Retrain Your Brain

Cognitive Behavioral Therapy in 7 WEEKS

A Workbook for Managing Depression and Anxiety

SETH J. GILLIHAN, PhD

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ALTHEA PRESS

Quick-Start Guide

Is this book for you? Check the boxes that often describe you:

- ☐ I have trouble sleeping.
- ☐ I feel like I have nothing to look forward to.
- ☐ I have a hard time unwinding.
- ☐ I'm not as interested in things I used to enjoy.
- ☐ I dread the next attack of anxiety.
- ☐ I struggle to concentrate and make decisions.
- ☐ I feel guilty and down on myself.
- ☐ I'm terrified of certain objects, animals, or situations.
- ☐ It's hard for me to find energy and motivation.
- ☐ I worry more than I need to.
- ☐ I often feel tense and anxious.
- ☐ I avoid things I need to do because they make me anxious.
- ☐ It's hard for me to control my worry.
- ☐ I feel extremely nervous is some social situations, and avoid them if I can.

If you checked several of the boxes, read on to learn about CBT and take part of the therapeutic process into your own hands.

Contents

Foreword 8
Introduction 10

PART ONE **BEFORE YOU BEGIN**

CHAPTER 1 Getting Familiar with CBT 14
CHAPTER 2 Understanding Anxiety and Depression 30

PART TWO **SEVEN WEEKS**

WEEK 1 Setting Your Goals and Getting Started 50
WEEK 2 Getting Back to Life 68
WEEK 3 Identifying Your Thought Patterns 84
WEEK 4 Breaking Negative Thought Patterns 104
WEEK 5 Time and Task Management 127
WEEK 6 Facing Your Fears 156
WEEK 7 Putting It All Together 186

The Next Seven Weeks 202
Resources 204
References 209
Notes 222
Index 228
Acknowledgments 234

Gradually, she gained the confidence to start socializing again and to reach out to family members she thought had given up on her. She was pleasantly surprised by the reaction she received from them. I watched her transform from someone who could barely muster the energy to go for a walk to someone engaged in social and family events, and someone who looked forward to the next day. Such is the potential of CBT to transform lives.

People often seek help for depression and anxiety in books but abandon these books when they encounter academic jargon or overly long explanations of psychological theory, or feel disheartened by the sheer length of the books. For those struggling with the weight of low mood or fraught with the exhaustion of anxiety, a thick book written in abstract language can feel overwhelming. But in these pages, Dr. Gillihan has provided us with a simple, succinct, and stress-free workbook. It is ideal for people who feel exhausted or defeated by their struggles. In nine easy-to-read chapters, Dr. Gillihan instills confidence and mastery in his readers by breaking down cognitive-behavioral strategies into easily digestible concepts and exercises.

I have known Dr. Gillihan for 15 years and have witnessed firsthand his compassion and empathy for patients who reach out to him for help at their most vulnerable moments. At their lowest point, he can provide the care they need and gently equip them with the skills to help themselves. Now, more than a decade after we were in school together, I appreciate being able to discuss clinical issues with Dr. Gillihan as he draws on his broad experience helping patients and their families fight anxiety and depression. He has written extensively on the topic of depression and anxiety, publishing over 40 academic and clinical manuscripts, and he is coauthor of the book *Overcoming OCD: A Journey to Recovery*.

Engaging in the process of CBT is indeed a journey, one that can be challenging and arduous, but one that is also exciting and rewarding. Like all difficult journeys it is best traveled with an experienced and knowledgeable guide. I can think of no better person to lead you on this journey than Dr. Seth Gillihan.

LUCY F. FAULCONBRIDGE, PHD

needed, to give us a place where we can say anything and be accepted as we are. If you've found a good therapist, you know exactly what I'm talking about.

Many people who come to my office also have had therapy before. They may have explored their childhoods, identified patterns in their closest relationships, and gained valuable insights. They probably found the therapy very helpful, even lifesaving. And yet they've sought out a CBT therapist because, for some reason, *they haven't been able to make the changes they want.*

Maybe they haven't been able to break their habit of avoiding uncomfortable situations. Or they continue to be plagued by constant worry. Or they can't stop their habitual self-criticism. What they're often looking for are tools and skills to address the issues that they're well aware of. CBT can help a person transform insight into change.

I want as many people as possible to experience the power of CBT to make their struggles more manageable. Unfortunately, many people simply don't know that short-term, highly effective psychological treatment is available. Others have trouble finding a therapist who provides CBT. Still others can't afford treatment. This book is part of an effort to make CBT more readily available to those who need it.

My goal in writing this book is to introduce you to a set of skills that can help relieve anxiety and depression. If you've read other CBT books, you might find this one to be different in some ways. I've strived to make the material easy to relate to, without unnecessary information.

I've also organized the topics around a seven-week plan that builds on itself week by week. Why seven weeks? The structure of this book is similar to what I do with my clients: In the initial session(s), we develop a solid treatment plan, and then work on learning the basic skills of CBT in the next few sessions. The rest of treatment focuses on applying these skills. This book is designed in the same way: Gain the CBT skills you need as quickly as possible, and then continue using the skills on your own—in other words, *learn to be your own therapist.*

CBT has helped countless individuals live better lives. Can everyone benefit from CBT? Probably not. But I've found that the people who do well with it tend to do three things: First, they show up—it's probably a given that coming to treatment consistently is a good thing. Second, they bring a healthy skepticism; being

PART ONE

BEFORE YOU BEGIN

Before we dive into our seven-week program, it helps to know a little bit about CBT—what it is, where it came from, and how it's used. It also helps to have a sense of what kinds of conditions are most effectively treated with CBT.

not getting enough air. "I can't do it," he thinks. "I can't cross this bridge." He looks across the bridge to where the trail continues on to the vistas he was looking forward to.

As he tries to collect himself, Ted wonders why this is happening. He didn't used to have problems with bridges, until he was stuck in traffic on an enormous suspension bridge during a powerful thunderstorm. Now these attacks happen often.

After he feels a bit calmer, he tries to muster courage enough to cross the bridge. A few paces into it, he's overwhelmed by fear and runs back, disappointed, and he heads back to his car.

If Ted had pursued treatment in the first half of the twentieth century, chances are he would have been in psychoanalysis, a therapy pioneered by Sigmund Freud and further developed by his followers. Psychoanalysis is based on a Freudian understanding of the mind, which includes tenets such as:

- Early life experiences are powerful determinants of personality.
- Important parts of the mind are "buried" far below our conscious awareness.
- Our animal drives of lust and aggression are at war with our consciences, leading to anxiety and internal conflict.

Accordingly, Freud intended psychoanalysis as a way to understand and address "unconscious" internal conflicts rooted in childhood.

In psychoanalysis sessions, Ted would probably lie down on a couch and talk for most of the hour, with occasional comments or questions from his psychoanalyst. He might explore what the bridge represents, with guidance from the analyst. For example, what from his childhood does he associate with the bridge? Did his mom and dad encourage him to explore, or did he receive mixed messages about "being brave" but also "staying close to Mom"?

At some point, according to Freud, the treatment would address Ted's feelings toward the analyst, which would be interpreted as being "transferred" from earlier relationships (particularly with his mom or dad). Ted might see his psychoanalyst four days a week, for years.

systematic desensitization. Also hailing from South Africa was Arnold Lazarus, a collaborator with Wolpe who designed a "multimodal" therapy that integrated behavior therapy into a more comprehensive approach.

How would these and other behavioral therapists explain and treat Ted's struggle? They would likely say something like this:

Well, Ted, it looks like you've learned to be afraid of bridges, maybe because you had that frightening experience on a bridge and now associate bridges with danger. Every time you approach a bridge, you start to panic, which feels really uncomfortable, to say the least. So understandably you try to escape the situation.

Every time you escape, you get a sense of relief—you avoided something that feels awful—so you're rewarded for avoiding. While avoidance feels better in the short term, it doesn't help you get across the bridge, because that reward strengthens the habit of avoiding.

Here's what we're going to do, if you're up for it. We'll make a list of situations that trigger your fear, and we'll rate each activity for how challenging it would be. Then we'll work through the list systematically, starting with the easier ones and working up to the harder ones. When you face your fears, they diminish. It shouldn't take long before you're feeling more comfortable on bridges, as your brain learns that bridges actually aren't that dangerous.

Notice that Ted's behavior therapist doesn't mention Ted's childhood or unconscious conflicts—he focuses on the behavior that keeps Ted stuck, and on changing that behavior to get him better.

COGNITIVE THERAPY

A second wave of short-term treatment, developed in the 1960s and '70s, emphasized the power of thoughts to drive our emotions and actions.

The two men generally considered to be the fathers of cognitive therapy could hardly be more different. Albert Ellis was a confrontational and irreverent psychologist; psychiatrist Aaron Beck, on the other hand, is a lifelong academic with

Let's examine what a cognitive therapist might say to Ted:

> *It sounds like your mind is overestimating how dangerous bridges are. You believe that either the bridge is going to fail or you're going to get so scared, you'll do something impulsive like hurl yourself over the side.*
>
> *What I'd like to do with you is look at the evidence. We can find out if bridges are as dangerous as it feels like they are. We'll just gather some data—from research, from your experience, and from experiments we can do together. For example, we could go on a bridge that you find difficult but manageable, and see if what you're afraid of actually happens.*
>
> *Chances are you'll learn fairly quickly that bridges are sound, and there's no realistic chance of your acting on an impulse and doing something awful. As your mind adjusts its estimate of the actual danger, you'll feel more comfortable on bridges and can get back to how your life used to be.*

COGNITIVE BEHAVIORAL THERAPY: AN INEVITABLE INTEGRATION

As you read the descriptions of behavioral and cognitive therapy for Ted, you might have thought that they don't sound all that different. And you would be right—our thoughts and actions are connected, and it's hard to imagine changing one without affecting the other.

Behavior therapy and cognitive therapy share the same aims and often use similar tools. It's telling that the names of the therapies have changed to include both cognitive and behavioral aspects, as Beck and Ellis each added the word "behavior" to their signature treatments. Even the professional organizations have gotten onboard, as the former American Association for Behavioral Therapy is now the Association for Behavioral and Cognitive Therapies.

Attention! If you are suffering from serious depression, having thoughts of hurting yourself, or experiencing other major mental health issues, call a psychologist, psychiatrist, or other mental health professional. If you're experiencing a psychiatric or medical emergency, call 911 or go to your nearest emergency room.

Think of a recent situation where you felt a strong emotion, perhaps anxiety or sadness. Briefly describe the situation in the space below.

Using the diagram below, write down the feelings you had, the thoughts you can remember having, and what you did.

What I felt:

What I thought:

What I did:

CBT IS GOAL ORIENTED

CBT is all about moving toward *your* goals. You should have a good sense of whether the treatment is addressing your goals, and how much progress you're making toward them.

CBT IS COLLABORATIVE

It can be easy to think of a CBT therapist as the one who does the "fixing." This view matches our typical model of seeking help—for example, a surgeon performs surgery to fix your bum knee. But CBT can't be done *to* a person. Instead, the therapist is an expert on CBT, and clients have specialized knowledge about themselves. Success in CBT requires bringing together these perspectives to tailor a treatment to the client's needs. In the same way, you and I will collaborate through this workbook: I'll provide the CBT techniques, and you'll customize them to fit your goals.

IS THAT CBT?

CBT is an umbrella term for many specific types of therapy. Some powerful CBT programs don't have "CBT" in their name. A few examples include:

- **Exposure and Response Prevention** for obsessive-compulsive disorder (OCD)
- **Prolonged Exposure** for post-traumatic stress disorder (PTSD)
- **Dialectical Behavior Therapy** for borderline personality disorder
- **Panic Control Therapy** for panic disorder

Each of these therapy programs adapts the basic ingredients of CBT to address the condition it's designed for. So if you're looking for CBT, know that it might not be called CBT.

On the flip side, not everything that's called CBT actually is. If you seek out a CBT therapist, make sure he or she has specialized training in this approach. The Resources section at the back of the book includes a link to guidelines for finding a CBT therapist.

CBT IS AN ACTIVE TREATMENT

This is a "roll your sleeves up" kind of treatment, with treatment emphasizing tackling clearly defined goals head-on. Both therapist and client are actively engaged in the process.

CBT IS SKILLS ORIENTED

Through CBT we learn techniques to manage the issues we're dealing with, practice them on our own, and take them with us when treatment is over. People in CBT often say things like, "I'm starting to recognize the tricks my mind plays on itself," "I can now test whether my thoughts are actually true," and "I'm getting better at leaning into my anxiety."

CBT EMPHASIZES PRACTICE

In most cases, therapy is one hour a week. That leaves 167 hours a week away from the therapist. And so a person must practice new skills between sessions to get the most benefit from them. Many studies have shown that people who do more work between sessions do better in CBT.

So far we've covered the basics of CBT and where it came from. In the past few decades, researchers have tested CBT treatments in clinical trials. Let's see what they've found.

How Well Does CBT Work?

Hundreds of research trials have tested the effectiveness of CBT for a wide range of problems. Fortunately, we don't have to read all of the studies to get the take-home message. Researchers can combine similar studies into a single study using sophisticated statistics in what is known as a meta-analysis.

Meta-analyses consistently find CBT has strong effects in treating anxiety, depression, and other conditions. And these effects are above and beyond any improvement we'd expect simply from the passage of time, because they were

Change I wanted to make:

Now write down (1) what went well, (2) what didn't go well, and (3) any obstacles you ran into:

Why CBT Works

CBT is based on a few basic principles about the relationships among thoughts, feelings, and behavior. While CBT has been recognized as a treatment method for only a few decades, the principles it rests on are hardly new. For example, as the Greek philosopher Epictetus wrote nearly 2,000 years ago, "People are not disturbed by things but by the view they take of them." Aaron Beck and Albert Ellis said essentially the same thing in their writings.

So what does CBT add to the basic tenets that have been around for hundreds or thousands of years?

Chapter Check-In

In this chapter, we covered a brief history of CBT as well as its basic principles and why it works. Now, take a few moments to check in with yourself and see how you can apply what you've learned in your own life. Write your thoughts and feelings, taking care to be as open as possible. Invest some time here. Resist the urge to skip this step and jump ahead to the next chapter. Once you're finished, we'll continue working toward the seven-week plan in chapter 2.

would have been if the owner hadn't called off his dog. Now, when she sees a dog, her heart pounds, she breaks into a sweat, and she avoids them if possible.

All the elements of a CBT framework are here. First, Mel believes that dogs are extremely dangerous. Given that belief, it's no wonder that she feels fear whenever she sees one. She experiences:

See Dog → Feel Afraid

With our CBT understanding, we can add the intervening thought:

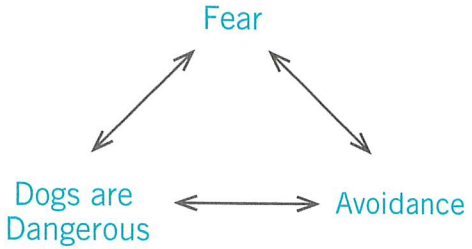
See Dog → "Dogs are dangerous" → Feel Afraid

Second, she avoids dogs. By avoiding them she gets some relief from her fear. In some sense, her avoidance is working, at least in the short term. Unfortunately, it also makes her more likely to run from dogs in the future.

By avoiding dogs, Mel *never gets to learn what would actually happen if she approached one*. Therefore, her avoidance behavior *reinforces* her belief that dogs are dangerous.

To complete the loop, her fear affects her behavior, compelling her to avoid dogs. The fear she feels also strengthens her belief that dogs are dangerous—"Why else would I be so afraid of them?"

When Mel came for treatment of her fear of dogs, she was locked in a vicious spiral of thoughts, behaviors, and emotions, depicted in the diagram we've seen before:



Let's see how CBT helped her to break free.

time doing her harder exposures. Now her thoughts, behaviors, and feelings were working together *for her* rather than against her.

By the end of treatment, Mel could hardly believe how far she'd come in just a few sessions. She felt proud of herself for having faced her fears. She even surprised the therapist by getting a small dog. Through being around dogs in therapy, she realized she loved them. She's still appropriately cautious around dogs she doesn't know, but she no longer fears or avoids them.

The Faces of Anxiety

Anxiety can be useful. Think about all the ways anxiety helps us take care of our responsibilities. Without anxiety, we might not get out of bed in the morning. I'd probably be watching TV or surfing the Web if I didn't have some anxiety about my deadline to finish this book.

In many situations, we would think it was strange if a person didn't seem at least a little anxious, like during a first date or job interview. We might think the person didn't care.

ANXIETY BY THE NUMBERS

Anxiety disorders are the most common psychiatric conditions that people experience. How likely are people to have a major type of anxiety at some point?

- **Eighteen percent** will have a **specific phobia**.
- **Thirteen percent** will have **social anxiety disorder**.
- **Nine percent** will have **generalized anxiety disorder**.
- **Seven percent** will have **panic disorder**.
- **Four percent** will have **agoraphobia**.

Women are about 70 percent more likely to have an anxiety disorder than men. The gender difference was greatest for specific phobias and least for social anxiety disorder.

SPECIFIC PHOBIA

Specific phobia involves excessive anxiety and strong, often irrational fear of a given object or scenario. People can have phobias about virtually anything—from spiders to injections to clowns. The *DSM-5* notes that certain fears are more common, including animals, certain "natural environments" like heights and storms, and situations like flying or riding in elevators. Sometimes a bad experience led to the fear (as with Mel's fear of dogs), but many times we can't identify a cause. If you've dealt with a specific phobia, you know how upsetting it can be, and how strong the drive is to avoid what you fear.

SOCIAL ANXIETY DISORDER

Social anxiety disorder involves a strong fear of social scenarios. While it might seem like a specific phobia of social situations, it is different from phobias in important ways. First, the fear is ultimately of embarrassment. It seems almost cruel that oftentimes the fear is that "I'll look anxious," which only leads to more anxiety.

Also, with phobias we usually know if the thing we're afraid of happened. For example, we know if we fell from a great height or if the elevator got stuck. Social anxiety disorder, on the other hand, involves *guesses* about what others are thinking: "Do they think I sound dumb?" "Am I making him feel awkward?" "Are they bored?" Even when people say nice things to us—"Great job on your talk today"—we might not believe them. We might be left believing that our performance was terrible, even though nothing clearly bad happened.

repeatedly and be unexpected, and a person has to either worry about having more attacks or change their behavior–for example, avoiding driving at certain times of day. The urge to avoid places where panic is likely to happen can be so strong that it leads to a condition called agoraphobia.

AGORAPHOBIA

While it sounds like a kind of specific phobia, agoraphobia is really about avoiding places where we think *it would be really bad to panic* (or do something else embarrassing, like have uncontrollable diarrhea). According to the *DSM-5*, a person with agoraphobia is likely to avoid things like public transportation, bridges, movie theaters, lines at the grocery store, or just being out and about without a "safe" companion who could help if something happened. In some cases, the anxiety and avoidance are so strong that a person will stop going out of the house at all, sometimes for years.

GENERALIZED ANXIETY DISORDER (GAD)

Persistent and pervasive worry is the hallmark of generalized anxiety disorder. In addition to excessive and hard-to-control worry, things like trouble sleeping, difficulty concentrating, and feeling tired all the time are part of GAD. While panic represents the threat of immediate danger, GAD is on the opposite end of the spectrum. The anxiety is spread over multiple areas (thus "generalized") and is experienced as a grinding dread about all kinds of "what ifs." As soon as one worry is resolved, another takes its place.

Do you suffer from a particular form of anxiety? The following checklist may help give you a sense of what kind(s) of anxiety you might have, if any.

CATEGORY C

- ☐ I generally feel intense anxiety about using public transportation and/or being in open spaces like a parking lot.
- ☐ I generally feel intense anxiety when I'm in enclosed places (e.g., a movie theater), being in a crowd, waiting in line, and/or going out of the house alone.
- ☐ I worry that I might have a hard time escaping these situations if I had a panic attack or some other crisis.
- ☐ When I can, I avoid these situations, or try to get someone I trust to go with me.
- ☐ The fear I feel is probably greater than the actual danger in these situations.
- ☐ I've been afraid of these situations for at least several months.

CATEGORY D

- ☐ I feel very anxious in situations where I think I may be judged or criticized. Examples include public speaking, meeting new people, or eating in public.
- ☐ I'm afraid that I'll be publicly humiliated and/or rejected by others.
- ☐ I avoid social situations whenever I can.
- ☐ If I can't avoid a social situation, I feel intensely uncomfortable.
- ☐ My social fears are probably excessive in light of the actual threat.
- ☐ I've had intense anxiety about social settings for at least several months.

Zeroing in on Depression

"What's the point?" Bill thinks to himself as his alarm clock goes off again. He realizes he definitely shouldn't hit snooze again if he's going to get to work on time. But he wants nothing more than to turn off the alarm, tell his boss he's not feeling well again, and stay in bed all day.

With a heavy sigh, he swings his legs around and onto the floor and sits with his head in his hands, trying to muster the energy to stand up.

Bill feels like he's moving through mud as he walks to the bathroom. He used to enjoy his morning shower—now it's all he can do to get in and wash up. For breakfast he manages to drink a small glass of orange juice; he looks at the boxes of cereal in his cabinet and closes the door.

He doesn't dare sit, knowing how hard it will be to get up again. Besides, his leg still hurts when he goes from sitting to standing. Three months ago, Bill broke his right tibia while trail running. For years, he would run with his friends several times a week, enjoying the outdoors and camaraderie. Now he can only ride the stationary bike at the gym as he heals.

As he drives to work, his leg hurts every time he presses the brakes. He curses himself for "being so stupid" as to break his leg. His mind wanders to other times he feels like he messed up—when he missed the last-second shot that would have tied the championship basketball game in high school; the unenthusiastic performance report he got at work last year; even the time he wet the bed at a seventh-grade sleepover. It all seems pathetic. He sighs as he parks his car and heads in for another day's slog at work.

Bill is caught in an episode of depression. It started with his injury, which led to losing many things he loves: conquering a difficult run, time with good friends, being outside. Many of the things that keep him feeling well were suddenly missing. As his mood dropped, he started to believe bad things about himself: that he's "pathetic" and "worthless."

MAJOR DEPRESSIVE DISORDER

The most common form of depression is major depressive disorder. It's what we usually mean when we say someone is "clinically depressed" or has "major depression." A person has to either feel down for most of the day or lose interest in almost all activities for at least two weeks. A person can be depressed but not actually feel "down." The average bout of major depression is about four months.

During the same two weeks, a person with depression will have other symptoms, such as sleeping a lot more or a lot less than usual, being much more or much less hungry, feeling exhausted, and having a hard time focusing or making decisions.

We also tend to feel bad about ourselves when we're depressed, either excessively guilty or completely worthless. Depression is a strong risk factor for suicidal thinking and even attempting suicide. Someone with major depressive disorder will probably feel like she's in mental pain and is likely to have a hard time doing normal activities.

Because there are nine symptoms of depression and five are needed for a major depression diagnosis, the condition can look quite different in different people.

PERSISTENT DEPRESSIVE DISORDER

Major depressive disorder tends to wax and wane, even without treatment. Within one year from when it begins, around 80 percent of individuals will have started to recover, according to the *DSM-5*. Others experience a more chronic form of depression called persistent depressive disorder. Consistent with the name, a person has to feel depressed most of the time for at least two years to receive this diagnosis. They will also have at least two other symptoms of depression, so the condition can be milder than major depressive disorder (which requires five symptoms). As the *DSM-5* makes clear, this is not to say that persistent depressive disorder is a "light" form of depression. Its negative effects can be at least as great as those of major depression.

With Anxious Distress. It might seem like anxiety and depression are opposites: anxiety is a high-energy state, depression a low-energy state. However, major depression is significantly correlated with every kind of anxiety diagnosis, meaning we're more likely to be anxious if we're depressed, and vice versa. The *DSM-5* includes a category of depression "with anxious distress," meaning that a person has at least two symptoms of anxiety or dread, e.g., feeling unusually restless, worrying that interferes with concentration, or fearing something awful might happen.

With Melancholic Features. Even when we're depressed, we often feel temporarily better when something good happens, like if we finish an important project

PHYSICAL MANIFESTATIONS OF DEPRESSION

Depression is best thought of as a whole-body illness. Physical manifestations of depression can include:

- **Changes in appetite:** People who are depressed commonly lose their appetite, often because food just doesn't taste as good. Others experience an *increased* appetite and may gain weight.
- **Trouble sleeping:** Sleep can change in either direction. Some people with depression have terrible insomnia, despite being exhausted; others sleep 12 hours a day and still want more sleep.
- **Physical agitation:** When a person is depressed, he might have a hard time sitting still and may constantly fidget, driven by an internal sense of unrest.
- **Being slowed down:** Some depressed individuals might move or talk slowly, to the point where other people might notice.
- **Slower healing:** Multiple studies have shown that we heal more slowly when we're depressed. For example, chronic wounds heal more slowly if we're depressed, and depressed patients recover more slowly from coronary bypass surgery.
- **Greater risk for dying from physical disease:** Among patients with coronary heart disease, for example, depression doubles the risk for dying.

Clearly depression is, quite literally, not just in a person's head.

THE DEPRESSION SCALE

Over the past two weeks, how often have you been bothered by any of the following problems? Circle the number that matches your response for each item.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Add up each column and write the totals here:	____ +	____ +	____ +	____

= Total Score: _____

Your total score provides an estimate of the degree of depression that you're experiencing:

0–4 Minimal
5–9 Mild
10–14 Moderate
15–19 Moderate to Severe
20–27 Severe

Depression can make it hard to focus on simple tasks, let alone taking on a workbook. If you're suffering from anything beyond mild to moderate depression, seek the services of a professional in addition to using this book.

You can find a copy of this form online at callistomediabooks.com/cbt.

PART TWO

SEVEN WEEKS

This rest of this book is organized around a seven-week plan that builds on itself week by week. First, we'll work to develop a solid treatment plan; then we'll focus on applying the skills of CBT.

Sometimes when we're starting a new program, we can be tempted to skip over certain parts, especially when we think we already know what will and won't work for us. Don't succumb to this temptation. I encourage you to do the full program, including each writing exercise. Interacting with the following material in multiple ways—reading, thinking, writing—will give you more opportunities to develop and follow the plan that will be most beneficial to you. You also won't have to wonder if you could have gotten more out of it when you get to the end; you'll know you did everything.

His wife, Michelle, said something this morning as they ate breakfast: "Maybe you should see someone." He knows what she means—see a therapist. He's been reluctant to seek professional help in the past.

The next day, Phil talks to a good friend whose wife is a psychologist. His friend recommends someone his wife went to graduate school with who specializes in cognitive-behavioral therapy. He calls the psychologist and sets up a time to meet.

During their first meeting, Dr. Whitman talks with Phil about what brought him to treatment. Phil tells him about his seasonal pattern of low mood and anxiety. They discuss Phil's life: his family relationships, work, and friends, among other things. When Dr. Whitman asks what his goals are, Phil says, "I want to feel better this fall and winter."

Dr. Whitman works with Phil to flesh out what "feeling better" would look like. How would his life be different? Are there things he would be doing more? Phil thinks it over and comes up with some specific goals to focus on.

Dr. Whitman gives a brief overview of the treatment and how it can help Phil move toward his goals. He emphasizes that Phil has already done a lot of the work by seeking help and being specific about what he wants to change. Phil leaves the session with forms and instructions to monitor how he spends each day.

That night at dinner, Phil talks with Michelle about the session and says he's optimistic that the work will be helpful. As part of his homework, he and Michelle review his goals together, and Phil gets Michelle's input on some more specifics that he wants to work toward.

What Brought You In?

When I meet with someone for the first time in my clinical practice, I start by asking what brought them in for therapy. I'd encourage you to answer this question, as well. What compelled you to pick up this book? How long have you been

Taking Stock

I'd like you to think about how your life is going, including the ways anxiety and depression may be affecting things. I've chosen six areas that I routinely assess as a psychotherapist. We'll consider each of these areas in turn. Take your time. The work you're doing this week is as important as anything you'll do in this program.

RELATIONSHIPS

Relationships have a powerful effect on our well-being, for better and for worse. An unhappy marriage, for example, is a strong predictor of poor life satisfaction and is even associated with being suicidal. On the other hand, during the hardest times in our lives, even one supportive relationship can make the difference between being crushed and coming through strong. We'll consider family and friend relationships separately.

Family. *Phil has a strong relationship with his wife, although he finds that when he's depressed he isn't as present and is quicker to snap at her. He also doesn't have the energy to do enjoyable activities with her, like going out to dinner, getting away for the weekend, even being intimate. He realizes that a certain "spark" has been missing from their relationship.*

Think about how things are going in your family relationships, including your family of origin (parents, siblings) and, if applicable, the family you formed as an adult (partner, kids, in-laws, etc.).

Consider the following questions: What's going well in your relationships? Where do you struggle? Is your family going through any major stresses? Is there a family member who's having a hard time, and who might be affecting the whole family dynamic?

Are there family members you're missing, who have moved out of your life either through death or for other reasons? As much as you love your family members, do you crave more time alone?

People vary in how many friends they need—some of us are satisfied with one or two close friends, while others need a big social network.

Do you have a strong group of friends? Do you get to spend as much time with them as you'd like? For example, have friends moved away or have your relationships changed for other reasons? Have your anxiety and depression had an impact on your friendships? Record your thoughts below.

BASIC HUMAN NEEDS

One way to think about our goals is to ask how much our psychological needs are being fulfilled. Countless studies have shown humans need three things:

- **Autonomy:** the ability to decide for ourselves what we do, without being overly controlled by others
- **Relatedness:** meaningful and satisfying connections to other people
- **Competence:** feeling like we're good at what we do and able to put our talents to use

The better these needs are met, the more life satisfaction we'll experience. For example, high satisfaction of our psychological needs is linked to lower shame, depression, and loneliness. Importantly, reaching our goals means more to us when these goals are in line with our basic psychological needs.

Consider the extent to which each of these needs is met in your own life as you formulate your goals.

FAITH/MEANING/EXPANSION

When Phil was younger, he felt like life had a purpose. He expected to do important things in his career and to make a meaningful contribution to others' welfare. Although he was never formally religious, he saw himself as part of an interconnected web of humanity.

Lately, though, Phil has felt less connected to humankind, and he misses a feeling of solidarity with others. As his anxiety and depression worsen, he feels cut off from other people and has a hard time connecting with anything outside himself.

What gives you a sense of purpose? As a general rule, we find purpose and meaning through connection to something larger than ourselves. Many of us find that connection through membership in a religious community. Perhaps we're inspired by sacred texts and by our belief in a divine being who cares about and communes with us.

Others among us find a sense of expansion—of extending our awareness and our connections—through the natural world or through a feeling of shared humanity with others. We may find our place in a vast universe through our identity as parents—as part of a continuing chain of breath and being that flows into the next generation.

At times, we may struggle to find a sense of identity and purpose. Maybe we've left the religion of our youth or suffered a major disappointment that calls into question so much that we held sacred.

PHYSICAL HEALTH

Dr. Whitman asks Phil several questions about his general health, his eating habits, how much physical activity he gets, and what substances (like alcohol) he regularly puts in his body. Phil makes connections between the state of his body and the state of his mind. When he exercises consistently, he feels mentally sharp and more optimistic. When he drinks too much or doesn't get enough sleep, his mood suffers. He also notices how feeling anxious and depressed can push him toward behaviors that make him feel worse.

There is greater recognition than ever before of the interdependence of the mind and the body, with the mind affecting the "machine" and vice versa. Take some time to think about your physical health.

General Health. Do you deal with any chronic health issues, like high blood pressure or diabetes? Do you worry about your physical health? What is your relationship with your body like?

Food. Consider any issues you may have related to food. Do you routinely eat out of boredom or to change your mood? Do you ever struggle to eat enough, either because you're uninterested in food or you fear "getting fat"?

Sleep. Poor sleep makes everything more difficult. How have you been sleeping? Too much? Too little? Any problems falling asleep or staying asleep? Do you often wake up long before your alarm, unable to fall back asleep? Consider anything else that might affect your sleep—kids, pets, neighbors, a partner who snores, a demanding work schedule, etc.

DOMESTIC RESPONSIBILITIES

"I'll get to it," Phil tells Michelle. He's been telling her for weeks that he'll organize the garage. They've had to park the car in the driveway lately because the garage is in such disarray. He feels bad, but he doesn't have the energy or the motivation to begin.

All of us have responsibilities at home, which may include cleaning, buying and preparing food, paying bills, mowing the lawn, and taking out the trash. Are you able to take care of your daily responsibilities? Are there any issues between you and your partner or roommate(s) about how chores are divided? Write any relevant issues below.

If any other important issues weren't captured in the categories above, write them here.

simple. Obviously, our days aren't neatly divided into one-hour blocks, so just do your best.

You'll also record how much you enjoyed each activity and how important it was to you. Remember, the enjoyment and importance ratings are yours alone to make—nobody else gets to decide what you enjoy and find important.

Finally, you'll rate your overall mood for each day on a scale from 0 to 10, where 0 is very bad and 10 is very good.

Plan to fill out the form the same day you do the activities, either at the end of the day or throughout the day. If you wait until the next day or later, you'll forget important information.

DAILY ACTIVITIES

Today's Date: Sat. 5/21/16

TIME	ACTIVITY	ENJOYMENT (0–10)	IMPORTANCE (0–10)
8:00–9:00 AM	Sleep	–	8
9:00–10:00 AM	In bed awake	2	0
10:00–11:00 AM	In bed awake	2	0
11:00 AM–noon	Breakfast with Michelle	5	7
noon–1:00 PM	Reading listicles online	2	0
1:00–2:00 PM	Watching golf	4	3
2:00–3:00 PM	Watching golf	4	3

The work you've done this week has clarified how anxiety and depression are affecting your life and what changes you want to make. Throughout the rest of the program, you'll be setting small goals to help you move toward your larger, overall goals.

Review your goal list several times this week to see if you want to add anything. Take a moment to put reminders in your calendar, or put a copy of your goals somewhere you'll see it each day. It's easy to let a week go by without returning to this work.

Remember to complete the Daily Activities form for **four days** over the following week. You can download copies of it online at: callistomediabooks.com/cbt.

You can also plan now for when you'll tackle week 2, where we begin the work of moving toward your goals and getting back to life.

Take a few minutes to write down your thoughts, feelings, and any concerns you may have in the space below.

ACTIVITY PLAN

1. Review your goal list several times.
2. Plan a specific time to do week 2.
3. Complete the Daily Activities form for four days.

When we do the right kinds of activities, we feel better. But what makes an activity "right"? The short answer is that it needs to be rewarding to you—it has to give you something you value. If we just said, "Do these things and you'll stop feeling depressed," we might be telling you to do things you don't care about. It's hard enough to do things we like to do when we're depressed and anxious, let alone activities we don't care about, or find aversive.

The developers of behavioral activation determined that the activities you plan have to come from your values, as described in a treatment manual by Carl Lejuez and his fellow authors. In this context, "values" doesn't have a moral or ethical overtone, although your values can include morality and ethics. Here, your values are anything that you enjoy, love, or get satisfaction from doing.

As with goals, you are the only person who can decide what your values are. The values you articulate here have to resonate with you. We often base our values on what we *think* should be important to us—maybe by relying on what our parents told us, or on what we think society expects of us. Instead, our values should be based on what brings us pleasure or enjoyment, gives us a sense of mastery or accomplishment, and feels like it's worthwhile.

And good news—you've already done a lot of thinking about these kinds of values through the work you did last week. Let's build on that work as you define your values.

WHICH COMES FIRST: DOING MORE OR FEELING BETTER?

When we're feeling down and stuck, we often become less active: We don't feel like socializing, exercising, taking care of our living space, and so forth. We can find ourselves stuck in a Catch-22: We won't feel better until we do more things, and we won't do more things until we feel better. We often tell ourselves that we'll be more active once we start feeling better. CBT takes the reverse approach, because we generally have more control over our actions than our feelings. If we wait till we feel well enough to be more active, we may be waiting a long time.

Like Kat, we're often rewarded in the short term for doing things that aren't in our long-term interest. While staying in for the night felt better to Kat *that night*, it didn't move her toward her goals of being more active and expanding her social network. It also left her feeling bad about herself for not facing her fears.

How do we engineer activities that will stop the short-term reward we get from withdrawing, and increase our long-term reward by doing things we really care about?

There are three main steps:

1 Decide what you value in the areas we examined last week.
2 Come up with activities that fall under each of those values.
3 Plan and complete specific activities.

An example of a value and some corresponding activities might be:

Value: Beautifying my living situation.

- **Activity:** Weed the front garden bed.
- **Activity:** Plant flowers.
- **Activity:** Buy cut flowers.

In the next section, we'll look at clarifying our values.

VALUES

Notice, in the example above, that values have no endpoint. There's no time when we say we've "completed" beautifying our living situation. Values can extend through our entire lifetime. Activities, in contrast, are specific and have a beginning and an end, though they can be repeated as many times as we wish.

Using the Values and Activities form starting on the next page, write down some of your values under each life area. There are three spaces under each life area, and it's okay if you come up with more or fewer for each one. Keep in mind: Your values don't have to be "heavy" or dramatic. Anything that makes our lives better is a value. (For now, leave activities blank.)

PHYSICAL HEALTH

Value: _____

Activity: _____

Activity: _____

Activity: _____

Value: _____

Activity: _____

Activity: _____

Activity: _____

RECREATION/RELAXATION

Value: _____

Activity: _____

Activity: _____

Activity: _____

Value: _____

Activity: _____

Activity: _____

Activity: _____

DOMESTIC RESPONSIBILITIES

Value: _____

Activity: _____

Activity: _____

Activity: _____

Value: _____

Activity: _____

Activity: _____

Activity: _____

You can find a copy of this form online at callistomediabooks.com/cbt.

Kat's completed Values and Activities Form

PHYSICAL HEALTH

Value: Enjoying good food

Activity: Have a friend over for homemade ice cream

Activity: Plan meals for the week

Activity: Buy bread, cheese, and fruit and have lunch by the river

Value: Feeling fit and strong

Activity: Get in bed by 10 pm

Activity: Join a gym with a pool near my apartment

Activity: Do high-intensity interval training with an online video

Notice that Kat's activities are *specific* enough that she'll know when she's done them, as opposed to loosely defined goals like "get in shape" or "learn to cook." Activities that are too vague can feel unmanageable, which can lower our motivation to do them. Vaguely defined activities also don't give us a clear sense of when we've completed them; rather than having a sense of accomplishment, we foster the nagging feeling that "there's always more I could do." When we define clear and manageable activities, we're more likely to complete them and to feel good about having done them.

You don't have to come up with all new activities; definitely include ones you're doing already if you want to do them more often. These activities can provide a good starting point as you build more rewarding activities into your schedule. Also, don't feel pressure to completely finish your activity lists now. Take some time to brainstorm a few activities for each life domain. It's helpful to start the list and then come back to it later. You'll almost certainly have more ideas when you come back to it later in the week.

Take a moment here to write down your observations and feelings about your recent activities:

WHERE TO BEGIN?

Now that you've made your list of values-based activities, we can figure out where to begin. Go through your list of activities and place a 1, 2, or 3 next to each activity, based on its difficulty. The easier activities will be a 1—things you're probably doing already or could do without much difficulty. An activity is a 3 if it's hard to imagine tackling just yet. To ones that fall somewhere in the middle, give a 2.

Like all of CBT, this part of the program will be progressive. You'll start by working your way through the 1s. For this week, pick three of the easiest activities that interest you the most. Usually it's best if they come from different life areas, to give yourself a variety of rewarding activities.

BENEFITS OF EXERCISE FOR ANXIETY AND DEPRESSION

Many studies have found that adding regular exercise into one's routine has a positive effect on both depression and anxiety. The effect is about the same size as that of antidepressant medication. Not surprisingly, the benefits diminish if a person stops exercising.

More intense exercise tends to be more beneficial, although it doesn't seem to matter whether the exercise is aerobic (e.g., running or cycling) or anaerobic (e.g., weights).

There are several explanations for why exercise might be beneficial for our psychological health:

- Exercise tends to improve sleep, and better sleep helps with pretty much everything.
- Exercise can distract us from negative thinking. When we're working hard physically, it's harder to focus on our problems.
- Exercise can lead to positive social contact if we're exercising with other people.
- Exercise can give us a sense of satisfaction from having done something good for ourselves.

Whatever the reason, regular exercise can be an important part of a treatment plan for depression and anxiety.

You can also benefit from carefully considering the "reward value" of each activity you plan. If an activity isn't enjoyable at the time, it needs to provide you with some satisfaction once it's done. Otherwise it's probably in the category of "not worth doing."

Whenever possible, plan a specific time to do the activity and protect that time. Without a time that's set aside, we can easily fall into the trap of "I'll do it later." When we can always do something tomorrow, we're less likely to do it today (or tomorrow).

Good work—you're now two weeks into this program. You've made your goals and have taken a big step in determining what activities will enhance your life. You divided your list of activities into easy, moderate, and hard, and chose three activities to do at specific times this week.

The goal of this program is to help you think and act in ways that move you toward your goals. In the next chapter, we'll begin identifying your thought patterns. Take a moment now to schedule time for week 3.

In the space below, reflect on what stands out to you from this week's work. What are the major takeaways? Was there anything that wasn't quite clear, which you'll need more time to think about? Note how you're feeling right now and as you look to the week ahead. I'll see you in week 3.

ACTIVITY PLAN

1. Complete your three activities at the scheduled times.
2. Continue to record your daily activities on the days of your scheduled activities.
3. Finish the Values and Activities forms you started.

Still, nobody hired him, even though several interviews had gone well. As his unemployment dragged on, Neil's enthusiasm began to flag. It got harder to get an early start on his day, and he felt like he was just going through the motions of his job search.

Just before he called to schedule an initial visit, he received notice that his unemployment benefits would expire soon. Before the notice, he'd felt like he was hanging by a thread, and this last blow felt enormously stressful and depressing all at once. He was 52 years old and had financial commitments to his young adult children—to help his daughter, a recent college grad, pay her rent, and paying for his son's college tuition. With 10 years left to pay on his mortgage, the financial stress was overwhelming.

His wife was extremely supportive and good at encouraging him to do what he needed to do. At the same time, Neil knew he could lean on her only so much, since she had stresses and a full-time job of her own. He knew he was really struggling when he had a passing thought: "Maybe my wife and kids would be better off if I were dead so they'd get the life insurance money." He called me the same day.

Neil's positive traits were easy to appreciate. He was committed first and foremost to his family, and he couldn't stand the thought that he might not be able to provide for them as he always had. I could see that he strongly resisted the downward pull of his situation, trying to stay upbeat. But as my initial evaluation went on, I could see his defenses breaking down. When I asked him about his job search, he concluded by saying, with a half-smile, "I guess no one wants to hire an old man."

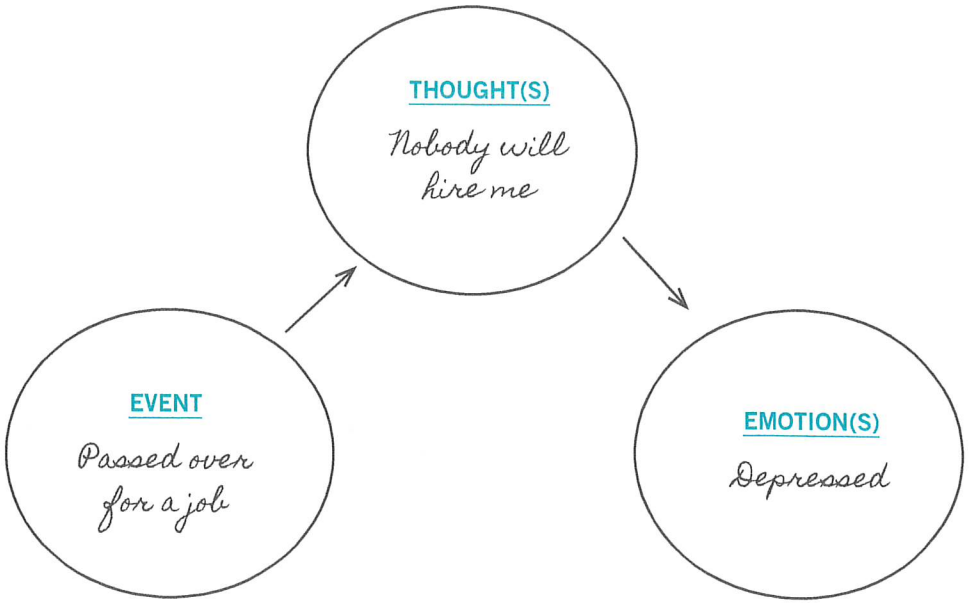
In the first couple of weeks of his treatment, Neil and I focused on getting him active again. His job search activities were a big part of his activity plan, of course, as was physical exercise and making time for enjoyable downtime (which he'd mostly given up because he didn't think he "deserved it"). As he worked through his activities, it became clear that powerful thoughts and assumptions were getting in his way. We would need to address his thinking head-on.

As you consider your own thoughts related to anxiety and depression, notice what time period the thoughts focus on. Some probably deal with explanations of things that have happened already. Others may be about future events—predictions of what could happen. Still others may be about what's happening right now. As you try to identify your thoughts, keep in mind that they could be about the past, present, or future.

Sometimes thoughts come as an image or an impression. Rather than thinking, "I'm weak," for example, we might have an image of ourselves as being small and powerless. When you're practicing identifying your thoughts, remember that they may or may not be in the form of words.

We can diagram the event, thoughts, and emotions from an episode. Neil's diagram for the recent job rejection looked like this:

Neil's Event/Thought/Emotion Diagram



that led to an emotion, don't worry—you'll have plenty of opportunities to practice. In truth, learning to hear what we're telling ourselves is a skill we can refine throughout our lives. This is just the beginning.

One part of your activity plan for this week will be to record at least three instances when your mood dipped. You'll simply note what was happening, what you felt, and what thought(s) you had. You can record these episodes on the Identifying Thoughts form.

Common Themes in Anxiety and Depression

As Neil got to know his thoughts better, he recognized a familiar "cast of characters." Most of his disturbing thoughts were about his "hopeless" future, which he believed was a result of his old age and "obsolescence," which he took to mean he wouldn't be able to provide for his family, which he thought made him a worthless human being. No wonder Neil was depressed! He was constantly bombarded with thoughts about being old, unwanted, and useless.

As you record your own thoughts and emotions over the coming week, chances are you'll begin to notice recurring themes. It's like our mind is a jukebox and only has a few "hits" to play over and over when a triggering event "pushes the button." Our individual experiences of anxiety and depression will be closely related to the kinds of thoughts we often have.

Let's consider some common types of thoughts that come up in certain psychological conditions. We'll start with the anxiety disorders. You can skip the exercises for conditions that don't apply to you.

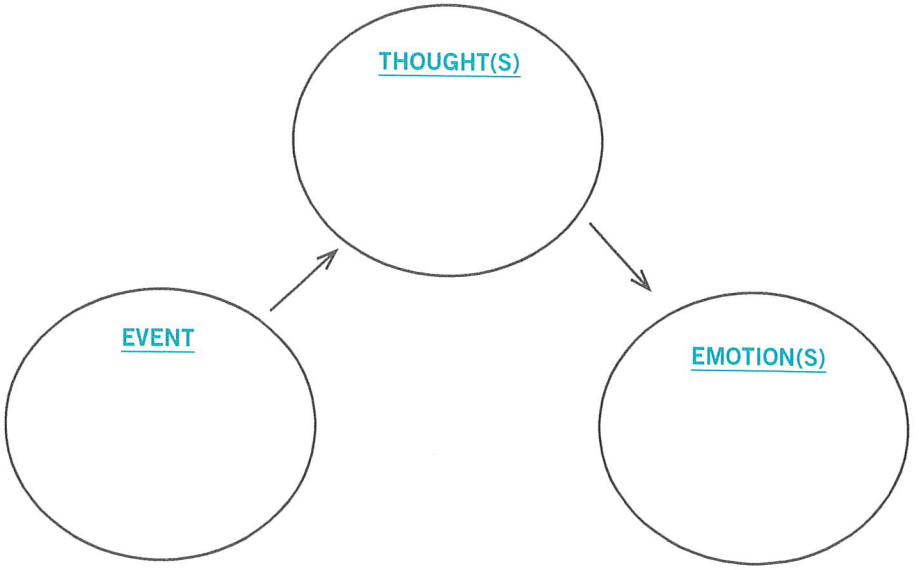
SPECIFIC PHOBIA

When we're afraid of something, we often believe it's dangerous. If we have a fear of flying, we might think mysterious noises on a plane indicate something's wrong. Two people might experience the same event in completely different ways,

Other common beliefs in panic disorder include:

- If I panic while driving, I'll crash the car.
- If my panic attack gets bad enough, I'll faint.
- Everyone will know I'm panicking, and I'll embarrass myself.
- If I panic I might lose control and attack someone.
- Panic will make me lose my vision, which could be really dangerous.
- If I don't stop panicking, I'm going to go crazy.
- I'm having a heart attack.
- I might not get enough air and suffocate from a panic attack.
- I'm going to have sudden diarrhea if I panic at the wrong time.

If you struggle with panic, think about specific times you've had a panic attack. What triggered the attack? Did you interpret the trigger in a way that led to more fear and more panic?



GENERALIZED ANXIETY DISORDER (GAD)

Thinking tends to be a very prominent part of GAD. The thoughts often start with "**What if . . . ?**" about something bad that could happen:

- What if I fail this exam?
- What if my headache means I have a brain tumor?
- What if something happens to my parents?
- What if I lose my job?
- What if the stock market tanks and wipes out my retirement savings?

Because it's "generalized," the worry in GAD can attach to anything. There also tends to be an implicit belief that *I need to do something to make sure this bad thing doesn't happen.* We feel like it's our responsibility to control the situation, whatever it may be. We might tell ourselves we have to "*make sure that doesn't happen,*" and so we'll do some mental activity (worrying) to try to work through the problem, but unproductively. It's like trying to play an entire chess game in advance, not knowing the other player's moves, but still trying to "solve" the upcoming game.

Unfortunately, the things we worry about typically aren't completely under our control. Can we be absolutely certain we won't fail an exam, have a medical crisis, lose someone close to us, and so forth? So we find ourselves caught in a thinking loop: From *What if,* we try to think of a solution that *makes sure* what we're afraid of doesn't happen. Since we can't have the certainty we seek, we're back to *What if . . . .*

For example, we might worry about our kids' safety: *What if they get badly hurt at camp?* We run through a list of bad things that might happen and try to reassure ourselves that our children will be fine. But of course we can't *know* they'll really be safe, so our minds go back to *What if,* and the loop continues.

A person with GAD may also believe that worrying is a useful exercise. We might think, for example, that if we worry about something, we can prevent it from happening, and so to stop worrying would be to let down our guard. It's easy to believe our worrying "works" if we're always worrying and what we've worried about hasn't happened–maybe it's because we worried! Or we might believe that our constant worrying says something good about us–*that we care.*

Not uncommonly we fear we'll "lose it" or "go crazy" from being too afraid. We may believe on some level that if we get too terrified, we can reach a place that's "beyond fear," some qualitatively different experience that's worse than bad. Maybe we think we'll get so "freaked out" that we "won't be able to stand it" and will do something embarrassing.

Think about your own experiences of fear and anxiety. Are there things you're afraid of even though you know they aren't dangerous? Think as carefully as you can about how you feel when confronted with the object or situation. Do you have any predictions about what will happen as a result of being terrified? Write your thoughts in the space below.

COMMON THEMES IN DEPRESSION

Neil got a second interview at a company that seemed like a good fit for him. Then a curious thing started to happen: He began to assume that there must be something wrong with the company, because why else would they want to hire him? He felt ashamed when he told his wife about the interview—he wasn't even going to tell her about it, but she asked where his interview was when she saw he'd set out his suit.

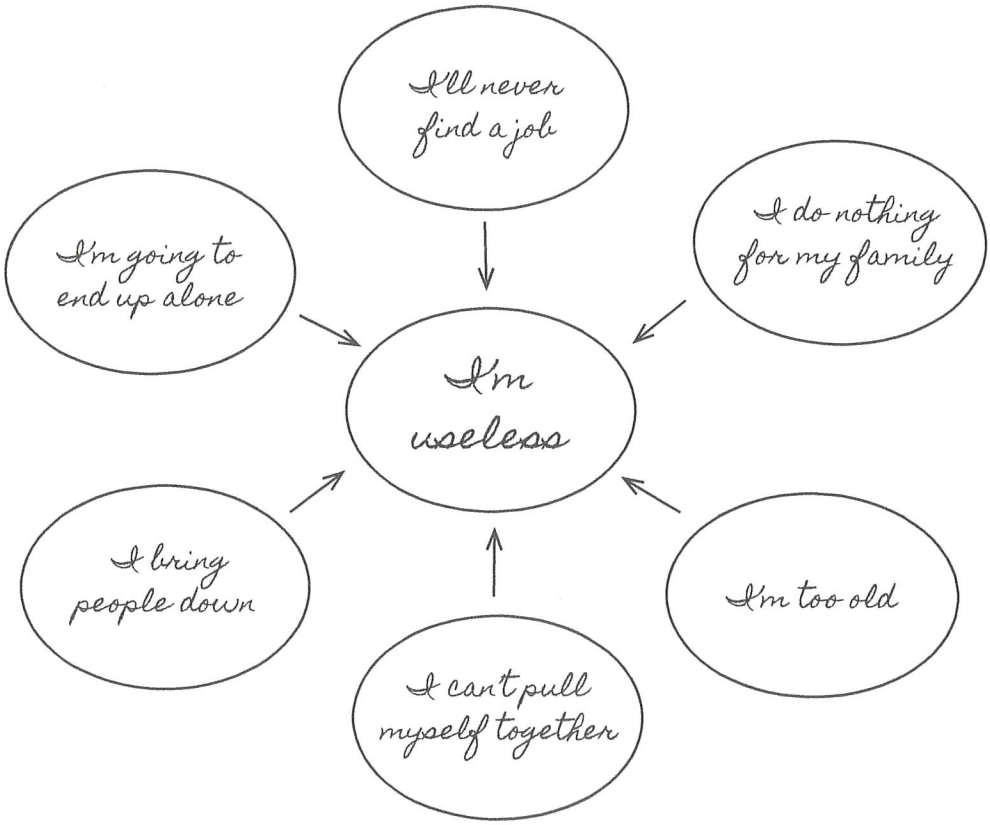
Neil and I worked together to understand his thought process. He discovered he was telling himself the company must be really desperate to hire someone if they were still interested in him after knowing his age. As a result he told himself he was pathetic for interviewing with the company.

When we're depressed, we often see any disappointing event as evidence of our own failure. Sometimes we even turn positive events into negative ones. Depressed thinking can turn even a win into a loss. Common thoughts

Getting to the Core

Over time, Neil noticed that all of his thoughts shared a "final destination." If he traced where all the thoughts led, he discovered that they all ended with his being useless and pathetic. He even had an image in mind that went along with this notion—he pictured a worn-out washcloth that's been dropped between the washer and dryer, and nobody bothers to pick it up. We diagrammed his thoughts like this:

Neil's Core Belief Diagram



Alex Breaks Through

"It was confirmation of everything I've thought was wrong with me," Alex said as her voice broke. "I'm letting everyone down. They're depending on me, and I can't even get myself together." She wiped away tears and sat with her hand over her eyes.

Earlier in the week, Alex's supervisor Dianne had called Alex into her office. Dianne told her she needed to be putting in more hours, including evening and weekends, if she wanted to meet the expectations of her job. She reminded Alex that she herself did what she had to do 20 years earlier, as a mother with young kids, and that women have to prove their dedication to their work to be taken seriously. Alex left the meeting promising to make more of an effort, and feeling completely demoralized.

Four weeks earlier, Alex had started treatment with me. She was struggling to find time for a demanding job as assistant director of a large executive MBA program and raising two young daughters. Her life was all work and no play: Her day started with the frantic morning routine from 5:30 to 7:30 a.m., then shuttling her four-year-old to preschool and her 18-month-old to day care, then on to a grueling day at the office till 6:00.

Her mother would watch the kids in the late afternoon till she got home. Then, the nighttime crunch happened till both kids were down around 7:30 p.m. Alex and her husband, Simon, might have 15 minutes to talk about their day while cleaning the kitchen before they each did their nightly chores and prepared for the next day. She often brought home files to review at night and was always amazed by how little she managed to do before it was 10:30 p.m. and she was falling asleep sitting up.

Since her younger daughter was born, Alex hadn't been sleeping well. Her nerves were frayed and she was often irritable, which was never her personality before. She wished she were more patient with her kids. "This morning I heard my four-year-old tell her sister to stop fussing because 'Mommy's cranky this morning,'" she told me. "I felt like such a failure as a mother."

Unhelpful Thoughts

Consider all the ways thinking is helpful to us. We can plan for the future, consider our past actions, evaluate others' motives, savor our favorite memories, and so forth. When our thoughts are a good enough fit with reality, they serve us well.

Some of the thoughts you recorded over the past week may be accurate, and therefore helpful. Our minds can also create thoughts that *do not accurately reflect reality*:

- We make predictions that are wrong.
- We misunderstand someone's intent.
- We misread a situation.

We all make errors in our thinking. After a talk I once gave as part of a job interview, I was certain my audience had been bored and severely underwhelmed. "I blew it," I thought as I walked home. When I got home, there was an e-mail in my inbox offering me the job. Fortunately *we can think about our own thinking* and recognize when our thoughts do and don't make sense.

Think of a time when you thought or believed something that turned out to be verifiably false, and describe it in the space below.

EXAMINING THE EVIDENCE

One of the episodes Alex recorded involved a particularly stressful morning trying to get everyone out the door on time. She felt irritated and overwhelmed and thought gloomily on her drive to work, "I am such a disappointment."

As we talked about this thought, it was clear she meant it in a global way: "I am nothing but a big disappointment to everyone." She found this belief very upsetting. We needed to think carefully together about this thought. Was it true?

We first looked for evidence to support Alex's thought, and there were indeed times that others were disappointed in her, like her supervisor recently and her kids when she snapped at them.

We then considered evidence against her thought. Could she think of anything that contradicted it? She thought for a moment and said, "My older daughter does tell me sometimes that I'm a good Mommy, 'even though you yell sometimes.'" She added this fact to the "Evidence Against . . ." column. We continued this exercise, and then looked at the columns side by side:

Evidence for my thought	Evidence against my thought
• Dianne was disappointed in me.	• Dianne also said I'm doing good work.
• I'm often irritable toward my girls.	• Libby sometimes tells me I'm a good Mom.
	• My husband says I'm handling a lot.
	• I'm working full-time and raising two daughters.

Event:	Thought:	Emotion:

Evidence for my thought	Evidence against my thought

You can find a copy of this form online at callistomediabooks.com/cbt.

Based on the evidence that you reviewed, how accurate is the thought you had?

How would you modify the thought to make it fit better with reality?

A big part of this practice is to grow toward *accepting* our imperfections, and not hating ourselves for being fully human.

Let's take a look at our tendency at times to see things as worse than they are.

IS IT A CATASTROPHE?

So far we've focused on thinking errors that involve bias or false predictions. We might think that getting a parking ticket means we're horribly irresponsible, or that we'll faint if we panic, or that people won't want to be friends with us if we show signs of anxiety. Each of these thinking errors involves mistaken beliefs.

But what about thoughts that aren't unrealistic? For example, what if our fear is that we'll blush when we speak up in a meeting, or that we'll have a panic attack on a plane? There might be a reasonably high chance that these things will happen. Often, in these cases, our error lies in *how bad we think the outcome is or would be*. We might believe that if we blush it will be *awful*, or that having a panic attack on a plane will be a *total disaster*. Our minds can treat an awkward, uncomfortable, or disappointing situation as if it's a complete catastrophe.

As you examine your own thoughts, do you notice any emotional reactions that seem overblown based on the thought you identified? For example, did you tell yourself that something you did was "awful," or that it would be "unbearable" if your fear came true? If that's the case, consider whether you might have told yourself something more—something that could be driving your emotional responses. Record your observations in the space below.

"You'll have to pardon the comparison, but it sounds a lot like you were describing yourself."

"I know what you're getting at," Alex said, "and I can see how everything I said could apply to me. It just . . . feels different. I mean, I could never say to her the things I say to myself. I love Laura."

I asked her, "What would you say to Alex if you loved her?"

Alex thought about this question during the week. When she came back, she said she'd been practicing talking to herself "like I'm someone I care about." She said at times she even felt a sense of caring for herself, and also of being cared for. "It feels weird to say this," she said, "but I'm starting to think it's not my job to run myself into the ground."

I asked her what kinds of thoughts she'd been working on, especially in situations that would trigger her self-loathing thoughts.

"I tell myself, 'You made a mistake, and that's okay.' The other day I lost patience with my kids on the drive to school, and I heard that familiar critical voice saying, 'Why couldn't you have held on for just a few minutes longer? Now you've ruined everyone's day.'

"And I answered the voice. I said, 'Because this morning, as much as I wanted to, I just couldn't. And maybe the day's not ruined—not yet.' I actually smiled. I know I'm not a perfect mother . . . and I can live with that. I'm also not a disaster."

Most of the time, the thinking errors we make apply only to ourselves. For reasons that aren't entirely clear, we're almost always harder on ourselves than we are on others. We rarely would make the same interpretation if the same event happened to someone else.

For many of us, practicing a gentler way of talking to ourselves will feel strange at first. We may have gotten so accustomed to being harsh with ourselves that we believe we deserve to be talked to that way. With practice, a kinder approach can start to feel more natural.

Remember to consider the following points in your examination of the evidence:

1 Am I ignoring any evidence that would contradict my thoughts?
2 How likely is it that I'm seeing it as worse than it really is?
3 What would I say to someone I care about if they had this thought?

Based on your examination of the evidence, would you revise your thought in any way to better fit the evidence you came up with? If so, write it below.

A more reality-based thought is:

Common Thinking Errors in Anxiety and Depression

By now, you may have begun to recognize recurrent errors in your thinking. While everyone's thoughts are somewhat unique, in the previous chapter we considered predictable themes that show up in depression and anxiety. Let's revisit these themes as we consider the common thinking errors in each condition.

DEPRESSION

As we saw with Alex, depression is linked to thoughts about ourselves that are overly negative, as Aaron Beck and colleagues described in their manual on cognitive therapy for depression. We might assume we'll fail, or that if we failed it's because we're defective in some fundamental way. When things go wrong, we'll take it personally and may assume we'll *always* mess things up.

If you deal with depression, look for signs that your thoughts about yourself are harsher than they need to be, based on the facts. When we take a close

ANXIETY

When we're highly anxious, we tend to overestimate the probability that what we're afraid of will happen. In panic disorder, for example, we often believe (erroneously) that panic leads to fainting or suffocation. We might also believe that panicking makes us likely to do something dangerous like impulsively jump from a bridge, when our instinct is to actually move *away from* danger when we panic. If we're afraid of flying in an airplane, we might be surprised how small the actual risk is.

Consider the things that cause you a lot of anxiety. Did you identify any errors in your beliefs related to the things you're afraid of?

Example: When I have a physical symptom, I often assume it's the worst possible disease rather than something more benign (which so far it's always been).

We can also exaggerate the *cost* of the outcome we're afraid of. In social anxiety, for example, we often believe it's awful to show embarrassment (like by blushing), but there's evidence that people actually think kindly of someone who blushes. We also might cringe over and over as we remember something foolish we said, and imagine that others are still thinking about it. In reality, chances are they've moved on to other things, just like we do when someone else makes a social misstep.

WEEK FIVE

Time and Task Management

Last week, you continued planning enjoyable and important activities, and you began actively confronting your unhelpful thoughts. This week, we'll continue with these techniques. We'll also turn to the topic of managing our time well and completing tasks effectively.

Review the list of five activities you planned to complete (page 106). How did they go? Record anything that stands out in the space below.

Choose five more activities from your list to complete in the coming week. Carefully consider which ones to do, and don't be afraid to challenge yourself with some of your hardest activities. There's a good chance the more difficult activities are the more rewarding ones.

How have depression and/or anxiety affected your ability to complete tasks?

Fortunately, the work you've done so far has already introduced some relevant skills—skills this chapter will build on. For example, we looked at ways to increase your odds of completing an activity when we discussed behavioral activation (pages 70–71). The thinking skills you've been working on will also be helpful as we look at some of the thoughts that can interfere with effectively using our time.

Take a few moments to think about your own time management. What do you tend to do well in managing your time? What strategies work well for you?

USING CBT TO ADDRESS DIFFICULTY SLEEPING

When we sleep poorly, it's harder to manage our time well and get things done. Poor time management can also interfere with sleep. It's a good idea to devote some attention to getting better sleep if yours has suffered.

The most effective treatment for bad sleep is CBT for insomnia, or CBT-I. Four to eight sessions can make a huge difference in a person's sleep. The main principles of treatment are:

- **Stick to a consistent bedtime and wakeup time.** By staying on a regular schedule, your body knows when it's time to sleep and when it's time to be awake, and it's easier to fall asleep and sleep soundly.
- **Don't spend more time in bed than you're able to sleep.** If you're able to sleep seven hours per night on average but you spend nine hours in bed, you'll have two hours that you're awake in bed (and probably stressed about not sleeping) or sleeping poorly. By spending less time in bed, we actually wind up getting more sleep. The average participant in CBT-I gets an additional 43 minutes of sleep while spending 47 *fewer* minutes in bed—which is time we can invest in other activities.
- **Get out of bed if you're not able to fall asleep.** If you know sleep isn't coming anytime soon, do something else in another room (like reading or watching a favorite show). Return to bed when you feel sleepy. Repeat as necessary. It's better to spend time doing something you enjoy than lying in bed feeling frustrated. This guideline applies at any point in the "sleep window"—beginning, middle, or end.
- **Generally avoid napping.** When we nap during the day, we decrease our body's drive for sleep, which can make it hard to fall asleep and sleep soundly at night. If you do nap, plan to do it earlier in the day and keep it short.
- **Avoid caffeine later in the day.** As a rule of thumb, caffeine after lunchtime is likely to interfere with nighttime sleep. Depending on your sensitivity to its effects, you may need to avoid caffeine even earlier.
- **Remember that a bad night's sleep is almost certainly not a disaster.** It's easy for us to panic when we can't sleep and to think we'll "be a wreck" the next day. In reality, we usually can function adequately, even if at times we're sleepier than normal.

If you continue to struggle with poor sleep, consider making an appointment with a sleep specialist.

For the following sections you'll need your calendar, so make sure you have it on hand. It can be an electronic calendar or a hard copy—whichever works for you. Just make sure it has all your appointments in it, rather than having separate calendars for different parts of your life (for example, separate work and home calendars).

IDENTIFYING TASKS

"What do you need to do?" I asked Walter.

He shook his head. "So much," he said. "It feels impossible."

"Let's find out if it is," I said. Together we made a list of all of Walter's outstanding assignments, including the Incompletes from last fall. His list looked like this:

- Finish Incompletes
- Read six chapters of psych textbook
- Six math problem sets
- Two experiments for intro psych
- Write History paper

As we looked at his list together, Walter said he had mixed feelings about it. On the one hand, it seemed like an incredible amount of work. On the other, it looked like less than he'd imagined. Before he'd written them down, it had felt like an infinite number of things, and now it was a big, daunting, but finite list of tasks.

When we've fallen behind, the first step is simply to list what we have to do. It's generally a lot easier to manage something on paper than in our heads. Choose activities that you need to complete in the next one to two weeks; you can apply the same principles to long-term goals at a later time. The list doesn't have to include activities of daily living—sleeping, bathing, eating, and so forth—unless you're not finding time for them.

Now, take a moment to review your list. What stands out? How do you feel as you look it over?

PRIORITIZING TASKS

Walter and I returned to his list and considered where he should begin. "I want to get these Incompletes finished over spring break," he said, which meant he'd need to have them done before the end of March. We went through each item in turn and wrote the date when he needed or wanted to complete it. These dates determined the order in which he would tackle each item.

1 - Finish Incompletes - March 18
5 - Read six chapters of psych textbook - April 6
3 - Two experiments for intro psych - March 30
4 - Six math problem sets - April 2
2 - Write History paper - March 23

Return to your list of tasks. When does each one need to be completed? Write the date next to each one. Based on these dates, assign an order number to each task, with a 1 for the first one that needs to be done.

Task:

_____

Subtasks:

_____

_____

_____

_____

Use the Breaking Down Tasks form at the end of this chapter (see page 155) if you need to do the same for other items on your list.

As Walter planned to work on his Incompletes, he set dates for when he needed to complete each part of the plan, with the final due date of March 18 in mind. We did the planning on March 12, so his plan looked like this:

Finish Incompletes:

Bio - 3/16

Research paper

- Review topic and research articles - 3/12
- Summarize existing studies - 3/13
- Describe outstanding question - 3/13
- Describe proposed answer #1 - 3/14
- Evidence for - 3/14
- Evidence against - 3/14
- Describe proposed answer #2 - 3/15
- Evidence for - 3/15
- Evidence against - 3/15
- Conclusions - 3/16

History - 3/18

Reflection paper one - 3/12

Reflection paper two - 3/13

Final paper - 3/18

- Make outline - 3/14
- Choose sources - 3/14
- Introduction - 3/15
- Section 1 - 3/16
- Section 2 - 3/17
- Conclusions - 3/18

REWARD YOURSELF

We're more likely to do things when they lead to reward. Although completing activities can be rewarding in and of itself, we can help ourselves even more by finding small rewards for meeting a goal.

> *A political junkie, Walter's reward to himself was pausing to read two news articles after working for 45 minutes. He got additional motivation from having something to look forward to immediately after his work. Knowing he only had to work for 45 minutes at a time also further divided his work into chunks that felt doable.*

Think about ways you might give yourself small rewards for working on your tasks. Examples include snacks, entertainment, relaxation, socializing—be as creative as you need to be to find something that works for you. One caveat: Avoid activities that tend to be addictive, like playing video games or watching TV. Minimize the risk that a reward interferes with getting back on task. Also remove the reward from immediate availability once you're back to work—for example, close your Web browser, or return the cookies to the cabinet.

MAKE SPACE

> *Once Walter was back at school, he found it was almost impossible to work in his dorm room. His roommate was a frequent distraction, as were the other students who often stopped by. Even when he was alone with the door closed, he was pulled toward various distractions: TV, video games, music. He realized he needed to work in a quiet part of the library to be productive.*

We work best when we have the space we need, both physical space and mental space. We can clear physical space by organizing our work area—whether it's an office, a desk, a kitchen, or a garage. Organization takes time up front and saves us time in the end.

We can also accept that we'll be facing our fear and that it's uncomfortable to resist the urge to run away. We can ask ourselves, "How uncomfortable am I willing to be to do what's important to me?" Often we can suffer less simply by accepting discomfort—by no longer resisting pain, but recogizing that it will be part of what we need to do for the time being.

When you meet your edge and are tempted to avoid, what can you tell yourself to encourage acceptance of the inevitable discomfort?

In the coming week, work through the activities you planned into your schedule. I also encourage you to choose two or three of the strategies for success to focus on as you work through your plan. Working on a limited number of strategies at a time can provide helpful focus as you practice what may be new skills. Write in the spaces below the strategies you plan to focus on.

1.

2.

3.

Walter recognized a theme in his thinking when he was avoiding doing something he knew he had to do. He would say to himself, "It's too hard to do it now. It'll be easier to do it later." And yet he found that it rarely got easier to do—he finally would complete the task out of desperation as the deadline was upon him. He crafted a more reality-based thought that read, "I'm probably never going to feel like doing this task, and so I may as well take care of it now rather than continue to dread it."

Are you aware of anything you tell yourself about procrastinating that may not be accurate? If so, what could you tell yourself that would be helpful?

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Problems with attention, task completion, punctuality, and procrastination are also prominent in attention deficit/hyperactivity disorder, or ADHD, according to the *DSM-5*. While many of the same techniques presented in this chapter are used in treating ADHD (see, for example, Ari Tuckman's *Integrative Treatment for Adult ADHD*), they are not intended to be stand-alone treatments for this condition. If you have ADHD as well as depression and anxiety, consider talking with a mental health professional about the best treatment approach for you.

unpleasant–by doing things like breaking it down into manageable pieces. We can also engage our accelerator by making the task more rewarding, like by giving ourselves small incentives for doing it. Thankfully, motivation builds as we gain momentum.

What have you found increases your motivation to complete tasks?

I SHOULD JUST BE ABLE TO DO THIS

At times, we might resist using time and task management strategies to help us take care of our responsibilities. We might tell ourselves things like, "This shouldn't be this hard," or, "I'm just going to force myself to do it."

A mind-set of acceptance is very helpful in this regard. When we accept that things are the way they are, we open ourselves to using the tools that will help us get unstuck.

Do you notice any misgivings of your own about using the tools presented in this chapter to help you get things done? Write down what you think it means if you rely on these kinds of strategies.

Breaking down tasks

Task: _____

Sub-tasks: _____

_____

_____

_____

Task: _____

Sub-tasks: _____

_____

_____

_____

Task: _____

Sub-tasks: _____

_____

_____

_____

Task: _____

Sub-tasks: _____

_____

_____

You can find a copy of this form online at callistomediabooks.com/cbt.

Over the coming week, continue to complete activities from your list. If there are some 3s you haven't gotten to, consider adding them to your schedule. Also, choose three days to monitor your activities using the Daily Activities form (page 66).

In the past week, did you catch yourself thinking things that weren't supported by facts? Record the kinds of thoughts you noticed and challenged in the space below.

By now, you may be at a point where you can begin to dismiss thoughts more efficiently, without going through the full evidence-finding exercise. It's usually helpful to have something to say in response to the thoughts. For example, in week 4, we saw how Alex, when she caught herself having an inaccurate thought, would say things like, "Someone's lying about me again." Other possibilities include:

1 "There go my thoughts."
2 "Okay, back to reality."
3 "Thank goodness *that's* not true."
4 "Not everything you think is true."

The options are endless—just find something that resonates with you. In the coming week, continue to notice if and when your thoughts aren't helping you. If you can't easily dismiss a troubling thought, plan to complete a Challenging Your Thoughts form for it.

Facing Fears

"I realize that, in some way, this fear has affected every part of my life."

Julie first experienced social anxiety in seventh grade. Now 27 years old, she's been struggling with it for more than half her life. As she tells me all the social situations she's afraid of, it's a little hard to square with the confident and articulate young woman with a quick sense of humor who is sitting in front of me. I tell her as much.

"It's not everywhere," she tells me. "I know you're not going to judge me. It's whenever I'm talking with someone who might think I'm stupid or awkward." She pauses, then continues. "The weird thing is, I know I'm not stupid or awkward. I mean, I know it now. But as soon as I'm around someone new, or I have to speak in front of a group, or I'm on a date, I seize up. It's like the spotlight's on me, someone hands me a mic, and I forgot to prepare my speech."

She's been working since college at a tech start-up, and she's been recognized for doing good work. Kevin, the senior member of her team, has let her know he's impressed with her innovative ideas, and encouraged her to speak up about them in their team meetings. Try as she might, Julie can't bring herself to volunteer her ideas in front of the team. She was mortified when Kevin asked her why she didn't give her input more in meetings, and she had to admit that she struggles with confidence when speaking in a group. She can feel him looking at her now in meetings when he asks if "anyone else has any suggestions." She often feels caught between his gentle but persistent pressure to speak, and her paralyzing social anxiety.

Recently, Kevin told her he wants to recommend her for an exciting new project, but he's concerned about her ability to lead a group. Julie is secretly relieved—she has major concerns about leading a group, especially the talking-in-front-of-the-group part. At the same time, she wants to move up in her field, and it would be a great opportunity. Besides, she's not dating, also because of her social anxiety, so she could use a bigger challenge at work. Once again, she

When Facing Fears, Use Common Sense

Naturally, the process of facing our fears is helpful only for things that aren't truly dangerous. Approaching an angry stinging insect or venomous snake would not provide a positive learning experience! Keep in mind: The activities you choose should be relatively safe. While there's a certain level of risk involved in any activity (even getting out of bed in the morning), the things you choose should not present more danger than our normal day-to-day activities.

MAKE IT PROGRESSIVE

Julie decided that the only way she was going to get to a better place was to face her fears directly. We developed a list of social situations Julie was afraid of, and rated each one for how much anxiety she would experience while doing it (on a scale from 0 to 10). The activities ranged from things she was doing already to ones that were difficult for her to imagine doing. We then arranged her activities into a hierarchy; an abbreviated version looked like this:

ACTIVITY	DISTRESS LEVEL (0–10)
Giving a presentation at work	9
Going on a date	8
Going out with friends from work	7
Speaking up in team meetings	6
Going to a movie with a friend	5
Telling supervisor my ideas	4
Making conversation with grocery cashier	2

As you can see from her hierarchy, Julie's activities range from low to high anxiety (from bottom to top), and there are no big jumps between levels. Ideally, we want to create a hierarchy like a ladder, with rungs that are relatively evenly spaced.

As we work through our hierarchy, it's important that we stay in a situation long enough to learn something new. If we run away at the first feeling of discomfort, we'll be reinforcing our avoidance behavior and the belief that had we stayed, things could have been really bad. It's nice if our fear goes down during the exposure itself, although, as recent research by Michelle Craske and others has shown, it doesn't have to for the exercise to be helpful.

Are there situations you've fled because you had a spike in your anxiety? What do you think would've happened had you stayed?

ELIMINATE UNNECESSARY PROPS

"I'm realizing how much of what I've been doing isn't necessary," Julie told me. "For instance, I always thought I had to type out a draft of what I was going to say in our team meetings. I'd go over it beforehand and memorize it as best I could. But then when I was talking, I'd either read what I'd written, which didn't make me sound very dynamic, or I'd try to remember it and get flustered if I forgot."

Julie described other things she would do to prevent her fears from coming true; for example, when she got together with friends, she preferred to go to a movie instead of dinner to avoid the possibility of "awkward silences."

I asked her what she's learned from letting go of some of these behaviors.

"I feel like Dumbo!" she said. I looked at her quizzically, and she continued. "He could fly because he had huge ears, but he thought he could fly because of the

EMBRACE DISCOMFORT AND UNCERTAINTY

"How'd your presentation go?" I asked Julie. She had worked up to the highest item on her hierarchy, which involved giving a presentation about her team's project in front of the entire firm.

"Worse than I expected," she told me, "and yet better than I expected." She continued, "I thought it was just going to be the people in our firm. But, before the meeting, Kevin pulled me aside and told me it was also going to be a kind of dog-and-pony show for current and potential investors. I didn't realize I was basically going to be pitching a project for funding. So my anxiety was worse than I'd expected—if there was an 11 on the scale, I'd have been there."

"So how'd it go?" I asked her.

"I just decided to treat it as an opportunity, and to lean into the anxiety instead of trying to make it go away. And really, what was I gonna do? Not give the presentation? So I just said to myself, 'This is not a comfortable situation for me, and I have no idea how it's going to go. Let's see where this takes me.' And it went all right. I was terrified at first, but it got easier as I went along. And it looks like we'll have new investors for the project."

When we do what we're afraid of, it's almost certainly going to be uncomfortable. We can resist that discomfort, or we can choose to embrace it. When we accept that it's going to be scary, the fear has less power over us. It will be uncomfortable—no better, and no worse. Just uncomfortable.

We can lean into uncertainty just as we lean into discomfort. Rather than backing away from unknowns, we can tell ourselves, "I don't know what will happen, and I'm willing to do it anyway."

Tailoring Exposure for Different Fears

While the general principles of exposure therapy hold for various types of anxiety, we can increase its effectiveness by adapting it for specific conditions.

SPECIFIC PHOBIAS

Exposure for specific phobias tends to be the most straightforward. In many cases, a single extended exposure session can effectively treat the condition. For example, one study found that, for 90 percent of people who did the treatment, about two hours of exposure led to lasting improvement or even complete recovery. The protocol can also be effective when done without therapist assistance.

Exposures for phobias should allow you to test the assumptions you have about what will happen when you interact with the thing or situation you fear. For example, if you're afraid you'll get stuck in an elevator, riding an elevator allows you to test that prediction.

If you struggle with a phobia, what do you think will happen if you confront it?

Keep these predictions in mind. They'll come in handy when you make your own exposure hierarchy later in this chapter.

is not dangerous (just very distressing). We can further test our beliefs about panic through exposure exercises.

What are some of the beliefs you have about what will happen if you panic? Have some of these fears been hard to counter simply through challenging your thoughts? For example, do you expect something bad to happen (other than the panic itself)?

When you design your exposure hierarchy, think about the beliefs you have and how you might test them.

Facing Our Fear of Fear. In panic disorder, we often start to fear our own bodies' reactions because they've become associated with panic. For example, we might start to fear having a fast heartbeat because our hearts race during panic; as a consequence, we might start avoiding activities that raise our heart rates, which further reinforces our fear.

Like any activity we avoid out of fear, we can practice approaching physical symptoms to decrease the discomfort they bring. This type of exercise is called interoceptive exposure; common activities and the symptoms they provoke include:

ACTIVITY	SENSATIONS
Breathing through a coffee stirrer for 1 minute	Feelings of suffocation
Running vigorously for 1 minute	Racing/pounding heart; shortness of breath
Taking 10 fast, deep breaths	Hyperventilation; numbness in extremities; feeling "unreal"
Spinning in swivel chair	Dizziness

SOCIAL ANXIETY DISORDER

CBT for social anxiety disorder includes customized techniques to address the specific cognitive components of the condition.

Using Exposures to Test Beliefs. *Julie was afraid that people would be terribly bored and uncomfortable during her presentation. We worked to identify how she would know they were feeling these things—what would they be doing? How would it differ from their behavior when others were speaking to the group?*

During her presentation, Julie forced herself to look up and see how people were responding, even though she was afraid of what she would see. To her pleasant surprise, her coworkers looked about the same as ever. Some were checking their phones, some were listening intently, others were nodding. Being specific about what she expected to see and then comparing her prediction to what actually happened allowed for a fair test of Julie's beliefs. She concluded that her fears were unfounded in this case, and probably in others.

If you'll be doing exposures for social anxiety, be sure to specify what you're afraid will happen and how you'll test whether it did. It's easy to rely on our gut feeling about how things went. If we're prone to a lot of social anxiety, our gut will be biased to believe we did badly.

Consider a social situation you fear and what you're afraid might happen when you confront it. How could you set up an exposure to test your predictions?

If you struggle with social anxiety, can you identify any of your own safety behaviors in social situations? What do you think are the advantages of using these behaviors? The disadvantages?

Turning Attention Outward. *As Julie prepared to do her exposures, we talked about where her attention is in social situations. "I'm usually checking to see how I'm doing," she said. "If I'm paying attention to the other person, it's often to try to see if I'm making them uncomfortable." She laughed. "That's probably why I never remember people's names when we're introduced–I'm just trying to see if this person thinks I'm weird!"*

As we discussed it further, Julie realized focusing on herself only increases her anxiety, which makes her more self-conscious, which leads to even greater anxiety. "What would happen if you stopped focusing on yourself during conversations?" I asked her.

"I don't know," she said. "It might go better. But I also worry I'll be acting weird and making people feel awkward and I won't know it." She agreed to practice taking the spotlight off herself in her social interactions and see what would happen.

Self-focus can be thought of as a type of safety behavior. Like other safety behaviors, it probably doesn't help us and likely makes things worse.

Do you find yourself repeatedly worrying about things? If so, list some of your recent worries in the space below.

Worry as Avoidance. It's hard to make an exposure hierarchy for worries; by definition, the anxiety in generalized anxiety disorder isn't confined to a specific set of situations or objects. Additionally, avoidance may not be as apparent as in conditions like panic disorder or specific phobia. Nevertheless, there is a version of exposure that can be helpful for the worry and *cognitive* avoidance—the effort to push certain fears out of one's mind—that are part of GAD.

The act of worrying itself can be an attempt (usually unintentional) to avoid thinking about really frightening things that could happen. For example, if we're terrified of losing our job and becoming homeless, our minds might cling to worries about things we have more control over, like getting to work on time. If we're afraid of losing our aging parents, we might focus our worries on making sure they take their medication. In the process, our minds are doing their best to push away the really scary image of being homeless, burying a parent, and other frightening prospects.

The problem with pushing things out of our minds is that they tend to come back more often. In one classic study by Daniel Wegner and his fellow researchers, participants were told not to think of a white bear during a five-minute period. Of course, the harder they tried not to think about it, the more often they did.

EXPOSURE HIERARCHY

ACTIVITY	DISTRESS LEVEL (0–10)

Reminders:

- Anxiety goes down when we face it.
- Work through your hierarchy progressively and systematically.
- Stay through discomfort.
- Eliminate unnecessary props and safety behaviors.
- Embrace discomfort and uncertainty.
- _____
- _____
- _____

You can find a copy of this form online at callistomediabooks.com/cbt.

If you had a hard time completing your planned exposures, take heart—many people have a hard time at first, and the vast majority go on to do very well. Review the principles of what makes exposure effective, and choose a more approachable starting point. You might also remind yourself what compelled you to face your fear—what, on the other side, makes the difficulty worthwhile?

Part of the activity plan from last week included monitoring your activities for three days. Take a look at your Daily Activities forms for this week. How do they compare to the Daily Activities forms you completed between weeks 1 and 2? Is there a difference in the overall level of activity? Also examine the Enjoyment and Importance columns: Do you notice any changes? Write your observations below.

Continue to do activities from your list, reviewing week 2 as needed.

How did completing the tasks you scheduled for yourself go over the past week?

If you've continued to struggle with getting things done, what has gotten in your way?

You can review the material in week 5 as needed to address ongoing challenges in this area. Remember to follow the plan closely, especially if you run into difficulty doing your tasks.

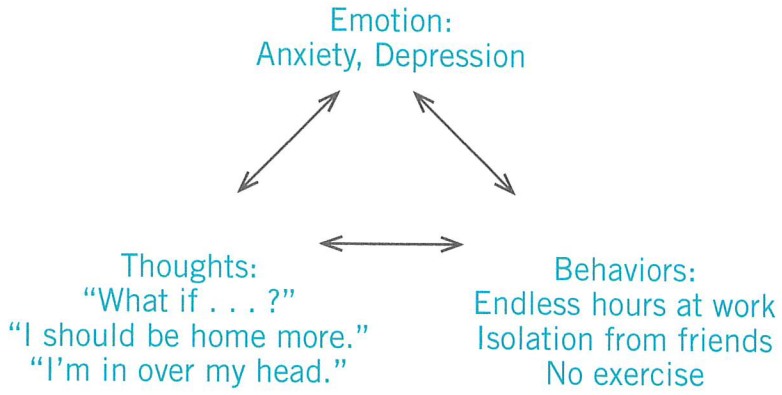
Looking Back

"When I first came here, I thought I was going crazy. Everything seemed to be falling apart, and I felt like I was drowning." John had completed the acute part of his treatment, and we had decided together to cut back our meetings to once every three weeks. In preparation, we reviewed how the treatment had gone for him thus far.

When John called me to discuss treatment options, I recognized his name but couldn't place it. Then I realized I'd seen it on the fleet of plumbing trucks that bore his name driving around the suburbs. John's anxiety had grown with his business, as he realized he was responsible not only for his own family, but for the families of his employees.

Later in this chapter we'll discuss ways to keep moving toward your goals.

John and I had used a CBT framework to understand his situation. At the beginning of treatment, his thoughts, emotions, and behaviors were working against him in a self-perpetuating cycle:



John's anxiety and depression led to his behaviors (isolating himself, no exercise, etc.), which in turn worsened his symptoms. Similarly, his thoughts and symptoms reinforced one another, as did his thoughts and behaviors.

We started with behavioral activation: finding activities to address the lack of reward he was getting from life, the social isolation, and the worsening depression.

We then spent several sessions examining his thoughts—how they were not only unhelpful, but also often untrue. For example, he compared himself unfavorably to his dad, a successful self-employed electrician who never seemed as stressed out as John felt. John came to realize that his dad had far fewer financial commitments and worked in a time when the cost of living was much lower. John also realized that his dad probably felt more stress than John realized as a kid, as John's kids probably weren't aware of his own.

Later sessions focused on time and task management, working to help John invest his time productively so he could spend as much time as possible doing

Think about your experience with each part of the program. Then, consider where you found the most benefit. Which parts do you feel went well? Write your reflections below.

I asked John what changed over the past few weeks. He told me a story. "Last week I was in my office at home, and my four-year-old daughter came in. She was looking for tape or something and didn't realize I was in there. When she saw me, I saw some fear come into her eyes and she started to back out of the room. She'd gotten so used to me being tense and irritable when I was working, so I must've surprised her when I smiled.

"When I did, she actually ran to me and gave me a hug. I scooped her up and we talked for a few minutes, and I felt like I was actually seeing her and hearing her for the first time in as long as I could remember, without a haze of dread and worry clouding everything. Then she hopped down, said, 'Bye, Daddy,' and went back to playing."

John's voice wavered, and his eyes filled with tears. "I couldn't help crying afterward. I was just thinking, 'What's more important than being able to show love to my kids?' I felt such a lightness, where I'd felt a weight before. Now I don't take everything so seriously, and I actually think I'm better at what I do."

Think back over the past six weeks. Does any event stand out that makes you feel like you're moving in the right direction? It could be something that happened at work or with your family or friends. It could be a major development

John also noted areas where he continued to struggle. It was hard not to fall back into worries when a situation came up at work. He also found it easy to skip workouts. While John wasn't exactly where he wanted to be in every way, he felt confident he could use his new tools to continue moving toward his goals.

No matter how much work we put into a CBT program, none of us meets our goals perfectly or feels like "the work is done." In what areas do you want to continue making changes?

Which of the tools from the past six weeks might be helpful in these areas?

Looking Ahead

"Even after all the work I've done over the past few months, I still get waves of anxiety and worry," John said. "But they feel more manageable. It's almost like I feel less anxious because I know I have a way of managing the anxiety."

Based on what he'd found helpful, John and I put together a plan for continuing the progress he'd made. He identified five main factors that led to his feeling

At the same time, beware of subtle ways of losing the ground you've gained. Be especially careful to prevent avoidance, which is powerfully addictive. And while I don't want a person to feel like progress is fragile, it's important to be vigilant for signs of slipping backward so you can employ the tools you have when needed. When in doubt over the next seven weeks (and beyond), err on the side of adhering to the practices that got you better. Remember to refer to your personal plan that summarizes what to do to feel well.

When to Consult a Professional

If you don't feel like this program has helped you—either because it didn't seem to address your struggles or you weren't able to really engage with the program—it may be a good idea to seek professional help. While many people are able to benefit from using a book like this one without a therapist's guidance, others require a higher level of care.

The Resources section in the back of this book has websites through which you can find the CBT therapists nearest you. You can also ask your primary care doctor for a recommendation. It's essential that you feel like you have a good working relationship with a therapist, so aim to find a therapist who is a good match for you.

Wherever you find yourself at the end of this program, I encourage you to continue pushing ahead toward the life you want. I wish you the very best in the journey.

FINDING HELP

Association for Behavioral and Cognitive Therapies (ABCT)
Find a CBT Therapist: www.findcbt.org
This website allows you to search for CBT therapists by ZIP code, specialty, and accepted insurance.

Psychological Treatments:
www.abct.org/Information/?m=mInformation&fa=_psychoTreatments
This website from the leading professional organization for CBT therapists covers topics like evidence-based practice, treatment options, and choosing a therapist.

Society of Clinical Psychology (SCP)
Research-Supported Treatments: http://www.div12.org/psychological-treatments/
Division 12 of the American Psychological Association, the Society of Clinical Psychology (SCP), maintains a list of research-supported psychological treatments. The website is searchable by treatment and psychological condition.

SUPPORT GROUPS

Anxiety and Depression Association of America (ADAA)
http://www.adaa.org/supportgroups
The ADAA provides information about support groups by state (as well as some international listings), including contact information for the support groups.

National Alliance on Mental Illness (NAMI)
www.nami.org/Find-Support
The NAMI website offers ways to find support whether you or a loved one has a psychological disorder. Many additional resources are available on the site, including links to local NAMI chapters.

ANXIETY

Antony, Martin M., and Peter J. Norton. *The Anti-Anxiety Workbook.*

Antony, Martin M., and Richard P. Swinson. *The Shyness and Social Anxiety Workbook: Proven Techniques for Overcoming Your Fears.*

Carbonell, David. *Panic Attacks Workbook: A Guided Program for Beating the Panic Trick.*

Clark, David A., and Aaron T. Beck. *The Anxiety and Worry Workbook: The Cognitive Behavioral Solution.*

Cooper, Hattie C. *Thriving with Social Anxiety: Daily Strategies for Overcoming Anxiety and Building Self-Confidence.*

Hope, Debra A., Richard G. Heimberg, and Cynthia L. Turk. *Managing Social Anxiety: A Cognitive-Behavioral Therapy Approach: Workbook*, 2nd edition.

Leahy, Robert L. *The Worry Cure: Seven Steps to Stop Worry from Stopping You.*

Reinecke, Mark. *Little Ways to Keep Calm and Carry On: Twenty Lessons for Managing Worry, Anxiety, and Fear.*

Robichaud, Melisa, and Michel J. Dugas. *The Generalized Anxiety Disorder Workbook: A Comprehensive CBT Guide for Coping with Uncertainty, Worry, and Fear.*

Tolin, David. *Face Your Fears: A Proven Plan to Beat Anxiety, Panic, Phobias, and Obsessions.*

Tompkins, Michael A. *Anxiety and Avoidance: A Universal Treatment for Anxiety, Panic, and Fear.*

White, Elke Zuercher. *An End to Panic: Breakthrough Techniques for Overcoming Panic Disorder.*

References

Abramson, Lyn Y., Gerald I. Metalsky, and Lauren B. Alloy. "Hopelessness Depression: A Theory-Based Subtype of Depression." *Psychological Review* 96, no. 2 (April 1989): 358–372. doi:10.1037/0033-295X.96.2.358.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5)*. Arlington, VA: American Psychiatric Publishing, 2013.

Antony, Martin M. "Behavior Therapy." In *Current Psychotherapies*, 10th ed., edited by Danny Wedding and Raymond J. Corsini, 193–230. Salt Lake City, UT: Brooks/Cole Publishing, 2013.

Asmundson, Gordon J. G., Mathew G. Fetzner, Lindsey B. DeBoer, Mark B. Powers, Michael W. Otto, and Jasper AJ Smits. "Let's Get Physical: A Contemporary Review of the Anxiolytic Effects of Exercise for Anxiety and Its Disorders." *Depression and Anxiety* 30, no. 4 (April 2013): 362–373. doi:10.1002/da.22043.

Association for Behavioral and Cognitive Therapies. "ABCT Fact Sheets: Guidelines for Choosing a Therapist." Accessed June 20, 2016. http://www.abct.org/Information/?m=mInformation&fa=fs_GUIDELINES_CHOOSING.

Association for Behavioral and Cognitive Therapies. "How It All Began." Accessed June 20, 2016. http://www.abct.org/About/?m=mAbout&fa=History.

Barth, Jürgen, Martina Schumacher, and Christoph Herrmann-Lingen. "Depression as a Risk Factor for Mortality in Patients with Coronary Heart Disease: A Meta-Analysis." *Psychosomatic Medicine* 66, no. 6 (November/December 2004): 802–813. doi:10.1097/01.psy.0000146332.53619.b2.

Chu, Brian C., Daniela Colognori, Adam S. Weissman, and Katie Bannon. "An Initial Description and Pilot of Group Behavioral Activation Therapy for Anxious and Depressed Youth." *Cognitive and Behavioral Practice* 16, no. 4 (November 2009): 408–419. doi:10.1016/j.cbpra.2009.04.003.

Cole-King, A, and K. G. Harding. "Psychological Factors and Delayed Healing in Chronic Wounds." *Psychosomatic Medicine* 63, no. 2 (March–April 2001): 216–220. doi:10.1.1.570.3740.

Cooney, Gary M., Kerry Dwan, Carolyn A. Greig, Debbie A. Lawlor, Jane Rimer, Fiona R. Waugh, Marion McMurdo, and Gillian E. Mead. "Exercise for Depression." *Cochrane Database of Systematic Reviews*, Issue 9 (2013). Art. No.: CD004366. doi:10.1002/14651858.CD004366.pub6.

Cooper, Andrew A., Alexander C. Kline, Belinda P. M. Graham, Michele Bedard-Gilligan, Patricia G. Mello, Norah C. Feeny, and Lori A. Zoellner. "Homework 'Dose,' Type, and Helpfulness as Predictors of Clinical Outcomes in Prolonged Exposure for PTSD." *Behavior Therapy* (2016). doi:10.1016/j.beth.2016.02.013.

Craske, Michelle G., and David H. Barlow. *Mastery of Your Anxiety and Panic: Workbook*, 4th ed. New York: Oxford University Press, 2006.

Craske, Michelle G., Katharina Kircanski, Moriel Zelikowsky, Jayson Mystkowski, Najwa Chowdhury, and Aaron Baker. "Optimizing Inhibitory Learning During Exposure Therapy." *Behaviour Research and Therapy* 46, no. 1 (January 2008): 5–27. doi:10.1016/j.brat.2007.10.003.

Cuijpers, Pieter. "Bibliotherapy in Unipolar Depression: A Meta-Analysis." *Journal of Behavior Therapy and Experimental Psychiatry* 28, no. 2 (June 1997): 139–147. doi:10.1016/S0005-7916(97)00005-0.

Cuijpers, Pim, Tara Donker, Annemieke van Straten, J. Li, and Gerhard Andersson. "Is Guided Self-Help as Effective as Face-to-Face Psychotherapy for Depression and Anxiety Disorders? A Systematic Review and Meta-Analysis of Comparative Outcome Studies." *Psychological Medicine* 40, no. 12 (December 2010): 1943–1957. doi:10.1017/S0033291710000772.

Eysenck, Hans Jurgen. *Behaviour Therapy and the Neuroses*. Oxford: Pergamon, 1960.

Fernie, Bruce A., Marcantonio M. Spada, Ana V. Nikčević, George A. Georgiou, and Giovanni B. Moneta. "Metacognitive Beliefs About Procrastination: Development and Concurrent Validity of a Self-Report Questionnaire." *Journal of Cognitive Psychotherapy* 23, no. 4 (2009): 283–293. doi:10.1891/0889-8391.23.4.283.

Foa, Edna B., and Michael J. Kozak. "Emotional Processing of Fear: Exposure to Corrective Information." *Psychological Bulletin* 99, no. 1 (January 1986): 20–35. doi:10.1037/0033-2909.99.1.20.

Francis, Kylie, and Michel J. Dugas. "Assessing Positive Beliefs About Worry: Validation of a Structured Interview." *Personality and Individual Differences* 37, no. 2 (July 2004): 405–415. doi:10.1016/j.paid.2003.09.012.

Freud, Sigmund. *An Outline of Psycho-Analysis*. New York: W. W. Norton and Company, 1949.

Gawrysiak, Michael, Christopher Nicholas, and Derek R. Hopko. "Behavioral Activation for Moderately Depressed University Students: Randomized Controlled Trial." *Journal of Counseling Psychology* 56, no. 3 (July 2009): 468–475. doi:10.1037/a0016383.

Gellatly, Judith, Peter Bower, Sue Hennessy, David Richards, Simon Gilbody, and Karina Lovell. "What Makes Self-Help Interventions Effective in the Management of Depressive Symptoms? Meta-Analysis and Meta-Regression." *Psychological Medicine* 37, no. 9 (September 2007): 1217–1228. doi:10.1017/S0033291707000062.

Gillihan, Seth J., E. A. Hembree, and E. B. Foa. "Behavior Therapy: Exposure Therapy for Anxiety Disorders." In *The Art and Science of Brief Psychotherapies: An Illustrated Guide*, edited by Mantosh J. Dewan, Brett N. Steenbarger, and Roger P. Greenberg, 83–120. Arlington, VA: American Psychiatric Publishing, 2012.

Gillihan, Seth J., and Edna B. Foa. "Exposure-Based Interventions for Adult Anxiety Disorders, Obsessive-Compulsive Disorder, and Posttraumatic Stress Disorder." In *The Oxford Handbook of Cognitive and Behavioral Therapies*, edited by Christine Maguth Nezu and Arthur M. Nezu, 96–117. New York: Oxford University Press, 2015.

Homer. *The Odyssey, Book XII*, translated by Samuel Butler. Accessed June 23, 2016. http://classics.mit.edu/Homer/odyssey.12.xii.html.

Hopko, Derek R., C. W. Lejuez, and Sandra D. Hopko. "Behavioral Activation as an Intervention for Coexistent Depressive and Anxiety Symptoms." *Clinical Case Studies* 3, no. 1 (January 2004): 37–48. doi:10.1177/1534650103258969.

Kaufman, Joan, Bao-Zhu Yang, Heather Douglas-Palumberi, Shadi Houshyar, Deborah Lipschitz, John H. Krystal, and Joel Gelernter. "Social Supports and Serotonin Transporter Gene Moderate Depression in Maltreated Children." *Proceedings of the National Academy of Sciences of the United States of America* 101, no. 49 (December 2004): 17,316–17,321. doi:10.1073/pnas.0404376101.

Kazantzis, Nikolaos, Craig Whittington, and Frank Dattilio. "Meta Analysis of Homework Effects in Cognitive and Behavioral Therapy: A Replication and Extension." *Clinical Psychology: Science and Practice* 17, no. 2 (June 2010): 144–156. doi:10.1111/j.1468-2850.2010.01204.x.

Kazdin, Alan E. "Evaluation of the Automatic Thoughts Questionnaire: Negative Cognitive Processes and Depression Among Children." *Psychological Assessment: A Journal of Consulting and Clinical Psychology* 2, no. 1 (March 1990): 73–79. doi:10.1037/1040-3590.2.1.73.

Keeley, Mary L., Eric A. Storch, Lisa J. Merlo, and Gary R. Geffken. "Clinical Predictors of Response to Cognitive-Behavioral Therapy for Obsessive-Compulsive Disorder." *Clinical Psychology Review* 28, no. 1 (January 2008): 118–130. doi:10.1016/j.cpr.2007.04.003.

Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Doreen Koretz, Kathleen R. Merikangas, A. John Rush, Ellen E. Walters, and Philip S. Wang. "The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (NCS-R)." *Journal of the American Medical Association* 289, no. 23 (June 2003): 3095–3105. doi:10.1001/jama.289.23.3095.

Kessler, Ronald C., Patricia Berglund, Olga Demler, Robert Jin, Kathleen R. Merikangas, and Ellen E. Walters. "Lifetime Prevalence and Age-of-Onset Distributions of *DSM-IV* Disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry* 62, no. 6 (June 2005): 593–602. doi:10.1001/archpsyc.62.6.593.

Leary, Mark R., and Sarah Meadows. "Predictors, Elicitors, and Concomitants of Social Blushing." *Journal of Personality and Social Psychology* 60, no. 2 (February 1991): 254–262. doi:10.1037/0022-3514.60.2.254.

Lejuez, C. W., Derek R. Hopko, Ron Acierno, Stacey B. Daughters, and Sherry L. Pagoto. "Ten Year Revision of the Brief Behavioral Activation Treatment for Depression: Revised Treatment Manual." *Behavior Modification* 35, no. 2 (March 2011): 111–161. doi:10.1177/0145445510390929.

Liu, Xinghua, Sisi Wang, Shaochen Chang, Wenjun Chen, and Mei Si. "Effect of Brief Mindfulness Intervention on Tolerance and Distress of Pain Induced by Cold-Pressor Task." *Stress and Health* 29, no. 3 (August 2013): 199–204. doi:10.1002/smi.2446.

Löwe, Bernd, Kurt Kroenke, Wolfgang Herzog, and Kerstin Gräfe. "Measuring Depression Outcome with a Brief Self-Report Instrument: Sensitivity to Change of the Patient Health Questionnaire (PHQ-9)." *Journal of Affective Disorders* 81, no. 1 (July 2004): 61–66. doi:10.1016/S0165-0327(03)00198-8.

Ma, S. Helen, and John D. Teasdale. "Mindfulness-Based Cognitive Therapy for Depression: Replication and Exploration of Differential Relapse Prevention Effects." *Journal of Consulting and Clinical Psychology* 72, no. 1 (February 2004): 31–40. doi:10.1037/0022-006X.72.1.31.

Martin, Alexandra, Winfried Rief, Antje Klaiberg, and Elmar Braehler. "Validity of the Brief Patient Health Questionnaire Mood Scale (PHQ-9) in the General Population." *General Hospital Psychiatry* 28, no. 1 (January–February 2006): 71–77. doi:10.1016/j.genhosppsych.2005.07.003.

McClatchy, Steve. *Decide*. Hoboken, NJ: Wiley, 2014.

McLean, Carmen P., Anu Asnaani, Brett T. Litz, and Stefan G. Hofmann. "Gender Differences in Anxiety Disorders: Prevalence, Course of Illness, Comorbidity and Burden of Illness." *Journal of Psychiatric Research* 45, no. 8 (August 2011): 1027–1035. doi:10.1016/j.jpsychires.2011.03.006.

Rachman, Stanley. *The Effects of Psychotherapy*. Oxford: Pergamon Press, 1971.

Redmoon, Ambrose. "No Peaceful Warriors." *Gnosis Journal*, Fall 1991.

Robustelli, Briana L., Anne C. Trytko, Angela Li, and Mark A. Whisman. "Marital Discord and Suicidal Outcomes in a National Sample of Married Individuals." *Suicide and Life-Threatening Behavior* 45, no. 5 (October 2015): 623–632. doi:10.1111/sltb.12157.

Rothbaum, Barbara, Edna B. Foa, and Elizabeth Hembree. *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook*. New York: Oxford University Press, 2007.

Schmidt, Norman B., and Kelly Woolaway-Bickel. "The Effects of Treatment Compliance on Outcome in Cognitive-Behavioral Therapy for Panic Disorder: Quality Versus Quantity." *Journal of Consulting and Clinical Psychology* 68, no. 1 (February 2000): 13–18. doi:10.1037/0022-006X.68.1.13.

Sheldon, Kennon M., and Andrew J. Elliot. "Goal Striving, Need Satisfaction, and Longitudinal Well-Being: The Self-Concordance Model." *Journal of Personality and Social Psychology* 76, no. 3 (March 1999): 482–497. doi:10.1037/0022-3514.76.3.482.

Skinner, Burrhus Frederic. *The Behavior of Organisms: An Experimental Analysis*. Cambridge, MA: B. F. Skinner Foundation, 1991.

Solomon, Laura J., and Esther D. Rothblum. "Academic Procrastination: Frequency and Cognitive-Behavioral Correlates." *Journal of Counseling Psychology* 31, no. 4 (October 1984): 503–509. doi:10.1037/0022-0167.31.4.503.

Spek, Viola, Pim Cuijpers, Ivan Nyklícek, Heleen Riper, Jules Keyzer, and Victor Pop. "Internet-Based Cognitive Behaviour Therapy for Symptoms of Depression and Anxiety: A Meta-Analysis." *Psychological Medicine* 37, no. 3 (March 2007): 319–328. doi:10.1017/S0033291706008944.

Stathopoulou, Georgia, Mark B. Powers, Angela C. Berry, Jasper A. J. Smits, and Michael W. Otto. "Exercise Interventions for Mental Health: A Quantitative and Qualitative Review." *Clinical Psychology: Science and Practice* 13, no. 2 (May 2006): 179–193. doi:10.1111/j.1468-2850.2006.00021.x.

Westra, Henny A., David J. A. Dozois, and Madalyn Marcus. "Expectancy, Homework Compliance, and Initial Change in Cognitive-Behavioral Therapy for Anxiety." *Journal of Consulting and Clinical Psychology* 75, no. 3 (June 2007): 363–373. doi:10.1037/0022-006X.75.3.363.

Williams, Chris, and Rebeca Martinez. "Increasing Access to CBT: Stepped Care and CBT Self-Help Models in Practice." *Behavioural and Cognitive Psychotherapy* 36, no. 6 (November 2008): 675–683. doi:10.1017/S1352465808004864.

Wolpe, Joseph. "Psychotherapy by Reciprocal Inhibition." *Conditional Reflex: A Pavlovian Journal of Research and Therapy* 3, no. 4 (October 1968): 234–240. doi:10.1007/BF03000093.

World Health Organization. "Media Centre: Depression Fact Sheet." Accessed June 23, 2016. http://www.who.int/mediacentre/factsheets/fs369/en/.

C

Caffeine, avoiding, 133
Calendar. *See* Task management
Career and education
  evaluating, 56
  values and activities, 74
Catastrophes, identifying, 115
CBT (cognitive-behavioral therapy)
  as active treatment, 25
  basing on evidence, 22
  behavior therapy, 16–17
  benefits, 27–28
  breaking loops, 28
  cognitive therapy, 17–19
  and collaboration, 23
  effectiveness of, 25–27
  emphasis on practice, 25
  focus on present, 24
  goal orientation, 23
  integration, 19–22
  and medication, 24
  practicing effects, 28
  principles, 22–25
  programs, 23
  research support, 26
  skills acquisition, 28
  skills orientation, 25
  structure, 24
  targeted exercises, 28
  time limitation, 22
CBT therapist, finding, 205
Challenge Your Thoughts form, 118
Challenges
  meeting in future, 197–198
  reviewing, 156, 188
Changes
  continuing work on, 195
  evaluating, 194
  making and evaluating, 27
  nature of, 58
Checklists, anxiety, 38–40
Clinical depression, 43
Clonazepam, 24
Cognitive therapy, 17–19, 88–89
Competence, human need for, 55
Completing activities, 82
Concentration, monitoring, 47
Core beliefs. *See also* Thoughts
  evaluating, 101–102
  identifying, 123–125
Courage, defining, 170
Craske, Michelle, 36, 167

D

Daily activities
  logging, 65–66
  reviewing, 78–79
Depression
  benefits of exercise for, 81
  Bill as example, 41–42
  causes of, 70
  elusiveness of, 70
  and errors in thinking, 119–120
  melancholic features, 45–46
  online resources, 204
  with peripartum onset, 46
  physical manifestations, 45
  PMDD (premenstrual dysphoric disorder), 44
  scale, 47
  with seasonal pattern, 46
  severity, 45–46
  statistics, 42
  themes, 99–100
  treating with medication, 24
Depressive disorders, 43–46
DeRubeis, Rob, 144
Dietary habits, evaluating, 61
Disability, depression as cause of, 42
Disasters, identifying, 115
Discomfort and uncertainty, facing, 169–170
Dog phobia. *See* Mel's dog phobia
Doing more and feeling better, 71
Domestic responsibilities
  evaluating, 63
  values and activities, 75
Drugs and alcohol, evaluating intake of, 60
DSM-5 (Diagnostic and Statistical Manual of Mental Disorders)
  ADHD (attention deficit hyperactivity disorder), 151
  agoraphobia, 37
  anxiety, 34
  depression with peripartum onset, 46
  GAD (generalized anxiety disorder), 37
  panic disorder, 36–37
  persistent depressive disorder, 43
  phobias, 35
  social anxiety disorder, 35

E

Education and career
  evaluating, 56
  values and activities, 74
Egan, Gerard, 58
Ellis, Albert, 17–19, 27
Embarrassment, concealing, 121. *See also* Social anxiety disorder
Emotions
  depression, 100
  describing, 21
  and panic, 94–95
  reacting to, 88
Errors in thinking. *See also* Thoughts
  addressing loved ones, 116–119
  and anxiety, 121–122
  challenging, 114
  and depression, 119–120

L

Lazarus, Arnold, 17
Lejuez, Carl W., 76
Logging time, 64-66

M

Ma and Teasdale study, 199
Medication, 24
Mel's dog phobia
  described, 30-31
  thoughts and behavior, 32-33
Mindfulness
  online resources, 206
  practicing, 198
  website, 206
Mise en place, 141
Moods
  impact of sleep deficit on, 59
  noticing changes in, 102
  relating to daily activities, 66
Motivation, increasing, 152-153
"Multimodal" therapy, 17

N

NAMI (National Alliance on Mental Illness), 205
Napping, avoiding, 133
Needs, evaluating, 55
Negative thinking. *See also* Positivity, seeing
  distracting, 81
  questioning, 120
Neil's thoughts
  core beliefs, 101-102
  depression, 99-100
  described, 86-87
  identifying, 89-93
  thoughts and emotions, 93
NIMH (National Institute of Mental Health), 204
Nolen-Hoeksema, Susan, 70

O

Observations of activities, writing down, 79
OCD (obsessive-compulsive disorder), 23, 26
Online resources
  anxiety and depression, 204
  finding help, 205
  mindfulness, 206
  support groups, 205
Organizing work area, 147-148
Outcomes, evaluating, 194. *See also* Goals
Overwhelmed, feeling, 152

P

Panic disorder
  beliefs in, 94-95
  dealing with, 162
  effects of, 36
  and exposure therapy, 172-174
  opening to, 174
  statistic, 33
  symptoms, 36-37, 172-173
  therapy, 23, 26
Pavlov, Ivan, 16
Peripartum onset, depression with, 46
Persistent depressive disorder, 43
Phil's treatment
  described, 50-51
  domestic responsibilities, 63
  education and career, 56
  faith/meaning/expansion, 57-58
  physical health, 59-61
  recreation/relaxation, 62
  relationships with family, 53-54
  relationships with friends, 54-55
Phobias. *See also* Specific phobia
  confronting, 171
  statistic, 33
Physical health. *See also* Exercise, benefits for anxiety and depression
  evaluating, 59-61, 77
  values and activities, 75
Planning and completing tasks, 158
PMDD (premenstrual dysphoric disorder), 44
Positivity, seeing, 114-115. *See also* Negative thinking
Present, returning to, 181
Procrastination, dealing with, 150-151
Professional help, seeking, 203
Progress
  looking for, 202
  thinking about, 190
Projects, starting, 146
Prozac, 24
Psychoanalysis, tenets of, 15
Psychological treatments, 205
PTSD (post-traumatic stress disorder), 23
Punctuality, improving, 152
Purpose, considering, 57
"Putting things in place," 141

Q

Questionnaires, reasons for seeking help, 51-52

R

Reality, reflecting accurately, 109
Recreation/relaxation
  evaluating, 62
  values and activities, 75
Redmoon, Ambrose, 170
Relapse, protecting against, 24