Topic
Professional & Personal Development

Subtopic
Thinking Skills

Cognitive Behavioral Therapy for Daily Life

Course Guidebook

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Jason M. Satterfield is a Professor of Clinical Medicine and the Academy Endowed Chair for Innovation in Teaching at the University of California, San Francisco (UCSF). He also serves as the director of the UCSF School of Medicine's Health & Society Block as well as its Health and the Individual Block. Professor Satterfield received his BS in Brain Sciences from the Massachusetts Institute of Technology with a special minor in Psychology from Harvard University. He completed his PhD in Clinical Psychology at the University of Pennsylvania (Penn), where he worked with Dr. Martin Seligman.

Professor Satterfield was trained as a cognitive behavioral therapist at Penn's Center for Cognitive Therapy under the supervision of Drs. Aaron T. Beck, Judith Beck, Robert DeRubeis, and others. His clinical work has included adaptations of cognitive behavioral therapy for underserved, medically ill populations and psychological interventions for patients with serious chronic illness. He is the past director of the UCSF Behavioral Medicine Unit, which integrates mental and behavioral health services into adult primary care.

Professor Satterfield's book *A Cognitive-Behavioral Approach to the Beginning of the End of Life* and the accompanying patient workbook, *Minding the Body*, were recognized as Self-Help Books of Merit by the Association for Behavioral and Cognitive Therapies. He is also an associate editor of the best-selling

textbook *Behavioral Medicine: A Guide for Clinical Practice*, now in its 5th edition. Professor Satterfield's special clinical publications include treatment models for cognitive behavioral therapy, treatment adaptations to improve cultural competence, and a transdisciplinary model to promote evidence-based behavioral practices in medicine, including interventions for smoking, weight management, drug abuse, and chronic disease management. He is a coauthor of a national report detailing the role of behavioral science in medicine, and he served on the Behavioral and Social Science Subcommittee that revised the Medical College Admission Test—work that was featured in the *New England Journal of Medicine* and *The New York Times*.

At UCSF, Professor Satterfield has been nominated for multiple teaching awards, including the Robert H. Crede Award for Excellence in Teaching and the Henry J. Kaiser Award for Excellence in Teaching. He is the past chair of the Academy of Medical Educators' Scholarship Committee and received the academy's Cooke Award for the Scholarship of Teaching and Learning.

Professor Satterfield grew up in Middle Tennessee and was the first in his family to attend college. After living in Boston and Philadelphia for school, he moved in 1994 to San Francisco. He is an avid traveler and enjoys a large circle of friends and family.

Professor Satterfield's other Great Courses include *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*; *Mind-Body Medicine: The New Science of Optimal Health*; and *Boosting Your Emotional Intelligence*.

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DISCLAIMER

This series of lectures is intended to increase your understanding of the emotional and social lives of children and/or adults and is for educational purposes only. It is not a substitute for, nor does it replace, professional medical advice, diagnosis, or treatment of mental health conditions.

These lectures are not designed for use as medical references to diagnose, treat, or prevent medical or mental health illnesses or trauma, and neither The Teaching Company nor the lecturer is responsible for your use of this educational material or its consequences. Furthermore, participating in this course does not create a doctor-patient or therapist-client relationship. The information contained in these lectures is not intended to dictate what constitutes reasonable, appropriate, or best care for any given mental health issue and does not take into account the unique circumstances that define the health issues of the viewer. If you have questions about the diagnosis, treatment, or prevention of a medical condition or mental illness, you should consult your personal physician or other mental health professional. The opinions and positions provided in these lectures reflect the opinions and positions of the relevant lecturer and do not necessarily reflect the opinions or positions of The Teaching Company or its affiliates.

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Cognitive Behavioral Therapy for Daily Life

Cognitive behavioral therapy (CBT) is a well-tested collection of practical tools for managing emotions, improving social relationships, maximizing work productivity, and even modifying health-related behaviors through self-awareness, critical analysis, and taking steps toward gradual, goal-oriented change. CBT provides a clear and compelling model that illuminates the relationships between thoughts, emotions, and behaviors and uses those connections to gather and tailor practical tools to stimulate change. Built on a solid foundation of cognitive and behavioral research, CBT is not just about treating mental illness. CBT is an approach almost anyone can use to promote greater mental health, manage emotions, and improve functioning in nearly any domain.

In this course, you'll learn about CBT by constructing your own CBT toolbox filled with strategies best suited to your goals. You'll learn about each tool through active exercises and by sitting in on therapy sessions where clients are learning and practicing the tools to address the problems they face. Those problems include worry, anxiety, sadness, grief, procrastination, perfectionism, rejection sensitivity, and a host of medical issues, including insomnia, pain, addiction, and chronic disease management.

Although this is the second Great Course on CBT, it is designed to stand alone and to complement the first CBT course: *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*. The focus in this new course is on building your toolbox and learning how to use it. The first CBT course includes many tools but also spends more time covering the conceptual basis for CBT, research that supports CBT, and the ways CBT is used to treat specific mental illnesses. Taken together, these two CBT courses will provide a complete and practical introduction to what has become the most popular form of therapy and self-improvement. You get the science as well as the practical tools you can apply to daily life.

This course begins where therapy begins: with a broad overview and some goal setting. First, the main goal for the course will be set: an understanding of the CBT toolbox, including foundational knowledge and skills like self-

monitoring, goal setting, and distinguishing between cognitions, emotions, and behaviors. You'll learn about the two compartments of the toolbox, in which you'll organize both cognitive and behavioral tools—all of which address emotion regulation and/or improvements in functioning in the social, occupational, and physical/medical domains. You'll be introduced to the three primary clinical cases that will be followed throughout the course, and you'll begin your own workbook to capture your goals and the milestones you'll set to achieve them.

From there, the course will present a variety of common concerns that your CBT tools can help you address. Unlike the first CBT course, nearly all of these appear in daily life and do not fall in the realm of mental illness—a distinction that the course will help you make throughout. These common concerns include how to worry less, how to let go of outdated beliefs about yourself, how to use a structured approach to solve complex social problems, how to accept imperfection, how to stop procrastinating, and how to better ease the sting of social rejection. The course will also address the challenges of living with a chronic illness or chronic medical symptom like pain or insomnia. You'll learn what tools fit and when and how to use them. Drawing on adult learning theory, toolbox recaps are nested throughout the course to help you solidify your knowledge and internalize your new skill set.

In perhaps a first for The Great Courses, the approach used in this new CBT course is based on feedback from customers who worked through the first, highly rated CBT course. Customers suggested that this second CBT course focus more deeply on skills and provide more opportunity to review and consolidate skills. They even shared some of their own CBT adaptations—making this a sort of open-source CBT. Their tips and tricks will be shared as you dig deeper to create a solid, scientifically sound toolbox worthy of everyday use. Roll up your sleeves, open your toolbox, and prepare to learn.

All of the worksheets from the therapist guide and patient workbook *Minding the Body* can be downloaded for free here: https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195341645.001.0001/med-9780195341645-appendix-1.

LESSON 1

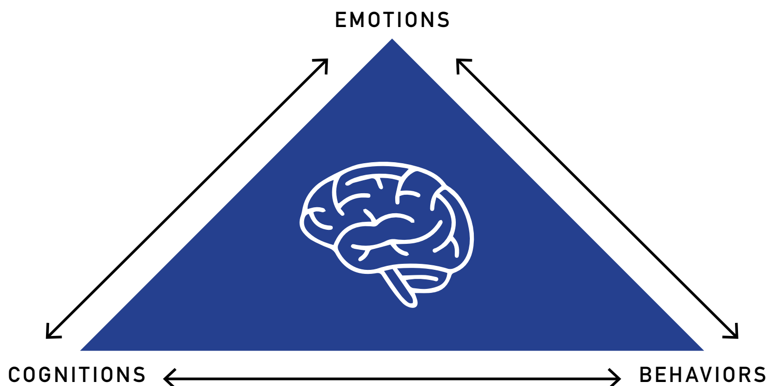
A CBT TOOLBOX: TOWARD WISE LIVING

For this skills-based course, the CBT toolbox is the organizing principle. Each tool will be illustrated through the use of exercises, and you'll explore the process of how to best select CBT tools and when to deploy them.

> If you are interested in the history of CBT, its conceptual underpinnings, or evidence supporting its use for various psychopathologies, check out the Great Course *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*.

OVERVIEW OF THE COGNITIVE BEHAVIORAL MODEL

- The CBT triangle is a simple diagram that has the words *emotions*, *cognitions*, and *behaviors* at each of its three corners.



- *Emotions* include both positive and negative feelings, such as depression, anxiety, and happiness.
- *Cognitions* are mental activities, such as thoughts, memories, and even mental images.
- *Behaviors* are activities.

- Each corner of the triangle influences the other. For instance, the way we think affects the way we feel. But the way we feel also affects the memories we call to mind—the lens through which we view the world. So it works in both directions.

- When you're in the behavior corner, if you're engaged in an activity you really enjoy, it's going to lift your mood. If you're engaged in an activity you don't enjoy, it's probably going to push down your mood. And this goes both ways, so if you start your day in an energetic, happy mood, you're more likely to be active.

- So if you want to change the way you feel—for example, if you want to push your way through grief and move forward—one way to do that is to look at how you're thinking (cognitions) and what you're doing (behaviors). And if there is a way for you to intentionally change them so that you can change your emotions, that might help you get unstuck.

- The tools that you'll be adding to your toolkit fall into the cognitive or behavioral categories—and some of them are a mix of both. You'll track whether those tools are effective in changing your emotions. Part of what you'll learn is not just which tool is right for which occasion, but also that you have the power to reach in, cognitively or behaviorally, and actually change the way you feel.

THE CORNERS OF THE CBT TRIANGLE

- Each of the three corners of the CBT triangle—behaviors, cognitions, and emotions—will be key in helping you organize and use your CBT toolbox.
  - The behaviors category includes all types of activities, either done alone or with others. Behaviors include things you have to do and things you want to do. They include activities that give you a sense of connection or achievement. They include both helpful and hurtful activities.
  - Cognitions is also a broad category that includes any type of mental activity, including thoughts, images, memories, and even music and fantasies. Cognitions occur on many layers of depth, from surface-level, automatic thoughts; to conditional assumptions; to the core beliefs that you hold at your center.

> "All that we are arises with our thoughts. With our thoughts, we make the world."
>
> »THE BUDDHA

  - The emotions category includes multifaceted sources of information that tell you something about yourself, your relationships, or the world around you. You can think of this category as a full-bodied weather report. Emotions include sensations, feelings, thoughts, and behaviors. Examples are sadness, anger, anxiety, and love.

- The goal of this course is to give you the CBT tools to help you become your own therapist. The course is goal-directed and symptom-focused, though it does not necessarily look at mental illness. You should take notes, do homework, and do what you can to test out the new ideas. Keep in mind that even if a bit of distress gets triggered, it might be helpful in the long run.

YOUR CBT TOOLBOX

- In your CBT toolbox, you'll deposit all of the various tools you use throughout this course. Some of them will fit for you and some won't, but at least you'll have a full toolbox and the ability to choose whatever you need when you need to.
- The foundation for your toolbox will include basic knowledge about CBT and the basic skills of self-assessment, goal setting, and self-monitoring (collecting data about yourself or about something related to your goals).
- Your CBT toolbox will have two primary compartments: cognitive tools and behavioral tools. Each of these will have two primary targets: emotion regulation and functional improvements (advances in social, occupational, or physical functioning, such as improved performance at work or in relationships or improved physical health).
- By better regulating your emotions or improving your level of functioning, you are then positioned to accomplish just about anything you want, such as getting a better job, forgiving a spouse, beating insomnia, or cultivating gratitude.

DISTINGUISHING COGNITIONS, BEHAVIORS, AND EMOTIONS

- Underneath both the cognitive and behavioral compartments of your toolbox, there are key ideas, knowledge, and foundational skills that need to be in place before you get to the more advanced tools. Let's start with what might seem deceptively simple: distinguishing cognitions, behaviors, and emotions.

YOUR RESOURCE LIBRARY

- The Great Course *Mind-Body Medicine: The New Science of Optimal Health* lays out the basic science of how the outside gets inside—or how your life and experiences influence your biological health—and what you can do about it.
- *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*, the first Great Course on CBT, heavily emphasizes basic tools to retrain your brain away from depression, anxiety, anger, or maladaptive ways of coping. Because the course leans heavily on the cognitive and behavioral sides of the CBT triangle, the next Great Course in this collection focuses on the third corner of the triangle: emotions.
- *Boosting Your Emotional Intelligence* is all about emotions and emotion regulation.
- This second CBT course, titled *Cognitive Behavioral Therapy for Daily Life*, is the fourth addition to this library of courses, and it features the CBT toolbox.

EXERCISE

- Classify each of the following as an emotion, a behavior, or a cognition.

1. sadness
2. worry
3. calling a friend
4. imagining a sick friend
5. envy
6. jogging

ANSWERS

1 emotion; 2 cognitive behavior *(You get credit if you answered either cognition or behavior; it's really an internal behavior.)*; 3 behavior; 4 cognition; 5 emotion; 6 behavior

- It can be tricky to sort things into the three categories of the CBT triangle. But it's important to know how to do this because if you know whether you're working with behavior or with cognition, you might use different tools. Or if it's an emotion you're trying to tackle, you would probably not try to hit the emotion immediately but instead look at the associated cognition or behavior.

- As you continue your work in this course, you'll keep practicing sorting. You will need to be able to separate emotions, cognitions, and behaviors so that you can begin to use your CBT skills—those three corners of the CBT triangle.

EXERCISE

- Give an example of an emotion,* a behavior,** and a cognition*** that you derive from this story:

Sally was gloomy. It had rained all day, and all she had done was look out the window and sigh. Why does it always have to rain on my birthday?

- Pulling these elements out of a story will prove particularly important as you begin to listen to your own stories and try to pull them apart.

* Feeling gloomy (maybe that's sad, dejected, disappointed, self-pitying, or just bored) is an emotion.
** Looking out the window and sighing is a behavior.
*** A cognition might be something like this: "Why does it always rain on my birthday? Poor me; this is so terrible."

HOW TO CHANGE YOUR BEHAVIORS AND EMOTIONS

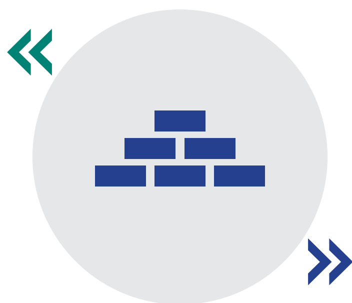
- Just as our brains can be exercised or trained to improve cognitive function, we can also train our brains to improve motivation, management of emotions, interpersonal and occupational skills, and even physical health.
- We know that social interactions—in other words, relationships—have the power to change the brain. We also know that school seminars and trainings can facilitate a rewiring as we learn new skills. It would follow that a therapy and skill set like CBT might do the same.
- We're hoping for something called a wise mind. Imagine that you have an emotional mind and a logical mind. Both can be important, but is there a middle road that draws from both? This is where we find a wise mind, which uses both logic and emotion.

HOW TO GET THE MOST OUT OF THIS COURSE

- It is essential that you apply the knowledge that you learn in this course by practicing it. Interleaved practice seems to be the most effective. In tennis, it's better to learn the backhand and the forehand at the same time. Learning one skill helps the other. The same will be true for your cognitive and behavioral skills. You'll first learn an overview of skills and then learn how to apply them.
- It will be important to keep a positive attitude as you work through the course. Accept what you're able to do and know that you can repeat, review, and revisit individual lessons as many times as you want.

> "Change is hard. Real change is real hard."
>
> »FRITZ PERLS

- As you learn about how thoughts and behaviors influence emotions and motivations, you'll be having thoughts about thoughts, and feelings about feelings. This course will trigger ideas, excitement, boredom, agreement, or even outrage. It's all grist for the mill. It's cognition and action. Use it as a real-world CBT opportunity to dig deeper—to understand your response and to possibly control it.
- CBT has been enormously helpful for many people. But it's really hard to find a good CBT therapist. So consider this course a way to bring CBT home to you.



LESSON 2

LAYING A FOUNDATION: ASSESSMENTS AND GOALS

Self-assessment and self-monitoring are foundational skills for your toolbox. While self-assessment gives you a better sense of your strengths and areas for improvement, self-monitoring allows you to collect real-world data about yourself. Both can help you determine whether you're making progress toward achieving your goals.

DOMAINS OF ASSESSMENT

- In terms of assessment, the first Great Course on CBT addressed specific questionnaires and scoring and where to find various assessments online. It also covered the diagnostic criteria for depression, anxiety disorders, post-traumatic stress disorder, and other mental illnesses.

- But some people may be on the same spectrum for anxiety or depression but don't yet meet diagnostic criteria—and may never meet diagnostic criteria.
- We all have difficult periods where we might experience heightened anxiety or a notable drop in mood or we just can't seem to shake off our irritability or social withdrawal. The assessment tools in this lesson are thus less about assigning a diagnostic label and more about assessing severity and maybe pointing toward an explanation and a possible solution—a tool from your CBT toolbox.
- And it isn't just about working through the hard times. It's also about creating (or at least promoting) happiness, satisfaction, and meaning.
- Although it would be terrific if people had mental wellness visits, where they focus on strengths and support ongoing growth, the reality is that most people seek out a mental health professional because something is wrong. They or someone they love is suffering, and they haven't been able to fix it themselves.
- So the initial domains of assessment usually focus on some sort of impairment: emotional, psychological, cognitive, social, or medical. The impairment often has a trigger, or something that started it all off and may still be sustaining the problem—such as losing a job, experiencing the death of a loved one, or getting a bad medical diagnosis. So the next domain is about stressors: the trigger and any sustaining factors. The last big bucket is any environmental or other contextual factors that may contribute to, or may help, the situation.
- The kinds of data a therapist wants to collect include a thorough social and medical history, any current medical and psychological symptoms, and signs of functional impairment (such as difficulty at work or problems in important relationships). The therapist wants a snapshot of the present troubles but also an idea of what the baseline was before this all started.
- The therapist also wants to get an idea of the timeline: Is this a new problem, or has it been going on for years? This gives the therapist a clue about how long it might take to provide relief. The therapist starts with hearing the patient's story but also uses a battery of quantitative questionnaires and hopes that the two sources of data match up.

FROM THE THERAPIST'S PERSPECTIVE

- In initial visits with patients, therapists have several goals. They want to gather data about their patients to figure out what's going on and how to help them. And while they do that, they need to establish a caring and collaborative relationship.
- There are also a number of implicit variables that therapists are interested in, such as body language, voice quality, and eye contact. For example, when a patient talks about his or her chief complaints, the therapist is listening for how organized those complaints are and what parts are emphasized. Has the patient thought about his or her issues? Is the patient trying to manage the therapist's impressions of him or her? What is said, what is unsaid, and what is implied?
- It would be quite difficult to assess your own implicit variables in this way, but instead you can do the following exercise.

EXERCISE

- Create a set of diary prompts and then respond to them as best as you can. Start with your demographics. Then, list your chief complaint, along with any symptoms you've noted, any strengths you have, and so on. This is a useful exercise in getting everything down on paper.

- When therapists are talking with a patient, they're also keeping in mind diagnostic criteria—for example, does the patient meet criteria for depression? They're also thinking about the patient's safety and whether he or she is in crisis.
- On a subtler level, therapists tune in to what feelings the patient is invoking in them; this is another important source of data. Is the patient a charmer, or is he or she somewhat prickly and pushing the therapist away? This gives the therapist an idea of what the patient evokes in others, too.

- Finally, therapists look for behaviors that may interfere with the patient's progress. Is the patient late to appointments? Is he or she unprepared? Does he or she have trouble focusing during the session? It's important to know these things so that they can be addressed later.

SOURCES OF QUANTITATIVE DATA FOR SELF-ASSESSMENT

- There are several different sources of quantitative data you might use to assess yourself. There are surveys, diaries, and journals; apps, websites, and wearable devices; and medical tests and labs. What you pick really depends on your interest and your needs.

- There's a relatively new online resource called the Patient-Reported Outcomes Measurement Information System (PROMIS)* that is free, evidence-based, and available in many languages. It was funded by the National Institutes of Health and includes a treasure trove of validated measures and scoring guides for physical, mental, and social well-being.

- In addition to measures like those found under PROMIS, you're also interested in measures of cognition, behavior, and emotion to flesh out the CBT triangle.

    - *Questions you might ask for thoughts*: What was it that just went through your mind? Could you put that into words? As you were feeling that particular emotion, what were you thinking?

    - *Questions you might ask for emotions*: What are you feeling right at this moment? When you went through that event, what were the emotions that were evoked for you?

    - *Questions you might ask for behaviors*: What's going on in your body? How does your body feel? What did you do next? What do you usually do? What are the things that you've stopped doing?

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* www.healthmeasures.net

- Once therapists have several sources of data on a patient, they want to start putting it all together. They want to better understand what makes a person tick. In CBT, this is called a case formulation.* And therapists want to keep it transparent, collaborative, and open to revision.
- A case formulation is an individualized theory that explains a particular patient's symptoms and problems, serves as a basis for an individual treatment plan, and guides the therapy process.
- With the help of a therapist, you would likely take a battery of standard assessments, set goals, keep a therapy journal, and do some self-monitoring. If you're doing this on your own, start with some simple global self-assessments. These are subjective by definition, so don't worry too much about them. But be sure to include any specifics about what's working well and what's not.
  - On a scale of one to 10, how would you rate your physical health?
  - On a scale of one to 10, how would you rate your social health?
  - On a scale of one to 10, how would you rate your mental health?
- Then, take your lowest rating—the worst score—and find a few quantitative questionnaires that resonate with you. You'll take those now and then again every week or two while you're actively working toward your goal.**
- It's recommended that you first go to the PROMIS website and then look up the issue that you think is most important. This will give you a starting point and a general progress score as you move forward.

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* If you're interested in case formulations, check out the now-classic book *Cognitive Therapy in Practice: A Case Formulation Approach* by Jacqueline Persons.
** It's unrealistic to be a 10 out of 10 in every category all the time.

SETTING SMART GOALS

- The goals you set are the next big area where you'll want some solid assessments. And this really depends on the goals you set.
- At first blush, the idea of setting goals might seem relatively simple and straightforward, but it's not. If you want to increase your chances of success, then you have to be very specific and concrete, not to mention realistic and strategic.
- In other words, you want to set goals that are SMART: specific, measurable, attainable, relevant, and timely.
  - *Specific*: You want to get very detailed about what you want to do.
  - *Measurable*: You need to be able to tell whether you're making progress.
  - *Attainable*: You want realistic goals that you can accomplish.
  - *Relevant*: Your goals need to fit what you're struggling with.
  - *Timely*: You need to define specifically when you'd like to complete your goals by—for example, in the next six or 12 months.
- You need to create SMART goals before you can start creating a formulation and selecting tools for your treatment plan.
- The other essential part of setting goals is accurately assessing your resources (knowing your strengths) and anticipating obstacles or challenges that might come up. You can't know the future, but you can prepare for it.
- Self-monitoring—or collecting objective data about yourself—is one of the foundational cross-cutting skills, and it relates closely to monitoring progress toward goals. Self-monitoring might focus on mood, activities, sleep, anger, etc. It really depends on whatever your goals are. It might capture triggers, contextual or environmental factors, or your response (or lack thereof).

- Self-monitoring can capture the positives and the negatives, but the point is that you're capturing real data essentially in real time rather than relying on faulty, biased memories.
- Self-monitoring can help you see patterns and refine formulations. It can help you test hypotheses or cognitions, and it can help you track your progress.

If you're interested in learning more about assessments and case formulations, check out the first Great Course on CBT: *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*.

READING

www.healthmeasures.net

Person, *The Case Formulation Approach to Cognitive-Behavior Therapy*.

LESSON 3

BEHAVIORAL ACTIVATION: POTENT MOOD BOOSTERS

This lesson takes a deeper dive into the behavior corner of the CBT triangle and how it affects the way you think and feel. In this lesson, you'll add behavioral activation tools—activity records, activity scheduling, and graded task assignment—to the behavioral compartment of your toolbox.

> The average American adult spends nearly three hours per day—out of maybe 16 to 18 waking hours—on a mobile phone. And research tells us that we're more depressed, anxious, and lonely than ever, and the world is a far more polarized and dangerous place.

WHY BEHAVIOR MATTERS

- Think about the behaviors you engage in when you're stressed. Unfortunately, most of us engage in unhealthy behaviors when we're stressed. We sleep less, pull away from family and friends, eat more junk food, drink more alcohol, and are less likely to exercise. All of these are behaviors, and they're mostly maladaptive behaviors.
- There are pretty common behavioral patterns that are paired with emotions and give us a clue as to what needs to be done.
- For depression, we slow down, withdraw, stop calling friends back, stop doing things that used to bring us joy, and become less productive at work. It's a negative downward spiral. We feel sad, so we do less. But that makes us more sad, so we do even less, and so on.
- For anxiety, it's about avoidance and engaging in safety behaviors. You might avoid social situations that make you nervous, or you might just avoid eye contact in social situations.
- Whatever your behavioral habits are, the point is to start increasing your level of awareness of the things you do, both big and small, and how these behaviors are related to your emotions. Once you understand that, you can start prescribing some behavioral changes.
- But why do we do the things we do, even if we know they aren't good for us? How many times have you eaten too much or maybe just eaten the wrong foods? How many times have you skipped the gym, had too many drinks, not gotten enough sleep, or procrastinated? It's easy to beat yourself up and write it off as a lack of willpower or discipline, but that's really just too easy.
- The drivers of our behavioral "choices" are complex. In fact, we really aren't entirely in control of what we do. We're almost constantly being nudged and influenced by friends, families, businesses, public health officials, neighborhoods, finances, etc. We still have choices, and we can still challenge our behaviors, but it's good to know why making "choices" might be difficult sometimes.

- So behaviors pop up in both good and adaptive ways but also in ways that aren't so helpful. And there are several tools you can add to your CBT toolbox to address such behaviors.

ACTIVITY RECORDS

- Activity records are a form of self-monitoring in which you monitor your behaviors. As with other kinds of self-monitoring, you don't have to change anything (not yet), but you do need to write down the activities you engage in throughout the day. You don't have to fill in every hour—just the major activities, such as waking up, eating breakfast, commuting to work, etc.
- Then, you'll write your mood on a scale of one to 10 at the end of the day, with 10 corresponding to a perfect mood and one corresponding to the worst mood imaginable.
- The form of recording activities basically looks like a weekly calendar: a column for each day and a row for each hour of the day, with an additional row added to the bottom for your average mood rating for that day.

> Often in CBT, you start with behaviors that are more concrete or easier to assess so that you can start making changes. Once you make those behavioral changes, you often see rapid improvements in mood and you feel better, and it's easier to do the cognitive part later.

- One of the ways that you can draw insights from this exercise is by scanning the numbers for your mood at the bottom and taking the highest day or two and the lowest day or two and see if there are any notable differences in what made a good day good and a bad day bad. Note what kinds of patterns emerge.

DAILY ACTIVITY DIARY

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
1:00							
2:00							
3:00							
4:00							
5:00							
6:00							
7:00							
8:00							
9:00							
10:00							
11:00							
12:00							
13:00							
14:00							
15:00							
16:00							
17:00							
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19:00							
20:00							
21:00							
22:00							
23:00							
24:00							

- One of the things to look for is the activities that are most potent for you in raising your mood and create a list of them. This helps you identify activities that might help. It also helps you see potential openings where you can add in more activities.
- The activity record also does something subtler, yet still powerful: It starts giving you a sense of power and control over your behavioral choices by linking your behaviors to your mood. You also start to see that you have some control over your mood.

ACTIVITY SCHEDULING

- Activity scheduling is the logical next step after activity records. It uses the same form, but now you will prospectively schedule activities. You start small, and you always monitor any effects the activity has on your mood—hopefully, raising your mood.
- You want to nudge the summative effects of a lot of activities over the course of a day. No single activity is going to be magical, but a lot of small activities can really add up and boost your mood.
- The analogy of nutrition and the need to have a balanced diet is relevant when considering activities to choose. Too much of any one thing can be problematic. Do you have a balance of things you want to do and things you have to do? Do you have activities that give you a sense of accomplishment? Do you have social activities? Solitary activities? Activities that require energy? Activities that recharge you?
- As with nearly all of your tools, you'll try certain activities and see if they work in boosting your mood. If any activity doesn't work for you, you'll just try something else.*

* In general, fillers—such as binge-watching shows on Netflix or scrolling through Facebook—are not mood-enhancing activities. They pass the time, but they really don't lift your mood or give you meaning.

- The goal of an activity schedule is to get you to be more active in terms of the things you do. Think of the open spaces in your schedule and then think of the potent activities you can schedule in advance into those open spaces to result in a mood-lifting effect overall.
- You also need to anticipate any realistic obstacles that might arise to prevent you from doing the activities you schedule. Feeling unmotivated is an example of an obstacle. Your physical health or physical ability is another potential obstacle.
- This is why it's always good to have a backup plan. So if you've scheduled to take a walk but it's rainy or your arthritis is flaring up, then reading a book might be a good plan B.
- Take out a blank schedule for the next week and decide what are likely days and times that you'll be able to do each activity. Keep in mind that there's no one right way to do this and that every step is a step forward, even if you feel like you might make a mistake or somehow fail.
- The most important part is getting out there in the world and giving it your best shot. And most times it doesn't go perfectly, but that's OK, because you can learn from things even if they don't turn out the way you wanted them to. Keep record of what goes wrong and why. And instead of viewing this as a failure, view it as an opportunity to adjust and improve.

PLEASURE PREDICTING

- Another type of obstacle you might face are thoughts that come up just prior to the activity that knock you off the rails. Sometimes these thoughts are practical concerns, such as ones about transportation or money or time.
- But these thoughts could also be about whether you're going to enjoy the activity or if it's going to make you feel worse. This involves predicting the outcome before you've actually done the activity, and it's thus called pleasure predicting,

- This is something that people do all the time. Imagining what it will be like if you engage in an activity is just that—your imagination. Your prediction may or may not be true. Either way, you're going to have thoughts and make predictions, so the most important thing is that you test them out.
- So before engaging in an activity, if you think it's going to make you feel worse, for example, go ahead and make that negative prediction. Actually write it down: On a scale of one to 10, how much are you going to enjoy the activity?
- Then, do the activity—because you're testing a hypothesis. Look at your rating after you've done the activity and rate how much you actually enjoyed it once you did it. Many times, people's predictions of how they think they'll feel while or after doing something are not the same as how they actually end up feeling.
- This is how your cognitions—your predictions about not enjoying something—can interfere with your motivation and behaviors.

GRADED TASK ASSIGNMENT

- Graded task assignment is especially good for tasks that are often skipped or postponed, such as cleaning out the garage or applying for jobs. A clue that you might need to use it is if an activity keeps getting postponed repeatedly or when you simply feel overwhelmed by the size or requirements of the task at hand.
- Although there are key thoughts and emotions linked to doing the task, the key part of graded task assignment is breaking the task into small, concrete steps. Does walking 10,000 steps per day seem too overwhelming? Break it down into smaller steps.
- First, you might just find your walking shoes and set them by the door. Success. Next, you might figure out what kind of step counter you're going to use and figure out your baseline. Success.

- By breaking the task into smaller steps, you set yourself up for a lot of small successes and move yourself closer to achieving your goal and feeling more motivated.

BEHAVIORAL ACTIVATION

- The tools you've added in this lesson—activity records, activity scheduling (with or without pleasure predicting), and graded task assignment—fall under the broader umbrella of a treatment called behavioral activation.*
- All of the techniques of behavioral activation are used in the service of the fundamental goal of increasing activation and engagement with life. To accomplish this, it also focuses on processes that might get in the way, such as avoidance behaviors or low motivation.

KEY BEHAVIORAL SUGGESTIONS

- If you're looking for particularly potent activities to generate more positive emotions, try these.
    - Do something good for another person, even if it's small. This taps into your human sense of altruism and its general mood-boosting effects.
    - Spend a day appreciating all that you see and do. There is a version of this called appreciative inquiry. What are all the positive things to notice in your environment? Here, you're using selective attention in a positive way.
    - Add in a physical activity or exercise. It doesn't have to be long or strenuous; just getting your body moving can boost your mood.
    - Engage in regular meditation, prayer, or other somatic quieting.
    - Learn something new every day, even if it's something small.

* If you'd like to learn more about behavioral activation, Christopher Martell has written one of the definitive how-to guides: *Behavioral Activation for Depression: A Clinician's Guide.*

READING

Martell, Dimidjian, and Herman-Dunn, *Behavioral Activation for Depression*.

LESSON 4

ADVANCED BEHAVIORAL TECHNIQUES

This lesson looks more deeply at strategies to alter behavior. In addition to the behavioral activation tools that were the focus of the previous lesson, this lesson introduces four more categories of behavioral techniques: somatic quieting, contingency management, exposures, and behavioral experiments.

SOMATIC QUIETING

- Somatic quieting* is a way for you to quiet or soothe your body. It targets the physical arousal that often accompanies stress or anxiety.

* Herbert Benson has called this the relaxation response and has written extensively about the biological effects of relaxation.

- Somatic quieting can be thought of as a collection of behavioral strategies that directly affect emotional tone and physical arousal. There are physical, emotional, and even cognitive benefits as you get better at focusing and concentrating on your somatic quieting strategy.
- Strategies might include breathing exercises, meditation, guided imagery, or progressive muscle relaxation but could also include prayer, soothing activities, biofeedback, or even massage.
- Whether you think you're good at this type of activity or not, all of us have developed self-soothing habits. We may read, take a bath, eat ice cream, or listen to music. But somatic quieting is different. It's an intentional and well-rehearsed intervention that explicitly targets arousal. And like any skill, the more you practice, the better you get at it.

Even if you already have a regular practice, such as yoga or meditation, try something else just to see how it feels.

- Most of us go throughout the day focused on the tasks at hand and give little thought to our back, neck, or feet—really to any physical sensation until it screams for our attention. Body awareness is a sort of somatic sensory mindfulness. It helps us sense and eventually appreciate our amazing bodies.
- As with most of these skills, it's all about attitude. It's OK to be a skeptic, but try it out. Adopt an attitude of agency and control, open-mindedness, and perceived value and be willing to just test it out and see what happens.
- The following somatic quieting activity is called a body scan.
    - Find a comfortable place. Close your eyes and direct your attention inward. Most people will direct their inner eye to a particular body part, starting at their toes, for example, and slowly working their way up.

- As you do this, what do you notice? Do you feel pressure? Is it even? Uneven? Supportive? Crushing? Strangling? Tickling? Do you feel changes in air temperature or even air current? Is it gentle, cool, hot, dry, moist? Are you noticing any tension? Is it solid, tight, inflamed, strong? Any pain? Is it stabbing, prickling, electrical, burning, gnawing, throbbing? Do you feel any itching or tingling? What's the temperature like as you move your attention higher and higher on your body?
- What do you notice as you move through this process? You might find your respiration rate slowing, and you might find yourself naturally relaxing. If not, you can suddenly slow and deepen your breaths, and you can begin to add in other sensations or images that can help you relax. For example, imagine a warm wave lightly massaging away any tension.

- Since it is often more difficult to think of a somatic quieting activity when you need it the most, it's recommended that you create a menu of choices, ranging from simple, quick exercises, such as taking a few deep breaths while standing at an elevator; to complex, expensive ones, such as taking a yoga class or getting a massage. If possible, test-drive these menu items in advance so you'll know if you need to make any adjustments in order to make them work for you.
- There's something more powerful and deep going on than just learning how to relax your muscles. By employing this level of self-care—by recognizing and prioritizing how your body and mind feel—you're engaging in the process of building self-compassion. Meditators refer to the three areas of growth that arise from meditation: somatic quieting, concentration, and self-acceptance—and maybe a fourth area of feeling more aware and more connected to something larger than themselves.
- There are many somatic quieting exercises that can get you there. It's something about the quiet that allows you to hear and maybe see things that you missed before. It's something about the practice and the patience that helps you see and accept your limitations. Sure, it's a behavior, but test it out and see if it can be more than that.

- Another variation on somatic quieting is a mixture of gratitude and body scan mindfulness. You do a body scan, noting the sensations and the feelings, but as you're on that journey, think of each body part and reflect on how amazing it is.

- Just look at your hand. Look at each finger—wiggle them, move them, clench them into fists. Think about all the complex things we can do with our fingers. Fingers can play the piano. They can speak ASL. They can give a tender caress and even help us do math.

- Think about your core. It holds you up the entire day, and we barely even notice it's there and working hard.

- Think about your vocal cords and the sounds that we can make, from the sounds that come from the mouth of an opera singer to the sound of laughter.

- Feel the ancestors visible in your face. Our bodies are miracles, and it feels magnificent to notice and appreciate that.

CONTINGENCY MANAGEMENT

- Contingency management refers to the application of operant conditioning, which uses rewards and punishments to change behavior. Your behaviors are rewarded—or, less often, punished—based on a predetermined rule book.

- Contingency management is used in nonclinical settings all the time. You earn rewards with points you accrue; you get fined for breaking a rule or law. The challenge is thinking about how to set this up in a way that promotes the behavioral changes you want.

- To understand this, we have to go back to our ABCs: antecedents, behaviors, and consequences—or the contingency. This is classic operant conditioning from B. F. Skinner. If you want to change a behavior, you need to figure out why it's been hanging around. There must be some kind of reinforcement. Are there rewards? Or is the behavior removing something negative, like avoidance behaviors do for the removal of anxiety? Next, you'll want to alter the consequences, or the contingencies.

- A classic example comes from smoking cessation. For each day you don't smoke, put $5 in a jar. If you make it to one year, you'll have a terrific fund to spend on yourself.

EXPOSURES

- Exposures are all about facing your fears rather than avoiding them or relying on rituals to distract you and help you feel safe. Avoidance and safety behaviors are completely understandable, but they're ultimately self-defeating. The prevention of exposure through avoidance allows irrational fears to persist or even amplify.
- Simple phobias are a good example of when irrational fears can persist and cause impairment. And the cure is exposure.
- But on a more everyday level, exposures are important therapy techniques. One technique involves using a subjective units of distress scale (SUDS) in an exposure hierarchy, where you create a fear ladder and slowly work your way up using exposures for each rung until you no longer feel anxiety.
- You don't have to have an anxiety disorder before you can use exposures. What are the things or people or places that you avoid? If this is driven by irrational fears, then exposure might be the tool to use.
- Examples might include traveling to a foreign country and trying to speak a new language, talking with people outside of your political bubble, or talking to a random stranger in public. Remember that feeling uncomfortable doesn't mean you're unsafe. You want to stretch yourself, and you don't want to break.
- With exposures, other than making sure the fear really is irrational, you want to set yourself up for success. That might mean taking a small step first—maybe getting some social support to help you through those first few shaky steps. So if you try exposures and feel worse, take a step back and see if you can find a better way to help you with those first few steps.

BEHAVIORAL EXPERIMENTS

- Behavioral experiments involve consciously engaging in a behavior to test out an idea or prediction. If you think an activity won't be fun, test it out. If you think you're too tired to get out of bed, test it out. You can argue with yourself all you want, but the best way to prove or disprove an idea is to do an experiment and test it out.

- There are at least a few types of behavioral experiments. One is called a discovery experiment. This is more about wanting to learn more about anything in general by collecting data. You don't really have a hypothesis to test, such as "People will reject me if I say hello," but maybe you want to learn more about how often others feel rejected or what they do to express interest in another person. It's almost like doing field research or a field survey.

- Another, more common type is a hypothesis-testing experiment. Sometimes, we have a very clear prediction or belief about ourselves or about others. Rather than rely on our assumptions—our habits of mind—we test it out. Pleasure predicting is a good example of a hypothesis-testing experiment.

Remember the interconnectedness of the CBT triangle. Find your favorite tool and you may just be able to alter the whole system.

- There are a few simple steps to set up a behavioral experiment (what follows is mostly about hypothesis testing).

  1. Identify the belief to be tested. Write it down in a single sentence.

  2. Rate the strength of that belief, perhaps using a scale from one to 10.

3. Plan the experiment that could test the belief. To test the example belief that "People will reject me if I say hello," then you want to go out in the world and say hello to different people and see what happens.
4. Identify any obstacles that might make it difficult to carry out the experiment.
5. Get out in the world and actually test it.
6. Record the results.
7. Reflect on your results.

LESSON 5

CAPTURING THOUGHTS AND MAKING CONNECTIONS

This lesson moves over to the cognitions corner of the CBT triangle, which includes thoughts, memories, predictions, assumptions, and rules of living. Following the same structure as behaviors, this lesson presents the basic cognitive tools to add to your toolbox.

COGNITIVE CONTENT AND PROCESSES

- Cognitions include attitudes and beliefs; generalizations, stereotypes, and biases; scripts and schemas; expectations and attributions; appraisals; intuitions, judgments, and assumptions; and automatic thoughts.
- You need to be able to identify cognitive content and cognitive processes in order to be able to figure out what you can do about them. First, let's address cognitive content.

EXERCISE

- What just crossed your mind in this instant? The emotion might have been curiosity, boredom, amusement, confusion, or something else. But what was the thought?
- Maybe you heard something, such as the noise of a car going by outside. Maybe you have a song running through your head. Whatever it is, it's cognitive content.
- Cognitive content is the thoughts, words, images, smells, sensory experiences, memories—all the stuff that pops up, often uninvited, and often disperses unexamined.

- The content is fragmentary, irrational, and sometimes just downright stream-of-consciousness bizarre, but it's our content, and it has the potential to influence our mood and our behavior.
- Your first foundational skill, then, is being able to tune into your cognitive content. The next step deals with cognitive processes, or how you take these data and process them to make meaning or to arrive at a decision.
- According to dual process theory, we have at least two distinct systems for cognitive processes: system 1 and system 2.
  - System 1 is the quick, automatic, intuitive system. This is the one that gives us a hunch or an instinct. It's responsible for the decisions we make in the blink of an eye. It's not good or bad—it's just quick and prone to errors, but it saves us tons of time and energy.
  - System 2 is very slow, careful, and rational. It's the system you would use when carefully weighing the pros and cons of taking a new job. Again, it's not good or bad, but it's slow and uses a lot of energy.
- Why do cognitions and cognitive processes matter? Recall the CBT triangle, where emotions, thoughts, and behaviors are all interconnected. If you want to understand or change your behaviors or feelings, you might need to turn to your cognitions—both the content and the process.

Thoughts are what make humans so interesting and so incredibly complicated and wonderful and frustrating all at the same time.

- The goal is to raise your awareness of your thoughts—what's going on in your head. How do they affect your mood? How do they affect your body? And are there ways that you can nudge them, shift them, or completely rewrite them so that you get better outcomes?
- Thoughts are neither right or wrong, or true or false. Think of them instead as helpful or hurtful, or balanced or unbalanced, or fair or unfair. It's important to first check your assumptions about thoughts.
- Thoughts are opinions, and thoughts can be changed. They're heavily influenced by our moods, environment, and activities, just as the CBT triangle says.
- But there are often thoughts underneath the thoughts. They come in layers, and each layer offers an important clue.

THE COGNITIVE MODEL

- Recall the ABCs from the previous lesson: antecedents, behaviors, and consequences. Cognition and cognitive processes work in similar ways. We have a trigger—maybe an event or sensation—which brings up a thought, or maybe a whole series of thoughts. And while we can look at consequences, rewards, and punishments tied to thoughts, they're not as obvious, and they carry much more complexity and nuance—particularly since they can be an exclusively internal experience.
- With cognition, the strategy is usually a little different, mainly because there can be many layers of thoughts that require analysis before we can change or accept them.

- The basic model is this: An event, or antecedent, triggers an automatic thought—it's quick and uninvited, and it could be positive, negative, helpful, hurtful, etc. Keep in mind that the CBT triangle tells us that thoughts, including automatic ones, are related to behavior and mood.
- If you think about the traditional model, you might say or think something like this: "My spouse made me angry." It's the event, or the exchange, that caused a particular emotion, and then maybe a behavior that followed.
- But the cognitive model inserts a very simple but important middle step: "My spouse did something that I interpreted as insensitive and selfish, and then I became angry and withdrawn."
- In this new cognitive model, it's still about the trigger, but it's also about how you thought about or interpreted the trigger—the meaning that you gave to it.

CATCHING COGNITIONS

- In order to change a thought, you first have to catch it. And you usually start at the surface by trying to catch or elicit automatic thoughts. Here are a few tips you might use to do this.
  - Use an emotion as a signal to look for an automatic thought. Reflect on what you are thinking just prior to feeling an emotion.
  - Schedule times during the day when you'll write down some of the thoughts that you've had over a specific amount of time in the past.
  - Think about events or behaviors—things you did or didn't do—that may be tied to particular cognitions. Think about what you might have been thinking just prior.
  - Use guided imagery. If you think more in pictures than in words, put words to the pictures that go through your head.
  - Role-play the situation with another person so that you can begin to evoke those thoughts.

- One process that is used to identify cognitions when working in a therapy session is called guided discovery. During this process, therapists might ask a patient questions like the following, which use emotion as a warning sign, consider the time course, and follow up on initial thoughts.
  - What were you just thinking when that emotion came across your face?
  - What were you thinking right before that event happened? What were you thinking during that event, and what have you thought since that event occurred?
  - Besides the automatic thought, what else were you thinking? And what did you think this meant?
- Guided imagery might be used in sessions where therapists would ask the patient to close his or her eyes and recreate the episode in question. Therapists might ask: "Where are you right now? What's going on around you?" The therapist's goal is to create a rich sensory experience so that the patient can remember the thoughts and emotions he or she was feeling at that particular time.

IDENTIFYING HABITS OF MIND

- Once you've captured a thought, what do you do with it? First, you write it down—in order to slow down and control this process. It's another form of self-monitoring, where the data you're collecting are cognitions. Next, you need to evaluate how you're thinking about this content. These are your cognitive processes.
- There are some baseline cognitive processes that we all share. They're sometimes called cognitive heuristics, but the term *habits of mind* conveys not just the process but the idea that we develop mental habits just as we have behavioral habits.

- Habits of mind are, by definition, nonnormative, or just irrational. They include things like overpersonalization, mind reading,* magnification, minimization, fortune-telling,** and all-or-none (dichotomous) thinking.***
- It's important to be familiar with these habits of mind because they help show you where your thinking goes wrong. If you can see that you are selectively attending to only negative information, for example, then you can more easily see what needs to be done to balance things out.
- The things we carry around in our head influence our mood. The things we notice, perceive, pay attention to, and remember are all cognitions—ideas, thoughts, memories. And each of those has some weight to it. And each can either lift up or push down our mood.
- There are both positive and negative things happening around us, and it's up to us to decide what we're going to pay attention to and what we're going to carry with us the rest of the day.
- Although not on purpose, we often selectively attend to the things that are negative or pessimistic or dark or sad or threatening. And that leaves us feeling depressed and anxious and stressed at the end of the day.
- But we can also think about the positive things about our day. And what if those were the things that we carried with us? Or think about both the negative and the positive so that the sum total at the end of the day is a more accurate reflection of what you've seen and experienced, rather than just the negative stuff that has a stickiness to it.
- This is a tool that helps with the habit of selective attention. It is an attention manipulation that directs you to focus your attention on the positive elements of the present. Savoring is a similar tool. It redirects your attention to something positive that has happened in the past and directs you to reexperience and re-enjoy it.

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* Imagining that you know what another person is thinking or know his or her internal motivations.

** Trying to make predictions about the future.

*** Thinking that something is either all good or all bad.

- Selective attention is at play all the time, and it matters. And it's not random. Our starting mood provides a lens that drives our selective attention and then spirals, sometimes escalating or intensifying that mood. It's first about what we attend to, but then it becomes how we think about what we've attended to. These are the automatic thoughts—the appraisals, or interpretations.
- Experiment with selective attention. Try selectively attending to negative content and excluding positive content, or vice versa, and see what happens.
- Selective attention is just one cognitive process. There are other, more complex processes and related, erroneous conclusions that can be more difficult for us to pick apart. First, we have to realize that we're making assumptions and not seeing facts.

EXERCISE

- Read the following list of statements and categorize them as facts or assumptions.

  1. Jonathan decided to get even by not texting me back.
  2. I did not receive a text message from Jonathan.
  3. My mother complains about her health because she wants attention.
  4. My mother complains about her health.

- This is a mistake we make all the time on the fly: We interpret something and just assume that we're right. But what if we aren't?

ANSWERS
1 assumption; 2 fact; 3 assumption 4 fact

- Let's say that you've captured your automatic thought and you've determined that you're drawing conclusions or making assumptions based on the automatic thought. Now what?
- First, you want to identify which habit of mind is being used. If you know the habit is mind reading, for example, then it's easier to beat.

EXERCISE

- What's the habit of mind in the following statement?*
  - I'm always such a hot mess when I go out with friends.

- Print out a list of all the different habits of mind so that you can become more familiar with them. Just do an online search for the terms *CBT* and *habits of mind* to see a few different versions of lists. The important thing to remember is that there's always something we can do about the way we think.

You need to identify your personal habits of mind. Once you know what they are, you can be on high alert for them whenever they occur.

READING

Kahneman, *Thinking, Fast and Slow*.

* There may be more than one at play, but it's mostly all-or-none thinking. Selective attention might also be happening.

LESSON 6

COGNITIVE RESTRUCTURING AND THOUGHT RECORDS

This lesson is on advanced cognitive techniques. In it, you will build the more complex skill of thought records for cognitive restructuring on top of the basic skill of self-monitoring. This skill includes various strategies to help you arrive at balanced thoughts.

HABITS OF MIND

- The idea of habits of mind—mental shortcuts we take to save time and energy—was introduced in the previous lesson. Habits of mind are common and often helpful, but sometimes they get us in trouble. We need to be familiar with our habits so that we can be on guard when they are in use.

- Self-monitor your cognitions to see if you can identify any habits of mind. These tend to be the most common:
  - mind reading, or imagining you know what another person is thinking;
  - fortune-telling, where you try to predict the future;
  - catastrophizing, where you jump to the worst-case scenario and then inflate the potential negative consequences;
  - labeling, where you affix labels to people instead of talking about situations or events;
  - discounting the positive;
  - selectively attending to the negative;
  - overgeneralizing;
  - dichotomous, or all-or-none, thinking;
  - putting *shoulds*, or unrealistic expectations, on yourself;
  - overpersonalizing; and
  - emotional reasoning, where you assume that if you have a strong feeling, then the thought must be true, when those two are actually different.
- You want to be able to identify the type of habit of mind you're using because this will help you with the next tool, the CBT thought record—the workhorse of cognitive therapy.

THOUGHT RECORDS

- A thought record is a tool that's used to do cognitive restructuring, where you rebuild, rewrite, or restructure your thoughts. In order for those new thoughts to be convincing and effective, you have to go through a structured, balanced process.

- You might conclude that your thoughts are spot-on, and then you need to cope with a very real problem in a very different way. But the thought record starts with simple self-monitoring, where you'll be capturing a trigger—an emotion—and then the automatic, or surface-level, thoughts. As you'll see, all of these are linked together, so once you have one of them, it's easier to access the others.

Usually, each of your emotions will have a thought, or even a family of thoughts, attached to it.

- There are different versions of thought records,* but let's work with the seven-column version. Take a blank sheet of paper in landscape orientation and make seven columns, labeled from left to right as follows:

    1. trigger
    2. emotion (plus emotional intensity rating)
    3. automatic thoughts
    4. evidence for
    5. evidence against
    6. new, balanced thoughts
    7. emotional intensity re-rating

- The first challenge is to figure out when to do a thought record. If you're working on your first thought record, pick an event that has a mild to medium emotional charge—nothing too intense or overwhelming. It's the emotion that often serves as a clue that it might be a good time to do a thought record.

* For various forms you can print out, just do a web search for *CBT thought record* or *CBT seven-column thought record*.

- Once you pick your event, start by filling out the first three columns.

ACTIVATING EVENT	EMOTION	AUTOMATIC THOUGHT

EVIDENCE FOR	EVIDENCE AGAINST	NEW BALANCED THOUGHTS	RE-RATE EMOTION

- When writing down the trigger, or activating event, keep it neutral; don't allow interpretations or emotions to creep in.
- Name each emotion* you are feeling** and rate the intensity of each from one to 100. You will reassess this number at the end of the exercise to see if your emotions have gotten more or less intense, or maybe stayed the same.
- To help you with the automatic thoughts portion, ask yourself these questions: "What was going through my mind right at that moment or just prior to that moment?" "What images or memories came up?" "What meaning did I give to it?" You might also use the downward-arrow technique, where you dig for thoughts underneath thoughts.

* You can build an emotional thesaurus of different emotion words if necessary.
** Since cognitions are so closely linked to emotions, cognitions often start creeping in when you're trying to name your emotions. Slow down and carefully pull them apart so that you can better analyze them.

- Before moving to the next stage, cognitive restructuring, make sure you've captured all the relevant and emotionally charged automatic thoughts that were triggered. They might all be related, but there also might be some link to entirely different emotions. For example, you can be proud of someone but also envious at the same time.

Although it takes a lot of practice to become comfortable with it, thought records are a core skill that's worth honing.

COGNITIVE RESTRUCTURING

- Once you've captured an automatic thought and its related emotions and emotional intensity—and linked it all to a trigger—it's time to do some cognitive restructuring. This is the part where you roll up your sleeves, wrestle with your thoughts, and try to come up with something that is more balanced and more helpful.
- Since there may be many automatic thoughts in play at the same time, you need to pick just one, often called the hot thought because it's usually associated with the highest-intensity negative feeling. As you're learning how to do this, though, you might want to start with a less hot thought that will be easier to challenge. Eventually, you want to get to that hottest thought. Once you've identified the negative automatic thought, circle it.
- Then, look at the evidence for and against and use other restructuring techniques, such as identifying the habit of mind, decentering, linguistic strategies, and behavioral experiments.

- **Look at the evidence for and against that particular automatic thought.** What are the facts, and what are the opinions, assumptions, or guesses? Can you find any counterexamples from the past or the present or by looking at the lives of other people? What would an investigative team find?

- **Identify the habit of mind, or "name it to tame it."** If you find yourself jumping to conclusions, look for an alternate explanation. If you're selectively attending, what's on the other side of the coin?

- **Use decentering.** Step outside of yourself and think, "What would I tell my friend or loved one if he or she had a similar thought?" You then say that same supportive statement to yourself.

- **Use linguistic strategies.** Look at your language and try to soften the edges just to be more balanced. Are you using absolute words like *always* and *never*? You might also try thinking "yes, but"—meaning you acknowledge the truthful parts of the automatic thought, but you list the other side of the coin or the things that maybe aren't quite so fair.

- **Do a behavioral experiment.** If you had the belief "I'm socially invisible; even if I try, no one wants to interact with me," set up a behavioral experiment to test that idea.

- Try a few thought records on your own and work your way through this list of strategies. In the early stages, you should use multiple strategies—partly so that you can learn them all but also so that you can figure out which one works best for you.

- The final step is to re-rate the intensity of the emotion. Did it decrease? If not, explore and learn why. Did you pick the right automatic thought? Was the new thought that you wrote believable? Is this an unchangeable fact, where you should work on acceptance?

- There is no doubt that thought records can be clunky and time-consuming, but practicing will help you to become faster and to eventually internalize the new thoughts.

COGNITIVE REHEARSAL

- There are a few other strategies that might help you with cognitive restructuring.
    - Start a compilation of new, balanced thoughts and keep this as a running list on your phone. Whenever you have a minute, take out your phone and scroll through the list. Eventually, the new thoughts will become familiar and easy to pull up in your head during the moment.
    - Write down common automatic thoughts on slips of paper and put them in a jar. When you have the time, pull out an automatic thought and rework a thought record until you get to a balanced thought. Do this over and over until you don't need to do a thought record anymore.
- Both of these are examples of cognitive rehearsal, where you practice first on paper and then in your head. You replay your automatic thoughts many, many times, so why not put on a new record and listen to some new music?

LESSON 7

WORRY, RUMINATION, AND STICKY THOUGHTS

The tools in this lesson address what to do when you simply think too much. You'll be adding both cognitive and behavioral strategies to your CBT toolbox.

WORRY

- Worry is a type of cognition and also a mental behavior. It's typically focused on some type of threat looming on the horizon. The intention is to help us prepare for and maybe avoid the imagined catastrophe, but it can become unproductive and ruminative.
- There may be an issue with the content of the worry: Is it really a threat or a problem? But it can also be a problem with the magnitude of the worry—the classic problem of making mountains out of molehills. Either way, it's a waste of energy, and it causes unnecessary distress.

- There are essentially two types of worry: worry about situations that are either amenable to problem-solving or not. For the former, you may need some training and problem-solving or coping techniques. For the latter—and this includes hypothetical problems that never happen—you'll need a different strategy, such as scheduling worry times or using exposures.

> Generalized anxiety disorder is marked by chronic worry in multiple life domains. Someone with generalized anxiety disorder typically spends more than 50% of his or her time worrying. Fortunately, it's treatable with interventions like CBT.

- Worries are just another form of cognition. They may be narrow or broad in scope, and by their very nature, they're often recurrent beyond the place of being useful.
- From a CBT perspective, then, ask yourself these questions:
  1. Is this a real and proportionally accurate worry?
  2. Will worrying about it help me address the problem? Is this a productive worry?
- Initial steps often require resizing the worry and maybe taking some active steps at problem-solving. However, talking down the size of the worry often doesn't solve the problem.
- Let's say you're worried about home security and you often feel anxious about a possible break-in. You look for evidence for and against, and you learn that your neighborhood is actually pretty safe. In fact, you have about a one-in-10,000 chance of being robbed. Does that erase all of your worry? Not if you're a worrier, because the risk still isn't zero. Someone's still going to get robbed, right?
- This shows the limits of the purely cognitive approach to tackling appraisals about threat or danger. But what about some of the other underlying cognitions or habits of mind that might be driving this process?

- In addition to overestimating threat, other types of cognition might include underestimating your ability to cope, underestimating the resources you have to help you face that threat, having beliefs about the value of worry, being intolerant of uncertainty, having a negative problem orientation, or using words of worry.
- For the underestimation of the ability to cope or of available resources to help, you can use the standard thought record and look for evidence for or against, try to find past examples of successful coping, or think about resources that you've been able to tap into.
- Beliefs about the positive value of worry are different. Many worriers worry because they imagine it's useful for helping them find a solution or solve a problem. They believe that it's motivating—it helps them get things done. They believe that worry protects them from negative emotions, even though worry is what's actually generating them. They believe that worry can prevent negative outcomes and that maybe it's even a positive personality trait.
- And what do you do with beliefs? You test them. So a behavioral experiment might just do the trick here.
- Worriers often have a very low tolerance for uncertainty, based on their beliefs about what that uncertainty brings or what uncertainty may mean. Worriers engage in safety-seeking behaviors—such as reassurance seeking, double-checking, or excessive information seeking—in order to reduce uncertainty or avoid it completely. They believe that uncertainty is an undesirable state that should be minimized as much as possible.
- But uncertainty is not always bad. In reality, uncertainty could lead to winning the lottery. To help you combat uncertainty, create a list of all the positive things that happened as a result of an uncertain environment.
- For people with a negative problem orientation, problems are seen as a threat to well-being. People who worry doubt their problem-solving abilities related to an underestimation of their ability to cope. They also tend to be pessimistic about possible outcomes.

- Words of worry are thoughts like "It will be horrible" or "This will be a disaster." The downward-arrow technique can help clarify worries and put them in a form that's appropriate for a thought record. You can chip away at the worry by shrinking down an appraisal of threat, being more accurate in estimating your ability to cope or your resources, or building a greater tolerance for uncertainty. But it's still not likely to be enough.

- Here are two distinct behavioral strategies:

  - distracting yourself from worry or obsessive thinking (you can do this by attending closely to sensory experiences in the moment); and

  - problem-solving, where you intentionally refocus on the task at hand.

- With attention to sensory experiences, these exercises shift attention to the outside instead of maintaining an automatic focus only on what's happening inside your head. You notice the sights, sounds, smells, and any other sensations that are occurring right then in that moment.

> The psychologist Thomas Borkovec believes that worry is a form of avoidance. By focusing your energy on the cognitive activity of worry, you get to avoid emotional processing. Worry is still unpleasant, but it may be seen as the lesser of two evils.

- A common intervention that's great for everyday worries is scheduling worry time. There are a few variations, but one is to schedule 30 minutes a day to worry. You just let yourself go wild with worries, which satisfies all of those ideas or needs for the value of worry. If worries come up at other times, just write them down and forget about them until your scheduled time to worry.

- Another variation involves keeping a worry list. For example, if you wake up worried about something, simply write it down on your phone or on a notepad and deal with it in the morning. That way, you don't have to rehearse the concern or fear because you might forget it the next day. It has been captured and will be managed at a more appropriate time.

RUMINATION

- A subset of worry, rumination* involves thinking that consists of reviewing something over and over again in one's mind. It is focusing repetitively on one's experience of depression or anxiety or distress, including the causes and consequences of having those feelings.
- According to Susan Nolen-Hoeksema, a leading rumination researcher, depressive rumination is typically focused on thinking about oneself and the condition in which one finds oneself—an ongoing perseveration on how bad one feels. It is focusing repetitively on one's negative internal emotional state without making plans, problem-solving, or taking steps to make changes and relieve the distress.
- There are two types of ruminating: processes reflection and brooding. Both involve turning inward, but reflection entails cognitive problem-solving, whereas brooding entails passively rehashing the differences between how you feel now (bad) and comparing it to an idealized you or idealized state. Only brooding is associated with feeling worse over time.
- You can ruminate about worries, but rumination is somewhat different. It has a similar obsessive quality to it, but it can include ruminating about your flaws or regrets. It's not just garden-variety worry.
- To identify rumination, Michael Addis and Christopher Martell suggest the two-minute rule: Give yourself a full two minutes to think about a problem. After two minutes, ask yourself if you've made progress toward solving that problem or if you now understood something about the problem that you didn't before. You might also ask yourself if you're feeling less critical or depressed after those two minutes. Unless you answered yes to one of these questions, the thinking is ruminating, and you need to use a tool to stop it.

* The term *rumination* is a derivative of *ruminat*, which is Latin for "chewed over."

- Remember that with behavioral activation, you don't examine the validity of ruminative thoughts, so there are no thought records. Instead, you would look at the ABCs—antecedents, behaviors, and consequences—and make sure that you aren't in some way rewarding your ruminations.

- If someone notes that behavioral activation isn't improving his or her mood, there's a good chance that rumination is in the way. It might be short-circuiting enjoyment or preventing exposures from being effective. Either way, it has to be addressed and reduced.

REGRET

- Regrets are the persistent, distressing thoughts that harass us about perceived mistakes, missed opportunities, or just general disappointments. There is the common and deeply unfair hindsight bias, where we torture ourselves with the "if only." But there are bigger regrets, too: the lost loves, the betrayals, the tragic decisions that maybe derailed our lives or hurt people we love.

- As with worry, you want to first think about whether there is a problem to be solved and whether your sense of regret is helping you learn and grow stronger. If the answer is no—and it often is—then your regret is probably more about punishing yourself, and you need to let it go. But how can you do that?

- First, you need to recognize that it's human to linger—to ask "what if?" Beating yourself up for having regrets doesn't help. Humans look back because we want to learn, but once we've learned, regret just makes us anxious or depressed.

- Here are some suggested steps for coping with regret, taken from Jennifer Taitz and published in *The New York Times*:

    1. **Evaluate how you cope with regret.** Do you push feelings away or roll around in them? Are you analytical, or do you get overwhelmed with emotions? Allow yourself to reflect on the experience and notice the pull. What do your instincts tell you to do?

2. **Interrupt your obsessing.** Dr. Taitz talks about regret spirals. This is really rumination. Think about a time when you did this. Was there any benefit? Did it make you feel better? Consider giving yourself a time limit and then starting some behavioral interventions. Distraction is a common strategy.*

3. **If you want to revisit your regret, then repeat these phrases:** "Everything can be viewed from a different perspective." "There is positive value in every experience." Here, you're going for a silver lining effect. You can't change what happened, but you can use it to learn and grow.

4. **Treat yourself like your ideal mentor would.** Researchers have found that self-compassion spurs positive adjustment in the face of regret. Imagine your mentor talking you down from a spell of regret. He or she would likely encourage you not to beat yourself up but instead to try to find tangible, practical lessons that you can learn from the experience.

5. **Clarify what matters most to you.** When you feel profound regret, use the emotion as a springboard to examine what is truly important to you. Consider the values you most want to stand for and those that are central to your identity.

6. **Take action.** Are there things you can do to right the wrong? If not, what steps can you take to use what you've learned and move forward?

- The ultimate cure for anticipating regret isn't feeling lousy or overthinking; it's thoughtfully pursuing solutions and using the wisdom gained through self-reflection to act.

* One way to jolt yourself out of a ruminative spiral is to dunk your face in a bowl of ice water. Or just try popping an ice cube in your mouth. This will draw your attention away and allow you to start focusing on new sensations.

READING

Clark and Beck, *Cognitive Therapy of Anxiety Disorders*.

———, *The Anxiety and Worry Workbook*.

Clark and Purdon, *Overcoming Obsessive Thoughts*.

LeJuene, *The Worry Trap*.

Martell, Dimidjian, and Herman-Dunn, *Behavioral Activation for Depression*.

Taitz, "6 Steps to Turn Regret into Self-Improvement."

Watkins, *Rumination-Focused Cognitive-Behavioral Therapy for Depression*.

Wells, "A Cognitive Model of Generalized Anxiety Disorder."

LESSON 8

DIGGING DEEPER: RULES AND CORE BELIEFS

This lesson digs deeper into cognition with a look underneath what drives automatic thoughts. You'll consider your conditional assumptions and rules as well as your core beliefs and schemas.

If you're not feeling comfortable with monitoring cognitions or doing thought records, go back to lessons 5 and 6, where these skills were introduced and elaborated on. This lesson builds on those skills and adds a few new challenges.

Previous lessons have addressed emotions and mood, both of which fall into the category of emotion regulation. This lesson moves closer to addressing what some might call personality—deep-seated, early-learned beliefs about ourselves, our world, and other people that are more difficult to change, if they can be changed at all.

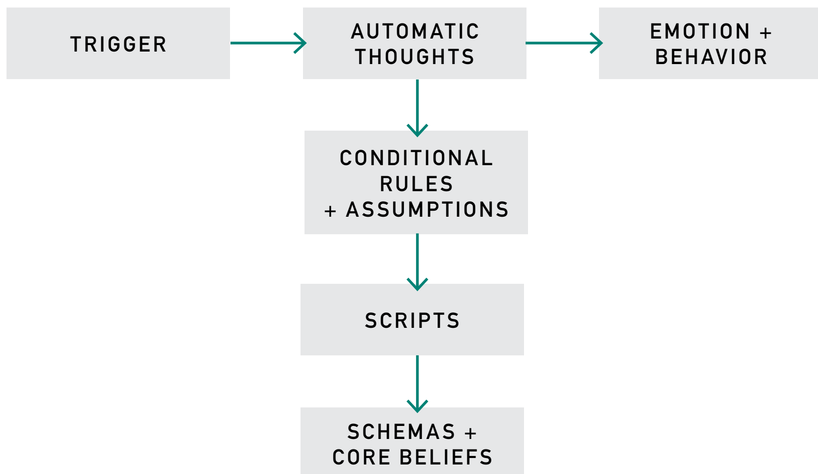
DEEPER STRUCTURES OF THE COGNITIVE MODEL

- We have elaborate sets of rules, scripts, schemas, and core beliefs that we've learned usually early in life with only minor revisions as we grow older. These deep-seated beliefs have a way of reinforcing themselves due to selective attention or confirmation bias. But that doesn't mean that they can't be changed or at least worked around.

- Picture the cognitive model with these deeper structures. The trigger, or activating event, sparks automatic thoughts, which then give rise to emotions and then maybe to behaviors.

- We can draw an arrow downward, beneath the automatic thoughts, where we might find conditional rules and assumptions—things like "If I stand up for myself, then I'll be hated and rejected." They are often if-then statements we use to guide our decisions in our relationships.

- If you keep drawing arrows downward, next would be scripts. These include conditional assumptions and rules, but they are more complex compilations that are dependent on context. They tell us how to think and how to act and what to expect. If we keep going downward, we finally get to schemas and core beliefs.



- Some cognitive behavioral therapists believe that core beliefs and schemas are the same thing, but from a cognitive psychology perspective, a schema is a rubric—a guide of how we process information. It includes the body of evidence or selective memories and images that support something like a core belief.
- If your core belief is something like "I'm unlovable," then the schema might be all the times you think that was proven true, all the behaviors you need to engage in due to your unlovability, and the predictions you make about how others will treat you.
- Both core beliefs and schemas are quite deep and difficult to access. That also means they're difficult to change.
- To complicate matters further, we might have developed defenses that tell us to cover up or even alter the way our schemas or core beliefs are expressed. Sometimes the person that feels unlovable can be hostile and rejecting (hurt others before they can hurt you!).

CONDITIONAL RULES AND ASSUMPTIONS

- Conditional rules and assumptions are the connective tissue between automatic thoughts and core beliefs. They're essentially our guidebook of what we need to do to get by, given what we believe about ourselves, others, and the world. They might tell us to hide our weaknesses because other people are dangerous and unsupportive. They might tell us to exploit others at every opportunity because it's a dog-eat-dog world. They might tell us that we have to be promiscuous if we expect to be loved.
- As you think about your conditional rules and assumptions, start writing them down. In fact, start a library of rules. Don't fight them or debate them yet—just write them down.
- It is this set of rules that helps us better understand our behavior. In fact, it is our rules that tell us the coping strategies that we need to adopt. Are you searching for a new job? Your conditional rules and assumptions will tell you what you need to do and what to expect.

CORE BELIEFS

- Core beliefs are simpler and more evaluative. They are estimations of our value, what we think we can expect from others, and what we think about the world.
- Common negative core beliefs about the self include statements like "I am unlovable," "I am a failure," "I am worthless," "I am incompetent," and "I am inadequate."
- Judith Beck, the daughter of the founder of CBT (Aaron T. Beck) and a CBT therapist herself, describes six key features of core beliefs.
  1. They develop early in life, usually in childhood and/or adolescence.
  2. By definition, negative core beliefs are biased and overly general.
  3. Negative core beliefs usually fall into three categories: thoughts of helplessness, worthlessness, or unlovability.
  4. Negative core beliefs are self-perpetuating through habits of mind.
  5. Core beliefs can be modified/replaced by more accurate and/or adaptive beliefs.
  6. Positive core beliefs can often get overlooked due to presenting distress.
- How do we start digging underneath an automatic thought to find rules, assumptions, and core beliefs?

THE DOWNWARD-ARROW TECHNIQUE

- Let's revisit the downward-arrow technique, which was first described in the context of thought records. You first write down a surface-level automatic thought, such as "I'm never going to get into college." Let's assume you never get into college. Why would that happen? You might say, "Maybe I just wasn't smart enough." And what would that mean or say about you? "Well, it means I'm just not good enough." And what would that mean or say about you? "Well, it just means I'm a failure."

- The strategy is to keep asking questions in this way. Sometimes you get to an exaggerated view of reality and you see a habit of mind. But sometimes you get to a core belief.
- Another, more direct assessment uses incomplete sentences and asks you to quickly come up with an answer before you think too much.

EXERCISE

- Complete the following sentences with the first thing that comes to mind.
  - I am ______________________________.
  - I've always ______________________________.
  - I'm known for ______________________________.
  - Others are______________________________.
  - You know he's just going to ______________________________.
  - The world is ______________________________.
  - I've learned you have to ______________________________.
  - People are just ______________________________.
- What did you come up with? Did you only come up with negatives? That wasn't part of the instructions. Did you only come up with positives? How do you think these beliefs might influence your behavior?

- You might also try a few of the validated questionnaires you can find online. The two most popular are the Dysfunctional Attitude Scale* and the schema checklist. Both are quite long, but they do give you an interesting picture of what might lie underneath.

* Here's a sample item from the DAS: "My value as a person depends greatly on what others think of me." You then rate your level of agreement with that statement.

CORE BELIEFS WORKSHEET

- Once you have your library of rules and an idea of some of your core beliefs, it's time to roll up your sleeves and see what you can do about them. Unlike automatic thoughts, where you can do a thought record and they suddenly change, in this case, change is more incremental.
- You already know most of the strategies that you might use: finding evidence for and against, listing advantages and disadvantages, or thinking what you would say to a friend if he or she thought or believed this.
- You can also view your core beliefs on a continuum. And here, you're looking for shades of gray since most core beliefs are all-or-none thinking. You can assign a percentage of believability to each thought: Do you believe it 100%, 50%, or 75%?
- You might also use behavioral experiments. Here, you might want to test the truth of a past belief or of a new, modified belief that you've just come up with.
- A core beliefs worksheet uses a combination of these strategies. First, you'll write your core beliefs at the top of the sheet. Don't filter them; it doesn't matter if they seem irrational or illogical. Then, you're going to rate the percent strength of your belief in that thought. Below this, divide your paper into two columns: evidence for and evidence against the core belief. Eventually, at the bottom, you're going to write a new, tentative core belief and rate its believability.
- How can you keep fighting back against those inner demons—those rules and core beliefs? First, through the restructuring, and then repeat over and over again.
- For example, you could call your new thoughts your mantras and create a list of them so that whenever you feel old thoughts bubbling up to the surface, just repeat your mantras. You could write similar statements on sticky notes and put them all over your house. You could even put them on postcards and mail them to yourself. It's all about repetition and using external reminders, at least in the beginning.

- You can think of the core beliefs worksheet* as a more advanced thought record. With a thought record, you pick the hot thought of the moment; with the core beliefs worksheet, you pick the deeper, long-held belief that often drives the automatic thought of the moment. Similar to a thought record, you look for evidence for and against. You fight against selective attention to confirming evidence and against all-or-none thinking. You step outside of yourself and try to evaluate your global judgment more fairly.
- Given the depth and stability of core beliefs, a worksheet isn't going to magically make them go away. However, you're sowing doubt, chipping away at the certainty with which these beliefs typically are held. It'll take a lot of repetition, but you'll slowly get to where you want to be.

SIGNATURE STRENGTHS

- Like core beliefs, signature strengths might be very much integrated into who we are. A strength is defined by Alex Linley, the leading researcher on the topic, as "a pre-existing capacity for a particular way of behaving, thinking, or feeling that is authentic and energising to the user, and enables optimal functioning, development and performance."
- Although every person has certain signature strengths, it's argued that most people are not truly aware of the strengths they possess. This assumption has been supported by research, which shows that only one-third of people when asked were aware of their strengths.
- We possess strengths, and we can exercise and build those muscles rather than letting them atrophy. But what are our signature strengths? What makes you noteworthy?

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* If you're interested in learning more about the core beliefs worksheet or seeing similar ones, do a web search for *CBT* and *core beliefs worksheet*.

EXERCISE

- To identify your signature strengths, you can use the following exercise from positive psychology. (Keep in mind that two-thirds of us don't know what our strengths are or will have trouble naming them.)
- You can start with a few signature strength prompts like "I am at my best when …" or "I really shine when I …." You can also try a number of surveys online to help you, such the VIA Institute Character Strengths Survey.
- The quickest way to know your strengths is to ask a friend, family member, or coworker. In fact, ask at least a few people, maybe even including an enemy. See where their reports overlap. Examples of strengths include curiosity, prudence, wisdom, courage, perseverance, honesty, kindness, humor, humility, and gratitude.
- Ask each person—including yourself—to write a page describing you when you're at your best. Then, sit down and see what you got. There is a good chance a strength or two emerged.
- Once you have your strength, you need to exercise it. If your superpower is curiosity, think about different contexts of your life where you can use it. Maybe ask more questions at work, start a book club, sign up for a class, or teach young people. The point is to see your best features and then do all you can to uncover them and use them proudly.

READING

Linley, *Average to A+*.

LESSON 9

TOOLBOX IN ACTION: STRESS AND ASSERTIVENESS

In this lesson on blended cognitive techniques, you'll add a few new tools to your toolbox that tap into both behavioral and cognitive skills: rehearsal, microaffirmations, savoring, stress management, and assertiveness.

SELECTING TOOLS AND SELF-COMPASSION

- When selecting a tool from your CBT toolbox, there are a few important things to consider.
    - You need to know when to select a tool.
    - You need to think about your goal. Do you need to regulate an emotion? Are you trying to address an interpersonal issue? Or a deficit in functioning of some sort?

- What are your current parameters? For example, how much time do you have? What resources will this require? Do you have the energy?

- With this roll-up-your-sleeves approach, it's easy to fall into the trap of self-blame. "I have to do all this work because I'm a mess." "I'm undeveloped." "I'm flawed." All of your core beliefs can come bubbling up.

- If that happens, it's a good time to break out the skill of nonjudgmental acceptance and kindness—or self-compassion—and to remember the cognitive skills of balance and selective attention.

- According to pioneering self-compassion researcher Kristin Neff:

> **Self-compassion entails being warm and understanding towards ourselves when we suffer, fail, or feel inadequate, rather than ignoring our pain or flagellating ourselves with self-criticism.**

- And you might even have to be a bit meta about it: You need to be self-compassionate about not being self-compassionate just yet. But how do you get there?

- In Neff's work, mindfulness meditation is the primary tool. The three main advantages of meditation are that it provides you with an increased focus or awareness, helps with somatic quieting, and—most related to self-compassion—assists you with developing a sense of self-acceptance.

REHEARSAL

- We've all done cognitive and behavioral rehearsal somewhat, especially the behavioral part. For example, we do disaster preparedness drills or rehearse a piece of music on the piano. But cognitive rehearsal is a bit different and probably underutilized.
- With cognitive rehearsal, the goal is still to reduce anxiety and help you tap into the skill set that you already have, but here, you use your mind's eye to begin imagining exposing yourself to the feared object or situation. Since it only exists in your mind, you're then free to embellish it however you want, and that usually means envisioning the desired outcome: your dazzling success.
- The technique is fairly straightforward. First, flesh out exactly what you want or need to imagine. Next, eliminate distractions and get yourself into a place of somatic quieting. Close your eyes and step up to your fear. The more vividly you imagine it, the better.
- Keep practicing your somatic quieting and try using some coping statements: "I can do this." "I have the skills." "The worst-case scenario isn't a catastrophe." "I've been through worse and survived." Stay focused on the fantasy and play it through until the end. Repeat as needed.

MICROAFFIRMATIONS

- The term *microaggressions* comes from the work of Derald Sue, who describes them as a death by a thousand paper cuts. Microaggressions are tiny insults—small instances where you're overlooked, demeaned, or denigrated. Each one is itself too small to speak up about, but they can add up over time.
- With *microaffirmations*—a term coined by Mary Rowe at MIT—people use their position, their social power, to do the opposite. They're called *micro* because they, too, are small, and they cost nothing, but the effect can be quite profound.

- For example, if someone takes a risk and speaks up in a meeting, thank the person and say that he or she made a difference. If a store clerk or an Uber driver seems a bit frazzled, express empathy and tell him or her that you know how hard he or she works.
- The effect on others is to give them a mood boost, and the effect on you is the same. These effects are further amplified if you're the person's supervisor or you just have a higher level of privilege or authority.
- Try making three to four microaffirmations every day and see what happens. It might just become a habit that we can all get behind.

SAVORING

- Savoring is a selective attention manipulation where we recall and elaborate a positive event that might have occurred in the past. It could be a vacation, a victory, some sort of success, or a happy memory.
- We recall negatives all the time; recalling positive memories requires a little more effort. Maybe you could list all of the big events and the small events that brought you joy or happiness each day.

STRESS MANAGEMENT

- Psychological stress is a complex and common problem that can be addressed with a combination of CBT tools. We've all had it, and it can manifest in vastly different ways for different people.
- Stress has been called a modern-day epidemic, and it can stem from almost anything—finances, politics, chronic illness, pollution, crime, and so on. Surveys show that we are more stressed now than we ever have been. However, stress is not equally distributed.

- For example, women are twice as likely as men to suffer from severe stress and anxiety. This most likely comes from the life demands and disempowerment that men simply don't experience.*

- Another population that has more than their fair share of stress are those in the lower-middle and lower range of family incomes. They have less power and fewer resources.

- What can we do about stress regardless of gender or income level? This would be a terrific time for you to break out your CBT toolbox and pick what you think might help. Be sure to look in both the behavioral and the cognitive categories.

- Behaviorally, you should pick some quick and direct tools to provide relief. These don't fix the problem that caused you to be stressed in the first place, but they do put you in a better place so that you can do that work later. Strategies would include things like getting regular exercise, cutting down on junk food, and drinking less alcohol. You'll also want to add some somatic quieting just to turn down the level of arousal.

- Next, you might try some activity scheduling, especially social activities, and you might try graded task assignment, where you can break this overwhelming task into smaller pieces.

- Remember that your coping will fall into two main categories: emotion-focused coping and problem-focused coping. You probably need both, but you'll do more with emotions if this is an unchangeable stressor. You'll do more to tackle the problem if the stressor is changeable.

- But what about cognitive tools? Let's go through a common cognitive exercise that draws on your thought record skills.

- Recall that when we face a stressor, we make at least two appraisals. Our primary appraisal assesses the stressor itself: Is it big? Does it matter? What are the implications? Our secondary appraisal assesses our ability to cope

* Women do nearly three times as much unpaid domestic work as men. Women, even ones with full-time jobs, still do the large majority of childcare. And think about the exposures to trauma and sexual harassment that women face compared to men.

and the resources we have to cope with that stressor. First, you'll want to make sure that you're making fair and balanced appraisals. To do this, you can use the Appraisal Worksheet* found in the therapist guide and patient workbook *Minding the Body*. Here are the main elements of the worksheet:

1. Name the stressor (e.g., your illness, finances, relationships, etc.).

2. Capture your appraisals.

   ▷ For the primary appraisal, ask yourself questions like these: How bad is this really? How important is it? What's the worst-case scenario? What does this stress mean?

   ▷ For the secondary appraisal, ask yourself questions like these: What will coping require? Will it work? Can I handle it? Do I have enough resources and help from others?

When we're feeling stressed or down, we tend to overestimate the severity of a stressor and underestimate our ability to cope.

3. Evaluate your appraisals.

   ▷ There are several important questions you can ask yourself to help you get to a more accurate primary appraisal: How likely is this stressor to occur? Is it helpful to worry about this right now? Have I been wrong before? Have I worried too much before? What are the most likely outcomes if it does occur? How long will it last? How

* You can download this worksheet for free here: https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195341645.001.0001/med-9780195341645-interactive-pdf-003.pdf.

accurate have I been in the past? What are the best- and worst-case scenarios? Can I live with the worst-case scenario? Could I learn more about the stressor or find someone who can answer my questions?

- ▷ There are also important questions to ask yourself to help you improve your secondary appraisal: What resources are realistically needed to cope with this stressor? What are high and low estimates on how much of these resources will be required? What resources do I have at my easy disposal? What new resources could I possibly acquire? Have I coped with similar stressors in the past? How? Have I underestimated my ability to cope in the past? Who is in my social support network, and what help can they provide? Are there new people or services I can recruit to assist with coping?

4. Rewrite your appraisals.

   - ▷ Once you've done your analysis, write down a new primary appraisal and a new secondary appraisal. Then, revisit your experience of stress. Has it changed? Do you feel less stressed or more prepared?

- Keep in mind that you'll still need to do some emotion regulation and probably some problem-solving, but at least you now have a more accurate and balanced appraisal of the stressor and of your coping skills and resources.

ASSERTIVENESS

- Recall that the majority of the tools in your toolbox target emotion regulation and/or social, occupational, or physical functioning—two related but distinct areas. Interpersonally, we may struggle with irritability or hostility, defensiveness, shyness, or just feeling like we don't have the right to speak up or a right to want what we want or to feel what we feel.

- Learning how to be assertive, another complex and important skill set, might help us move forward. In the moment, unassertive behavior has certain rewards. You put aside your needs and take care of someone else. You get to be the hero. But if done over and over, it's a recipe for dissatisfaction, frustration, and resentment.

The difference between aggression and assertiveness is a common source of confusion. As Randy J. Paterson, a psychologist who wrote *The Assertiveness Workbook*, says, "If you take an aggressive posture, you're allowed on stage and your mission is to get everyone else off." And as Catherine Saint Louis adds in *The New York Times*, "By contrast, assertive people are collegial thespians who don't mind sharing the stage. They can be cordial even as they express an unpopular opinion."

- The classic book *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships*, written by Robert Alberti and Michael Emmons, has the goal of teaching people to express themselves while being respectful to others. They write: "Equality is fundamental to assertive living." Put simply, assertiveness is a skill. It includes being able to say no as well as expressing negative feedback, making your needs known, and standing up for yourself in a way that doesn't make others feel small.
- If you think of your CBT toolkit, you'll want to think about strategies that promote each of those skills. What beliefs or rules do you have about saying no? What do you think it means about you? Does your lack of assertiveness stem from a core belief? Are you using mind reading or fortune-telling that discourages you from acting? This is a great opportunity to take out your journal and start clarifying the problem, the goals, and the tools you will use.
- Here are a few tips on how to say no and how to stand up for yourself from Catherine Saint Louis, a health reporter for *The New York Times*.
    - **Be brief.** As the psychotherapist Julie de Azevedo Hanks says, "No is a complete sentence." You don't have to go into an elaborate justification.
    - **Be gracious in declining an invitation.** Express thanks for the offer and regrets at not being able to accept.

- **Stall.** Try using the 24-hour rule: If you're offered an opportunity, wait at least 24 hours before you say yes or no. In the meantime, express gratitude and tell them you'll get back to them ASAP.
- **Act it out.** Use your rehearsal skills. Do a role-playing exercise in which you ask your boss for a promotion, for example, to get comfortable with the idea of actually doing it.

READING

Alberti and Emmons, *Your Perfect Right.*

Brown, *The Gifts of Imperfection.*

Chodron, *The Places That Scare You.*

———, *When Things Fall Apart.*

Davis, Eshelman, and McKay, *The Relaxation & Stress Reduction Workbook.*

Marneffe, *The Rough Patch.*

Parker, *The Art of Gathering.*

Paterson, *The Assertiveness Workbook.*

Sue, *Microaggressions in Everyday Life.*

LESSON 10

UNDERSTANDING AND MANAGING EMOTIONS

Emotions and emotion regulation are phenomena that are so ingrained that we might not even notice that they are there. But our emotions influence everything, including how we think and what we do.

Whether we feel expert or unskilled, we are all emotional artists working in a complex media. We need to learn to appreciate nuance, to blend, and to regulate our emotions as best we can.

EMOTION REGULATION

- Emotions communicate information about relationships to the self and the world. They can motivate us to either withdraw from or approach something or someone. They're very much influenced by learning and memory. Emotions are body-based and phylogenetically old. They emerge developmentally early in life, and some would even say that they're hardwired.*

- Recall the CBT triangle, which has emotions, thoughts, and behavior at each of its three corners. If we want to understand our emotions, we have to look at our thoughts and our behaviors.

- What's the meaning of our primary emotions? There are cognitive themes around emotions. For anger, it's usually about a perceived violation, an injustice, or a frustration of a wish or desire. For happiness, it's often about the perception or expectation of gain. Anxiety or fear is often about the perception of threat or danger or difficulty with coping. Sadness is usually about the perception that something of value, either real or symbolic, has been or will be lost.

- Knowing these themes, or meanings, may help you use emotional information, but there are a number of steps you'll need to take.

    1. You need to be able to perceive and correctly identify the emotion. This might include physical, cognitive, or behavioral cues.

    2. You need to know the trigger for that emotion: Was it internal or external? Was it real or imagined? Was it in the present moment or a memory of things past?

- Although these two steps might seem simple, they may not be, depending on your emotional style.

* We know that blind infants make facial expressions that match the emotion that they happen to be feeling.

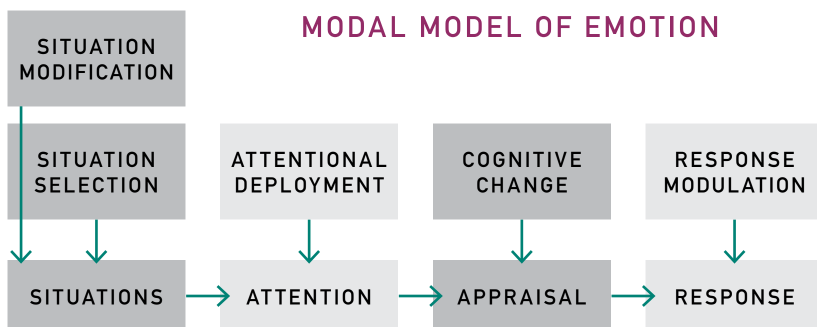
- You might try identifying your emotions and their triggers for a few days. Be more aware of muscle tension; look in the mirror and see how your face holds certain emotions. Notice what your stomach does. Notice what happens to your energy levels. Although the trigger usually happens first, you're most likely to notice the emotion, and then you can backtrack to figure out the trigger. Consider adding a few pages on this to your journal.
- Once you've identified an emotion and its trigger, you've reached the interpretive step. Understanding the themes associated with emotions might help you understand just what's going on. Write down the associated cognitions.
- What are the thoughts that go along with this theme? And remember that there are likely to be associated behaviors, too, according to the CBT triangle. Depression or sadness is usually associated with inactivity, which is a behavior. It might also include rumination and social withdrawal or sleeping a lot more. Anxiety usually triggers avoidance and safety-seeking behaviors. Happiness and joy are activating and help people lower their walls and more fully engage in activities with others.
- Capturing the emotion, the trigger, the associated cognitions, and any linked behaviors are all part of your basic CBT tools related to self-monitoring and interpretation. They also fit nicely in a seven-column thought record.
- Once you have the data, the next step is deciding if you need or want to regulate the emotions you're having. The distinction to make here is between hurtful and helpful. Feeling dysphoria or distress isn't necessarily a bad thing—in fact, it can be helpful—but being stuck with excessive distress is something that you might want to change.
- Recall that all of your CBT tools target emotion regulation and functioning to some degree, so really any of your tools thus far might do the trick. But before you start testing out tools, it behooves you to develop a deep understanding of your emotional habits. Are you easily angered? Are you typically anxious? Are you mostly a happy-go-lucky person?

THE MODAL MODEL OF EMOTION

- The modal model of emotion helps you slow down and better understand how an emotional response gets evoked. It helps you identify opportunities to manage emotions before they occur or to ease them after they've already happened.
- The modal model helps you understand a series of events that causes you to have an emotional response. And if you understand all the links in the chain, you can think about different strategies that target each link. This gives you different opportunities to begin to understand and manage the emotions you have.
- The basic model has four elements: situation, attention, cognition/appraisal, and response. First, there's a situation that you find yourself in. In that situation, you are paying attention to something.* Then, there's an appraisal—that's the cognitive part; it's how you think about the situation. And that ultimately helps you understand your emotional reaction.
- If your goal is to feel less anxious or angry or worried, you want to look at different scenarios where something has happened that made you feel that way and think about which emotion regulation strategy would be most helpful.
- Starting at the first link in the chain—the situation—strategies to regulate emotion include situation selection and situational modification. Situation selection involves preselecting the kind of situation you're going to be in. For example, if you know that going to visit your in-laws is going to stir up frustration and anxiety, then you can maybe choose not to go on that particular visit. Alternatively, you could use situational modification, which would involve making sure that you go at a time of day when you know you'll have the most patience and be in the best mood.

* You could be in a negative situation, but if your mind is somewhere else, it's probably not going to affect you that much.

- Moving to the next link in the chain, you're going to be paying attention. If paying attention is causing you to stir up feelings, you can use distraction or attentional deployment to move your mind elsewhere so you're not as bothered by the situation. For example, if you're sitting in traffic and feel frustrated, you can turn on the radio or listen to a podcast.
- Keep going along that chain and you get to appraisal, where you can do thought records or cognitive reappraisals. If someone cuts you off in traffic, you might have the automatic thought, "What a jerk! He did that on purpose!" You can put the brakes on that thought and think, "Everybody's just trying to get home. They're probably being a little thoughtless and not entirely generous. I've probably cut people off before, too." You've taken a step back and reappraised the situation so that it is less charged.
- And if you haven't stopped the emotion through all those chains and you still get to that emotional reaction, you can try somatic quieting strategies, such as relaxation and breathing exercises. There is also emotional suppression, which involves putting the emotion on a back shelf. And there are different ways to express emotions that are more constructive than others. The goal is to mitigate, or at least reduce, your emotional reaction.



Note the similarities between the modal model (situation, attention, cognition/appraisal, and response) and the CBT model (situation, automatic thought, and emotional response).

EMOTIONAL INTELLIGENCE

- Emotional intelligence—otherwise known as emotional quotient, or EQ—is another way to conceptualize emotion regulation skills and the ability to perceive and understand emotions.
- There's a lot of debate about what EQ means and what it truly predicts, but a model developed by John Mayer, Peter Salovey, and David Caruso frames EQ as an ability that can be learned. They define EQ as "the ability to perceive and express emotion, assimilate emotion in thought, understand and reason with emotion, and regulate emotion in the self and others."*
- In this model, emotion regulation is conceptualized as the process of shaping which emotions one has, when one has them, and how one experiences or expresses them. The creators of this model aren't cognitive therapists, but a lot of what they talk about falls squarely into CBT territory.
- This model is hopeful: It tells us that we can get better at perceiving emotions, understanding emotions, and regulating emotions. But how?
- Here's an example of a CBT-based program. It was developed by Karen Reivich, a psychologist trained in CBT and positive psychology. The positive psychology curriculum she leads teaches us how to overcome the emotional effects of negative events by using seven core principles:

    1. emotion awareness and control
    2. impulse control
    3. realistic optimism
    4. flexible thinking
    5. self-efficacy
    6. empathy
    7. reaching out

* You can think of perception, understanding, and reasoning as foundational skills and emotion regulation as an advanced skill.

EXERCISE

- Take this list of seven core ideas and translate them into tools in your CBT toolbox. For example, impulse control can be achieved through somatic quieting and challenging the beliefs about not acting. Flexible thinking falls squarely into habits of mind and using thought records.
- This exercise highlights the fact that the tools you have are truly foundational. They can get repackaged and renamed a bit, but you have the core skills in your toolbox to use at your discretion.

EXERCISE

- Write out the modal model and populate it with at least two examples of emotionally charged events from your life. Identify what was happening at each step in the model. Then, identify emotion regulation strategies. Finally, try them out. What helped? What didn't work?

READING

Goleman, *Emotional Intelligence*.

Gross, ed., *Handbook of Emotion Regulation*.

Leahy, Tirch, and Napolitano, *Emotion Regulation in Psychotherapy*.

Mayer, Salovey, Caruso, and Cherkasskiy, "Emotional Intelligence."

McKay and West, *Emotion Efficacy Therapy*.

Reivich and Shatte, *The Resilience Factor*.

Satterfield, *Boosting Your Emotional Intelligence*.

LESSON 11

KEY STEPS TO SOLVING PROBLEMS

This lesson is about the practical and important skill set of problem-solving. You will be introduced to a new package of skills called problem-solving therapy, which is usually delivered by a trained professional—but you don't need one to use the skills and see results.

PROBLEM-SOLVING THERAPY

- Problem-solving therapy (PST) teaches you to effectively manage the negative effects of stressful events. These stressors can be large—such as getting a divorce, experiencing the death of a loved one, losing a job, or having a chronic illness—or the stress can result from the accumulation of multiple minor things, such as ongoing family conflicts, finances, or commuting. This stress not only affects your mood but also can affect your health, including how you cope with an existing chronic illness.

Life is full of opportunities cunningly disguised as problems. What can you do to make the most of those opportunities?

- PST helps you make more effective decisions, generate creative means of dealing with problems, and accurately identify barriers to reaching your goals.
- In general, the goals of PST are to help you:
  - identify which types of stressors tend to trigger emotions, such as sadness and anger;
  - better understand and manage negative emotions;
  - become more hopeful about your abilities to deal with difficult problems in life;
  - be more accepting of problems that are unsolvable;
  - be more systematic in the way you attempt to solve stressful situations;
  - be less avoidant when problems occur; and
  - be less impulsive about wanting a quick-fix solution.
- In conjunction with your other CBT skills, PST makes a nice addition to your toolbox, particularly when you need to roll up your sleeves and fix something.*
- What sorts of issues might be amenable to PST? At the core, these tools were developed for depression and stress, but in practice, they've been used for just about any problem, big or small.

* For practical tips and advice, check out *Problem-Solving Therapy: A Treatment Manual* by Arthur and Christine Nezu and Thomas D'Zurilla.

- PST has been effective in helping individuals suffering from a variety of health and mental health problems, including depression, anxiety, emotional distress, suicidal ideation, cancer, heart disease, diabetes, back pain, hypertension, and post-traumatic stress disorder.
- Here are some things that might make solving a problem difficult:
  - novelty
  - ambiguity
  - unpredictability
  - conflicting goals
  - performance skills deficits
  - lack of resources
- Addressing these types of challenging problems primarily depends on your problem orientation and your problem-solving style.

THE EIGHT STEPS OF PST

- There are eight steps of PST:
  1. **Get the right attitude.** When life isn't going right, go left. Reframe. Think about the solution and not just the problem. The goal is to have a positive problem orientation. Yes, it would be ideal to never have problems, but that's not going to happen. So view a problem as a challenge—a puzzle that needs to be solved. Here's how you can use your CBT tools to help you get the right attitude: Write down the sensations, circumstances, or feelings you were having when you noticed you were getting stressed about a problem. Next, write down all the thoughts you have about the situation or problem. Use the "yes, but" technique or other cognitive restructuring techniques to play devil's advocate with the discouraging thoughts. Consider what kind of attitude will be most helpful to solve this problem.

2. **Define the problem.** The problem should be current, specific, and doable. Describe it in objective and behavioral terms. You want to be able to explore and clarify the problem if necessary, and you want to be able to break it down into simpler parts. Ask yourself questions like, What makes this a problem? When does the problem occur? Where does the problem occur? Who is involved? How often does it happen? Have you already tried to solve it? Do you realistically have control? Review the facts and then redefine your problem. If it has several elements, then list all of the elements separately. Each element might require a different list of solutions.

3. **Set realistic, achievable goals and identify obstacles.** What is the problem element you've defined? What would you like to change in the short term? What would you like to change in the long term? What outcomes would make you believe that this problem has been successfully addressed? What are the obstacles to achieving your goal? What might get in the way? What might help?

4. **Generate multiple solutions.** This is the brainstorming part. You might use something like the List Your Options Worksheet.* You list 10 possible solutions to a problem. Make some of them as zany as possible. Don't critique or judge them. Just write down whatever comes to mind.

5. **Evaluate and compare solutions.** What's most likely to work? What will be the easiest to try out?

6. **Select a solution.** Keep in mind that if one solution doesn't work, you can try a different one. So the stakes are low.

7. **Implement your action plan.** Are there any preparations or early steps you need to take to maximize your chances of success? Do other people need to be involved? What resources might be needed? Write down a specific date when you're going to implement your plan and make sure that there's some accountability.

* You can download this worksheet for free here: https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195341645.001.0001/med-9780195341645-interactive-pdf-008.pdf.

8. **Evaluate and adjust as needed.** Did it work? If not, what might you do differently to make it better the next time? Do you need to select a different strategy and then implement it and evaluate it?

- Keep in mind that this is an iterative process. Use it until you get where you want to be.

UNCHANGEABLE OR UNFIXABLE PROBLEMS

- PST is great for problems that have a solution, or at least problems that are somewhat under our control. But what if the problem is unchangeable or unfixable? What if we are truly powerless to change the outcome? Examples include being diagnosed with an incurable illness or having a significant other end the relationship. What do we do then?
- We can still partly use the PST model. We can still define the problem, including its causes and consequences. Our attitude won't be one of rolling up our sleeves to find a solution, but it will still fully reflect our beliefs that we have some control—if not over the situation, then over our moods.
- We can still define our goal. And here, being realistic is the key. Sure, miracles happen, but not always. Goals usually include reducing harm, regulating emotions, and doing something to help us connect with others to sooth our wounds. These strategies all fall into the category of emotion-focused coping. When tackling the problem no longer works, the thing to do is soothe our minds and bodies.
- PST is an overall process for solving problems that draws on many of the CBT skills you already have. The advantage of PST is how clearly it spells out the steps of the problem-solving process. But your basic CBT skills will come in handy at any step of the way if you get stuck.

READING

Nezu, Nezu, and D'Zurilla, *Problem-Solving Therapy*.

LESSON 12

GRIEF, SADNESS, AND DEPRESSION

This lesson primarily focuses on grief and loss—things that unite us all—but will also address depression, including how it's diagnosed and how it's treated.

The first Great Course on CBT—*Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*—details how to assess and diagnose depression and guides you through a CBT treatment program that's typically delivered by a therapist.

CLINICAL VERSUS NONCLINICAL DEPRESSION

- Depression is a family of related conditions that range from everyday sadness to profound clinical depression, where even getting out of bed is a challenge. CBT can help at all points along the depressive continuum.
- Normal, or nonclinical, depression includes sadness, grief, mourning, disappointment, disillusionment, melancholy, despair, and even anguish. We may feel shame or embarrassment. We may withdraw or seek the comfort of others.
- Keep in mind that sadness is a natural response to loss. It slows us down, causes us to reflect on our loss, and hopefully motivates us to find what we need to heal. We become more concerned about sadness when it doesn't go away.
- Clinical, or major, depression is marked by low or depressed mood and/or loss of interest in normal activities, most of the day, nearly every day, for at least two weeks. To meet criteria for a diagnosis, you have to have five out of nine hallmark symptoms, and they have to cause significant impairment and distress:

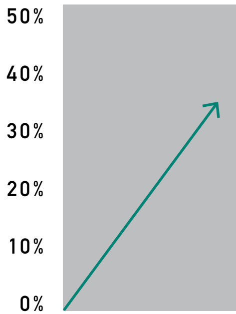
    1. low or irritable mood
    2. anhedonia (inability to enjoy things you used to enjoy)
    3. appetite or weight changes (increases or decreases)
    4. sleep changes (insomnia or hypersomnia)
    5. psychomotor agitation (anxious restlessness) or psychomotor retardation (slowed thinking and movements)
    6. poor concentration and memory
    7. fatigue or low energy
    8. worthlessness or guilt
    9. suicidal ideation (thoughts about suicide)

- Major depressive disorder affects nearly 15 million adults, or close to 7% of the US population of those over 18 years of age, in a given year. Overall lifetime prevalence is about 17%. The average age of onset is around 32 years old, but major depressive disorder can develop at any age. It is the leading cause of disability in the US for people ages 15 to 44.

Compared to men, women experience about double the rate of depression.

- A major depressive episode usually remits within a year to two. However, once you have one episode, you have a 50% chance of having a second if there have been no interventions. If you have two episodes, you have a 70% chance of a third, and after three episodes, you have a 90% chance—again, if there are no interventions. So it's best to intervene as early as possible.
- The suicide rates in the US have increased 33% over the past few decades. As of 2020, it's the fourth leading cause of death for people ages 35 to 54. It's the second cause of death for people ages 10 to 34. It's the 10th cause of death overall, outnumbering homicides. In the US, there is one suicide every 10 minutes, or about 47,000 deaths per year. That's more deaths than all traffic fatalities combined.
- Other countries—including Japan, China, Russia, and most of Western Europe—have seen their suicide rates fall. So what's going on in the US? We don't know for sure, but one theory involves suicide as a "death of despair" that has been linked to economic hardship, with some of the biggest increases in white lower-middle-class Americans.
- There are three things to look for when assessing depression: ideation, plan, and intent. Suicidal ideation is quite common and isn't necessarily cause for crisis, but if a person has suicidal ideation and a plan of how he or she is going to do it and the intent to carry out that plan, then you have a crisis and you need to call for help.

PERCENT INCREASE OF SUICIDES (1999-2017)



» HIGHER THAN HOMICIDE

» ONE SUICIDE EVERY 10 MIN

» 47,000 DEATHS PER YEAR

» MORE DEATHS THAN ALL TRAFFIC FATALITIES

RANK AS THE LEADING CAUSE OF DEATH (SUICIDE)

#2 AGES 10-34

#4 AGES 35-54

#10 OVERALL

If you need help, call 1-800-273-TALK at any time on any day of the year.

- The FCC has designated 988 as an emergency crisis number. So instead of calling 911—which you can do, but that connects you to the police and the paramedics—if you call 988, you will get a trained professional who can send trained professionals to your home to help with a crisis.
- Another service that's available is the Crisis Text Line, which has been popular with young people. All you have to do is text HOME to 741741 and you're able to have an anonymous or private conversation with a trained professional.

- The first thing you want to do is to place yourself on a depressive continuum, or you can see your doctor and ask him or her to do this for you. All primary care providers see depression often and know how to do a basic assessment.

- Assessment tools include the DSM-5, which involves the list of nine diagnostic criteria for depression; the Beck Depression Inventory; and the PGQ-9, which is a shorter instrument that asks nine questions about the nine symptoms of depression and is most commonly used by primary care providers.

- Additionally, PROMIS (Patient-Reported Outcomes Measurement Information System) tools are available online at www.healthmeasures.net. There are both short and long measures for depression as well as a multimodal compilation called the PROMIS-29, which addresses physical, social, and psychological symptoms.

- If you fall into a subclinical category, then you'll probably want to try out some of your CBT tools on your own or with a friend. If you fall within the clinical category, reach out to a health-care professional.

THE CBT MODEL FOR DEPRESSION

- A person with depression often exhibits depressive spirals.

  - In terms of cognition, depressed mood causes us to think more negatively biased thoughts, which causes us to feel more depressed, which causes us to think more negatively, etc.

  - In terms of behavior, depressed mood causes inactivity, which lowers our mood, which makes us less active, etc.

  - In terms of social contacts, depressed mood often causes us to pull away from others, resulting in fewer social contacts, but that lowers our mood, which causes us to withdraw more, etc.

- What tools in your CBT toolbox would address each of these downward spirals (cognitive, behavioral, and social isolation and withdrawal)? And which of the three spirals would you address first?

- In the CBT model for depression, there are typically four stages:
  1. education and data collection (i.e., activity record)
  2. behavioral activation and mood monitoring (i.e., activity scheduling)
  3. cognitive challenges and restructuring (i.e., thought records)
  4. social and environmental changes
- Interventions include behavioral activation, self-monitoring, cognitive or behavioral checklists, thought records, social activity scheduling, journaling and self-reflection, and development of self-kindness and self-compassion.
- Is the depression sending you a message about changes that you need to make? Remember that stage four of the CBT model for depression is to take a step back and think about what needs to change in your life. Do you need more social relationships? Do you need to end certain social relationships? Do you need to move? Do you need to take better care of your health? Do you need to break up with a significant other?
- Let's dig deeper into the cognitive side of the toolbox and look specifically at how cognitions might drive depression and what you can do about it.
- The following are common habits of mind that are associated with depression:
  - overpersonalization
  - magnification or minimization
  - selectively attending to negative things
  - all-or-none thinking
  - mind reading
  - fortune-telling
- There are specific clusters of thoughts that arise with depression: negative thoughts about the self, about others, and about the world. For tools to address such thoughts, consult lesson 8 on conditional assumptions, rules, and core beliefs.

One of the most poignant and classic books about grief is *The Year of Magical Thinking*, written by Joan Didion, who lost her husband and then her daughter less than two years later.

WHAT TO EXPECT WITH LOSS AND GRIEF

- There is no right or wrong way to grieve, and there is no predetermined amount of time that it should take. It should not include self-harm or serious suicidal ideation. It should not include destructive behaviors, such as binge-drinking or violence. But that leaves a lot of room. What should a person expect?
- Classic stage models of loss include shock, denial, anger, bargaining, depression, testing, and acceptance. These are similar to the stages of coping with a terminal illness because both were developed by Elisabeth Kübler-Ross.
- Not everyone has all of these stages, and they really aren't linear, but it does help to normalize the range of emotions a grieving person might experience.
- You might also notice that Kübler-Ross added two new stages: shock and testing. Shock is that state of disbelief that can be almost emotionless. Testing is a little further down the trajectory when the person is moving forward and testing out a new life without his or her loved one in it.
- Part of the task of grieving—which is very complex and sometimes very long—means emotionally experiencing the loss you've had. And when something hurts, the tendency is to run away from it. If you put your hand on a hot stove, you pull it away.
- Similarly, when your mind starts thinking about a deceased loved one, you feel that pain. And you want to put it on a shelf right away. But at some point, the grieving process requires reexperiencing and reconnecting with the emotions and the memories.

- One behavioral exercise that's designed to help with grief involves taking your grief off the shelf, examining it, and appreciating and savoring the relationship you had. Ultimately, it will help you move forward to test out a life without your loved one physically in it.
- Reclaim all of the good memories you have with the person. Go through an old photo album or tell funny stories. Those are parts of the life that you shared together that are yours—that you get to keep. Reexperience and reclaim the person who was so important to you.
- As you move through this process, you'll want to use your CBT toolbox—particularly by applying your emotion regulation skills, scheduling social activities, and challenging negative cognitions.

WHAT TO SAY TO A MOURNER

- Consider the role of a friend responding to a friend who has lost someone. It's awkward and uncomfortable, and many times people don't know what to say. So here are a few tips, but keep in mind that these will not apply universally to all mourners.
    - It's not about you. Don't share your story of loss or talk about how the loss affects you.
    - There is no bright side. Don't say things like, "At least he isn't suffering anymore."
    - Be careful with religion. People have different religious beliefs, and if you're not sure what those beliefs are, you might not want to go there.
    - Don't tell the mourner how to feel—e.g., "Be strong."
    - If you knew the person who died, tell the mourner a story about that person, ideally in a written format because the family passes those stories around.
    - If you didn't know the person who died, then try something like, "I didn't know your loved one, but based on who you are, he or she must have been pretty special."

- Try something like, "I can't imagine what you're going through, but I'm here to listen if you need me."

> "There is a huge range of support. A hug in that moment, bringing food, listening when the person needs to talk, checking in, reaching out during the holidays," wrote Patrice Werner, who lost her 35-year-old husband to cancer when she was only 26. "Just do *something*. You will feel worse in the long run if you do nothing."

READING

Beck, Rush, Shaw, and Emery, *Cognitive Therapy of Depression*.

Didion, *The Year of Magical Thinking*.

Kübler-Ross and Kessler, *On Grief and Grieving*.

Munoz, Ying, Perez-Stable, and Miranda, *The Prevention of Depression*.

LESSON 13

PANIC ATTACKS AND ANXIETY

Anxiety disorders are the largest and most common family of mental illness. If we expand further to include subsyndromal levels of anxiety—worry, panic, and phobias—we're talking about something that has affected all of us. The frightening phenomenon of panic attacks is one of the most common but least understood episodes of anxiety.

NORMAL ANXIETY VERSUS ANXIETY DISORDER

- Fear and anxiety are psychological and physiological responses to danger. In general, fear is conceptualized as an emotional and physiological response to a definite threat. Think about fight-or-flight reactions. Fear is basic, primal, and gripping. Its purpose is to keep us alive.

- Anxiety is "a diffuse, unpleasant, vague sense of apprehension," according to psychiatrists Benjamin and Virginia Sadock and Pedro Ruiz. It's influenced by culture, cognition, personality, and a number of other internal factors.

Does your anxiety have a purpose? Is it communicating any new information? Does it direct you to solve a problem or work through a conflict? Is it long-lasting, or is it acute? Is the severity excessive? Depending on how you answer these questions, you may or may not need to address your anxiety.

- Anxiety can trigger fear, and fear can result in lingering anxiety. Fear is more about the present moment, and anxiety is more future-focused.
- Fear and anxiety are protective emotional reactions in response to real or anticipated threats. Fear and anxiety are healthy and can be helpful. They are central to our essential harm-avoidance system.
- There is a wide range of "normal" in the population and large cultural differences in what is considered normal.
- The diagnosis of an anxiety disorder is based primarily on the degree of interference with normal function at work or in your social life.
- Anxiety disorders refer to a heterogeneous group of syndromes characterized by abnormally increased sensitivity to fearful stimuli, inappropriately intense experiences of fear or anxiety, or inappropriately extreme action based on fear or anxiety.
- For anxiety disorders, the anxiety has gotten so extreme it has taken on a life of its own, and in a way, the disorder becomes the stressor. It becomes a mental illness.

GENERAL TREATMENT OPTIONS FOR ANXIETY

- There are a number of different treatment options for anxiety.
- In terms of medication, there are three primary categories: benzodiazepines, antidepressants, and beta-blockers.
  1. Benzodiazepines—such as Xanax, Ativan, and Klonopin—are effective in turning down a physiologic response to anxiety, but they have a number of side effects and are also habit-forming and can be abused.
  2. Antidepressants include a category called selective serotonin reuptake inhibitors (SSRIs)—such as Zoloft, Paxil, Celexa, and Lexapro—which were developed initially for depression, but they also seem to be helpful for anxiety and fortunately are not habit-forming.[*]
  3. Beta-blockers lower your blood pressure and essentially turn down some of the physical symptoms in a person who is anxious.
- Of course, treatments for anxiety include cognitive and behavioral interventions. And these aren't just for anxiety disorders; they can also be relevant for subclinical anxiety. Some of the components from CBT for anxiety are as follows:
  - Behavioral components include exposure to a feared stimulus.[**] The goal is to diminish avoidance[***] and safety behaviors,[****] which are the most common behaviors that occur with anxiety.
  - Cognitive interventions include challenging your thoughts.
  - Mixed behavioral-cognitive strategies include reality testing, developing a sense of mastery, and somatic quieting or relaxation techniques.

* Even though SSRIs tend not to be habit-forming, if someone is on an SSRI for a long period of time, when he or she stops taking it abruptly, there's sometimes a rebound syndrome, so it's best to taper down slowly. For help with this, consult your physician or mental health provider.
** This temporarily raises anxiety, but in the long run, it will diminish anxiety.
*** We avoid what we fear—that threat on the horizon, whether it's real or imagined.
**** We try to do things to keep ourselves safe, including things like reassurance seeking, excessive preparation and rehearsals, and maybe even excessive reliance on somatic quieting.

- A well-researched and well-established system of treatment for anxiety disorders, particularly for phobias or generalized fears, is a systematic desensitization that uses a subjective units of distress scale (SUDS). Here, you create an exposure hierarchy, or a ladder ranking things that cause you anxiety.

- For example, if you have a phobia of spiders, a ranking of 100 would be holding a tarantula in your hand. A zero might be sitting on your couch and reading a book that has nothing to do with spiders. A 10 might be looking at the word spider; a 20 might be looking at a pretty realistic plastic spider.

- Next, you do graded exposures: You start at a low level, feel your anxiety begin to rise, and use somatic quieting until there's no more anxiety. Then, you go up to the next level, or rung, and repeat the process. This is a more gradual, gentle way to do exposure therapy.

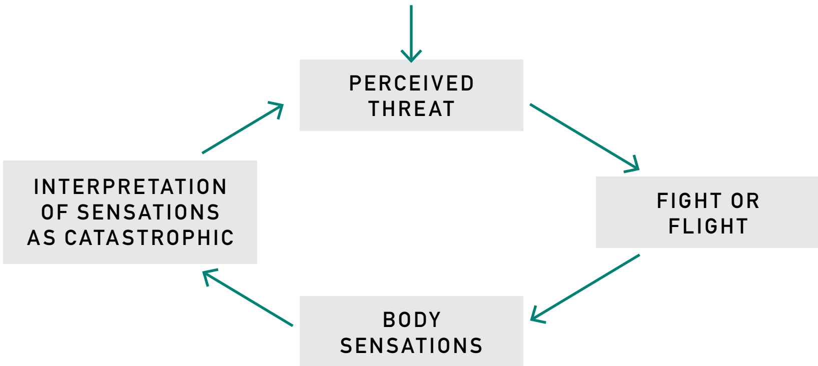
- But sometimes there are good reasons to feel anxious. For many young people—particularly those raised in abusive families or who live in poor or violent neighborhoods—anxiety is a rational reaction to unstable, dangerous circumstances.

- Recall that the cognitive theme of anxiety is the misperception of threat and the estimation that our coping resources are insufficient. Our habits of mind might come into play, causing us to overestimate the severity of threat and/or misjudge our ability to cope.

- When self-assessing or assessing others, we have to be very careful about assuming that a threat is misperceived or that resources have been underestimated. Both scenarios are important, but they call for different interventions.

PANIC ATTACK VERSUS PANIC DISORDER

- Clinically, a panic attack is defined as a sudden episode of intense fear that triggers severe physical reactions when there is no real danger or apparent cause. They may be cued, such as getting on an airplane if you're afraid of flying, or uncued—completely out of the blue. Fortunately, they rarely last for more than 20 to 30 minutes.



- Panic disorder is what occurs when someone has had multiple attacks or has had one attack and now lives in terror of when the next attack might occur. A common fear that then develops in addition to panic disorder is agoraphobia, or fear of open spaces. People become afraid of leaving home because they may have another panic attack and other people may not want to or be able to help.

- As with any patient in CBT, a therapist would first want to do a semistructured diagnostic interview. Then, the therapist might send the patient home with some questionnaires and some self-monitoring homework regarding anxiety and stress.

- Questionnaires that measure anxiety include the Beck Anxiety Inventory; the GAD-7, which is used in primary care practices and is available online; and the depression, anxiety, and stress scale, or DASS-21, which is not used as commonly but is beneficial because it addresses three different measures.

CBT FOR PANIC DISORDER

- As with nearly all treatments, CBT for panic disorder includes an early focus on patient education—including directly addressing any misinformation the patient might have received about panic disorder and any misattributions the patient might have already made about the symptoms or episode he or she experienced.
- We first want to name the disorder—name it to tame it—and then describe what's happening so that we can begin building an alternate explanatory model of what's going on.
- Patients often begin with an ambiguous, overly catastrophic model that blames themselves for their symptoms or that may forecast a dire future, such as having a heart attack or stroke. By knowing that their symptoms are a "thing"—a diagnosis—they can start being nudged by a therapist in more helpful directions, including treatments.
- Thought records can help balance beliefs about the danger of uncertainty or the value of worry, but they aren't the preferred treatment for anxiety. The most effective strategies are behavioral, with the most potent being exposures with response prevention. In terms of panic, these are called interoceptive exposures, because you're being exposed to internal sensations.

Exposure therapy was first developed in the 1950s and has become an essential component of CBT for anxiety. Exposure outperforms medications alone, but the best outcomes are often seen when SSRIs are combined with CBT exposures. Success rates then tend to exceed 80%.

Although exposure works well, it isn't always offered to people who need it. Part of the reason is that exposure work is hard, and it really isn't all that appealing to anxious people. The trick is getting over that initial hump and realizing that the short-term "pain" is worth the long-term gain.

- The treatment for panic in a therapeutic context contains the following elements: education about the panic cycle, challenging catastrophic cognitions, maybe somatic quieting, interoceptive exposure in sessions, and exposures outside of sessions. The goal is to be able to experience high levels of anxiety and develop mastery. This is usually accomplished in only four to six weekly sessions. This treatment protocol is one of the shortest and most effective in the CBT playbook.

- For everyday anxiety, there are several tools in your toolbox that you might use. If you're feeling keyed up, try somatic quieting. If you're feeling neurotic and ruminating a lot, try a thought record or use behavioral activation strategies for rumination. If you're feeling overly fearful, try exposures. If you're worrying, consult lesson 7. You can target thoughts about the value of worry, habits of mind, and beliefs about uncertainty, or you can try behavioral activation strategies.

HOW TO HELP AN ANXIOUS LOVED ONE

- But what if it's your loved one—a child or even a spouse—who is anxious? What's the best way to be supportive? When is pushing someone going to help because he or she has to face his or her fears? And when is it going to make the situation worse?

- This is a tough one with no clear answer. But remember that all of us need to learn distress tolerance and tolerance for uncertainty. Think of these as developmental milestones or maybe skills of living. It's not on you to force exposure therapy; after all, you aren't the person's therapist.

- All emotional challenges—whether it's anxiety or depression—place stress on a relationship, so it's important to address and not just enable. At the same time, it's important to express love and not judge. You can say no or disagree and still be supportive.

- But you can also read about anxiety together. You can create a CBT toolbox together. You can even take this course together. But you can't force someone to get help.

- If you're interested in learning more about how to help someone with anxiety, you might start with the website for the Anxiety Disorder Association of America: adaa.org.
- If you're interested in finding a CBT therapist, start with the online referral directory at abct.org. Just click on the link that's labeled Find a CBT Therapist.
- And if you're interested in a more in-depth discussion of how to find help, consult lesson 24 of the first Great Course on CBT: *Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*.

READING

Clark and Beck, *Cognitive Therapy of Anxiety Disorders*.

———, *The Anxiety and Worry Workbook*.

Zuercher-White, *An End to Panic*.

LESSON 14

ADDICTION AND PAIN MEDICATIONS

This lesson on addiction—which is now more formally known as substance use disorder—focuses on opioids because there has been such an incredible rise in prevalence rates for opioid use disorders and overdose deaths, mostly triggered by the overprescribing of pain medications.

The first Great Course on CBT (*Cognitive Behavioral Therapy: Techniques for Retraining Your Brain*) addresses addiction to alcohol and other substances.

Every 11 minutes, another life is lost to the opioid epidemic.

THE OPIOID EPIDEMIC

- The opioid epidemic is devastating the United States. Overdoses have surpassed car crashes and gun violence to become the leading cause of death for Americans under the age of 55. The epidemic has killed more people than HIV at its peak, and its death toll exceeds those of the wars in Vietnam and Iraq combined. So how did we get here?

- In the mid-1990s, there was a reconceptualization of pain as the fifth vital sign, in addition to temperature, blood pressure, respiratory rate, and heart rate. Historically, when you went to the doctor, these four vital signs were typically measured, but nowadays, you're also often asked about pain, usually ranking it on a scale of one to 10.

- This practice increases the awareness of pain, but it also perhaps nudges doctors to prescribe pain medications more frequently than they normally would have. There has also been pressure from drug companies in marketing medications like OxyContin.

- There were also a number of less scrupulous doctors and medical facilities—now called pain pill factories—that were all about making money and getting people hooked on these expensive medications.

- Some have argued that maybe our opioid crisis is the sign of broader societal distress. Is it about income inequality? Is it about depression? Is it about the lack of connection with others?

- Around 2 million Americans are addicted to opioids—yet many more have overcome their addictions. A large national study found that nearly all of those who once met criteria for opioid use disorders achieved remission during their lifetimes, and half of those recovered within five years.

- Although heroin and street fentanyl are more dangerous than opioids, most of those who avoid fatal overdoses recover from opioid addiction. So let's not write these people off.

- Recovery is achieved through medication-assisted treatment, in which medications like buprenorphine are used to stop withdrawal and promote recovery. Studies have shown that these types of medications reduce mortality by half or more when used long term and cut relapse rates more than an abstinence-only approach.
- Other people take their own routes entirely. They might find new passions in relationships, parenting, culture, exercise, work, art, spirituality, activism, or community service. Some recover by learning better ways to manage the trauma and mental illness that underlie many addictions.
- Johann Hari, the author of *Lost Connections*, argues that the opposite of addiction is not sobriety, but connection. Bruce Alexander, an addictions researcher, supports this notion with his Rat Park experiments. He gave rats two types of water bottles: one with just water and one with water plus heroin or cocaine. Rats only preferred drugs when the cage was empty. If they had companions and things to do, the rats chose water only.
- Many Vietnam veterans used heroin during the war, and 95% didn't get hooked. They came back home to their lives and families and didn't need it anymore. What if addiction is about your cage? What if addiction is about a lack of connection?
- Regardless of the path and whether assistive medications are used, the CBT toolbox can be applied. CBT helps patients overcome substance use disorders by helping them dismiss false beliefs and insecurities that lead to substance use disorders, providing self-help tools to improve their moods, and teaching them effective communication skills.
- Therapists teach patients to recognize, avoid, and cope: to recognize which circumstances lead to using drugs or drinking, to avoid triggers whenever possible, and to cope using CBT techniques to regulate emotions and challenge thoughts.

THE OPIOID SPIRAL

- Imagine finding yourself in the situation that thousands of people are in: In good faith, you see your doctor about pain. You are given opioids and feel a little better, at least in the short term. But soon you need more. And then you need more. The focus is so much on the sensation of pain that you forget about improving your level of functioning. You become trapped in a cycle of needing more and taking more. As part of this process, you become physically dependent on opioids and get physically sick—not just feel pain—if you don't keep taking them.
- It seems like there is no exit except to keep increasing your dose. Then, someone shuts off the pipeline of drugs and tells you that you have to taper down and maybe even stop.
- People in this situation are trapped in a spiral of hedonic dysregulation. When someone is using a drug like an opioid, it activates the endogenous opioid system, which is why it helps with pain. But it also releases dopamine, which helps with the experience of pleasure.
- If you're getting more and more dopamine because of the opioids, it means that you're going to require more and more dopamine to enjoy your everyday activities. You enjoy things less and less because of the medication you're taking. And because of that, you have an increased risk for depression. You're less able to derive joy from life.

ASSESSING OPIOID USE DISORDER

- Just like with other potential drugs of abuse, the DSM diagnostic criteria are used to assess whether someone has an opioid use disorder. A person needs to have at least two to three of the following criteria in order to have a mild disorder, four to five to have a moderate level of severity, and six or more to be considered severe.

    1. Opioids are often taken in larger amounts or for a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. There is craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use results in a failure to fulfill major role obligations at work, school, or home.
6. Opioid use is continued despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. There is recurrent opioid use in situations in which it is physically hazardous.
9. There is continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
10. Tolerance is exhibited (criterion not used if the person is just following a prescription).
11. Withdrawal is exhibited (criterion not used if the person is just following a prescription).

SELECTING TOOLS AND MAKING A PLAN

- The CBT skills that might be used to address opioid use disorder fall into the cognitive or behavioral buckets and target either emotion regulation or interpersonal relationships. Addiction and its fallout certainly include both of those.

- In thinking about tool selection, it's important to first think about some of the cognitive and behavioral phenomena that contribute to addiction. Here are a few key examples to consider:
  - Behavioral and environmental factors include high-risk situations or areas, triggers, social networks, biological predisposition/addiction potential, cravings for the substance, and rituals or habits around drug use.
  - Cognitive factors include dysfunctional beliefs about drugs, oneself, and one's relationship with drugs; automatic thoughts that increase arousal and the intention to drink and/or use the drug; permission-giving beliefs that patients hold to justify their drug use; and adverse psychological reactions to a lapse or relapse that lead to a vicious cycle of feeling more and more hopeless and using the drug as a way to cope.
- And remember to always look for underlying or concurrent factors. With addiction, there is nearly always stress, depression, anxiety, and a profound lack of connection. Hopelessness is common. Fortunately, CBT tools can address all of these.
- Foundational skills might include looking at self-awareness and self-monitoring; identifying triggers, supports, and obstacles; examining cognitions about coping, substance use, and pain; and assessing and tracking mood.
- Behavioral skills might include doing activity scheduling; using somatic quieting for stress; developing refusal skills;* engaging in healthy social activities with a new network learning stimulus control (limiting access to opioids and limiting triggers and cues); addressing ways to cope with craving, such as distracting oneself, reframing sensations, or addressing misperceptions about craving or substance use disorders;** engaging in physical exercise; and substituting opioid use with a different strategy to help manage pain.

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* Our social networks are often the drivers for the choices we make about whether we use drugs in a particular occasion. Learning how to refuse drugs from your social network is an important skill to cultivate and develop.

** Often people have irrational beliefs that cravings will continue to escalate and then become absolutely unbearable. But what usually happens is that there is a physiologic craving, but it reaches a plateau, evens out, and then eventually goes back down.

- Cognitive skills might include examining primary and secondary appraisals to help manage stress, using thought records, and doing cognitive restructuring for beliefs about the self, others, and the world.
- Fortunately, there are many tools that could help. The challenge is coming up with a coherent plan—a plan that will be driven by goals set by the patient. Some patients want total abstinence. Some want to continue pain medications. Some want to continue recreational use but reduce harm.
- What are the elements of a good plan?
  - It matches the patient's level of readiness to change.
  - It enhances motivation by keeping the issue alive in the patient's mind.
  - It reduces harm and/or provides an important learning experience.
  - It is concrete, specific, and realistic.
  - The patient agrees to it and is able to repeat it back to the therapist.
- Here are some plan examples; consider the micro-skills that might need to be employed for each.
  - learn more about opioid use disorders or pain management
  - monitor use
  - reduce use and/or harm
  - explore treatment options
  - abstain from use
  - begin a treatment program

MEDICATIONS FOR OPIOID USE DISORDER

- What makes opioid use disorder so incredibly difficult is the strong biological need that develops—a need that if not answered can be excruciating. Fortunately, there are medications that can greatly help and are an essential adjunct to CBT.
- Some of the medication options include methadone, buprenorphine, and naloxone.
  - Methadone helps prevent withdrawal and can help with pain management. You have to go to a special clinic to get it, and often you have to go there every day, so it can be inconvenient.
  - Buprenorphine doesn't give you a high, but it does prevent withdrawals and gives you some pain relief. You take it either once or twice a day, depending on the size of the dose, and you dissolve it under your tongue.
  - Naloxone is given to people to save their lives if an overdose happens. It comes in several different preparations, but the nasal spray is most common. You can get a prescription for it.
- A federally funded report came to a striking conclusion: More than 80% of the roughly 2 million people struggling with opioid addiction in the US are not being treated with the medications they need to prevent withdrawals or overdose.
- Methadone was approved to treat opiate addiction in 1972 and buprenorphine in 2002. Some countries have shown that increasing access to these drugs can significantly drive down the rate of overdose deaths. In France, for example, policies that enabled more doctors to prescribe buprenorphine helped lead to a tenfold increase in the number of people whose opioid use disorder was being treated and to a nearly 80% decline in overdose deaths in just four years.

- In many states in the US, would-be buprenorphine prescribers must wrestle with insurance companies for reimbursements—restrictions that are not justified by scientific evidence. These restrictions don't exist in other countries and aren't applied to other diseases.
- Less than 7% of medical providers have gone through all the hurdles needed to prescribe these lifesaving treatments. As a result, more than half of all counties have no licensed buprenorphine prescriber at all. This affects adults, adolescents, children, and pregnant women—all populations that might need this medication.
- Public health forecasts indicate that opioid overdoses might claim another 500,000 lives in the next decade. Many of those deaths could be avoided if existing medications—such as naloxone, which reverses overdoses, or buprenorphine, which treats opioid use disorder—would just be put to use.

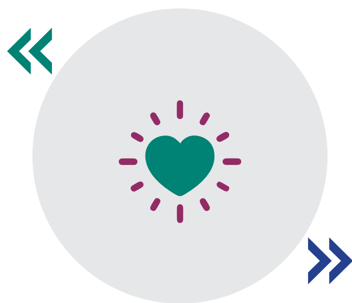
If you or someone you know might have a problem with opioids, reach out for help. Consider these resources:

- Substance Abuse and Mental Health Services Administration's treatment locator
- American Society of Addiction Medicine's Patient Resources page
- National Helpline: 1-800-662-HELP

READING

Beck, Wright, Newman, and Liese, *Cognitive Therapy of Substance Abuse.*

Hari, *Lost Connections.*



LESSON 15

EMBRACING IMPERFECTION

Perfectionism is a common but sometimes vexing habit that can cause quite a bit of stress in both you and those you love.

PERFECTIONISM AS A PERSONALITY TRAIT

- Perfectionism is a personality trait characterized by a person's striving for flawlessness and setting high performance standards, accompanied by critical self-evaluations and concerns regarding others' evaluations.
- Perfectionism can manifest in three domains: self-oriented perfectionism, where you believe that you have to be perfect; other-oriented perfectionism, where you believe that others have to be perfect; and socially prescribed perfectionism, or perceiving unrealistic expectations of perfection from others toward you.

- Perfectionism implies a high-stress control freak who can't relax. Perfectionists have a reputation of being relentless, uncompromising, and never satisfied.

> A group of Olympic athletes was asked the following question: Would you take a pill that would ensure your victory but kills you in five years? Half of them said they would be willing to die for the ultimate perfection—winning a gold medal.

- For these reasons, perfectionists can be quite successful. *Rolling Stone* calls Bruno Mars a "pop perfectionist." Serena Williams self-identifies as a perfectionist. Steve Jobs was a notorious perfectionist. But at what cost? And do these outliers justify perfectionism for other people?
- Some of the costs of perfectionism are anger, irritability, impatience, stress, abrasiveness, rigidity, being overcontrolling, being overly critical, procrastinating, and being indecisive. And remember that it can be self-directed or directed at others.
- People might also believe that others are having these thoughts about them. It's that report card that's never enough—a likely road that leads to depression, eating disorders, anxiety, or just feeling stressed out all the time.
- What makes perfectionism especially toxic is that it uses a negative problem orientation. It isn't about savoring your successes. It's that gut-churning desperation to avoid failure and disapproval—to do so much, to be so good, that people have to love you.

SELF-ASSESSING PERFECTIONISM

- Perfectionism isn't just having high standards or being ambitious or even having a critical eye. Technically, perfection is impossible. Striving for it can bring us success but can also lead to procrastination. It can also create a hypercritical eye that erodes our self-confidence and can damage our relationships.

- Do you expect yourself to be perfect? In all domains or just in a certain domain, such as work or relationships? Do you expect others to be perfect? Your spouse? Your kids? Your boss? Your coworkers? Do you think that others expect you to be perfect? At work? At home?
- Here are nine subtle signs of perfectionism from Ellen Hendriksen in *Psychology Today*:
    1. You always look great.
    2. You don't share your ideas until they're ready.
    3. You live by lists.
    4. It's difficult to relax.
    5. You can only concentrate if everything is in its rightful place.
    6. You procrastinate.
    7. You do one of two things when it comes to decision-making: You're either completely indecisive or you're overly certain and rigid.
    8. You have a lot of trouble delegating.
    9. You hate waste.
- So what can you do about it? The intervention depends on what you think is driving the behavior and what you see as the biggest costs you'd like to address.
- When thinking about your own perfectionism, consult your CBT toolbox. Exposure with response prevention is a likely choice from the behavioral compartment. Here, you intentionally do things or sit with things that are imperfect. You learn to unclench around them and maybe even enjoy them. Make things asymmetrical and leave them that way. Dress sloppily and don't fix your hair. Delegate a task to someone who won't do it as well as you but refrain from any instruction or criticisms.

- A tool from the cognitive side might be using a thought record to do cognitive restructuring or digging a little deeper to uncover conditional assumptions that you would address in something like a core beliefs worksheet.
- Do you believe that love and acceptance from others depend on your being perfect? Find evidence for and against that belief. What would a more balanced thought be? You might also try problem-solving therapy (PST). Are you procrastinating because of perfectionism? Use PST to define the problem, generate possible solutions, and test them.
- Two new tools that may help with perfectionism are standard-setting and planned imperfection.
- For standard-setting, you prospectively set a bar—a performance standard that you need to reach for a particular task to be successful. Once you've made this goal, you're done, so setting the right goal is important. It's OK to stretch yourself a little, but carefully think about the importance of the task first.
- For menial tasks, such as housecleaning, yard work, or grocery shopping, you might set a time limit since these tasks are never really completely done. For example, set aside an hour per Saturday and just do as much as you can—it doesn't have to be perfect.
- At work, make sure that you know what the performance standard is. Is there a set due date? Is there a productivity metric? Is it realistic and necessary? Some standards will be set by others, but you can always set your own standards, too—just be sure that they're necessary.
- Planned imperfection goes back to exposure exercises. You have a task—that maybe isn't so important—and you plan for the outcome to be imperfect. Then, you sit with the discomfort; that's the exposure part.
- The Japanese term *wabi-sabi* refers to the art of embracing imperfection. It's based in Zen Buddhism and has roots that go back to ancient tea ceremonies, where a master performs a very precise ritual but does it with misshapen and imperfect bowls. It's about embracing the beauty in the imperfect—about appreciating flaws.

- Lesson 9 addressed the importance of self-compassion and even being compassionate if we aren't yet compassionate. Perfectionism is another area where we need to build compassion for ourselves and for others. We're evolutionarily predisposed to nitpick at our failings, yet doing so makes us insecure and possibly anxious or sad.

- Self-compassion—the practice of being kind and understanding to ourselves when confronted with a personal flaw or failure—can be an essential antidote for when we fall short of perfect.

> As self-compassion researcher Kristin Neff said, "Research shows that the No. 1 barrier to self-compassion is fear of being complacent and losing your edge," but "all the research shows that's not true. It's just the opposite"—meaning that self-compassion can lead to greater achievement than self-criticism.

- Although it may sound paradoxical, research has shown that self-acceptance, not self-flagellation, is the best strategy to improve performance. Of course, it depends on the issue and the context, but in general, taking a step back, using some somatic quieting, and repeating some self-acceptance coping statements will get you further on your next attempt. Think of it as parenting: You need limits, but you need a whole lot of love and acceptance, too.

DEVELOPING PATIENCE

- A related and important concept, particularly when we are thinking about perfectionism directed toward our expectations of others, is impatience. Do slow drivers make you crazy? Do you hate slow talkers? Does the chatty checker at the grocery store irritate you? It's about patience—and about imperfection.

- Patience is defined as the ability to keep calm in the face of disappointment, distress, or suffering. It's associated with a number of positive health outcomes, such as reducing depression, stress, and anxiety. Patient people exhibit more prosocial behaviors like empathy and are more likely to be generous and compassionate.
- The good news is that even though patience has been described as a personality trait, it is modifiable. Even if you're not a particularly patient person today, there's still a chance for improvement tomorrow. So if you find yourself getting exasperated more than you'd like, here are a few ways to keep those testy impulses in check.
- First, you need to identify your triggers. M. J. Ryan, author of *The Power of Patience*, tells us that impatience is the "fight" component of the fight-or-flight response. Our amygdalae, those midbrain structures responsible for sussing out threats, are telling us that we need to step up and fight. While this was probably adaptive at some point in our prehistoric past, it's a misfire in the modern world. As a result, we overreact to minor triggers as if they were matters of life and death.
- The amygdala, Ryan says, is too unsophisticated to know the difference between a true danger—for example, a growling tiger—and something substantially less life-threatening, such as dealing with an obnoxious person.
- So what are your triggers? Figure out which situations set you off—careless drivers, technological glitches, slow-moving coworkers—and you've taken your first step to becoming more patient.
- Next, take a step back and perform a balanced assessment of the risk presented by that trigger. Here, you'll use your cognitive restructuring tools. Did the trigger unleash any automatic thoughts? Probably. Is there an associated image? Maybe.
- Figure out the automatic thought and then fill in the seven-column thought record. And since this tends to be a repetitive pattern, be sure to save that thought record. You'll want to create a compilation of more balanced thoughts to review later in order to build your skills with patience.

- Next, be sure to use reappraisals and reattributions. If you're annoyed by a chatty neighbor, try creating a different narrative. Why might your neighbor be reaching out to connect with you? What might this conversation be providing to him or her?
- Have there been times when maybe you were feeling a little lonely, too, and just needed some conversation? Maybe it's a good opportunity to show grace or kindness. We all need it, and we can all give it—with practice.
- And that brings us to the next point: practice, practice, practice. The same has been true for most of the skills that you've learned about throughout the course, but here it's particularly important because we might get impatient with our impatience.
- This habit has probably been around for a long time, so give yourself some time to gradually change it. And be sure to concurrently use your emotion regulation skills. Are you practicing stress management? Are you reducing arousal with somatic quieting?
- Finally, be realistic. It seems like the pressure to do more and more every day is ever present. You did 10 things today? You should do 11 tomorrow. But is that reasonable and realistic? Where's that pressure coming from?
- If your to-do list has 10 items on it but you can only reasonably accomplish five, then you're sabotaging yourself. Any inconvenience has the potential to throw you off track when your day is planned down to the minute.
- You might even try having an unscheduled day. This will sound funny, but try scheduling unscheduled times—sometimes a few hours or sometimes an entire weekend. The plan is to have no plan.

PRACTICING DOING NOTHING

- *Niksen* is the Dutch concept of doing nothing. It's a stress-relief technique that can also help us work with our perfectionism and impatience. It's a little hard to imagine doing nothing since it seems like we're always doing something.

- Doreen Dodgen-Magee, a psychologist who studies boredom, compares *niksen* to a car whose engine is running but isn't going anywhere. She thinks of boredom as the moment when we have no plan—we just are.
- More practically, the idea of *niksen* is to take conscious, considered time and energy to do activities like gazing out of a window or sitting motionless. Does this sound lazy? Indolent? Probably. But just suspend disbelief for now.
- Think about the demands that our modern world places on us, particularly with technology, which prevents us from ever really unplugging. We need a space, a time when we can literally and figuratively unplug. After all, the fast pace of life is rewiring our brains. We need to push back a little.

Research has found that daydreaming—an inevitable effect of idleness—"makes us more creative, better at problem-solving, and better at coming up with creative ideas."

- Olga Mecking, a science writer from the Netherlands, offers these helpful tips in her *New York Times* article "The Case for Doing Nothing."
    - **Resist the culture of busyness.** If you're doing nothing, own it. When someone asks you what you're doing during a nothing break, simply respond, "Nothing." Be unapologetic about taking breaks or holidays, and if you start to feel guilty about being seen as lazy, think of *niksen* not as a sign of laziness but as an important life skill. Choose the initial discomfort of *niksen* over the familiarity of busyness.

- **Manage your expectations.** Ironically, learning to do nothing will take time and effort, so don't get discouraged. Know that sitting still might actually be uncomfortable at first and might take practice.
- **Reorganize your environment.** Your home should be a *niksen*-friendly place. Designate a place where you sequester digital devices and have comfy furniture oriented toward a fireplace or window.
- **Think outside of the box.** If you can't sit still in your home or workplace, go to the park or the library or go enjoy a sauna or spa. Dodgen-Magee encourages people to host boredom parties, during which a host invites a few friends over so that they can all be bored together.

READING

Hendrickson, "Nine Little-Known Signs of Perfectionism."

Mecking, "The Case for Doing Nothing."

Ryan, *The Power of Patience*.

LESSON 16

BEATING PROCRASTINATION

Procrastination is an unfortunately common and vexing problem that nearly everyone has experienced. But why does it occur? On the surface, it seems irrational. However, our brains tend to prioritize immediate rewards over long-term rewards. And although you might be good at delayed gratification, it's still easy to fall into the procrastination trap.

PRESENT VERSUS FUTURE SELF

- Research has shown that we're more likely to perform smaller but urgent tasks that have a deadline than more important tasks that don't have a deadline. This can be explained by thinking of ourselves as two different people: our present self and our future self.

- It's easy to imagine goals for our future self: We want to exercise, eat better, clean out the garage, have a clean house. We might even carefully weigh the pros and cons and come up with an action plan. Our future self is all about long-term rewards.
- However, although we can make plans with our future self, it's our present self that takes action—and our present self is more concerned about short-term rewards. Our future self wants financial security, but our present self really wants a big-screen TV.
- So we have these two warring selves: future and present. This is reminiscent of the dual process theory, where we have the quick-and-dirty cognitive processing of system 1 and the more effortful but more accurate and rational processing of system 2.
- So what's a person to do? Are we doomed to procrastinate and undermine our long-term goals?
- Procrastination is defined as the avoidance of doing a task that needs to be accomplished by a certain deadline. It is the intentional delay of starting or finishing a task, despite knowing that there will be negative consequences. So, by its very definition, it is irrational.
- The future versus present self—or what is called temporal discounting—gives us some idea of why it happens. But we can apply CBT ideas to better understand the cognitions, behaviors, and emotions that might be at play.

APPLYING CBT TO PROCRASTINATION

- Everyone has procrastinated at some point in their lives, but some of us do it much more than others—even at the worst-possible times. It might be temporal discounting, but we all have that presumably to some degree.
- In the previous lesson, you learned that perfectionism can be a driver of procrastination. You can't get started or finish a task unless everything is perfect—and perfect never comes. As you discovered, there is a core set of beliefs associated with perfectionism that can be tackled and might help with procrastination, too.

- But what else? Piers Steel, author of *The Procrastination Equation*, tells us that it's not about laziness. That's something else entirely. Steel provocatively describes procrastination as self-harm.
- People engage in an irrational behavior that they know will hurt them. Steel and other procrastination researchers believe that self-harm occurs due to an inability to manage negative moods around a task.
- Think of the task that needs to be done as the trigger, and now we're in CBT territory. The task, the trigger, activates automatic thoughts, which create negative feelings. The behavior, then, is avoidance of the task, the trigger. It is immediately reinforcing because we avoid something that we might dread.
- The emotions might include things like dread, anxiety, sadness, boredom, frustration, or resentment, but the key feature is that the emotion is dysphoric. And the behavior—procrastination—can be conceptualized as a maladaptive emotion regulation strategy. It's not a character flaw or a personality defect; it's just an understandable attempt to manage an emotion.
- And what gives rise to those emotions? It's the cognitions we have about the task. And cognitions are amenable to cognitive restructuring or other CBT tools.
- However, the damage from the problem of procrastination can deepen depending on our response to it when it occurs. Self-blame and recrimination are common: thoughts about our worth, character, intelligence, or abilities. These thoughts layer on more dysphoria—now maybe some sadness or shame, which is more dysphoria to avoid—or, if we think about it constructively, more dysphoria we can manage using our CBT skills.
- In fact, there's an entire body of research that's dedicated to the ruminative, self-blaming thoughts many of us tend to have in the wake of procrastination. These are known as procrastinatory cognitions.
- So what should you do? Think about your CBT toolbox.
- On the behavior side, you might use graded task assignment and contingency management. You would break the task into small, manageable pieces and make sure you are rewarded when each one is completed.

- On the cognition side, the thought record and maybe even the core beliefs worksheet stand out. Capture the automatic thoughts about the task and find an alternate, more balanced thought. Were you using magnification about how bad the task might be or about how long it might take? Capture the procrastinatory cognitions that are used to beat yourself up. Are they fair? Are they balanced? How can you rewrite them or maybe construct a behavioral experiment to test out a new thought?
- You might also use the steps of problem-solving therapy—first working on your problem-solving attitude and then defining the problem, listing possible solutions, and trying something out.
- A clear candidate would also be the many skills that were tied to the modal model of emotion in lesson 10. If you can regulate the dysphoria with something other than procrastination, then there's no need to procrastinate!
- And importantly, keep self-compassion and kindness in mind. We are wired to procrastinate, so it's bound to happen. It's up to you to fight back and do what you need to do to get things done.
- One thing that might make this whole process a little more enjoyable is a variant of savoring—focusing on how good, fun, and enjoyable something is or was or might be. Swap out those negative cognitions with an image of you finishing that task, with a sensory-rich imagining of what it will feel like once you finish.

As you begin thinking about things that go undone, make sure the expectations are fair and reasonable. It's not procrastination if you've just been given too many things to do.

STRATEGIES FOR PROCRASTINATORS

- The Eisenhower box—developed by our 34th president, Dwight D. Eisenhower—is an exercise designed to help you prioritize what's most important and to get the right things done first.
- The Eisenhower box is a two-by-two square with four boxes total. At the top of the square are two labels: *important* and *not important*. On the left side, there are two other labels: *urgent* and *nonurgent*. Think of all the things you have to do and sort them into one of these four boxes—with important and urgent stuff ideally getting done first.
- Many people get sucked into the urgent category, and often it's urgent but not important, such as checking your emails. It's up to you to take control of your time.
- But what about fun? What about downtime? What about pleasant activities? These kinds of activities are important but often nonurgent. They should still get priority, but it's up to you to figure out the right amount of things you have to do versus things you want to do—concepts you learned about in lesson 1.
- Here are some general strategies adapted from Phyllis Korkki, author of *The Big Thing: How to Complete Your Creative Project Even If You're a Lazy, Self-Doubting Procrastinator like Me*.
    - **Identify small goals.** This refers to graded task assignment. Break down an overwhelming task into smaller parts. These small tasks accumulate, ultimately turning into a completed project. You might set a goal of sitting down to work on a project for at least 10 minutes a day. This is a strategy that many writers use. That 10 minutes doesn't feel overwhelming, and you might actually find that once you get started, you just keep going.
    - **Create a prioritized to-do list.** Here you can use something like the Eisenhower box and start with the urgent and important items first. Still having trouble getting started? Think of other CBT tools like graded task assignment or contingency management. Just don't use a thought record as a way to avoid doing something urgent and important.

- **Use your natural patterns to your advantage.** If you're more alert in the mornings, schedule more difficult tasks in the mornings. Do you feel more social after lunch? Schedule meetings or phone calls after lunch. Is there a time of day when you prefer to be quiet and withdrawn? That may be a good time for organizing your desk. The point is to pick the optimal time and circumstances you need to make the job easier and get it done.

- **Complete quick tasks immediately.** If a coworker asks you to simply forward an email, send it to him or her immediately rather than adding this to your to-do list.

- **Increase the pressure.** Use a timer or an alarm to limit yourself to a certain amount of time to complete a task. This strategy might create more anxiety, but it also prevents task creep, where you spend 30 minutes editing a document that should have taken 10 minutes. The alarm and the pressure it creates also change the contingencies. Getting the task done is a bigger relief.

- One of the favorite tools that psychologists use to overcome procrastination is called a commitment device, which can help you stop procrastinating by designing your future actions ahead of time.

- For example, you can curb your future eating habits by purchasing food in individual packages rather than in bulk size. You can stop wasting time on your phone by deleting games or social media apps. You can limit TV time by putting your TV in a closet and/or making it difficult to pull out and hook up. You can buy a nonrefundable gym membership or set up an automatic payroll deduction to put money into your 401(k). The less you have to think about it, the better.

- But what if you're just not motivated? Flip the script. Sometimes action precedes motivation. Run it as a behavioral experiment. Not feeling motivated? Do that 10 minutes of activity and reassess your level of motivation. It likely will increase, even just a little.

- But can't you just sometimes relax and miss a deadline or two? Of course you can. But first, sort your tasks into an Eisenhower box, get that urgent and important stuff done, and then maybe reward yourself with some relaxation time.

- When is it time for tough love? When should you use a punishment instead of a reward? In general, rewards work much better than punishments. So before you go and find a stick, you might want to reconceptualize the kinds of rewards that you might use to move yourself forward.

READING

Kahneman, *Thinking, Fast and Slow.*

Korkki, *The Big Thing.*

Mecking, "The Case for Doing Nothing."

Steel, *The Procrastination Equation.*

LESSON 17

SOOTHING REJECTION, PROMOTING CONNECTION

This lesson returns to anxiety—specifically to social anxiety and rejection. You'll use your standard CBT skills and acquire some new knowledge about the nature of rejection, common maladaptive reactions, and something called the liking gap.

SOCIAL ANXIETY

- According to a large survey by the health-care provider Cigna, most Americans suffer from loneliness and dissatisfaction with their relationships. Nearly half say they sometimes or always feel alone or left out. And 13% of Americans say that zero people know them well. The survey measures social isolation using the UCLA Loneliness Scale and shows that loneliness has gotten worse in each successive generation.

- In the book *Them: Why We Hate Each Other—and How to Heal*, Senator Ben Sasse argues that "loneliness is killing us," citing rates of suicide and overdose deaths in America. In 2018, about 50,000 Americans committed suicide and about 70,000 died from drug overdoses.
- What has happened to our sense of community? Why do so many feel loneliness and despair? Some have argued that what we need is a *thick community*: a sociological term that refers to a community with deeply shared values, a common story, and a sense of loyalty and commitment to the group, all in the service of a powerful purpose. Or at least that's the traditional model—and one that was much easier to achieve when people weren't so mobile and were more homogeneous.
- We may always need to feel rooted to a place and a community, but perhaps there are other ways to be thick. Perhaps there's a place beyond tribalism and populism that helps us see that we're all part of a larger community that needs to learn how to support one another.

People are social animals, and social animals have hierarchies. It's all about power and dominance—about learning your place on the social ladder. Where do you stand? And how does it affect you? What was it that pushed you up or pushed you down? And how does your position affect your ability to connect with others—to counteract this epidemic of loneliness?

- Meeting new people and forming new relationships is hard for anyone, but imagine what it must be like for a person with heightened shyness or social anxiety, or for a person with a history of interpersonal trauma. And what if such a person manages to find the courage to reach out and then gets rejected?

THE NATURE OF REJECTION

- Brain scans of people who have been rejected by their ex or cruelly excluded from an online game are almost indistinguishable from those of people in physical pain.

- Apparently, this was adaptive in our evolutionary past. If rejection didn't sting, you might have been perfectly comfortable leaving your tribe, which would lower your chance of survival. But it means that we're still wired to be overly sensitive to rejection. How often does that one negative comment in a performance evaluation feel crushing?

- We know that it's common and hardwired, but shyness pushes us further out on the social anxiety spectrum. Up to 80% of people report that they were shy at some time in their lives, and 40% describe themselves as shy now. However, if you think of yourself as shy, it doesn't mean that you have a problem that requires professional help.

- As with depression and other forms of anxiety, we can think of social anxiety—and especially anxiety around rejection—as existing on a continuum. Small amounts of it might actually be a good thing. The negative feelings associated with rejection also mean that connection is implicitly valued.

- But how do you start pulling this complex idea apart? How can you know when social difficulties might be more about you than about the people you're around? And is it really an either/or—you versus them?

COPING WITH REJECTION

- Unfortunately, people who struggle with rejection sensitivity often cope with it in ways that may push others away. Many times, such people believe that they are rejected by others who either don't like them or just don't understand them. They might turn their hurt feelings into anger and withdraw from others. They might cope with their anxiety by being quiet and detached. But then they feel left out and overlooked.

- While the diagnosis for such people would likely be in the realm of social anxiety, their problems are more about the ingrained and understandable but unhelpful habits they have developed to cope with their hypersensitivity to rejection.

- If you are hypersensitive to rejection, there are two parallel strategies that you might use: strategies that help you manage the internal sensation of anxiety and those that help other people understand you. If others understand who you are, it's probably easier for them to connect with you—and vice versa.
- Consider your habits of mind, or thinking shortcuts, which might include selective attention, confirmation bias, personalization, and/or magnification/minimization.
- Push back against your habits of mind. Is there a different way to just as accurately think about a situation that leaves you feeling less rejected, or maybe just generally puts you in a better mood? Look for a more helpful, balanced interpretation of the situation.
- You might also be using behavioral responses to anxiety that sustain or maybe even exacerbate it. For example, you might do a lot of avoidance, particularly of social situations.
- This is a great opportunity to use some of your CBT skills. As an example, you could use a thought record to tone down the anxiety and the sting of rejection. Make sure to do the hard part of rewriting more balanced thoughts. Do this enough so that you internalize the new beliefs and can dispute thoughts on the fly.
- By analyzing your habits of mind and doing thought records, you will start to see patterns and have some insight about your behavior. It's not about blame—it's about understanding the complicated dance of social relationships.
- The good news about seeing that you play a role is that you can do something about it. You may have to risk rejection by stepping forward and reaching out to others, but it will also send the message that you're interested and available to connect.
- The real tragedy of people who are socially anxious is that they really want to connect, but they unintentionally send the message that they really couldn't care less. Showing their interest and vulnerability won't always work, but it will get them closer to where they want to be.

COGNITIVE STRATEGIES

- Given the ambiguity of most social interactions, especially those with new people, the circumstances are ripe for habits of mind to take over, which points to the cognitive side of the CBT toolbox.
- Behavior is important—you have to be doing something social—but it's really how you think about the social interaction, both during and afterward. We all have an internal monologue. What's yours?
- Researchers have shown that there's a phenomenon called the liking gap. Most of us are far too negative in rating how we performed in a social interaction, and most of us believe that new people don't like us as much as they really do.
- Researchers conclude that people can be their own worst critic, and it's hard to see that others do not have the same perspective on their faults. The lesson here is to keep in mind that self-doubt is the norm, no matter how cool someone might look on the outside. Odds are that people like you a lot more than you think they do.
- There are also a few adaptations of cognitive strategies that are already in your CBT toolbox: reframing and cognitive restructuring.
- Reframing is simply a way to reexplain a situation from a different perspective. The same event happened, but it might be attributed to different, more helpful or hopeful causes.
- Most rejections occur due to a lack of fit. For example, your skills don't match the job requirements. Or you and the person you were dating just didn't share enough common ground. It's about the chemistry, not about something that's attributable just to you.
- Research has shown that looking at the relationship or fit, instead of the people involved, helps assuage the sting of rejection. After all, everyone gets rejected many times in their life. Fortunately, when one door closes, another soon opens. Just don't miss it because you're busy looking at closed doors.

- Another cognitive restructuring tip has to do with the idea that we have multiple selves—which is really just another way of saying that we have lots of layers and lots of attributes, all of which are not always involved in a rejection. It's just part of us that wasn't a good fit. There is more to you than that particular job or relationship.
- If part of you is feeling bruised, do a thought record and write about the positive attributes that you have as part of an alternate thought. Just be fair and balanced and remember that we all contain multitudes.

TIPS FOR SMOOTHER SOCIAL SITUATIONS

- Recall that difficulty in interpersonal relationships can generally have two root causes: a lack of practical skills and/or anxiety that prevents a person from using the skills he or she possesses.
- This lesson has focused on emotion regulation—managing the anxiety. But the behavior of asking questions is an example of a tip that can be used to build those practical skills. It's a habit that you can develop and fine-tune to better manage your likability.
- By looking at impressions following first dates and initial social encounters, research has shown that people who ask more questions are better liked. Asking questions shows that you are interested in the other person and gets the other person talking. The more a person shares, the closer he or she feels to you—assuming that you clearly indicate you're listening while the person is talking.
- Come up with a few stock questions that are open-ended and somewhat matched to the context. At a fun social event, it might be something like "Tell me about an adventure you've had" or "What are you most looking forward to next week?"
- Practice different questions and see which seem like a good match with your personality. And remember that you should try to stretch yourself. It's OK to feel awkward. Social relationships, especially new ones, are

awkward. Even if it feels a little bumpy, others will notice that you're making an effort. It will be appreciated, and the favor may be returned—so be sure that you have some answers to your own questions.

READING

Cain, *Quiet*.

Sasse, *Them*.

LESSON 18

EARLY CHILDHOOD TRAUMA AND NEGLECT

Kintsugi, or "golden repair," is the Japanese art of repairing broken things, such as cracks in pottery. Rather than hide an item's imperfections, the reparation process highlights them. Those imperfections are considered part of the item's history, and repairing it this way—for example, using precious metal like gold to fix cracks in pottery—can add beauty to the original items. We all have cracks and scars. How do we get from damage to repair?

ADVERSE CHILDHOOD EXPERIENCES

- The ACE study is an important and relatively new area of research that's caused quite a stir in the medical and mental health community. *Adverse childhood experiences* (ACEs) is the term used to describe all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18.

- The landmark CDC-Kaiser ACE study examined the relationship between these experiences during childhood and reduced health and well-being later in life.
- Between 1995 and 1997, more than 17,000 people receiving physical exams completed confidential surveys containing information about their childhood experiences and current health status and behaviors. The information from these surveys was combined with results from their physical exams to form the study's main findings.
- Almost two-thirds of adults surveyed reported at least one ACE—and the majority of respondents who reported at least one ACE reported more than one ACE. And 12.5% of the sample reported four or more ACEs.
- The ACE study looked at three categories of adverse experiences: childhood abuse, which included emotional, physical, and sexual abuse; neglect, including both physical and emotional neglect; and household challenges, which included growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation or divorce, or a member of the household who went to prison.
- Respondents were given an ACE score between zero and 10 based on how many of these 10 types of adverse experiences they had before the age of 18. The ACE score was used to assess cumulative childhood stress. Study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course.
- In terms of longevity, people with six or more ACEs died nearly 20 years earlier on average than those without ACEs. As the number of ACEs increases, so does the risk for several different issues, including the following:
    - alcoholism and alcohol abuse
    - chronic obstructive pulmonary disease
    - depression

  - fetal death
  - drug use
  - ischemic heart disease
  - liver disease
  - poor work performance
  - financial stress
  - intimate partner violence
  - sexually transmitted diseases
  - smoking
  - suicide attempts
  - unintended pregnancies
  - early initiation of smoking
  - early initiation of sexual activity
  - adolescent pregnancy

- One study estimated that 90% of people with a heroin addiction have had early childhood trauma. Opioids, including heroin, appear to be a soothing but ultimately destructive self-medication for deep wounds. But how does this work?
- Potential ACE mechanisms include the following:
  - brain development*
  - stress physiology**

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* Our brains aren't fully formed until we're 25, so events that happened before 18 are bound to have an effect on the way our brains develop.
** If a child is often, or maybe always, in a fight-or-flight response, that's bound to cause some wear and tear on their bodies.

   - immune system function
   - epigenetics*

- A lot of the work that's being done in the area of ACEs focuses on early detection and prevention, typically involving pediatricians and family medicine doctors.** But for people who are older than 18, prevention isn't going to help—at least not in terms of the prevention of ACEs.

- But we still want to prevent additional trauma as an adult, and we want to minimize any maladaptive coping, such as smoking, excessive drinking, binge-eating, high-risk sexual behaviors, or physical violence. Depending on the individual, we might also need to treat lingering symptoms of post-traumatic stress disorder (PTSD). And this is where CBT can really shine.

COGNITIVE PROCESSING THERAPY

- Cognitive processing therapy (CPT) is typically delivered by a mental health professional, often a CBT therapist, and it was designed for survivors of sexual assault. Given its efficacy with trauma in general, it has also been used for veterans and others with PTSD symptoms. It's typically delivered in 10 structured weekly sessions and makes use of many of the tools that are already in your CBT toolbox.

- Stuck points are the first skill introduced in CPT,*** and they might be the most important skill of all. In a sense, the entire project of CPT is finding stuck points and then learning how to unstick them.

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* These early life experiences would not actually change our genome, but they might change which genes are turned on or off.

** In California, it's now mandatory to screen all kids for all ACEs and hopefully connect them with services.

*** An episode of the *This American Life* podcast titled "Ten Sessions" followed a woman undergoing CPT at the University of Washington with a therapist named Debra Kaysen.

- A stuck point is basically something that you hold to be true but might in fact not be true. A stuck point is a belief or a thought that is keeping you stuck in the trauma. You're stuck in any number of upsetting or inaccurate or harmful ways of remembering what happened, such as thinking that it's your fault or that there's something you could have done to avoid it.
- Stuck points are tracked using a stuck point log. This is very similar to the CBT tools of self-monitoring and writing down automatic thoughts.
- The process in CPT is all about finding and challenging stuck points. Often they occur around blame—not listening to a parent, not being able to protect yourself, not being safe anywhere, or believing that maybe it was your fault because you wore something too provocative.
- Eventually, patients rewrite stuck points into more balanced thoughts. They rate the believability before and after the exercise to see if it was effective. This is straight-up CBT, plus some exposure and behavioral activation.
- Themes that often come up occur around feeling safe, having self-esteem, or feeling in control. Here's a sample stuck point: "When I'm not in control, bad things will happen." And you would want to find counterexamples. A sample exercise might be to give a compliment to a stranger. This pushes against the social isolation that often comes with PTSD.

YOUR ACE SCORE

- To figure out your ACE score, answer yes or no to the following 10 questions. Assign yourself one point for each yes, for a maximum score of 10. Consider the time when you were growing up, during your first 18 years of life.

1. Did a parent or other adult in the household **often** …

   swear at you, insult you, put you down, or humiliate you?

   or

act in a way that made you afraid that you might be physically hurt?

2 Did a parent or other adult in the household …

often push, grab, slap, or throw something at you?

or

ever hit you so hard that you had marks or were injured?

3 Did an adult or person at least five years older than you **ever** …

touch or fondle you or have you touch their body in a sexual way?

or

try to or actually have oral, anal, or vaginal sex with you?

4 Do you **often** feel that …

no one in your family loved you or thought you were important or special?

or

your family didn't look out for each other, feel close to each other, or support each other?

5 Did you **often** feel that …

you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6 Were your parents **ever** separated or divorced?

7 Was your mother or stepmother

often pushed, grabbed, slapped, or had something thrown at her?

or

sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
10. Did a household member go to prison?

- There are a few really important things to remember.
  - ACEs are very common. In fact, most people have had at least one, and close to 13% of the adults in the ACE study had four or more. So having ACEs is not a predictor of doom.
  - The ACE survey only captures risk factors and doesn't assess protective factors, such as teachers, friends, or neighbors that provided support.
  - These studies are correlations. They are associations only and are not proof of causation. Having more ACEs means that you might have an elevated risk, but it's not definite that you will get one or many of those issues in the long list near the beginning of the lesson.
- That said, it is still wise to step up your preventive health interventions if you scored a three or higher. Here are a few examples of how this might work.
- First, you'll want a snapshot of your current health and wellness. Do you have high blood pressure and/or high cholesterol? Are you overweight? Are you a smoker? Look for those risk factors that might be telling you what chronic diseases are in your future.

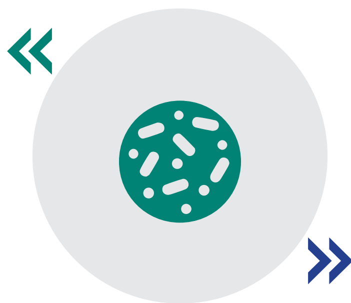
- We should all do this, regardless of ACEs, but remember that ACEs increase your risk, so there should be even more motivation to do something. What are your health behaviors like? Consider the usual list: diet, exercise, stress management, drinking, drug use, and getting enough sleep.
- Remember that close social relationships are also key to being healthy and can have an important health effect. Again, this is important for anyone, but it's especially important for people with three or more ACEs.
- Keep in mind that your risk also includes things like depression and anxiety—both full-blown episodes and excessive amounts of the everyday stuff. A daily practice of something like mindfulness or yoga or running or prayer will be especially important for you.
- Remember that both the cognitive and the behavioral tools in your CBT toolbox target emotion regulation and social, occupational, and physical functioning. You already know how these tools can be used for depression, anxiety, and stress. The extra piece here is to think about how regulating your emotions with your CBT tools will influence your motivation and ability to engage in health-promoting behaviors.
- For example, think about how a tool like a thought record or activity scheduling with pleasure predicting might help you get unstuck around starting an exercise routine or coping with cravings for sweets.
- The bottom line is that you can knock your health risks back down despite your childhood experiences.

One of the best resources to learn more about ACEs is the CDC web page on them: http://www.cdc.gov/violenceprevention/acestudy/. You'll find a list of studies, a summary of findings, and resources.

READING

https://acestoohigh.com/aces-101/

Glass, "Ten Sessions."



LESSON 19

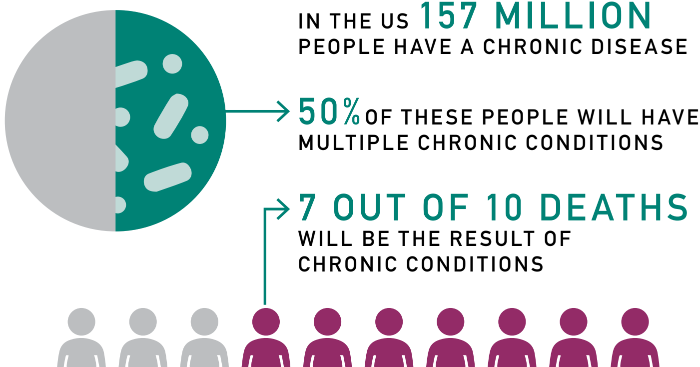
MANAGING CHRONIC DISEASE

This lesson digs into what it means to have a chronic disease: how it affects your self-image, sense of hope, and social position, and how it even challenges your notions about mortality and vulnerability.* These are all beliefs—cognitions—that can be better understood by examining them with the tools you already have in your CBT toolbox. And potentially, these are beliefs that can be challenged or savored—again, using your CBT tools.

* The goal is not to eliminate dysphoria. Sometimes learning that you have a chronic disease and having to face your mortality is an important wake-up call, but it's essential that you're able to use that dysphoria constructively to learn, grow, and get healthier.

OUR AGING POPULATION

- Our population is aging—which means we're living longer. It also means we have more time to develop a chronic disease, often one that's related to our behavior.
- It's estimated that the number of people living with a chronic disease in the US is around 157 million. Half of these people will have multiple chronic conditions, and about seven out of every 10 deaths will be the result of a chronic condition.
- Some of the most common chronic diseases are heart disease, cancer, diabetes, hypertension, stroke, pulmonary diseases, and depression—at a cost of more than $1 trillion per year in the US alone.
- The high prevalence of chronic diseases, and the death rates from them, are relatively new phenomena and are in a strange way the result of the success of modern medicine.
- A century ago, people were dying from acute infectious illnesses, such as pneumonia, influenza, and tuberculosis. Nowadays, people live much longer and have more opportunity to develop a slower, chronic disease, such as heart disease or diabetes—both of which have strong ties to our health-related behaviors, including diet, exercise, and smoking.



- This matters because if we're thinking about preventing, or at least managing, a chronic disease, then we need to know how we got here and whether CBT tools can help.

Even if you don't have a chronic disease now, odds are that you will someday, so why not delay the onset as long as possible?

IMPACTS OF CHRONIC ILLNESS

- The impacts of chronic illness can be divided into three categories: psychological, physical, and behavioral.
  - Psychological impacts include stress, depression, and anxiety; changes in self-image and self-esteem; the challenging of core beliefs; the activation of conditional assumptions;* and existential challenges of facing mortality.
  - Physical impacts depend on the type of disease as well as the severity of that disease, but common ones include lower energy, more fatigue, and limited endurance; chronic pain and discomfort; insomnia; gastrointestinal distress; dizziness; sweating; and poor circulation.
  - Behavioral impacts include changes in social and occupational functioning; engaging in fewer activities (it takes more energy to overcome the inertia); and changes in social roles and power dynamics.**

* Conditional assumptions include beliefs about what it means to be a sick person, how others might treat sick people, etc.

** Maybe your kids are adults now and they see you in a different way—as more vulnerable and needing more support. You might still be the matriarch or patriarch, but maybe now your kids are stepping up as adults, too.

- There are also deeper and maybe subtler changes that can greatly contribute to stress and challenge even the best coping skills. There's the financial strain (at least in the US, health care and medications are very expensive). But there's also the looming loss of independence—of autonomy.
- Most of us dread the idea of becoming a burden on others and needing to be taken care of. It's easy to fall into catastrophic thinking and imagine yourself as an invalid when you're first diagnosed with a chronic disease.
- And even if you don't slide too far down that slippery slope, you might notice that everything that used to give you joy is slipping through your fingers and there's nothing you can do about it—or at least it seems that way.
- Most of the habits of mind, or thinking shortcuts, are in play. There's selective attention, magnification and minimization, fortune-telling, all-or-none thinking, etc.
- The good news about that is you have the tools to help you come up with more balanced cognitions. You don't want to be a Pollyanna, and you don't want to use denial. But coming up with thoughts that are more helpful might help you cope more effectively. Then, you might want to break out your problem-solving therapy skills and see what you can do to address the very real problems that chronic illness can create.

EMOTION REGULATION AND SOCIAL FUNCTIONING

- When dealing with chronic disease, the two primary targets of your CBT tools are emotion regulation and addressing changes in social, occupational, and physical functioning.
- First, to target emotion regulation, pick one of the cognitions you have about your chronic condition and do a thought record.
- It's common to have a whole cluster of thoughts around a trigger, and these thoughts might pull you toward completely different emotions—some might even be helpful and constructive. Your challenge is to figure out

where to start and then stay focused until you complete all seven columns of the thought record. You can always go back and start another thought record for one of the other cognitions.

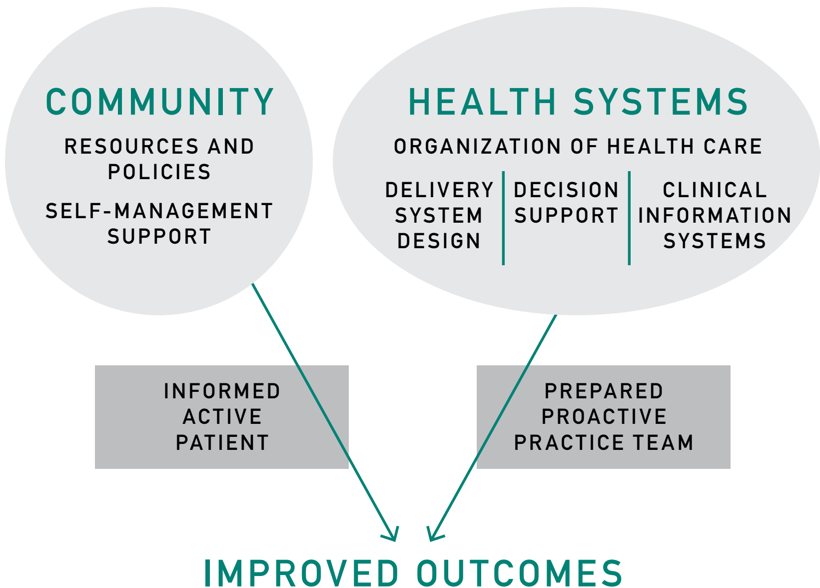
Nearly 40% of adults over the age of 65 take five or more prescription medications daily, and that doesn't include vitamin supplements or any over-the-counter drugs.

- The trick is to start with the hottest cognition—the one that stings the most, or has the highest emotional intensity related to it—and stay focused on that one until you've rewritten a more balanced thought that lowers the emotional intensity.
- Strategies that can be used to get you to a more balanced thought include looking for evidence for and against; decentering, or imagining yourself talking to a friend who had this thought; identifying the habit of mind (name it to tame it); and using linguistic strategies like "yes, but" or softening absolute words like *always* or *never*.
- The next challenge with chronic illness is the impact it can have on your relationships. It's hard to be a good employee when you need extended time off. It's hard to be a good friend when you cancel plans at the last minute. It's hard to be a good partner or parent when you barely have the energy to get out of bed.
- No matter how supportive people are or how often you explain, it feels terrible. You feel like you're violating your own rules about what it means to be a friend, a parent, a spouse, or an employee.
- It's also your relationship with yourself that changes. You aren't that healthy, vibrant person anymore. You're no longer going to be that perky, healthy grandma you always saw in your mind's eye. Life has taken a wrong turn, or at least a detour. So what can you do? You can grieve the loss of that imagined future and then make necessary adjustments.

THE CHRONIC CARE MODEL

- The chronic care model was designed to encourage cooperation between community members—including you and your family—and health-care systems. The model is meant to promote patient and family involvement, including disease self-management and shared decision-making.
- The emphasis is on both quality and quantity of life. So even though a cure may not be possible, maximizing functionality and minimizing suffering might be possible.
- Chronic disease management includes both primary prevention—how to prevent the disease in the first place—and secondary and tertiary prevention, or how to prevent, or at least slow, the disease's progression once you actually have it.

CHRONIC CARE MODEL



- Some of the mechanisms at play might include promoting positive health-related behaviors, such as dieting, exercising, not smoking, and taking medications as prescribed; enhancing medical adherence; reducing stress; improving emotion regulation; and building motivation to change, which includes hope and self-confidence.
- The job of your health-care team isn't just to prescribe things; it's to help you take better care of yourself. In the chronic care model, this is called self-management support, where a patient steps up to manage his or her own disease.
- This isn't a free pass for doctors, but remember that even if you see your doctor every month of so, the vast majority of the time, it's just you and your family and your diseases. So it really behooves you to develop some strategies to manage things on your own.

By definition, a chronic disease can't be cured, but its symptoms can be managed, and its progression can be halted, or at least slowed.

- Self-management support might involve the patient using thought records to manage emotions and using activity scheduling and problem-solving therapy to change health-related behaviors. It's an ongoing, iterative process; there's no quick fix.
- There are four categories of tasks that patients need to perform:
    1. Manage the illness itself.
    2. Carry on normal roles and activities.

3. Manage the emotional impact of the illness.
4. Promote health and prevent additional illness.*

- For managing the illness—which includes taking medication and keeping doctors' appointments—there's always data collection and thought records. What are the thoughts that might be keeping you stuck? What thoughts might be driving avoidance?
- The behavioral tools can help you maintain normal activities and behaviors. Yes, you may have less energy, but will you feel better if you're inactive? Find a meaningful compromise. Find a plan B if plan A gets derailed due to pain, energy, or other symptoms.
- Another element of the chronic care model you could address is the need for shared decision-making, where you become an active participant in understanding your disease and treatment options and in making decisions about what might come next.
- On average, a physician will interrupt you within the first 10 seconds of a visit. You're rushed, you're shushed, and you're mostly told what to do. You often don't get a chance to ask questions. But it's a two-way street.
- In a 2018 survey published in the *Journal of the American Medical Association*, 81.1% of patients have withheld medically relevant information from their doctor, 45.7% avoided telling their doctor they disagreed with him or her, and 81.8% withheld information because they didn't want to be lectured or judged.
- This is not a recipe for collaboration or making decisions together. Both medical providers and patients/families need to take the time to define the problem, set some goals, and go over treatment options together. Research shows that although this may take a little more time up front, it saves time in the long run and promotes better outcomes.

* It's easy to develop tunnel vision once you have a chronic disease and forget that you're trying to prevent all of the other diseases from occurring as well.

- You are an expert on yourself. Only you know as much about you—what works, what doesn't, and what you prefer. You not only get a vote, but you should be the ultimate decision maker who uses the expert input from your medical doctor and medical team.

READING

Feldman, Christensen, Laponis, and Satterfield, *Behavioral Medicine*.

Lorig, *Living a Healthy Life with Chronic Conditions*.

Satterfield, *Minding the Body*.

LESSON 20

COPING WITH CHRONIC PAIN

This lesson is about chronic pain. It focuses on how you can use your CBT toolbox to improve assessment, diversify and improve your pain treatment portfolio, and manage the psychological suffering that usually accompanies chronic pain.

Emotion regulation and improved social, occupational, and physical functioning—which are targeted by your CBT toolbox—will be important as you think about enhancing your quality of life in the face of chronic pain.

Both the sensation and the neuroscience of chronic pain are covered in the Great Course *Mind-Body Medicine: The New Science of Optimal Health*.

CBT is not meant to be a substitute for other pain interventions, but you'll likely find that it makes a nice addition to your pain treatment protocol.

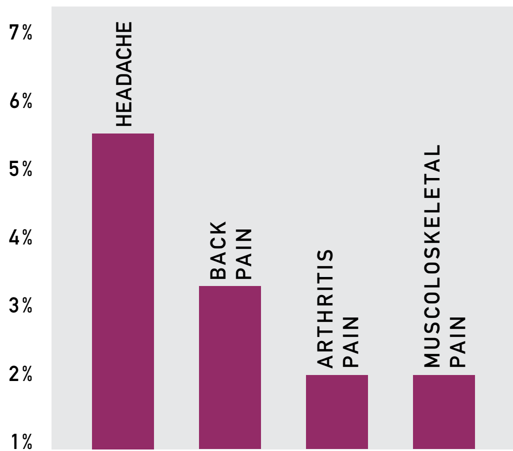
ACUTE VERSUS CHRONIC PAIN

- The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage."
- Just like anxiety or depression, pain in the right amount and at the right time can be a valuable source of information. We need to be alerted if we're damaging our bodies.
- But there are times when it misinforms us, such as when we feel pain even when an injury has ended and a wound has healed or when we feel physical pain resulting from a psychological injury, such as a trauma or social rejection. Or sometimes the location of the pain doesn't match the location of the injury, such as with referred pain.
- It's important to first distinguish between short-term, acute pain and chronic pain. Chronic pain has usually been defined arbitrarily as pain that persists for three to six months or longer, or beyond the period of expected healing. Ongoing or progressive tissue damage may be present

in some types of chronic pain, including progressive neuropathic pain and rheumatologic conditions. In other cases, chronic pain may be present when tissue damage is stable or even undetectable.

- Unlike acute pain, chronic pain is now thought to be a disease of the central nervous system that involves some sort of maladaptive reprogramming of the brain and/or spinal cord. The brain can generate terrible pain in a wound that has long healed or even chronic pain in a limb that no longer exists.

ABOUT
15%–20%
OF PEOPLE EXPERIENCE CHRONIC PAIN EACH YEAR, OR APPROXIMATELY 46 MILLION PEOPLE.



- Clinically, we think of chronic pain as a syndrome—really as an entirely different disorder. In a way, it takes on a life of its own.
- The reprogramming of the brain and/or spinal cord is not all that happens. It also has potentially devastating consequences on mood, depression, anger, social relationships, finances, and self-image.
- You can think of chronic pain as a chronically stressful condition that essentially keeps the stress response turned on all the time. This sounds like a perfect time to break out your CBT toolbox.

- Using CBT to cope with pain doesn't in any way detract from the realness of the pain. It's not that the pain is all in your head—that it's just psychological. There are ways to use your CBT tools to help you cope.
- It helps to think of the pain as the trigger—really just the starting point. That trigger is by definition unpleasant. It's painful. However, you can either grow or shrink the experience of pain, depending on what you do next.

ASSEMBLING YOUR PAIN TREATMENT PACKAGE

- CBT will be just one treatment for your chronic pain. You may still need medical treatments, such as medications. You may need behavioral interventions, such as physical therapy. You might also work in integrative medicine treatments, such as yoga, tai chi, mindfulness meditation, or acupuncture.
- All told, with the help of your medical team, you should put together a pain treatment package: one for everyday pain management and one for those really bad days where nothing seems to be working.
- As with any issue you might be working on, you want to start with assessing your pain baseline and then plan to reassess as you move forward. Is it working? Is it not working?
- Remember that you always want data to let you know if your interventions are working or not. After your assessments, you should break out your foundational skill of self-monitoring.
- The assessment surveys will be helpful, but you'll also want some day-to-day data on your pain levels, what helps, what hurts, what things you've tried, and what things you haven't tried yet.
- To find initial assessment tools, use whichever search engine you prefer and enter specific terms to find PDF surveys that relate to your condition.

- For example, if you enter the terms *chronic pain assessment* and *public domain*, you'll see three of the most popular surveys: the McGill Pain Questionnaire; the Pain, Enjoyment of Life and General Activity (PEG) scale; and the Brief Pain Inventory.
- Primary care practices need something brief, so they often use the three-item PEG. All of the items are scored on a scale from one to 10, with one meaning "not at all" and 10 meaning "completely."

    1. What number best describes your pain on average in the past week?
    2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?
    3. What number best describes how, during the past week, pain has interfered with your general activity?

- Notice that each of these has a time course of one week, meaning that the PEG is meant to be readministered on a weekly basis. You can use it as an initial assessment, but you probably also want to use it as a weekly assessment or form of self-monitoring.
- In your search, something called the visual analogue scale (VAS) might pop up. It's a simple scale from one to 100 where you rate the intensity of your pain, but really you can use it for just about anything. A VAS is great because you can essentially create your own quantitative assessment items.
- So you'll repeat your initial pain assessment at least every week or two. Next, you need some sort of self-monitoring form. Again, there's no need to reinvent the wheel. Go back online and search. What terms would you use?
- For example, if you type in *"My Pain Diary"* and *CBT*, you'll find a free PDF for My Pain Diary put out by a nonprofit in Australia. The column headings, starting from the left, ask you for the date and time and then ask you to describe your pain, rate your pain intensity, note what made your pain worse, note what helped, and describe your activity and mood. And on the far right is a column for general comments.

- You can either use this self-monitoring form—which is nice because it taps into the biological, psychological, behavioral, and social elements—or just create your own. Make sure you include what you tried to better manage your pain and whether it worked. Remember that this is frontline, real-world data that tells you what helps and what doesn't.
- Once you've tackled assessment and self-monitoring—both CBT tools—you should think about your broader package of interventions, where CBT is just one of potentially many.
- For example, your package might include medication for pain, physical therapy, exercise, and CBT for stress management and emotion regulation.
- Think about the tools in your CBT toolbox. What might help? You might try doing a thought record, a core CBT tool. You might also try graded task assignment, behavioral activation, somatic quieting, cognitive coping statements, or attentional deployment—really any tool that you feel comfortable with.
- If you're thinking of goals for yourself or a loved one, think of functionality. What is it you'd like to get back? Going for walks, holding your little one, being able to sit and read without discomfort? Get concrete and specific and then measure your baseline so that you can see your starting point.

A COPING PLAN AND A PANIC PLAN

- In the end, you'll want to come up with both a coping plan and a panic plan (panic in the sense of what to do during a serious pain flare-up other than panic).
- Your coping plan is really a compilation of strategies that you might find helpful. Here's a sample plan:

  1. **Emphasize movement and exercise.** Even if you're in pain, it's always important to move.

2. **Get a change of scenery.** Even though you might be in a lot of pain and don't want to go anywhere, sometimes getting out of the house is just the enjoyment you need.
3. **Use distraction.** Whether you're at home or out of the house, take your mind elsewhere—otherwise known as attentional deployment.
4. **Join support groups.** Talking to people who understand what you're going through—either in person or online—can be really helpful.
5. **Know your limits and don't overdo it.** It's important to stay active but also to know how active is the right amount.

- For your panic plan, you'll need to consult your doctor about what you should or shouldn't do in terms of adjusting your medication. Your doctor can also give you a better sense of when chronic pain is an emergency that requires an ER visit versus something you can maybe power through on your own or with your family.
- Can you take extra pain pills? Maybe. Should you use massage? Or heat? Be sure to list out all your strategies and have them handy when you need them. You can print out your pain panic plan* and include your doctors' numbers on it so that family members can stay oriented, too.

READING

Feldman, Christensen, Laponis, and Satterfield, *Behavioral Medicine*.

* You can download My Pain Panic Plan for free here: https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195341645.001.0001/med-9780195341645-interactive-pdf-030.pdf.

LESSON 21

HOW TO END INSOMNIA AND FINALLY SLEEP

Insomnia is one of the most common medical complaints seen in primary care clinics today. Fortunately, sleeping problems are often temporary—you might just be stressed at work—but for some, insomnia becomes chronic. And unfortunately, chronic insomnia is on the rise.

INSOMNIA FACTS AND FIGURES

- *Insomnia* is defined as difficulty with the initiation, maintenance, duration, or quality of sleep that results in the impairment of daytime functioning, despite adequate opportunity and circumstances for sleep.
- Most research studies adopt an arbitrary definition of a delay of more than 30 minutes in sleep onset or a sleep efficiency of less than 85%. Your sleep efficiency is simply the ratio of time asleep to time spent in bed.

- Fewer than half of Americans say they get a good night's sleep on most nights, and 10% have chronic insomnia, with *chronic* being defined as lasting more than one month.
- People with chronic pain, psychiatric disorders, and alcohol or drug use disorders have higher rates of insomnia, and the prevalence of insomnia rises with age.
- In 2017, McKinsey & Company estimated the US sleep industry to be worth $30 billion to $40 billion a year, which includes sleep clinics (some of which are at spas); conducting overnight tests for sleep disorders like apnea; prescription medications, over-the-counter medications, and herbal sleep aids; how-to books; and sleep-encouraging gadgets, including spooning robots and vibrating weighted blankets. Unfortunately, most of these gadgets just don't work.

SLEEP MEDICATIONS

- About 50 million prescriptions for sleep aids are written per year, equating to about $4 billion in prescription drug costs. Over-the-counter sleep aids also represent a big industry that makes a lot of money.
- Sleeping pills fall into a number of different categories.
  - **Sedatives or hypnotics** are the heavy tranquilizers, and they aren't used much anymore.
  - **Benzodiazepines** are habit-forming and have a lot of side effects, and they are unfortunately still used. Things like Halcion and Restoril fall into this category.
  - Even more common are the benzodiazepine-like drugs, or **benzodiazepine agonists**—such as Ambien, Sonata, and Lunesta. These can maybe give you three or four hours of sleep but might not give you restorative sleep.

- Older **antidepressants** are often used, not because of their antidepressant effect, but because many of them make you drowsy and help you go to sleep. Probably the most common one that's used is Trazodone.

- The most commonly used **over-the-counter drug** is diphenhydramine, also known as Benadryl. It's an older antihistamine that's the active ingredient that makes you sleepy in drugs like Tylenol PM. Other over-the-counter remedies include melatonin supplements; Valerian, an herbal sleep aid; and lavender, which comes in a pillow spray.

- Although the bias and the preference usually are for pills, several well-designed studies show that pills are not more effective than psychological interventions—and they have side effects.

PSYCHOLOGICAL INTERVENTIONS

- The leader of the pack of psychological interventions is CBT-I, where the *I* stands for *insomnia*. It's a well-researched, evidence-based treatment that is short-term and impressively effective.

- But there are also a few other options. Although these aren't used that commonly anymore, they are still sometimes used, and parts of them have been incorporated into the broader package of CBT-I.

  - **Stimulus control therapy**: This involves going to bed only when you're sleepy, using the bed only for sleep and sex, and getting out of bed if you're not asleep within 30 minutes. The idea here is to not pair your bed with feeling frustrated or disappointed or anxious that you're not sleeping.

  - **Sleep restriction therapy**: This is probably the least popular intervention, even though it is effective. This involves reducing the time you spend in bed to your estimated total sleep time at baseline. So if you only get four hours of sleep on average, that's where you start, and you don't allow yourself to stay in bed for more than four hours. You then increase by 15-minute increments each night, as long as your sleep efficiency stays at 90% or higher.

- **Relaxation therapy**: There are a number of somatic quieting interventions—such as progressive muscle relaxation, breathing exercises, and guided imagery—that might help your body get into a state in which you might be able to sleep.

THE CBT-I TREATMENT PROGRAM

- In head-to-head trials comparing CBT-I with sleep medications, CBT-I is the clear winner for both short- and long-term outcomes. In fact, CBT-I is one of the rare behavioral therapy interventions that makes it into the *Journal of the American Medical Association*, a publication that's not known for its psychological-mindedness. Here's what a five-session program of CBT-I might look like:

  1. The first session involves basic education about insomnia and about the CBT-I treatment program. You might be encouraged to begin a sleep log, and you might be given educational reading about sleep hygiene.
  2. In the second session, you'll work with the therapist to calculate sleep efficiency using the information gathered in your sleep log. You might discuss sleep restriction. You want to avoid developing a negative association with being in bed, so you might be told to shrink down somewhat the amount of time you spend in bed.
  3. In the third session, you'll discuss sleep hygiene behaviors, including making a fairly detailed assessment of these behaviors, setting goals regarding the ones that aren't being done, and doing some problem-solving if it's hard to get these behaviors in place.
  4. In the fourth session, you're going to start analyzing your thoughts—specifically, your automatic thoughts about sleep or the consequences of insomnia. You might use thought records.
  5. In the fifth session, you look back to see where you encountered difficulties or obstacles and begin to solidify, practice, and elaborate those skills.

SLEEP HYGIENE

- Sleep hygiene is a set of structured, concrete recommendations that has been proven to help with sleep. As you read through the following sleep hygiene list, think about how any of these recommendations might apply to you and make some goals to put them into action.

1. **Go to bed only when you're sleepy.** Note that feeling sleepy and feeling tired are not the same.
2. **Keep the same wake-up time every day**, including weekends, no matter how much or how little you slept the night before.
3. **Maximize your sleep environment.** Keep your bedroom quiet, comfortable, and dark. Consider using white noise, and if you're someone who looks at the clock a lot, hide the clock.
4. **Have a wind-down routine before bed.** This might include relaxation or a warm bath.
5. **Get regular exercise**—but not within an hour of going to bed, as that might be too arousing.
6. **Don't nap during the day** if you can help it. If you do nap, don't nap after 2 pm and limit naps to no more than 30 minutes.
7. **Don't lie in bed for long periods of time feeling worried, anxious, or frustrated.** If you can't sleep within 30 minutes or so, get out of bed and do something relaxing. Only return to bed when you're sleepy.
8. **Only use your bed for sleep or sex.**
9. **Limit your use of alcohol,* caffeine, and nicotine.**
10. **Limit screen time** at least one hour before bedtime.**

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* In general, alcohol helps with sleep onset but interferes with sleep quality and sleep duration.
** This includes TVs, cell phones, iPads—anything with a screen.

- None of these recommendations is complex, but most people have trouble complying with them—particularly the ones about having a regular wake-up time, limiting naps, and getting out of bed if you can't sleep. If you have doubts about any of the recommendations, try running them as behavioral experiments to test them out.

SLEEP LOG

- As with CBT for other problems, you'll need some way to monitor progress and gather daily data. You'll use self-monitoring, in part as a way to limit the biases we all have in recalling things we might be upset about. If you're upset about your insomnia, you'll be a less objective and less accurate reporter, unless you write down your data on a self-monitoring form.
- For pain, you searched online for a pain diary and then made some adaptations. Do the same thing for insomnia, using the term *sleep log*. If you don't find what you want, specify a *CBT sleep log*. Try the term *public domain* and look in the image search for screenshots.
- A sleep log* is just a sleep diary or sleep record. Here are the elements you'll want to keep track of:
  - time entering and leaving bed
  - sleep onset latency (how long it took you to fall asleep)
  - number and duration of awakenings during the night
  - time of final awakening (when you last get up in the morning)
  - whether you took a nap
  - one-to-10 rating of sleep quality
  - one-to-10 rating of daytime sleepiness
  - whether you ingested any medications, alcohol, or caffeine

* The morning, when your sleep experience is still fresh in your mind, is usually a good time to fill out your sleep log.

- sleep efficiency (time asleep divided by time in bed multiplied by 100)

SAMPLE SLEEP LOG

Date	*Mon 7/14*				
What time did you go to bed?	*10:30 pm*				
About what time did you fall asleep?	*12:00 am*				
In total, about how long were you up in the middle of the night?	*1 hour*				
What time was your final awakening?	*6:30 am*				
What time did you get out of bed for the day?	*7:00 am*				
Total time in bed	*8.5 hours*				
Total time asleep	*5.5 hours*				
Sleep efficiency (time asleep divided by time in bed)	*65%*				
How would you rate the quality of sleep?	*Poor*				
In total, how long did you nap or doze yesterday?	*45 minutes*				
Comments	*I have a cold*				

If you'd like to learn more about CBT-I, there are several free manuals online you can find with a quick web search. You might also try downloading the free CBT-i Coach app.

READING

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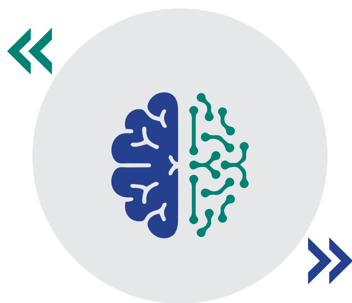

LESSON 22

CBT FOR THE BEGINNING OF THE END OF LIFE

This lesson tackles the difficult but important topic of death and dying. You'll learn how to use your CBT toolbox to better understand and better cope with the beginning of the end of life. You will also be introduced to the "tasks" of dying: the psychological, physical, ethical, legal, and spiritual challenges that may arise.

END-OF-LIFE CARE

- When you've been given a terminal diagnosis, or perhaps your chronic disease has progressed to the point of becoming life-threatening, death is not imminent, but it is certain. It might be a year, two years, or even three years away, but you most likely know the cause of your death.

- This direct, unapologetic look at death and dying is very much culturally bound. In some cultures, terminal diagnoses are not shared for fear of stressing out the individual and hastening death, though there is no data to support this idea.
- On the other hand, there also is no data that preparing for death gives you any additional time—but what it may lack in quantity, it can give you in quality. It's not about helping you live longer. It's about helping you make the most of the time you have and ultimately helping you have a "good death."
- *End-of-life care* is defined as "medical care for patients with an advanced, progressive, incurable illness." It includes the transition from curative care to palliative care, and it almost always includes a multidisciplinary team with mental health providers.
- Most commonly, end-of-life care is focused on medical symptoms—such as the alleviation of pain or the alleviation of shortness of breath—but it's intended to include mental health—such as depression, anxiety, and stress—as well as quality of life. According to the National Academy of Medicine:

> Palliative care seeks to prevent, relieve, reduce, or soothe the symptoms of disease or disorder without effecting a cure. ... Palliative care in this broad sense is not restricted to those who are dying or those enrolled in hospice programs. ... It attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them.

- Although the focus of these interventions is on the end of life, they can be helpful to anyone, whether you're healthy or ill.
- There are structured approaches to working with end-of-life care. The structure is helpful in that it binds the anxiety that might emerge from a freer-form therapy. A structured approach has clear assessments and clear goals rather than peering into the abyss.

- In particular, there is a four-module, 12-session program that grew out of the UCSF Comprehensive Care Team, funded by the Robert Wood Johnson Foundation. Many of the core CBT tools make an appearance.

- Each of the modules and accompanying worksheets* that are used in this program can be found in the therapist guide and patient workbook called *Minding the Body*.

  1. Module 1 has three sessions and focuses on stress and coping.

     - The first session addresses the phenomenon of medical illness and its relationship to stress.

     - The second session tackles the relationship between stressors, how you think about stressors, and the primary and secondary appraisals that you might make.

     - The third session analyzes your coping skills with regard to stress and addresses both emotion-focused coping and problem-focused coping.

  2. Module 2 also has three sessions but focuses on mood management, or emotion regulation.** Each of the three sessions deals with each of the following three primary emotions:

     - depression/sadness

     - anxiety/fear

     - anger/irritability

  3. Module 3 has only two sessions and focuses on social supports.

     - The first session helps you define and maybe expand your social support network.

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* All of the worksheets from the workbook *Minding the Body* can be downloaded for free here: https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195341645.001.0001/med-9780195341645-appendix-1.

** The emotion regulation strategies that are already in your CBT toolbox are used in this module.

    - ▷ The second session helps you develop your skills around communication and dealing with conflict.

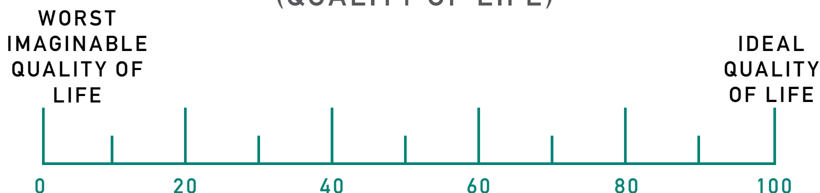
4. The fourth focuses on quality of life and includes three sessions.
    - ▷ The first session addresses the management of medical symptoms.
    - ▷ The second session focuses on the goals you might want to set for the remainder of life that you have and what you can do looking forward.
    - ▷ The third session promotes resilience and even transcendence.

- The 12th and final session involves recapping and practicing all of these skills.

QUALITY OF LIFE

- Quality of life is a multidimensional construct that includes
    - physical symptoms and functional abilities (activity);
    - psychological functioning (mental health);
    - social adjustment (status of social relationships); and
    - spirituality (defined broadly).
- The most common proxy measure for quality of life is the Karnofsky Performance Status Scale. Or you can use the PROMIS-29,* which measures the quality of life in multiple domains. You can also just create your own definition for *quality of life* and use a visual analogue scale (VAS) from one to 100, where higher scores equal higher quality of life.
- Defining and measuring the important construct of quality of life can be really interesting, even if you aren't ill. What raises your quality of life? What sustains it? What are the things that might be taken away?

* Available at www.healthmeasures.net.



WHICH CBT TOOLS MATTER

- From a purely CBT perspective, the end of life is a time when nearly all the CBT tools can be in play. It's about emotions, behavior, interpersonal conflicts, managing medical symptoms, and more. So it's time to revisit your CBT toolbox. Which tools matter?
- Of course, you are going to do an initial assessment. Depression and anxiety assessments are common, as are measures of the intensity of the more worrisome medical symptoms, such as chronic pain, fatigue, or nausea.

> Our ending is just as important as our beginning. Unless we die suddenly and unexpectedly, we have a critically important opportunity to make things right, to grow, to love, and to help those who love us.

- You'll also want to measure quality of life, first with a simple VAS of one to 100, along with fleshing out what it means subjectively. Then, you want to find or create some self-monitoring tools—another foundational CBT skill—usually in conjunction with setting some SMART goals, remembering to keep them concrete and realistic.
- From the behavioral section of your toolbox, you'll want to do some activity monitoring and scheduling, but with an eye to finding realistic activities given any physical limitations or symptoms. You'll also want to make sure that there's a good showing of social activities, since social withdrawal is common with end-of-life challenges. Communication, training, and assertiveness will be key, both with family and medical providers. Somatic quieting exercises, such as meditation or progressive muscle relaxation, can also be quite helpful.
- From the cognitive side, you will absolutely use thought records, but also savoring, directed attention, and your problem-solving therapy skills. The more advanced and nuanced skills will include acceptance (of the situation and of the self), forgiveness (of others and of the self), and expressions of gratitude.

HOW TO HAVE A "GOOD DEATH"

- It will be key to remember that there is no one right way to go about this, and there are many ways to have a "good death." This goes back to the ideas of self-acceptance and self-compassion.

The silver lining of a chronic illness is that it gives family the time they need to say goodbye. Nothing has to go unsaid; no opportunity has to be missed.

- There is a relatively short list of the things that patients usually want at the end of life:
    1. to have freedom from pain
    2. to be at peace with God
    3. to have family around
    4. to be mentally aware
    5. to make sure that their treatment choices are followed
    6. to have their finances in order
    7. to feel that their life was meaningful
    8. to resolve interpersonal conflicts
    9. to die at home
- Of course, CBT can't ensure that all of these will happen, but it can at least offer tools that might help.
- Here are some important questions to consider when defining a "good death":
    - What worries you the most?
    - How do you envision your death happening?
    - Who would you like to have around you?
    - What's left to do before you die?
    - Given your biology and your biography, what challenges do you think might get in the way?
    - What resources can you bring forward? What resources are lacking?

FOUR FINAL TASKS

- Relationships or breaches in relationships come up quite often. Ira Byock, an end-of-life physician, wrote a lovely book on this process called *Dying Well*. In a more recent book called *The Four Things That Matter Most*, he lists the four tasks of dying as the following simple but powerful phrases.
  - *"Please forgive me."* Who hasn't made mistakes? Who doesn't have regrets? As you approach the end of your life, these regrets circle back. They are open wounds that need to close. Ask for forgiveness. Who was at fault probably doesn't matter anymore.

> "Death can show us the way to live. It's only when we truly understand that we have a limited time on earth—and that we have no way of knowing when our time is up—that we will begin to live each day to its fullest, as if it was the only one we had."
>
> »ELISABETH KÜBLER-ROSS

  - *"I forgive you."* Holding grudges wastes energy. It's like swallowing poison and thinking it will hurt the person you're mad at. People make mistakes—sometimes terrible mistakes. Begin the process of forgiveness.
  - *"Thank you."* This goes back to gratitude. In CBT terms, it helps you savor the positive. It helps you remember counterevidence to your negative core beliefs.

- *"I love you."* This is a direct, honest, and vulnerable expression of your feelings toward another person. It's poignant and irreplaceable and will not soon be forgotten, even after you're gone.

- From a CBT perspective, negative emotions can hold you back from these four tasks. Negative automatic thoughts can stop your progress. So use your CBT skills to regulate emotions and find more balanced thoughts so that you can move forward with these four tasks.

READING

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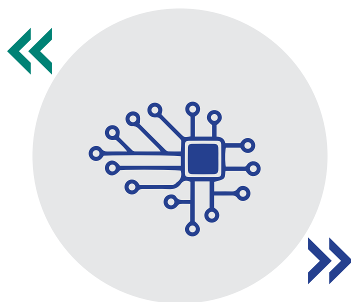

LESSON 23

EXPANDING CBT WITH TECHNOLOGY

This lesson recaps and refreshes all the tools in your CBT toolbox. It also addresses how you can use digital health tools—such as apps, virtual reality, and video games—to expand and improve your CBT skill set.

CHATBOT THERAPISTS

- In 2014, the Defense Advanced Research Projects Agency funded the development of an artificially intelligent therapist named Ellie, complete with an embodied avatar.
- They had a theory that although a chatbot therapist might sound a little robotic, people would feel safer and open up more. So they enrolled more than 200 patients in a randomized clinical trial. Half of them got the real automated Ellie, and the other half got an actual therapist who was talking through the avatar.

- Of course, no one knew what group they were really in. Interestingly, the people who thought they were talking with a robot therapist actually disclosed more sensitive information and took more risks. When asked why, they said they knew that a robot wouldn't judge them.
- And then the race was on. There are now more than 100 start-ups working in the realm of digital mental health. And the new craze is chatbots, or automated conversational agents.
- Whether you know it or not, you use chatbots all the time. For example, that customer service window that pops up when you're on Amazon is probably a chatbot.
- Despite the hype and the abuses, there is some potential—particularly in reaching more people and helping people help themselves.

One of the most exciting aspects of technology is that it helps CBT reach more people.

RECAP OF YOUR CBT TOOLBOX

- Recall that underneath all the tools in your CBT toolbox is a necessary foundation of knowledge, attitudes, and basic skills.
- You have the knowledge of the CBT triangle and specifically how thoughts, behaviors, and emotions all influence one another.
- You have knowledge about the cognitive model that tells you it isn't a situation that makes you feel a certain way; it's the situation plus how you think about it that makes you feel a certain way.
- You have the knowledge and the basic skill that allows you to distinguish between an emotion, a behavior, and a cognition—something that seems deceptively easy but can be somewhat tricky.

- You have the foundational skills of self-monitoring—collecting data about yourself regarding a key activity, mood, or symptom—and the skill of setting SMART goals, remembering to keep them concrete and specific.
- And you have the skill of being able to find and select assessment instruments that can tell you your baseline and help you track your progress.
- Your foundational attitude is one of empowerment, collaboration, and intellectual curiosity. You know that improvements are not linear or guaranteed, so you might have to try a number of strategies before finding something that works. You know that nothing lasts forever, including unhappiness and suffering. Even if you don't yet have a sense of hope, you're willing to suspend disbelief and at least test things out.
- It was on this foundation that you started adding CBT tools, which fit into the broad categories of behavioral and cognitive. All of these tools in some way are intended to help you regulate emotion—think of the CBT triangle—and/or improve social, physical, or occupational functioning. These tools can also help with improving health-related behaviors, but they do so by helping you manage stress, regulate emotions, and improve your level of intrinsic motivation to change.
- In the behavioral category, there's behavioral activation, which includes activity records—really just a form of self-monitoring—and activity scheduling. Other behavioral tools include situational avoidance and situational modification, stimulus control, attentional deployment or distraction, graded task assignment, somatic quieting, exposures, contingency management, behavioral experiments (to challenge automatic thoughts and core beliefs, sleep hygiene, and behavioral rehearsal.
- In the cognitive category, there's the core knowledge about cognitions—what they are—and the core skill of how to capture them. In addition, there's essential knowledge about habits of mind, such as personalization, selective attention, and magnification.
- Also recall your foundational knowledge about the cognitive model, in which you learned about the workhorse of this category: the thought record. The toughest part of this process is getting to a balanced thought,

and you need to select one or more strategies to help you through the process, such as evidence for and against, decentering, naming the habit of mind, and linguistic strategies like "yes, but."

EXAMPLES OF GOOD BALANCED THOUGHTS

- **Example 1**
  - *activating event*: I didn't sleep very much last night.
  - *automatic thought*: Today is going to be miserable. I'm not going to get anything done.
  - *new, balanced thought*: I'll probably be pretty tired today, but I'll see what I can do to rearrange my schedule and maybe lighten my load. I've been here before, and I managed to do OK.
- **Example 2**
  - *activating event*: My husband came home from work later than expected, and he didn't call or text me.
  - *automatic thought*: Here he goes again. What an inconsiderate jerk. Does he think I don't get busy at my job too?
  - *new, balanced thought*: Yes, he should've texted me, but he's always been easily distractible and somewhat scattered. It makes him fun and spontaneous, but he's definitely not a planner. He's there for me 100% in other ways.
- **Example 3**
  - *activating event*: I was at a meeting at work and kept raising my hand to speak, and no one called on me or seemed to notice.
  - *automatic thought*: Am I invisible? No one thinks I have anything important to say.

- *new, balanced thought*: To be fair, other people weren't raising their hands. They were just speaking up. It was kind of a free-for-all. Our manager should've noticed me and should've controlled the discussion better, but I could also be more assertive. I could use my voice next time and just jump right in.

- Other cognitive tools include the core beliefs worksheet, challenging your rules and conditional assumptions, changing your attributions (internal, external, and global), coping statements, reappraisals and reframing, suppression or postponement, attentional deployment or distraction, savoring the positive, microaffirmations, self-acceptance and self-compassion, and cognitive rehearsal and exposures.

- And of course, the more challenging situations become, the more these tools seem to blend. Skills like problem-solving require concurrent behavioral and cognitive skills. Tackling issues like improving quality of life in the face of terminal illness requires a lot of skills in play at the same time.

- The last level of skills is really a meta-skill level. You have to know when you need to use the skill—meta-skill number one—and you need the skill of being able to select and sequence the skills that will be needed. You'll also need to be able to make adjustments on the fly and decide when you're finished. But that's probably the case at just about any level. So you can add the meta-skills of a needs assessment—your needs—and tool selection.

- It will be helpful for you to print out your toolbox inventory or even create a tailored one for yourself. The more you see it and the more you use it, the more likely you are to internalize it. Eventually, you'll find your favorites, and you'll most likely add in a few new tools on your own.

This CBT toolbox has been conceptualized as an open-source project. If you've discovered great tools, please share them with others, either through a Twitter post to @DrJSatterfield or a post on Twitter using #CBTworks.

- For example, you could print out your toolbox and post it on the refrigerator. Whenever you feel stressed, walk over to the fridge to get some ideas. You could also make merit badges for yourself, and whenever you feel like you've mastered a skill, give yourself another badge. In the end, you'll have a long sash full of badges that serve as a toolbox inventory.
- Whatever you do, make the toolbox yours, and be sure to share it with whomever needs it.

NEW TECHNOLOGY TOOLS

- Thanks to technology, there are several new CBT tools that you might consider adopting, including mobile apps, websites, video games, virtual reality, and whatever new tech tools are on the horizon.
- The nature and philosophy of CBT tend to lend themselves to technology. Consider some of the core skills, such as concrete goal setting and symptom measurement and assessment—both of which you can type into an app or fill out via survey on a mobile app or website. CBT is client-driven, and you do homework, most of which is written down or typed. In addition, psychoeducation (think of a reference library of videos) and self-monitoring fit well into a technology platform.
- There are about 500 mobile apps that claim to do something like CBT or at least perform some of the skills in your CBT toolbox, such as tracking mood or scheduling activities.
- In terms of research, the jury's still out. Some of them look promising, but it's unclear if they work as well as the old-school style of CBT, where you write things down on paper. Paper forces you to slow down and brings fewer distractions. This may increase the chance for internalization. With that said, there might still be a place for technology.
- If you're curious about CBT apps, you can start with these:
  - CBT-i Coach for insomnia
  - Calm for anxiety

  - Moodfit for emotion regulation
  - Depression CBT Self-Help Guide
  - Happify for stress and worry
  - Woebot, a self-care chatbot

- If you are a gamer or have a teenager unwilling to try an app, consider some of the video games that have been made to promote mental health. Here are a few examples. You can find all of these online or at any gaming store.
  - *Sea of Solitude* for loneliness
  - *Celeste* for depression and anxiety
  - *Night in the Woods* for self-identity, anger, and post-traumatic stress disorder
- What's next? Apps and other digital tools will likely keep getting better and more seamlessly integrated into our lives.
- If you're looking for an objective guide to help you find quality tools, check out psyberguide.org, a free online guide that does a terrific job rating the quality of mental health apps.

LESSON 24

RECLAIMING AND REWRITING OUR STORIES

Everyone has a story to tell, and each day is a new chapter. What stories do you tell about yourself? About your loved ones? What's on your highlights reel? In this lesson, you will discover how CBT and the search for cognitive balance can inform and reshape your stories in constructive ways. Whether you make small tweaks or big revisions, you are the master of your own story.

Even if you aren't a writer or a natural storyteller, we all have stories to reclaim, revise, and share.

NARRATIVE THERAPY

- Let's step outside of the CBT toolbox and borrow some tools from narrative therapy, which contains the following core tenets:
  - **Our realities are socially constructed.** This draws on the philosophical tradition of constructivism. Our realities don't just involve piecing things together in our own minds to construct our own private realities; our realities are also informed by our relationships, others, and the social norms that we pick up from others.
  - **Our realities are constituted through language.** This is all about psycholinguistics, hermeneutics, and epistemology. What are the words that we use? Those words matter. Think about some of the linguistic strategies you use when doing thought records. Sometimes subtle changes in words can have big effects.
  - **Our narrative organizes and maintains our reality.** Some might call this how to spin a story. This is the work of historians, who spin stories all the time. And in politics, people can have dueling narratives, or different realities.
  - **There are no essential truths.**
  - **Our lives are storied.** We're always creating our own narrative—our story. The sum total of all of your stories is who you are.
  - **Identity is generated through stories.** We categorize others and the world. We identify with certain categories, or groups, and then we begin to internalize traits of those groups. Are you a Southerner? Are you a woman? Are you Latino?
  - **People are not problems.** People have problems, but people themselves are not problems. Problems should be externalized and deconstructed.
- There are a number of techniques that can be used to help people write and revise their stories. Here are just a few examples for you to try.

EXERCISE

- Write your own novel—a novel about you. What would the title be? Feel free to write down several versions. What would be in the prologue? What are the main chapters or sections of the book? Would there be an epilogue? Write a character sketch of the main character—you! How would a playwright describe you? How would a director instruct an actor who was going to play you?
- Write down what you have and review your novel later. Once you go back and read it, what jumps out? Which chapters made the cut? Which ones were left out? It might be helpful to show it to a spouse or friend. What are their impressions?

EXERCISE

- Curate your library of stories. You can think of it as a collection of short stories instead of the novel from the previous exercise. What volumes of stories have you lovingly tended? What volumes are tattered and torn from overuse? Which lean more toward fiction? What about those dusty volumes on the back shelves?

- Narrative therapy asks you to reflect on why you tell the same stories over and over. Why do you tell those stories and not others? Why were the stories told with that particular emphasis? Is confirmation bias at play? Magnification? Minimization? Are you telling stories to compensate for what you think are your flaws? A narrative therapist might have you do an analysis of your opus. What does it say about you?
- What are the summative effects of the stories that you tell? What about the stories your spouse or sibling tells? Are you the Eeyore, the wise Owl, the Piglet, or the Pooh? Are you in control of that narrative? Can others

see and relate to your humanity? Although it's highly context-dependent, sometimes showing our warts and all—making ourselves just a little vulnerable—can help others relate and see us as more human.

WHY SOME STORIES CHANGE AND OTHERS DON'T

- Our stories change and evolve over time. The most common clinical example is how a person's story of trauma changes, but this happens in nearly every other area, too. The critical question is this: Why do some stories evolve while others remain static? Why do some stories stick in our memory while others fade away?
- The short answer is that we don't really know. But it likely has to do with heuristics, or habits of mind. We recall stories that match our preexisting beliefs. We seek out or revise stories to support our point of view.
- A behaviorist might say that behaviors stick around because they're being reinforced. Think back to the ABCs: antecedent, behavior, and consequences. Do these stories give you a personal reward? Do these stories maybe take away some pain?
- Our stories are also inherently social, both the story itself and in telling the story to others. Social norms and reinforcement undoubtedly shape our stories, as do generational and even geographic influences.

> Don't just think of yourself as the storyteller; you might also be the listener. And the listener shapes the story, too. Do you listen with rapt attention? Do you nod or squeal or groan as you empathize with the characters? It's emotion regulation but directed toward the storyteller—and ultimately, it will affect the listener, too. Telling stories is a gift, but so is being a good listener.

- Think of your story in conjunction with friends and family. We share our communal stories far too infrequently, particularly in this modern age of TV, Facebook, and Twitter. Just remember that our stories will diverge. Even who plays the hero or the antagonist might change from storyteller to storyteller. It's all part of the process. So unplug the TV, hide the digital devices, pour a glass of wine or make a hot cup of tea, and curl up with the story.

STORIES FROM RELIGION AND SPIRITUALITY

- Some of the oldest, and perhaps the most powerful, stories are those that fall within the realm of religion and spirituality. And here, let's not debate what's true or false or right or wrong. There are many different religious and spiritual beliefs, and they all serve at least one common function.
- We often hear the secular refrain about how religion civilizes, provides a moral code, and possibly made collaborative societies possible. But let's think of religion on an even more basic level. A critical outcome of religion is emotion regulation and emotional healing, both socially and individually.
- Recall that our emotions tend to arise from the more primitive parts of our brains. We can influence those areas with higher cortical functioning like CBT tools. But religion, and the rituals that come along with it, tap into a more basic level.
- When we pray, we reduce our stress hormones. When we commune with others, we release oxytocin. When we are soothed by rituals and readings, we release endogenous opiates. When we lose someone we love, religion gives us a way to move forward. It's not the only way, but it's an important and a common way.
- Of course, we have to be wary of zealotry and piousness and judgment that sometimes emerge. But that doesn't mean that we can't appreciate what religion gives us that maybe science—or CBT—cannot. It's not an *either-or*; it's a *both-and*. Use what works directly on those emotion centers and builds social relationships *and* cultivate your CBT skills.

- So what are some of those powerful stories? And how have they shaped your conditional assumptions or schemas? It depends on what religion you follow, but there are a few seemingly universal themes, and one of the most powerful is about redemption—realizing your mistakes, your flaws, and reaching out, touching the hem of another to be healed.
- The stories are about acceptance, grace, humility—about realizing that maybe there are things much larger and more magnificent out there. It's really about wonder, awe, love, transformation.
- Whether you see religious texts as sacred or as transformational fables, you can't help but be moved by the preciousness of life and the sacred connections we have with one another. Enjoy the stories and allow yourself to be transformed.

Now that you've reached the end of this course, go back and repeat any exercises that resonated with you, and continue to build and refresh your toolbox as needed.

READING

Asma, *What Religion Gives Us (That Science Can't).*

MULTIPLE-CHOICE QUIZ

1. Which of the following would be considered a cognition? (Select all that apply.)

   a. jealousy
   b. surfing online
   c. This is boring!
   d. daydreaming
   e. snoring

2. The CBT triangle includes which three key concepts?

   a. emotions-feelings-behaviors
   b. activities-behaviors-social contacts
   c. emotions-behaviors-cognitions
   d. cognitions-family history-biology

3. Triangulation refers to which of the following?

   a. the CBT triangle that relates emotions, cognitions, and behaviors
   b. when social, occupational, and physical functioning are maximized
   c. when multiple sources of data converge to support the same conclusion
   d. when power is equally shared between client, therapist, and family

4. **True or false?** Quantitative surveys (such as the PHQ-9 or the GAD-7) can be validly used to make a diagnosis of depression or anxiety.

5. Completing an activity record can be helpful in which of the following ways? (Select all that are correct.)

   a. It assigns more effective activities to manage moods.
   b. It identifies potent activities that alter moods.
   c. It provides data to highlight opportunities for change.
   d. It improves an individual's sense of control over his or her mood.

6 **True or false?** Mood is primarily determined by the quantity of activities completed in a given day.

7 Which of the following is an example of contingency management?

a facing your fears by reducing avoidance
b using deep breathing or relaxation to reduce stress
c conducting a behavioral experiment to manage cognitions
d giving yourself a reward every time you complete a task

8 A behavioral experiment is most commonly used for which of the following?

a to stimulate more positive activities that boost mood
b to actively test a belief in the real world
c to prove to yourself that you have control and agency
d to generate hypotheses about behavioral antecedents

9 Cognitions do not include which of the following?

a mental images
b daydreams
c envy
d memories
e assumptions

10 **True or false?** Savoring is a form of selective attention for positive events.

11 Which habit of mind best describes this common scenario? "I walked into a crowded room and heard a woman laughing. I just knew she was laughing at me."

a all-or-none thinking
b magnification
c fortune-telling
d personalization
e emotional reasoning

12 Which of the following are strategies to help you arrive at a more balanced thought on a thought record? Select all that apply.

a finding evidence for and against
b downward arrow
c rating emotional intensity
d decentering
e "yes, but"

13 Which of the following best describes worry?

a a recurring and persistent chain of often catastrophizing thoughts regarding a perceived threat and/or an inability to cope
b a memory or anticipation of loss that triggers sadness and grief
c to focus repetitively on one's experience of distress, mistakes, or perceived inadequacies
d to excessively replay and brood over one's sense of suffering and disadvantage

14 Which of the following play an important role in the creation and maintenance of worry?

a underestimation of an ability to cope
b beliefs about the value of worry
c intolerance of uncertainty
d negative problem orientation
e all of the above

15 **True or false?** Given the depth and personal histories involved, core beliefs are thought to be permanent and unchangeable.

16 Which technique or tool is designed to help you identify a core belief?

a reframing
b postponement
c critical reflection
d downward arrow
e decentering

17 In the context of psychosocial stress, which of the following refers to our subjective estimation of the severity of the stressor and its possible implications?

a stressor appraisal
b secondary appraisal
c subjective estimations
d primary appraisal
e attributional style

18 Imagining yourself moving step by step in a future, challenging activity is an example of which of the following?

a savoring
b stress anticipation
c cognitive rehearsal
d cognitive restructuring
e emotional regulation

19 Which of the following is *not* a stage or element in the modal model of emotion?

a situation
b assumptions
c attention
d appraisal
e response

20 Emotional intelligence is thought to include which of the following skills? Select all that apply.

a perception of emotion
b understanding of emotion
c flexibility of emotions
d management of emotions
e suppression of emotions

21 Which of the following is *not* a key step in the problem-solving process?

a Get the right attitude.
b Define the problem.
c Set goals and identify obstacles.
d Postpone interventions until resources are aligned.
e Generate multiple solutions.

22 **True or false?** If a desired goal is not achieved after three attempts, the goal is probably flawed and should be changed.

23 What three features of suicidality tell you that a crisis might be imminent and emergency help should be called? (Select three.)

a ideation
b plan
c anhedonia
d intention
e hypersomnia

24 **True or false?** Grief that lasts for more than six months is unusually long and should be reconsidered as clinical depression.

25 Anxiety is often caused by which of the following? (Select all that are true.)

a a misperception of threat
b a magnification of one's ability to cope
c a real or symbolic loss
d an underestimation of coping resources
e none of the above

26 Place the following steps of the panic cycle in the correct order.

___ Benign sensations are catastrophically misinterpreted.
___ A fight-or-flight response is activated with more sensations.
___ A physical sensation is noticed.
___ The sensation is interpreted as a threat.
___ A panic spiral is launched, causing a full-blown panic attack.

27 **True or false?** Patients who are prescribed opioids for their chronic pain can still develop tolerance and withdrawal even if they are taking their medication as prescribed.

28 Which of the following is *not* a DSM criterion for a substance use disorder?

- a a persistent desire and/or failed attempts to cut down
- b craving
- c failure to fulfill major role obligations
- d legal difficulties or run-ins with the law
- e withdrawal symptoms if usage stops

29 Believing that others expect you to be perfect refers to which of the following?

- a self-directed perfectionism
- b other-directed perfectionism
- c socially prescribed perfectionism
- d mind-reading perfectionism

30 Which of the following CBT tools might be helpful for perfectionism? (Select all that apply.)

- a exposure with response prevention
- b thought record
- c core beliefs worksheet
- d activity scheduling
- e graded task assignment

31 Temporal discounting refers to which of the following?

- a We tend to assume that temporary gains will last forever.
- b Temporary improvements are not given adequate value.
- c Immediate rewards take precedence over longer-term rewards.
- d We give too much value to longer-term goals.

32 **True or false?** Procrastination can be conceptualized as a maladaptive emotion regulation strategy.

33 Which of the following is *not* a feature of a thick community? (Select all that apply.)

- **a** racial homogeneity
- **b** deeply shared values
- **c** a common story
- **d** a flattened social hierarchy
- **e** commitment to the group

34 The liking gap refers to which of the following?

- **a** People who are anxious often dislike themselves.
- **b** Most people don't think others like them as much as they really do.
- **c** People tend to overvalue their social skills compared to others.
- **d** Older adults are often liked less by millennials.

35 The categories for adverse childhood experiences include which of the following? (Select all that apply.)

- **a** childhood abuse
- **b** minority status
- **c** neglect
- **d** household challenges
- **e** learning disabilities

36 **True or false?** There are no known interventions that might help reduce the risk of disease in an individual with four or more adverse childhood experiences.

37 Chronic disease self-management refers to which of the following?

- **a** ways to prevent the onset of a chronic disease
- **b** setting personal health goals, monitoring symptoms, and trying strategies to minimize impairment
- **c** keeping close tabs on communications between all of your medical providers
- **d** advocating for yourself with health insurance companies to improve coverage of care

38 **True or false?** Problem-solving therapy skills are well suited to address the functional impairments that arise from chronic diseases.

39 When does pain become chronic pain? (Select all that apply.)

- a when it exceeds an eight out of 10 for more than a week
- b when it lasts for at least three to six months
- c when it lasts beyond the expected duration given the injury
- d when it is nonresponsive to treatment

40 A pain panic plan refers to which of the following?

- a creating a multimodal pain-management plan
- b creating a plan to deal with pain flare-ups
- c compiling a list of anxiety-management strategies
- d using somatic quieting to reduce arousal caused by pain

41 If you slept for six hours last night but were in bed for a total of 10 hours, what was your sleep efficiency?

- a 40%
- b 160%
- c 60%
- d 1.66%

42 Which of the following is a standard recommendation for sleep hygiene? (Select all that apply.)

- a Keep a regular time to go to bed each night.
- b Get up at the same time every morning.
- c Vigorously exercise right before bed to promote sleep onset.
- d Limit naps to no more than 30 minutes in duration.
- e Get out of bed if you haven't fallen asleep within 30 minutes.

43 **True or false?** Palliative care refers only to the alleviation of symptoms (and suffering) in patients who are terminally ill.

44 Which of the following is typically included as part of quality of life?

- a spirituality
- b social relationships

c functional ability
d pain and symptom severity
e all of the above

45 Which of the following is considered a meta-skill for the CBT toolbox? (Select all that apply.)

a savoring
b behavioral experiments
c assessing your need
d selecting a tool
e self-awareness

46 Mr. Jones decided to try several CBT tools to help him overcome his social anxiety at parties. First, he imagined himself at a party, including what he would say and do. Second, he invited a friend to attend a party with him. Third, he used some deep-breathing exercises to help him relax. Select the three tools he used.

a cognitive restructuring
b graded task assignment
c situational modification
d somatic quieting
e pleasure predicting
f imaginal rehearsal

47 **True or false?** According to narrative therapy, all reality is subjective and all stories are socially constructed.

48 Picking a specific story or subset of stories to play over and over again is an example of what habit of mind?

a selective attention/selective recall
b magnification/minimization
c personalization
d mind reading
e fortune-telling

ANSWERS

1 c, d; 2 c; 3 c; 4 False (Self-administered surveys should never be used to make definitive diagnoses. They are good to indicate possible areas for further exploration with a professional); 5 b, c, d; 6 False (While quantity matters, it is also about quality, or type of activities completed. People need a balanced mix of high-potency activities); 7 d; 8 b; 9 c; 10 True (People selectively attend to positive events and replay them to reexperience the positive emotions); 11 d; 12 a, d, e; 13 a; 14 e; 15 False (Although this remains an area of debate, it is clear that core beliefs can be gradually adapted, or at least softened to be less all-or-none and more balanced); 16 d; 17 d; 18 c; 19 b; 20 a, b, d; 21 d; 22 False (It often takes several attempts before a complex problem is solved. It doesn't hurt to review the goal, but it would be a mistake to abandon what you want because you encountered troubles); 23 a, b, d; 24 False; 25 a, d; 26 4, 3, 1, 2, 5; 27 True; 28 d; 29 c; 30 a, b, c; 31 c; 32 True; 33 a, d; 34 b; 35 a, c, d; 36 False; 37 b; 38 True; 39 b, c; 40 b; 41 c; 42 b, d, e; 43 False; 44 e; 45 c, d; 46 c, d, f; 47 True; 48 a;

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