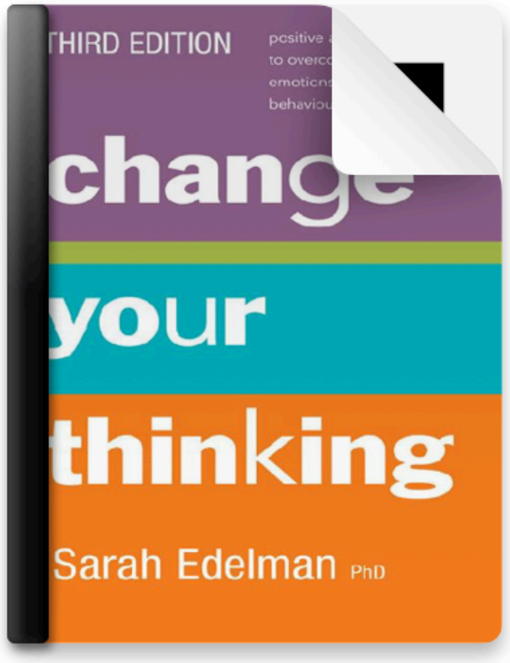
# 10月学习

用CBT认真“想太多”

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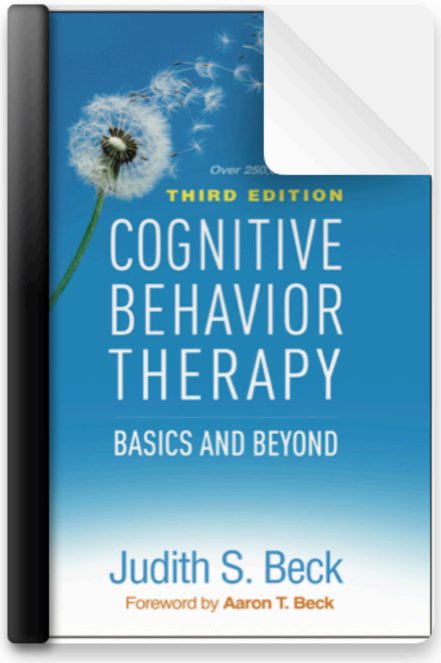


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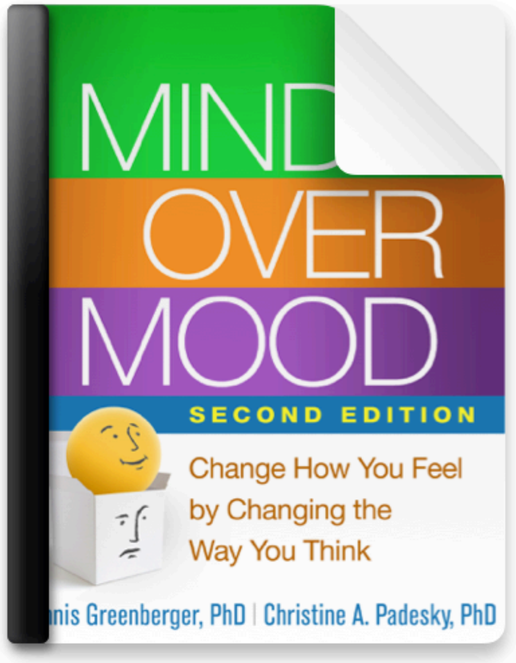


Mind Over Mood.pdf

张海露 Eric🎺

今晚开始10月的学习，这个月读3本CBT相关的书。由于这几天要发2024年社群的广告，尽量减少对读者的打扰，10月课程就不对外开放报名了。

读这几本书，除了了解CBT、应用CBT分析问题、解决问题，我还想把CBT的一些理论和英语学习结合起来。同时提升自己诊断和解决问题的能力，为明年的社群的咨询做准备。

我也希望英语学习者们都读读这类心理学书籍--之前我们读过有关逻辑、思考的书，但我发现当我们底层认知失调时，这些逻辑和思考模型很难发挥作用。CBT不是鸡汤、口号、正能量，是帮我们从认知出发理解行为和情绪，这恰恰也是英语学习者们最需要、最容易忽略的地方。

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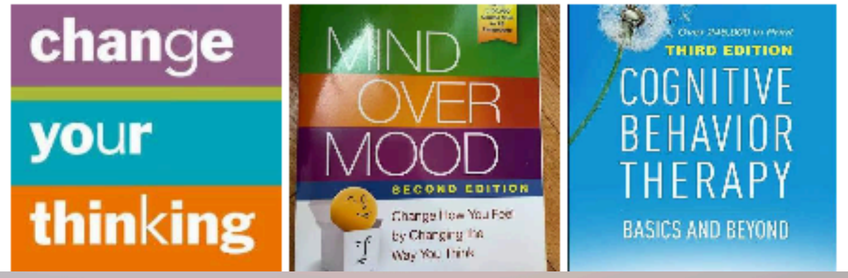

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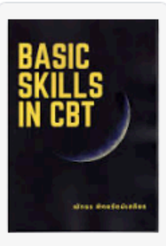


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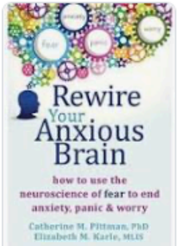


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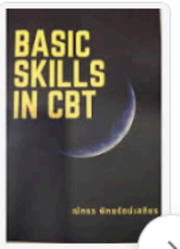


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## Books / Cognitive behavioral therapy

From sources across the web

Overcoming Unwanted In...
Sally M. Winston, 2017


Cognitive Behavior Thera...
Judith S. Beck, 2011

Retrain Your Brain: Cognit...
Seth Gillihan, 2016


Cognitive Behavioural Th...
Seth Gillihan, 2018


Mind Over Mood
Dennis Greenberger, 1995


The CBT Deck: 101 Practi...
Seth Gillihan, 2019

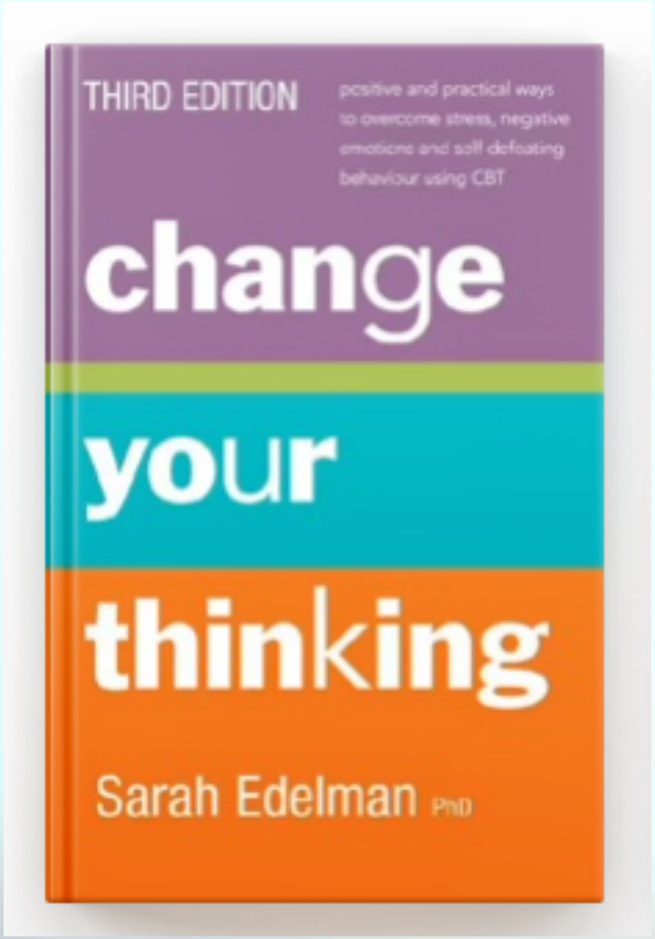

Feeling Good: The New ...
David D. Burns, 1980


Cognitive Behavioral The...
Olivia Telford, 2020


The CBT Couples Toolbox...
Tereza Grubr, 2018

42 more

Feedback




## Contents

# Introduction

‘The greatest discovery of my generation is that a human being can alter his life by altering his attitudes of mind.’

**WILLIAM JAMES (1842–1910)**

Have you ever found yourself ruminating over some issue for hours or days, and later realised that it wasn’t really important after all? Or maybe you have experienced a time when you were feeling upset about a particular issue, and then you talked it over with a friend. They said some things that you hadn’t thought about, and when you took their ideas on board you felt much better? Talking to your friend showed you another way of thinking about your situation, and when you started to think differently, your feelings changed.

Every day we experience situations that demonstrate the simple principle — the way we think determines the way we feel. Things go wrong; people act selfishly; disappointments happen. Whether or not we get upset by them and the degree of distress we feel depends largely on our thinking. Sometimes we can make ourselves feel very miserable, even when our life circumstances are really not that bad, by thinking in a negative, self-defeating way. While we may blame people or life events for our unhappiness, it is actually our perceptions that create our suffering.

This is good news because while we may not be able to change people or our life circumstances, we can change the way we think about them. And if we can learn to think in a healthy balanced way, we can stop upsetting ourselves unnecessarily.

Changing the way we think about things changes the way we feel. This simple concept is a key principle of cognitive behaviour therapy (CBT for short) — an approach that is used in psychological therapy and stress management programs all over the world. (The word 'cognitive' refers to thought processes. Therefore a cognitive therapy is one that helps us to change aspects of our thinking.)

Since the 1970s, CBT has emerged as the most common form of psychological therapy used by mental-health practitioners. This is because studies conducted around the world have shown CBT to be helpful in the management of a wide range of psychological problems, including anxiety, depression, panic attacks, sleep problems, phobias, relationship difficulties, shyness, eating disorders, anger, drug and alcohol abuse, sexual dysfunction, post-traumatic stress disorder, chronic pain, health problems, bipolar disorder and social phobia. While different components of the CBT approach are used for treating different problems, the focus is always on changing cognitions and behaviours.

CBT has been described as a 'living therapy' because it continues to evolve over time. The techniques that make up current CBT treatments have been evaluated at research institutions around the world and their results have been compared to waitlist control groups, other psychological treatments, sham treatments and placebo pills. The findings of these studies are continually being published in psychology journals and presented at conferences. Through this process new treatments are developed, and earlier treatments are modified and improved. Psychologists then update the techniques that they use, based on the findings of the most recent research.

While CBT was originally developed for the treatment of particular disorders, it is now widely used by people wanting to reduce stress and improve their quality of life. CBT strategies are helpful in the management of daily life stressors — from minor hassles to major psychological challenges. Because the principles of CBT are easy to learn, the approach is highly suitable for use as a self-help tool.

In recent years, mindfulness-based techniques have been added to treatments widely used by psychologists. Based on ancient Buddhist practices, mindfulness has been popularised in the West, prompted by the pioneering work of Professor of Medicine Emeritus at the University of Massachusetts, Jon Kabat-Zinn. A large body of research is currently under way examining the effects of mindfulness practices for various psychological conditions. Emerging evidence suggests that mindfulness techniques may augment treatment outcomes when combined with CBT strategies. For this reason a chapter on mindfulness has been added to this edition of *Change Your Thinking*.

This book describes how to apply the principles of CBT to potentially stressful events that arise in our daily life. Readers will learn to recognise some of their own thinking patterns that create unnecessary distress, and they will discover strategies to help modify these. This may involve taking certain actions, as well as challenging some of the thoughts and beliefs that contribute to unhappiness.

Although this book is designed for self-help, it is not a substitute for psychological therapy. If you suffer from a particular psychological problem or disorder (e.g. depression, obsessive compulsive disorder, eating disorder, bipolar disorder, etc.), it is important to receive treatment from a qualified mental-health professional. While *Change Your Thinking* may help to reinforce some of the information provided during treatment, it does not cover specific disorders in detail. Books that describe CBT approaches to managing specific psychological problems are listed in the Recommended Reading section at the end of this book.

# Recommended reading

## Anger


Carter, L. & Minirth, F. (2012). *The Anger Workbook: An interactive guide to anger management*. Tennessee: Nelson.

Schiraldi, G. R. & Hallmark-Kerr, M. (2002). *Anger Management Source Book*. Chicago: Contemporary Books, Inc.


## Anxiety


Antony, M. & Norton, P. (2009). *The Anti-Anxiety Workbook: Proven strategies to overcome worry, phobias, panic and obsessions*. New York: Guilford Press.

Antony, R. & McCabe, R. (2004). *10 Simple Solutions to Panic: How to overcome panic attacks, calm physical symptoms and reclaim your life*. Oakland, CA: New Harbinger Publications.

Brantley, J. (2007). *Calming Your Anxious Mind: How mindfulness and compassion can free you from anxiety, fear and panic*. Oakland, CA: New Harbinger Publications.

Bourne, E. (2005). *The Anxiety and Phobia Workbook*. Oakland, CA: New Harbinger Publications.

Knaus, W. J. & Carlson, J. (2008). *The Cognitive Behavioral Workbook for Anxiety: A step-by-step program*. Oakland, CA: New Harbinger Publications.

Leahy, R. L. (2010). *Anxiety Free: Unravel your fears before they unravel you*. Carlsbad, CA: Hay House Inc.


## Depression


Aisbett, B. (2000). *Taming the Black Dog: A guide to overcoming depression*. Sydney: HarperCollins Publishers.

Gilbert, P. (2009). *Overcoming Depression: A self-help guide using cognitive behavioral techniques*. London: Robinson Publishing.

Greenberger, D. & Padesky, C. A. (1995). *Mind Over Mood: Change how you feel by changing the way you think*. New York: Guilford Press.

Parker, G. (2004). *Dealing with Depression: A commonsense guide to mood disorders*. Sydney: Allen & Unwin.

Tanner, S. & Ball, J. (2012). *Beating the Blues*. Sydney: NewSouth Books.

Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007). *The Mindful Way through Depression*. New York: Guilford Press.


**Effective communication**


Alberti, R. E. & Emmons, M. L. (2008). *Your Perfect Right* (9th ed.). San Luis Obispo, CA: Impact Publishers.

McKay, M., Fanning, P. & Paleg, K. (2006). *Couple Skills*. Oakland, CA: New Harbinger Publications.

McKay, M., Davis, M. & Fanning, P. (2009). *Messages*. Oakland, CA: New Harbinger Publications.

Paterson, R. J. (2000). *The Assertiveness Workbook*. Oakland, CA: New Harbinger Publications.


**Generalised anxiety disorder; worry**


Forsyth, J. P. & Eifert, G. H. (2007). *The Mindfulness and Acceptance Workbook for Anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger Publications.

Gyoerkoe, K. L., Wiegartz, P. S. (2006). *10 Simple Solutions to Worry: How to calm your mind, relax your body, and reclaim your life*. Oakland, CA: New Harbinger Publications.

Leahy, R. L. (2005). *The Worry Cure: Seven steps to stop worry from stopping you*. New York: Harmony.


**Mindfulness meditation**


Brantley, J. (2007). *Calming Your Anxious Mind: How mindfulness and compassion can free you from anxiety, fear and panic*. Oakland, CA: New Harbinger Publications.

Kabat-Zinn, J. (2012). *Mindfulness for Beginners*. Boudler, CO: Sounds True.

Williams, M. & Penman, D. (2011). *Mindfulness: Finding peace in a frantic world*. London: Piatkus.

Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007). *The Mindful Way through Depression*. New York: Guilford Press.


**Motivation**


Burka, J. B. & Yuen, L. M. (2008). *Procrastination: why you do it, what to do about it now*. Cambridge, MA: De Capo Press.

Emmett, R. (2000). *The Procrastinator's Handbook: Mastering the art of doing it now*. Toronto: Doubleday Canada.

Pink, D. H. (2011). *Drive: The surprising truth about what motivates us*. New York: Riverhead Books.


**Obsessive compulsive disorder**


De Silva, P. & Rachman, S. (2009). *Obsessive-Compulsive Disorder: The facts* (4th ed.). New York: Oxford University Press.

Foa, E. B. & Wilson, R. (2001). *Stop Obsessing: How to overcome your obsessions and compulsions*. London: Bantam Books.

Hyman, B. & Pedrick, C. (2010). *The OCD Workbook: Your guide to breaking free from obsessive compulsive disorder*. Oakland, CA: New Harbinger Publications.

St Clare, T., Menzies, R. & Jones, M. K. (2008). *DIRT [Danger Ideation Reduction Therapy] for Obsessive Compulsive Washers: A comprehensive guide to treatment*. Bowen Hills, QLD: Australian Academic Press.

Vaccaro, L. D., Jones, M. K., Menzies, R. G. & St Clare, T. (2010). *DIRT [Danger Ideation Reduction Therapy] for Obsessive Compulsive Checkers: A comprehensive guide to treatment*. Bowen Hills, QLD: Australian Academic Press.


**Panic attacks**


Aisbett, B. (2000). *Living With It: A survivor's guide to panic attacks*. Sydney: HarperCollins Publishers.

Bassett, L. (1997). *From Panic to Power: Proven techniques to calm your anxieties, conquer your fears and put you in control of your life*. New York: Harper Perennial.

Page, A. C. (2002). *Don't Panic: Anxiety, phobias and tension*. Sydney: ACP & Media 21.

Silove, D. & Manicavasagar, V. (2009). *Overcoming Panic: A self-help guide using cognitive behavioral techniques*. London: Robinson.


**Perfectionism**


Antony, M. & Swinson, R. (1998). *When Perfect Isn't Good Enough: Strategies for coping with perfectionism*. Oakland, CA: New Harbinger Publications.

Shafran, R., Egan, S. & Wade, T. (2010). *Overcoming Perfectionism: A self-help guide using cognitive behavioural techniques*. London: Constable & Robinson.


**Self-esteem**


Fennell, M. (2009). *Overcoming Low Self-esteem: A self-help guide using cognitive behavioral techniques*. London: Robinson.

McKay, M. & Fanning, P. (2000). *Self-Esteem*. Oakland, CA: New Harbinger Publications.

McKay, M. & Fanning, P. (2005). *The Self-Esteem Companion*. Oakland, CA: New Harbinger Publications.

Schiraldi, G. R. (2001). *The Self-Esteem Workbook*. Oakland, CA: New Harbinger Publications.

ONE

# Cognitive Behaviour Therapy (CBT)

'We are what we think. All that we are arises with our thoughts. With our thoughts we make the world.'

**BUDDHA**

## CBT STRATEGIES

CBT strategies comprise the following:

**Cognitive strategies:** learning to recognise the negative thinking habits that create distress, and using various techniques to develop more reasonable ways of thinking.

**Behavioural strategies:** undertaking various behaviours that help us to change the way we think and feel. These include behavioural experiments, repeated exposure to feared situations, practising deep relaxation and breathing techniques, problem solving, goal setting, using assertive communication, utilising social support and activity scheduling.

In recent years a third component has been added to many CBT treatments:

**Mindfulness strategies:** bringing one's full attention to present-moment experiences with an attitude of openness and curiosity. This may include awareness of one's breath, thoughts, emotions or body sensations as they arise. Through meditation and mindful attention during daily life experiences, thoughts come to be seen as objects of the mind rather than 'reality' or 'truth' (see Chapter 12 on Mindfulness).

## COGNITIONS

Our **cognitions** are mental processes including the thoughts, beliefs and attitudes that we operate with on a daily basis. Some of our cognitions are conscious, or may be brought to conscious awareness through brief reflection. Other cognitions are unconscious, and may require more specific processing in order to be brought to awareness. Still others will always remain unconscious.

While they are related, our thoughts and beliefs are not the same thing. **Thoughts** are transient and often conscious. It has been estimated that the average person has between 4,000 and 7,000 thoughts each day. Most of the time we are not aware that we are thinking; however, if we are to stop and observe our current thoughts we can usually identify their presence. Our thoughts influence the way we feel and behave.

**Beliefs** are reasonably stable and usually unconscious assumptions that we make about ourselves, others and the world. Although we can sometimes consciously think about our beliefs and even challenge their validity, we don't do this most of the time. Our beliefs influence the contents of our thoughts, as well as our emotions and behaviours.

> *Bob narrowly avoids a car accident when another motorist fails to give way to him. As he gestures angrily at the other driver, Bob thinks to himself, 'Stupid idiot!'*
>
> Bob's thoughts are easy to identify — 'Stupid idiot!' But what about the beliefs that gave rise to them? Like many people, Bob believes that *others should always do the right thing* — and, in particular, *they should obey the road laws*. In fact, it was this belief, and not the other person's poor driving, that made Bob feel angry. If Bob only held a preference that people should obey the road laws rather than a belief that they *must always* do so, Bob would have responded with brief irritation rather than anger. Similarly, if you believe that people must always do the right thing, chances are you are going to get upset on occasions when they don't.

## EMOTIONS

We all know what it feels like to be happy, sad, fearful, angry, disgusted or surprised, but what exactly are emotions? They are actually difficult to define. In general terms, emotions can be described as the way we **feel** in our mind and body in response to events that occur. They originate from a **trigger**, which may be:

- an *external event* (e.g. noise from next door; a comment from a friend) or
- an *internal event* such as a *body sensation* (e.g. tightness in the chest, surge of heat) or a *thought* (e.g. 'I said a silly thing', 'I will be alone all day', 'I did a great job').

The resulting emotions include a combination of cognitive appraisals and physiological responses.

**Cognitive appraisal** (the way we think about things) is based on the meaning that we give to the event. So, for instance, if your friend has not returned your call, you may feel angry ('She only calls when she needs something'), worried ('I hope she's OK'), indifferent ('She's so busy; I'll need to call her again') or hurt ('She doesn't care about me'). Our appraisals can be brought to consciousness quite readily; however, sometimes it may be difficult to identify what we are perceiving at the time (for instance, when you feel upset, scared or annoyed but don't know why).

**Physiological response** (e.g. increased heart rate; tightness in tummy muscles or chest; feelings of heat, arousal, heaviness, etc) — as emotions always involve physical sensations, to get in touch with emotions, people are often encouraged to 'notice what's happening in your body'.

Emotions evolved as signals to motivate behaviours and help us to survive. By feeling pleasant (e.g. happiness, love, excitement) or unpleasant (e.g. anxiety, guilt, hurt, despair), they direct our attention to issues we perceive to be significant, and motivate us to respond by *doing* something. As we want to experience pleasant emotions and avoid unpleasant ones, both types of emotion play a role in motivation, although the desire to avoid unpleasant emotions is the stronger motivator.

**Unpleasant emotions** alert us to issues that need our attention, and motivate us to address them. Doing so helps us to achieve things that contribute to our wellbeing.

For example:

- Kirstin's anxiety motivates her to work on her essay over the weekend.
- Neil's anger motivates him to communicate assertively with his supervisor.
- Corrine's loneliness motivates her to join a singles group.
- Sid's guilt motivates him to turn off the TV and take his children to the park.

Sometimes, however, we respond to unpleasant emotions by trying to numb them, rather than addressing the issue they are alerting us to. Our actions may provide short-term relief but do not address the original problem and, consequently, the unpleasant emotions continue to dog us.

For example:

- Cheryl procrastinates doing her tax because she finds it boring.
- Laura avoids medical appointments because of anxiety about her health.
- Leonie numbs anger and fear by playing on poker machines.
- Chris avoids social situations because they make him feel sad and inadequate.
- Jim responds to feelings of guilt by drinking to excess.

**Pleasant emotions** are sometimes the 'carrot' that motivates us to make sacrifices in the 'now'. Behaviours such as working long hours, cleaning the house, going to the gym or putting in a long day with the kids are often done in the knowledge that rewards (feeling good) will come later. Pleasant emotions, such as joy, personal satisfaction, feelings of security or self-worth are the long-term rewards that motivate us to put our current desires on hold. However, as with unpleasant emotions, their pursuit can also motivate us to engage in self-defeating behaviours. This may happen when we pursue short-term rewards at the expense of longer-term benefits, such as living beyond our means, partying too hard or pursuing an exciting romance that we know is going to end in tears.

### Cognitions affect emotions

Our cognitive appraisals — the ways we think about the things happening in our lives — determine our emotions. Some examples are demonstrated below:

| COGNITION | EMOTION |
|---|---|
| Something bad might happen. | anxiety |
| They did a bad thing and they shouldn't be able to get away with it. | anger |
| I did a bad thing, and I deserve to be punished. | guilt |
| Things are going really well for me. | contentment |
| I have lost something that I value. | sadness |
| The world is a bad place, I am a worthless person, and the future is hopeless. | depression |
| I did an immoral thing and people think badly of me. | shame |
| Things are not going the way that they should. | frustration |
| Something good is going to happen. | excitement |
| That is repulsive. | disgust |
| I am inferior to others. | inadequacy |
| I am a bad person. | self-loathing |

| | |
|---|---|
| That's not what I expected. | surprise |
| S/he does things to deliberately hurt me. | contempt |

**Emotions affect cognitions**

Not only do our cognitions influence our emotions, but our emotions also influence our cognitions. Indeed, the 'content' of our thoughts and the meanings we give to current events is shaped by the emotions we are experiencing at the time. So, for example, when we feel angry, many of our thoughts focus on perceived injustice and desire for revenge. When we feel depressed we interpret events in a negative way, often perceiving failure, hopelessness and rejection where it does not exist. When we feel anxious we focus on threats, and start to perceive dangers in situations we would normally view as harmless.

## BEHAVIOURS

Behaviours include the way we respond in specific situations, as well as our regular habits and routines. Our cognitions play a central role in influencing our behaviours. Below are some examples:

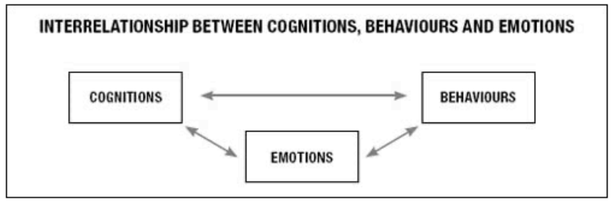
| COGNITION | BEHAVIOURS |
|---|---|
| I must be loved and approved of by everyone. | Excessively try to please others; avoid assertive behaviour. |
| I must do things perfectly. | Procrastinate; perform slowly and inefficiently. |
| Making mistakes is an opportunity to learn — it's not a catastrophe. | Willing to try again — several times, if necessary — to reach goals. |
| People should do what I believe is right. | Unfriendly or hostile towards those who do not meet expectations. |
| I am likeable and worthwhile. People respond positively towards me. | Willing to reach out to people, initiate friendships and take social risks. |
| My life should be easy — I shouldn't do things that are difficult or not enjoyable. | Avoid activities that are challenging or unpleasant, even if they are for the best. |
| I am incompetent. | Avoid trying to learn new things. |
| I must have someone stronger than myself whom I can rely on; I can't cope on my own. | Stay in unhealthy, loveless or destructive relationships; tolerate abusive treatment. |
| I can get anything I want if I'm willing to work hard towards it. | Willing to spend time and effort in working towards goals. |
| If I want something, I must have it immediately. | Engage in addictive behaviour, such as drinking alcohol, smoking, taking drugs, poor diet, etc. |
| Everyone is trying their best. No one deserves to be judged or condemned. | Get on well with most people. |
| I am flawed; I am not OK. | Self-monitoring in social interactions; avoid eye contact; avoid taking social |

### THE INDIRECT EFFECT OF BEHAVIOUR ON THE WAY WE FEEL — VIA COGNITIONS

Many of our behaviours serve to reinforce existing cognitions. For instance, avoiding social contact with other people can reinforce the belief that we are not OK, or that people don't like us. This in turn may lead to feelings of loneliness, depression or poor self-esteem. Behaving unassertively much of the time may reinforce the belief that it's not acceptable to ask for what we want. The behaviour reinforces our feelings of inadequacy. Choosing to avoid situations that we fear reinforces the belief that those situations are highly threatening. As a result, we feel anxious whenever we need to confront those situations. Trying to do things perfectly all the time reinforces the belief that everything we do must be perfect. As a consequence, we become anxious or immobilised in situations where we may not be able to do a perfect job.

Conversely, changing some of our behaviours can help us to think differently about our situation, and feel better as a result. For instance, initiating social contact may help to challenge the belief that we are incapable of making friends, and our new cognition — 'I can make friends when I make the effort' — may cause us to feel better about ourselves. Confronting some of the things we fear — the dreaded social function, the speech or that unpleasant phone call — can lead us to stop perceiving those situations as highly threatening, and our revised cognitions — 'I can handle it; it's not so bad' — help to reduce our anxiety in those situations. Completing some tasks less than perfectly can help us to recognise that things don't have to be perfect, and this revised belief frees us from unnecessary anxiety. Communicating assertively in order to resolve a conflict can make us to realise that we are capable of solving certain problems, and to feel happier as a result. Doing certain things that we keep putting off (e.g. doing your tax return, having the in-laws for dinner, painting the bedroom) can help us to recognise that they are not so bad after all, and so reduces our guilt and frustration, and increases our confidence. And, believe it or not, being nice to someone we dislike can enable us to perceive them more positively and feel more comfortable in their presence. All of these behaviours can help us to feel better through their influence on our cognitions (see also Chapter 3).

Cognitions, emotions and behaviours interact with and influence each other. Understanding the interrelationship is helpful because it reminds us that making a positive change in one of these areas will have a positive effect on the others. The strategies described in the following chapters provide ways in which such changes can be made.



## WHY DO WE THINK THE WAY WE DO?

As cognitions play such an important role in the way we feel and behave, the question arises: 'Why do I think this way?' And why is it that some people think in a healthy, balanced way most of the time, while others have negative, biased and self-defeating perceptions much of the time?

The answer lies in the various influences that have shaped our thinking over the course of our lives. Most important of these are:

- early infancy — the bonds that were formed with our parents during our infancy, based on their love, availability and responsiveness to our needs;
- childhood experiences — the messages we received from our parents, as well as significant others (e.g. grandparents, siblings, teachers, school friends, etc.) during childhood and adolescence; and
- temperament — aspects of our personality that are innate (i.e. biologically determined).

Events that occur early in our lives influence the way we subsequently think and feel. Individuals who were fortunate enough to have loving, emotionally attuned, sensible parents are more likely develop the capacity for dealing with stress or adversity, compared to those who were not. At the other end, those who experienced neglect, trauma or abuse during childhood are more likely to suffer emotional difficulties later in life. However, while early life experiences play an important role, even those who had good parenting may develop psychological problems because temperament (see below) also influences the way we think and feel. Conversely, some individuals who suffered adversity in childhood manage to develop a healthy psychological outlook in adulthood due to their inherently resilient nature.

In addition to early life experiences, other factors at various stages of life also influence our thinking. These include:

- key relationships throughout our lives, including our partners, friends, family members and work colleagues;
- significant experiences, including achievements, losses, failures, successes and rejections;
- the accumulated messages we receive from the popular culture via social media, TV, billboards, magazines, newspapers and cinema; and
- the knowledge and information we acquire through various sources, including the internet, reading, courses and educational institutions.

### The role of temperament

While there is no gene for negative thinking, biological factors influence the way we respond to situations, and the meanings we give to them. Our **temperament** is the biologically determined component of our personality.

Aspects of temperament are often visible in early childhood, sometimes as early as just a few months of age. Some people are born with a nervous system that is very sensitive to change or threats, and are therefore particularly prone to experiencing upsetting emotions like anxiety, depression and anger. Some have a highly anxious temperament and therefore perceive lots of neutral events as threatening ('Why is that van driving in this street?'; 'Why is my right cheek so red?'). Others have a melancholic temperament, and are therefore more likely to perceive themselves and their experiences in a negative way ('I have achieved very little today'; 'I have failed yet again'). Some are introverted by nature, and may therefore be particularly shy or sensitive in social situations. They may, for instance, perceive rejection or disapproval in response to neutral social situations ('Why did they sit over there, and not next to me?'; 'He just looked away — he is obviously bored with me'; 'She laughs when speaking to my colleagues, but not when she

speaks to me'). And some people have an irritable temperament, which makes them more likely to overreact or get angry in situations that might not bother others.

Although biology can influence our psychological disposition, this does not mean that negative feelings are unavoidable. People who have a biological disposition towards cardiovascular disease do not necessarily end up having a heart attack or stroke. However, they need to work harder than others at maintaining a healthy diet, getting regular exercise and reducing cholesterol levels. Similarly, those with a temperament that increases their likelihood of experiencing upsetting emotions need to work harder at managing their cognitions and responses compared to those with a resilient temperament. CBT strategies can help us develop greater cognitive flexibility, and therefore increase our resilience. Doing so will reduce the frequency and intensity of upsetting emotions, and enable us to recover faster in situations where we do get upset.

**Messages from society**

Many of the messages we receive from popular culture contribute to unhappiness by influencing our beliefs. Communications via social media, TV, movies, billboards and magazines promote the importance of things like:

- having wealth and material possessions;
- popularity — having lots of friends;
- career success — having a high-status, well-paid job;
- being young and attractive; and
- having happy, harmonious family relationships.

People buy into these messages to different degrees. Many believe that to be successful they must have a highly paid job and own expensive consumer items, or that they must be slim and youthful in appearance or have lots of friends. The more strongly we hold our beliefs, the more likely we are to feel unhappy when our life circumstances don't live up to them. For example, if you believe that you must have happy, harmonious family relationships, but in reality your family relationships are dysfunctional, the belief that things must not be this way makes you feel miserable or inadequate. While there is no problem with preferring to have happy family relationships, beauty, friends, achievements or material wealth, believing that things *must* be a certain way is guaranteed to create unhappiness.

**CBT is not just 'positive thinking'**

If you are a reader of popular psychology and self-help books, you have probably come across books that suggest positive thinking can be achieved by repeating certain affirming statements over and over again. Typical statements include:

- I am prosperous and I am a winner.
- Every day, in every way, I'm getting better and better.
- My world is full of abundance.
- Things are working out to my highest good.
- I love myself and I approve of myself.
- The universe lovingly takes care of me.

Many people use statements like these in an attempt to think more positively, but do they really work? The answer is: it depends on whether or not you believe them. Affirmations can help to reinforce things we already know, but ignore. For instance, reminding ourselves of our strengths, achievements and the people who love us may improve our perspective at times. However, reciting statements that we don't believe will not magically imprint them on our unconscious mind. In CBT the emphasis is on realistic, balanced thinking, not wishful thinking.

## APPROPRIATE VERSUS INAPPROPRIATE EMOTIONS

The aim of CBT is not to eliminate all unpleasant emotions, but to respond to situations appropriately. There are some situations in which it is reasonable and appropriate to feel sad, regretful, angry or disappointed. If we lose something that we value, it is appropriate to feel sad. If we fail to achieve a particular goal, it is appropriate to feel disappointed. If we do something that we subsequently discover has been hurtful to another person, it is appropriate to feel regret. If someone else does something we consider to be unfair, it is appropriate to feel annoyed. Psychologically healthy responses produce emotions that are appropriate, given the circumstances. Accordingly, we experience regret rather than crippling guilt, disappointment rather than devastation, concern rather than overwhelming anxiety, sadness rather than depression, annoyance rather than explosive anger.

As we saw earlier, upsetting emotions have benefits when they motivate us to *act* in order to improve our situation. For instance, unpleasant emotions may motivate us to apologise, communicate, arrive early, complain to the manager, focus on a task, make amends for hurting someone or get a second opinion.

Even emotions like grief are appropriate at times. The death of a loved one, the loss of one's home, the diagnosis of a serious illness or the loss of a long-held dream is likely to generate grief for most people. The pain of a significant loss can sometimes last for years, and although time eventually heals or at least lessens the pain, the scar often remains. Unfortunately, there is no easy way to shortcut grief. However, even in grief, negative thinking can generate additional unnecessary suffering.

> *Gabriel is grieving for the loss of his wife, who died of cancer two years ago. While his grief is an appropriate response to the loss of his wife, his guilt and anger are not. By blaming himself for not having been a better husband, and blaming the doctors who were unable to save her, Gabriel creates additional distress that serves no useful purpose. His anger and guilt only intensify his pain and prolong his torment.*

## THE ABC MODEL

Most of us presume that it is the things that happen to us that make us feel the way we do. So, for instance, when we feel angry, anxious, frustrated or depressed we tend to blame other people or our life circumstances. However, as Ellis pointed out, events and people do not make us feel good or bad — they just provide a stimulus. It is actually our cognitions that determine how we feel.

To illustrate this, Ellis devised the ABC model, where:

A stands for 'activating event' — the situation that triggers our response.
B stands for 'beliefs' — our cognitions about the situation.
C stands for 'consequences' — emotions (including physical sensations) and behaviours.

While we tend to blame 'A' (the activating event) for 'C' (the consequences), it is actually 'B' (our beliefs) that make us feel the way we do. Let's look at a simple example:

Imagine that you are running late for an appointment, and you are feeling anxious.
A activating event — running late for an appointment
C consequences — physical tension, anxiety, fretting, reckless driving

You are feeling tense and anxious and driving recklessly (C) not because you are running late (A), but because of your beliefs (B) about punctuality and the consequences of running late. Your beliefs might include things like, 'I must always be punctual'; 'People won't like me if I arrive late'; 'People should approve of me' and 'The consequences are likely to be dire'.

## INTRODUCING D: DISPUTE

Ellis used the term **dispute** to describe the process of challenging the way we think about situations. Once we identify the thoughts and beliefs that make us feel bad, our next step is to dispute them. For instance, in the above example we might tell ourselves, 'My past experiences have taught me that even when I'm running late, I usually still get there on time or just a little late. I prefer to be punctual, and I usually am, but if I am late on this occasion, it's unlikely to have dire consequences.'

Disputing is a key component of CBT. Learning to change rigid, inflexible cognitions enables us to avoid or release emotions that cause unnecessary distress. In the above example, it might result in our feeling concerned rather than overwhelmingly anxious. It may also cause us to modify our behaviour; for instance, not driving recklessly.

**IN SUMMARY**

- Cognitive behaviour therapy (CBT) is based on the tenet that cognitions — our thoughts, beliefs and attitudes — determine the way we feel and behave.
- Cognitions, behaviours and emotions interact with and influence each other. Making changes in one of these areas usually results in changes in the others.
- Unpleasant emotions (such as anger, anxiety, sadness, resentment, guilt) can sometimes be helpful if they motivate us to do things that benefit us in the longer term. However frequent upsetting emotions often reflect a negative cognitive style, which gives rise to pointless distress.
- Various factors contribute to the way we think and feel, including our early history, temperament and environment.
- The aim of CBT is not to eliminate all upsetting emotions, but to develop reasonable, balanced cognitions and respond appropriately to life's challenges.

TWO

# Recognising faulty thinking

‘If you’re pretty crazy then you’re in good company because the human race as a whole is out of its goddam head … Now the problem is to admit this about yourself, and then to do something about it.’

**ALBERT ELLIS**

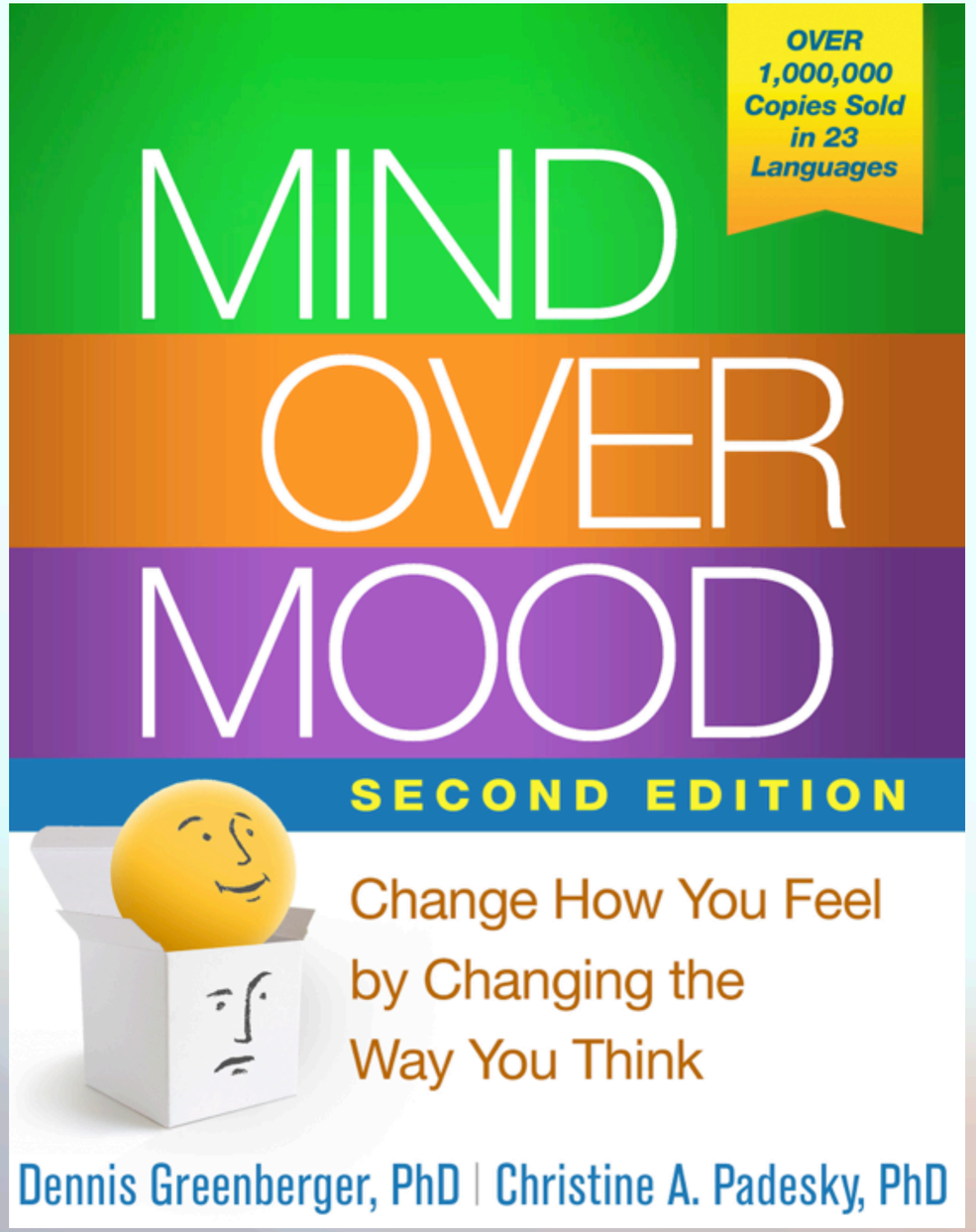
If we brought together the happiest people in the world, what do you think they would have in common? Lots of money? Good looks? Career success? Fame and admiration from others? Wrong! The happiest people are those with the most flexible attitudes. Of all the people you consider to be genuinely happy (most of us can count them on one hand), are any of them rigid, demanding or uncompromising? Do they get upset when things don’t go their way?

A key characteristic of happy people is their ability to adapt to life circumstances — a trait called **cognitive flexibility**. This doesn’t mean that they are weak or apathetic — in fact they are often keen to work towards the things that they care about. But they are also willing to accept that some things are beyond their control. Much of the distress that we experience in our daily lives stems from rigid, inflexible thinking.

## IRRATIONAL BELIEFS

Albert Ellis observed that most people by their very nature are inclined to think in ways that are irrational and self-defeating. He noted that some people are particularly predisposed towards upsetting emotions because they habitually think in self-defeating ways. According to Ellis, our thinking is irrational if it goes against our basic desire for happiness and long life. So, if holding a particular belief makes you experience inappropriate anger, frustration, anxiety, depression or feelings of worthlessness, or if it thwarts your ability to experience good health and long life, then by Ellis’s definition the belief is irrational. This includes beliefs that cause us to engage in self-defeating behaviours such as procrastination, social avoidance, aggression and neglecting our physical health. Ellis described many irrational beliefs that contribute to unhappiness and psychological distress, including the common irrational beliefs listed below.

| COMMON IRRATIONAL BELIEFS | CONSEQUENCES |
|---|---|
| I must be loved and approved of by everyone. | anxiety, unassertive behaviour, depression, poor self-esteem |
| I must be competent, adequate and achieving in every respect. | anxiety, self-downing, depression, frustration, shame, procrastination |
| The world should be a fair place and I should always be treated fairly. | anger, resentment, frustration, depression |
| People should have the same values and beliefs as me, and they should do things the way I would do them. | anger, resentment, poor relationships |
| Certain people are bad, and they should be blamed or punished for their misdeeds. | anger, resentment, hatred, depression |
| When I do something badly, I am a bad person, a failure, an idiot. | poor self-esteem, frustration, depression |
| | frustration, depression, despair |



Only rarely does a book come along that can truly change your life. *Mind Over Mood* is such a book. Dennis Greenberger and Christine A. Padesky have distilled the wisdom and science of psychotherapy and written an easily understandable manual for change. The first edition of this book has been read, reread, and recommended to others by therapists, patients, and people seeking to improve their lives.

When I first began developing cognitive therapy (CT) in the late 1950s, I had no idea that it would become one of the most effective and widely practiced psychotherapies in the world. Originally, this therapy was designed to help people overcome depression. Our positive results in treating depression were followed by widespread interest in CT. Today CT is the most widely practiced form of psychotherapy in the world, in large part because the treatment has been shown to produce positive, often rapid outcomes with enduring effects.

CT has been successfully used to help patients with depression, panic disorder, phobias, anxiety, anger, stress-related disorders, relationship problems, drug and alcohol abuse, eating disorders, psychosis, and most of the other difficulties that bring people to therapy. This book teaches readers the central principles that have made this therapy successful for all these problems.

*Mind Over Mood* has proven to be a significant milestone in the evolution of CT. Never before have the nuts and bolts of CT been spelled out so explicitly in a step-by-step fashion for the lay public. Drs. Greenberger and Padesky generously provide the guiding questions, hints and reminders, and worksheets that they have developed in their own clinical practices; these materials can serve as both a vehicle and a road map for people seeking to make fundamental changes in their lives. This is a rare and special book that can easily be used for self-help or as an adjunct to therapy. Not only a self-help book, it has been used to teach graduate students in mental health fields and psychiatric residents

Outcome research demonstrates the effectiveness of cognitive-behavioral therapy (CBT) for a wide variety of psychological problems, including depression, anxiety, anger, eating disorders, substance abuse, and relationship problems. *Mind Over Mood* is a hands-on workbook that teaches CBT skills in a clear, step-by-step format. It is designed to help readers understand their problems better and make fundamental changes in their lives, either with the aid of a therapist or on their own.

Clinicians can use *Mind Over Mood* to structure therapy, to reinforce skills taught to clients, and to help clients continue the therapeutic learning process after formal therapy ends. With extensive worksheets and mood questionnaires, this book actively enlists clients' participation in applying what is learned in therapy to everyday life experiences. CBT skills are taught sequentially, and as readers progress through the book, new skills build upon previously learned skills. The book's structure, along with Helpful Hints and troubleshooting guides on how to navigate common "stuck points," helps readers successfully apply CBT principles so they can resolve their problems and experience greater happiness and life satisfaction.

We are very pleased and humbled by the widespread popularity of the first edition of *Mind Over Mood*. At the time we wrote it, we intended to use empirical findings about what made therapy effective to write a book that therapists could use to improve their own therapy outcomes. One of the exciting features of CBT is that it teaches clients skills to help them become their

# List of Worksheets

## HOW WILL THIS BOOK HELP YOU?

*Mind Over Mood* teaches you strategies, methods, and skills that have been shown to be helpful with mood problems such as depression, anxiety, anger, panic, jealousy, guilt, and shame. The skills taught in this book can also help you solve relationship problems, handle stress better, improve your self-esteem, become less fearful, and grow more confident. These strategies also can help you if you are struggling with alcohol or drug use. *Mind Over Mood* is designed to teach you skills in a step-by-step fashion, so you can rapidly make the changes that are important to you.

The ideas in this book come from cognitive-behavioral therapy (CBT), one of today's most effective forms of psychotherapy. "Cognitive" refers to what we think and how we think. Cognitive-behavioral therapists emphasize understanding the thoughts, beliefs, and behaviors connected to our moods, physical experiences, and events in our

For example, if we are standing in line at the grocery store and think, "This will take a while. I might as well just relax," we are likely to feel calm. Our bodies stay relaxed, and we may start a conversation with someone standing nearby or pick up a magazine. However, if we think, "They shouldn't have such a long line. They should hire more clerks," we may feel upset and irritated. Our bodies become tense and fidgety, and we may spend our time complaining to other customers and the clerk.

*Mind Over Mood* teaches you to identify and understand the connections among your thoughts, moods, behaviors, and physical reactions in everyday situations like this one, as well as during major events in your life. You will learn to think about yourself and situations in more helpful ways, and to change the thinking patterns and behaviors that keep you stuck in distressing moods and relationships. You will discover how to make changes in your life when your thoughts alert you to problems that need to be solved. In the end, these changes should help you feel happier, calmer, and more confident. In addition, the skills you learn using *Mind Over Mood* help you create and enjoy more positive relationships.

## Can You Use *Mind Over Mood* Skills for Issues Other Than Moods?

Yes. The same *Mind Over Mood* skills that help manage moods can also help you with stress; alcohol and drug use; eating issues such as bingeing, purging, or overeating; relationship struggles; low self-esteem; and other issues. It also can be used to develop positive moods, such as happiness and a sense of meaning and purpose in your life.

*Mind Over Mood* skills and strategies are based on decades of research. These are proven, practical, and powerful methods that, once learned, lead to greater happiness and life satisfaction. By investing time in reading this book and practicing what you learn, you are taking steps to transform your life in a positive way.

## Chapter 1 Summary

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

# 2

# Understanding Your Problems

BEN: *I hate getting old.*

One afternoon a therapist received a telephone call from Sylvie, a 73-year-old woman who was concerned about her husband, Ben. She had read an article about depression, and it seemed to describe him. For the past six months, Ben had complained constantly about feeling tired; yet Sylvie heard him pacing around the living room at three in the morning, unable to sleep. In addition, she said he was not as warm as usual toward her, and he was often irritable and negative. He had stopped visiting his friends and didn't seem interested in doing anything. After his doctor checked him and said he didn't have a medical problem that would explain these symptoms, Ben complained to his wife, "I hate getting old. It feels lousy."

The therapist asked to talk with Ben on the phone, and Ben reluctantly came on the line. He told the therapist not to take it personally, but he didn't think much of "head doctors" and didn't want to see the therapist because he wasn't crazy, just old. "You wouldn't be happy either if you were 78 and ached all over!" He said he would go to one appointment just to satisfy Sylvie, but he was sure it wouldn't help.

How we understand our problems has an effect on how we cope. Ben thought that his sleep problems, tiredness, irritability, and lack of interest in doing things were normal parts of growing older. Growing old was something Ben couldn't change, so he didn't expect that anything could help him feel better.

At their first meeting, the therapist was immediately struck by the difference in Sylvie's and Ben's appearance. In a rose-colored skirt with a coordinating floral blouse, earrings, and shoes, Sylvie had dressed herself carefully for the meeting. She sat upright in her chair and greeted the therapist with an expectant smile and bright, eager eyes. In contrast, Ben sat slumped in his chair, and although he was neatly dressed, he had a slight stubble on the left side of his chin. His eyes were dull and surrounded by the dark circles of fatigue. He stood up stiffly and slowly to greet the therapist, saying grimly, "Well, you got me for an hour."

As the therapist gently questioned Ben over the next 30 minutes, his story slowly unfolded. With each question, Ben sighed deeply and then responded flatly. Ben had been a truck driver for 35 years, making local deliveries for the last 14 of those years. After his retirement, he met regularly with three retired friends to talk, eat a meal, or watch sports. Ben also liked fixing things, working on house projects, and repairing bicycles for his eight young grandchildren and their friends. He regularly saw his three children and the grandchildren, and he felt proud to have a good relationship with each of them.

Eighteen months earlier, Sylvie had been diagnosed with breast cancer. Her cancer had been detected early, and she had recovered well after surgery and radiation treatment, with no further signs of cancer. Ben became teary as he talked about her illness: "I thought I'd lose her, and I didn't know what I'd do." As he said this, Sylvie jumped in quickly, patting Ben on the arm: "But I'm OK, dear. Everything turned out OK." Ben swallowed hard and nodded his head.

While Sylvie was undergoing cancer treatment, one of Ben's best friends, Louie, became suddenly ill and died. Louie had been Ben's friend for 18 years, and Ben felt his loss deeply. He felt angry that Louie had not gone to the hospital sooner, because early treatment might have saved his life. Sylvie said that Ben focused all his attention on tracking her cancer treatment appointments after Louie's death. "I think Ben thought he would be responsible for my death if we missed an appointment," said Sylvie. Ben stopped seeing his friends and devoted himself to Sylvie's care.

"After Sylvie's treatment ended, I knew the relief was only temporary. The rest of my life will be filled with illness and death. I feel half dead already. A young person like yourself can't understand this." Ben sighed. "It's just as well. What use am I, anyway? The grandkids fix their own bikes now. My sons have their own friends, and Sylvie would probably be better off if I wasn't here. I don't know what's worse – to die, or to live and be left all alone because all your friends are dead."

After hearing Ben's story and reviewing his physician's report that there was no physical cause for the way Ben was feeling, it was clear to the therapist that Ben was depressed. He was experiencing physical symptoms (insomnia, appetite loss, fatigue), behavior changes (stopping his usual activities, avoiding friends), mood changes (sadness, irritability, guilt), and a thinking style (negative, self-critical, and pessimistic) consistent with depression. As is often the case with depression, Ben had experienced a number of losses and stresses in the preceding two years (Sylvie's cancer, Louie's death, and the sense that his children and grandchildren didn't need him any more).

Although Ben was skeptical that therapy could help, with Sylvie's encouragement he agreed to go to three more sessions before deciding whether to continue or not.

## UNDERSTANDING BEN'S PROBLEMS

During their second meeting, his therapist helped Ben understand the changes he had experienced in the past two years. Using the five-part model in Figure 2.1 on the facing page, Ben noticed that a number of *environmental* changes or major life events (Sylvie's cancer, Louie's death) had led to *behavior* changes (the end of regular social time with friends, extra trips to the hospital for Sylvie's cancer treatment). In addition, he began to *think* differently about himself and his life ("Everyone I care about is dying," "My children and grandchildren no longer need me") and to feel worse both *emotionally* (irritable, sad) and *physically* (tired, more trouble sleeping).

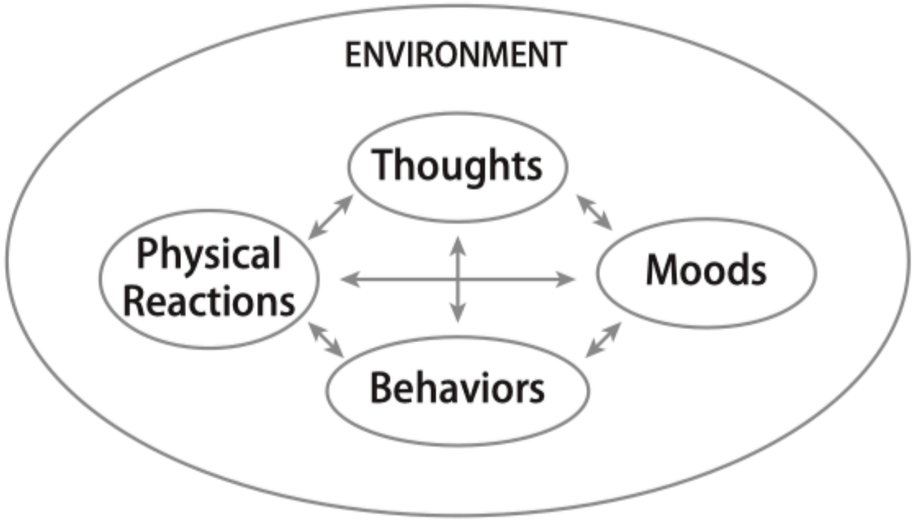



**FIGURE 2.1.** Five-part model to understand life experiences.

Ben could see how each of these five parts of his experience influenced the other four, pulling him deeper into his sad mood. For example, as a result of thinking, "All my friends will die soon because we're getting old" (thought), Ben stopped calling them on the phone (behavior). As Ben became more isolated from his friends, he began to feel lonely and sad (mood), and his inactivity contributed to his sleep problems and tiredness (physical reactions). Since he no longer called his friends or did things with them, many of them stopped calling him (environment). Over time, these interacting forces dragged Ben into a downward spiral of depression.

At first, when Ben and his therapist recognized this pattern, Ben was discouraged: "It's hopeless, then – each of these things will just get worse and worse until I die!" His therapist suggested the possibility that since each of these five areas was connected to the other four, small improvements in any of the areas could contribute to positive change in the others. Ben agreed to experiment to figure out what small changes would make him feel better.

LINDA: *My life would be great if I didn't have panic attacks!*

"One of my friends told me cognitive-behavioral therapy can stop panic attacks. Do you think it would help me?" The phone caller was very direct in her questioning. Her voice was firm and confident as she quizzed the therapist about CBT. She was equally direct in describing her recent experiences that prompted her call. "My name is Linda. I'm 29 years old, and except for a fear of flying in airplanes, I've never had any problems I couldn't handle myself. I'm a marketing supervisor for a company and have always loved my job – until two months ago, that is. Two months ago I was promoted to regional supervisor. Now I need to fly a lot, and I find myself breaking into cold sweats whenever I think about getting on an airplane. I was thinking of going back to my old job when my friend told me to call you first. Can you help me?"

# UNDERSTANDING LINDA'S PROBLEMS

Linda had panic attacks, worries, and also a fear of flying in airplanes – all anxiety-related problems. Can the model in Figure 2.1 be used to understand anxiety? Notice how the five areas summarize Linda's experiences:

*Environment/life changes/situations:* My father's death; job promotion.

*Physical reactions:* Cold sweats; racing heart; difficulty breathing; jumpy.

*Moods:* Fearful; nervous; panicky.

*Behaviors:* Avoiding flying; thinking of giving up job promotion.

*Thoughts:* "I'm having a heart attack," "I'm dying," "What if things go wrong and I can't cope?," "Something bad will happen if I fly."

## EXERCISE: Understanding Your Own Problems

Just as Ben, Marissa, Linda, and Vic used the five-part model to understand their problems, you can begin to understand your own problems by noticing what you are experiencing in these five areas of your life: environment/life changes/situations, physical reactions, moods, behaviors, and thoughts. On Worksheet 2.1, describe any recent changes or long-term problems in each of these areas. If you have difficulty filling out Worksheet 2.1, ask yourself the questions in the Helpful Hints on the facing page.

## WORKSHEET 2.1. Understanding My Problems

Environment/life changes/situations: _____

_____

Physical reactions: _____

_____

Moods: _____

_____

Behaviors: _____

_____

Thoughts: _____

**HELPFUL HINTS**

If you are having trouble filling out Worksheet 2.1, you might find it helpful to look again at the five-part models filled out by Linda, Marissa, and Vic. Then ask yourself the following questions:

*Environment/life changes/situations:* What recent changes have there been in my life (positive as well as negative)? What have been the most stressful events for me in the past year? Three years? Five years? In childhood? Do I experience any long-term or ongoing challenges (e.g., discrimination or harassment by others, physical/health challenges for me or family members, ongoing financial problems)?

*Physical reactions:* What physical symptoms am I having? (Consider general changes in energy level, appetite, pain levels, and sleep, as well as occasional symptoms such as muscle tension, tiredness, rapid heartbeat, stomachaches, sweating, dizziness, and breathing difficulties.)

*Moods:* What single words describe my most frequent or troubling moods (sad, nervous, angry, guilty, ashamed)?

*Behaviors:* What behaviors are connected to my moods? At work? At home? With friends? By myself? (Behaviors are the things we do or avoid doing. For example, Linda avoided airplanes, Vic tried to be perfect, and Ben stopped doing things.)

*Thoughts:* When I have strong moods, what thoughts do I have about myself? Other people? My future? What thoughts interfere with doing the things I would like to do or think I should do? What images or memories come into my mind?

## Chapter 2 Summary

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

# IS POSITIVE THINKING THE SOLUTION?

Although our thoughts affect our moods, behavior, and physical reactions, positive thinking is not a solution to life's problems. Most people who are anxious, depressed, or angry can tell you that "just thinking positive thoughts" is not that easy. In fact, thinking only positive thoughts is overly simplistic, usually does not lead to lasting change, and can lead us to overlook information that might be important.

*Mind Over Mood* instead teaches you to consider all information and many different angles on a problem. Looking at a situation from all sides and considering a wide range of information – positive, negative, and neutral – can lead to more helpful ways of understanding things and new solutions to difficulties you face.

# TINY

The Small Changes that

# HABITS

Change Everything

BJ FOGG PhD

Founder of the Behavior Design Lab at Stanford

## CONTENTS

# INTRODUCTION

## Change *Can* Be Easy (and Fun)

### Tiny is mighty.

At least when it comes to change.

Over the last twenty years, I've found that most everyone wants to make some kind of change: eat healthier, lose weight, exercise more, reduce stress, get better sleep. We want to be better parents and partners. We want to be more productive and creative. But the alarming levels of obesity, sleeplessness, and stress reported by the media — and seen in my Stanford lab's research — tell me there is a painful gap between what people want and what they actually do. The disconnect between *want* and *do* has been blamed on a lot of things — but people blame it on themselves for the most part. They internalize the cultural message of "It's your fault! You should exercise more, but you aren't doing it. Shame on you!"

I am here to say: It isn't your fault.

And creating positive change isn't as hard as you think.

For too many years, myths, misconceptions, and well-meaning but unscientific advice have set you up to fail. If you've attempted change in the past and haven't seen results, you may have concluded that change is hard or that you can't succeed because you lack motivation. Neither is accurate. The problem is with the approach itself, not with you. Think of it this way: If you tried putting together a chest of drawers with faulty instructions and parts missing, you would feel frustrated. But you probably wouldn't blame yourself for this, would you? You would blame the manufacturer instead. When it comes to failed attempts at change, we almost never blame the "manufacturer." We blame ourselves.

When our results fall short of our expectations, the inner critic finds an opening and steps on stage. Many of us believe that if we fail to be more productive, lose weight, or exercise regularly then something must be wrong with us. If only we were better people, we wouldn't have failed. If only we had followed that program to the letter or kept those promises to ourselves, we would have succeeded. We just need to get our act together and pull ourselves up by our bootstraps and *do better*. Right?

Nope. Sorry. Not right.

We are not the problem.

Our *approach* to change is. It's a *design* flaw — not a *personal* flaw.

Building habits and creating positive change *can* be easy — if you have the right approach. A system based on how human psychology really works. A process that makes change easier. Tools that don't rely on guesswork or faulty principles.

Popular thinking about habit formation and change feeds into our impulse to set unrealistic expectations. We know habits matter; we just need more good habits and fewer bad ones. But here we are, still struggling to change. Still thinking it's our fault. All my research and hands-on experience tell me that this is exactly the wrong mindset. In order to design successful habits and change your behaviors, you should do three things.

+ Stop judging yourself.
+ Take your aspirations and break them down into tiny behaviors.
+ Embrace mistakes as discoveries and use them to move forward.

This may not feel intuitive. I know it doesn't come naturally to everyone. Self-criticism is its own kind of habit. For some people, blaming yourself is just where your brain goes — it's like a sled in the snow, slipping into a well-worn path down the hill.

If you follow the Tiny Habits process, you'll start taking a different route. Snow will quickly start covering those self-doubting grooves. The new path will soon be the default path. This happens quickly, because with Tiny Habits you change best by *feeling good* — not by *feeling bad*. The process doesn't require you to rely on willpower, or set up accountability measures, or promise yourself rewards. There is no magic number of days you have to do something. Those approaches aren't based on the way habits really work, and as a result, they aren't reliable methods for change. And they often make us feel bad.

This book says good-bye to all that change angst and — even more important — shows you how to easily and joyfully bridge the gap (no matter the size) between who you are now and who you want to be. *Tiny Habits* will be your guide to disrupting the old approach and replacing it with an entirely new framework for change.

The system I'll share with you is not guesswork. I've road tested the process with more than 40,000 people during years of research and refinement. By coaching all these people personally and gathering data week by week, I know that the Tiny Habits method works. It replaces misunderstandings with proven principles, and it trades prescriptions for process. You'll take what the cofounder of Instagram, my former student, learned about human behavior to design a breakthrough app, and you'll use the same methods to create breakthrough changes in your own life — and the lives of others. And best of all, you get to have fun. Once you remove any hint of judgment, your behavior becomes a science experiment. A sense of exploration and discovery is a prerequisite to success, not just an added bonus.

# Behavior Design

Welcome to Behavior Design! This is my comprehensive system for thinking clearly about human behavior and for designing simple ways to transform your life. My early work in Behavior Design helped innovators create products that millions of people use every day to get fit, save money, drive efficiently, and more. After seeing the power of these methods to successfully design business solutions, I shifted my focus to the personal: How do we change our *own* behavior? I got focused on changes that people want to make for themselves. And when I looked in the mirror, I saw plenty that could be improved on. I decided to do what every gung-ho scientist does at one time or another — I experimented on myself.

I tinkered with the behaviors I wanted to incorporate into my life. I did silly things that turned out to be wildly successful, like doing two push-ups after every time I pee. I did seemingly rational things that totally failed, like trying to eat an orange every day at lunch. Whenever something didn't work, I went back to my models and analyzed what happened. I started seeing patterns. I followed hunches. I pivoted. I iterated endlessly.

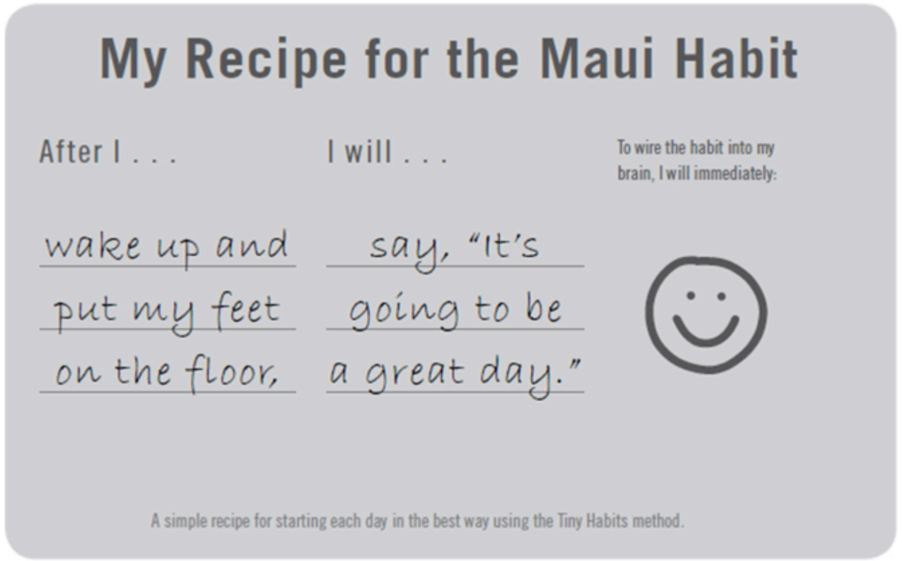
Even though I was a behavior scientist, I had to learn how to create habits in my own life. It wasn't obvious or natural for me; it was a deliberate process. But with practice I turned a weakness into a strength, and six months later, I had significantly changed my life. I lost twenty pounds and felt

system.

I won't prescribe exact habits in this book. I'm sharing a method for wiring in *any* habit you want. You pick the habits. But right here, right now, I'm making an exception. I invite you to start practicing a new habit first thing each and every morning. It's simple. And it takes about three seconds. I call it the Maui Habit.

After you put your feet on the floor in the morning, immediately say this phrase, "It's going to be a great day." As you say these seven words, try to feel optimistic and positive.

The recipe in Tiny Habits format looks like this.




## TINY CAN GROW BIG

Over the last twenty years, I've found that the only consistent, sustainable way to grow big is to start small. Amy, a former student of mine, was a stay-at-home mom who was trying to get an educational-media company off the ground. The idea of being her own boss and doing something she loved was thrilling. But there was so much to think about: hiring new employees, shopping around for office space, deciphering tax codes. She would procrastinate the important stuff, like legal agreements, and chose to work on tasks she loved, like designing her logo. But she was running out of time to build her business plan, and the thought of the venture falling apart in her hands paralyzed her. Amy wanted to get her business off the ground, and she kept making promises to herself that she'd tackle the big stuff soon — but months after the talking, she still hadn't done any walking.

## TINY DOESN'T RELY ON MOTIVATION OR WILLPOWER

When it comes to chatter about behavior change, a lot of what you hear will mislead you. Be careful. Even highly cited academic theories often fail to transform people's lives in the real world.

## TINY IS TRANSFORMATIVE

With the Tiny Habits method, you celebrate successes no matter how small they are. This is how we take advantage of our neurochemistry and quickly turn deliberate actions into automatic habits. Feeling successful helps us wire in new habits, and it motivates us to do more. I see these results week after week in my Tiny Habits data. But there's more: With Tiny Habits, you also learn *how to feel good* in your life. The ability to pat yourself on the back instead of beat yourself up grows solid, life-changing roots.

# The Anatomy of Tiny Habits

### 1. ANCHOR MOMENT

An existing routine (like brushing your teeth) or an event that happens (like a phone ringing). **The Anchor Moment reminds you to do the new Tiny Behavior**.

### 2. NEW TINY BEHAVIOR

A simple version of the new habit you want, such as flossing one tooth or doing two push-ups. **You do the Tiny Behavior immediately after the Anchor Moment**.

### 3. INSTANT CELEBRATION

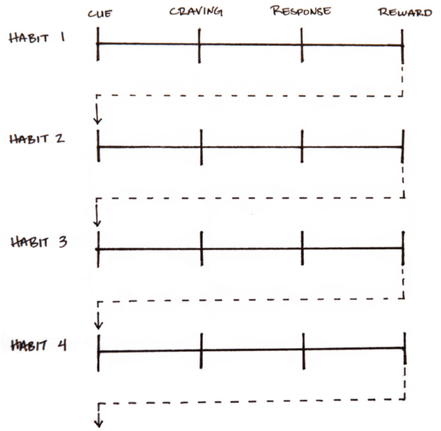
Something you do to create positive emotions, such as saying, "I did a good job!" **You celebrate immediately after doing the new Tiny Behavior**.

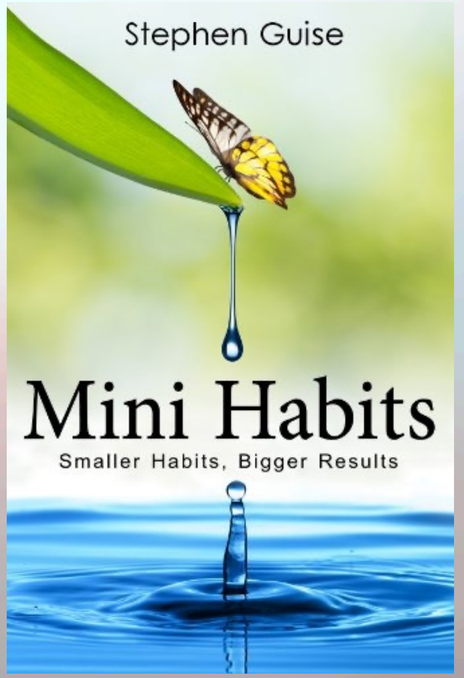
**Anchor**

**Behavior**

**Celebration**

**HABIT STACKING**



CHAPTER

# 1

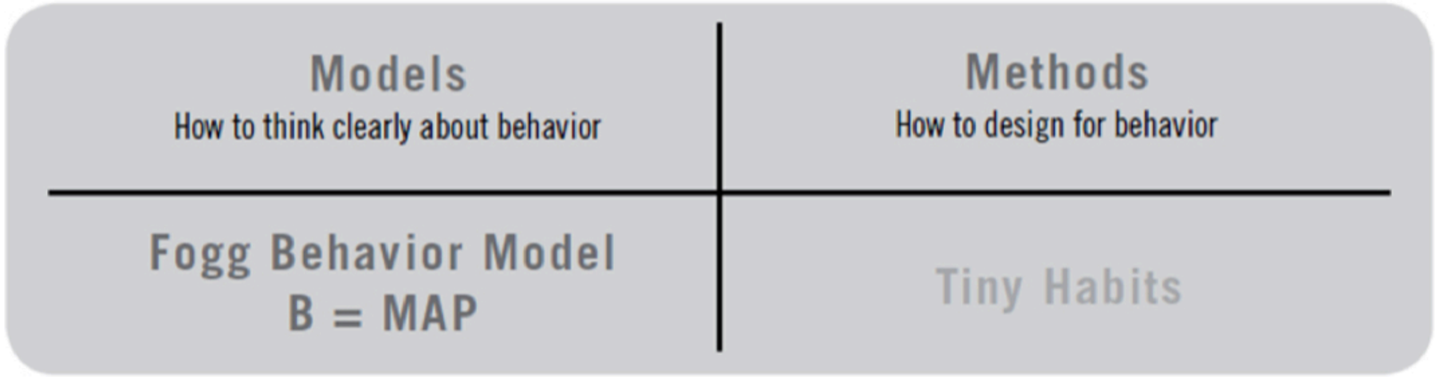
# THE ELEMENTS OF BEHAVIOR

## You can change your life by changing your behaviors. You know that. But what you may not know is that only three variables drive those behaviors.

The Fogg Behavior Model is the key to unlocking that mystery. It represents the three universal elements of behavior and their relationship to one another. It's based on principles that show us how these elements work together to drive our every action — from flossing one tooth to running a marathon. Once you understand the Behavior Model, you can analyze why a behavior happened, which means you can stop blaming your behavior on the wrong things (like character and self-discipline, for starters). And you can use my model to design for a change in behavior in yourself or in other people.


A behavior happens when the three elements of MAP — Motivation, Ability, and Prompt — come together at the same moment. Motivation is your desire to do the behavior. Ability is your capacity to do the behavior. And Prompt is your cue to do the behavior.

# Behavior Design




## B=MAP APPLIES TO *ALL* HUMAN BEHAVIOR

When I first teach people my Behavior Model, they are sometimes a little dubious when I tell them this is a universal model. They wonder how one model with just four letters could possibly account for every kind of behavior in every culture. After all, there are "good" behaviors and "bad" behaviors — are they really equivalent? Many people have a hard time understanding how their online shopping diversion has anything to do with their workout regimen. People think that there must be something fundamentally more complex about the fitness regimen because it's a challenge. On the flip side, if a change is easy, like hanging your coat in the closet instead of on the banister, there must be something fundamentally different about that action.

Let's consider both of Katie's habits together: desk tidying and binge scrolling.

Two behaviors, two wildly different feelings.

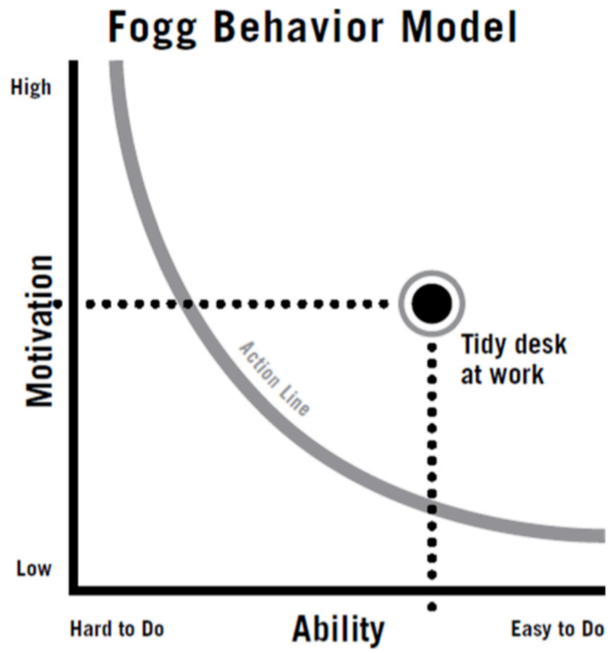
One behavior makes Katie feel good and helps her to achieve her larger aspiration of being productive. This tidiness habit has become so automatic that she hardly even thinks about it. In contrast, the scrolling habit is enjoyable in the moment but makes her feel disappointed in herself afterward. Scrolling in bed drives her crazy, but she often can't resist doing it.

These behaviors *feel* very different to Katie. Yet the components aren't. *All* behavior is driven by the same three elements. I wanted Katie to know that she hadn't run out of "togetherness," or willpower. She merely had a third habit — a scrolling habit — that was getting in the way of a *poorly designed* exercise habit.

Remember, for a behavior (B) to occur, three elements must converge at the same moment: Motivation, Ability, and Prompt.

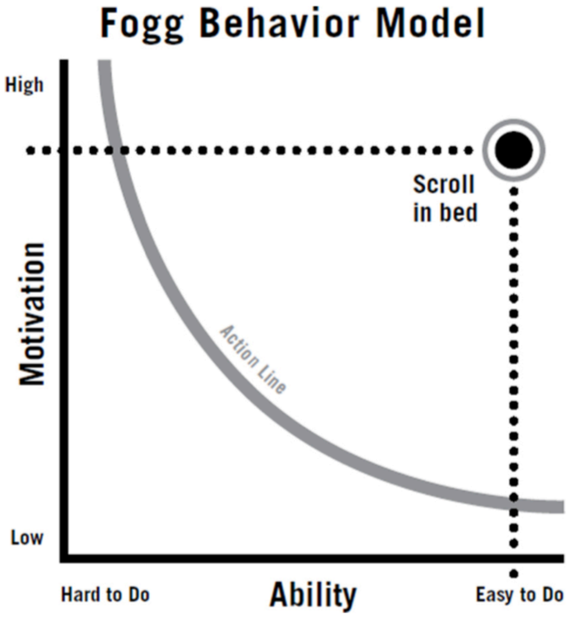
It's a model that has profound implications. Each person's motivation, ability, and prompt will be different in any given situation. The specifics of motivation or ability may differ by culture or age. And that's okay. The universe is unendingly complex, yet we can observe a phenomenon and break it down using some basic principles that apply to *every* circumstance.

Consider this visual representation of B=MAP, which shows how motivation and ability work in relationship to each other.




The first thing to notice is the big dot. That's Katie's habit of tidying her desk. The dot's location tells us where her motivation and ability are when she is prompted to act. You can see that her motivation is in the middle and that her ability to tidy her desk is on the easy-to-do side of the spectrum.

Now take a look at the curved Action Line.



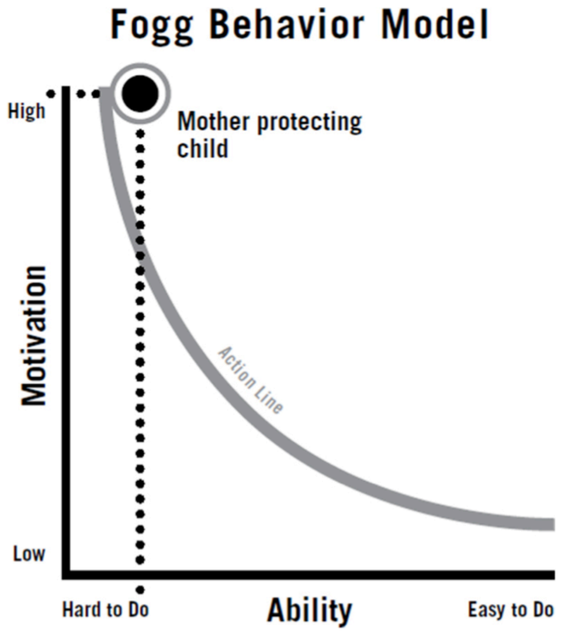

Yikes! Look at that big dot. Sky-high motivation and high ability — easy to do. On top of that, you know that Katie's prompt is reliable. Her phone blasts an alarm every morning at four thirty a.m.

# MOTIVATION AND ABILITY HAVE A COMPENSATORY RELATIONSHIP

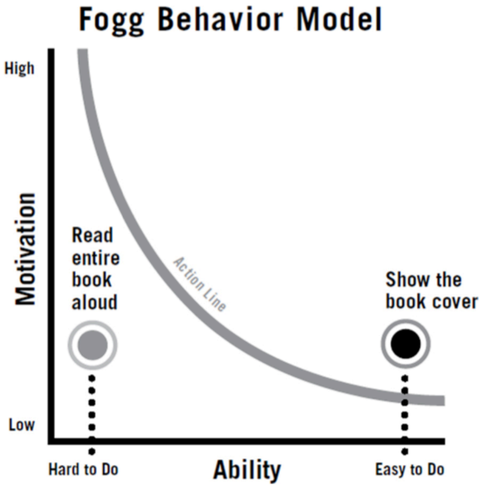
Once you understand how this principle works, you can design for almost any behavior you want.

The curved Action Line on our graphs visually represents this principle, but here's the explanation in plain English.

1. The *more motivated* you are to do a behavior, the *more likely* you are to do the behavior

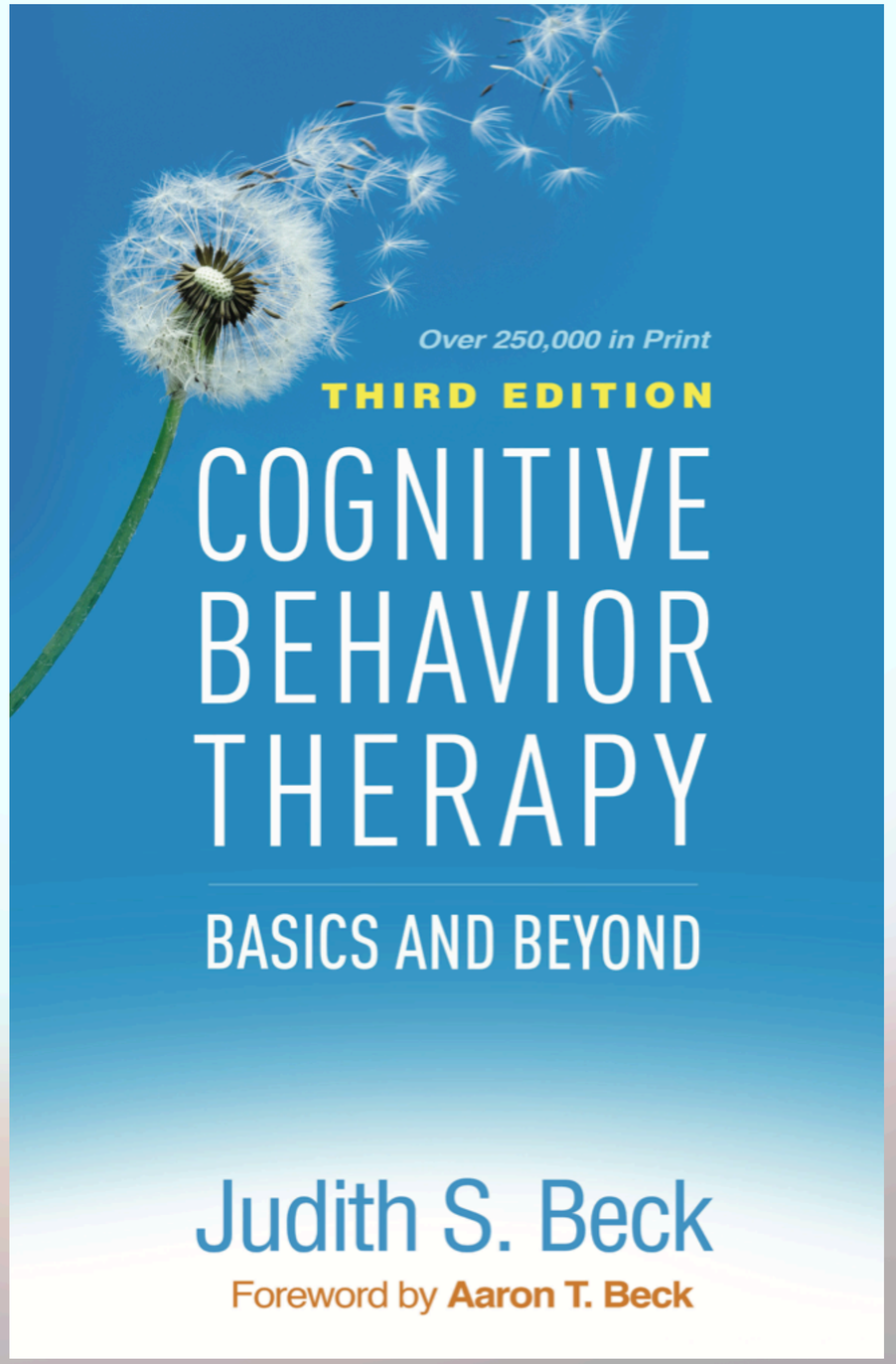



2. The *harder* a behavior is to do, the *less likely* you are to do it




Here's a related insight that might begin to transform your life (it transformed mine): The *easier* a behavior is to do, the *more likely* the behavior will become habit.

This applies to habits we consider "good" and "bad." It doesn't matter. Behavior is behavior. It all works the same way.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THIRD EDITION
COGNITIVE BEHAVIOR THERAPY
BASICS AND BEYOND
Judith S. Beck
Foreword by Aaron T. Beck

In the 1950s, other psychotherapeutic approaches started to emerge. Among these were some derived directly from Freud's theories (including 'psychodynamic', 'existential' and 'humanistic' psychotherapies), and others that took a very different approach. The most significant of these was later to become known as Cognitive Behaviour Therapy (CBT).

The two most influential figures in the development of CBT were psychologist Albert Ellis and psychiatrist Aaron Beck. Both started their careers as Freudian therapists and both ultimately became disillusioned with psychoanalysis. **Albert Ellis** criticised the painstakingly slow exploration of childhood experiences that was central to psychoanalysis, as well as many of Freud's underlying theories. In the early 1960s, Ellis started to focus on the role of thoughts and beliefs in creating psychological distress. He argued that individuals upset themselves by thinking irrationally, and that

**Aaron Beck** made his initial contribution to the development of CBT in the area of depression. He observed that depressed individuals have faulty or distorted thinking patterns. These stem from what he called **schemas** — core beliefs developed in childhood in response to early life events, which bias the way we subsequently perceive our experiences. Beck described schemas as 'templates' we unconsciously use to determine the meanings we give to our experiences. Schemas like 'I am inferior', 'people can't be trusted', 'I will be abandoned' or 'the world is dangerous' influence the content of people's thoughts in day-to-day situations, and therefore contribute to distress and psychological problems. Like Ellis, Beck maintained that the aim of therapy should be to help individuals recognise and change faulty thinking and self-defeating behaviours, using a variety of cognitive and behavioural strategies.

In the rest of this chapter, you'll find answers to the following questions:

- What is CBT?
- What is the theory behind CBT?
- What does research tell us about its effectiveness?
- How was it developed?
- What is CT-R?
- What does a typical cognitive intervention look like?
- How can you become an effective CBT therapist?
- How can you best use this book?

## SUMMARY

CBT was developed by Dr. Aaron Beck in the 1960s and 1970s and has since been demonstrated to be effective in more than 2,000 published outcome studies. Today, it is considered the "gold standard" of psychotherapy (David et al., 2018). It's based on the theory that people's thinking influences their emotions and behavior. By helping their clients evaluate and change dysfunctional or unhelpful thinking, CBT therapists can bring about lasting change in mood and behavior. CBT therapists employ techniques from many different psychotherapeutic modalities, applied within the context of the cognitive model and of their individualized conceptualizations of their clients. A recovery orientation focus has recently been added to traditional CBT, emphasizing values and aspirations, drawing positive conclusions from their day-to-day activities, and experiencing positive emotion in and outside of the therapy session.

### REFLECTION QUESTIONS

What new ideas have you learned about CBT or CT-R in this chapter? How could CBT techniques help you? What thoughts could readers have that would deter them from applying CBT skills to themselves? What would be good responses to those thoughts?

## PRACTICE EXERCISE

As of right now, start noticing when

- your mood has changed or intensified in a negative direction,
- you are having bodily sensations associated with negative emotion (such as your heart beating fast when you become anxious), and/or
- you are engaging in unhelpful behavior or avoiding engaging in helpful behavior.



Ask yourself what emotion you are experiencing, as well as the cardinal question of cognitive therapy:

> "What was just going through my mind?"

This is how you'll teach yourself to identify your own automatic thoughts. Pay particular attention to automatic thoughts that get in the way of achieving your goals, especially the ones that interfere with reading this book and trying techniques with clients. You may recognize thoughts such as these:

## WHAT IS CBT?

Aaron Beck developed a form of psychotherapy in the 1960s and 1970s that he originally named "cognitive therapy," a term that is often used synonymously with "cognitive behavior therapy" (CBT) by much of our field. Beck devised a structured, short-term, present-oriented psychotherapy for depression (Beck, 1964). Since that time, he and others around the world have successfully adapted this therapy to a surprisingly diverse set of populations with a wide range of disorders and problems, in many settings and formats. These adaptations have changed the focus, techniques, and length of treatment, but the theoretical assumptions themselves have remained constant.

In all forms of CBT that are derived from Beck's model, clinicians base treatment on a cognitive formulation: the maladaptive beliefs, behavioral strategies, and maintaining factors that characterize a specific disorder (Alford & Beck, 1997). You will also base treatment on your conceptualization, or understanding, of individual clients and their specific underlying beliefs and patterns of behavior. One of Abe's underlying negative beliefs was "I'm a failure," and he engaged in extensive behavioral avoidance so his (perceived) incompetence, or failure, wouldn't be apparent. But his avoidance ironically strengthened his belief of failure.

## THE CBT THEORETICAL MODEL

In a nutshell, the *cognitive model* proposes that dysfunctional thinking (which influences the client's mood and behavior) is common to all psychological disturbances. When people learn to evaluate their thinking in a more realistic and adaptive way, they experience a decrease in negative emotion and maladaptive behavior. For example, if you were quite depressed and had difficulty concentrating and paying your bills, you might have an *automatic thought*, an idea (in words or images) that just seemed to pop up in your mind: "I can't do anything right." This thought then leads to a particular reaction: You might feel sad (emotion) and retreat to bed (behavior).

In traditional CBT, your therapist would likely help you examine the *validity* of this thought, and you might conclude that you had overgeneralized and, in fact, you still do many things well, despite your depression. Looking at your experience from this new perspective would probably decrease your dysphoria and you might engage in more functional behavior (start paying bills). In a recovery-oriented approach, your therapist would help you evaluate your automatic thoughts. But the focus would be less on cognitions that have already arisen and more on cognitions that are likely to arise in the coming

Cognitions (both adaptive and maladaptive) occur at three levels. Automatic thoughts (e.g., "I'm too tired to do anything") are at the most superficial level. You also have intermediate beliefs, such as underlying assumptions (e.g., "If I try to initiate relationships, I'll get rejected"). At the deepest level are your core beliefs about yourself, others, and the world (e.g., "I'm helpless"; "Other people will hurt me"; "The world is dangerous"). For lasting improvement in clients' mood and behavior, you will work at all three levels. Modifying both automatic thoughts and underlying dysfunctional beliefs produces enduring change.

For example, let's say you continually underestimate your abilities. If so, you might have a core belief of incompetence. Modifying this general belief (i.e., seeing yourself in a more realistic light) can alter your perception of specific situations that you encounter daily. You will no longer have as many thoughts with the theme of incompetence. Instead, in specific situations where you make mistakes, you will probably think, "I'm not good at this [specific task]." In addition, it's important in a recovery orientation to cultivate realistically positive automatic thoughts (e.g., "I can do a lot of things well") and intermediate and core beliefs (e.g., "If I persevere, I can probably learn what I need to" and "I have strengths and weaknesses like everyone else").

# RECOVERY-ORIENTED COGNITIVE THERAPY

In recent decades, there has been an innovation in the field of mental health: the recovery movement, which was started as an alternative approach to the medical model for individuals diagnosed with a serious mental health condition. Aaron Beck, our colleagues at the Beck Institute for Cognitive Behavior Therapy, and I are now refining recovery-oriented cognitive therapy (CT-R) for individuals diagnosed with a wide range of conditions. CT-R, an adaptation of traditional CBT, maintains the theoretical foundation of the cognitive model in conceptualizing individuals and planning and delivering treatment. But it adds an additional emphasis on the cognitive formulation of clients' *adaptive* beliefs and behavioral strategies, and factors that maintain a positive mood. Rather than emphasizing symptoms and psychopathology, CT-R emphasizes clients' strengths, personal qualities, skills, and resources.

One difference between traditional CBT and CT-R is the time orientation. In traditional CBT we tend to talk about problems that arose in the past week and use CBT techniques to address them. In CT-R, we focus more on clients' aspirations for the future, their values, and steps they can take each week toward their goals. The usual CBT techniques are used in overcoming challenges or obstacles clients will face in taking these steps.

## A TYPICAL COGNITIVE INTERVENTION

Below is an excerpt from a therapy session with Abe. It provides the flavor of a typical CBT intervention. First, we agree to talk about a goal Abe wants to work on. We discuss steps he can take and the obstacles that could get in the way.

JUDITH: Okay, did you want to start by talking about your goal to get a job?

ABE: Yeah, I really need the money.

JUDITH: What's one step you'd like to take this coming week?

ABE: (*Sighs.*) I guess I should update my résumé.

JUDITH: That's important. [starting problem solving] How will you go about doing that?

ABE: I don't know. I haven't even looked at it in years.

JUDITH: Do you know where it is?

ABE: Yeah. But I'm not sure what to put on it.

JUDITH: What are some ways you could figure this out?

ABE: I guess I could go online. But my concentration hasn't been too good lately.

JUDITH: Would you be better off talking to someone who knows more about résumés than you do?

ABE: Yeah. (*Thinks.*) I could talk to my son.

JUDITH: What would you think about calling him today? Could anything get in the way?

ABE: I don't know. I should be able to figure out what to do myself, without bothering him.



JUDITH: That's an interesting idea—that you should be able to figure it out. Have you had a lot of experience looking at other people's résumés?

ABE: No, I don't know that I ever saw one from someone else.

JUDITH: How much bother do you think it would be for your son?

ABE: Not that much, I guess.

JUDITH: So, what would be good to remind yourself before you call him?

ABE: That he's had much more recent experience with résumés than I've had. That he'd probably be okay with helping me.

JUDITH: (*Praising Abe.*) That's excellent. Could you call him today?

ABE: Tonight would be better.

Abe was easily able to identify and respond to an unhelpful thought that could have posed an obstacle to taking a step toward achieving a valued goal. I asked him to imagine that, with his son's help, he had successfully revised his résumé. Then I asked him how he felt emotionally in the image and helped him experience some of the positive feeling right in our session. (Some clients, facing a similar problem, might require a greater therapeutic effort before they're able to follow through behaviorally.)

## BECOMING AN EFFECTIVE CBT THERAPIST

I hope you have an aspiration to become an excellent therapist and help hundreds or thousands of individuals in your career. Keeping this aspiration in mind can help you persevere if you become anxious while reading this book. If you do feel nervous, remember that the cognitive model proposes you've had some negative thoughts. You'll be learning tools throughout the book to address these kinds of unhelpful thoughts. Meanwhile, it helps to think about a specific reading goal each week and the obstacles you might face in taking the steps you need to. And make sure your expectations for yourself are reasonable.

The learning process is the same for the beginning CBT therapist. Keep your goals small, well defined, and realistic. Compare your progress to your ability level before you started reading this book or to the time you first started learning about CBT. Be careful not to undermine your confidence by contrasting your current level of skill with your ultimate objective.

If you feel anxious about starting to use CBT with clients, make yourself a "coping card," a physical or virtual index card on which you have written statements that are important to remember. You'll be using coping cards or their equivalents with your clients (because we make sure that anything we want clients to remember is written down). My psychiatric residents often have unhelpful thoughts before they see their first outpatients. After a discussion, they create a card that addresses these thoughts. The card is individualized but generally says something such as follows:

| |
|---|
| My goal is not to cure this client today. No one expects me to. |
| My goal is to establish a good relationship, to inspire hope, to identify |
| what's really important to the client, and perhaps to figure out a step |
| the client can take this week toward achieving his or her goals. |

## MAKING THE BEST USE OF THIS BOOK

This book is intended for students and clinicians at any stage of experience and skill development who lack mastery in the fundamental building blocks of cognitive conceptualization and treatment—or who want to learn how to incorporate principles of CT-R into treatment. It's critical to master the basic elements of CBT (and CT-R) so you can



understand how and when to vary standard treatment for individual clients.

The chapters of this book are designed to be read in the order presented. You might be eager to skip over introductory chapters and jump to the "how-to" chapters. The sum of CBT, however, is not merely the use of cognitive and behavioral techniques. Among other attributes, it entails the artful selection and effective use of many different kinds of interventions based on your conceptualization of the client. Visit *beckinstitute.org/CBTresources* to find videos of Abe's treatment and downloadable worksheets. You'll find a list of additional CBT resources in Appendix A.

# APPENDIX B

# Beck Institute Case Write-Up

## SUMMARY AND CONCEPTUALIZATION

### PART ONE: INTAKE INFORMATION

**Identifying Information at Intake**

**Age:** 56

**Gender Identity and Sexual Orientation:** Male, heterosexual

**Cultural Heritage:** American with European heritage

**Religious/Spiritual Orientation:** Belongs to the Unitarian Church; was not attending church at intake

**Living Environment:** Small apartment in large city; lives alone

**Employment Status:** Unemployed

APPENDIX C

# Steps in the AWARE Technique

1. **Accept anxiety.** Anxiety is natural, normal, and necessary for survival. The sensations you experience are a normal part of anxiety, even when they become intense. Anxiety increases when you get anxious about feeling anxious. But just because you feel anxious doesn't necessarily mean there's anything wrong. Your brain reacts in the same way whether it perceives actual danger or imagined danger. You can view anxiety as energy, given to help you deal with dangerous or difficult situations. Don't try to avoid, suppress, or control anxiety. If you do, it will become more intense and prolonged.
2. **Watch it from a distance.** Look at it without judgment—not good, not bad. Rate it on a 0–10 scale, and watch it go up and down. Be detached. Remember, you are not your anxiety. The more you can separate yourself from the experience, the more you can just watch it. Look at your thoughts, feelings, and actions as if you're a friendly, but not overly concerned, bystander.
3. **Act constructively with it.** Act as if you aren't anxious. Whatever you can do without anxiety, you can do it with it. You can hold a conversation, do chores, walk, drive, exercise, dance, sing, pray, and write with anxiety. Breathe slowly and normally. Don't run away from anxiety or avoid anxiety-provoking situations. If you do, you give yourself the message that anxiety is bad or dangerous.
4. **Repeat the above.** Continue to Accept, Watch, and Act constructively with the anxiety.
5. **Expect the best.** Most of the time, what you most fear doesn't happen. Give yourself lots of opportunities to use the steps above so you can gain confidence that anxiety always decreases. And your difficulties with anxiety will decrease once you stop fighting it or trying to avoid or control it.