APPENDIX B

# Review of Selected Cognitive Concepts and Techniques

## INTRODUCTION TO COGNITIVE AND COGNITIVE-BEHAVIORAL THERAPY

The basic premise of cognitive approaches to therapy is that dysfunctional or distorted ways of thinking can cause or exacerbate dysfunctional emotions and behaviors. Cognitive interventions identify and target specific distorted automatic thoughts, maladaptive assumptions, and negative or otherwise dysfunctional schemas. The cognitive-behavioral therapist also utilizes behavioral interventions (e.g., behavioral activation and exposure) to assist the patient in testing and challenging cognitive distortions. An information handout for patients about cognitive-behavioral therapy is provided in Form B.1.

## THE THREE LEVELS OF COGNITIVE DISTORTIONS

Beck identifies cognitive distortions at three levels of thinking: "automatic thoughts," "assumptions," and "schemas." Automatic thoughts are thoughts that come spontaneously and seem plausible to a person, but they may become distorted in depressed or anxious patients. Distorted automatic thoughts can be associated with negative affect or dysfunctional behavior. They can be arranged into specific categories (see Form B.2, which is also a handout for patients).

Assumptions are at a deeper cognitive level than automatic thoughts; they are more abstract and generalized. In depressed or anxious patients, assumptions can become maladaptive: They take the form of a set of rules, "shoulds," imperatives, or "if–then" statements that can have disabling effects. Examples of some maladaptive assumptions are provided in Form B.3 (another patient handout).

Schemas exist at a still more fundamental level than assumptions; they reflect deep-seated models of the self and others. Depressed or anxious patients may have a selective focus on certain schemas that mark their vulnerability. Beck, Freeman, and Associates (1990) have identified a variety of negative or otherwise dysfunctional schemas that characterize the various personality disorders (see Table B.1), as well as various types of attempts to avoid or compensate for these

## FORM B.1. General Information for Patients about Cognitive-Behavioral Therapy

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

*(cont.)*

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**FORM B.1.** General Information about Cognitive-Behavioral Therapy (p. 2 of 2)

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

# FORM B.2. Categories of Distorted Automatic Thoughts: A Guide for Patients

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."
2. **Fortunetelling:** You predict the future negatively: Things will get worse, or there is danger ahead. "I'll fail that exam," or "I won't get the job."
3. **Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. "I'm undesirable," or "He's a rotten person."
5. **Discounting positives:** You claim that the positive things you or others do are trivial. "That's what wives are supposed to do—so it doesn't count when she's nice to me," or "Those successes were easy, so they don't matter."
6. **Negative filtering:** You focus almost exclusively on the negatives and seldom notice the positives. "Look at all of the people who don't like me."
7. **Overgeneralizing:** You perceive a global pattern of negatives on the basis of a single incident. "This generally happens to me. I seem to fail at a lot of things."
8. **Dichotomous thinking:** You view events or people in all-or-nothing terms. "I get rejected by everyone," or "It was a complete waste of time."
9. **Shoulds:** You interpret events in terms of how things should be, rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events, and you fail to see that certain events are also caused by others. "The marriage ended because I failed."
11. **Blaming:** You focus on the other person as the *source of* your negative feelings, and you refuse to take responsibility for changing yourself. "She's to blame for the way I feel now," or "My parents caused all my problems."
12. **Unfair comparisons:** You interpret events in terms of standards that are unrealistic—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "She's more successful than I am," or "Others did better than I did on the test."
13. **Regret orientation:** You focus on the idea that you could have done better in the past, rather on what you can do better now. "I could have had a better job if I had tried," or "I shouldn't have said that."
14. **What if?:** You keep asking a series of questions about "what if" something happens, and you fail to be satisfied with any of the answers. "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"
15. **Emotional reasoning:** You let your feelings guide your interpretation of reality. "I feel depressed; therefore, my marriage is not working out."
16. **Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as *irrelevant* any evidence that people like you. Consequently, your thought cannot be refuted. "That's not the real issue. There are deeper problems. There are other factors."
17. **Judgment focus:** You view yourself, others, and events in terms of evaluations as good–bad or superior–inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. "I didn't perform well in college," or "If I take up tennis, I won't do well," or "Look how successful she is. I'm not successful."

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# FORM B.3. Examples of Maladaptive Assumptions: A Guide for Patients

"I should be successful at everything I try."

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

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

"Failure is intolerable and unacceptable."

"I should get the approval of everyone."

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

"I should be certain before I try something."

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

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

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

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

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

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

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schemas. For example, patients with obsessive–compulsive personality disorder (which, incidentally, is *not* the same thing as the anxiety disorder called obsessive–compulsive disorder) attempt to compensate for their problems by trying to achieve perfection, or, in some cases, they may avoid any tasks in which mistakes appear probable. These compensatory and avoidant strategies are also targets for cognitive therapy.

These three levels of cognitive distortions are related in a hierarchical fashion, such that distorted automatic thoughts are the most directly and easily accessible, followed by maladaptive assumptions and then dysfunctional schemas. For example, consider a female patient who goes to a party and thinks of approaching a man. Her automatic thought might be "He'll reject me." The underlying assumption could be "I need to be approved of by men in order to like myself." The patient's schema about herself might be "I'm unlovable," and her schema about men might be "Men are rejecting." These different levels are depicted in Table B.2.

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

## IDENTIFYING AND CHALLENGING COGNITIVE DISTORTIONS

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

Once the therapist has educated the patient about the nature of automatic thoughts and the various categories into which distorted thoughts can be classified (Form B.2 is helpful in this regard), the patient is told that moods (such as sadness or anxiety) are related to the thoughts he or she is having at the time. The patient is therefore asked to keep regular records of events in his or her life and the moods and thoughts related to them, as well as to rate the intensity of these moods. The Patient's Event–Mood–Thought Record (Form B.4) can be used for this purpose; the Patient's Daily Record of Dysfunctional Automatic Thoughts (see Form 2.7 in Chapter 2) can also be used, once the patient has received some coaching in methods of developing rational responses to automatic thoughts (see below). The identification of maladaptive assumptions and dysfunctional schemas is usually not as easy for a patient as the identification of distorted automatic thoughts; therefore, these two types of cognitive distortions are usually identified by the patient and therapist working together in sessions.

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

**TABLE B.1. Dysfunctional Schemas in Personality Disorders**

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

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|---|---|---|---|---|
| Paranoid | Righteous<br>Innocent, noble<br>Vulnerable | Interfering<br>Malicious<br>Discriminatory<br>Abusive motives | "Motives are suspect."<br>"Be on guard."<br>"Don't trust." | Be wary<br>Look for hidden motives<br>Accuse<br>Counterattack |
| Antisocial | Loner<br>Autonomous<br>Strong | Vulnerable<br>Exploitative | "I'm entitled to break rules."<br>"Others are patsies [wimps]."<br>"Others are exploitative." | Attack, rob<br>Deceive<br>Manipulate |
| Narcissistic | Special, unique<br>Deserving special rules, superior<br>Above the rules | Inferior<br>Admirers | "Since I'm special, I deserve special rules."<br>"I'm above the rules."<br>"I'm better than others." | Use others<br>Transcend rules<br>Be manipulative<br>Be competitive |
| Histrionic | Glamorous<br>Impressive | Seducible<br>Receptive<br>Admirers | "People are there to serve or admire me."<br>"They have no right to deny me my just deserts." | Use dramatics, charm<br>Throw temper tantrums, cry<br>Make suicide gestures |
| Schizoid | Self-sufficient<br>Loner | Intrusive | "Others are unrewarding."<br>"Relationships are messy [undesirable]." | Stay away |

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

# FORM B.4. Patient's Event–Mood–Thought Record

Patient's Name: _____

| **Date/time** | **Event:** Describe what happened. What were you doing at the time? | **Mood:** Describe your feelings (sad, anxious, angry, hopeless, etc.), and rate their intensity on a 0–100% scale. | **Thought:** Write down your automatic thoughts at the time. |
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**TABLE B.2. Relationship between Cognitive Levels**

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

Tables, forms, and in-text examples in several chapters of this book (see Tables 2.5 and 2.6; the examples given in the "Cognitive Interventions" section of Chapter 3; Form 3.6 and Table 3.3; Form 4.5 and Table 4.3; Tables 5.3 and 5.4; and Table 6.3) provide practical demonstrations of how cognitive distortions can be challenged and rational responses can be produced.

Table B.3 summarizes the cognitive techniques that can be used to identify and challenge cognitive distortions. More details about these are provided in the CD-ROM that accompanies this book.

**TABLE B.3. Summary of Cognitive Techniques**

| Technique | Description or example |
|---|---|
| | Socializing patient |
| Establishing therapeutic contract | Directly ask the patient about commitment to therapy, such as willingness to come regularly and do homework. |
| Bibliotherapy | Assign readings, such as patient information handouts or books (e.g., Burns's *The Feeling Good Handbook*). |
| Indicating how thoughts create feelings | Example: "I feel anxious [mood] because I think I'll fail [thought]." |
| Distinguishing thoughts from facts | Example: "I can believe that it is raining outside, but that doesn't mean it's a fact. I need to collect evidence—go outside—to see whether it's raining." |
| | Identifying and categorizing distorted automatic thoughts |
| Identifying negative thoughts that come spontaneously and seem plausible | Examples: "I think I'll fail," "I always fail," "It's awful to fail." |
| Identifying the emotions these thoughts create | Examples: Sadness, anxiety. |
| Rating confidence in accuracy of thoughts, as well as intensity of feelings | Example: "I feel anxious [80%] because I think I'll fail [95%]." |
| Categorizing thoughts (see Form B.2 for complete list of categories) | Examples: "I think I'll fail" (fortunetelling), "I always fail" (dichotomous/all-or-nothing thinking), "It's awful to fail" (catastrophizing). |
| | Challenging distorted automatic thoughts |
| Providing direct psychoeducation | Example: Give information about elevator safety to a patient with a specific phobia of elevators. |
| Defining the terms (semantic analysis) | Example: Ask patient, "How would you define 'failure' and 'success'?" |
| Examining testability of thoughts | Can patient make any real-world observations that will confirm or refute thoughts? |
| Examining logic of thoughts | Is patient jumping to conclusions that don't follow logically from premises (e.g., "I'm a failure because I did poorly on that test")? |
| Examining limits on patient's information | Is patient jumping to conclusions without sufficient information? Is patient only looking for evidence that supports his or her thoughts, not evidence that might refute them? |

| Technique | Description or example |
|---|---|
| Vertical descent | Ask, "What would it mean [what would happen, why would it be a problem] if *X* occurred? What would happen next? And what would that mean [what would happen, why would it be a problem]?" |
| Double standard | Ask, "Would you apply the same thought [interpretation, standard] to others as you do to yourself? Why/why not?" |
| Challenging recursive self-criticism | Is patient locked in a loop of self-criticism for being self-critical (e.g., "I think I'm a loser because I'm depressed and I'm depressed because I think I'm a loser")? |
| Examining internal contradictions | Does patient have contradictory thoughts (e.g., "I'd like to meet as many people as possible, but I never want to be rejected")? |
| Reductio ad absurdum | Are implications of patient's thought absurd (e.g., "If I'm single, I'm unlovable; all people who are married were once single; therefore, all married people are unlovable")? |
| Distinguishing behaviors from persons | Example: Indicate how failing on an exam is different from being a failure as a person. |
| Challenging reification | In self-criticisms, is patient making "real" something that is abstract/unobservable (e.g., worthlessness)? Can patient change reifications into "preferences" (e.g., "I prefer doing better at exams")? |
| Examining variability/degrees of behavior | Help patient examine evidence that his or her behavior varies across time, situations, and persons, and that it occurs to varying degrees (not in all-or-nothing ways). |
| Weighing the evidence for and against a thought | Example of thought: "I'll get rejected."<br>Evidence in favor: "I'm anxious [emotional reasoning]," "Sometimes people don't like me."<br>Evidence against: "I'm a decent person," "Some people like me," "There's nothing rude or awful about saying hello to someone," "People are here at the party to meet other people."<br>For: 25%. Against: 75%.<br>Conclusion: "I don't have much convincing evidence that I'll get rejected. Nothing ventured, nothing gained." |
| Examining quality of evidence | Would patient's evidence stand up to scrutiny by others? Is patient using emotional reasoning and selective information to support arguments? |
| Keeping a daily log | Have patient keep a daily log of behaviors/events that confirm or disprove a thought. |
| Surveying others' opinions | Have patient survey others for their opinions and see whether these confirm or disprove a thought. |

*(cont.)*

TABLE B.3 *(cont.)*

| Technique | Description or example |
|---|---|
| Cost–benefit analysis | Example of thought: "I need people's approval."<br>Costs: "This thought makes me shy and anxious around people, and lowers my self-esteem."<br>Benefits: "Maybe I'll try hard to get people's approval."<br>Costs: 85%. Benefits: 15%. |
| Alternative interpretations | Example: Ask patient, "If someone doesn't like you, might it simply be that the two of you are different? Or perhaps the other person is in a bad mood, or shy, or involved with someone else? Or perhaps there are many other people who can and do like you?" |
| Negation of problems | Have patient list all the reasons why the current situation is not a problem, rather than all the reasons why it is a problem. |
| Defense attorney | Tell patient, "Imagine that you have hired yourself as an attorney to defend yourself. Write out the strongest case you can in favor of yourself, even if you don't believe it." |
| Carrying out an experiment | Have patient test a thought by engaging in behavior that challenges the thought (e.g., for the thought "I'll be rejected," approaching 10 people at a party). |
| Continuum technique | Have patient place current situation or event on a 0–100 continuum of negative outcomes and examine what would be better and worse than this situation/event. |
| Putting situation/event into perspective | What would patient still be able to do even if a negative thought were true? Or how does patient's situation compare to that of someone with, say, a life-threatening illness? |
| "Pie" technique | Have patient draw a "pie chart" and divide up responsibility for situation/event. |
| Examining mitigating factors; reattribution | Are there other causes for a situation/event that should be considered (e.g., provocation, duress, lack of knowledge or preparation, lack of intention, failure on others' part, task difficulty, lack of clear guidelines)? If so, can patient reattribute some of the responsibility for the situation/event to these causes? |
| Externalizing both sides of a thought through role play | Take the "con" aspects of a thought while patient takes the "pro" aspects, and engage in a role-play argument (e.g., say, "You'll fail the exam"; patient replies, "There's no evidence that I'll fail"; and continue in this manner). |
| Using role play to apply a negative thought to a friend | Take the role of a friend to whom patient applies a negative thought. How does it sound? |

| Technique | Description or example |
|---|---|
| Acting "as if" | First in role play and then in actual situations, have patient act as if he or she does not believe negative thoughts. |
| Challenging absolutistic thinking | Example: Ask patient, "If you believe that no one will like you, is it plausible that no one in the whole world will?" |
| Setting a zero point for comparisons; depolarizing comparisons | If patient always compares himself or herself to the best, how does he or she compare to the worst? And how does patient compare to people in the middle of the distribution? |
| Positive reframing (finding positives in negatives) | Is there a more positive way of interpreting patient's behavior or situation (e.g., instead of saying, "I really bombed on the exam," can patient say, "I learned I can't procrastinate" or "Thank God that course is over")? |
| Decatastrophizing | Ask patient, "Why would *X* not be so awful after all?" |
| Examining the "feared fantasy" | Ask patient, "Imagine the worst possible outcome of *X*. How would you handle it? What behaviors could you control even if it happened?" |
| Anticipating future reactions | Ask patient, "How will you [or others] feel about *X* 2 days, a week, a month, and a year from now?" |
| Examining past predictions, failure to learn from false predictions, and self-fulfilling prophecies | Has patient generally made negative predictions in the past that have not come true? If so, has patient failed to learn that these predictions have been distorted and biased? Have these predictions turned into self-fulfilling prophecies (i.e., has patient behaved as if they will come true and thus ensured that they will come true)? |
| Testing predictions | Have patient make a list of specific predictions for the next week and keep track of the outcomes. |
| Examining past worries | Has patient worried about things in the past that he or she no longer thinks about? If so, have him or her list as many of these as possible and ask, "Why are these no longer important to me?" |
| Examining future distractions | What are all the other events (unrelated to current event) that will transpire over the next day, week, month, and year and that will cause patient not to care as much about the current event? |
| Distinguishing possibility from probability | Example: Ask patient, "It may be possible that you will have a heart attack if you are anxious, but what is the probability?" |

*(cont.)*

**TABLE B.3** *(cont.)*

| Technique | Description or example |
|---|---|
| Calculating sequential probabilities | Have patient multiply the probabilities of a predicted sequence of negative events. |
| Fighting overgeneralization | Ask patient, "Just because X happened once, does that mean it will inevitably happen?" |
| Challenging the need for certainty | Tell patient, "You can't have certainty in an uncertain world. If you are trying to rule out absolutely all possibility of negative outcomes, you will be unable to act." |
| Advocating acceptance | Suggest to patient, "Rather than trying to control and change everything, perhaps there are some things you can learn to accept and make the best of. For example, perhaps you won't be perfect in your job, but perhaps you can learn to appreciate what you can do." |
| Using "point–counterpoint" with difficult thoughts | For difficult thoughts that are resistant to other techniques, engage in "point–counterpoint" role play with patient. |
| Reexamining original negative thought and emotion, confidence in accuracy of thought, and intensity of emotion | Example: "I feel anxious [15%] because I think I'll fail [20%]." |
| Developing rational response to thought (new, more realistic, more adaptive thought) | Example: "There isn't much actual evidence that I'll fail; therefore, there's no real reason for me to think I'll fail, and no real reason for me to be anxious." |
| <u>Identifying maladaptive assumptions</u> | |
| Determining contents of patient's "rule book" ("shoulds," "musts," "if–then" statements underlying distorted automatic thoughts) | Examples: "I should succeed at everything I do," "If people don't like me, it means there's something wrong with me," "I must be approved by everyone." |
| <u>Challenging maladaptive assumptions</u> | |
| Using techniques for challenging distorted automatic thoughts | See above. |
| Evaluating patient's standards | Ask patient, "Are you setting unrealistic expectations for yourself? Are your standards too high? Too low? Too vague? Do your standards give you room for a learning curve?" |

| Technique | Description or example |
|---|---|
| Examining patient's value system | Ask patient, "What is your hierarchy of values? For example, do you place success above everything else? Are you trying to accomplish everything simultaneously?" |
| Examining social standards | Ask patient, "Are you trying too hard to measure up to society's standards—for example, beauty and thinness for women, or power and status for men? If you don't exactly meet these standards, do you think this makes you a bad or worthless person?" |
| Distinguishing progress from perfection | Help patient examine the advantages of trying to improve, rather than trying to be perfect. |
| Challenging idealization of others | Have patient try to list all the people he or she knows who are completely perfect. Since it's unlikely that there will be any, what does this mean about patient's achieving perfection? Or have patient ask an admired person whether he or she has ever made any mistakes or had any problems, and consider what this person's response implies about patient's idealization of others and devaluation of self. |
| Advocating adaptive flexibility | Help patient examine the benefits of being more flexible in standards and behaviors. |
| Borrowing someone else's perspective | Ask patient, "Instead of getting trapped by your way of reacting, try to think of someone you know who you think is highly adaptive. How would this person think and act under these circumstances?" |
| Emphasizing curiosity, challenge, and growth rather than perfection | Example: Suggest to patient, "If you do poorly on an exam, work on how you can develop curiosity about the subject matter or feel challenged to do better in the future, rather than focusing on your grade as a final measure of your worth." |
| Reexamining maladaptive assumptions and substituting new, more adaptive assumptions | Example: "I'm worthwhile regardless of what others think of me," instead of "If people don't like me, it means there's something wrong with me." |
| Examining costs and benefits of more adaptive assumptions | Example of more adaptive assumption: "I'm worthwhile regardless of what others think of me."<br>Costs: "Maybe I'll get conceited and alienate people."<br>Benefits: "Increased self-confidence, less shyness, less dependence on others, more assertiveness."<br>Costs: 5%. Benefits: 95%.<br>Conclusion: "This new assumption is better than the one that I have to get other people to like me in order to like myself." |

*(cont.)*

**TABLE B.3** *(cont.)*

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

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

*(cont.)*

TABLE B.3 *(cont.)*

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