAPIST: Anyone in the group want to try to answer that?

EMMIE: The way that I understand it is that if you cannot find any real evidence that supports your hot thought, then you can develop an alternative thought. But if there is some legitimate evidence in column 4 that supports your thought and evidence in column 5 that does not support your thought, then you should develop a balanced thought that is at least somewhat believable to you.

THERAPIST: That's almost right. We can always write a balanced thought by summarizing the evidence in both columns 4 and 5. Sometimes an alternative thought will just pop into our minds and seem really true to us. Sometimes this is because there is no real evidence that supports your hot thought, like Emmie said. But sometimes an alternative thought holds a lot of weight for us, even if there is some evidence in column 4. In general, if no alternative thought jumps out at you, write a balanced thought.

EMMIE: So David has had some hurtful experiences that make him think people will hurt him over time, even if they seem trustworthy at the start. But he also has some evidence in column 5, so I guess this would be a situation where he looks for a balanced thought?

THERAPIST: Good. David, is there a way of understanding the evidence written in

columns 4 and 5? Is there one statement you could believe that includes all the evidence?

DAVID: As I look at columns 4 and 5 on the whiteboard, I guess I would say, "Even though in the past my trust has been broken, some people may be trustworthy."

EMMIE: For me, it is also important to include the idea that "It takes time to build trust."

DAVID: Yes, I agree with that.

THERAPIST: David, would you come up and write your balanced thought on the whiteboard? (*David does so.*)

PADMA: I saw in the book something about rating your belief in your new thought. Is that really necessary?

THERAPIST: Yes, that is important. The more believable the new thought is to you, the more likely it will be to have a positive impact on your mood. Also, some new thoughts are not very believable in the beginning, but we believe them more over time, especially if we have experiences that are consistent with them. Given that, David, on a 0–100% scale, with 100% being totally believable and 0% being not at all believable, how much do you believe your balanced thought: "Even though in the past my trust has been broken, some people may be trustworthy. It takes time to build trust"?

DAVID: Maybe 25%. I'm not too sure about it just yet. I've been hurt too many times.

THERAPIST: I understand. Trust is very fragile and difficult to repair once it is broken. And I agree that it takes time to build trust.

In this brief vignette, the group members were building their skills for objectively analyzing the evidence gathered in columns 4 and 5 on a thought record in order to generate alternative or balanced thoughts. This is a skill set that requires a few weeks of practice in any group before it becomes easier.

Group Session 10

In the Troubleshooting Guide at the end of this chapter, there is a section called "Falling Behind or Getting Ahead of Schedule." It is suggested that the proposed 15 group sessions can be extended to 16 sessions if there is flexibility to do so. The benefit of adding a group session is that many therapists find group members need additional practice in gathering evidence and developing alternative or balanced thoughts. These two skills can seem complicated at first; having an extra session to consolidate this learning can be worthwhile. In a 16-session *MOM2* depression group, more time can be spent on the thought record in Group Session 10. In a 15-session group, or if members understand and are able to experience mood improvements when they fill out 7-Column

Thought Records, then Session 10 can introduce new ideas. These new ideas are likely to be drawn from Chapter 10 of *MOM2* on strengthening new thoughts, making Action Plans, and developing acceptance. Detailed step-by-step applications of these three skills are offered in Chapter 5 of this clinician's guide.

The choice of whether to use the worksheets on strengthening new beliefs, making Action Plans, or developing acceptance depends on what group members discover from completing their thought records. If the evidence supports an alternative or balanced thought, and yet a person only believes this new thought a small amount, then Strengthening New Thoughts (Worksheet 10.1, *MOM2,* p. 119) can be used to help increase confidence in the alternative or balanced thought. If the evidence gathered mostly supports the hot thought or indicates a life problem that is maintaining depression, then people are encouraged to make an Action Plan (Worksheet 10.2, *MOM2,* p. 125) and take steps to solve this problem. Developing greater acceptance is recommended whenever there is little someone can do to solve a problem and/or a problem is likely to last a long time even when Action Plan steps are taken. Acceptance practice can be guided by Worksheet 10.3 (*MOM2,* p. 129).

The following vignette illustrates setting up and beginning an assignment to strengthen a new thought.

THERAPIST: Any of you who want to try to strengthen your belief in one of your alternative or balanced thoughts this week can use Worksheet 10.1 to help. For example, Sadie, you had the hot thought "People don't like me and I'm unlikable." You only believed your alternative belief, "Some people like me," a small amount—10%. Let's make a list on the whiteboard of what kind of evidence Sadie could look for this week in order to strengthen her new thought, "Some people like me."

VICTORIA: Would people calling her count?

EMMIE: What about people sitting with her at lunch?

Depression Group Suggested Agenda: Session 10

- Mood check, agenda setting.
- Review learning assignment: Worksheet 9.2 (troubleshoot columns 4, 5, 6, and 7 of the thought record).
- Introduction to *MOM2* Chapter 10.
- Learning assignment: Read Chapter 10 in whole or in part, depending upon how much has been introduced in this session. Complete all worksheets in chapter or the portion assigned.
- Elicit and give feedback.

David: Sadie, do you notice if people say hello to you or make eye contact with you?

Sadie: Not really. I tend to look down and avoid eye contact when I'm around people.

David: I wonder what would happen if you looked up or said hello to them?

Emmie: Sadie, you have so many good qualities. There is so much about you to like.

Sadie: I don't know. I don't think so.

Lily: What about people starting a conversation with you?

Belinda: Or continuing a conversation that you start?

Therapist: (*At the whiteboard*) So here is what you've suggested so far for experiences Sadie can look for that could support her new thought, "Some people like me." (*Writes*:)

1. People call me.
2. People sit with me at lunch.
3. People say hello to me.
4. People make eye contact with me (I need to look up at them to notice this).
5. People start a conversation with me.
6. People continue a conversation that I start.
7. ???

Therapist: These are things other group members think might be evidence that some people like you, Sadie. What do you think?

Sadie: I'm not completely sure about 3, 4, and 6. But I think if people call me or sit with me or start a conversation with me, then that might be evidence.

Therapist: OK, why don't you write those ideas down on Worksheet 10.1 in your book? (*Pauses while she writes.*) I have put question marks for number 7, because we have not listed all the experiences you could have this week that could support your new thought. I think we are all curious to find out next week what experiences you have that we haven't listed here that support your new thought. (*Group members nod and murmur agreement.*)

This exercise primed Sadie to continue with this exercise, engaged other group members in learning how to use the Strengthening New Thoughts worksheet, and modeled the types of evidence each group member could look for to strengthen new thoughts.

Group Session 11

Group Session 11 debriefs any work group members did on the worksheets introduced in the previous session. Some group members, like Sadie, will have worked on gathering evidence to strengthen alternative or balanced beliefs (Worksheet 10.1, *MOM2,*

Depression Group Suggested Agenda: Session 11

- Mood check, agenda setting.
- Review learning assignments.
- Introduce and practice how to identify underlying assumptions.
- Learning assignments: Read pages 132–142 of *MOM2* Chapter 11 and complete all worksheets; continued work on Worksheets 10.1, 10.2, and 10.3 as indicated for each person.
- Elicit and give feedback.

p. 119). Others will have begun to devise and implement Action Plans (Worksheet 10.2, *MOM2,* p. 125) or to practice acceptance (Worksheet 10.3, *MOM2,* p. 129). It is best to spend time on each of these worksheets that group members employed during the week, so people can learn more about their use and effectiveness, even for exercises they did not actively work on in the preceding week. Any of these worksheets not introduced in Group Session 10 can be introduced this week.

In addition, this session can introduce and provide group practice in identifying underlying assumptions (Worksheet 11.1, *MOM2,* pp. 140–141) if the group is ready to learn a new skill. Therapists are referred to Chapter 6 of this clinician's guide to review guidelines and methods for identifying underlying assumptions.

Group Session 12

More individualized skills development is required as more skills are introduced. For example, some group members in the previous week will have primarily worked on developing an Action Plan, and others on acceptance or strengthening new thoughts. Some debriefing of each type of learning assignment is necessary. All group members will have made efforts to identify underlying assumptions (Worksheet 11.1, *MOM2,* pp. 140–141). The underlying assumptions identified can be discussed, and lingering questions about them can be answered.

The new skill set introduced this week is that of designing and carrying out behavioral experiments to test underlying assumptions. Padma volunteered to have the group figure out how to test one of her underlying assumptions: "If people get to know me, then they will reject me." The group and Padma agreed to use a direct test of Padma's belief, which is Experiment 1 on p. 142 of *MOM2.* Before beginning her experiment, Padma filled out the top and the first four columns of Worksheet 11.2 (*MOM2,* p. 149) on the whiteboard: her assumption being tested (see top of Figure 15.6), the experiment, predictions, possible problems, and strategies to overcome these problems (Figure 15.6, first four columns). This information was summarized by the group therapist just before Padma began her experiment:

THERAPIST: So, Padma, you are testing your assumption "If people get to know me, then they will reject me." Your prediction is that when you tell people certain things about you, you will be rejected. You are worried that you will be too nervous to follow through with this experiment, but you are going to remind yourself of how important this is to you and what a unique opportunity you have in this group to experiment with self-disclosure.

PADMA: Yes. It feels like my heart is going to beat out of my chest. I know it is important for me to do. I made a list of a number of things that I don't normally reveal to other people—things that I am embarrassed about or things that just let people in too close. So maybe I can just read off of my list—it might be easier.

THERAPIST: Sure, please do.

PADMA: OK. Here goes. I've been married and divorced twice—and both marriages were abusive, physically and mentally. I have never been in a good romantic relationship. Sometimes I think I just don't deserve it. So much of the time now I just feel alone and unlovable. Actually, I have felt that way most of my life. (*Momentary group silence*)

EMMIE: Oh, Padma, my heart aches for you. I know how terrible that is—my father used to hit my mother before we all left. That helps me understand you so much more. I'm so sorry that you had to go through that.

VICTORIA: It makes me sad to hear that you went through that. It also helps me better understand you—in a good way.

PETER: This must be hard for you to talk about. Men who abuse women make me so mad.

THERAPIST: Thanks for taking a risk to tell the group these things about your life, Padma. How do you feel right now?

PADMA: I'm not sure. A lot of different things. I feel some reassurance and comfort from the group and appreciate that. It's good to know that Emmie understands what it is like to be in that kind of home. I guess I just don't know

Depression Group Suggested Agenda: Session 12

- Mood check, agenda setting.
- Review learning assignments.
- Introduce and practice designing individualized behavioral experiments to test identified underlying assumptions.
- Learning assignments: Read remainder of *MOM2* Chapter 11; begin recording behavioral experiments on Worksheet 11.2.
- Elicit and give feedback.

how to process everything right now. I've never really opened up about these things.

THERAPIST: OK, maybe we can help. Let's think about what just happened in terms of your behavioral experiment and testing the thought "If people get to know me, then they will reject me." Based on what just happened, do you have any sense of being rejected?

EMMIE: Padma, I know that I feel even closer to you now than I did a few moments ago. I feel like you have partially opened a door and let us into your life.

PADMA: What do you mean "partially"?

EMMIE: Well, I'm sure there is much more to the story, and what you did today is just the beginning. But there is so much more that I want to know about you.

VICTORIA: Lord knows, we all have skeletons in our closets. Padma, do you think that any of us have judged you negatively?

PADMA: Honestly, I don't know if you have or haven't. Doesn't seem like it.

THERAPIST: Padma, your prediction was that if you opened up to people, and when they got to know you, then they would reject you. How would you describe the outcome of this experiment?

PADMA: Well, I don't feel rejected. People here seem to be supportive. I appreciate that. No one did anything that felt rejecting or judgmental. I'm not sure what to do with that right now.

THERAPIST: You don't need to do anything right now except write your observations down on your experiments worksheet, in the column for the outcome of the experiment [see Figure 15.6]. Then you can do more experiments like this, and figure out what you learn.

PADMA: I don't know if I can do more experiments. It's hard for me.

EMMIE: Padma, maybe as you open up and people get to know you, some people will have a greater appreciation for who you are.

PADMA: That's kind of hard to believe.

THERAPIST: It does seem consistent with what happened today, though. Maybe we can keep that notion in the back of our minds for now. How did you say that, Emmie?

EMMIE: I think I said that "as you open up and people get to know you, some people will have a greater appreciation for who you are."

THERAPIST: Let's help Padma summarize the outcome of her experiment. First, I know how difficult this was for you, Padma, and I appreciate your taking that risk; it took a lot of courage. What you said earlier is that no one in the group did anything rejecting—and, in fact, the group was supportive. It also may be important to consider Emmie's observation that as people get

WORKSHEET 11.2. Experiments to Test an Underlying Assumption

ASSUMPTION TESTED		If people get to know me, then they will reject me.			
Experiment	**Predictions**	**Possible problems**	**Strategies to overcome these problems**	**Outcome of experiment**	**What have I learned from this experiment about this assumption?**
Tell people in the group some of my secrets.	I will be rejected when I self-disclose and people get to know more about me.	I will be too nervous to follow through with this experiment.	I can remind myself how important this is and what a unique opportunity I have in this group to experiment with self-disclosure.	I don't feel rejected. People here seem to be supportive. No one did anything that felt rejecting or judgmental. What happened (compared to your predictions)? Do the outcomes match what you predicted? Did anything unexpected happen? If things didn't turn out as you wanted, how well did you handle it?	Maybe as people get to know me, some people will have a greater appreciation for who I am. (I'm not sure about this.)

FIGURE 15.6. Padma's behavioral experiment, using Worksheet 11.2. From Greenberger and Padesky (2016). Copyright © 2016 Dennis Greenberger and Christine A. Padesky. Adapted by permission.

to know you, they will have a greater appreciation for who you are. Would that be something that you would be willing to consider?

PADMA: I guess so. Maybe that can be true for some people. I have to give it some thought.

THERAPIST: Fair enough. For now, let's write down the outcome of this experiment and what you have learned today about your assumption on the whiteboard.

An advantage of group therapy is that the observable interactions among group members provide evidence/data regarding interpersonal assumptions and beliefs. As Padma's example illustrates, acceptance and support offered by other group members often run counter to members' long-held beliefs about other people and themselves. Astute therapists pay close attention to these interactions to harvest group acceptance and support, and to bring these into members' awareness while they are building skills that can help them move closer to their goals.

Group Session 13

Group Session 13 continues work on underlying assumptions and behavioral experiments, and introduces the new skills of gratitude and acts of kindness. This group session is an opportunity to strengthen all components of the processes of identifying underlying assumptions and designing behavioral experiments. Group members can review the results of any experiments they have conducted during the past week, and can practice the three types of behavioral experiments described in *MOM2* in the group: (1) Does "then . . ." always follow "If . . . ?"; (2) observe others and see if your "If . . . then . . ." rule applies to them; and (3) do the opposite and see what happens (pp. 142–147).

Empirical studies from the field of positive psychology support the connection among gratitude, acts of kindness, and happiness (see Wood et al., 2010). Focused attention on things in life for which people are grateful is linked to greater happiness and reductions in depression. Exercises such as keeping a gratitude journal (Worksheets

Depression Group Suggested Agenda: Session 13

- Mood check, agenda setting.
- Review learning assignments.
- Introduce gratitude and acts of kindness.
- Learning assignments: Continue with behavioral experiments; read pages 175–187 in *MOM2* (Chapter 12) and begin Worksheets 12.10, 12.11, and 12.12; it is optional for members to choose beginning Worksheets 12.14 and/or 12.15.
- Elicit and give feedback.

12.10 through 12.14, *MOM2,* pp. 176–183) and doing acts of kindness (Worksheet 12.15, *MOM2,* p. 185) help deliberately focus attention on positive aspects of a person's life and can help to strengthen positive moods.

Core belief work is not recommended in a brief therapy group for depression. Recent research suggests that work on core beliefs in group therapy for depression (like the group described here) can be accompanied by worsening depression (Hawley et al., 2017). Generally, development of new core beliefs takes many months. Thus it does not make sense to begin this work with only a few group therapy sessions remaining. Instead, group members are directed to read only the sections of *MOM2* Chapter 12 that pertain to gratitude and acts of kindness—skills that can boost well-being.

Group Session 14

The primary objectives of this session are to debrief the members on their use of the gratitude and acts of kindness worksheets, and to introduce the important processes involved in preparing a relapse management plan. Even so, the session is also likely to include review of various ongoing learning activities. Group members may be continuing to complete worksheets related to behavioral activation, thought records, behavioral experiments, strengthening new thoughts, Action Plans, and acceptance. Each person is probably only working on one or two of these, yet group learning is enhanced when ongoing progress for each member is briefly reviewed in each session.

The following group interaction illustrates how to incorporate gratitude into CBGT.

THERAPIST: One of our agenda items today is reviewing your gratitude journal practice. Who would like to start?

BELINDA: I can start. I enjoyed this exercise. I listed that I am grateful for my physical health and the physical health of my family. I am grateful that I live in a safe neighborhood and I have a job that I enjoy. Those were the main ones on my list.

Depression Group Suggested Agenda: Session 14

- Mood check, agenda setting.
- Review learning assignments.
- Introduce idea of maintaining gains after group therapy through continued skills practice. Help members identify personal high-risk situations and early warning signs of relapse.
- Learning assignments: Read *MOM2* Chapter 16 and complete all worksheets.
- Elicit and give feedback.

EMMIE: I'm not sure if I did this correctly, but I did the gratitude journal somewhat differently. My gratitude list was mostly on smaller things. I put on my list gratitude about the warmth of the sun on my skin, cuddling with my dog, hearing one of my favorite songs, hearing children laugh in my home, and being able to enjoy a museum with my best friend. I hope that I didn't do this wrong.

THERAPIST: No, you did great. We can be grateful for big things like health and safety, and we also be grateful for the moment-to-moment experiences in our lives. One purpose of the gratitude journal is to focus our attention on the positive parts of our lives. There is no right or wrong in terms of what you are grateful for.

PADMA: This is difficult for me, but I wanted to express to Emmie, Victoria, and Peter how grateful I am to them. A few sessions ago when I was talking about being abused, I appreciated your responses to me. You all were very comforting and reassuring, and it meant a lot to me. I put this down on my Expressing Gratitude worksheet.

Therapists can ask members if they want to continue with the gratitude journal, expressions of gratitude, and acts of kindness after the conclusion of the therapy group.

To begin work on relapse management, therapists can conduct several group exercises. The first asks group members to fill out some items on Worksheet 16.1, *Mind Over Mood* Skills Checklist (the Core Skills and Depression Skills items apply to this depression group), to make sure they understand how to use this worksheet. Completing this worksheet will be one of their learning assignments for the week. Next, the group members can define and identify personal high-risk situations that could spark a depression relapse. Each member can be asked to identify early warning signs of potential relapse. If there is time, the group can begin to brainstorm plans of actions for how to implement skills learned in the group to reduce depression in its early stages when warning signs first appear. The learning assignment for this session is for each group member to make a specific personal plan to reduce relapse risk by completing Worksheets 16.1 (*MOM2,* pp. 282–285) and 16.2 (*MOM2,* p. 288) at home.

Group Session 15

The final group session ensures that each group member has constructed a relapse management plan. Progress toward goals is reviewed, along with plans for continued use of *MOM2* to continue progress toward goals not yet met. Describe additional skills not covered in this group (e.g., anxiety, anger, guilt, or shame management methods) that some members may want to explore in *MOM2* after the group ends, to build a stronger sense of well-being over time. This final group session is also an opportunity for its members to say good-bye to each other and to express any gratitude or appreciation toward other members and/or the group therapist.

The following dialogue is taken from the portion of this final session devoted to relapse prevention.

Depression Group Suggested Agenda: Session 15

- Mood check, agenda setting.
- Review learning assignments.
- Review members' progress toward goals.
- Discuss ways group members plan to continue to use *MOM2* to consolidate and expand their improvement and build greater well-being.
- Good-byes.

THERAPIST: Worksheet 16.2, My Plan to Reduce Relapse Risk, was part of your learning assignment for last week. For those who want to share their responses to this worksheet, it might be interesting to draw this worksheet on the whiteboard and show how different people in the group filled it out. Do you want to do that?

EMMIE: Sure.

BELINDA: OK with me. (*Others nod.*)

THERAPIST: OK, who wants to start? I'll mark down what you all say here on the board and use a different-colored marker for each of you. [Figure 15.7 shows how Sadie, Victoria, David, and Peter filled out this worksheet.].

SADIE: I can go first. I think that my highest-risk situation will be people not returning my phone calls or people not wanting to hang out with me—basically whenever I feel like I am being rejected. One thing I learned in this group is that this is what I have the hardest time dealing with. My early warning signs will be feeling hurt and beginning to isolate myself by not asking anybody to do anything.

THERAPIST: Good. And what about your plan of action?

SADIE: What has worked for me so far is reminding myself that I am likable. I understand now that some people genuinely appreciate me.

THERAPIST: Right. If I remember correctly, you did some work on that on the Strengthening New Thoughts worksheet. You could refer back to that.

VICTORIA: Feeling rejected is also a high-risk situation for me. Spending too much time alone is a warning sign for me. As part of my plan of action, I have to keep calling friends or family to find someone to spend some time with.

SADIE: Oh, yes. I need to remember to do that also. I think that would help.

THERAPIST: Be sure to add that to your worksheet, then.

DAVID: For me, my high-risk situation is getting close to other people—especially in a romantic way. Under "My early warning signs," I wrote that I start

to get real anxious and I start to think that I am going to be hurt by this person. I had a hard time with the plan of action, but it was helpful to look over the skills in Worksheet 16.1. I think what may help me is to remember to accept and tolerate those uncomfortable feelings.

BELINDA: I think it is necessary to feel that anxiety and get through it if you ever want to be close to someone again. You might need to do some behavioral experiments.

DAVID: Yeah. I need to remind myself that. I'll write it down.

WORKSHEET 16.2. My Plan to Reduce Relapse Risk

1. My high-risk situations:

Sadie: People not returning my phone calls, people not wanting to hang out with me—whenever I feel like I am being rejected.

Victoria: Feeling rejected.

David: Getting close to other people—especially in a romantic way.

Peter: Being more intensely depressed for a longer period of time than normal.

2. My early warning signs:

Sadie: Feeling hurt and beginning to isolate myself by not asking anybody to do anything.

Victoria: Spending too much time alone.

David: When I start to get real anxious and I start to think that I am going to get hurt.

Peter: More and more tired. Lying in bed whenever I can. Not answering my phone. A Mind Over Mood Depression Inventory score of 15 or more.

Rate my moods on a regular basis (monthly, for example). My warning score is ______

3. My plan of action (review Worksheet 16.1 for ideas):

Sadie: Reminding myself that I am likable. Remembering that some people genuinely appreciate me. Review my Strengthening New Thoughts (Worksheet 10.1). Call people to spend time with.

Victoria: To not spend time alone. Keep calling people to find someone to spend time with.

David: Accept and tolerate my uncomfortable feelings. Behavioral experiments.

Peter: Activity scheduling. Thought records.

FIGURE 15.7. Selected group members' relapse management plan ideas, as developed in Group Session 15 with Worksheet 16.2.

PADMA: I need to remember that, also. (*Writing on her worksheet*)

PETER: I'm not sure if it is a "situation," but I wrote down in the "My high-risk situations" section being more intensely depressed for a longer period of time than normal. I have been feeling so much better in the last month or so, but I worry that this isn't going to last and that I will spiral down again.

THERAPIST: OK, that works as a "high-risk situation." So what would the early warning signs be?

PETER: I generally become more and more tired, I stay in bed whenever I can, and I don't answer my phone when it rings. I wrote down on Worksheet 16.2 that a *Mind Over Mood* Depression Inventory score of 15 or more would be a warning sign, also.

THERAPIST: Peter, I thought that you really developed a good ability to use thought records. Did you mark that down in your plan of action?

PETER: No, but I will. I wrote down to get back to the activity scheduling that we did way back in the beginning of these groups. That was very helpful in lifting me out of a low place, and it would probably be helpful again.

THERAPIST: OK, so I'll mark on the board "Activity scheduling and thought records" for when your early warning signs appear. Would activity scheduling and thought records be helpful for anyone else's plan of action? (*Most members nod their heads.*) Write those on your relapse management plan if they might help you. Be specific: Do you want to do one or two thought records a week until your mood improves? Are there specific types of activities that tend to help you the most? (*Pauses while people write.*) Also, I'd like everyone to think about what *Mind Over Mood* Depression Inventory score might be an early warning sign for you, and write that down in the "My early warning signs" section of Worksheet 16.2.

Notice how this therapist prompted group members to recall skills they developed, and reminded them of what they had learned that might work well when their early warning signs appeared. Group members sometimes forget skills they have practiced earlier. It is helpful to ask them whether behavioral activation and thought records can be helpful parts of their relapse plan.

Postgroup Individual Session

Each group member's progress toward therapy goals is reviewed in a postgroup individual session. Together, the therapist and the group member take a close look at the progression of *Mind Over Mood* Depression Inventory scores (or any other measures of progress) as recorded on Worksheet 13.2 (*MOM2,* p. 192). The review also includes what the member has learned in the group sessions as documented on Worksheet 16.1 (*MOM2,* pp. 282–285), as well as available resources that can help the member achieve or maintain progress toward goals. The Imagine Yourself Coping exercise (*MOM2,* p. 289) can be used to gauge the member's confidence in the relapse management plan.

Depression Group Suggested Agenda: Postgroup Individual Session

- Set session agenda.
- Review client's progress toward goals.
- Review mood inventories and other measures of progress.
- Make referrals or recommendations if more interventions are necessary.
- Conduct imagery rehearsal of relapse management plan, and help client make additions/revisions as needed.
- Review individualized plan for continued progress.

Relapse prevention strategies can be addressed in more detail in this session, to make this plan highly specific: What worksheets and activities? How often? When and how? What plans to overcome barriers?

MODULAR CBGT: SKILLS-FOCUSED AND PROBLEM-BASED APPROACHES

An alternative to protocol-driven CBGT is to develop group "modules" based on the needs and time availability of the populations served. The 15-session group for depression (plus 1 pre- and 1 postgroup individual session) outlined above focuses on building behavioral and cognitive skills as part of a full depression treatment package. It is sometimes necessary or preferable to offer shorter, more focused groups. When this is the case, modules can be developed around particular clinical issues, skills, or sets of skills.

Skills-Focused Modular CBGT

For example, the version of CBGT for depression described above can be thought of as consisting of several modules. There is a module on behavioral activation (Group Sessions 2–5); a module on identifying and testing automatic thoughts by using thought records (Group Sessions 6–10); and a module on addressing underlying assumptions, developing gratitude, acts of kindness and acceptance (Group Sessions 11–14). Therapists are encouraged to use creativity and flexibility to customize groups by using a variety of *MOM2*-inspired modules.

For example, one therapist might develop a 4- to 6-session group for depression that simply focuses on behavioral activation and an understanding of the five-part model. This could be done by providing information and exercises drawn from the

first 5 sessions of the 15-session group model described earlier. If this group decides to continue, another 5-session module can be added that focuses on identifying, evaluating and modifying automatic thoughts (Group Sessions 6–10 as described above). An advantage of this modular approach is that some group members might benefit from taking either a behavioral or a cognitive module twice, rather than flowing immediately from one to another. Other group members might benefit from independent practice of behavioral activation for a few weeks before learning to use thought records. Also, different therapists could lead these modules, in the event that one therapist excels at teaching behavioral activation and another therapist excels in use of thought records.

Similarly, modules can be developed for working with anxiety disorders that target skills described in *MOM2* Chapter 14 (mindfulness; acceptance; overcoming avoidance; recognizing safety behaviors; constructing Fear Ladders to plan exposure experiments; and tolerating exposure to situations that evoke anxiety through use of breathing strategies, imagery, and progressive muscle relaxation). As described in Chapters 9 and 10 of this clinician's guide, a central component of effective anxiety treatments is the use of behavioral experiments to test important underlying assumptions (e.g., "If I start to feel anxious, then I won't be able to tolerate it"). Thus anxiety group modules will incorporate identification of underlying assumptions and testing them with behavioral experiments. The length and types of modular anxiety groups vary, depending on what skills a therapist determines are important, the types of anxiety treated (see Chapter 10 of this guide), and the time available for participants.

The variety of skills taught in *MOM2* is summarized on Worksheet 16.1 (*MOM2,* pp. 282–285). Mood management group modules can be developed, based either on the skills clusters described there or on specific *MOM2* chapters. Therapists can determine what skills will be most beneficial for the populations they serve by considering information drawn from available community survey data and protocols provided in this clinician's guide.

Problem-Based Modular CBGT

An alternative to thinking about groups based on diagnosis or presenting mood is to think about group modules based on a common issue or problem. Often therapists treat a number of people with various diagnoses who struggle with perfectionism, procrastination, rumination, avoidance, relapse prevention, emotional dysregulation, or some other transdiagnostic issue. A sample five-session CBGT module for perfectionism is outlined here.

Perfectionism Module: Group Session 1

- Introduce members and review their goals.
- Socialize members to group therapy.
- Set session agenda.
- Review *MOM2* Chapter 2 (five-part cognitive model).

- Have group provide examples of perfectionistic experiences and put these into five-part model.
- Group exercise with Worksheet 5.1: Set goals pertinent to perfectionism.
- Learning assignments: Read *MOM2* Chapters 2–5, and complete all worksheets
- Elicit and give feedback.

Perfectionism Module: Group Session 2

- Mood check, agenda setting.
- Review learning assignments
- Group exercise with Worksheet 4.2: Identify and rate moods associated with situations that trigger perfectionism.
- Assumption/mood/behavior connection: Practice identifying underlying assumptions associated with perfectionism (Worksheet 11.1).
- Learning assignments: Read *MOM2* Chapter 11, pages 132–142 (identifying underlying assumptions); write down situations this week that trigger underlying assumptions; continue practice with Worksheet 11.1.
- Elicit and give feedback.

Perfectionism Module: Group Session 3

- Mood check, agenda setting.
- Review learning assignments
- Group practice with Worksheet 11.2: Design behavioral experiments to test the underlying assumptions identified.
- Learning assignments: Read *MOM2* Chapter 11, pages 142–151, and continue practice with Worksheet 11.2.
- Elicit and give feedback.

Perfectionism Module: Group Session 4

- Mood check, agenda setting.
- Review learning assignments
- Learning assignment: Continue doing behavioral experiments and considering alternative assumptions with Worksheet 11.2.
- Elicit and give feedback.

Perfectionism Module: Group Session 5

- Mood check, agenda setting.
- Review learning assignment

- Have members make plans to continue behavioral experiments.
- Review skills learned.
- Good-byes.

TROUBLESHOOTING GUIDE: GROUP THERAPY

Different Rates of Client Progress and Skill Development

Group members inevitably learn and progress at different speeds, and so it is important to anticipate differences and have a plan to address them. A skilled group therapist balances the needs of group members who are ready to learn new and more complex skills with the needs of group members who have not yet mastered more basic skills.

One strategy for accommodating clients' different paces of learning is to continue to emphasize basic skills while working on more advanced skills. For example, some group members may be ready to look for evidence that does or does not support their hot thoughts, while other group members need continued work on identifying hot thoughts. The group therapist can draw the first five columns of a thought record on the board. Using examples from group members, the therapist can work with the evidence columns (columns 4 and 5) while continuing to emphasize the skills and processes involved in identifying automatic thoughts and hot thoughts (column 3). Time spent on column 3 provides review and practice for more advanced group members, and another opportunity to learn how to identify thoughts for group members still struggling to do so. Work on the evidence columns is new material for the entire group. Thus more advanced group members begin to learn a new, more complex skill, while less advanced group members continue to practice current skills and are introduced to the next step.

A second strategy for addressing varying levels of progress is to give individual learning assignments tailored to each group member's level of skill development. This ensures that every group member practices appropriate skills between sessions. Although this chapter suggests generic assignments, the assignments are usually collaboratively set with each group member during the session. Often several participants choose the same or similar assignments. Collaboratively setting separate learning assignments takes extra time, but it ensures that all group members are working on skills appropriate to their individual rates of progress.

A third strategy for addressing varying rates of progress and skill development is to pair a more advanced group member with a less advanced group member. The pairs can work together on exercises in group sessions. Ideally, the less advanced group member gets additional help, while the more advanced group member learns the material more thoroughly via teaching. If this paired approach is followed, the group therapist should make efforts to ensure that the interaction is beneficial for both members of each pair.

Group Members Who Are Silent or Too Talkative

Overly talkative or extremely quiet group members are likely to evoke responses from other group members. A nonverbal group member may or may not be problematic. It is

possible to learn, practice, and integrate CBT skills and not be verbal in group sessions. One group member who exemplified this possibility was a man who, despite encouragement from the group therapist, did not say one word during group sessions. At the end of therapy, this man demonstrated in an individual session that he had mastered, practiced, and assimilated the skills taught. Although he offered no comments or feedback to the group, he learned skills, altered his behavior, and made significant therapeutic progress.

It is especially important to check regularly on the learning assignments of silent or quiet group members, to ensure that they are developing skills and progressing toward goals. Therapist feedback on assignments provides valuable guidance for quieter group members. Therapists can also assess the assumptions and beliefs that accompany silence in group sessions. These assumptions and beliefs can sometimes be tested during the sessions. Finally, therapists should offer the quieter/silent group members opportunities to speak in sessions. Although talking is not a demand, quieter group members should be encouraged to talk any time they choose.

Other group members talk so much that it becomes distracting or impedes the group process. Setting standards for group participation at the beginning of a group makes this easier to manage. For example, a therapist can state in the first session that one of the therapist's roles is to make sure there is balanced participation over the course of the group. A sample Session 1 statement could be this:

> "Some people find it easier to talk in groups, and others find it more difficult. Some people are quick to think of things to say, and others need more time. We want everyone to have an opportunity to talk in group sessions. If you have already made a few comments one week, try to wait for others to speak before you talk again. If you forget, I'll either remind you or choose someone else to talk. So don't take it personally if your ideas aren't always the focus of the sessions. It's my job to keep a good balance in this group. To do that, I will sometimes look for ideas from people who have not yet spoken as much."

When one or more members speak too much in group sessions, the therapist can remind them of this statement and encourage them to wait a bit and allow others to speak.

Falling Behind or Getting Ahead of Schedule

Therapists often fall behind or get ahead of a planned group schedule. If a group is ahead of schedule, it can continue to move forward at a pace that is responsive to the members' needs. It can be worthwhile to use the extra time available for group practice of more complicated skills. If a group is consistently ahead of schedule, a therapist should consider whether the sessions are just offering cursory coverage of topics instead of going in depth with skills practice.

Groups can also progress more slowly than the plan outlined in this chapter. It is important for group therapists to be responsive to the needs of their groups. It is preferable for a group to master a few skills than to move along at a pace that is too fast for the members' comprehension. Once a group begins falling behind schedule, the allocation

of session time needs to be reviewed. Is too much time being spent on didactic material, group examples, or interactions that don't benefit the group as a whole? It can be worthwhile to ask the group members for feedback regarding time allocation, pacing, session structure, and content, and to make modifications based on this feedback.

If it is possible to allow 16 group sessions instead of 15 for the *MOM2* depression group outlined in this chapter (in addition to the pregroup and postgroup individual sessions), a group session can be added where necessary in the outlined plan. For example, earlier in this chapter (see the section on Group Session 10 for the depression group), we have noted that many therapists find it useful to add an extra session between Sessions 9 and 10 to provide additional time to practice 7-Column Thought Records.

In a 90-minute group session, approximately 30 minutes are devoted to mood check, agenda setting, and review of the previous week's assignments. Approximately 30 minutes are spent on introducing the new skill(s) of the week, and the remaining 30 minutes are devoted to assigning and beginning the new learning assignments, as well as eliciting and giving feedback. If each group session is two hours long, then these time suggestions can be adjusted accordingly. Time frames for each task should always be flexible, to remain responsive to the changing needs of the group.

Open Groups

This chapter describes "closed groups." In a closed group, all members begin and end the group at the same time. However, in some settings, "open groups" are the norm: Group members enter and exit groups at any time. Guidelines for open groups are similar to those for closed groups in which group members are progressing at different speeds. It is the therapist's task to balance the needs of group members who are more experienced with the needs of newer group members. A beneficial group experience can be achieved by providing both basic and new material in each session.

When more advanced material is presented in an open group, the group therapist can emphasize the basic skills portion of this material for new group members. Sometimes therapists begin each group with a review of the cognitive model guiding the group (i.e., the five-part model). More experienced group members can explain introductory information to newcomers as review and practice of what they have already learned. Throughout the group sessions, in fact, more experienced group members can explain principles, provide encapsulated summaries, and offer examples that can foster learning for the entire group. New group members are encouraged to participate in group exercises at their own skill levels.

Appendix A

Specific Mood Reading Guides from *MOM2*

Depression Reading Guide

A. Chapters 1–4 as an introduction to *Mind Over Mood*.

B. Chapter 13 to learn more about depression and increase the types of activity that help your mood.

C. Chapter 5 to set goals and identify personal signs of improvement that are meaningful to you.

D. Chapters 6–9 to learn how to use Thought Records to identify and test your negative thoughts and generate more balanced or alternative ways of thinking.

E. Chapter 10 to learn how to strengthen your alternative thoughts, use Action Plans to solve problems, and develop an attitude of acceptance for problems that can't be solved.

F. Chapter 11 to learn how to use behavioral experiments to test out negative predictions, address perfectionism, and develop new assumptions that can lead to meaningful change and greater happiness.

G. Chapter 12 to help you develop new core beliefs; sections later in the chapter (on gratitude and acts of kindness) to strengthen positive core beliefs and lead to better relationships and greater happiness.

H. Chapter 14 if you also struggle with anxiety; Chapter 15 if you experience difficulties with anger, guilt or shame.

I. Chapter 16 to help you make a plan to continue to feel better over time.

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Anxiety Reading Guide

A. Chapters 1–4 as an introduction to *Mind Over Mood*.

B. Chapter 14 to learn more about anxiety and make your Fear Ladder.

C. Chapter 5 to set goals and identify personal signs of improvement that are meaningful to you.

D. Chapter 11 to learn how to use behavioral experiments as you move up your Fear Ladder.

E. Chapter 10 to learn either to solve problems in your life with Action Plans, or to develop an attitude of acceptance for problems that can't be solved.

F. Chapter 13 if you also struggle with depression; Chapter 15 if you experience difficulties with anger, guilt, or shame.

G. Chapters 6–9 and 12 to help with other mood and life issues once your anxiety improves.

H. Chapter 16 to help you make a plan to continue to feel better over time.

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Anger Reading Guide

A. Chapters 1–4 as an introduction to *Mind Over Mood*.

B. Chapter 15 to learn more about anger and effective methods to express and/or manage it.

C. Chapter 5 to set goals and identify personal signs of improvement that are meaningful to you.

D. Chapters 6-9 to learn how to use Thought Records to identify and test your angry thoughts and generate more balanced or alternative ways of thinking.

E. Chapter 10 to learn how to strengthen your alternative thoughts, use Action Plans to solve problems, and develop an attitude of acceptance for problems that can't be solved.

F. Chapter 11 to learn how to use behavioral experiments to test out assumptions associated with anger and develop new assumptions that can lead to meaningful change and greater happiness.

G. Chapter 12 to help you develop new core beliefs; sections later in the chapter (on gratitude and acts of kindness) to strengthen positive core beliefs and lead to better relationships and greater happiness.

H. Chapter 13 if you also experience depression; Chapter 14 if you also struggle with anxiety.

I. Chapter 16 to help you make a plan to continue to feel better over time.

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Guilt or Shame Reading Guide

A. Chapters 1–4 as an introduction to *Mind Over Mood*.

B. Chapter 15 to learn more about guilt and shame and effective methods to express and/or reduce them.

C. Chapter 5 to set goals and identify personal signs of improvement that are meaningful to you.

D. Chapters 6–9 to learn how to use Thought Records to identify and test thoughts related to guilt or shame and generate more balanced or alternative ways of thinking.

E. Chapter 10 to learn how to strengthen your alternative thoughts, use Action Plans to solve problems, and develop an attitude of acceptance for problems that can't be solved.

F. Chapter 11 to learn how to use behavioral experiments to test assumptions associated with guilt or shame and develop new assumptions that can lead to meaningful change and greater happiness.

G. Chapter 12 to help you develop new core beliefs; sections later in the chapter (on gratitude and acts of kindness) to strengthen positive core beliefs and lead to better relationships and greater happiness.

H. Chapter 13 if you also experience depression; Chapter 14 if you also struggle with anxiety

I. Chapter 16 to help you make a plan to continue to feel better over time.

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Appendix B

A Personal History of the 7-Column Thought Record

I (Christine A. Padesky) first learned Beck's cognitive therapy in 1978 when he sent a prepublication draft copy of *Cognitive Therapy of Depression* (Beck, Rush, Shaw, & Emery, 1979) to my professor, Connie Hammen, at UCLA, where I was a graduate student. Connie and I had recently published a paper in the *Journal of Abnormal Psychology* on gender differences in responses on the Beck Depression Inventory (Hammen & Padesky, 1977), and this paper put us on Beck's radar. He wrote a note accompanying their manual to tell us that he and his colleagues were developing a new depression treatment at the University of Pennsylvania. He asked us to consider trying this approach at UCLA and tell him what we thought.

One of the interventions used in Beck and colleagues' cognitive therapy approach for depression was a five-column thought record titled the Daily Record of Dysfunctional Thoughts (Beck et al., 1979, p. 288). The five columns of this thought record were labeled Situation, Emotion(s), Automatic Thought(s), Rational Response, and Outcome. While using this thought record in the first few months of doing cognitive therapy, I began to chafe at the language incorporated into it. One of the things I loved about cognitive therapy was its empirical nature. The model clearly stated that we needed to understand clients' beliefs and *investigate* them, rather than directly *challenge* them. And yet here was a primary thought evaluation tool whose titles seemed to prejudge clients' thoughts as "Dysfunctional" and irrational. In addition, as a woman who had been reading feminist writings throughout the 1970s, I was well aware of how often women in emotional distress had been (and still were) viewed as "irrational," and I did not want to perpetuate that view within depression treatment.

I couldn't see how I could use this worksheet and still convey to my clients that I was open to considering their beliefs with an open mind. Thus, after treating several depressed clients, I stopped using the preprinted Daily Record of Dysfunctional Thoughts and began using my own handwritten version, which I titled the Automatic Thought Record (ATR). My five-column ATR relabeled Beck's fourth column

(Rational Response) as Alternative Thoughts, which I hoped would remove the implied assumption that the original automatic thoughts were irrational.

Now that the language of my handwritten form was more acceptable to me, I dived enthusiastically into using it with my clients. Using my new ATR with clients throughout 1979 was enlightening. One day a depressed client noted that this worksheet was much more helpful to him when we completed it together in session than when he used it at home. I asked him why he thought this was so. He wryly smiled and said,

> "I'm depressed, not stupid. When I write a thought in the third column like 'I'm no good,' I know I can write in the Alternative Thoughts column, 'I'm good at some things.' But when we talk about a thought like that in here, you ask me lots of questions and get me thinking about lots of examples from my life. So by the time I write an alternative thought [in a therapy session], I have a lot of ideas in my head to back it up. So it feels more true to me."

With this feedback in mind, he and I spent the remainder of the session creating a new thought record personalized to him that would remind him to think about evidence that fit or did not fit with his automatic thoughts before he wrote an alternative belief.

This session was a turning point in the evolution of the 7-Column Thought Record as it appears in *MOM2*. Over the next few years, I made regular changes in the language and format of my 7-Column Thought Record to match the language and philosophy I was embedding into my therapy with clients. I also sought frequent feedback from clients about how I could make this worksheet more helpful for them. I changed the second column label from Emotions to Moods, to match the more informal language used by most of my clients. In the early 1980s, the importance of imagery began to be discussed in CBT, so I changed the third column heading from Automatic Thoughts to Automatic Thoughts (Images) and added instructions at the top of that column to prompt my clients to look intentionally for images. I also introduced the concept of "hot thought" into this column, because my clients and I were learning that some automatic thoughts were more important than others to test.

This concept of the hot thought was added to the evidence columns, which were carefully titled to reflect empirical and neutral language: Evidence That Supports the Hot Thought (column 4) and Evidence That Does Not Support the Hot Thought (column 5). As my clients and I learned more about writing evidence, the Alternative Thoughts heading (column 6) was rewritten as Alternative/Balanced Thoughts, because sometimes evidence yielded a completely new (alternative) idea, and at other times evidence was mixed in its support of the hot thought. In this latter case, a balanced thought that summarized the evidence in both columns 4 and 5 was more credible to my clients. Since the outcome we were most interested in assessing was whether or not mood had shifted, column 7 was more clearly labeled Rerate Mood and, later, Rate Moods Now.

By 1983, I had been using my 7-Column Thought Record unchanged for more than a year. I copyrighted it and began teaching its use outside our clinic, distributing it to therapists in my training workshops. Most of them had learned to use Beck's Daily

Record of Dysfunctional Thoughts in their training programs. The feedback I received was overwhelmingly positive. Therapists told me that this 7-Column Thought Record, by requiring clients to look actively for evidence that did and did not support their hot thoughts, was much more effective. I was proud of this contribution, and yet I worried a bit: What would Beck think about a recently minted PhD making such a major change to one of his central interventions? He and I were regularly teaching workshops together during this time, so he saw my 7-Column Thought Record during presentations, but he did not make any comments about it. Of course, after the first edition of *Mind Over Mood* was published in 1995, hundreds of thousands of therapists were introduced to this 7-Column Thought Record as an alternative to his five-column Daily Record of Dysfunctional Thoughts.

As a coda to this history, I was honored in 2007 to receive the Aaron T. Beck award (now the Lifetime Achievement Award) from the Academy of Cognitive Therapy (now the Academy of Cognitive and Behavioral Therapies) for my "enduring contributions to the field." To my pleasure, Aaron T. Beck gave me this award himself, and we enjoyed reminiscing in front of the audience about our years of teaching together and our other collaborations over the years. The next day, he invited me to lunch. After nearly 25 years of use of my 7-Column Thought Record, and 30 years of friendship with him, I decided to directly ask him how he felt about my changing his original Daily Record of Dysfunctional Thoughts in such substantial ways. To my relief, Beck smiled and said, "Your 7-Column Thought Record is so much better. Calling that third column 'Rational Response' [in his original record] was one of the biggest mistakes I ever made. For years this marked me as a rationalist, which was never my intent. We use *Mind Over Mood* and your 7-Column Thought Record in our own clinic" (Aaron T. Beck, personal communication, November 17, 2007).

Appendix C

Additional Resources from Christine A. Padesky

Audio and video training materials for mental health professionals, as well as information on workshops, conferences, and other training resources, are available from *www.padesky.com,* a CBT website for mental health professionals. A website for the public, *www.mindovermood.com,* offers links to find CBT therapists and additional information on *Mind Over Mood*.

Clinical demonstrations of CBT include the following (all of which are available via the "Store" link on *www.padesky.com*):

Padesky, C. A. (Filmed appearance). (1993). *Cognitive therapy for panic disorder*[DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (1996a). *Testing automatic thoughts with thought records* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (1996b). *Guided discovery using Socratic dialogue* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (1997). *Collaborative case conceptualization* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (2003). *Constructing NEW core beliefs* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (2004). *Constructing NEW underlying assumptions and behavioral experiments* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (2008). *CBT for social anxiety* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

Padesky, C. A. (Filmed appearance). (2015). *Building resilience with Strengths-Based CBT* [DVD]. Huntington Beach, CA: Christine A. Padesky (Producer).

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