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**Cognitive treatment through positive self-verbalisation,
a multiple case study**

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This article deals with the modification of self-statements as a specific strategy in cognitive therapy. After discussing theoretical and empirical backgrounds, a method is described in which patients modify their self-talk by reading aloud positive self-statements that are incompatible with original self-deprecatory thoughts. Next, several cases are presented that illustrate the manner in which this intervention can be integrated in the treatment of anxiety disorders, eating disorders and psychosomatic pain disorders. In all cases, positive self-verbalisation was combined with other elements of cognitive and behavioural interventions. In the discussion, the indications for using this intervention are considered and compared to other cognitive strategies.

Introduction

The focus of cognitive therapy is on the modification of irrational, self-deprecatory cognitions that are operative when patients are in distress (Granvold, 1994). Cognitive therapists such as Ellis (1962; 1977), Beck (1967; 1970) and Meichenbaum (1974; 1975) suggested that symptomatic behaviour can be influenced by covert verbalisations ('self-talk'). The impact of negative self-talk on performance anxiety and on depression has been confirmed in clinical research (Cramer & Kupshik, 1993; Huber & Mitchell Altmaier, 1983; Ingram, 1989; Missel & Sommer, 1983). A large number of studies shows that negative self-talk may also be operative in impairing the performance of creative tasks, problem solving skills and the control of fear (Meichenbaum, 1974; Meichenbaum & Cameron, 1974; Bonadies & Bass, 1984; Eifert & Lauterbach, 1987; Rosin & Nelson, 1983; Safran, 1982).

Cognitive therapies generally challenge dysfunctional cognitive schemata and beliefs, through Socratic questioning and behavioural experiments (Beck, Freeman & Associates, 1990; Beck & Weishaar, 1989; Granvold, 1994). There is not much literature describing how patients may directly be stimulated to verbalise positive thoughts opposing the previous negative self-statements. In the past, however, some authors did describe their results with such an approach. As early as in the twenties, in his book on self-suggestion, the pharmacist Coué advised patients to recite the text 'Every day my life gets better and better in every

respect' at the day's beginning and end (Coué, 1925, p 129). Baudouin (1920) and Shaffer (1947), cited by Meichenbaum (1979), also reported on the effects of such interventions.

Meichenbaum and Cameron (1974) introduced the idea of 'self-instructional training' (SIT). They showed that hospitalised schizophrenics could be trained to change dysfunctional self-statements to more appropriate self-talk (Meichenbaum, 1975), thus improving their cognitive skills. Emmelkamp, Brilman, Kuiper and Mersch (1986) compared self-instructional training to Rational Emotive Therapy and exposure with patients suffering from panic disorder and agoraphobia. Differences among the three experimental conditions were minimal, leading the authors to conclude that RET and SIT add little to the value of exposure training.

Mavissakalian, Michelson, Greenwald, Kornblith and Greenwald (1983) reported similar effects with self-instruction training in comparison to paradoxical intention. Their data, however, are difficult to interpret since both experimental treatments were combined with exposure. Unclear as well are the results with self-instruction in the study on obesity by Bennett (1986) and the study on fear for dentists by Prins (1988).

On the basis of two meta-analyses of controlled studies, Dush, Hirt and Schroeder (1983; 1989) conclude that in combination with other cognitive techniques, self-instructional training is an effective technique for adult patients. A disproportionate amount of the studies, however, was devoted to simple phobias such as fear of animals and performance-anxiety.

Although the number of controlled studies is growing (e.g. Lange, Richard, Gest, de Vries & Lodder, in review), apart from one case study by Mahoney (1971), no detailed descriptions have appeared on the manner in which self-verbalisation can be used in clinical practice. Hence, this article describes a method in which patients modify their self-talk by reading aloud positive self-statements that are incompatible with original self-deprecatory thoughts. Furthermore, case illustrations are presented in which positive self-verbalisation is integrated in broad spectrum cognitive-behavioural treatment of anxiety disorder, eating disorder and somatoform pain disorder.

A model for therapeutic use of self-verbalisation

In the proposed method two stages can be distinguished. In the first stage, patients reflect on their psychological assets, write an essay about the positive themes that came up and, finally, reduce this essay to a number of positive self-statements. In stage two, they challenge self-deprecatory cognitions by frequently reading aloud their positive self-statements.

There are several reasons to start the therapeutic process with patients writing an essay on their assets. In the first place, this is likely to produce a suitable positive framework for the stage in which the actual self-verbalisation finds place. Secondly, the writing of this essay stimulates patients to put more effort in the production of positive self-statements which could lead to the formation of more accessible positive attitudes toward the self. Since accessible attitudes have been shown to have a more profound directive influence on people's behaviour (Fazio, 1989), the writing of the essay may mitigate symptomatic behaviour. Thirdly, by writing an essay about one's positive qualities a person may form scripts of appropriate behaviour (Abelson, 1981). Availability of such scripts decreases the likelihood of problematic behaviour (Anderson, 1983; Anderson & Godfrey, 1987).

Patients are asked to write the essay in first person and reach agreement with the therapist about the frequency and time of writing that is carried out at home. During the sessions, therapist and patient discuss the content of the essay and patients are encouraged to continue to write about their psychological assets until they feel that there is nothing more to add. The therapist then advises how to summarise the essay on a small card. The patient may always modify the card.

In the second stage, patients read aloud their positive self-statements which contrasts with their habit of ruminating over their negative characteristics. In this way, self-deprecatory thoughts are directly replaced by more constructive cognitions, which is the method's main manipulation. Depending on the nature of the disorder, patients may be encouraged to read aloud their positive self-statements at fixed times and places or at the onset of distress.

Figure 1 summarises the method.

Figure 1: Model for application of self-verbalization and self-instruction

In his comments on some group studies, Meichenbaum (1979) concluded that positive effects of self-verbalisation techniques may only be expected if the patient is trained to implement the behaviour he wants to achieve, and when the text applies specifically to him and is drawn up by himself. Below, we describe the case of Mr. Hanks, an artist with urinary retention. For reasons of time-efficiency the therapist had dictated the self-verbalisation text for Mr. Hanks. We shall see that this did not have the effect intended.

Self-verbalisation training for anxiety disorders

Social Anxiety: The inferiority feelings of a 40-year old lawyer

Mister Jones was a successful lawyer. He worked in a large company where everybody was pleased with his work. He was nevertheless under continuous strain. Most unexpectedly, he experienced outbursts of cold sweat and was soaking wet within seconds. These spells of perspiration occurred at work as well as in social situations, to such an extent that he had to take a six-months leave, which did not have favourable effects.

The therapist advised him to monitor every anxiety provoking event. In the evening, he reflected on the 'data' to gather insight on what made him anxious and stressed. This *self-monitoring* taught him that his anxiety was triggered by the thought that he had to share something about himself or his work with others, who would then evaluate him. He panicked at the thought of a negative evaluation.

Treatment consisted of the following elements:

- *Disclosure*. The patient practised methods of disclosing his fears to people who were close enough to him. Since one cannot fail if one has already announced that failure is imminent, this helped to decrease his fear and be more relaxed in social and professional situations (Lange, 1980).

- *Awareness and the challenge of automatic thoughts*. When he became anxious, he took time-out to reflect and write about "which terrible things might happen and why these terrible things might not really be so terrible."

- *Positive self-verbalisation*. The patient was encouraged to reflect on the strong points in his personality. Subsequently, he composed an *essay* about these **aspects**. Contrary to his expectations, he came up with many points: he was good at his work, he was appreciated by his colleagues, and he was a good father and friend. After he finished the essay he was instructed to summarise the main points on a card. Like the essay, the abstract was written in the first person (see box 2). This card had to be available always and was read aloud twice a day. Box 1 presents the therapist's literal instructions.

Box 1: Instruction for positive self-verbalisation

People with social anxiety tend to exaggerate their weak points and disregard their strong points. Thus, they continuously indoctrinate themselves with negative self-statements. We already discussed the significance of systematically challenging those negative thoughts. You may enhance the value of the challenge by replacing the negative self-indoctrinations with positive self-statements. It might appear somewhat strange but it works. The first step is writing down everything that you regard as positive about yourself. You shouldn't occupy yourself with this too long at a stretch. You better stop after an hour and continue another day, at a time that is convenient to you. When nothing new comes up, you write a short story about yourself, about 30 lines, based on the things you have written down. This story is to be written in the first person. When you have finished, make an abstract of about 10 lines on a small card, which you can carry with you everywhere.

Box 2: Positive self-verbalisation for social anxiety by a 40-year old lawyer

I'm a good father to my children. We have a strong relationship. I support them emotionally and we do a lot of things together. My friends say I'm very active with my kids. I don't mind if they criticise me. I allow them to have their own opinions. I've done more interesting things in my life than most other people have. I spent two years at sea, and lived in different countries. I earn a comfortable income for my family. I love my work and my colleagues value me highly. They frequently ask me for advice and I have considerable influence on business matters. Many people in my company take my advice. I should be proud of all these things and I've got nothing to be ashamed of. Since there are many positive things, I don't have to withhold anything negative. Weak points are well compensated for. Difference of opinion is a normal thing. People may very well comment on what I say.

The patient was enthusiastic about the method. When he thought of new positive things about himself he modified the card. This happened several times. Quite soon he did not have to read the card since he knew the text by heart. He made it a habit to say the text aloud every day when he was alone in his car.

Since he still had frightening moments at work, he later created a card that applied specifically to this area of his life. He wrote about his professional skills, the relationship with his colleagues and concluded that making a mistake is not the end of the world. A third card also comprised the text: "if someone thinks negatively about me, it may say more about him than it does about me".

The ten-session treatment was quite successful. Mr. Jones still perspired more than most other people do, but perspiration spells occurred seldom and he felt more comfortable with his colleagues. In a follow-up session he revealed that he had experienced the self-verbalisation as the most positive and effective of all interventions. It had reduced his symptoms, and had a good influence on his general attitude to life.

Panic attacks: A 23-year old college student

One year ago, Angela began to have panic attacks every night before going to sleep. She tried to control the attacks by engaging in distracting activities or talking to her roommate. She only entered public places or used public transportation if accompanied by a close friend. Compared to the out-patient psychiatric population her pre-treatment scores on the symptom checklist SCL-90 (Derogatis, 1977) were high on phobia and average on feelings of insufficiency. She also scored high on the agoraphobia subscale of the Marks and Mathews (1979) Self-Rating for Phobic Patients. There were no clear clues on the etiology of her symptoms.

Treatment consisted of the following elements:

- *Panic control.* The main components were self-monitoring, breathing retraining and exposure (De Beurs, Van Balkom, Lange, Koele & Van Dyck, 1995; Clark, 1989; Clark, Salkovskis & Chalkley, 1985; Lange & de Beurs, 1992).
- *Behavioural experiments and focusing on strong points.* Self-monitoring revealed that when most needed, her fear of failure was so high, that she dared not rely on breathing retraining. She then fell back on former strategies such as distraction or visiting a friend. The therapist suggested to carry out some behavioural experiments to challenge the fear of failure. As a result she discovered many situations in which she did not fail; she appeared to be capable of tackling

problems by herself and did not give up easily. By concentrating on these aspects of her personality she convinced herself of her strength.

- *Manipulating self-verbalisation*. To modify the negative internal dialogue while practising in anxiety provoking situations, she wrote a card expressing her ability to overcome her fear. The moment that she felt her anxiety growing during exposure training, she read the card aloud. Box 3 shows the text on the card.

Box 3: Self-verbalisation for fear of panic by a 23-year old college student

"Come out, fear, I can handle you, just like in breathing retraining. I wonder how long you'll stay today, I can stand it."

In the fifth session Angela reported that she had attained her first goal (spending one hour studying by herself). The card had been of great help. Every time she experienced anxiety while carrying out exposure exercises as well as on other occasions, she took the card out of her bag and read it aloud after which she went on with the breathing retraining.

By the tenth session, Angela had accomplished all her goals. She no longer needed to use the card. The therapy took twelve sessions over a period of nine months. The follow-up sessions, 6 and 12 months later, showed no relapse. Her scores on the SCL-90 had dropped considerably in comparison to pre-treatment: from 27 to 8 on agoraphobia (which is low compared to the norm group) and from 27 to 10 on insufficiency. The agoraphobia score on the Marks and Mathews self-rating scale was also remarkably reduced (from 32 to 3).

Paruresis: the case of a 75-year old artist

For more than 45 years Mr. Hanks had suffered from psychogenic urinary retention, classified as a social phobia with obsessive symptoms (Nicolau, Toro & Prado, 1991). He was frightened to urinate anywhere except at home when there were no guests. He had first experienced the inability to urinate at age 28. He avoided all social situations in which he might have to visit the bathroom. This prevented him from travelling and from participating in lengthy social gatherings. All day long, he was obsessed with the fear of not being able to urinate. He arranged his activities in a manner that ensured him of access to his own

bathroom at the "appropriate" time. He also suffered from periods of depression during which the symptoms worsened. Years ago he had been treated along psychoanalytical lines, followed by a behavioural treatment based on systematic desensitisation. His problem had remained unsolved. Medical examination, instigated by the new therapist, revealed that there were no somatic irregularities. But the urologist, demonstrating a subtle insight in psychotherapy, explained that unimportant somatic fluctuations may incidentally and temporarily cause some difficulties in urinating, thus providing the patient with a new less fearful attribution of his problem.

Mr. Hanks had been married for 45 years and his wife was present at most sessions (spouse aided therapy). Treatment consisted of the following elements:

- *Exposure in combination with paradoxical assignments* (Butler, 1989; Ascher, 1979). The therapist asked the patient to make a list of increasingly threatening situations, and subsequently encouraged him to expose himself to the relatively easy situations of this hierarchy. He was not to urinate before leaving his house to visit these social occasions.

When he was in the target social situation he was to visit the bathroom, but not to urinate. He had to engage in all the preparatory acts of urination, and remain in the bathroom for some minutes but refrain from urinating. After five sessions the patient was able to visit the easy places and go to the bathroom to urinate. He was then instructed to expose himself to more difficult situations, visit the toilet and eventually urinate (McCracken & Larkin, 1991). -

Changing selective reinforcement. When it became clear that the patient habitually and incessantly informed his wife about his worries and fears, which she not particularly fancied, he agreed to only discuss his phobic fears and obsessions with her for fifteen minutes a week, at a set time.

- *Disclosure.* The therapist encouraged the patient to inform his friends and relatives of his anxiety, especially when visiting with them and upon leaving the room to go to the bathroom (Lange, 1980).

- *Positive self-verbalisation.* After ten sessions there had been some improvement regarding the easy targets in the hierarchy. The ruminating, however, had been only partially reduced. The therapist then formulated a self-verbalisation text, which was to be rehearsed by the patient several times a day, and always when visiting the bathroom.

This intervention was unsuccessful as the patient had not felt comfortable with the text. The therapist then encouraged him to formulate his own self-verbalisation text (box 4), which proved to be effective.

Box 4: Self-verbalisation for paruresis by a 75-year old artist

Not peeing is no disaster

Pee will come anyhow!

Being nervous is spilt energy;

Be proud of your achievements

Try and go through the exercise as an interested observer

When pee doesn't come immediately, this probably has a medical cause.

Once he started using his own text, the patient improved rapidly and therapy was concluded after 17 sessions. The data obtained through the patient's continuous monitoring of avoidance behaviour showed that there were hardly no social situations he avoided. His anxiety scores and depression scores on the SCL-90 fell from 17 to 10, and from 30 to 19 respectively. Two follow-ups at half a year and a year later showed no relapse.

Self-verbalisation for patients with eating disorders

Little is known about the use of self-verbalisation measures in the treatment of eating disorders. A detailed description of a case involving the treatment of bulimia nervosa, provided by Lange, De Vries, Gest and Van Oostendorp (1994), will be presented here briefly.

Bulimia nervosa: a 24-year old student

Susan was attending a college of music, when she applied for therapy. At age 15 she had developed anorexia nervosa which at age 18 turned into bulimia nervosa. Her irrepressible urge to binge came up at an average of four times a week. While she was only slightly overweight, she compensated for bingeing by dieting stringently, and by taking

approximately 40 laxatives daily. She had been treated before, but without any effect. Besides bingeing, the patient exhibited symptoms of depression (dysthymia), including lack of energy and social withdrawal. She was offered a ten-session treatment, comprising the following elements:

- *Refraining from taking laxatives*. The therapist emphasised that laxative usage, like vomiting, is not a response to an urge but a method deliberately chosen for not getting fat. Henceforth, the patient is able to quit taking them.
- *Self-management*. This consisted of:
 - a. Monitoring all ingested calories and picture the data on a graph.
 - b. Monitoring the bingeing attacks and reflecting on the antecedents and consequences.
 - c. Composing and applying menus for breakfast, lunch and dinner containing a fixed amount of calories (altogether: 1800 calories).
 - d. Stimulus control, by refraining from buying more food than necessary for one day.
 - e. Response prevention. When she felt the urge to binge she applied a number of preventive measures in the following order: 1) *Positive self-verbalisation* by means of a card she had prepared herself. 2) A distracting activity. 3) Calling a friend. 4) Calling the therapist.

If she had given in to her binge urge despite these preventions, then self-punishment would follow. Together with the therapist she decided upon a useful but unpleasant activity (cleaning her house), the duration of which had to be related to the amount of calories she ingested.

- *Action plan*. Every evening she went about composing an action plan for the following day, containing both obligatory and leisure activities.
- *Self reward*. By spending less money on food, Susan could afford things she had denied herself until now. She chose to subscribe to a morning paper; that way she could thoroughly enjoy her 'obligatory' breakfast.

Treatment progressed quickly. The patient took her daily meals and refrained from abusing laxatives. The self-management program suited her quite well, and she especially valued the self-verbalisation card (box 5) which she had prepared by writing an essay about her efforts

in the treatment as well as the pride she took in it. Further prevention of the bingeing response was hardly necessary.

Box 5: Self-verbalisation in the self-management program for bulimia nervosa

I'm not really hungry

1800 Cal. is enough

THINK! Bingeing = shit

Don't spoil it

Because - I look super in my jeans!

Because - I have energy for anything!

Because - I feel good!

---> I'M NICE - LET'S KEEP IT THAT WAY!

and: compensating is no use!

GO OUT AND DO SOMETHING WORTHWHILE!

Pick something from the action list, and make time!

- *Self-verbalisation Poster against relapse.* To prevent discouragement by an incidental relapse, she wrote on a large sheet of paper that she pinned to her wall: "An occasional lapse is not the end of the world: It is always possible to correct this".

After six sessions (9 weeks) no more bingeing occurred and her daily caloric intake had stabilised at about 1800. The three final sessions were spread over a one-year period. No relapse occurred, neither in bingeing nor regarding the depression (the depression score on the SCL-90 had dropped from 57 to 17). The follow-up after six more months indicated a stable recovery.

Self-verbalisation training for patients with somatoform disorder

To our knowledge, the literature does not reveal any studies on the use of self-verbalisation training for patients with a somatoform disorder. Below we describe one case involving unexplained pain.

Pain: a 36-year old publisher

For more than a year, Mr. Williams had suffered from intense abdominal pains. Twenty years earlier, the patient had been treated for what was thought to be an incurable form of abdominal cancer. He received radiation therapy. Ten years later he was declared completely cured. Serious medical examination had not revealed any link between the previous illness and the pain spells, nor did they reveal any other somatic cause. The spells of pain occurred in weekends and on business trips. These lasted one to two hours in which he felt sick and could not sit down. Consequently, he paced up and down the room, which exhausted him completely. In the past months he suffered an attack every weekend when at home. For prevention, the patient used benzodiazepines. He was owner of a publishing firm and the work did not appear to be stressful. According to him, he was happily married (during twenty years).

The patient scored relatively low on all subscales of the SCL-90. Anamnestic data, self-rating questionnaires and clinical interviews revealed no specific psychopathological symptoms or stressors. According to his wife, her husband's pain was caused by his avoidance of family problems.

The treatment consisted of the following elements:

- *Self-monitoring of the pain attacks.* This was carried out according to the ABC method (Antecedents, Behaviours and Consequences, Watson & Tharp, 1989). It did not reveal any new information.
- *Discussing marital issues.* In the conjoint sessions with the patient and his wife, the couple agreed to preserve 30 minutes a day to discuss what had bothered them.

- *Cognitive reframing*. The therapist suggested that the pain probably had its basis in a somatic condition that was no longer present. Fear of this somatic condition had probably sensitised Mr. Williams to any interoceptive abdominal sensation.
- *Relaxation training*. Mr. Williams reacted well to the muscle relaxation training according to the method described by Bernstein and Borkovec (1973).
- *Paradoxical suggestion*. The therapist encouraged the patient to view any occurring pain spells as "allies", offering him the opportunity to apply his exercises (Meichenbaum & Cameron, 1974; Ascher, 1989).
- *Positive self-verbalisation*. Although the treatment led to improvement, the patient still experienced fear when he felt the early signs of a pain attack. His fear sometimes prevented him from carrying out the necessary steps of the program. Therefore, he wrote a text expressing his ability to cope with an attack. The text (box 6) was to be read at the first signs of an attack.

Box 6: Positive self-verbalisation for pain spells

Let the pain come out. I can cancel appointments. Even if it lasts long, it will be over in half an hour. Warn wife. Anxiety makes the pain worse. So lie down. Relax. Cold sweat means: after this comes sickness, and than it's over! Write down date and degree of pain, what preceded this attack?

Mr. Williams was enthusiastic. The treatment took fifteen sessions. In the last three sessions (spread over two months) he had suffered no attacks. At the follow up, four months later, he had suffered one attack that hardly affected him. He knew what he had to do! On the SCL-90 he scored very low on all scales, with a total score of 91.

Discussion

The sample of disorders, presented here, for which positive self-verbalisation might be beneficial, is not exhaustive. Self-verbalisation may prove to be effective for other disorders in which dysfunctional cognitions are operative and for disorders that are treated by inducing self-

control. For instance, addictions and interactional problems are areas in which it may be beneficial to directly modify self-statements. The criteria for using this technique seem to be based not primarily on symptomatology but on the centrality of cognitions as part of the problem, and on the possibility to create realistic positive self-verbalisations. Although cognitive interventions have a long standing tradition in the treatment of depression (Beck, 1967; Fennell, 1989; Gotlib & Hammen, 1992) and manipulation of self-verbalisation might be considered an important intervention, case studies show that depressive patients who demonstrate extremely negative self-talk do not generally react positively to the suggestion of writing an essay about their assets (Lange, 1994). Usually, they are unable to come up with anything positive about themselves. With depression, the method is apparently only useful after other interventions have already been used with at least partial success. The timing of the intervention is clearly an important factor.

There are two types of positive self-verbalisation. More often discussed in the literature is the instrumental type, supporting a treatment program: 'I'm solving this problem in this way and I can do it'. The patients with panic attacks, binge eating disorders and somatoform disorders are most illustrative for this type of self-verbalisation (box's 3, 4, 5 and 6). Discussed less is the type of self-verbalisation that focuses on general aspects of the patient, on his self-esteem: 'I have these strong points and I am a valuable person' (box 1 and 2). This type of self-verbalisation is especially useful with patients with social phobia. As indicated above, depressive patients on the other hand often find this type of self-statement unrealistic. With them it should not be used in the first stage of treatment.

The literature on cognitive therapy often describes how patients may discover the faultiness of their dysfunctional beliefs and unrealistic expectations by challenging them through Socratic questioning and behavioural experiments (Granvold, 1994). Although this method is elegant and its effectiveness has often been proved, it requires a capacity for rational deliberation which not all patients possess. Direct modification of negative self-talk by suggesting positive self-verbalisations might be less demanding for patients while they directly improve their self-perception. Theoretically, the latter is based on Bem's self-perception theory (1967; 1972), but also on the Talmudic saying 'Na-assè we-nishma', or: 'act first, and believe will come later'.

As argued in the introduction, there is little experimental evidence that clearly proves the effectiveness of positive self-verbalisation. In the studies investigated by Dush et al. (1983; 1989), the modification of self-statements was always induced as part of a broad cognitive-behavioural treatment. Since the above cases were also integrated in broad spectrum treatments, this article is not intended to deal with the evaluation of the effectiveness of positive self-verbalisation. The aim of this paper is rather descriptive, to demonstrate how the method may be used in clinical practice. Nevertheless, the method appears to be promising, as shown by the patient's positive evaluations at follow-up.

To evaluate the effectiveness, however, controlled trials are needed in which experimental groups that are taught to use positive self-verbalisations are compared to control groups. Lange et al. (in review) conducted such an experiment in which the method was tested in a pre-post controlled trial with participants characterised by low self-esteem. Participants in the experimental condition improved significantly more than participants in the control condition, and positive self-verbalisation was concluded to be a convenient and powerful technique for enhancing self-esteem. The next step is to experimentally investigate which elements of the procedure are necessary. For instance, is it really necessary that patients generate their own text (as is suggested by the case of the artist with urinary retention) or is the method as effective when the therapist provides the text? This is investigated in an experiment by Schoenmakers, de Jongh and Lange (in preparation). Patients with extreme fear of dental treatment who are instructed to write a positive essay followed by using a self-verbalisation card, are compared with regard to anxiety and their co-operation in treatment to a group of similar patients who use a self-verbalisation card provided by the experimenter. We will report on both experiments in the near future.

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