CHAPTER 1

Introduction

This second edition of *Cognitive Therapy Techniques* provides the clinician with a wide range of cognitive and behavioral interventions that can be used to address depression, anxiety, anger problems, relationship problems, and many other forms of psychopathology. Although the orientation is primarily cognitive in the sense of focusing on the content, function, and form of thinking, I have included techniques that reflect contributions from metacognitive, acceptance, dialectical behavioral therapy, behavior activation, and compassion-focused therapy.

The cognitive model has expanded since its early formulation by Beck and Ellis. In the early cognitive model emphasis was placed on the specific content of thinking, such as the typical categories of distortion of automatic thoughts, underlying assumptions, and core schemas or beliefs. The cognitive model emphasizes the need to determine the role of schemas in affecting attention and memory and in the maintenance of problematic beliefs. Thus, the cognitive model would identify the role of confirmation bias and schematic processing in maintaining the negative beliefs of the depressed individual, even in the presence of positive information that might presumably contradict these beliefs.

This cognitive architecture is preserved in the current formulation as well as expanded to include a recognition that personality disorders are characterized by persistent schemas about self and others, and styles of compensation, avoidance, or schema maintenance. In addition, the concept of modes introduces systemic and coordinated patterns of response that organize cognition, motivation behavior, interpersonal functioning, and emotional responses around consistent and self-maintaining systems such as anger, mania, or depression (Beck & Haigh, 2014). The mode is a superordinate construct that represents the coordination of these various components and serves to maintain and expand the mode to new areas of life.

While recognizing the significant contribution of the cognitive model, other models have contributed to the range of formulations, strategies, and techniques available to the therapist. In particular, this new edition recognizes the important contributions of the metacognitive model advanced by Wells (2007, 2008, 2011); the behavioral activation model advanced by Martell, Dimidjian, and Herman-Dunn (2010); acceptance and commitment therapy (ACT) advanced by Hayes, Strosahl, and Wilson (2003); dialectical behavior therapy (DBT) advanced by Linehan (2015); compassion-focused therapy (Gilbert, 2009); and other approaches. In addition, I have also included ideas from

the cognitive science of decision making (Kahneman, 2011), mindfulness (Teasdale et al., 2012), and my work on emotional schemas (Leahy, 2015).

As will become clear in the first few chapters, the cognitive model proposes that depression, anxiety, anger, and other problems are maintained, activated, or exacerbated by biases in thinking. In particular, at the center of these biases are schemas that are consistent patterns of organizing information around a preexisting concept. The concept of schema is an old one in psychology, dating back to Bartlett and Piaget. In the 1970s, the fields of cognitive science and social cognition placed a great deal of emphasis on the role of schemas in determining selective attention, memory, and the interpretation of information. Thus, the cognitive model is partly derived from the information-processing revolution in the psychology of that era. Although both the Beck model and the Young model of schemas place an emphasis on the early development of these schemas in childhood, the research on schematic processing indicates that schemas can be formed at any time and that the formation of these schemas is outside immediate awareness (Bargh & Morsella, 2008; Andersen, Saribay, & Przybylinski, 2012; Fiske & Macrae, 2012). Although these schemas operate with automaticity, the cognitive model proposes that they can be accessed into conscious awareness through a variety of techniques. Thus, the goal is partly to make the implicit explicit.

The cognitive model of therapy places an emphasis on psychoeducation of the patient regarding his or her fundamental assumptions and the approach to be utilized in therapy. Thus, the therapist may indicate to the patient in the first session of therapy that they are going to focus on what the patient is consciously thinking and doing currently, how he or she can look at things differently and behave differently, and how self-help homework between sessions will allow the generalization of the gains in the session. In addition, bibliotherapy is a frequent component of cognitive therapy, with therapists providing information sheets on various problems or recommendations of books to read to help guide the patient through the process.

The cognitive approach stresses the importance of testing the patient's construction of reality against the facts as they become available. Thus, the therapy attempts to uncover, through questioning and behavioral experiments, what the patient believes to be true and the habitual patterns of thinking underlying his or her problems. For example, the depressed individual often reveals a negative view of self, life in general, and the future and, as a result, may be reluctant to attempt new behavior that might fail and lead to further demoralization and regret. Therapy attempts to encourage a greater awareness of the thoughts that may be shaping and fueling this negativity and introduce fundamental doubts about the infallibility of this way of thinking. The therapist encourages skepticism toward any thoughts that disable a patient and points out that thoughts have consequences and need to be evaluated as to whether they are pragmatic and whether they conform to the facts. In short, this approach emphasizes an empirical approach to reality: "What are the consequences of thinking this?," "What would be the consequence of an alternative view?," or "Let's test your thought against reality."

Moreover, cognitive therapists examine the meaning, or the lack of meaning, in the salient concepts with which depressed or anxious individuals berate themselves. These might include concepts that have no empirical referent, such as "worthless person" or "loser." I have found it immensely helpful to encourage patients to avoid general labels of fixed qualities (e.g., "I'm a *failure*") and to consider more specific, behavioral descriptions (e.g., "I did not achieve my goal *on this task at that time*"). By specifying and limiting descriptions to behaviors, situations, and time, the therapist and patient can introduce the understanding that performances vary depending on the context, beliefs held, motivation to engage, and the behavior enacted. This more nuanced perspective allows the patient to move from fixed to flexible thinking and to consider an experimental approach to testing his or her negative thoughts—for example, I might say, "Let's try a different way of approaching this

and see what happens." Behaviors can be changed, but traits give us the illusion of permanence and a subsequent belief in the hopelessness of ever changing.

In the cognitive model, "reality" is an *open system*. Thus the cognitive model is constructivist to the extent that the "knower"—here, the therapist and the patient—will never have all of the facts. There is no exhaustive test of information. Decisions in the real world are made with incomplete information, in real time, always under conditions of uncertainty. This view of an open system is an important recognition in the decision-making process, which I discuss in some detail in Chapter 6. *Knowing* in the empirical world is a statement more of probabilities than of certainties. Predictions are based on incomplete information—always. The recognition that inferential thinking is always incomplete, indeterminate, and probabilistic is an essential component of the cognitive therapist's perspective. Thus, when the patient demands certainty—"Yes, but I could be the one whose plane crashes!"—the cognitive therapist should recognize that existential possibilities do exist and cannot be eliminated. The real question for the patient demanding certainty is, "Why is it difficult to accept uncertainty?" This kind of questioning leads to a new approach to the patient's "knowledge needs": that is, the need to predict with certainty. Often examining this need reveals that the patient views "certainty" as part of a desire for absolute control—without which disasters will occur. We will see how uncertainty training is an important antidote to worry and rumination whereby the "thinker" attempts to exhaust all possibilities of outcomes and solutions in an attempt to gain certainty. Patients need to recognize that we all make decisions in an uncertain world, and there is no certainty in an uncertain world. Life occurs in real time under conditions of limited information and control.

Cognitive therapy does not proffer the power of positive thinking. The therapist is not a cheerleader for optimism. The therapist asks the patient to look at the evidence for and against his or her beliefs and to consider the pragmatic implications of various ways of viewing things. It is important to recognize that a single examination of a thought is not a final verdict. New information is always coming available. Reality is a fluid system. This perspective allows the patient to recognize that beliefs can be revised, behavior can be modified, new decisions can be made, new strategies can be considered. Thus, the search for solutions is organic, constantly evolving through an ongoing dynamic system of mutual feedback—that is, feedback among thoughts, behavior, and outcomes. Indeed, if one were to imagine an epistemological antidote to helplessness and hopelessness, it is this organic, open, and dynamic system of viewing thoughts, behavior, and new strategies. There is always another possibility, always another way to look at things, and always something new to try.

Cognitive therapy necessarily involves behavioral techniques such as activity scheduling, practicing exposure, providing self-rewards, constructing reward menus, practicing assertiveness, and other valuable techniques. These behavioral techniques are then evaluated by obtaining initial predictions ("What do you predict will happen if you do this exposure? How long will your anxiety last? How intense will it be? What will you not be able to do if you experience anxiety?"), collecting the evidence ("Exactly what happened?"), and comparing this information with the initial predictions. An important component of behavioral techniques is to modify the beliefs and therefore the future expectations and willingness to engage in behavioral strategies. Behavior affects cognition, and cognition affects the willingness to engage in behavior as well as what is learned from the behavioral experiments. We like to view these as behavioral experiments because they not only enhance the repertoire for the patient but they also modify the beliefs that have maintained the problem for so long. The therapist might invite the patient to test the belief that the consequences of not getting approval will be disastrous. This testing would involve behavioral experiments such as assertiveness exercises, through which the patient learns that experiencing disapproval (or giving disapproval) often results in no change in real life. By changing the beliefs associated with inactivity, the therapist can assist the patient in developing a new perspective about taking action. These behavioral tests

are also important in treating panic disorder; the therapist encourages the patient to intentionally induce the feared sensations to see what will happen and in exposure to induce feared thoughts by using thought flooding. The key point here is to articulate what has been learned. Behavior is followed by reflection.

Although the traditional cognitive model emphasizes the content of a thought (e.g., "I'm a loser"), newer models in cognitive-behavioral therapy (CBT) propose that it is the patient's response to the thought that may be more significant. In this volume I have included techniques from mindfulness approaches, metacognitive therapy, acceptance models, and an integrative cognitive model that recognizes that patients often respond to intrusive thoughts with rumination and worry. Patients often get "hijacked" by the thought and view the occurrence of the thought as an unacceptable mental experience. The various approaches described above help the therapist address the following: the interpretation of the thought as dangerous, personally significant, and out of control; the ability to "decenter" or gain distance from the thought; the willingness to take action despite the background noise of the occurrence of the thought; and placing the thought in the context of other transitory mental experiences. A wide range of techniques is discussed that the therapist can use to address these concerns.

Therapy often involves discomfort. In fact, it can be an important component in using ACT, mindfulness, behavior therapy, DBT, and emotional schema therapy. Topics arise that may be unpleasant, memories are activated that bring sadness and anxiety, new behavior is enacted that leads to an escalation of discomfort. Discomfort may be unpleasant but it may also be inevitable, and when experienced in pursuit of valued action, the discomfort may be a useful experience. The patient can learn that he or she can tolerate discomfort if the task is worth pursuing. In the current volume I review a wide range of approaches relevant to emotion regulation—and to tolerating difficult feelings. For example, my emotional schema therapy can help patients recognize and modify their beliefs that their emotions will last for an indefinite period of time and will escalate and need to be suppressed or controlled. These problematic beliefs about emotion will lead to more avoidance and passivity. The question for them is, "Are these beliefs about your emotions valid?" Thus, the therapist can use a wide range of techniques from different approaches to address these problematic beliefs about emotion in order to facilitate not only behavioral change but to deepen therapy and enhance the meaning of therapy. If therapy is to avoid being superficial, it will sometimes be unpleasant, even painful.

The use of techniques should also include a case conceptualization. Now there is no one case conceptualization, and therapists from different orientations will have different ways of going about it. The cognitive therapist will often place an emphasis on the levels of cognition—automatic thoughts, underlying assumptions, and schemas about self and others—and relating these schemas and coping strategies to childhood experiences, significant life events (current and past), and the outcome of these coping strategies. I have found that the case conceptualization evolves over the course of therapy, as the therapist learns more about the patient's problematic metacognitive strategies (e.g., worry and rumination) and his or her tendencies toward behavioral avoidance, inertia, dysfunctional patterns of decision making, poor choice of partners or friends, and other important components that may maintain a long pattern of problems. The therapist can deepen the meaning and significance of what is uncovered in therapy by periodically asking, "How does this fit together with other things we know?" Thus, techniques may help the patient overcome obstacles and change thinking, but the evolving case conceptualization may broaden the picture and help the patient recognize future vulnerabilities not only in what triggers problems but also which thoughts, behaviors, and choices make matters worse. Indeed, the goal of therapy should not be simply "feeling better"; it should help the patient develop a wide range of effective techniques that can enable him or her to cope with future problems. Thus, techniques along with conceptualization can empower the patient.

The cognitive therapist recognizes that rational analysis and descriptions of thought processes may not be sufficient to effect change. Evocation of emotion, development of motivation, and experiential techniques that activate new phenomenological experiences and feelings also may be essential. The patient may need to confront reality with new thoughts and behaviors in order to experience, on an emotional level, the existential importance of a "rational" response or simply a new way of thinking. Cognitive therapists help clients put thoughts into action by engaging in behavioral experiments that translate insight into practice.

Some critics of cognitive therapy argue that it is too rational and too simplistic, more an exercise of words than an exercise of emotion. I have included a chapter on the experiential techniques of emotion-focused therapy as well as other models, including some of my work on emotional processing. It is essential to balance the techniques of cognitive therapy with empathy, validation, and motivational interviewing—styles of conducting therapy that assist the patient in viewing cognitive interventions as emotionally relevant. I often wonder, though, how such critics can account for the dramatic changes in emotion that cognitive therapy facilitates in individuals who are depressed and anxious. After all, if cognitive therapy helps people become less depressed and anxious, it *is* addressing emotion in the most important way—by changing negative feelings.

Therapists who practice cognitive therapy often seem to have their "favorite techniques." Some rely heavily on activity scheduling, examining the evidence and daily records of dysfunctional thoughts, whereas others may rely more on the techniques of rational role play, double standard, and testing predictions. The problem with this circumscribed repertoire is that different techniques work for different clients and problems. Some patients respond well to cognitive restructuring, others to behavioral activation, others to metacognitive techniques, and others to acceptance. The clinician should not feel limited to a particular school of therapy. After all, patients are coming to us to get the best tools that we have and, as in pharmacotherapy, no one approach works for everyone. It is important to fit the treatment to the patient, not the patient to the treatment.

A number of years ago I recall a trainee asking, "But how do you know which question to ask?" I assumed that he was referring to "which technique" to use. Initially I thought it was not a very good question—probably because I did not have a ready answer—but I realized it was an excellent question (and I regretted not asking it myself). Years later, I still do not have the answer, but I do have a lot of techniques. Interested readers may find numerous techniques they have never used (or even heard of). But most likely, readers will find this compendium of techniques a valuable "refresher"—that is, something that will jog their memory and help them recognize that the, say, five techniques they are using on their current patient can be augmented by 50 other techniques that they have not used in recent months (or years). In using this book, I imagine that clinicians will refer to it on a regular basis—especially in planning sessions, but also in addressing the roadblocks we will inevitably experience. Having the flexibility to ask oneself "What else can I try?" can lead to significant changes.

The current volume describes a wide range of techniques that can be used for almost any psychiatric disorder. In this sense, it is *transdiagnostic*. For example, although schizophrenia and generalized anxiety differ considerably, they both involve intrusive thoughts and problematic strategies and interpretations that can be modified.

Although this volume is not a step-by-step approach to CBT, it is essential that the therapist assist the patient in understanding the nature of the therapy. Gaining this understanding is an ongoing process, of course, with the therapist introducing the idea that one's thoughts and feelings about something and the reality of that something may be quite different, and that one of the goals of therapy is to examine how habits of thinking may negatively affect the patient's life. Many patients come to therapy with assumptions that may not be helpful—for example, that therapy involves simple ventilation, that reviewing the past is the essential issue, or that all psychological problems can be

reduced to biological causes and treated with medication. Although these ideas share some validity, the cognitive-behavioral approach is action-oriented, focused on the current problems, involves self-help, and engages the patient in a collaborative relationship with the therapist.

For example, in the first session with a patient with a history of a suicide attempts and a recent serious plan that was almost carried out, I asked her what she hoped to gain out of therapy. She said, "I want to understand why I'm so negative."

I responded, "Understanding can be interesting and at times useful, but this therapy is about *change*. So, I'm interested in what you want to change. Your thinking, your behavior, your passivity, your way of relating, your tendency to ruminate, and your hopelessness—those are things that we might try to change. Understanding might give us a theory that could be intriguing, but I think we could get a lot further if we focused on change."

She returned the next session, saying, "I have been in therapy for many years, and this is the first time that I thought about it this way—'What do I want to change'?"

The emphasis on identifying problematic ways of thinking and coping and then suggesting that there might be an alternative is the central tenet of all of the CBT approaches. It is about change. So, if we were to think about the initial "first technique," it is—"What do you want to change?" I often introduce this idea by what I have come to call the "magic wand technique": "If I had a magic wand—which I don't have—and I could wave it, what would have to change so that you would feel better?" Emphasizing change—engaging the patient in looking for alternatives—is a key antidote to helplessness and hopelessness.

The first four chapters—"Eliciting Thoughts," "Evaluating and Testing Thoughts," "Evaluating Assumptions and Rules," and "Examining Information-Processing and Logical Errors"—provide an overview of the basic techniques used in cognitive therapy. These chapters should be read in sequence. Chapter 2 reviews a number of techniques that can help the patient understand the difference between thoughts, feelings, and reality and how to recognize automatic thoughts that may determine their mood and behavior. For example, a thought can be a description of reality and the description can be either consistent or inconsistent with the facts of reality. These thoughts or interpretations of reality lead to specific feelings. The goal in therapy is to evaluate the correspondence between thoughts and the reality to which they refer. Chapter 3 provides a range of techniques to evaluate and test these thoughts against the facts and develop more adaptive and flexible ways of viewing experience. Chapter 4 addresses the conditional rules ("should" statements, "if–then" statements, and "rules about what you must do") that often lead to faulty inferences, problematic coping, and the maintenance of negative schemas. Chapter 5 examines the typical information-processing and logic errors that lead to confirmation bias and maintenance of more general negative beliefs. Recognizing these errors and correcting them is an essential component of effective cognitive therapy. Chapter 6, "Modifying Decision Making," reviews a number of issues that underlie problematic approaches to decision making and provides the therapist with conceptualizations, strategies, and techniques to improve decision making. Many people are depressed and anxious because of the problematic decisions that they have made or their tendency to ruminate and procrastinate rather than to accept reasonable risk. Change is about decisions, after all. In Chapter 7, I review techniques from a range of theoretical models that address how one experiences, evaluates, and responds to unwanted intrusive thoughts. Drawing on metacognitive, acceptance, mindfulness, and other approaches, the therapist can acquire useful strategies for addressing these frequent roadblocks. In Chapter 8, I review a wide range of techniques to address worry (or rumination) that can provide the clinician with a detailed approach to this vulnerability. Again, techniques are drawn from cognitive models and models of emotional avoidance, uncertainty training, metacognitive theory, acceptance, and other approaches. My observation in treating worry over many years is that having a wide range

of techniques can be helpful, since some patients benefit from some approaches, but not others. The reader will need to experiment with these techniques to determine which ones fit and which do not for a particular patient. In Chapter 9, I address a frequent problem in anxiety, depression, and anger: *putting things in perspective*. Indeed, one needs to remind oneself that the word "rational" is derived from the Greek word "ratio," which is precisely about putting things in perspective. Chapter 10 addresses schema therapy approaches; I review some of the issues involved in eliciting and identifying schemas; tracing their developmental origin; reviewing patterns of schema avoidance, compensation, and maintenance; and reversing the rigidity and pervasiveness of these schemas using a wide range of techniques. In Chapter 11, I review emotion regulation using techniques drawn from DBT, emotional schema therapy, mindfulness and acceptance approaches, as well as other approaches. In some cases, clinicians may find that emotion regulation may be the first order of business if the patient's emotional dysregulation is so severe that cognitive reflection, behavioral activation, and exposure are difficult to do and when the patient's safety, or that of others, is an issue.

In Part III on specific applications, I include four chapters. In Chapter 12, I offer a list of specific techniques for each of the cognitive distortions. For example, there are 10–15 techniques with brief examples for examining, challenging, and changing mind reading, personalizing, labeling, and other categories of distorted thoughts. (Some therapists may object to the use of the term "distorted," but I have kept this term because I believe much of depression, anxiety, and anger can be due to distortions in thinking. The reader can replace "distortions in" with "biased," "unhelpful," or "problematic," if this seems less pejorative or more useful.) This chapter may be a handy reference guide for therapists looking for a way of structuring a session—or series of sessions—and therapists are encouraged to add other techniques to the list for each cognitive distortion. In Chapter 13, I provide a case example along with dialogues of how one may modify the need for approval. Again, there is no set way to approach any session, but the reader can get some idea of what a session might sound like and what one can say. In Chapter 14, I provide a similar example of how one can modify self-critical thinking. Again the reader will see what a dialogue sounds like and consider how his or her own style might be different.

I always found it helpful to observe experienced clinicians actually doing therapy. But how you will do therapy will reflect your own style and the techniques that you personally find helpful. In Chapter 15, I describe the treatment of a man with anger management issues and the threat of divorce hanging over his head. Many patients with anger problems have mixed motives—some want to change, whereas others want to continue blaming others and minimizing their problem. The dialogues described here provide an example of how to approach anger management with one particular individual. Specific intervention strategies for disorders—such as panic, social phobia, and obsessive–compulsive disorder—are not covered here but may be referenced in Leahy, Holland, and McGinn (2012). A detailed description of a specific case, utilizing many cognitive therapy techniques, is available in Judith Beck's (2011) excellent *Cognitive Behavior Therapy: Basics and Beyond, Second Edition*.

Critics may be eager to point out that cognitive therapy is already too technique-oriented and too formulaic. I agree that cognitive therapy can become mechanical, invalidating, nonconceptual, shallow, and just plain boring. That is why I wrote a book on resistance in cognitive therapy, emphasizing validation concerns, risk aversion, victim roles, schematic processing, self-limitation, and self-consistency (Leahy, 2001b), and why I have written about the importance of emotion in CBT and how to address this (Leahy, Tirch, & Napolitano, 2011; Leahy, 2015). There are excellent books that describe case conceptualization in CBT (Persons & Tompkins, 1997; Beck, 2005; Kuyken, Padesky, & Dudley, 2009). Countertransference issues can be conceptualized and addressed within a cognitive therapy framework and may assist the therapist in utilizing his or her countertransference

response to understand the patient's interpersonal world and interpersonal strategies (Leahy, 2001b; Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). But we should keep in mind that there is something essential in the utilization of techniques that elicit, examine, test, challenge, and modify thoughts and behaviors. Cognitive therapy is based on these established—and proven—approaches.

Many therapists prefer to practice their own style of therapy and their own integration of models. Independence and innovation are laudable, but they should take second place to starting the patient with empirically supported treatments. For example, it might make sense to postpone the schema work until the treatment modules for depression and anxiety disorders—interventions that have proven effective—have been given a vigorous trial. Don't we owe it to our patients to employ, as our first line of treatment, those techniques we know actually work (based on outcome literature)? I recall how one of our trainees, who was quite intelligent but thought she could do cognitive therapy "her way," had a significantly high premature termination rate with her patients. To her credit, she modified her eclectic style (which did not include homework assignments) to utilize a more basic cognitive therapy model focused on techniques, structure, and homework assignments. Her effectiveness and premature termination rate improved dramatically. Essentially, I recommend that therapists first master the techniques and treatment approaches that have been shown to be effective. Before developing a grand theoretical scheme about how cognitive therapy needs to be modified for a particular patient, it would be valuable to utilize the interventions that have already been shown to be empirically valid.

In conducting cognitive therapy, I often utilize several techniques with a patient—even after the patient has seemed to change a negative thought. I believe in *overpractice* or *overlearning*—especially when it comes to modifying habits of thinking that have persisted for years. An advantage of utilizing a variety of techniques to test or challenge a single negative thought is that the patient has alternative techniques for future use, should his or her initial challenge not work. This approach was impressed on me years ago when I was learning cognitive therapy in individual supervision with the master of technique, David Burns. I would present a problem with a patient, let's say, a hard-wired negative thought, and David would say, "Tell me 10 techniques that you could use." In actual practice, I found this reliance on a multiplicity of techniques to serve as a powerful way of structuring sessions that had an enormous impact on patients. They were getting a lot of ideas about how to cope with their negative thoughts!

I have found it is essential to elicit ongoing feedback from patients. In addition, it is useful for the patient and therapist to intermittently summarize the techniques they have used, write them down, and examine which were useful, which were not, and why. For example, it is always helpful to examine why weighing the evidence for an automatic thought does *not* work. Perhaps there is a more fundamental belief, conditional rule, or demand for absolute certainty that needs to be explored. When techniques fail, the failure allows us to discover something even more fundamental, such as schemas or absolute rules. In fact, the ambitious and curious clinician should look forward to the failure of techniques, because failure (and resistance) in therapy can serve as windows into more fundamental problems, which in turn provide excellent opportunities to develop case conceptualizations and then bring to bear more techniques to examine patients' core beliefs.

I think behavioral techniques are essential, and I have included a list of these in Appendix A of *Treatment Plans and Interventions for Depression and Anxiety Disorders* (Leahy, Holland, et al., 2012). Readers interested in a comprehensive review of behavior therapy can consult *Contemporary Behavior Therapy, Sixth Edition*, edited by Michael D. Spiegler (2016). As a cognitive therapist (or cognitive-behavioral therapist), I view the behavioral techniques as serving the purpose of testing out negative thoughts. For example, activity scheduling, graded task assignments, and pleasure predicting are behavioral interventions that allow the patient to test out negative beliefs, such as "I don't

enjoy anything" or "I'm always depressed." Assertiveness training is used to test out the thoughts "No one likes me" and "I'm just shy." Attentional distraction is used to test out the idea that "I have no control over my thoughts" or "I just worry all the time." Exposure hierarchies can modify the belief that a specific stimulus is dangerous and cannot be tolerated. Imaginal exposure challenges the idea that even thinking about something is unbearable. Relaxation training can accomplish several goals: (1) It can test the thought that, for example, "I'm always nervous"; (2) it can help the patient induce more calming thoughts or moods that can be used to challenge the negative thoughts; and (3) it can reduce overall level of arousal, thereby reducing the likelihood of emotional priming for negative thoughts. Finally, self-reward and self-contingency management can be helpful in modifying negative beliefs about competence. In each case when using behavioral techniques, it is helpful to have the patient identify the automatic negative thoughts and to use behavioral tests as a challenge to these thoughts.

I include examples of therapist–patient dialogues for each technique. I always find it helpful to see how a therapist actually talks with a patient—for me it provides a good role model of what to do. Although I hope this volume will prove to be helpful, it cannot substitute for direct training and supervision. Fortunately, there are excellent opportunities for continuing education through webinars, conferences sponsored by the Association for Behavioral and Cognitive Therapies, the British Association for Behavioural and Cognitive Psychotherapies, the Anxiety and Depression Association of America, as well as local and regional workshops and conferences. The Academy of Cognitive Therapy is a credentialing and membership organization with worldwide participation and offers unprecedented opportunities for discussions about therapeutic issues. And, of course, the best source of knowledge is to listen to our patients—to listen carefully—as to what works and why other things do not work. In a sense, if we listen and learn from those we help, we will have a therapy that makes more sense to other patients in need. Therapy is not an abstract, theoretical endeavor. It is experienced in real time with real people coping with real problems.

This is a book about techniques, but the most valuable technique and the most meaningful intervention is whatever you do to help someone feel cared about and heard. I recall when I closed my practice in Philadelphia to move to New York City many years ago, I asked my patients what they liked and did not like about the treatment that I had provided. Much to my surprise almost no one said it was too structured and rational. One woman captured the sentiment: "I knew that you really cared. I knew you would always be there if I needed you." And, what did you not like? "You would not let me hug you."

In using this book, please keep in mind that behind every technique should be a genuine person who cares, who has compassion for those who are suffering. Perhaps that is the best technique. We can call it *compassion*.

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