

# **The Williams Trouble Box**

## **The Williams Trouble Box A Therapeutic Perspective and Tool** *Understanding the Differential Anticipation of Emotional Reaction to Troubles vs. Problems ©2007, Sharon Easley Williams*

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# The Williams Trouble Box

## *The Williams Trouble Box A Therapeutic Perspective and Tool*

### *Understanding the Differential Anticipation of Emotional Reaction to Troubles vs. Problems*

#### **Background:**

This paper outlines a theory; ways of thinking about everyday situations that can, if not meted with ingenuity, become compounded and seem insurmountable. As a social worker, I have found that people react curiously to the concept of *troubles* verses the concept of *problems*.

Indeed the definitions of the two words indicate a distinct difference. In Webster's New World College Dictionary (3<sup>rd</sup> ed.), 1997, one definition of problem is as follows "a question, matter, situation, or person that is perplexing or difficult" while trouble is defined as "to cause mental agitation to: worry; harass; perturb; vex". In addition, the word problem is identified as a noun and the word trouble is identified as a verb. The same text also defines problematic as an adjective meaning "not settled; yet to be determined; uncertain" and troublesome as an adjective meaning "characterized by or causing trouble, irritation, difficulty, distress, inconvenience, etc."(p. 106).

Therefore, it is logical that the general philosophy of most people is that everyone has problems, difficult decisions to ponder, and situations that must be fixed. Life is full of problems and we all have to deal with them. Some problems are larger than others by everyday standards; however, this is a matter of subjectivity and therefore; what one individual might consider and insurmountable problem, others may consider a slight annoyance.

These problems can cause distress, mental agitation, worry or trouble and are internalized and stored in an *internal trouble box*. However, because of the subjective

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view of problems, some individuals may be troubled while others choose to determine a solution and settle the problem; avoiding their troubling affects. The Williams Trouble Box Therapy suggests using *minimal negation* to assist clients in assigning more positive aspects to problem situations, thereby reducing troubling associated feelings stored in the *internal trouble box*.

Minimal Negations refer to redefining client's problem descriptions in an effort to reassign the associated feelings. For example, if a client is emotionally troubled due to not landing a job at an interview that he/she now feels totally embarrassed/ashamed leading to self doubt that he/she is even qualified for this or any job, the client will continue to hold the emotions surrounding this event (the internal trouble box) .The therapist will use *minimal negation*, such as discussing the clients qualifications and reassigning a new title to “not good enough for the job” to “not prepared for the interview”.

The problem and troubling emotions associated will be placed in the Williams Trouble Box (external holding place for troubles). This suggests to the client a new less intrusive holding place for the event(problem) and the emotional consequences(troubles) are now lessened and externalized, giving the client more positive future expectations of the next interview because of better preparation and not based on the negative outcome of the last interview. The client begins to realize that negative events do not define who they are as these events are externally contained and controlled.

There are many approaches for helping individuals cope with irrational thought processes that may be causing anxiety, however The Williams Trouble Box Therapy

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looks at ways to assist individuals in systematically dismantling problems and the associated negative anticipation of outcomes.

Many of today's theorists have their own websites discussing their theories and approaches. Since these websites include first hand accounts of these approaches, I thought it relevant to include their information.

Rational Emotive Behavior Therapy (REBT) is one psychotherapeutic approach that has gained much acclaim. It was created by Albert Ellis in the 1950's and according to the REBT network (2007), "REBT is based on the premise that whenever we become upset, it is not the events taking place in our lives that upset us; it is the beliefs that we hold that cause us to become depressed, anxious, enraged, etc. The idea that our beliefs upset us was first articulated by Epictetus around 2,000 years ago: *'Men are disturbed not by events, but by the views which they take of them.'*".

According to Albert Ellis (2006),

...the vast majority of us want to be happy. We want to be happy whether we are alone or with others; we want to get along with others—especially with one or two close friends; we want to be well informed and educated; we want a good job with good pay; and we want to enjoy our leisure time.

Of course life doesn't always allow us to have what we want; our goal of being happy is often thwarted by the "slings and arrows of outrageous fortune." When our goals are blocked, we can respond in ways that are healthy and helpful, or we can react in ways that are unhealthy and unhelpful. (rebtnetwork.com, 2006).

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Albert Ellis' REBT ([rebtnetwork.com](http://rebtnetwork.com), 2006) posits that

Our reaction to having our goals blocked (or even the possibility of having them blocked) is determined by our beliefs. To illustrate this, Dr. Ellis developed a simple ABC format to teach people how their beliefs cause their emotional and behavioral responses: **A.** Something happens. **B.** You have a belief about the situation. **C.** You have an emotional reaction to the belief.

Another approach was developed by Aaron T. Beck. ([beckinstitute.org](http://beckinstitute.org), 2007),

Dr. Beck developed cognitive therapy in the early 1960s as a psychiatrist at the University of Pennsylvania. He had previously studied and practiced psychoanalysis. A researcher and scientist at heart, Dr. Beck designed and carried out a number of experiments to test psychoanalytic concepts of depression. Fully expecting research would validate these fundamental precepts, he was surprised to find the opposite. This research led him to begin to look for other ways of conceptualizing depression.

Working with depressed patients, he found that they experienced streams of negative thoughts that seemed to pop up spontaneously. He termed these cognitions "automatic thoughts," and discovered that their content fell into three categories: negative ideas about themselves, the world and the future. He began helping patients identify and evaluate these thoughts and found that by doing so, patients were able to think more realistically, which led them to feel better emotionally and behave more functionally.

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Beck, according to Keuhlwein (1988), described "... the automatic activation of certain Cognitive-affective-behavioral modes...[that] cause people both to process incoming information along certain dysfunctional lines and to preferentially seek out certain types of data that support their negatively biased views(Gielser et al., 1997)" (p133).

Keuhlwein (1988) further states that according to Beck, "...it is a natural function of the activation of certain deep, personal meaning-making structures (schemas) that are evoked by situations in the world that are thematically related to them" (p. 133).

Therefore, every event triggers an emotional reaction predicated by a previously held belief. Cognitive therapy does not necessarily seek to determine what caused these previously held beliefs, but on how the client is currently interpreting situations and the feelings that accompany those interpretations.

According to rcpsych.com, 2007,

CBT is a way of talking about how you think about yourself, the world and other people; how what you do affects your thoughts and feelings. CBT can help you to change how you think ("Cognitive") and what you do ("Behavior)". These changes can help you to feel better. Unlike some of the other talking treatments, it focuses on the "here and now" problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve your state of mind now. CBT can help a client to make sense of overwhelming problems by breaking them down into smaller parts. This makes it easier to see how these problems are connected and how they affect you. These parts are a Situation - a problem, event or difficult situation from *this can follow*: Thoughts, Emotions, Physical feelings, and Actions. Each of these areas can affect the

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others. How you think about a problem can affect how you feel physically and emotionally. It can also alter what you do about it (p.1).

According to Hollon and Beck (1994), "...In this approach [RET], clients are taught to examine the rationality of their beliefs and are encouraged to adopt a more stoic philosophy (Ellis, 1980)" p. 429.

These authors also note that "RET tends to rely more on verbal persuasion than do the other cognitive and cognitive-behavioral approaches. The role of the therapist is to help the client identify and actively dispute his or her irrational beliefs" p. 429. Hollon and Beck state that although behavioral approaches are often included with this therapy, it is more to assist clients in adapting to their new beliefs than to assist in changing the beliefs.

Hollon and Beck (1994) also discuss Meichenbaum's stress inoculation training (SIT) which assists clients in coping with problematic life events by incorporating "cognitive restructuring with training in verbal self-instruction and behavioral self-management techniques" p. 430.

In addition, Turner (1996) lists several theories and theorists who have made contributions to cognitive therapeutic approaches aimed at helping individuals to alter negative and/or irrational thought patterns that hinder optimal functioning. He included Alfred Adler, Joseph Furst(Rational Psychotherapy), Albert Ellis(RET), William Glasser(Reality Therapy), Maxie Maultsby(RBT), Arnold Lazarus(Multimodal Therapy), Don Tosi( Rational Stage Directed Hypnotherapy), Victor Raimy(Self-concept), Rollo May((unactualized being) and Viktor Frankl(Socratic approach) among others.

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According to Freeman and Reinecke (1995),

The development of cognitive psychotherapy encompasses early work by Bandura(1979, 1977a, 1977b, 1985), Beck(1970, 1972, 1976), Ellis(1962, 1973, 1979), Goldfried(see Goldfried & Merbaum, 1973), Kelly (1955),(A. Lazarus(19876, 1981), Mahoney(1974)Maultsby(1984), Meichenbaum(1977), Mischel(1973), Rehm(1977), and Seligman (1974, 1975)”(p. 185). These authors also state, “The cognitive therapy model posits that three variables play a central role in the formation and maintenance of common psychological disorders; the cognitive triad, schemata, and cognitive distortions (Beck et al., 1979, Freeman, Pretzer, Flemming, & Simon, 1990) (p188).

Nichols and Schwartz (2001) identified several approaches to reducing anxiety and depression in family therapy.

In contrast to these views, Moretti, Feldman, and Shaw (1990), argue the merits of the role of cognition in psychopathology. They state, "Cognitive models of psychopathology stand in marked contrast to traditional psychodynamic and behavioral schools of thought” (p 217).

They indicate that cognitions are significant in the etiology and maintenance of psychopathology, but assert that self reports of negative thoughts are secondary and not primary symptoms of a disorder (mainly depression and anxiety) and may reflect transformed or indirect expressions of underlying conflicts, or they may operate as a form of defense to divert attention away from more significant emotionally distressing issues...and [therefore] interventions directed at changing

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cognitions in depression are only effective in treating a symptom of the disorder and not the cause (p 217) .

These authors relate negative cognitions to patient's lack of positive reinforcements caused by social maladjustment and social skills deficits. They point out that Behaviorists see negative thoughts as additional behaviors holding no etiological significance and therefore if the behaviors, which they believe to be primary change, the thoughts which they believe to be secondary will also change. This argues the age old question of which came first, the chicken or the egg...the action or the thought.

Then there are those theorists who suggest that suppression of the intrusive thoughts or thought stopping techniques are the answers to overcoming anxiety and depression related to anxiety. Still others disagree with this notion and suggest that these thoughts need to be met head on and altered; the pattern of negative thinking should be altered by changing the way thoughts are interpreted and addressed in the mind. They also suggest that attempting to stop negative thoughts has the opposite affect and that the negative thoughts are increased. According to Wells and Butler (2001, in Clark and Fairburn, Eds.),

Wells and Davies (1994) developed the Thought Control Questionnaire (TCQ) to measure individual differences in strategies used to control unwanted/unpleasant thoughts" (p. 165). Others have developed instruments to measure anxiety or worry. Again, Wells and Butler (2001in Clark and Fairburn) state, "Three questionnaire instruments have recently been developed to measure worry; the Penn State Worry Questionnaire (PSWQ, Meyer *et al.* 1990), the Worry Domains Questionnaire (WDQ, Tallis *et al.* 1992), and the Anxious Thoughts Inventory

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(AnTI, Wells 1994b). ... The AnTI is a multi-dimensional measure of worry that assesses process characteristics of worrying in addition to worry content. It has three subscales that measure social, health, and meta-worry. Meta-worry consists of worrying about worry, and includes negative appraisals of thought as uncontrollable and intrusive. Meta-worry is likely to be an important dimension of worrying since the appraisal of worries as uncontrollable, disruptive, and less successfully reduced by control attempts differentiates the worry of people with GAD from the worry of non-anxious individuals (Cranske *et al.* 1989) (p. 166).

This suggests that once worry begins, it is akin to the “horse out of the barn” scenario and cannot be addressed as if it has never happened. I agree that the anxious thoughts or feelings should be addressed and that attempts to thwart these thoughts and feelings are futile and may cause more harm. I believe that these thoughts and feeling should be acknowledged and diverted, to be addressed one at a time.

According to [panicandxietyattacks.com](http://panicandxietyattacks.com),

...the most effective way to eliminate intrusive thoughts is to try and not suppress them. Thought suppression studies, (Wegner, Schneider, Carter, & White, 1987) have proven that the very act of trying to suppress a thought, only results in a higher frequency of unwanted intrusive thoughts occurring. This reoccurrence of the thought has been termed the ‘rebound effect’. Simply put: the more you try suppressing a thought, the more the unwanted thought keeps popping up (rebounding). ..There needs to be a change of attitude. By a change in attitude, I mean a change in the way you have been reacting to the intrusive thoughts. A

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change in attitude will quickly disarm the emotional reaction you are having to the fearful thoughts. Once the emotional reaction has been significantly reduced, the anxious intrusive thoughts will dissipate. In the past you have probably tried to rid yourself of the thoughts by attempting to struggle free of them. (p.2)

The list of theorists and theories related to cognitive distortions and their association with depression and anxiety is ever expanding. The cognitive theorists listed above and others have investigated the reasons why some thoughts become troubling and have devised theories to assist in changing the ways in which people think about situations so as to make them less troublesome. Many of these approaches are empirically based and touted by many. In contrast, Behaviorists have investigated and reasoned why behavior change is the catalyst to thought change and have devised theories and models to support their claims.

The Williams Trouble Box therapy and tool is not in contrast to these findings, but rather offers a therapeutic, external holding place for problems and troubling thoughts, so that individuals are not overwhelmed and therefore; have time to work on each problem while addressing not only their current troubling issues related to the problem, but more; their anticipated beliefs about the future outcomes to these problems and how they will cope with the accompanying emotions.

I think that Cade and O'Hanlon (1993) summed up the issues very well in surmising that people use frameworks or hierarchies of constructs to make sense of their worlds and that these frames are the major focus of therapy. They go on to state that "changes can only occur where alternate meanings become available"(111).

They emphasize this point and give an example by citing de Bono (1971)

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A frame of reference is a context provided by the current arrangement of information. It is the direction of development implied by this arrangement. One cannot break out of this frame of reference by working from within it. It may be necessary to jump out, and if the jump is successful then the frame of reference is itself altered. (de Bono, 1971, p.240)(p. 111).

Therefore, it is important to help these individuals "jump out" and change thoughts, emotions, and physical feelings by helping them first, store them in a physically external environment, identify these *anticipated negative emotions associated with the anticipated negative outcome*, construct a plan to alter the negative outcomes (if possible) and/or devise a plan to cope with the anticipated negative emotions. Having a Plan (*Positive Level Alternative Negotiation*) or a viable alternative for positive solution helps the client release these negative anticipatory emotions.

### **Review of Issues, Theory, and Model**

#### **Issue:**

The problems that trouble most people are the ones for which they seem to have no viable positive solutions or outcomes and thus they begin to imagine the negative outcomes of these problems and to anticipate the negative emotional reaction to these negative outcomes. This negative anticipation of negative emotions begins to interfere with pleasurable life experiences causing anxiety and stress in the present and in the future. The client is paralyzed with negative anticipation and is unable to function in a way that will help resolve the problem, further reinforcing the negative anticipation.

The current arsenals of approaches are proven effective in reducing anxiety and depression in most cases, when those thoughts are irrational. However, there is no viable

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approach to assist clients in prioritizing real problems (social, cultural, family, school, etc.), rationally anticipating outcomes, assisting the client (if possible) in averting negative outcomes, creating a psychological and physical holding space for problems, and preparing the client to work through the outcomes with a neutral emotional anticipation.

### *Theory:*

Troubling thoughts begin with the negative anticipation of the consequences of the problem, and then escalate into negative anticipation of the negative emotion one will feel when the negative consequences of the problem are realized. If negative anticipation of the negative emotion were not attached to the problem, the individual could then focus on solutions to alleviate the troubling thoughts associated with the problem, lessen the affective decisions hindering remedy of the problem, and eventually find viable solutions for eliminating the problem. Negative anxiety caused by specific negative anticipation will be identified and more quickly addressed and eliminated and/or reversed so that the anticipation of outcomes is more positive for each specific problem as well as the overall outlook of problems that may arise in the future.

The negative anticipation of negative emotions is based on **personal past experiences, implanted commentary of others current and past experiences, and environmental influences of current and future expectations (these could be socio-political, traditional, or spiritual).**

Personal past experiences are based on the individual's actual lifelong experience with similar situations and actual outcomes.

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Implanted commentaries are verbal accounts by others of similar situations and the actual outcomes. These could be past or present commentaries of current or past events.

Environmental influences are the socio-political, traditional, or spiritual underpinnings of similar situations experienced by the client and/or his or her identified culture. These could be past, present, or future projections based on the past and the present circumstance.

Therefore, the client's problems are in the here and now (present). The repercussions of the problem (i.e., the troubling thoughts) are rooted in the past, present, and future.

These emotions are best resolved externally. The Williams Trouble box is an external device to hold problems and troubling emotions.

**Example:** Not having a job is a big problem to most people because without a job there are normally no funds to pay for living expenses. This is a present environmental influence. However, what is troubling to people in this situation is that they feel helpless, embarrassed, afraid that they may not have electricity, water, food, or a car. Troubles are those negative feelings associated with problems or the negative consequences or outcomes of the problems (*past environmental influences, personal past experience and implanted commentary*).

If the negative anticipation of negative emotion based on an assumed negative outcome were not associated with this problem, the individual would merrily go about the business of finding another job and find one much quicker than if they allowed negative anticipation of negative emotions to fill their thoughts. Not having a job is not imaginary or delusional and the troubling emotions associated with not having a job are not irrational.

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The Williams Trouble Box helps the client understand how to separate problems from his/her emotional reactions to the problems (*troubles*) and store them externally. Client's can then prioritize problems, store them in the box, and work with the therapist to reduce the anticipation of negative emotions associated with each problem. Current as well as anticipated emotions become more positive.

Although all of the problems may not have a positive outcome, the client learns to reduce negative anticipation of negative emotions to the outcomes. The client learns to resolve the trouble even if the problem remains.

Clients become more relaxed and confident and thus, begin to experience more positive outcomes. Clients gradually experience positive changes in environmental influences and negative and positive implanted commentary is weighed against positive anticipation of outcomes.

This is done one problem at a time. Helping the client to think of opportunities for positive change rather than troubles will shed a more positive light on the situation and prepare the client to view these situations as opportunities rather than a calamity waiting to happen.

Problems are an expected part of living. There is normalcy to having problems. Problems are anonymous for the most part, embedded in a stream of endless, everyday occurrences. However, the word "trouble" conjures up a more concrete, identifiable, tangible agitation, discomfort, anxiety and distress because of the negative emotion ascribed to the negative anticipation of negative outcomes. These emotions are rooted in the negative anticipation of negative consequences that if not disposed, create greater/heightened emotions associated with these problems.

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## ***The Trouble Box Therapeutic Model***

Most people do not believe that they will ever resolve all of their problems, but do believe that it is possible to remedy their troubles (troubling feelings associated with problems), one by one. The Trouble Box therapy is a physical simulation that therapists can use with their clients to replicate an external storage place for troubling emotions associated with problems and to periodically and systematically dispose of these troubles one by one. Realizing that most humans fail to remedy these troubles because of the sheer volume; that is, they become lost in the quagmire and decide that there are just too many problems and troubles with which to tackle and therefore, tackle with none, the Trouble Box allows clients to tackle one problem and one troubling emotion at a time.

Troubling emotions associated with problems are symbolically placed and taken out one by one to discuss, dismantle, and dispose. A small box is used to hold the problems/troubles for the client. The Trouble Box provides a place to put each problem/troubling emotion. This is done by having the client think through their problems. Then the therapist and the client will discuss each problem, assigning any troubling emotions the client feels to that problem. The client then writes each problem down separately on a slip of paper with the accompanying troubling emotion and places the slips of paper into the box. At each session, the client then blindly takes a problem slip out to discuss with the therapist and find reasonable and reachable solutions. This allows the client to deal with each problem and troubling emotion individually without feeling overburdened by them all. Clients are told that their troubles remain in the box and they are no longer allowed to carry the troubling emotion with them in their head or their heart. They are only allowed to “shoulder” their troubles if it is pulled out of the

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box. This allows the client a needed reprieve of their troubles, time to focus on work, life, and daily responsibilities and do what is necessary to help resolve the Problem.

For example, the client who had lost his job would still have to look for a job; he/she would not be allowed to carry the negative anticipation of negative emotions associated with not having a job or not finding a job. This will allow the client to focus fully on the task at hand and not the emotions attached to the negative anticipation of negative outcomes.

In addition, by allowing clients to pull one slip of “trouble” from the box, they are given control over these troubles. Also, clients may choose a different trouble from the box at each session, which will help them to realize that none of their troubles has more merit than the other if any of them are causing the client to experience overwhelming negative anticipation of outcomes and negative emotional responses. This is determined by the client and the therapist, based on the client's perspective of the importance of each problem.

Over the course of therapy, the troubles they had thought were so huge, will slowly dissolve into the box with the other problems and seem less gigantic. They will ultimately understand that trouble is trouble and the difficulty of lessening the troubles become smaller as the anticipation of outcomes becomes more positive. As each trouble is resolved, the client begins to gain confidence that all of the troubles in the box may be successfully resolved. This increased positive anticipation of outcomes further enables the client to think more positively about the possible solutions. The client begins to realize that his/her negative anticipation of the negative emotions associated with the outcomes (not necessarily the client's fear or beliefs about the problem) may be flawed.

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Thus, as the client begins to think more positively about the possible outcomes, the solutions will be formulated with a positive outcome in mind and will be more likely to produce more positive results.

**Process:** This tool may be used for individual or group therapy.

*Before each individual or group session, the therapist should explain the Trouble Box concept as follows:*

The Trouble Box is a simple tool that will allow the client to take troubles/troubling thoughts from their mind and put them someplace else so that they can manage them better.

### *Individual Therapy*

The therapist will explain to the client that they will be discussing problems and troubles. The therapist will define the difference between troubles and problems; that is, problems are situations which occur and troubles are their feelings about those situations. The therapist will ask the client to discuss what he/she believes to be his/her problems. The therapist will review each problem asking the client "How does this problem *trouble* you? How does this problem cause you agitation, discomfort, anxiety and distress or some other negative emotion?"

The therapist will ask the client to take as many strips of paper as needed to write each trouble, and then decide on the top three. The other troubles will be taped to the bottom of the box. The therapist will ask the client to write each of their troubles on one slip of paper, fold it, and place it in the box.

The therapist will tell the client that each time he/she comes into my office; he/she will be allowed to blindly remove one of the slips of trouble from the box. The therapist

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will inform the client that they will discuss that one issue taken from the box for that session. The therapist tells the client that just before the session ends, he/she will decide whether this issue has been solved. If it has been solved, the client will be allowed to shred the slip of paper and will consider that “trouble” removed from the box and from his/her mind as a source of stress or anxiety. If the client does not believe that the issue has been resolved and wishes to continue work on that issue, the client will be allowed to place the slip of paper back into the box to be randomly drawn at another session. The therapist tells the client that they will continue with this process until all of the troubles have been addressed successfully.

If after three weeks ( for each problem) , the client feels that one of his/her troubles has not been successfully resolved, the therapist and client will determine what steps to take next to further address that issue. This may mean adding another week or two to the identified problem for further discussion. After the top three troubling emotions have been successfully resolved, the client is asked if he/she remembers the other troubles taped to the box. If the client remembers these troubling emotions and wants to discuss them, they are removed and discussed to determine if these are indeed still troubles for the client. If these are, the therapist should try to help the client resolve these issues as with the top three. If these are no longer troubling emotions for the client, the client is allowed to shred the slips of paper.

### *Group Therapy*

The same therapy format should be used when working with groups. The only change is that the group decides what the problems and troubles are and which ones should be

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placed into the box, when the troubles have been resolved, and who is allowed to shred them.

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