2

Fundamental Skills

(*MOM2* CHAPTERS 1–4)

When *MOM2* is fully integrated into therapy, clients read Chapters 1 through 4, no matter what mood, behavior, or other goal they are targeting. These four chapters introduce fundamental ideas of CBT theory and practice. Understanding these chapters is easy for most people. They show how a CBT model can be applied to everyday issues. This chapter illustrates how to support your clients' understanding of these first four chapters of *MOM2,* and also how to encourage relevant skills practice. We begin with a demonstration of how you can introduce *MOM2* to your clients.

INTRODUCING *MOM2*

How many psychotherapy books are sitting on your shelf that you have not read? Presumably you bought these books because you thought they would be helpful or interesting. What determines which books you read and use? The first goal in introducing someone to *MOM2* is to increase the likelihood that it will be read and used. It is important to allow time in a therapy session to describe or show the book to your client, give a rationale for its use, discuss your mutual expectations for how it might be helpful, and present clear instructions on how you would like your client to use the book in subsequent weeks. A dialogue illustrating one way to introduce *MOM2* follows. Notice how this therapist used collaboration and guided discovery (principles described more fully in Chapter 14 of this clinician's guide) to increase Kyle's interest in using it.

THERAPIST: You've been very clear in describing your anxiety to me today. Thank you. If I've heard you correctly, you feel anxious all the time.

KYLE: Yes, I can hardly stand it.

THERAPIST: Most people who are anxious want to learn to manage it as quickly as possible. Do you feel that way?

KYLE: Yes!

THERAPIST: Ironically, this means that over the next few weeks, I'm going to ask you to allow yourself to feel anxious instead of trying to get rid of it. When you feel anxious, I'm going to ask you to pay close attention and write down some of the things you notice about it. This will help us understand your anxiety better, so we can set off on the best treatment path.

KYLE: Are you saying I need to feel anxious to learn about it?

THERAPIST: Yes. Does that make sense to you?

KYLE: I think I understand, but I don't like it.

THERAPIST: Being anxious isn't fun. So we better make sure that when you experience anxiety, we learn something that is likely to help you.

KYLE: I'm not sure what I'll learn.

THERAPIST: In the beginning, it would help if you could make some observations about your anxiety. When does it increase or decrease? What goes through your mind when you are anxious? What do you feel physically? This information can help us figure out together what your anxiety is all about and how to best help you.

KYLE: OK. But I'm not exactly sure how to do that.

THERAPIST: There is a lot to learn in the beginning of therapy. So we're going to use a written reminder of what we've talked about, and some written instructions about how to observe your anxiety.

KYLE: OK.

THERAPIST: I'd like to recommend a book called *Mind Over Mood,* which can help you learn about your anxiety and remind you of some of the things we talk about in our appointments.

KYLE: Do I have to read the whole book?

THERAPIST: No. If you like the book, I'll recommend certain chapters that can help us during therapy. You will just read chapters that teach skills to help you with your anxiety.

KYLE: OK.

THERAPIST: My first suggestion would be for you to read the first two chapters—the first 15 pages of the book—before our next appointment, and see if you can fill out Worksheet 2.1, Understanding My Problems (opening the book and pointing to this worksheet on p. 14). You see, there is a Helpful Hints box on this page (points to p. 15) that will help you fill out the worksheet. Then bring the book to therapy next week, so that we can look at the worksheet together. If you have any problems with it, I'll help you next time.

KYLE: OK.

THERAPIST: If you want to do more, you could also read the first six pages of Chapter 14, the anxiety chapter, and fill out the anxiety questionnaire there so we know how anxious you are now. Here it is on page 221. We'll aim to help you become less anxious in the coming weeks. If you fill it out, we'll use this as your starting anxiety score, so we can measure and track how you are doing. Do you think you'll have time to start reading Chapter 14, or do you just want to read Chapters 1 and 2?

KYLE: I might have time.

THERAPIST: You can see how Chapters 1 and 2 go, and then decide if you want to read the first part of Chapter 14. Why don't you circle on the table of contents what you've agreed to do this week so you don't forget?

KYLE: (Circles Chapters 1 and 2, and writes, "If I have time, first six pages," next to Chapter 14.)

THERAPIST: Is there anything that might get in the way of reading these first two chapters this week?

KYLE: No. They don't look too long.

THERAPIST: If you have difficulty, I'll help you next time. But I think you'll find this interesting. I'm certainly curious to learn more about what things are connected to your anxiety. So bring the book back next week, even if you don't complete everything. OK?

KYLE: OK.

Clinical Tip: Introducing *MOM2* to Clients

- Give a rationale for its use.
- Allow time for discussion.
- Link *MOM2* to clients' goals.
- Collaborate on setting expectations for how *MOM2* will be used in therapy.
- Provide clear instructions on how to use it (which pages and worksheets).
- Ask your clients to write down what they agree to do.
- Remind your clients to bring *MOM2* to therapy sessions.
- Review clients' worksheets in therapy sessions.
- Offer to help with difficulties.
- Express interest and curiosity in what your clients will learn.

Kyle's therapist did not hurry the discussion of *MOM2*. She introduced the workbook during the session at a point when he was expressing a need that might be helped by it ("I'm not exactly sure how to do that"). She also gave a rationale for using a workbook (it would "help you learn" between appointments, provide a written reminder of what was discussed in therapy, and teach Kyle how to observe anxiety), as well as clear instructions on what portions of *MOM2* to complete in the following week.

Furthermore, his therapist collaborated with Kyle, asking with each request if he was willing to give it a try, and figuring out with him how much of the book to read and complete. The therapist also asked about roadblocks that might interfere with reading it, and offered to help if Kyle was not able to complete the assignment. Her communications fostered collaboration and implied that using *MOM2* was intended to help Kyle, not to be a burdensome task. Finally, Kyle's therapist signaled that the workbook would play an integral part in the next session ("bring the book back next week"), and she expressed her own interest and curiosity in discovering what he would learn.

As this example illustrates, a few minutes of discussion linking *MOM2* to therapy goals and the learning process can weave this workbook into the fabric of therapy. Clients are more likely to actively use *MOM2* if therapists encourage its use outside the therapy sessions and review what is completed within therapy sessions. Clients with whom we have used the workbook bring it to each session, along with any other therapy notes or journals they keep, and we discuss or review their writings and observations that are pertinent to that week's learning.

Caution: Read Before Use!

Before using *MOM2* with clients, become familiar with its contents. The more thoroughly you know the workbook, the easier it will be to tailor readings and worksheets to particular clients. Weaving *MOM2* into therapy encourages its use at home and provides a bridge toward independent practice of therapy skills learned. Finally, *MOM2* provides many Helpful Hints boxes that you and your clients can use to navigate "stuck" points in therapy sessions.

If you read *MOM2* carefully, you can learn change strategies and paths for client discovery that are new to you and this might help improve the quality of therapy you provide. The following sections help you understand how to use each of the first four chapters of *MOM2* more effectively.

MOM2 CHAPTER 1: HOW *MIND OVER MOOD* CAN HELP YOU

Expectancy plays a large role in the success of psychotherapy and other treatment interventions. The first chapter of *MOM2* is only four pages long, and yet it provides an overview of *MOM2*'s potential benefits and supports readers' expectancies for positive outcomes. You can support positive expectancies for therapy and use of *Mind Over Mood* by making brief, genuine statements such as these:

"The CBT approach used in this book is one of the most successful therapies for the types of issues you are experiencing. That's why I'd like you to try it."

"Many people [or "my clients," if that is true for you] have used this book success-fully to learn to manage *XYZ*. If you are willing, we can see if it will help you."

It is important that whatever statements you make are honest. Do not oversell therapy or *MOM2*. Do not say, "I'm sure this will help you quickly." Instead, it is better to say, "I expect that this approach will be helpful. If you are willing, we will give it a try for a few weeks and see if it seems to be helping. Of course, there are no guarantees. If it doesn't help, we will try something else."

MOM2 includes summaries at the end of each chapter. These summaries remind us as therapists of the main learning points we want to make sure our clients understand. For this reason, these summaries are reprinted in the relevant chapters of this clinician's guide. See the *MOM2* Chapter 1 Summary in the box below.

Because there are no worksheets to complete or skills to practice in Chapter 1, most people can also read Chapter 2 in the same week. If you are uncertain about clients' reading ability or motivation, ask them to read Chapter 1, and add that they are welcome to go ahead and read all or part of Chapter 2 if they want. When someone agrees to read Chapter 1 and then does not read it, it can be a sign that this person is reluctant to use a workbook, has difficulty reading, or is ambivalent about therapy or working with you. In this rare instance, the person's thoughts and feelings about therapy and/or using *MOM2* can be explored in the next session.

Chapter 1 Summary
(*MOM2,* pp. 1–4)

✓ 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.

MOM2 CHAPTER 2: UNDERSTANDING MY PROBLEMS

Four Primary Characters

Four primary characters are followed throughout *MOM2,* and we meet them in Chapter 2: Ben, Linda, Marissa, and Vic. They represent people with well-defined and discrete diagnoses, as well as persons with multiple problems.

- **Ben** was depressed. His depression was of recent onset.
- **Marissa**'s depression was recurrent and sometimes included suicidal thoughts and behaviors.
- **Linda** reported a variety of anxiety-related problems, including panic attacks, worries, and a fear of flying on airplanes.
- **Vic** was recovering from alcoholism. He was experiencing bouts of anxiety, low self-esteem, guilt, and shame, as well as anger outbursts that had begun to strain his relationship with his wife, Judy.

The purpose of including four primary characters throughout the book is to help readers observe a variety of ways the principles and skills taught in *MOM2* can be applied to common issues and life challenges. Most of the skills-building worksheets in *MOM2* are illustrated with examples from one or more of these four characters, to provide readers with concrete examples for how to complete them. Readers can follow the learning progress of these four characters throughout the workbook, and can even learn what happened to them after therapy in the Epilogue of *MOM2.* Readers often identify with one or more of these characters, especially when their presenting issues are similar. However, it is not necessary for people to identify with a single character in *MOM2.* Many secondary characters are introduced in various chapters who illustrate a wide variety of human struggles.

The Five-Part Model

A simple five-part model (Padesky & Mooney, 1990) for describing and understanding difficulties is introduced in Chapter 2. Readers see how the four primary characters in *MOM2* put information from their lives into this model. The fact that four diverse sets of presenting issues can fit this model encourages readers that their own personal issues will fit this model as well. The five-part model is a simple, client-friendly way to begin to draw a descriptive case conceptualization of presenting issues (Kuyken, Padesky, & Dudley, 2009).

One of the common misconceptions about CBT is that it considers thoughts the main starting point for moods and behavior. The five-part model shown in Figure 2.1 (p. 7) of *MOM2* (and presented here, also as Figure 2.1) is a more accurate drawing of CBT theory. It reflects a constant interaction among behavior, thoughts, moods, and physical experience. Changes in any one of these areas can lead to changes in the others. And these four intrapersonal elements are constantly influenced by the environment,
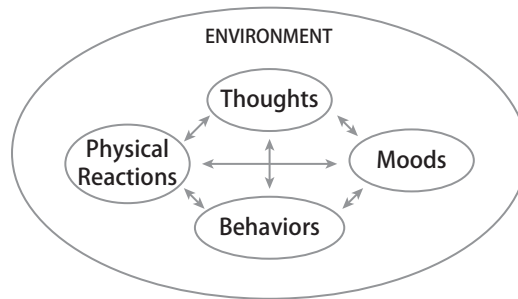
FIGURE 2.1. Five-part model for understanding life experiences. Copyright © 1986 Christine A. Padesky.

which includes situational (e.g., financial difficulties) and interpersonal (e.g., social supports and demands) contexts, as well as the broader environment (e.g., urban setting vs. small town) and a person's cultural factors (e.g., ethnic, racial, LGBTQ+, religious), both current and historical (Padesky & Mooney, 1990). Clients are asked to complete Worksheet 2.1, Understanding My Problems (*MOM2,* p. 14). Remind them that there are guiding questions they can ask themselves in the Helpful Hints box on p. 15 of *MOM2*. When clients have difficulty filling out this worksheet on their own, you can complete it with them in session. The *MOM2* Chapter 2 Summary describes what clients can learn from this exercise.

Rather than just reviewing these summary learning points with each client, it is more memorable to derive these learning points from their worksheet responses, as illustrated in the following dialogue:

THERAPIST: It's interesting to see everything you wrote on this worksheet. Was this difficult to fill out?

JONTELLE: I got stuck a few times, but the Helpful Hints box on the next page helped.

Chapter 2 Summary
(*MOM2,* pp. 5–15)

✓ 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, *MOM2,* p. 14).

THERAPIST: I'm glad. Well, you did a good job filling it out. I do notice that the trouble you told me you are having with your daughter is missing from this worksheet. Are things going better there, or did you just forget to put it in?

JONTELLE: Oh. I forgot about that.

THERAPIST: Do you want to add it?

JONTELLE: Yes.

THERAPIST: Where would you put that on the worksheet?

JONTELLE: Under "situations"?

THERAPIST: That makes sense.

JONTELLE: (*Writes the additional information on Worksheet 2.1.*)

Notice that the therapist did not provide more help than necessary and supported the client's correct understanding of the model.

THERAPIST: The chapter said that each of these five parts interacts with the others. Can you give me any examples of how that might work for you?

JONTELLE: Well, I notice I tend to stay home more when I get anxious.

THERAPIST: Let's draw a line between your behavior [staying home] and your mood [anxious], then.

JONTELLE: OK. (*Draws line.*)

THERAPIST: When you stay home more, do you think that this affects any of your thoughts?

JONTELLE: (*Looks at her worksheet.*) I guess that's when I start to think, "I'm weak."

THERAPIST: OK. Let's draw a line, then, between your behavior and your thoughts.

As her therapist and Jontelle worked together and drew lines connecting various parts of the model, Jontelle began to understand what the Chapter 2 Summary means by "Each of these five parts interacts with the others." It was not necessary to make all the connections once she grasped this idea. Next, her therapist linked her five-part model worksheet to treatment options a few minutes later in this session:

THERAPIST: When I see how these parts all interact for you, it helps me understand how you've gotten into such a tough spot with your anxiety. Small changes in one area lead to small changes in other areas, and pretty soon you are really stuck. Does that make sense to you?

JONTELLE: Yes, it really does. I never realized this before. Now I'm really stuck in a mess.

THERAPIST: Actually, I see good news in this picture.

JONTELLE: You do? I don't see it.

THERAPIST: The good news seems to be small changes. If small changes for the worse can lead to such a mess, then small improvements in one area can lead

to small improvements in other areas, and eventually your mess can get solved.

JONTELLE: Do you really think so?

THERAPIST: Yes. If you are willing to work with me, our job will be to figure out what are the smallest changes you can make that will lead to the biggest positive improvement over time.

JONTELLE: How do we do that?

THERAPIST: Take a minute and look at this worksheet. Are there any areas where you think you could make a small positive change? We could start there and see if that small change can help shift some of the other areas as well.

JONTELLE: (*Silent for a minute*) I want to stay home when I'm anxious. But I notice on days when I have to go out, I sometimes feel a little bit better. Maybe I could start by figuring out some easier things to do outside the house when I'm feeling anxious.

THERAPIST: That's an interesting idea. We could experiment with that and see what happens. Do you have any predictions?

Making links between case conceptualization and treatment steps is important in therapy. When clients are invited to collaborate in making connections among different parts of their experience (as Worksheet 2.1 guides them to do), they often begin to think of steps they can take to help themselves. In this way, the problems a client lists on Worksheet 2.1 can be used as a springboard for developing therapy goals and even an initial therapy plan.

Thoughts and behaviors are the two parts of the five-part model that are usually easiest for people to directly change. For these reasons, behaviors and thoughts are often targets of CBT change efforts. Behaviors are generally easier to identify, even though changing them sometimes can prove challenging. Thoughts are often out of people's awareness. Therefore, *MOM2* teaches readers how to become more aware of their thoughts. Even though thoughts are not necessarily the root causes of many issues addressed in therapy, the beliefs people hold can interfere with (e.g., "Why try? It won't make any difference") or support (e.g., "If I take it one step at a time, I can do this") change efforts.

Thoughts often serve a maintenance function for mood and behavioral difficulties, and thus have a strong influence over change efforts. Beliefs people hold can make it difficult for them to change behaviors, even when they see the benefits of doing so. Therefore, the next chapter of *MOM2* teaches people more about the roles thoughts play in their lives.

MOM2 CHAPTER 3: IT'S THE THOUGHT THAT COUNTS

The third chapter of *MOM2* is only eight pages long, and yet it includes a variety of examples that demonstrate why it is so important to learn to identify thoughts. The most

Chapter 3 Summary
(*MOM2,* pp. 16–24)

✓ Thoughts help define the moods we experience.

✓ Thoughts influence how we behave and what we choose to do and not to do.

✓ Thoughts and beliefs affect our physical responses.

✓ Life experiences (environment) help determine the attitudes, beliefs, and thoughts that develop in childhood and often persist into adulthood.

✓ *Mind Over Mood* helps you look at all the information available; it is not simply positive thinking.

✓ While changes in thinking are often central, mood improvement may also require changes in behavior, physical reactions, and home or work situations/ environments.

important ideas are highlighted in the Chapter 3 Summary. As noted in this summary, Chapter 3 addresses two misconceptions about CBT that can be addressed early in therapy. The first is a common belief that positive thinking is a solution to life's problems. In fact, positive thinking "is overly simplistic, usually does not lead to lasting change, and can lead us to overlook information that might be important" (*MOM2,* p. 23). A second misunderstanding about CBT is that changing beliefs is the sole focus of the therapy. The final page of Chapter 3 offers a variety of scenarios that demonstrate the equal importance of making changes in thoughts, moods, behaviors, physical responses, and environment/life situations. So, while identifying, testing, and sometimes changing thoughts can help people solve many of life's problems, it is equally important to consider what changes need to be made in all the other areas of the five-part model.

The Thought Connections

Readers of *MOM2* have just one worksheet to complete in the third chapter: Worksheet 3.1, The Thought Connections (*MOM2,* pp. 22–23). Most people find this an easy worksheet to complete, because it offers a concrete scenario about a parent (Sarah) at a school meeting, and then asks readers to imagine what moods, behaviors, and physical reactions are likely to be connected to Sarah's thoughts as described at the top of the worksheet. They simply need to check one or more responses in each of three areas.

This worksheet is designed to encourage readers to apply the ideas in this chapter to a real-life situation. There is no one correct set of answers, because people could imagine responding in a variety of ways to particular thoughts. Instead, therapists can ask clients to say a bit more about why they chose the answers they did, in order to make sure they understand the connections between thoughts and these other parts of

human experience. Alternatively, a therapist can simply ask, "Did this worksheet help you understand how thoughts are linked to moods, behaviors, and physical reactions?" If the client says that it did, the therapist can ask, "Can you give me an example from your own life this week that demonstrates this same connection between thoughts and one of these other areas of your life?"

What Else Therapists Need to Know about Thought Connections

While Chapter 3 provides clients with a simple introduction to the roles thoughts play in people's lives, therapists benefit from a more complete understanding. For example, specific types of thoughts are linked to specific moods. This is called "cognitive specificity." Second, there are three levels of thought commonly addressed in therapy. Therapy proceeds more smoothly when therapists learn to recognize what levels of thought are present, because different therapy tools are used to address each level of thought.

Cognitive Specificity

One of Beck's early contributions to an understanding of the links between thoughts and moods was the idea that each emotional state or mood, regardless of origin, is accompanied by characteristic patterns of thinking (Beck, 1976). Anxiety is accompanied by thoughts of danger and vulnerability; depression by negative thoughts about the self, world, and future; and anger by thoughts of violation and unfairness. Therapy can be hampered if these thoughts are not identified and evaluated. For example, even though increased activity can serve as a powerful antidepressant, many depressed individuals refuse to do activities because of the characteristic thoughts that occur in depression: "It won't help" (hopelessness), "I'm no fun to be around" (self-criticism), and "I won't enjoy myself anyway" (pessimism).

CBT therapists teach clients to identify, evaluate, and change dysfunctional thinking patterns that interfere with improvement in their moods, behaviors, and other aspects of their lives. By understanding cognitive specificity, therapists can make sure that the types of thoughts addressed in therapy are the ones linked to targeted moods. Relevant cognitive changes often also help clients change their environments (e.g., "If I have worth, then maybe I deserve more nurturing relationships") and can be accompanied by neurobiological changes as well.

Three Levels of Thought

Three levels of thought are addressed in CBT: "automatic thoughts," "underlying assumptions," and "core beliefs" (sometimes referred to as "schemas"). Here we offer a succinct primer on these three levels as linked to *MOM2*.

AUTOMATIC THOUGHTS

Automatic thoughts are the moment-to-moment, unplanned thoughts (words, images, and memories) that flow through people's minds throughout the day. These thoughts

are the easiest to change, especially when they are tested within the situations in which they arise. Thus *MOM2* teaches readers to identify automatic thoughts in connection to particular situations. The tool most often used to test automatic thoughts is the thought record (see Figure 6.1 in *MOM2,* pp. 40–41). This 7-Column Thought Record (Padesky, 1983) used in *MOM2* asks people to identify their thoughts (column 3) connected to a strong mood (column 2) they felt in a specific situation (column 1). Then they are asked to look within that situation for evidence that supports (column 4) or doesn't support (column 5) their automatic thoughts. Finally, they are asked to generate an alternative or balanced thought (column 6) that fits the evidence from the situation, and see if this new thought leads to any changes in their mood (column 7). Chapters 4 and 5 of this clinician's guide teach you in depth how to help your clients learn to use 7-Column Thought Records. For a description of how and why this 7-Column Thought Record was developed, see Appendix B.

UNDERLYING ASSUMPTIONS

Underlying assumptions are cross-situational beliefs or rules that guide people's lives; they include "should" statements (e.g., "A mother should always think of her children first") and conditional "If . . . then . . ." beliefs (e.g., "If people get to know me, then they will reject me"). Underlying assumptions are predictive; they guide behaviors and expectations, even though often they are not articulated consciously. The predictive nature of underlying assumptions makes it easier to test them by doing experiments rather than looking for evidence in a single situation. Thus readers of *MOM2* are taught about underlying assumptions in connection with a chapter on testing beliefs with active experiments. Chapter 7 of this clinician's guide provides step-by-step guidance for how to identify underlying assumptions and test these with behavioral experiments.

CORE BELIEFS (SCHEMAS)

Core beliefs or schemas have been described as screens or filters that help process and code information (Beck, Rush, Shaw, & Emery, 1979). In this clinician's guide, we prefer the term "core beliefs" and use it to describe core beliefs about the self, others and the world. Core beliefs are absolute (e.g., "I am strong") and dichotomous (e.g., "I am strong" or "I am weak"). For this reason, they are best examined on a continuum (scale), which can help people see the middle ground between these endpoints. Most life experiences are likely to fall in the middle rather than at the endpoints of a continuum/ scale. We include a Rating Behaviors on a Scale Worksheet in *MOM2* (Worksheet 12.8, p. 171), which can be very helpful for clients who tend to judge themselves, others, and life experiences in "all-or-nothing" core belief terms.

Again, core beliefs usually come in pairs/dichotomies (e.g., "People are cruel" or "People are kind"). According to cognitive theory, only one core belief of a pair is activated at a time (see Beck, 1967). When an intense mood is activated, core beliefs associated with that mood are generally the ones activated. Thus people who are depressed are more likely to believe "I'm unlovable" than "I'm lovable." People who are extremely anxious are more likely to believe "This is dangerous" and "I can't cope" than "This is

manageable" and "I can handle this." When these moods lift, then the alternative paired belief is likely to return.

The core belief that is currently active guides people's interpretations of events in their lives. Thus, when people face a life challenge on a day when they feel highly anxious, they are likely to focus on all the problems ("This is dangerous") and their weaknesses ("I can't cope"); as a result, they feel overwhelmed. On a day when they are not feeling anxious, they could face the same life challenge with resignation or even optimism, because different core beliefs would be active: "This is tough," and yet "I can manage and get through it one step at a time." Work with core beliefs is described more fully in Chapter 8 of this clinician's guide.

WHICH LEVEL OF THOUGHT SHOULD BE ADDRESSED IN THERAPY?

We expect maladaptive core beliefs to be active during intense mood states, because the paired core belief connected to that mood will be the one activated. Automatic thoughts, underlying assumptions, and core beliefs are connected with each other. When a particular core belief is activated, automatic thoughts and underlying assumptions related to this core belief are also likely to be activated. For example, the core belief that "People can't be trusted" is likely to be accompanied by underlying assumptions such as "If I get close, then I'll be hurt," and by automatic thoughts such as "She is trying to hurt me."

Even though core beliefs sound really important to address, it is generally advisable for therapists to work with beliefs at the levels of automatic thoughts or underlying assumptions when clients are experiencing intense moods. Why? Automatic thoughts and underlying assumptions can be tested more quickly than core beliefs can. Most of the time, work on automatic thoughts or underlying assumptions will lead to fairly rapid mood improvement, and more adaptive core beliefs will naturally return. Thus it is better to work with automatic thoughts and underlying assumptions earlier in therapy, and only work with core beliefs if these do not naturally shift over time once clients' moods have improved. If therapy does eventually need to focus on direct interventions with core beliefs, these can take a long time to shift (Padesky, 1994).

When the aim of therapy is behavior change, the best level of thought to focus on is usually underlying assumptions. This is because behavioral patterns are guided by

Reminder Box

The majority of the time, therapists will not need to work with core beliefs at all. Even though core beliefs sound really important to address, it is generally advisable for therapists to work with beliefs at the level of automatic thoughts or underlying assumptions when clients are experiencing intense moods. Once clients experience positive shifts in moods and behaviors, more positive core beliefs are likely to reemerge.

underlying assumptions. For example, addictive behaviors are maintained in part by underlying assumptions about urges (e.g., "If I have an urge, then it will go on forever or get worse if I don't satisfy it") and control (e.g., "If I'm tired, then I can't control myself"). Similarly, underlying assumptions are often at the root of behaviors in relationships. For example, the assumption "If we disagree about things, then that means we aren't compatible" can lead to either avoidance of conflict or unwillingness to make a commitment to a highly positive and yet occasionally contentious relationship.

WHEN WOULD A THERAPIST WORK ON CORE BELIEFS?

Core beliefs may not naturally shift as mood improves if the one of these paired beliefs is either weak or missing. This is sometimes the case for people with lifelong chronic mood difficulties or those diagnosed with personality disorders. For these clients, it can be necessary to identify, build, and strengthen more positive core beliefs (Padesky, 1994) by using worksheets from Chapter 12 of *MOM2*. Even so, the processes of building and strengthening more adaptive core beliefs are easier and more likely to be successful when people experience more balanced mood states. Thus therapists are encouraged to follow the Reading Guides for particular moods (see Appendix A, pp. 456–459, or Guilford's companion website to *MOM2*) and help clients develop mood management skills prior to making efforts to build more positive core beliefs.

LEVELS OF THOUGHT: SUMMARY

In summary, there are three interconnected levels of thought. Core beliefs ("I'm unlovable") give birth to underlying assumptions ("If people meet me, then they won't like me"). Together, core beliefs and underlying assumptions determine what types of automatic thoughts occur. For example, in the presence of an activated core belief that "I'm unlovable," and an underlying assumption that "If I'm depressed, then nothing will help me feel better," a more likely automatic thought would be "I won't have any fun at the party," rather than "I'll go to the party and enjoy my friends."

Many cognitive therapy texts label only two levels of thought: automatic thoughts and schemas. In these cases, both underlying assumptions and core beliefs are considered "schemas." We believe that the three-level system is a more helpful way of classifying thoughts, because therapists can differentially choose therapy methods based on the type of thought to be evaluated.

As a reminder:

- Automatic thoughts are best evaluated on thought records (*MOM2* Chapters 6–9; Chapters 4 and 5 of this clinician's guide).

- Underlying assumptions are best tested with behavioral experiments (*MOM2* Chapter 11; Chapter 7 of this guide).

- Core beliefs can be shifted over time by rating experiences on a continuum and by identifying and strengthening more positive core beliefs (*MOM2* Chapter 12; Chapter 8 of this guide).

The chapters noted in this clinician's guide teach these skills in greater depth.

MOM2 CHAPTER 4: IDENTIFYING AND RATING MOODS

THERAPIST: How did you feel when your friend said that to you?

RICK: I don't know. Bad.

THERAPIST: What type of bad? Sad? Mad? Scared?

RICK: I don't know. Just bad.

As shown in the summary box on the facing page, Chapter 4 is designed to help people become more aware of their moods, identify and name a variety of moods, and rate the intensity of those moods. The ability to identify moods is important, especially because different skills are likely to be helpful, depending upon the types of moods someone experiences. Like Rick in the brief dialogue above, some clients cannot identify and label their moods, or they do not have very big mood vocabularies. For these clients, Chapter 4 offers strategies and exercises to help them learn this useful skill.

Identifying Moods

Identification of moods is a particularly important skill, because it ensures that therapists and clients are speaking a common language. Also, at the end of *MOM2* Chapter 4, readers are asked to go to the chapter with the topic most closely matching the mood that distresses them the most: depression (Chapter 13), anxiety (Chapter 14), or anger, guilt, or shame (Chapter 15). So it is important that people spend enough time in Chapter 4 to identify the moods that are most important for them to understand and manage. To help, Worksheet 4.1, Identifying Moods (*MOM2,* p. 28), asks people to identify moods in five separate situations. If people have mood issues, it is likely that the same mood or moods may show up in several of these situations.

Like Rick in the dialogue above, some people identify all their moods in terms of "I feel bad" or "I feel good." These clients need additional help to learn to be more specific in identifying moods. In therapy, we want to help clients begin to replace vague words like "bad" or "numb" or "tense" with more specific mood descriptions like "nervous," "angry," "irritated," "sad," and "disappointed." Chapter 4 of *MOM2* begins with a mood list (*MOM2,* p. 25) they can use to help identify variations in moods. We suggest that clients who are completely unaware of moods pay attention to their physical reactions or situations that they want to avoid. When they notice physical tension, arousal, or times when they feel "bad," they can use these circumstances as opportunities to scan the mood list and see if any of these moods might fit their reactions.

MOM2 Chapter 4 includes suggested exercises clients can do in terms of paying attention to their body tension to see if different moods affect their bodies in different ways. For example, sadness might feel like a complete lack of energy—"Someone pulled a plug and drained me." Anger might be connected to tension in a client's neck or shoulders. Some people find it helpful to actively search their memories for situations

in which they probably felt particular moods in the past. They can then try to recall what these moods felt like. When clients are struggling to identify specific moods, it can be very helpful to do these types of exercises *in session* until they begin to notice the differences between particular moods. It is also helpful to include more enjoyable moods such as happiness or excitement.

Rating Moods

Once people can identify and label moods, they can learn to rate their intensity. The ability to rate moods is an essential skill, because many people come to therapy to learn how to manage distressing moods, and also to increase positive moods. Changes in mood ratings over time is one way to measure whether the skills they are learning and practicing are helping them reach their mood management and improvement goals. One indicator your clients are able to do this is their ability to complete Worksheet 4.2, Identifying and Rating Moods (*MOM2,* p. 30).

While the worksheets in *MOM2* Chapter 4 use generic mood ratings, readers are alerted that there are more specific mood inventories in later chapters. Specifically, there is a *Mind Over Mood* Depression Inventory (Worksheet 13.1 in *MOM2,* p. 191); a *Mind Over Mood* Anxiety Inventory (Worksheet 14.1 in *MOM2,* p. 221); and a set of scales for Measuring and Tracking My Moods (Worksheet 15.1, *MOM2,* p. 253), which can be used to track a variety of moods, including positive moods such as happiness. The use of ongoing mood measurements to track progress is emphasized in the *MOM2* Chapter 4 Summary.

Chapter 4 Summary
(*MOM2,* pp. 25–32)

✓ Strong moods signal that something important is happening in your life.

✓ Moods can usually be described in one word.

✓ Identifying specific moods helps you set goals and track progress.

✓ It is important to identify the moods you have in particular situations (Worksheet 4.1, *MOM2,* p. 28).

✓ Rating your moods (Worksheet 4.2, *MOM2,* p. 30) allows you to evaluate their strength, track your progress, and evaluate the effectiveness of strategies you are learning.

✓ *Mind Over Mood* can be customized to help with the moods that are most distressing to you. After completing this chapter, go to the recommended mood chapter pertaining to that mood. At the end of that chapter, additional chapters and the order in which you should read them are recommended.

If you know early in therapy that certain clients are experiencing depression, anxiety, or another mood, you can ask them to fill out the relevant *Mind Over Mood* inventories or other mood measures before they read Chapter 4 of *MOM2.* In fact, we recommend asking all clients to fill out relevant mood measures at the beginning of therapy. Tracking change on these measures is one of the best ways to get feedback on whether therapy is helping or not. Most CBT therapists ask their clients to fill out a variety of mood measures at intake; then, throughout the course of therapy, they regularly ask them to complete measures pertaining to moods targeted in therapy.

As noted in Chapter 1 of this clinician's guide, your clients can download fillable .pdf versions of the *MOM2* mood measures from Guilford's *MOM2* companion website (again, see the end of the *MOM2* table of contents, p. vi there) and load these onto an electronic device to facilitate easy completion and storage. If you choose to suggest this, remember to advise your clients about potential limits to confidentiality if they load and store their worksheets on devices that can be accessed by others.

TROUBLESHOOTING GUIDE: *MOM2* CHAPTERS 1–4

A variety of dilemmas can arise when you decide to incorporate *MOM2* into therapy. Most of these are variations on potential roadblocks that can occur in therapy even if you are not using a workbook. The most common issues are addressed here.

When Clients Have More Than One Primary Mood

People commonly struggle with more than one mood. Depression is often comorbid with anxiety, guilt, shame, and/or anger, for example. This is actually one of the rationales for why we have covered a variety of moods in *MOM2,* rather than taking the easier course of writing a self-help book for a single mood. It can be encouraging for clients to see that skills they are learning can be helpful for several or even most of their moods. On the other hand, at the end of *MOM2* Chapter 4, we ask people to choose one mood and follow the Reading Guide for that mood (see Appendix A, pp. 456–459, or Guilford's *MOM2* companion website) during the opening weeks and months of using the workbook. If clients are struggling with more than one mood, how do they choose? Some clients have no difficulty choosing the mood they want to tackle first.

When clients are uncertain which mood to choose, ask them to consider the following questions:

1. "Which moods do you experience most intensely? Which moods interfere with your life the most?" (Note: The *MOM2* mood measures can help determine mood intensity.)

Paul experienced both anger and anxiety. He rated both moods at a level of about 80/100 at their worst. However, his anger was leading to difficulties at work and home that were reaching crisis levels. Thus he decided to target anger first, even though he also wanted help with his anxiety.

2. "Which moods do you find most troubling?" This is often not the same as intensity.

Emma experienced intense anxiety, but she had been experiencing anxiety for many years and was "used to it." When she began to feel depressed, she became very worried and concerned about suicidal thoughts. Thus she reported being more troubled by depression than by anxiety, even though her anxiety scores were higher.

3. "Is one mood primary, in that it probably gives rise to most of your other moods?"

Mahmoud came to therapy to get help with depression, which had become quite severe over the past year. His therapist discovered that Mahmoud also had a long history of social anxiety. Over the past three years, he had increasingly withdrawn from live social interactions. Mahmoud spent more and more time at home and only participated in activities he could do online. As he and his therapist began discussing activities he could do that might help lift his depressed mood, it became clear that Mahmoud's social anxiety was creating a barrier to standard CBT for depression. They agreed that they needed to address his social anxiety first.

4. "Which mood do you want to work on first?"

Occasionally therapists have concerns that their clients are not choosing the "right" mood to work on, or they disagree with the choices their clients make. It is generally better to begin therapy by targeting the goals that are most important to your client, even if you think a different starting point would be better. Clients' perception that their therapists agree with and are working toward client-chosen therapy goals is among the components of a good therapy alliance (Bordin, 1979; Horvath & Greenberg, 1989). For example, if Mahmoud in the example above wanted to work only on his depression, rather than starting with his social anxiety, then his therapist would be better off figuring out ways to modify depression treatment in the early weeks of therapy. If Mahmoud made some progress in reducing his depression, their therapy alliance would be likely to increase (Strunk, Brotman, & DeRubeis, 2010). At this time, his therapist might be able to help Mahmoud consider the pros and cons of addressing his social anxiety as well.

When Clients Have Limited Reading Ability

The first edition of *Mind Over Mood* was rated on a variety of readability scores and given an average reading score rating of age 15 (Martinez, Whitfield, Dafters, & Williams, 2007). When writing the second edition, we aimed to simplify the words used and shorten sentences so that even those adults and older adolescents with lower reading abilities could read and understand it. To date, we are not aware of any analyses of the second edition's reading level, although most adults are capable of reading all of *MOM2*.

Even so, some clients will have limited reading abilities or attention spans. For

example, a client who is severely depressed may find it challenging to read more than a page or two at a time. One way to simplify *MOM2* is to describe the four characters followed in the manual (Ben, Marissa, Linda, and Vic) and ask clients to pick the character who is most like them. A client can then be instructed to follow this one character while reading *MOM2,* and to ignore most of the text related to the other characters.

Suppose that Rita, who is severely depressed, chooses to follow the *MOM2* character Marissa, who was also very depressed. In *MOM2* Chapter 2 (Understanding Your Problems), the therapist crosses out the sections describing Vic and Linda, and asks Rita to read only the opening pages of the chapter (which introduce concepts via Ben, who was also depressed), the section describing Marissa, and the exercise titled Understanding Your Own Problems. Eliminating the sections on Vic and Linda reduces the chapter length almost by half; it also eliminates the discussion of anxiety, which Rita does not need at this time. Her therapist can similarly trim the following chapters to help create a shorter, easier-to-read version of *MOM2*. Rita's therapist should provide guidance on what to read in each chapter, because some important learning points will be missed if *all* references to Vic and Linda are skipped.

Clients who are unable to read and write may not be able to use *MOM2* directly. However, some of these clients may benefit from using an audio reader for *MOM2,* or their therapists can use *MOM2* to guide treatment planning and client exercises. Keep in mind that we ask clients to read and write things down for two reasons: to help clients consolidate skills and to help them remember important learning points. In our experience, clients who do not read or write have often created other ways to remember things. Therapists are encouraged to be curious as to how these clients remember important things, and to incorporate these methods into therapy. For example, clients can benefit from pictorial reminders of what they are learning in therapy. A client keeping a Core Belief Record (Worksheet 12.6, *MOM2,* p. 166) can cut out and save magazine pictures to help remember events that support a new core belief. Clients who can read but cannot write can use a digital recorder to complete *MOM2* exercises. In these ways, therapists can creatively adapt the material in *MOM2* for use with many clients who otherwise might seem poorly suited to benefit from this workbook.

When Clients Don't Do What They Agree to Do

What we ask clients to do in therapy, and how we ask this, will have a big influence on their level of participation. Following a few simple guidelines will greatly increase the likelihood that clients will read and complete *MOM2* exercises and other types of skills practice between appointments.

1. Make Assignments Small

Reading and writing assignments should be workable enough to fit in a client's schedule. For example, a working mother with two small children may have to make an enormous effort to spend even five minutes a day reading or writing. Discuss reasonable expectations with each client. Some clients will commit to spending 15–20 minutes per week on assignments; others may be able to spend as much as an hour per day.

2. Assign Tasks Within the Client's Skill Level

MOM2 is written to help clients develop skills that have been linked with improved mood and more effective problem solving. If therapy moves too quickly through the workbook, clients can begin to feel lost and stop doing assigned readings and worksheets. Clients will have to complete some chapters and worksheets more than once to learn skills. Occasionally chapters presuppose that clients can use the skills taught in earlier chapters. For example, if a client is asked to fill out a complete 7-Column Thought Record (Chapters 8 and 9) before learning to identify hot thoughts (Chapter 7), the client may not be able to complete the assignment. If you follow the Reading Guides on pages 456–459 of Appendix A, you can be assured that skills are being learned in an order that makes sense for a particular mood. It is also wise to assess skills in session via written, role-play, or imagery practice.

3. Make Assignments Relevant and Interesting

Link therapy assignments to clients' goals, and make the assignments as interesting as possible. One way to increase the interest level is to use action phrases like these:

"Let's see what happens if . . ."
"Let's plan an experiment for this week . . ."
"I'm curious what you will notice when . . ."
"Write down what happens, and we will see what we can learn from it next time."

This type of language is much more engaging than using a phrase like "homework assignment," since very few people get excited about doing homework. People are more likely to feel energized by the idea of doing experiments, investigating, noticing and writing down what they observe, or trying something out to see if it helps.

One study found that clients were more likely to do homework that was directly linked to learning that they found most helpful in a session (Jensen et al., in press). Consider Bill, who wants greater success in his relationships. When his therapist asked him 30 minutes into their meeting what had been most helpful about the therapy session so far, Bill reported he was most interested in what his therapist taught him about automatic thoughts and images, because he realized he had many of these that interfered with his dating efforts. Which of these assignments do you think he will be most likely to complete?

a. "Write down ten automatic thoughts and images this week"

b. "Read *MOM2* Chapter 6."

c. "Imagine that you are preparing to call Pat for a date. Write down three automatic thoughts or images that could stop you from making the call. Pick one of these thoughts or images, read *MOM2* Chapter 6, and see if you can complete the evidence columns of a thought record, using the questions in the Helpful Hints box on page 75 for guidance. Notice if you feel more or less inclined to call Pat after you work on the thought record."

Although the third assignment (c) is more complex, Bill is more likely to complete it, because it is directly relevant to his problem. Also, if calling for dates has been a road-block for Bill, he will probably be interested to learn more about this experience. The Helpful Hints box on page 75 of *MOM2* can help him begin to resolve his difficulty. Therefore, Bill will benefit more from the third assignment than from either of the first two, which are more rote.

4. Collaborate with Clients in Developing Learning Assignments

Encourage your clients to collaborate with you in selecting and planning therapy assign-ments. Clients can often figure out what steps need to be taken and how quickly they can take these steps. Part of planning assignments together is discussing whether a client is willing to do particular assignments. Don't ask clients to do things that they are not willing to do, or that you would not be willing to do yourself. Clients are more likely to complete collaboratively designed learning tasks rather than tasks simply assigned by a therapist.

5. Provide a Written Summary and a Clear Rationale for Each Assignment

Often clients are motivated to do therapy exercises, but they forget what to do or why they are doing them. Once you and a client have chosen a learning assignment for the week, write it down. A written summary can include a rationale for the assignment (What is the client going to try to learn? How is this linked to therapy goals?); a specific description of what the client will observe, read, write, or do; and an alternative plan if the original task proves impossible. For example, the alternative learning exercise may be to write down thoughts and moods that interfere with completion of the original assignment.

6. Begin the Assignment during the Session

One of the best ways to make certain a client understands and can complete a learning exercise is to begin it during the therapy session. For example, a client who is asked to write down automatic thoughts related to self-doubt can notice any doubts regarding the ability to complete this assignment. If so, these doubts can be written down as a sample of the type of thoughts that will be recorded. Beginning an assignment in the therapy session increases the client's understanding of what is expected. Furthermore, difficulties that can interfere with completion of the assignment often emerge when the client attempts to begin it (in writing, role play, or imagination) under your guidance. You then can address these roadblocks in advance.

7. Identify and Problem Solve Impediments to the Assignment

It is not enough to clearly assign a therapy task. Ask the client, "What could interfere with completing this exercise?" When asked, clients usually are able to anticipate likely difficulties. Discussing these difficulties ahead of time increases a client's ability to

fulfill learning assignments. For example, if a client says, "I might forget," the two of you can discuss a plan for remembering. If a client says, "I'm not sure I'll have time to complete these observations this week," you can discuss whether to reduce the size of the assignment or how to prioritize observations so that the client can learn the most from whatever time is available for the task.

It is helpful to encourage clients to solve on their own any difficulties they identify. Instead of offering a quick solution ("Maybe you could take 10 minutes during lunch each day"), it is better to ask a client, "How would you like to handle that? What do you think would help?" and then allow a period of silence for the client to think it through. People are more likely to employ strategies they think of themselves than to follow another person's advice. Also, people often devise better solutions for their difficulties than the ones you suggest, given they know themselves and their daily schedules much better than you do.

8. Emphasize Learning, Not a Particular Desired Outcome

A prime goal of therapy is learning. Sometimes people learn more from undesirable outcomes than from successful ones. Clients can become discouraged if a therapist seems to expect particular outcomes that do not occur. Therefore, do not predict what clients will learn from their activities. Instead, be open to whatever learning emerges from experiments, observations, or written exercises.

To set the stage, you might say, "We've talked today about how directly saying what you want could make you feel less burdened by your friends. We won't know if this works until you try it. Do you think it could be worthwhile to try what we practiced today a few times this week?" If the client agrees, you can continue: "When you do this, notice how you feel and how your friends react. That will help us learn if this idea is helpful or not." This instruction keeps the door open to both expected and unexpected results. For example, Marla could discover that her friends become irritated when she expresses her wishes. Although unexpected, this outcome provides important information that could shift your mutual understanding of her issue. Perhaps she feels burdened by friends because they do not respect her feelings, or perhaps she expresses herself in ways that are interpersonally harmful.

It is part of therapists' role to help clients learn *something* from every exercise completed. Therapists should strive to help clients learn from incomplete tasks as well. For example, when a client expressed willingness to read a chapter or complete a worksheet and then did not do it, exploration of this lapse can uncover life events, moods, or beliefs that are interfering with progress. Or the therapist can learn that certain aspects or purposes of an assignment were not clear to the client.

9. Show Interest and Follow Up in the Next Appointment

Ideally, you will be interested in what your clients learn from their activities between sessions. Showing your own enthusiasm encourages clients and so does spending time each session discussing their efforts. How do clients' reading, writing, experiments, or observations contribute to learning or bring them closer to their therapy goals?

When you link clients' learning activities to therapy progress, you encourage clients to continue their efforts.

It is a good therapist practice to write down what each client has agreed to do that week. Reviewing these notes before the next session helps you remember, so you can greet the client with genuine curiosity in the next meeting—for example, "I am really interested to learn how that Action Plan worked with your family this week." Reviewing your clients' between-session learning activities should be part of each session's agenda. For more about agenda setting, see the "Collaboration: Agenda Setting" section of Chapter 14 of this clinician's guide.

10. Learn from Nonadherence

Don't think of clients' nonadherence with learning assignments as "resistance" to therapy. There are usually very good reasons why clients do not complete activities they have agreed to do. Ask your clients why they didn't do what you discussed. Identifying these reasons helps both you and them problem solve impediments to therapy progress. Review the previous nine therapist guidelines to make sure you are doing everything possible to make adherence easy for your client. If you are implementing all of these principles, then examine client factors. Two types of client factors that commonly underlie nonadherence are life factors or problems that need to be solved, and beliefs that interfere with adherence.

LIFE FACTORS OR PROBLEMS TO BE SOLVED

Quite often when clients come to a session without having done a learning assignment, they explain that they forgot or didn't have time to do the assignment. Ask clients to estimate how much time they think an assignment could take. If their estimate is different from yours, review what is expected and begin the assignment in the session, to evaluate the likely time demand. It also can be worthwhile to develop practical, specific strategies to help clients complete assignments. The two most common strategies are scheduling a particular time to do assignments and doing assignments on an as-needed basis.

Some clients find it helpful to schedule a predesignated time to do assignments. If the designated time precedes or follows a daily activity such as brushing teeth, eating dinner, or taking a coffee break, then the daily activity becomes a cue and a reminder to do the assignment. A depressed client who agrees to fill out one thought record at a designated time every day can be asked to mentally review the previous 24 hours and choose the most depressing moment as a focus for that thought record. One disadvantage of designating a time to write out detailed observations such as those required by a thought record is that the memory of the experience may have dimmed by the time the thought record is written.

An alternative to the predetermined time method is the as-needed method. Some clients find it easier to do thought records and other assignments during or immediately following a mood-related experience. They can take *MOM2* with them to work,

carry it with them in their car, keep it available while at home, use a printout of the 7-Column Thought Record, or use the fillable .pdf forms on their electronic devices. For these clients, the cue or reminder to do a thought record is the experience of a particular emotion or behavior. The advantage of the as-needed method is that clients address difficulties immediately, when details of the experience are fresh in their mind. The disadvantage of this method is that events may not occur frequently enough for rapid skill building. To increase the number of situations addressed, clients who experience moods infrequently can use previous experiences for skills practice.

You and your clients can consider a broad spectrum of issues that can interfere with learning activities (e.g., nonsupportive family members, an abusive partner or colleague, or substance misuse). For example, Mary did not complete her written assignments three sessions in a row. During the fourth session, she revealed that she was reluctant to write anything on paper at home, for fear that her physically abusive husband would find it and become enraged. Mary and her therapist decided that it would be safer for her to come to therapy sessions 30 minutes early, do her written assignments in the waiting room, and leave written material with her therapist. In this way, Mary could benefit from written assignments and be assured that her husband would not see what she had written. Of course her therapist also explored with Mary issues related to keeping her safe from abuse.

INTERFERING BELIEFS

Some clients believe that seeing a therapist will lead to improvement if they just show up for every session. They can think of therapy as analogous to seeing a physician and expect that they merely need to attend each appointment, perhaps take some medication, and not do anything else until the next appointment. In CBT, and when using *MOM2,* clients are asked to be much more active and collaborative in their treatment. You can check, especially early in therapy, whether your clients understand that they are required to play an active role. Even if they do, it is helpful before making the first assignment to offer a rationale for between-session efforts. You can assert that what happens between therapy sessions is as important as what happens during them. Clients' adherence with learning assignments has prognostic implications: clients who do assignments tend to get better faster (Kazantzis et al., 2016). This explanation is often sufficient to increase adherence.

When clients routinely do not complete agreed-upon activities, nonadherence becomes a therapy focus. Nonadherence is a valuable opportunity to discover beliefs that need to be addressed before therapy is likely to be beneficial. For example, consider how each of the following beliefs would affect adherence to therapy learning assignments:

"It's hopeless; nothing I do will make a difference."
"I won't do it right."
"I won't do it perfectly."
"My therapist will criticize me."

"If I show my therapist what I am thinking, she will know I'm crazy."
"If my therapist really cared, he would know how tough it is for me and not ask
        me to do more."

Therapists can identify beliefs like these that accompany nonadherence and address them
by using the methods detailed in *MOM2*. Evaluating these types of beliefs increases
the likelihood of changing nonadherence to adherence. In addition, beliefs related to
nonadherence sometime mirror underlying assumptions that are contributing to other
problems in clients' lives.