Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers

Therapist Manual

Amy Wenzel, Ph.D. • Gregory K. Brown, Ph.D. • Bradley E. Karlin, Ph.D.

Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers

Therapist Manual

Amy Wenzel, Ph.D.
Gregory K. Brown, Ph.D.
Bradley E. Karlin, Ph.D.

Suggested Citation: Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). *Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual.* Washington, DC: U.S. Department of Veterans Affairs.

TABLE OF CONTENTS

TABLE OF FIGURES AND EXHIBITS

ACKNOWLEDGMENTS

Support for this manual was provided by the Office of Mental Health Services, VA Central Office, U.S. Department of Veterans Affairs.

PREFACE

In an effort to bring evidence-based psychotherapies from the laboratory to the therapy room and realize the full potential of these treatments for Veterans, the Department of Veterans Affairs (VA) has developed national initiatives to disseminate and implement evidence-based psychotherapies for depression, posttraumatic stress disorder (PTSD), serious mental illness, and other conditions throughout the Veterans Health Administration (VHA), the health care arm of VA. As part of this effort, VA has developed a national staff training program in Cognitive Behavioral Therapy (CBT) for depression. This training in CBT represents the largest CBT training initiative in the nation. The overall goal of the CBT for Depression Training Program is to provide competency-based training to VA mental health staff, which includes experientially based workshop training followed by ongoing, weekly consultation with an expert in the treatment. The training focuses on both the theory and application of CBT for the treatment of depression on the basis of the protocol described in this manual, which has been adapted specifically for the treatment of depressed Veterans and Military Servicemembers. Initial program evaluation results have shown that the training and implementation of this therapy protocol by VA mental health therapists have significantly enhanced therapist skills and patient outcomes (Karlin, 2009; Karlin et al., 2010). This manual is designed to serve as a training resource for therapists completing the VA CBT for Depression Training Program, as well as for others inside and outside of VHA and the military who are interested in further developing their CBT skills.

Although the focus of this manual is on the application of CBT for depression, the manual and treatment protocol are based on core CBT competencies that can be adapted and applied to treat other mental health and behavioral health conditions. In this protocol, cognitive and behavioral theory and strategies are incorporated in an integrated fashion and guided by a careful case conceptualization, which is an important component of this treatment. In addition, the protocol places significant emphasis on the therapeutic relationship, which is a critical contextual variable in CBT. We believe that CBT done well requires a very strong and supportive therapeutic alliance. In this way, *CBT for Depression in Veterans and Military Servicemembers* strongly emphasizes the *therapy* in Cognitive Behavioral Therapy and differs from more psychoeducational or primarily skills-based approaches to CBT. In our experience, case conceptualization-driven treatment and the focus on the therapeutic relationship are especially important therapy ingredients when working with depressed Veterans.

We believe that CBT done well requires a very strong and supportive therapeutic alliance.

Included throughout this manual are fictitious cases that represent composites of depressed Veterans and Military Servicemembers we have treated. These cases are designed to illustrate and make concrete the application of CBT skills with "real-life" patients. In addition to this manual, we have developed a companion therapist training video (U.S. Department of Veterans Affairs, 2010) that demonstrates many CBT strategies with the case examples presented in this manual. Key therapist and patient worksheets and forms for use in implementing this protocol are referenced throughout this manual and are provided in the Appendix.

Whether you are new to CBT or are seeking to expand your CBT skills, our hope is that this manual will be a useful resource to you and will help promote the delivery and fidelity of CBT with depressed Veterans and Military Servicemembers.

INTRODUCTION

INTRODUCTION

What Is Cognitive Behavioral Therapy?

Cognitive Behavioral Therapy (CBT) is a structured, time-limited, present-focused approach to psychotherapy that helps patients develop strategies to modify dysfunctional thinking patterns or cognitions (i.e., the "C" in CBT) and maladaptive emotions and behaviors (i.e., the "B" in CBT) in order to assist them in resolving current problems. A typical course of CBT is approximately 16 sessions, in which patients are seen on a weekly or biweekly basis. CBT was originally developed to treat depression (A. T. Beck, 1967; A. T. Beck, Rush, Shaw, & Emery, 1979), and it has since been adapted to the treatment of anxiety disorders (A. T. Beck & Emery, 1985), substance use disorders (A. T. Beck, Wright, Newman, & Liese, 1993), personality disorders (A. T. Beck, Freeman, Davis, & Associates, 2004), eating disorders (Fairburn, 2000), bipolar disorder (Basco & Rush, 1996), and even schizophrenia (A. T. Beck, Rector, Stolar, & Grant, 2009)! Many patients show substantial improvement after 4 to 18 sessions of CBT (Hirsch, Jolley, & Williams, 2000). Contemporary research shows that CBT is efficacious in treating mild, moderate, and severe mental health symptoms (e.g., DeRubeis et al., 2005; Elkin et al., 1989), that it is equally as efficacious as psychotropic medications in the short term, and that it is more efficacious than psychotropic medications in the long term (see Hollon, Stewart, & Strunk, 2006, for a review). There is a great deal of research supporting CBT's efficacy for treating an array of mental disorders using both individual (Butler, Chapman, Forman, & Beck, 2006) and group (Craigie & Nathan, 2009) formats.

Organization of This Manual

This manual is organized into five main parts: (a) cognitive behavioral theory and the manner in which the theory translates to treatment, (b) CBT session structure, (c) interventions that take place in the initial phase of treatment, (d) interventions that take place in the middle phase of treatment, and (e) interventions that take place in the later phase of treatment.

Throughout these five main parts, case examples created on the basis of actual clinical experience are provided to illustrate the application of cognitive and behavioral strategies. Moreover, specific pointers for implementing the strategies, as well as common obstacles that therapists experience and ways to overcome them, are summarized. This manual was written specifically for implementing CBT with Veterans and Military Servicemembers. The content of the protocol, as well as specific issues in the application of CBT, are presented with this particular population in mind. In addition, certain therapy components and processes are given emphasis in this protocol to address commonly observed issues in the delivery of CBT with depressed Veterans and Military Servicemembers. For simplicity, we primarily use the terms *patients* and *Veterans*. These terms are used interchangeably and are inclusive of active duty Military Servicemembers (including members of all branches of the military and reserve forces).

Cases

In the pages that follow, we present descriptions of four fictitious cases throughout this manual to illustrate the strategies that have been described.

JACK

Jack is a 63-year-old Vietnam Veteran who has been in and out of mental health treatment for the past 20 years. He has a history of depression, anger, and significant impairment in his relationships with his wife, children, and co-workers. Recently, Jack was let go from his job as a manager at a car dealership; although he was told that he was laid off because the company was downsizing, he believes that the regional manager has "had it out" for him for many years. Jack had expected to work for another five years, but he has been unable to find a new job that is acceptable to him. As a result, he reports significant financial concerns. In addition, Jack's relationships with his wife and children continue to deteriorate. His children live out of town, and when they call they want only to speak with his wife. He and his wife barely speak, and they sleep in separate rooms. Jack has a few "buddies" with whom he plays poker, but he claims that he does not feel comfortable "crying to them" about his problems. Finally, Jack has been experiencing medical problems that have increasingly been of concern to him. He has recently developed diabetes that is secondary to chronic pancreatitis, and he has expressed frustration at the strict diet and medical regimen that he must maintain.

MICHAEL

Michael is a 24-year-old, African American, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veteran who was referred to treatment for depression and suicide ideation. He recently returned from Iraq after serving in the Army for two years. He joined the military as a means of paying for school, and, unexpectedly, he was mobilized for an OIF deployment in his senior year of college. He left a girlfriend, his schooling, and a promising part-time job for a 12-month deployment that ultimately was extended to almost 18 months. During his time in Iraq, Michael survived the force of an IED explosion, after which he was unconscious for two days. In the time since he has returned from Iraq, he has become increasing isolated from others and is estranging himself from his family and loved ones. Michael tried to return to his part-time job, but he left after two weeks because he found it difficult to concentrate and made many errors. He states that he has no plan for the future and wonders whether his life is worth living. Neuropsychological testing at his local VA Medical Center revealed mild brain injury. He has significant concern about his current abilities and his perceived reliance on others.

KATE

Kate is a 40-year-old National Guard nurse who recently returned from deployment to find that her husband had left her and moved with her kids to another state. In addition, despite thinking that she was going to retain her job upon her return, she found that the hospital where she worked replaced her, given that her deployment was a voluntary extension of her original tour. In theatre, the option of extending was not presented to her as a choice and, thus, she assumed that her previous position would be protected. Kate's efforts to find a job in her small town have been unsuccessful, and her husband has not been cooperative with arranging times for visitation. Her depression has become increasingly severe, and for the past three weeks, she has stayed in bed most of each day. Kate also reports significant symptoms of anxiety and has had four panic attacks in the past week.

CLAIRE

Claire is a 28-year-old Army CPT rotary wing pilot (Blackhawks) who experienced severe injuries from a crash in Afghanistan. While flying a low-level search-and-rescue mission, her rotary system was hit by a rocket-propelled grenade, and the helicopter lost hydraulic power and ultimately crashed into a mountain side. Two soldiers were killed in action, and most on board were severely injured. Claire endured significant leg injuries, and she is unable to walk without assistance. Claire reports that she has been experiencing a great deal of tension and apprehension over the past few months. She is eager to return to flying, but she is encountering major obstacles from her command and from the military more generally. She is waiting for her medical board to be complete so that she may return to flying and perceives that they are putting her off because they do not believe that an amputee can fly. She has few outside interests and close relationships to keep her occupied as she is waiting for this decision. In addition, Claire becomes extremely irritable when she perceives that she is treated differently because of her injury.

This manual illustrates the manner in which all four of these individuals are treated with CBT. The next part describes cognitive behavioral theory and the manner in which the theory can be applied to understanding their clinical presentations.

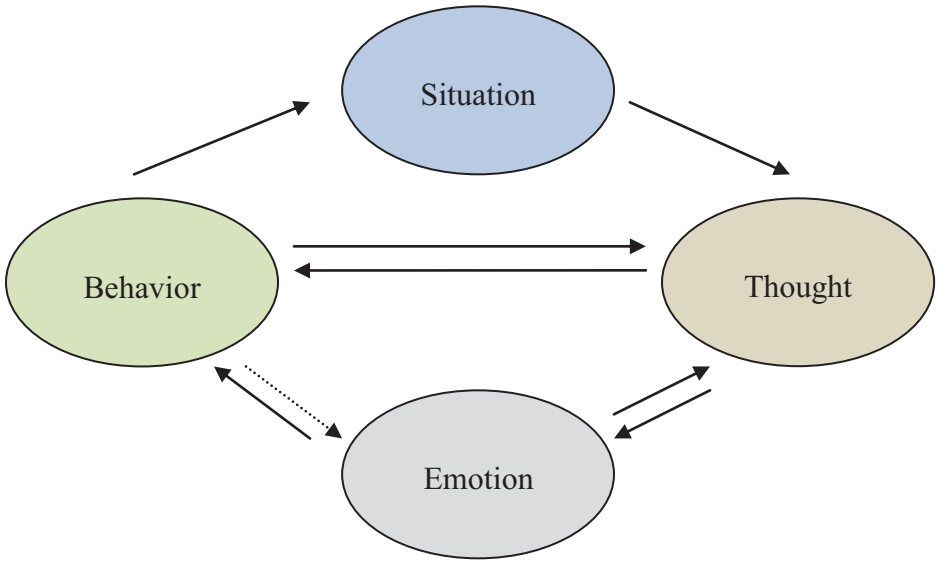
PART I: COGNITIVE BEHAVIORAL MODEL

PART I: COGNITIVE BEHAVIORAL MODEL

Underlying Theory of CBT

For any type of psychotherapy, it is important to understand the underlying theory so that patients' symptoms can be integrated into a coherent conceptualization, and treatment strategies that follow logically can be identified. CBT is no different. According to the cognitive behavioral model, emotional experiences are influenced by our thoughts and behaviors. Mental health problems arise when people exhibit maladaptive and extreme patterns of thinking and behavior, and these often interact with each other to escalate patients' symptoms and problems. The following is a visual description of the general CBT approach.

Figure 1.1: General CBT Approach



- **General CBT approach**

As is illustrated in Figure 1.1, there is no one cause of mental health problems. Instead, the interplay between stressful life situations, dysfunctional or unhelpful thoughts, highly charged emotions, and maladaptive behaviors causes and exacerbates patients' symptoms. There are two theoretical approaches that contribute to CBT—cognitive theory and behavioral theory. Both of these theories are described briefly in the following sections.

Cognitive Theory

- **Cognitive theory**

The word *cognition* refers to the process of knowing or perceiving. Thus, the central focus of cognitive theory is on thinking and the manner in which our thought content and styles of information processing are associated with our mood, physiological responses, and behaviors. According to cognitive theory, the manner in which we think about, perceive, interpret, and/or assign judgment to particular situations in our lives affects our emotional experiences. Two people can be faced with similar situations, but because they think about those situations in different ways, they have very different reactions to them.

> According to cognitive theory, the manner in which we think about, perceive, interpret, and/or assign judgment to particular situations in our lives affects our emotional experiences.

CASE EXAMPLES: JACK AND KATE

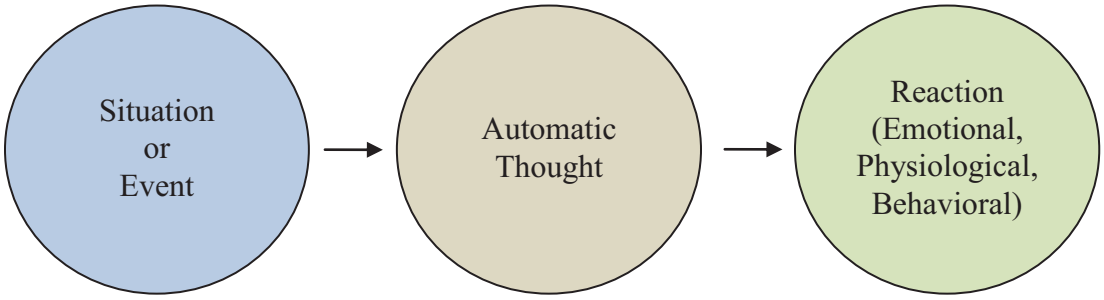
Both Jack and Kate recently lost their jobs, both continue to be unemployed, and both have impaired relationships with their spouses and children. When Jack thinks about these problems, he thinks, *The world has screwed me over. Everyone I know makes my life difficult. I'm better off without them.* Kate, in contrast, thinks, *My life means nothing now. I'm a horrible person because I cannot do what I wish to do.* Not surprisingly, Jack and Kate report two different emotional experiences—Jack's primary emotional experience is anger, whereas Kate's primary emotional experience is depression. Jack's subsequent behavioral response is to ignore his wife and children and complain about his life, whereas Kate's behavioral response is to cry and stay in bed most of the day.

Basic Cognitive Model

We refer to the thoughts that arise in response to particular situations or events as *automatic thoughts*. The term *automatic* is used because these thoughts occur so quickly that they are often not recognized by the patient and, more importantly, the significant impact these thoughts have on subsequent emotional and behavioral reactions goes unnoticed. Despite the fact that these thoughts emerge very quickly, they often have profound effects on our mood because they offer some sort of evaluation or judgment of our current circumstance. We refer to this sequence as the basic cognitive model. Figure 1.2 is a visual description of the basic cognitive model.

- **Automatic thoughts**

Figure 1.2. Basic Cognitive Model



- **Basic cognitive model**

Characteristics of Automatic Thoughts

There are some additional important points to keep in mind about the basic cognitive model and the nature of automatic thoughts. First, the situation need not always be an external event in one's environment. In fact, memories, thoughts, emotions, and physiological sensations can prompt additional automatic thoughts.

CASE EXAMPLE: JACK

Jack often thinks back to an argument he had with his supervisor over a year ago. As he recalls their conversation, he thinks to himself, *My supervisor never respected the years of hard work that I put into the company*. He subsequently becomes angry all over again despite the fact that he has not spoken to his supervisor since he was laid off. The behavioral consequences of this include moping around, watching television instead of actively looking for another job, and being short with his wife.

Second, thoughts need not always be represented verbally in patients' minds. Indeed, many patients report that they experience vivid images in response to particular situations or events.

CASE EXAMPLES: KATE AND CLAIRE

When Kate thinks about the fact that her husband left her and took their children to live in another state, she has an image of a new woman in her husband's life putting the children down to bed and reading them stories. This image represents a "worst case scenario" for the future. When Kate has these images, her depressed affect increases substantially, and she closes her blinds and goes back to bed. In contrast, other patients report vivid images of difficult or traumatic experiences from their past, which in turn facilitate negative emotional experiences. This is the case with Claire, who sometimes becomes agitated when she experiences intrusive memories of the plane crash that led to her injury.

- **Schemas**

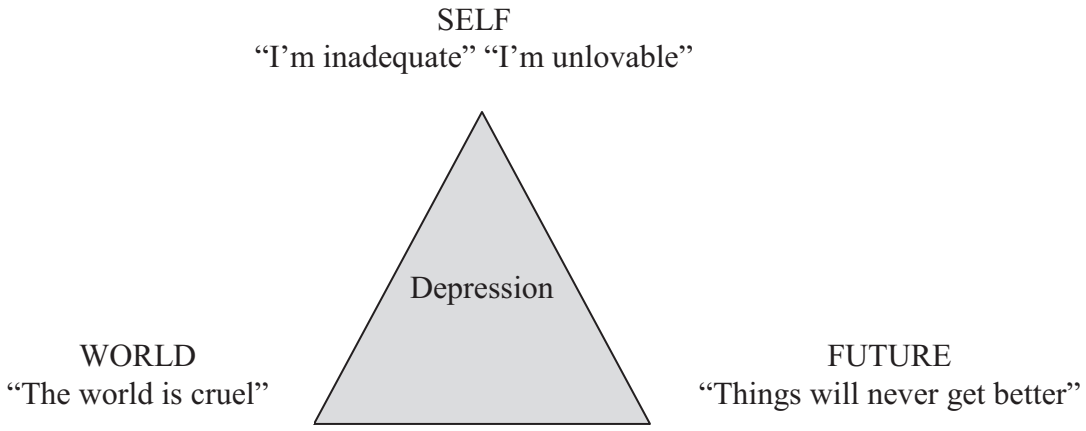
Third, the automatic thoughts that people experience are not random. Over time, people develop certain ways of viewing the world, which are represented in schemas. According to Clark and Beck (1999), schemas are "relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way, thereby determining how phenomena are perceived and conceptualized" (p. 79). That is, schemas are like lenses that color the manner in which people see the world. Schemas give rise to beliefs people have about themselves, others, the world, and the future (i.e., *core beliefs*) and influence the manner in which we process incoming information in our environment. Maladaptive or unhelpful core beliefs, which can arise from schemas associated with mental health problems, are often targets for treatment in CBT.

Schemas give rise to beliefs people have about themselves, others, the world, and the future (i.e., core beliefs) and influence the manner in which we process incoming information in our environment.

- **Core beliefs**

Schemas, in and of themselves, are not inherently problematic. In fact, without schemas we would have great difficulty organizing and making sense of the stimuli that we encounter in our daily lives, as they give us shortcuts for classifying and evaluating information. However, according to cognitive theory (e.g., Clark & Beck, 1999), some people develop schemas and core beliefs that are consistent with mental disorders such as depression or anxiety. For example, a person with a depression-relevant schema would have negative or pessimistic core beliefs about himself, the world, and/or the future (i.e., the negative cognitive triad, shown in Figure 1.3), and he would filter incoming information through a depressive "lens." The case example that follows illustrates the manner in which core beliefs are manifest in these three areas.

Figure 1.3. Negative Cognitive Triad



- **Negative cognitive triad**

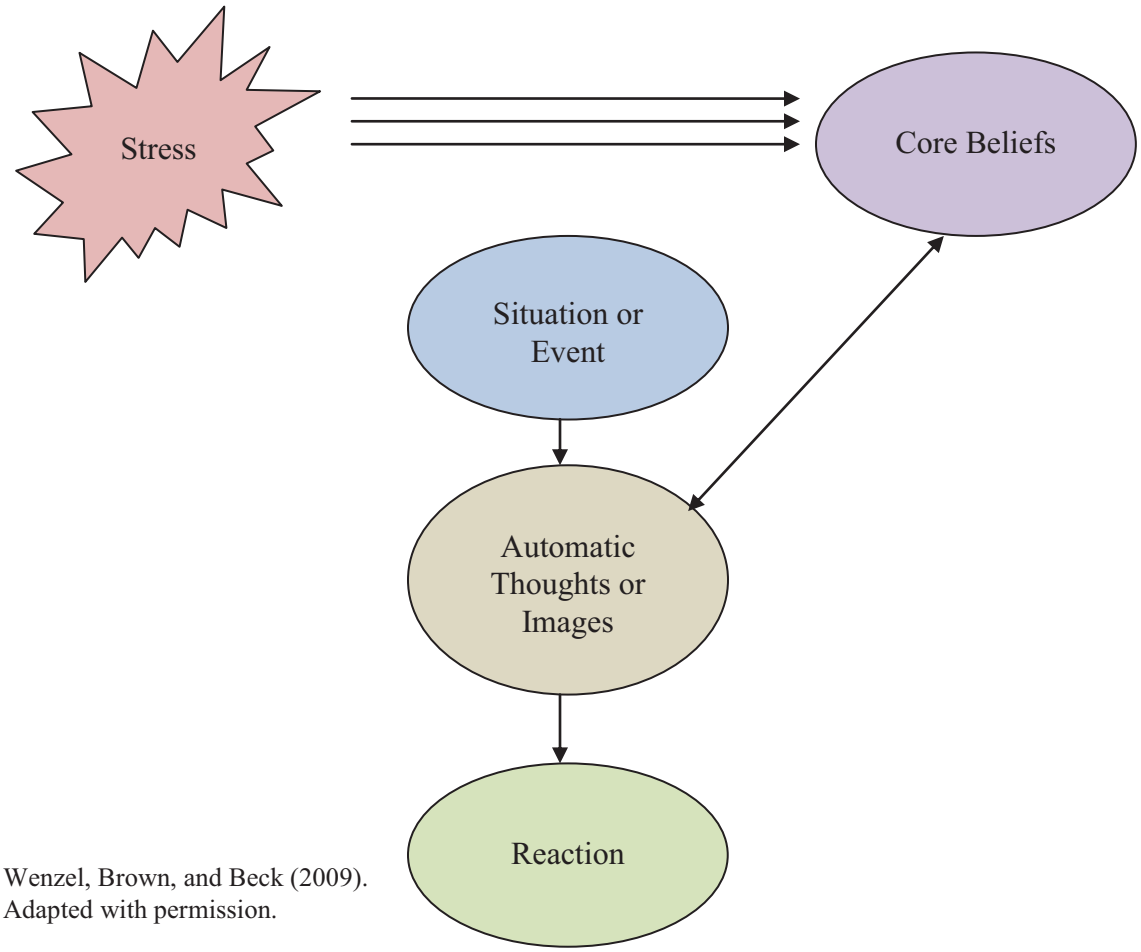
CASE EXAMPLE: MICHAEL

Michael has the core beliefs that he is damaged beyond repair (i.e., a negative belief about himself), that life does not treat him fairly (i.e., a negative belief about the world), and that his life will not improve (i.e., a negative belief about the future). Not surprisingly, he is quick to identify things that are negative and consistent with these beliefs and ignore things that are positive and inconsistent with these beliefs. These core beliefs influence the types of automatic thoughts that he experiences in particular situations. Michael mentioned to his therapist that, recently, his mother had found a job listing that looked promising. Michael's automatic thoughts were, *There's no use in applying. I won't get the job anyway*. According to cognitive theory, these thoughts stem from his core beliefs that he is damaged, life does not treat him fairly, and his life will never change.

Expanded Cognitive Model

Although cognitive behavioral therapists often begin treatment by working with patients in developing skills to evaluate and modify automatic thoughts, as treatment develops, they work to evaluate and modify core beliefs and their associated schemas. Figure 1.4, adapted with permission, illustrates the manner in which core beliefs and automatic thoughts are related.

Figure 1.4. Expanded Cognitive Model



Wenzel, Brown, and Beck (2009). Adapted with permission.

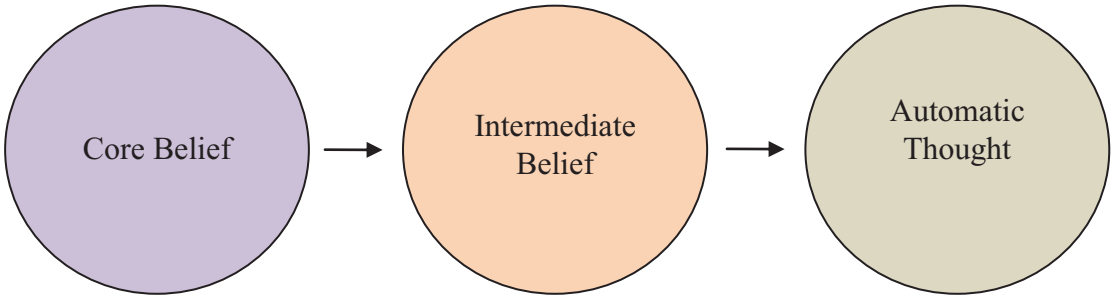
Notice the "stress" icon in the top left corner of Figure 1.4. Core beliefs and their associated schemas related to depression and anxiety are not perpetually active. According to cognitive theory, they develop during childhood or in other formative experiences during adulthood and lay dormant until they are activated in times of stress or adversity. In other words, it is the combination of schemas and stress that typically bring on an episode of depression or anxiety.

CASE EXAMPLE: MICHAEL

Michael grew up in a low-income, inner city area where people commonly experienced negative beliefs about people, the world, and the future. He was often told that people from that neighborhood did not have a chance of escaping, so why bother? Nevertheless, before Michael's time in Iraq, he ignored those messages from people in his neighborhood and was, instead, considered a go-getter. If his mother had found a promising job listing, he would have seen an exciting opportunity and immediately investigated it further. Back then, he would have been more inclined to think, *Although it is not certain the job is available, I have nothing to lose but a little time and effort by applying and seeing if I can land it.* However, Michael's core beliefs about himself, the world, and the future were activated only in the context of the stress associated with his injury in Iraq and subsequent adjustment to his previous life. Now, when informed about a promising job listing, he responds with self-defeating automatic thoughts such as, *There's no use in applying. I won't get the job anyway.*

When patients hold rigid core beliefs, they often form rules and assumptions about the way life works. We call these rules and assumptions *intermediate beliefs*, a term that illustrates the fact that these beliefs stem from core beliefs and then feed into automatic thoughts in particular situations (see Figure 1.5).

Figure 1.5. Levels of Cognitive Processing



Like core beliefs, intermediate beliefs are inflexible and absolute. They are often expressed as conditional assumptions (e.g., *If people don't admire me, then I'm a failure. If I don't complete this task perfectly, then I'm incompetent. If I work very hard, then my hard work should pay off.*). These assumptions can set up patients for failure by creating unrealistic standards that they believe they must reach at all costs. Moreover, they can set up patients for disappointment because the assumptions do not account for the unexpected events that people invariably experience in life. Conditional assumptions can be either negatively or positively worded. An example of a negative conditional assumption is, *If I don't get this promotion, then I'm a loser*. Such statements establish an arbitrary association between a particular criterion (e.g., getting a promotion) and a maladaptive core belief (e.g., *I'm a loser*) and ignore the many other factors that would be considered in making such an absolute judgment. In contrast, an example of a positive conditional assumption is, *If I get this promotion, then I'm successful*. Such statements specify criteria (which are oftentimes unrealistic) that prevent the activation of a maladaptive core belief. Thus, the problem with conditional assumptions is that they are rigid, failing to take into account the ebb and flow of people's life circumstances with which they are faced and giving excessive weight to some life circumstances or accomplishments at the expense of equally significant life circumstances or accomplishments.

- **Conditional assumptions**

In addition, people often engage in behavioral *compensatory strategies* to cope with their painful core beliefs. The particular compensatory strategy exhibited is often linked to the rigid rules and assumptions that form the basis of intermediate beliefs. There are three main types of compensatory strategies observed in depressed and anxious patients: (a*) maintaining behaviors* that support the core belief, (b) *opposing behaviors* that are acted upon to prove that the core belief is wrong, and (c) *avoidance behaviors* that are done so as not to activate the core belief.

- **Compensatory strategies**

CASE EXAMPLE: KATE

Kate harbors several unhelpful core beliefs and has exhibited all three types of compensatory strategies. One of her core beliefs is, *I cannot cope with adversity*, and she often does things that strengthen this core belief, such as letting others make difficult decisions for her and avoiding conflict with others at all costs. By not dealing with adversity, she cannot disconfirm the belief that she is unable to cope. Another of Kate's core beliefs is, *I'm unlovable*. Kate often goes to the extreme in order to please close others, such as agreeing to do whatever others want to do and not speaking up when she is being mistreated in order to make it easy for others to love her. Although these behaviors satisfy others in the short term, in the long term others lose respect for her and perceive that she has little to offer the relationship, which in turn causes them to distance themselves from her. This cycle ultimately reinforces her unlovability core belief and activates a related core belief: *I am a failure*. Kate also has behaved in ways to avoid activating this core belief altogether. For example, in active duty, she rarely spoke to others with whom she lived so that she would not risk the possibility of rejection.

Thus, the cognitive model of mental health problems identifies many layers of maladaptive cognition that potentially cause problems for patients. Although the automatic thoughts that arise in particular situations are usually the most easily accessible, lasting cognitive change is most likely when intermediate beliefs and core beliefs are modified. Later in this manual, you will learn specific strategies for addressing problematic automatic thoughts and beliefs.

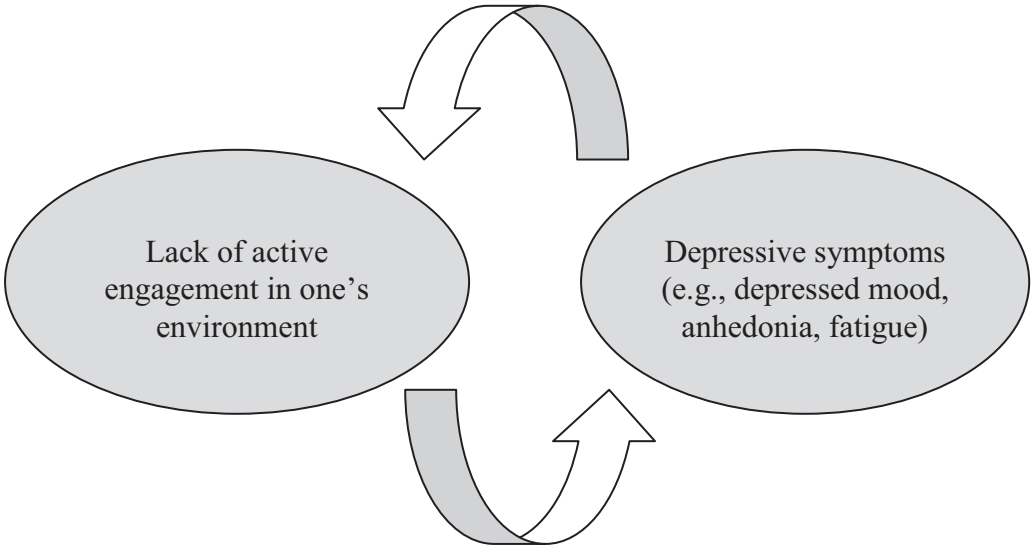
Behavioral Theory

- **Behavioral theory**

The process of identifying and modifying problematic cognitions is only one route to achieving meaningful change in CBT. Cognitive behavioral therapists also focus their work directly on maladaptive behavior. According to Lewinsohn's behavioral model (e.g., Lewinsohn, Sullivan, & Grosscup, 1980), there are two behavioral patterns associated with depression—a low rate of response-contingent positive reinforcement and/or a high rate of punishment. Positive reinforcement is regarded as person-environment interactions associated with positive outcomes or that, quite simply, make a person feel good. One central tenet of Lewinsohn's behavioral theory is that depressed individuals do not get enough positive reinforcement from interactions with their environment to maintain adaptive behavior. This pattern creates a "vicious cycle" (Addis & Martell, 2004)—as people engage less actively in their environment, they become depressed and exhibit symptoms such as anhedonia and fatigue. The more depressed they become, the less they pursue the activities and interactions that they usually enjoy, which further strengthens depression and its associated symptoms (see Figure 1.6). This is very common among depressed Veterans, in which inactivity leads to further inactivity and increased despair. In Part IV of this manual, you will learn strategies to help depressed Veterans break out of this cycle.

One central tenet of Lewinsohn's behavioral theory is that depressed individuals do not get enough positive reinforcement from interactions with their environment to maintain adaptive behavior.

Figure 1.6. Vicious Cycle of Depression



According to Lewinsohn et al. (1980), there are three reasons why people might experience low rates of positive reinforcement: (a) there are few available positive reinforcers in their environment; (b) they do not have the skills to capitalize on positive reinforcers; and/or (c) the potency of positive reinforcers is diminished.

CASE EXAMPLES: CLAIRE, JACK, AND MICHAEL

Claire's situation fits the first explanation. She had wanted to become a pilot all of her life, and she thoroughly enjoyed flying. At the time she presented for treatment, she was prevented from flying until her medical board was complete; thus, her major source of satisfaction was unavailable, and because her leg had been partially amputated, she was in a position in which she had to negotiate an entirely new way of engaging with her environment. Jack's situation, on the other hand, fits the second explanation. He lacks the social skills to have satisfying interactions with other people. Although he has several hobbies, his cognitive style often interferes with obtaining full enjoyment from them because he ruminates on conflicts with others while he is engaging in activities associated with his hobbies. Michael's situation fits the third explanation. He was very close with his mother and his girlfriend before he left for Iraq. Since his return, he perceives that they are burdened by his depression and physical health conditions. The excessive guilt that he experiences prevents him from fully appreciating their support.

- **Response-contingent positive reinforcement**

Although the central feature of Lewinsohn's model is on the lack of response-contingent positive reinforcement in patients' lives, it also indicates that depression can result from a high rate of aversive, or punishing, experiences. Lewinsohn et al. (1980) define punishment as person-environment interactions associated with negative outcomes and/or emotional distress. According to this model, depression can also result when (a) there are many punishers in patients' lives; (b) patients lack the skills to cope with adversity; or (c) the impact of aversive events is heightened. All of the cases described in this manual are coping with aversive events—Jack lost his job and is coping with disturbed familial relationships; Kate returned from her duty and learned that she lost her job and her husband had left her; Michael is having trouble functioning in a familiar environment after suffering mild brain injury; and Claire is

struggling with the after-effects of amputation and uncertainty regarding whether she will be allowed to return to her post. Thus, another behavioral strategy in CBT for depression is to help patients to develop effective problem-solving strategies and social skills to overcome adversity.

The behavioral approach can also be applied to the understanding of anxiety. According to Mineka and Zinbarg (2006), people can develop clinically significant problems with anxiety by having a traumatic experience with uncontrollable or unpredictable events, by watching others having a traumatic experience or behaving fearfully, or by receiving messages from others that certain things are dangerous or should be avoided. Anxiety is maintained and/or exacerbated when people avoid thoughts of or actual encounters with the stimuli or situations associated with anxiety. However, not everyone develops an anxiety disorder simply because they have an encounter with a stressful or traumatic life event. Factors that make people vulnerable to develop clinically significant anxiety problems include a genetic predisposition (i.e., family history of anxiety), personality traits (e.g., neuroticism, the inability to tolerate uncertainty), being reared in an environment in which they had little control, and previous experiences with the feared stimulus or event. Moreover, things that happen during and after a stressful or traumatic life event can contribute to the degree to which a person has subsequent problems with anxiety. Specifically, people are more likely to develop clinically significant problems with anxiety when they have little control over a stressful or traumatic event, such as not being able to escape it; when they experience another stressful or traumatic event shortly thereafter; when they learn after the fact that the stressful or traumatic event was more dangerous than they originally perceived it to be; and when they mentally rehearse the stressful or traumatic event (Mineka & Zinbarg, 2006).

CASE EXAMPLES: CLAIRE AND KATE

Claire and Kate have difficulties with anxiety in addition to their depression. Claire was in a plane crash in which she sustained major injuries, leading to the partial amputation of her leg. Thus, she had a direct experience with an unpredictable and uncontrollable traumatic event. Subsequently, she has experienced anxiety symptoms such as intrusive memories of the plane crash and an increased startle response. However, Claire's anxiety did not develop into full-fledged posttraumatic stress disorder (PTSD). On the basis of Mineka and Zinbarg's (2006) behavioral theory, it can be speculated that several factors "protected" her against the development of PTSD, including a family history free of anxiety problems, previous experiences with mastery and control over her environment, and no other experience with other traumas.

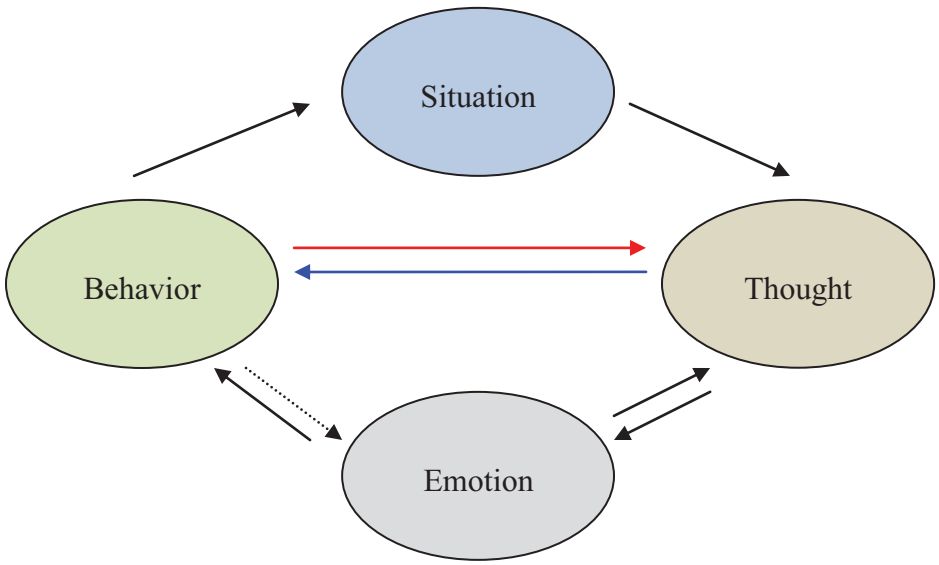
In contrast, Kate reported having an increasing number of panic attacks in the time since she learned that her husband and her children left the state. Although she had the first panic attack when her mother broke the news to her, she has experienced subsequent panic attacks without warning. Behavioral approaches to anxiety would suggest that the first panic attack served as a powerful conditioning event for Kate, much like a traumatic event, and that similar external events (e.g., receiving a letter addressed to her husband at their address) or internal events (e.g., increased heart rate) would prompt future episodes of anxiety and panic (Bouton, Mineka, & Barlow, 2001). In addition, behavioral approaches to anxiety would suggest that Kate was vulnerable to develop anxiety problems because she had an introverted, anxious personality style, and she had little experience with mastery and control over her environment.

Integration of Cognitive and Behavioral Theory

By now, it should be clear that both cognitive theory and behavioral theory are central to understanding the various manifestations of depression and anxiety that therapists see in their patients. Although we present these theories separately, in most instances, therapists will draw on their principles simultaneously in treatment because clinical strategies that are derived from them can work synergistically. As commonly observed in depressed Veterans, inactivity reinforces depression, both behaviorally and through its impact on cognitions. For example, continued inactivity may strengthen beliefs that a depressed Veteran may have that he is *incompetent* or that *life is meaningless*, which leads to further inactivity. Moreover, patients who develop strategies to modify cognitions ultimately *do* things differently because they are no longer inhibited by their maladaptive thoughts and beliefs. Once having done things differently, the new self-enhancing cognitions are strengthened. At the same time, patients who develop behavioral strategies to manage depression and anxiety learn that they *can* manage distress and adversity, which makes them more likely to engage in similar adaptive behavioral strategies in the future. Because of the interactional nature of cognitions and beliefs, as displayed in Figure 1.7, new cognitions reinforce new behaviors, and new behaviors strengthen and reinforce new cognitions. Simply put, thoughts impact behaviors, and behaviors (or lack thereof) impact thoughts!

Thoughts impact behaviors, and behaviors (or lack thereof) impact thoughts!

Figure 1.7. General CBT Paradigm



CBT Case Conceptualization

Case conceptualization is the process by which therapists develop an individualized formulation of their cases in order to guide treatment planning and intervention (Kuyken, Padesky, & Dudley, 2009; Persons, 2006). It is an essential component of CBT and is an important factor that differentiates CBT from cognitive behavioral approaches or techniques that focus exclusively on teaching skills, often in a psychoeducational class format. In the case conceptualization process of CBT, therapists apply an empirical approach to each case, meaning they generate

- **Case conceptualization**

hypotheses about the cognitive, emotional, behavioral, and situational factors that contribute to, maintain, and exacerbate a patient's mental health problems. For example, early childhood experiences (e.g., parental divorce, conflict, abuse) or other formative experiences in adulthood may lead to the formation of particular core beliefs, conditional assumptions (i.e., intermediate beliefs), and compensatory strategies that impact present-day cognitive, emotional, and/or behavioral reactions to situations or circumstances in the patient's present life.

- **Empirical approach**

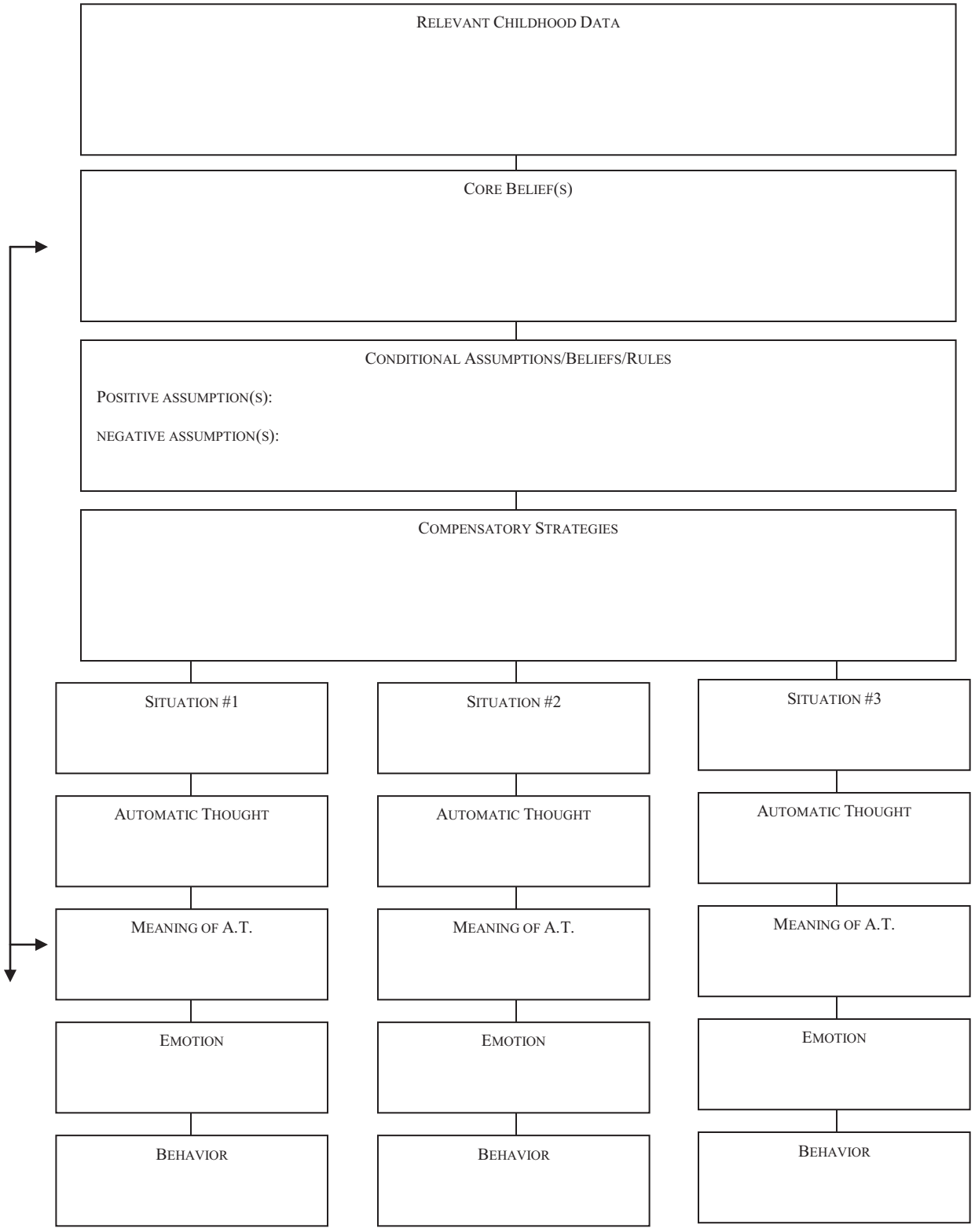
The information for the case conceptualization is obtained from an initial patient interview or assessment, the patient's records, behavioral observation, and/or interviews with other care providers or family members. This information is then incorporated into a case conceptualization model that reflects the manner in which cognitive and behavioral theory can be applied in understanding the specific patient's clinical presentation. The case conceptualization is modified over the course of treatment as new information is acquired and as specific hypotheses are verified or disconfirmed.

Figure 1.8 displays the commonly used Cognitive Conceptualization Diagram, as presented by J. S. Beck (1995). Therapists can use this form to record core beliefs, intermediate beliefs (i.e., conditional rules and assumptions), and compensatory strategies. Although the first box is labeled "Relevant Childhood Data," it is our experience that many Veterans develop core beliefs and conditional assumptions through formative military experiences in young adulthood. Therapists working with Veteran patients can include such experiences in this box. In addition, the Cognitive Conceptualization Diagram allows therapists to record three problematic situations reported by patients and the associated automatic thoughts (and the meaning behind them), emotions, and behaviors. The completion of this form will help therapists organize relevant information about their patients and illustrate the manner in which maladaptive beliefs and compensatory strategies facilitate dysfunctional thoughts, emotions, and behaviors in actual situations encountered in patients' lives.

- **Cognitive Conceptualization Diagram**

J. S. Beck's (1995) Cognitive Conceptualization Diagram heavily emphasizes the cognitive processes we present in the expanded cognitive model. Conceptualization of a case according to this model is especially useful when the primary intervention is cognitive in nature, such as cognitive restructuring or modification of core beliefs (see Part IV). However, there are other models for cognitive behavioral case conceptualization, and cognitive behavioral therapists can feel free to use whatever model with which they are most comfortable. For example, Wright, Basco, and Thase (2006) present a model for case conceptualization that takes into account diagnoses, formative influences, situational issues, biological/genetic/medical factors, and strengths/assets and allows for the therapist to evaluate the manner in which these domains influence the selection of treatment goals, patients' schemas, and automatic thoughts, emotions, and behaviors associated with specific situations. This conceptualization might be especially useful in instances of comorbid diagnoses that are associated with different cognitive behavioral profiles, multiple pathways hypothesized to contribute to a patient's clinical presentation (e.g., medical, cognitive, situational), and/or the use of more than one treatment modality (e.g., CBT and medications).

Figure 1.8. Cognitive Conceptualization Diagram



From Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford Press. Reprinted with permission.

We now turn to examples of case conceptualizations for the four Veteran patients described at the beginning of the manual.

- **Case conceptualization examples**

CASE EXAMPLE: JACK

During his intake evaluation, Jack was diagnosed with major depressive disorder, moderate, recurrent, and alcohol dependence, in full remission. Although he was not assigned an Axis II diagnosis, the assessor noted that he exhibited features of paranoid personality disorder. During the point in the interview in which his psychosocial history was gathered, Jack admitted that he endured substantial physical abuse at the hands of his father. His father struggled with alcoholism and was unable to hold down a steady job. Consequently, the family had significant financial limitations, and Jack wore hand-me-downs and clothing bought from secondhand stores. Jack was often teased because of his appearance and, as a result, he kept to himself. As he got older, when he was teased or taunted by other children, he would strike back aggressively and usually win the fight. By the time Jack was in high school, he was known as a troublemaker who should be avoided. Jack was expelled from school for repeatedly fighting during his junior year. As soon as he was of age, he joined the military to start a new life and get out of the house. Although he ultimately was discharged honorably, he was disciplined several times for fighting and insubordination.

Jack's therapist took all of this background information into account when she met him for his first session, and she recorded the key points of this information under Relevant Background Data. She developed the hypothesis that his most salient core belief is, *Others will hurt me,* when he rapidly listed the people in his life who have "screwed" him.

The following is the line of questioning that the therapist used in order to more completely identify Jack's core beliefs, intermediate beliefs, and compensatory strategies as she formulated her case conceptualization.

Jack: I just knew my regional manager would do this to me. I knew it! And did the store manager do anything to defend me? *No*, of course not. And then, to make matters worse, things are awful at home. My wife doesn't do anything to take care of the house or cook me dinner, but yet she expects me to give all of my money to the household so that she can keep her salary for whatever the hell she wants…

Therapist: [gently intervening to de-escalate Jack's anger] So, it sounds like one thing that brought you here is problems with some of the people you are closest to, both at home and at work.

Jack: It's their problem, not mine. That's just the way people are. Hell, I've been going through this since I was two years old. If my dad wasn't beating me, he was breaking promises left and right, leaving me and my two brothers to fend for ourselves.

Therapist: It sounds like you've had a lot of tough experiences, Jack. I appreciate the fact that you're willing to open up about them with me.

Jack: [grunts]

Therapist: You know, Jack, these kinds of experiences can make a big impact on people. What kind of an impact did they make on you? [Therapist asks this question to assess for additional core beliefs and intermediate beliefs]

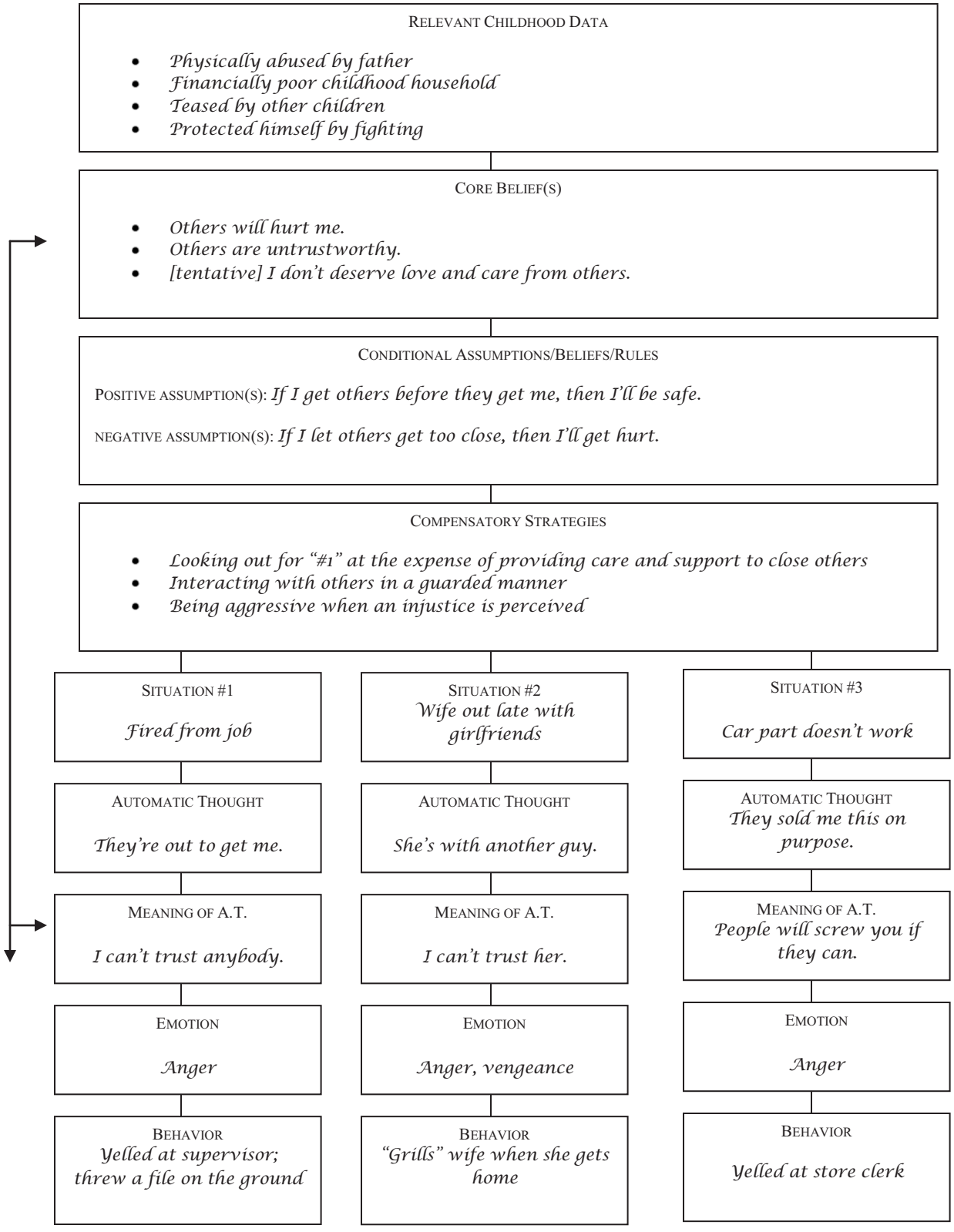
Jack:	[lacking insight] I wouldn't say that they did. I don't let them get to me. I look out for #1.
Therapist:	What do you mean by that, looking out for #1?
Jack:	Just like it sounds. You can't trust anybody, even your family. So, I'll provide for them and do my duty as a father, husband, son, whatever. But the minute I see you do something to screw me over, that's it. You don't get another chance.
Therapist:	How has this attitude served you in your life?
Jack:	It's the *only* way to get through war.
Therapist:	Yes, I can imagine that you have to look out for #1 during war. How has this attitude affected you at other times in your life?
Jack:	I don't know; it hasn't affected other areas of my life from my point of view, I guess.
Therapist:	What about from the points of view of others?
Jack:	I don't know. I guess some people just don't like the way that I am. They say that I complain a lot, that I'm always looking for the worst in people. But you know what? That's their problem. It's served me well.
Therapist:	[noting that Jack has changed from saying this attitude has not affected his life to saying that this attitude has served him well] In what way has it served you well?
Jack:	If anyone's going to do the damage, it's me, not them. I won't let them get to me first.
Therapist:	So, you've been able to protect yourself throughout your life. [Jack nods] How does all of this play out with your family members? Do you use the same approach with your family members?
Jack:	[pauses] Well, yes and no. I mean, they're family. It's not like I want to do anything to hurt to them, even if my father was like that to me. But, I tell you, I'm not going to take it from them when they take advantage of me. I won't stand for it!
Therapist:	And do you perceive that your family members take advantage of you from time to time?
Jack:	More than I'd like to admit.

Notice that Jack's therapist did not actively point out any of his core beliefs or intermediate beliefs. Because these beliefs are so central to people's self-concept, particularly when they are experiencing acute symptoms of a mental disorder, it is often too threatening to verbally acknowledge them when the therapeutic relationship is in its infancy. Nevertheless, the therapist can ask targeted questions in order to generate hypotheses about core beliefs, intermediate beliefs, and compensatory behaviors, and she can revisit the conceptualization as more information is gathered in subsequent sessions. Jack's therapist completed the case conceptualization form after meeting with him for the first time (Exhibit 1.1). The majority of the information that she recorded was specified directly by Jack throughout the session, supplemented by explicit examples that Jack provided to support some of these statements (as summarized in the situation → thought → emotion → behavior sequence). However, notice that his therapist also proposed an additional core belief—"I don't deserve love and care from others." Although Jack did not verbally express thoughts or perceptions consistent with this core belief, she reasoned that many children who endure physical abuse and teasing from peers develop similar core beliefs, and she hypothesized that

- **Self-concept**

part of his anger is driven by a belief that he is unlovable. After the first session, the therapist requested Jack's previous treatment records and saw that a previous therapist had made a similar speculation.

Exhibit 1.1. Cognitive Conceptualization Diagram for Jack



The majority of Jack's case conceptualization was centered on his perception of others or the world. At times, patients will present with many different core beliefs that drive different aspects of their clinical presentation, such that some core beliefs are associated primarily with one disorder (e.g., depression), whereas other core beliefs are associated primarily with another disorder (e.g., anxiety).

CASE EXAMPLE: KATE

Kate was diagnosed on Axis I with major depressive disorder, recurrent, severe, and provisionally with panic disorder, and on Axis II with dependent personality disorder. She indicated that she was the middle child in a family of seven children, two of whom had special needs. As a result, she received little attention from her parents or older siblings. Although she desperately wanted to fit in with her peers during her school years, she was a homely child and was often neglected. Whenever a new student was introduced to the school, she seized the opportunity to make a "best friend." Unfortunately, the friendships often did not last as those friends expanded their social circle with other peers whom they regarded as more exciting. She spent most of her time on the playground reading on the steps while the other children played. Not only did these circumstances provide a context for Kate to develop a core belief about being unlovable, but they also deprived her of the opportunity to develop effective social problem-solving skills that are necessary for managing relationships. Thus, Kate also has little confidence in her ability to handle adversity, which often prompts anxiety.

Kate met her husband, Kevin, when he relocated to her school in their senior year of high school. This was Kate's first boyfriend, and she was thrilled to finally engage in some of the same social activities as her peers. He had a strong personality, and she usually "followed his lead" in social circumstances. Although Kate was planning on attending college after high school, Kevin strongly encouraged her to get a job so they could move in together and start their life. She acquiesced and began working as a waitress. Approximately six months later, she learned that Kevin was cheating on her while she worked evening hours. She described herself as being so "mortified" about this betrayal that she joined the military to get away from him as fast as she could. When she returned home on leave a year later, Kevin claimed he had made a big mistake and begged her to marry him. They were married four months later.

Kate's therapist developed hypotheses about Kate's core beliefs, intermediate beliefs, and compensatory strategies in the first session as Kate described two major and recent disappointments—her husband leaving her and taking the kids to another state, and the unexpected loss of her job at the hospital. Notice that the therapist asked questions not only about the sequence of events associated with these problems, but also about the *meaning* these events had for her (to identify core beliefs and intermediate beliefs) and the manner in which she coped with them (to identify compensatory strategies).

Kate:	...And then when I came home, my mother picked me up from the base and told me that Kevin had moved with the kids out of state. [becomes tearful]
Therapist:	[gently] That sounds very hard. What did you do next?
Kate:	Nothing. Absolutely nothing. I went home, pulled down the blinds, and slept for three days.
Therapist:	Did you try to call Kevin or the kids on their cell phones?

Kate: What's the use? If they left, they probably don't want to talk to me.

Therapist: What do you think would happen if you tried to call them?

Kate: I think they'd tell me they don't need me…that they're a lot happier without me.

Therapist: [gently] What makes you think that?

Kate: Because *everyone* would be better off without me. I'm boring. I never really *say* or *do* anything.

Therapist: Is that why you think they left? Because you don't contribute anything meaningful to their lives?

Kate: [crying out loud] Yeah. I used to just try not to make waves, thinking that they wouldn't leave me if I didn't cause them problems. But after I was deployed, they probably saw that life is even better without me.

Therapist: [Later in the session, when Kate was describing the unexpected loss of her job] When did you find out about the loss of your job?

Kate: Well, I realized that I could not stay in bed forever and that the hospital would be expecting me. So I went to the hospital administrator's office to let her know that I'm back and wanted to start taking shifts.

Therapist: What happened then?

Kate: She looked surprised to see me. She said they had filled my position six months ago. [looks down at her hands]

Therapist: I can imagine that this would be quite a shock for you.

Kate: Well, yeah! She told me that they did not hold the position for me because I volunteered to stay longer. But that's not true at all. I was *told* that I had to stay longer. I didn't volunteer for anything!

Therapist: Did you try to explain this to the hospital administrator?

Kate: [shyly] No.

Therapist: What prevented you from clarifying with her what had happened?

Kate: I just couldn't. I can never tell my side of the story. I just get too tongue-tied and emotional.

Therapist: So then what did you do?

Kate: Nothing. I just said "Thank you" and left her office.

Therapist: Do you have a new job lined up?

Kate: [tightly wadding up a tissue in her hand] No, I can't find one.

Therapist: This sounds like a difficult situation, and I'm sensing that there is a lot running through your mind right now. What are you thinking?

Kate: [crying] I can't deal with this! There are already bills that are piling up, and I have no money to pay them!

Therapist: Might it be useful for us to put together a game plan for addressing some of these stressors that are piling up?

Kate: What's the use? I've never been able to deal with stress!

Therapist: How have you dealt with stress in the past?

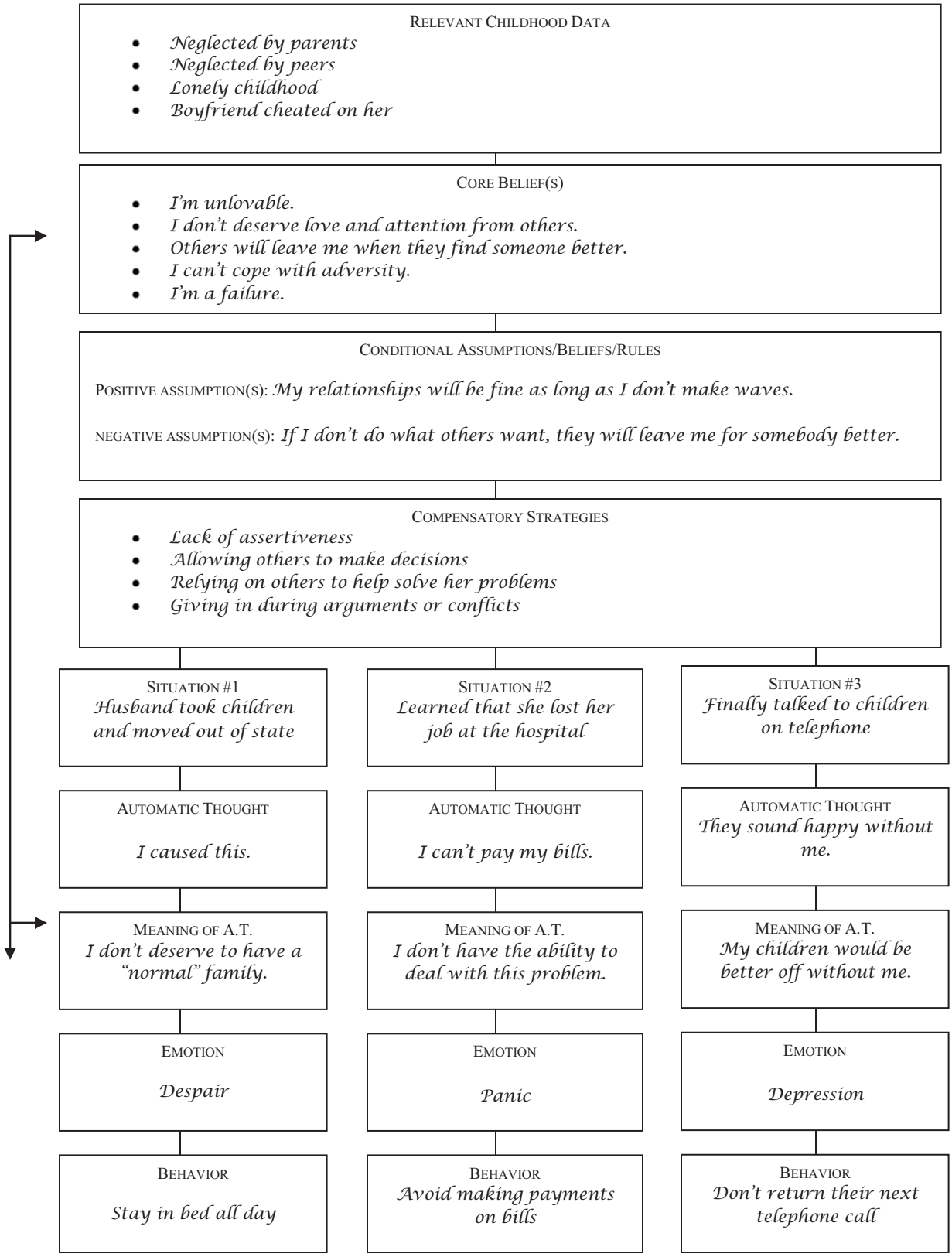
Kate: I don't think I've *ever* dealt with it. I just try to ignore it.

Therapist: Are you doing that now?

Kate: [pauses] Yeah. I'm not even trying to make any form of payment on any of the bills, even the small ones. And I'm not even really sure how to go about finding a new job, since there is only one hospital in town. I'm stuck. I'm such a failure.

Notice that Kate's therapist alternated between asking her how she handled events in the sequence (e.g., "So then what did you do?") to identify compensatory strategies with asking her about her perceptions of the events (e.g., "What makes you think that?"). Exhibit 1.2 displays the case conceptualization that Kate's therapist completed after meeting with her for the first time.

Exhibit 1.2. Cognitive Conceptualization Diagram for Kate



The case conceptualization helped Kate's therapist to identify the hypothesized cognitive and behavioral sources of her depression and anxiety. Kate experienced *depression* when beliefs about being unworthy of love were activated, but she experienced *anxiety* when beliefs about an inability to cope were activated. Both her depression and anxiety were also associated with the belief that she is a failure. Behaviors that maintained Kate's depression included ungratifying interactions with others, such as times when she would appease the other person at the expense of getting her own needs met. In contrast, behaviors that maintained Kate's anxiety were avoidance of solving problems and making decisions, which reinforced her belief that she was unable to cope with adversity. Both of these cognitive and behavioral profiles contributed to her Axis II presentation of dependent personality disorder.

CASE EXAMPLE: MICHAEL

Michael's clinical presentation is different from Jack's and Kate's because Michael experienced a dramatic change in his beliefs and behaviors after he returned from service. Prior to his deployment, he was an ambitious, driven young man who hoped to go to law school and one day get into politics. Michael was reared as an only child by a single mother who worked two jobs to "make ends meet." Despite the fact that she was not around much of the time, the two had a close relationship, and she instilled many strong values in him. She often told him that he could do anything he set his mind to and that education and hard work were the keys to living a better life than she did.

Michael and his mother lived in a bad section of the city, where there were street gangs and poor-quality schools. Nevertheless, Michael excelled in school—his intelligence and abilities were quickly recognized by his teachers, and they took him "under their wings" to ensure that he stayed away from deviant crowds and achieved the milestones necessary for him to be admitted to a good university. Michael was often teased by his peers, who called him a "teacher's pet" and said that he was trying to be "too White." These comments generally did not bother Michael because his focus was on doing more with his life than he saw others around him doing. Michael was admitted to the flagship state university to study political science. When he realized that he and his mother would have trouble covering expenses, he joined the National Guard to pay for his tuition, with the idea that it was unlikely that he would be called to duty. However, he was called upon to serve in Iraq during his senior year of college.

At the time of his intake evaluation, Michael's diagnosis was major depressive disorder, single episode, severe. The assessor noted that he endorsed persistent suicide ideation with a desire to kill himself, although he denied having a specific plan to do so. He was not assigned a diagnosis on Axis II.

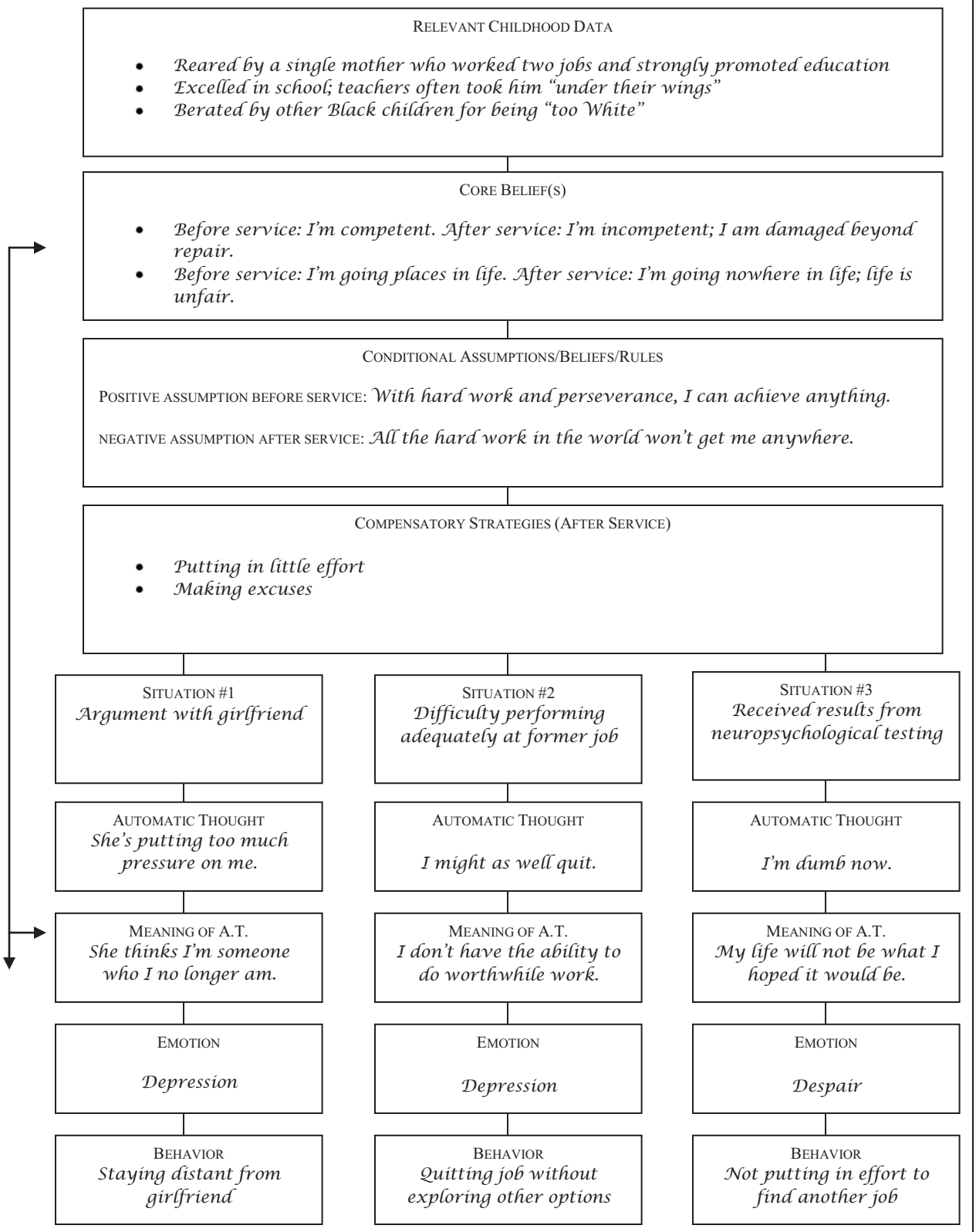
The following dialogue illustrates the manner in which Michael's therapist identified his core beliefs, intermediate beliefs, and compensatory strategies that operated before his time in service and since his return.

Therapist: Let me summarize what you've just told me to make sure I understand what you have experienced. You were in your senior year at the university, applying to law schools, and working part-time in a law firm where you hoped to eventually be employed. Unexpectedly, you were sent to Iraq. You were told that you would be there for a year, but you ended up being there for almost a year and a half. Is this correct?

Michael: [dejected] Yeah.
Therapist: Have you made plans to take classes and get your degree?
Michael: I'm not going to finish.
Therapist: What is behind the decision not to finish?
Michael: [angry] Everything's changed, that's why! I can't do it anymore. I tried to go back to the law firm when I came back to the States, and all that happened was that I made lots of mistakes and couldn't keep up. When they first told me that I had mild brain injury after the explosion, I didn't think it would really affect me. I used to be able to do anything I set my mind to. But now all of the abilities I had that were important to me are gone. I'm going to rot in the 'hood, just like everyone I went to school with!
Therapist: [gently] How had you hoped your life would have gone?
Michael: I had dreams, man. All my life I was different, but I didn't care because I knew I was going somewhere. I was gonna go to law school, maybe even go into politics someday. I was gonna get my mom out of the inner city so that she could actually have a house somewhere. With a real yard. You know, not having to worry about living paycheck to paycheck.
Therapist: [gently] And that's not possible now?
Michael: [laughs sarcastically] Do you know any successful lawyers that are brain damaged? Everything I used to be able to do—focus no matter what else was going on, be organized, think on my feet—it was loud and clear to me when I went back to the law firm that those days are long gone.
Therapist: So what I'm hearing is that, before, you were on an academic and career track that was very meaningful to you, which seemed to contribute to your view of yourself as a competent, successful person. Now that you're seeing that the mild brain injury has affected some of your ability to perform on this track, you no longer view yourself as competent or successful.
Michael. Yeah. That's exactly it.

Michael's therapist noticed many examples of unhelpful or maladaptive thinking, such as his perceptions that he is no longer competent or successful and that his life was destined to be one in which he "rots in the 'hood." However, she noted these beliefs on his cognitive case conceptualization (see Exhibit 1.3) and decided to revisit these cognitions using cognitive strategies in the middle phase of treatment (see Part IV). Michael's therapist also suspected that some of the cognitive deficits he reported could also be explained by depression, rather than his brain injury, and that he might see some improvement as his depressive symptoms improved. She was sure to communicate this to Michael in the initial phase of treatment in order to motivate him for treatment by explaining some potential benefits of CBT (see Part III).

Exhibit 1.3. Cognitive Conceptualization Diagram for Michael



After reviewing Michael's case conceptualization, his therapist realized an unspoken belief that likely drove his current perceptions of incompetence and his life not going anywhere—that a life worth living is one characterized by high achievement, such as having a high-status job with a high salary. If Michael no longer had the opportunity to attain this level of achievement (which was a hypothesis in and of itself that still needed to be tested), then he would have to radically redefine the components of a meaningful life. Michael's therapist speculated that his suicide ideation was related to his perception that he no longer has reasons for living.

CASE EXAMPLE: CLAIRE

Claire, like Michael, was faced with major life adjustments after she returned to the U.S. following her injury. She was unsure whether she would be medically cleared to resume her position as a pilot. The possibility of not flying was exceptionally threatening for Claire, as she had dreamed of becoming a pilot since she was a child and had directed her entire academic and professional career toward achieving this goal. Because Claire was so focused on professional success, she had done little to develop other aspects of her life, such as close relationships and interests outside of work. Thus, she had very little to do while she was awaiting the results of her medical review, and she spent most of her time ruminating over "what if's" and frequently checking on the status of her medical board.

Claire's anxiety spanned across a number of anxiety disorder diagnoses—she worried excessively about professional success; she compulsively checked the status of her medical board; she demonstrated perfectionistic behavior; she worried about whether others judged her as a success; and she had occasional intrusive memories and nightmares of the plane crash. At the intake interview, Claire was given a diagnosis of anxiety disorder not otherwise specified. A diagnosis on Axis II was deferred.

Claire revealed information about her background that was relevant to understanding her anxiety problems during the portion of the intake interview that focused on her psychosocial history. Claire's parents are successful and well-to-do—her father is a well-respected ophthalmologist who owns his own practice, and her mother is a partner at a prominent law firm. They had pushed Claire and her brother to succeed throughout their childhood. Claire did not disappoint her parents, as she graduated in the top 2% of her class from a private high school and attended a prestigious university on an Air Force ROTC scholarship to prepare her to become a pilot. Despite these achievements, Claire often worried that she would under-perform on her examinations and that she would somehow achieve less than was expected of her. As a result, she studied excessively for examinations and participated in extracurricular activities not because she enjoyed them, but because she thought they would help her reach her academic and professional goals.

The following dialogue is a discussion between Claire and her therapist at Claire's first visit. At this point in the conversation, Claire had been expressing frustration and agitation about the length of time it was taking to receive the results of her medical board.

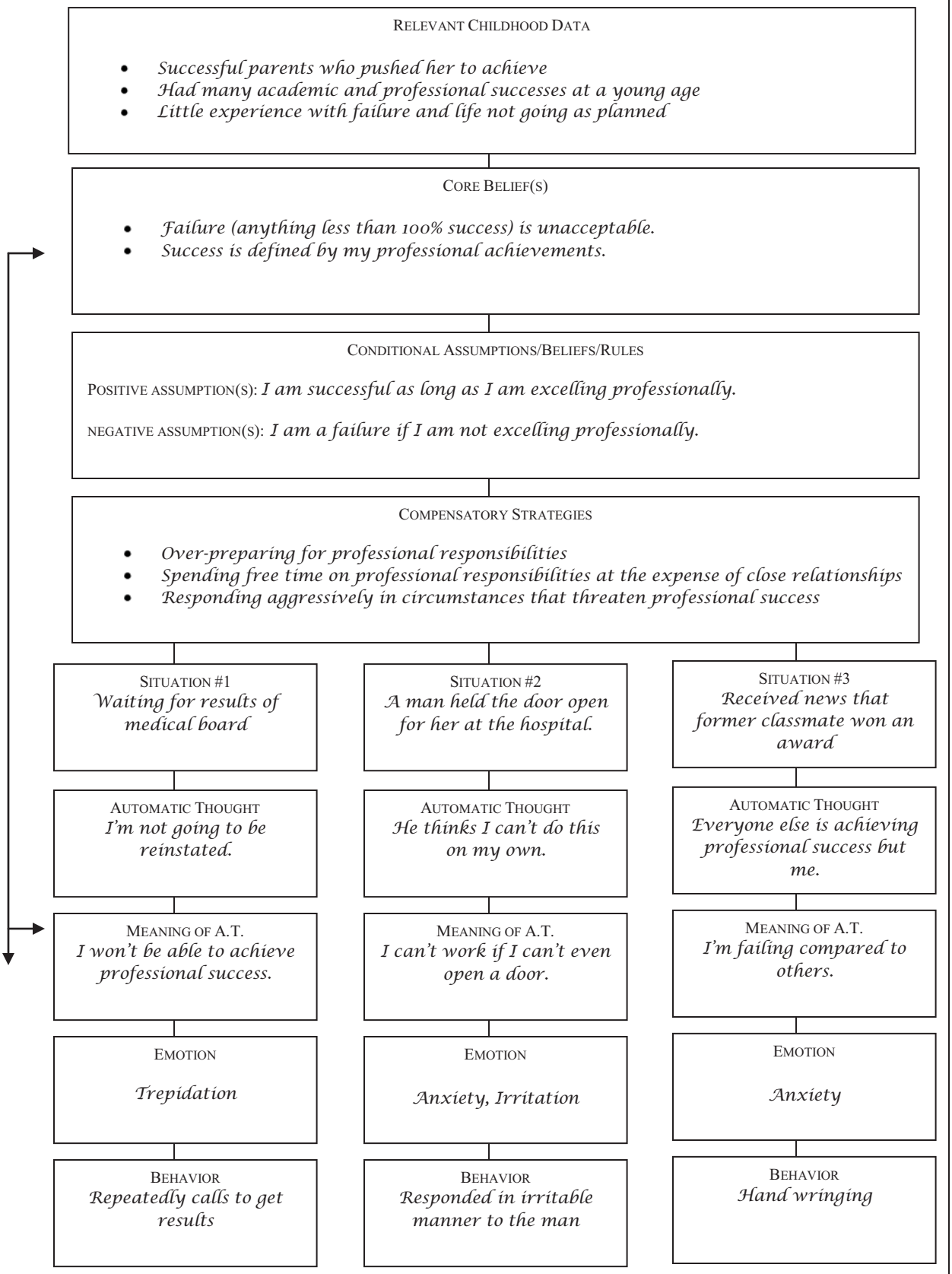
Therapist: I'm sorry to hear that this process has taken so much time. What have you been doing with yourself in the meantime?

Claire:	Just getting ready to get back in the air. You know, reading up on the next stage of training. Also doing a bit of searching on the Internet about accomplishments of other people who have had leg injuries.
Therapist:	Claire, do you have a plan in place for what you will do in the event that the conclusion of your medical review is that you can no longer fly?
Claire:	[looks stunned] That's not going to happen. It can't! It just can't. [slows down and speaks more softly] Not flying, that's really just not an option for me.
Therapist:	[gently] Why not?
Claire:	Because I've been preparing my entire life to be a pilot. That's what I've been telling everybody ever since I was a little girl. [becomes tearful] Everything I've worked for, it would all just go down the drain. And everyone else would think I'm a failure.
Therapist:	Would *you* think you're a failure?
Claire:	Oh yes, without a doubt.
Therapist:	Even if you could no longer fly due to circumstances beyond your control? Even if you take into consideration all of the accomplishments you've had at such a young age?
Claire:	It doesn't matter. I didn't do what I said I was going to do. I came up short.
Therapist:	It sounds like you get a lot of your self-esteem from flying. [Claire nods] What else contributes to your self-esteem?
Claire:	Nothing. Just flying.
Therapist:	[making another attempt to identify other areas in which Claire has the potential to view herself as successful] Well, tell me about some other aspects of your life, like your friends or your interests outside of work.
Claire:	I don't really have a life outside of work. Ever since I graduated from college, it's just been work and preparing to get to the next level in my career. I was hoping to do more than any other woman ever had in the Air Force.
Therapist:	It sounds like your work and the accomplishments and promotions you get through your work are what you value most.
Claire:	Yeah. I've always viewed other things—hanging around doing nothing with other people, meaningless hobbies—as a waste of time.

Through this conversation, Claire's therapist hypothesized that Claire's core beliefs center on themes of success vs. failure (see Exhibit 1.4). It appeared that Claire had a rigid definition of failure, such that anything less than a 100% match between her expectations and actual accomplishments was defined as a failure, as well as a rigid definition of success, such that only pre-determined professional accomplishments could contribute to her perception of success. As a result, she spent most of her time engaged in work activities and over-preparing for various duties at work at the expense of other activities that had the potential to enhance her emotional well-being, such as developing close relationships with others. At the time she met with her therapist, Claire's primary symptom was anxiety because she was coping with the ambiguity of whether or not the results of her medical board would support her reinstatement as a pilot. However, Claire's therapist predicted that Claire would also exhibit symptoms of depression in the event that she was told that she could no longer

fly, as (a) flying was central to her view of herself as having achieved professional success, and (b) she had few, if any, other sources of pleasure and esteem in her life.

Exhibit 1.4. Cognitive Conceptualization Diagram for Claire



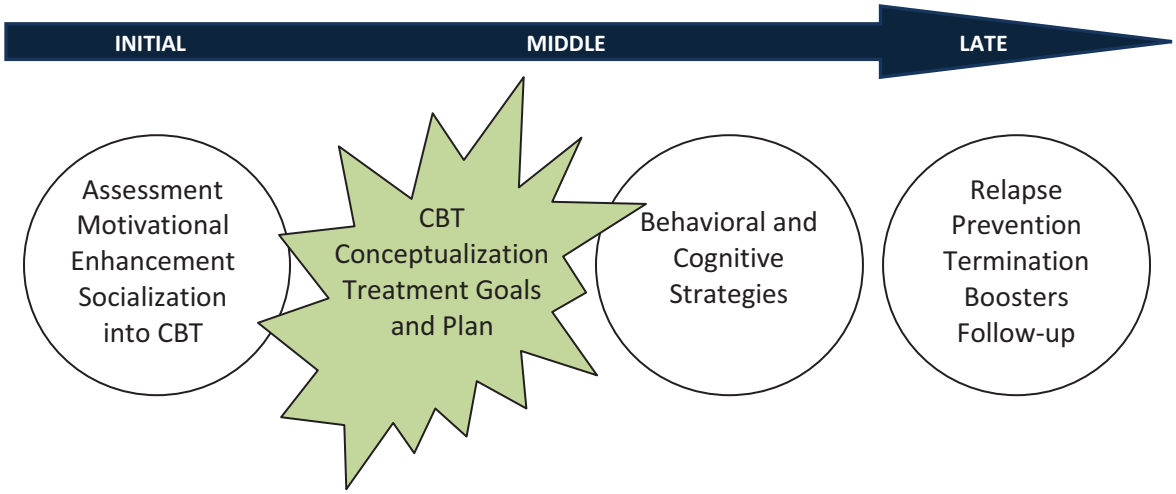
The case conceptualization provides a means for applying cognitive behavioral theory to understanding patients' clinical presentations. It helps therapists to identify the particular "lens" through which their patients view the world. In addition, the case conceptualization forms the basis of treatment and can serve as a guide to help therapists select particular interventions.

CASE EXAMPLES: JACK AND CLAIRE

Jack views the world as one in which others will hurt him if they get the chance. A useful focus of treatment with him would be to develop (a) cognitive strategies to consider alternative explanations for people's behavior toward him and (b) behavioral skills for interacting with others more effectively than he does now. Claire, on the other hand, views the world in terms of rigid conceptualizations of success vs. failure. A focus of treatment with her would be to develop (a) cognitive strategies to redefine her view of success and failure and to see the "shades of gray" in between, and (b) behavioral skills to expand the repertoire of meaningful activities in which she engages.

As illustrated in Figure 1.9, we view the timeline of CBT as having three distinct phases: (a) the initial phase, (b) the middle phase, and (c) the later phase. During the *initial phase* of treatment, the therapist focuses on clinical assessment, motivational enhancement, and socialization to the CBT approach. Following the initial phase of treatment, the case conceptualization is developed and specific treatment goals are established. On the basis of the case conceptualization, specific cognitive and behavioral strategies are selected and implemented during the *middle phase* of treatment. During the *later phase* of treatment, therapists focus on relapse prevention and work collaboratively with their patients to develop a plan for termination.

Figure 1.9. Timeline of CBT



The manner in which the case conceptualization influences particular intervention strategies is illustrated at length in Parts III through V of this manual. We also note that the selection and implementation of specific CBT strategies derived from the case conceptualization are specifically tailored to the Veteran in light of his or her cognitive, physical, and/or social limitations. Before discussing these strategies, we first describe the basic CBT session structure, which applies to all phases of treatment, in the next part.

PART II: GENERAL SESSION STRUCTURE

PART II: GENERAL SESSION STRUCTURE

- **CBT session structure**

CBT follows a session structure in order to make efficient use of time, ensure that goals are achieved in each session, and maintain a thread across sessions so that progress is made toward longer-term goals. The components of CBT session structure include (a) a brief mood check, (b) a bridge from the previous session, (c) the setting of an agenda, (d) a review of the previous session's homework assignment, (e) a discussion of agenda items, (f) periodic summaries, (g) a homework assignment, and (h) a final summary and feedback. Our experience is that this structure models for patients an adaptive problem-solving approach and communicates hope that their problems can be addressed in a systematic manner. Of course, sound clinical judgment might point to an alternative course of action during a session that should be pursued in specific situations, such as in response to crises or when patients report or display behaviors that suggest a specific action should be taken to assess or address potential suicide risk. Throughout this section, examples are provided in which the session structure proceeds as described and in which the therapist encounters obstacles in implementing the session structure.

- ☐ Mood Check
- ☐ Bridge from Previous Session
- ☐ Agenda Setting
- ☐ Review of Previous Session Homework
- ☐ Discussion of Agenda Items
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

We strongly encourage cognitive behavioral therapists to be cognizant of the therapeutic relationship as they structure the session. We remind you that CBT is fundamentally a *collaborative* enterprise between the therapist and patient. Patients are active participants in all aspects of therapy and contribute to the structure of therapy as much as is possible (e.g., helping to set the agenda, developing homework assignments). We find that many patients welcome CBT session structure so that expectations for what will be accomplished and their roles in treatment are clear. However, some patients have an adverse reaction to the session structure. Jack, for example, believed that therapy is a time to "vent frustrations" and found it offensive that his therapist wanted to "take care of business" before letting him "get things off of his chest." For this reason, early socialization to CBT and discussion of the therapy process are important. Furthermore, in some instances, such as that with Jack, we encourage therapists to be creative in modifying session structure to respond to the preferences of patients in order to foster a strong, collaborative therapeutic relationship, which should always take precedence. In Jack's case, he and his therapist agreed that he could spend the first 10 to 15 minutes of each session "venting" about the previous week, and then they would move onto the other CBT session components (see J. S. Beck, 2005).

> CBT is fundamentally a *collaborative* enterprise between the therapist and patient.

Brief Mood Check

- **Brief mood check**

At the beginning of each session, the therapist briefly assesses patients' mood in the time since the previous session. The purpose of the brief mood check is to track patients' progress over time and to make this progress explicit so that it instills hope and builds momentum. It also alerts the therapist to symptoms that require immediate attention in session (e.g., a patient who endorses suicide ideation accompanied by a plan in the time since the previous session). One way to facilitate the brief mood check is to have patients arrive 5 to 10 minutes before their sessions and complete a standardized self-report inventory. The therapist can scan patients' responses to such

an inventory and ask follow-up questions about symptoms that show improvement or decline, or about symptoms that have been the most concerning for patients in the past.

- **Beck Depression Inventory**

The most commonly used self-report inventory for this purpose is the *Beck Depression Inventory-II* (BDI; A. T. Beck, Steer, & Brown, 1996). It is a 21-item self-report instrument developed to measure severity of depression in adults and older adults in the previous one or two weeks. The measure assumes that the respondent is able to read at an 8th grade reading level; for patients who cannot read at this level, therapists can administer the measure orally. Each item consists of four statements reflecting increasing levels of severity of a particular symptom of depression. The score for each individual item ranges from 0 to 3. The total score ranges from 0 to 63 and is achieved by adding the 21 ratings. If more than one statement for an item is endorsed, then the statement with the highest score is selected for that item. The BDI manual (A. T. Beck et al., 1996) provides interpretation guidelines on the severity of depression based on total BDI score: 0–13 (minimal), 14–19 (mild), 20–28 (moderate), and 29–63 (severe). These scoring guidelines were established for adult patients who were seeking outpatient mental health services; therefore, therapists are cautioned to interpret these scores with respect to the clinical sample and setting in which the measure is used.

- ✓ **Mood Check**
- ☐ Bridge from Previous Session
- ☐ Agenda Setting
- ☐ Review of Previous Session Homework
- ☐ Discussion of Agenda Items
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

Although, in general, higher total BDI scores are associated with increased risk of suicide, special attention should be paid to two particular items. If the patient endorses a 1 or higher on the suicide item (Item 9) or a 2 or higher on the hopelessness item (Item 2), then further assessment of suicide risk may be warranted. Thus, the completion and evaluation of the BDI at each therapy session provides the therapist with one strategy for monitoring ongoing suicide risk.

The following is an example of a straightforward mood check with Kate.

Therapist:	Hi, Kate, come on in. It's good to see you today.
Kate:	Thanks. It's good to be here.
Therapist:	Did you have a chance to fill out the *Beck Depression Inventory* in the waiting room? [Kate hands her paperwork to her therapist] Good. Let me take a second to look this over. [Therapist quickly reviews Kate's responses and sees that her overall score on the inventory is similar to the previous week's score, although her sleep disturbance had improved] It looks like you're still feeling pretty down, although you haven't been sleeping as much this week as you had in previous weeks. Is that right?
Kate:	Yes, that's right. I'm still not feeling like myself at all. But, I'm trying to stay up and do things even if I just feel like crawling back into bed.

A few patients find the completion of weekly self-report inventories aversive, or they have difficulty organizing their lives in order to arrive to their sessions early enough to complete the forms. In these cases, the brief mood check can be done verbally, such as by asking patients to rate their moods in the past week on a scale of 0 to 10 (0 = not depressed; 10 = the most depressed I have ever felt). At this time, the therapist

can also ask specifically about other symptoms that had been particularly problematic in the past, such as concentration difficulties, anxiety, or suicide ideation. The following is an example of the manner in which Michael's therapist modified his mood check when he complained about completing the BDI.

Therapist:	Hi, Michael, come on in. Good to see you today.
Michael:	[grunts]
Therapist:	Did you have an opportunity to complete the *Beck Depression Inventory* in the waiting room?
Michael:	[hands the therapist a blank form] I think this form is really dumb. It's just asking the same thing over and over again. Half of the questions don't even apply to me.
Therapist:	It sounds like filling out these forms is aversive to you, Michael.
Michael:	Yeah.
Therapist:	I understand that it seems like these forms ask the same things over and over—you're not the first person to say that to me. [makes one more attempt to solicit Michael's agreement to complete the inventories] Believe it or not, these forms really do provide us with important information, as they give a fairly comprehensive picture of how therapy is working for you.
Michael:	I can tell you how therapy is working for me right now. Things still suck.
Therapist:	I'm sorry to hear that. I'm hopeful that, as therapy continues, we'll be able to turn that around. [pause] I have an idea. How about, instead of filling out the forms, I just ask you to rate your depression on a scale of 0 to 10, with 0 being no depression and 10 being the most depression you've ever experienced. Would you be willing to give that a try?
Michael:	Why is this important again?
Therapist:	So that I can track how therapy is working for you and see if what we are doing is helping your depression.
Michael:	OK, I guess so.
Therapist:	Good. How would you rate your mood over the past week on that 0 to 10 scale?
Michael:	A 10. Maybe a little bit of 9, but mostly a 10.
Therapist:	OK, Michael, this is helpful for me to know. We'll be sure to continue to address depression in today's session. The other thing that has been causing you problems recently is your suicidal thoughts. Have you continued to have suicidal thoughts in the past week?
Michael:	They're about the same as before.
Therapist:	[goes on to conduct a suicide risk assessment]

By making this adjustment, the therapist demonstrates to Michael that CBT is a collaborative enterprise and that his opinions and wishes are important.

Another common obstacle that therapists encounter in conducting the brief mood check is that patients immediately launch into their problems or how bad they feel, which often escalates their agitation and hopelessness. In these instances, the therapist gently intervenes, validates their experience, and invites them to place the items on

the agenda for the session. On many such occasions, the brief mood check and agenda setting are accomplished simultaneously.

Claire, for example, was extremely frustrated that she had not heard any news in the time since the previous session regarding the reinstatement of her position in the Air Force. During the mood check, she ignored her therapist's questions about her mood and produced a litany of complaints against the military.

Below is an example of the manner in which her therapist handled this.

Therapist:	Hi Claire, good to see you today.
Claire:	I'm glad my appointment is today because I really need it.
Therapist:	Well, then I'm glad to be of service. Did you have a chance to complete the *Beck Depression Inventory* in the waiting room?
Claire:	No, I was late.
Therapist:	Then, why don't you just tell me right now how your mood has been in the past week. Any changes from last week?
Claire:	I've still not heard anything about the results of my medical exams despite putting in several calls. They never get back to me. I'm just sitting here, doing nothing, while the fate of my professional career is in the hands of bureaucrats. Just because I'm an amputee doesn't mean that I can't function. I mean, it's… [becomes increasing agitated]
Therapist:	[gently] Claire, let me jump in here to make sure I'm understanding everything you're saying. Clearly, it seems that the problems you've been experiencing in the time we've worked together have not been solved. That sounds very frustrating. Let's be sure to make this a high priority agenda item. What I'm wondering about is the effects of all of this on your mood.
Claire:	Well, if they would just acknowledge that I exist, I would feel a lot better.
Therapist:	[noting that Claire still did not provide a direct response to this question] So, on a scale of 0 to 10, with 0 being no anxiety and 10 being the most anxious that you've ever been, how would you rate your mood?
Claire:	I don't know that I would call this anxiety. So I can't answer that.
Therapist:	What *would* you call what you've been experiencing emotionally?
Claire:	I don't know—frustration, I guess. Exasperation. I'm at my wit's end!
Therapist:	OK, frustration, exasperation. Are you more frustrated and exasperated than when I saw you last week, or less frustrated and exasperated?
Claire:	Oh, God, definitely more! This is probably the most frustration and exasperation I've ever felt in my life.
Therapist:	Have the frustration and exasperation been causing problems for you?
Claire:	[slows down a bit] I hate to admit it, but yeah. I think I'm coming across as really pissed in my phone messages, and I wonder if that's going to hurt me in the long run. And my mother says she can't even talk to me right now because I just go off at the littlest things.
Therapist:	So, in addition to addressing your problems getting reinstated, should we also put on the agenda ways to manage your frustration and

	exasperation so that you're doing things to help your situation, rather than hurt it?
Claire:	[thoughtful] Yes, I think that would be wise.
Therapist:	[goes on to work with Claire to set the remainder of the agenda]

Although the brief mood check focuses mainly on symptoms patients experienced in the time since the previous session, the therapist uses this opportunity to check in on other important issues as well. For example, many Veterans who are in psychotherapy are also taking psychotropic medication, or they struggle with medical problems that require ongoing monitoring. Thus, during the brief mood check, the therapist also assesses these patients' adherence to other treatment regimes and whether they are attending other scheduled appointments. If patients report problems in these areas, the therapist likely would suggest that they include this as an agenda item to be covered in session. Patients who have a history of alcohol or substance use (or who are actively using alcohol or other substances) should be asked about their substance use in the time since the previous session.

Bridge from Previous Session

The bridge from the previous session is a very brief strategy to ensure that patients remember the work completed in the previous session and to follow up on relevant issues. It is helpful to bridge from the previous session so that coherent themes across the course of treatment will be evident, and goals established at the beginning of treatment are met. It also provides an opportunity for the therapist to identify any negative reactions that patients might have had to the previous session. Below we summarize questions that the therapist can ask to bridge from the previous session.

- ✓ Mood Check
- ✓ **Bridge from Previous Session**
- ☐ Agenda Setting
- ☐ Review of Previous Session Homework
- ☐ Discussion of Agenda Items
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

Strategies for Bridging from the Previous Session

- What did we cover in the previous session that you found helpful?
- What did we cover in the previous session that you did *not* find helpful?
- What did you learn from the previous session?
- What stood out for you about our last session?
- What message did you take home from the previous session?
- Are there things from the previous session on which we need to follow up in this session?
- Was there anything that bothered you from our previous session?

- **Bridge from previous session**

When patients have done their homework and have thought about therapy in the time between sessions, the bridge from the previous session runs smoothly and usually takes only a minute or two.

It is undoubtedly frustrating for therapists to have patients who claim not to remember what was covered in the previous session, but it *will* happen. When this occurs, it is important for therapists to monitor their own automatic thoughts, which could lead to counterproductive therapeutic responses, and quickly restructure these thoughts. For some patients, like Michael, memory problems are secondary to

traumatic brain injury. Others, like Jack, are not fully invested in therapy and have negative attitudes about treatment that prevent them from taking it seriously. Moreover, concentration difficulties (and often disorganization) often co-occur with depression, which could affect the degree to which patients like Kate can bridge from the previous session. It often is important for patients to write down key points that emerge from sessions so that they can consult those notes in their daily lives. In Part III, strategies for motivating patients to invest fully in CBT are presented. However, in the initial phase of treatment, therapists can also take the lead and provide a summary of the previous session. The following is an example of the manner in which Jack's therapist handled the bridge from his first to second session.

Therapist:	[finishing the brief mood check] Well, I'm sorry to hear that things continue to be tough for you. Perhaps as we continue to work together and address these problems we will make some headway. What did we cover in the previous session that you found to be the most helpful?
Jack:	[grunts] I don't know. All we did was get to know each other.
Therapist:	You're right. The first session is geared a bit more toward learning more about one another. Let's see…last session, we talked about how you felt about being laid off from your job. You were feeling angry toward your manager and upset about your financial situation. We also talked about the communication problems with your wife and how you tend to not discuss problems that you're having with her. I also recall that toward the end of the session, we were discussing some things you could be doing to improve your mood and how you could begin to open up with your wife. Is there anything that you would like to add?
Jack:	[pause] You make it sound like I am the one with the problem.
Therapist:	I understand how you may think I see you as the problem. I'm glad you can share this with me, but I just want you to know that I don't blame or judge you for the problems that you're having. I also understand that dealing with a job loss and family problems can be very difficult, and I hope that we can put our heads together and figure out ways to improve things for you.
Jack:	[pause] OK. I appreciate that.
Therapist:	Is there anything else that we talked about during the last session that was important?
Jack:	Not really…just the problems that I'm having in managing my diabetes.
Therapist:	Yes, and that you were having some concerns about sticking to the diet that your doctor had recommended.
Jack:	Yeah, but it's been less of an issue for me this week.
Therapist:	That's good. So now that we have covered the most important issues from the last session, I thought we could talk about the homework from last week and set an agenda for today's session. Would that be OK?
Jack:	Sure.
Therapist:	[goes on to work with Jack to formulate the remainder of the agenda]

Agenda Setting

Agenda setting is a collaborative process between the patient and therapist in which they identify the topics to be addressed during the therapy session. Agenda setting also facilitates the prioritization of the most important problems, which are usually related to the treatment goals. It occurs near the beginning of the session, usually after the brief mood check and bridge from the previous session. This process allows for the most efficacious use of time and facilitates goal setting and skill acquisition. Moreover, it models to patients a systematic approach to organizing their life problems.

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ **Agenda Setting**
- ☐ Review of Previous Session Homework
- ☐ Discussion of Agenda Items
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

Many patients find that the agenda setting process is quite different than the usual manner in which they address problems in their lives. Thus, it is important for therapists to socialize patients into the agenda setting process early in the course of treatment. In the first session, patients are educated about what agenda setting involves and its purpose, as well as the expectation that both parties will contribute to agenda setting at the beginning of each subsequent session. The therapist, then, takes care to follow through on this. Not only do the patient and therapist identify the items to place on the agenda, but they may also allocate an approximate amount of time to devote to each agenda item. Many therapists find it helpful to write down the agenda and keep it in a location so that both the therapist and patient can refer to it throughout the session.

It is important for the therapist to strike a balance between ensuring that items on the agenda will help patients achieve the goals they established at the beginning of treatment and the items that patients deem important (whether or not they are related to treatment goals) are given attention. We encourage therapists to be flexible during agenda setting. It may be necessary to deviate from what the therapist believes is most important in order to maintain the therapeutic alliance and to help the patient with immediate issues that may have arisen in the time since the previous session.

A straightforward manner to commence agenda setting is to ask the patient, "What items would you like to place on the agenda for today's session?" However, some patients find the use of the term "agenda" aversive. In these cases, the therapist can ask, "What topics do you think are important to discuss today?" or "What would you like to have accomplished by the end of today's session?" to obtain the same information. Some patients find more informal language easier to digest, such as using the term "game plan" rather than "agenda."

The following is an example of agenda setting with Kate, who has easily acclimated to this process. This transcript occurred in the same session as the brief mood check illustrated previously. It begins after Kate summarized the take-home message from the previous session—to combat depression, it is necessary for her to re-engage with activities that used to give her pleasure.

Therapist: A few moments ago, we talked about discussing your increased depression. What else would you like to put on the agenda for today?

Kate:	I would like to talk about some ways to deal with feeling irritable and tense at times. I'd also like to talk more about figuring out how to start seeing my children again. I mean, my husband isn't even returning my phone and text messages.
Therapist:	That sounds frustrating. Let's put these issues on the agenda. Anything else that's important to cover in today's session?
Kate:	I don't think so—those are the main issues.
Therapist:	Do you see any problems about other issues that might arise in between now and the next time that I see you?
Kate:	Um, I don't think so. [pause] Unless you count the fact that I still don't have a job and that I don't know how I'm going to pay my bills this month.
Therapist:	Those are some pressing financial concerns. Should we leave some time to address this issue as well?
Kate:	Yes, we probably should.
Therapist:	So, we've identified three topics—finding ways for combating depression, re-connecting with your children, and addressing your financial concerns. All three of those are big topics. How should we allocate our time in session to make sure that we get to all of them?
Kate:	I'm not sure.
Therapist:	Which of the three is the most important to you to cover?
Kate:	Definitely getting in contact with my kids.
Therapist:	OK, why don't we spend the most amount of our time on that topic?
Kate:	Yeah, but how about dealing with my tension first?
Therapist:	How's this for a plan, then? Let's go over some strategies for improving your tension and mood first. Then, we can spend the majority of our time on your difficulties resuming contact with your children. After that, we can spend the last part of the session talking about the financial problems. At the end of session, we can review what we've accomplished, set a new homework assignment if we haven't already done so, and get feedback on the session. How does that sound to you?
Kate:	That sounds fine.

The identification of issues to be discussed in therapy should be something that the patient thinks about during the period between sessions. When patients come prepared for each session, agenda setting proceeds smoothly and in a straightforward manner, allowing for maximal time to engage in the therapeutic process. Thinking about agenda items in between sessions also keeps patients focused on growth in between sessions, maximizing the potential for change. Although it is optimal for patients to come prepared with items to place on the agenda, there are many instances when this does not occur. In fact, many of the patients who have difficulty remembering what had occurred in the previous session also have difficulty with agenda setting. When asked what they would like to put on the agenda, they respond with "I don't know." In these instances, the therapist takes a more active lead in agenda setting with the intention of modeling the process to patients.

The following transcript exemplifies this process with Michael, who claimed he did not remember much about the previous session.

Therapist:	What would you like to put on the agenda for today's session, Michael?
Michael:	I have no idea.
Therapist:	What issues or problems do you feel are important for us to cover today?
Michael:	I don't know. Nothing. Everything. My life's a mess.
Therapist:	Yes, in getting to know you over the past couple of weeks, it's clear that you have a lot on your plate. It often is helpful to choose a subset of two or three issues to work on in session so that our time together is meaningful and you'll leave with ways to deal with each issue. You may even see positive changes in your life over the upcoming weeks. Are there any issues that stand out as more important to address than others?
Michael:	No. They're all weighing on me right now.
Therapist:	Fair enough. Why don't we decide, together then, how we might prioritize these problems? One thing that concerned me when I saw you last is that you were pretty hopeless about the future and wondered if your life was worth living.
Michael:	[slight nod]
Therapist:	That is one issue I'd like to put on the agenda. Perhaps we can figure out one or two ways to manage that hopelessness. Would that be agreeable to you?
Michael:	OK.
Therapist:	Why don't I supply you with some choices for the remainder of the agenda for today's session, and you can tell me what is most important to you from this list.
Michael:	I guess so.
Therapist:	OK, when we first started treatment, you had mentioned problems in many areas of your life. One [holds up one finger] was that your relationship with your girlfriend is strained. Two [holds up two fingers], you're also having trouble deciding on a direction for your life career-wise, such as deciding whether you will finish school and what you should do after that. And finally, three [holds up three fingers], you were concerned about the results from neuropsychological testing, saying that you had mild brain injury. Of those three things, has anything happened in the past week that would indicate that we should focus on it in today's session?
Michael:	I don't know…I guess the thing with my girlfriend. We've had a lot of fights this week.
Therapist:	That sounds very frustrating, Michael. We'll be sure to talk about that. How about we spend half of the session on ways to address your hopelessness and the lack of meaning in your life, and the other half of the session on the relationship with your girlfriend and ways to improve that?
Michael:	Sounds like a plan.

Michael's therapist was patient with him, realizing that two factors were potentially interfering with his ability to remember the contents of the previous session and his ability to organize an agenda—his severe depressive symptoms and his mild brain

injury. She took the lead in establishing one agenda item—his suicidal thoughts—because she judged that these symptoms were of high priority in order to keep him safe. However, to model the agenda setting process and involve him in the collaborative venture, she gave him a "menu" of three choices to add to the agenda. On the basis of information she obtained from his psychological evaluation, she knew that problems in his relationship with his girlfriend contributed to his depression and suicide ideation, so she reasoned that discussion of this topic would be consistent with Michael's treatment goals of reducing depression and suicidal thoughts.

Patients who have difficulty contributing to the agenda often benefit from a homework assignment designed to facilitate the agenda setting process. A simple but straightforward homework assignment is to have patients jot down possible agenda items as they think of them in the time between sessions. A more advanced homework assignment is to have patients not only jot down potential agenda items, but also prioritize them before they present for session. In fact, therapists could construct a worksheet that would serve as a place to record potential agenda items and provide tangible instructions for how to organize them. As patients progress through therapy, they take more and more responsibility for determining the agenda.

- **Homework assignment**

At times, therapists encounter a problem with agenda setting that is opposite of what Michael's therapist experienced—patients launch into excessive detail and identify too many problems than can reasonably be covered in one session (i.e., the "Chatty Cathy" problem). When patients launch into excessive detail, therapists gently intervene and model *naming the problem* before going into a detailed description of the problem. When patients identify an array of problems, therapists identify an underlying theme that unifies many of the problems.

CASE EXAMPLE: JACK

When Jack was asked to contribute to the agenda, he mentioned frustrations with his wife, his son, his daughter, and a former co-worker whom he believes said negative things about him to his supervisor. His therapist regarded these issues as "problems with close relationships" and anticipated that many strategies to deal with one of these relationships would generalize to other relationships.

If there are truly a large number of disparate problems with no unifying theme, then therapists can work collaboratively with patients to prioritize the agenda items. For example, patients can rate the importance of each agenda item on a scale of 0 to 10 (0 = very low priority; 10 = very high priority), and the agenda would then unfold on the basis of these ratings.

Sometimes, patients suggest trivial items for the agenda, avoiding more meaningful topics that the therapist predicts would result in the greatest therapeutic change. In these instances, the therapist takes a more active role and gently suggests agenda items. If patients object to placing these items on the agenda, the therapist can ask them to identify the pros and cons of addressing the topic. During such an exercise, it is often found that patients fear that their symptoms will escalate if they talk about difficult topics. Many patients indicate that they do not want to "fall apart" during the session and then have to go back and resume "normal life" at their jobs or with their families. Therapists can take the opportunity to use the cognitive strategies described

in Part IV to evaluate the veracity of these predictions. Moreover, they can work collaboratively with patients to identify strategies for managing distress that arises when discussing difficult topics, such as taking a break, changing topics, engaging in a distracting activity, engaging in a controlled breathing or muscle relaxation exercise, or arranging for a follow-up telephone or face-to-face session.

Even the most seasoned therapists find that as the session progresses, it is clear that they are not maintaining the time allocated to each agenda item and that one or more agenda items likely will not be covered in that session. In these instances, therapists make this explicit to patients and work collaboratively with them to revise the agenda. Oftentimes, this means that the latter items on the agenda are tabled until the subsequent session. During the subsequent session's bridge, therapists can remind patients that one or more items were tabled from the previous session and assess the degree to which they are still causing problems for them. However, fluidity in the agenda should be avoided when it is not therapeutically indicated or when the changes are driven by the patient's tendency to lose focus on the tasks at hand. If this is allowed, it may serve to undermine progress and will reinforce the use of unstructured time.

Review of Previous Session Homework

- **Review of previous session homework**

It is imperative that cognitive behavioral therapists review the homework assigned in the previous session. Failure to review the previous homework assignment may increase the risk of communicating to patients that homework is not important. Although we reference homework review in between agenda setting and discussion of agenda items, in reality, it can occur at many different points in the session. Many patients spontaneously mention their homework assignments during the brief mood check or when they bridge from the previous session. If homework has not been reviewed by the time the therapist and patient set an agenda for the session, then, in most cases, the therapist encourages the patient to put it on the agenda. If it is clear that discussion of homework will be lengthy, then it is best to put it on the agenda, rather than reviewing homework before setting the agenda.

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ Agenda Setting
- ✓ **Review of Previous Session Homework**
- ☐ Discussion of Agenda Items
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

It is important to use the review of the previous session homework as an opportunity to consolidate learning and to reinforce the application of CBT strategies in patients' daily lives. It is not enough to simply acknowledge that a patient has completed a homework assignment. Instead, it is important to ask patients what they learned from doing the assignment, how it made a difference in their lives, and how they might use the skills they practiced in a similar situation. Such discussion allows patients the opportunity to articulate the process by which the homework worked, which reinforces underlying CBT principles and increases the likelihood that they can generalize those principles to other instances they encounter outside of the therapist's office.

All therapists have instances in which their patients fail to complete their homework assignments. Although this can be discouraging for therapists, it can also be seen as an opportunity to model problem-solving using cognitive and behavioral strategies. Therapists are advised to monitor their own automatic thoughts about the

noncompliant behavior of their patients in order to avoid counterproductive emotions during the sessions. Novice therapists often think, *Patients should always do their homework because it was well designed and will lead to therapeutic progress*. Such thinking may seem sensible but will contribute to therapist discouragement. Alternatively, therapists could think, *Homework is often difficult even when it is well designed and, therefore, it is best for me to graciously bear and problem solve this with my patient.* When patients report that they have not completed their homework assignments, therapists can encourage them to review the rationale for the homework, identify the obstacles to completing the assignments, and brainstorm ways to overcome similar obstacles in the future. Therapists also can prompt these patients to identify the pros and cons of completing the assignment. An illustration of the manner in which the pros outweigh the cons can motivate patients to engage in similar assignments in the future. When it is clear that the cons outweigh the pros, therapists regard this as useful information and take care to approach future homework assignments in as collaborative a manner as possible. The following transcript illustrates the manner in which Jack's therapist handled his failure to complete his homework assignment, which was to eat dinner with his wife one evening in between sessions.

When patients report that they have not completed their homework assignments, therapists can encourage them to review the rationale for the homework, identify the obstacles to completing the assignments, and brainstorm ways to overcome similar obstacles in the future.

Therapist:	Let's go on to the second item on our agenda—reviewing your homework assignment. It sounds like you did not have the opportunity to eat dinner with your wife in the past week.
Jack:	Nope.
Therapist:	[gently] What got in the way of doing that?
Jack:	Just didn't think of it. She does her thing, I do my thing.
Therapist:	Is this something you wanted to do?
Jack:	Yeah, I guess.
Therapist:	Jack, do you remember the reason why, last week, we determined that having dinner with your wife might be a good thing for you?
Jack:	You were saying that it could help me to see that other people care, make those relationships better.
Therapist:	You're right—my theory was that your depression and anger problems might soften up a bit if you were able to connect with someone who cares about you. But that's *my* theory. Do you buy that?
Jack:	I don't know; it just seems too far gone.
Therapist:	What seems too far gone? The relationship with your wife? Or relationships in general?
Jack:	That one in particular, I guess.
Therapist:	Do you buy the general idea that re-establishing relationships with others with whom you were once close would have a positive effect on your mood?
Jack:	[bitterly] Sometimes I think I would be better off without anyone. Everyone just disappoints me anyway.
Therapist:	[reinterprets] So are you saying that maybe we were barking up the wrong tree? That it might be more effective to develop strategies to improve your mood that *don't* involve other people?

Jack:	I don't know. I think part of my problem is that I'm lonely, too. It's just that the thing with my wife—it's probably my worst relationship.
Therapist:	Ah, so perhaps it would be easier to start with a relationship that wasn't so strained?
Jack:	[seems relieved] Yeah, definitely.
Therapist:	Who might that be?
Jack:	Maybe I could go over to my neighbor's. He fixes his truck in the garage a lot.
Therapist:	Would it be enjoyable to you to go over there and chat with him while he's fixing his truck? Maybe even help him out?
Jack:	Yeah. [shows pride] I probably could even show him a thing or two. I used to sell a lot of trucks.
Therapist:	Given our current discussion, then, what might be a logical homework assignment for the next week?
Jack:	I see where you're going. OK, I'll go over to my neighbor's when he's working on the truck.
Therapist:	OK, we've addressed one problem—the fact that last week's assignment wasn't a good match for you, since you're just starting with therapy. We can focus on the relationship with your wife after we've had some success with other relationships that have less baggage associated with them.
Jack:	[laughs out loud] Baggage is an understatement!
Therapist:	[makes sure to respond to Jack's positive affect, especially in light of the fact that to this point, he has not demonstrated much motivation for treatment] It certainly sounds like it! [pause] The other issue, I wonder, is having trouble remembering to do the homework. Do you think that's a problem for you?
Jack:	Yeah, I guess I just didn't think about it after I left the office.
Therapist:	How might we solve that problem?
Jack:	I don't know. I'll have to remember just to look out the window to see if my neighbor is out there.
Therapist:	What if I were to write down your assignment on this appointment card, underneath the date and time of your next appointment?
Jack:	That would work.
Therapist:	And where would you keep this card, so that you have easy access to it?
Jack:	I'll have it in my wallet. I have so many appointments these days, it seems like I have to go through the cards every day just to keep them straight.

Notice that not only did the therapist enlist Jack's help in brainstorming a way to remember his homework assignment, but she also worked with him to identify a location where he would store the reminder. Helping patients to identify locations for reminders, homework assignments, and the like is crucial, as disorganization and procrastination are problems for many patients, and a concrete plan for doing their homework assignment needs to be in place.

Discussion of Agenda Items

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ Agenda Setting
- ✓ Review of Preview Session Homework
- ✓ **Discussion of Agenda Items**
- ☐ Periodic Summaries
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

Discussion of agenda items is the central activity that occurs in a CBT session. Typically, agenda items are addressed in the order agreed upon by both the therapist and patient. As each issue is discussed, the therapist remains cognizant of cognitive behavioral principles underlying the problem itself and begins to identify ways to use the problem as a means for advancing the case conceptualization and/or skill building. In other words, regardless of the specific content of the problem introduced by the patient, the therapist encourages the application of strategies that balance empathic understanding and cognitive and behavioral change to resolve it. Some of these strategies may have been used or taught in previous sessions, and the therapist will work with the patient to identify ways to generalize them to a new problem or issue. Other times, the situation requires a strategy that has not yet been considered in the course of treatment, and the therapist uses that opportunity to introduce it. Throughout the discussion of agenda items, the therapist works to understand the patient's symptoms and problems in light of the therapeutic relationship and cognitive behavioral theory, and she strategically selects specific cognitive and behavioral intervention strategies (including those interventions that primarily enhance the therapeutic relationship) to address those symptoms and problems. The most important point here is that agenda setting is strategic, rather than an open-ended discussion of the details of patients' life problems.

Many novice cognitive behavioral therapists find it difficult to maintain an agenda as patients begin to talk about their problems. As they begin to discuss their problems, some patients provide excessive detail and background information, which can easily lead to discussion of tangential or secondary issues. In fact, it is often the case that the tendency to become derailed in session mirrors patients' tendency to become derailed outside of session as they attempt to cope with stress. Thus, we strongly suggest that therapists *not* reinforce the use of unstructured time. For patients who become unfocused during the discussion of agenda items, we encourage the therapist to model adherence to the predetermined schedule in order to (a) model an organized approach to dealing with life problems, and (b) ensure that there is time to implement one or more cognitive behavioral interventions, so that patients will leave the session with a tangible strategy for addressing their problem and/or managing their distress.

Although cognitive behavioral therapists strive to maintain the agenda set at the beginning of the session, there will undoubtedly be instances in which new topics or problems are identified during discussion of agenda items. When these new topics or problems are associated with significant affect, it is natural for therapists to want to shift focus. It is understandable that the agenda might be tabled in these instances; however, we suggest that therapists address this directly and collaboratively with patients, such that both work to re-prioritize the items on the agenda in light of this new topic or problem. In addition, as stated previously, on occasion the therapist realizes that he did not allocate enough time to a particular agenda item. When this occurs, the therapist clearly acknowledges this, and the two collaboratively revisit the agenda and reallocate the time that will be devoted to remaining items. If they decide that one or more items should be put on hold until the following week, then the

therapist takes care to make note of this and adds it to the agenda in the following session if the patient continues to view it as a priority.

Periodic Summaries

Periodic summaries occur throughout the course of the session and ensure that the therapist and patient have a mutual understanding of the nature of the problem being discussed as well as the solutions that have been identified. Periodic summaries are often made at the close of discussion of an agenda item. The therapist and patient can both make periodic summaries. When a therapist makes periodic summaries, it communicates empathy because it demonstrates an accurate understanding of the symptoms and problems with which patients present. When patients make periodic summaries, it consolidates learning and provides a base from which they can implement meaningful changes in their lives. Below we summarize prompts that therapists can use to encourage patients to make periodic summaries.

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ Agenda Setting
- ✓ Review of Previous Session Homework
- ✓ Discussion of Agenda Items
- ✓ **Periodic Summaries**
- ☐ Homework Assignment
- ☐ Final Summary & Feedback

Strategies for Eliciting Periodic Summaries from Patients

- Can you summarize for me, in your own words, the key elements to this problem? The key parts of the solution?
- What are you going to take away from this discussion?
- What are you going to do differently as a result of this discussion?
- What have you learned from this discussion?

Periodic summaries also can be used strategically when the therapist perceives that the session is not running as smoothly as it might. For example, patients who are becoming increasingly agitated and unfocused while discussing an agenda item benefit from periodic summaries that slow down the pace of the session and hone in on the main points of the issue. Moreover, periodic summaries allow the therapist and patient an opportunity to revisit the agenda and make modifications to existing agenda items as necessary. At other times, the therapist may feel "stuck" in determining the next step to take or may find that the patient is responding negatively to *all* of the therapist's interventions. In such instances, periodic summaries allow for time for both the patient and therapist to reflect on the problem and may facilitate engagement in the therapeutic process. As Dr. Aaron Beck has said numerous times when training therapists, "When you feel 'stuck,' then do a summary."

As Dr. Aaron Beck has said numerous times when training therapists, "When you feel 'stuck,' then do a summary."

We caution therapists to resist making statements of interpretation during periodic summaries. The purposes of periodic summaries are to reinforce the learning that has taken place, communicate that the therapist accurately understands the patient's problems, and link the patient's problems back to the cognitive behavioral model. Making interpretations of the material patients discuss in session runs the risk of inaccurately characterizing their internal reality or telling them which maladaptive cognitions and/or behaviors contribute to their problems, rather than allowing them to determine this on their own. The following is a dialogue that represents a straightforward periodic summary with Michael, which occurred after he and his therapist finished the first item on their agenda—addressing suicidal thoughts.

Therapist: Michael, can you summarize for me what we've done here for the past 15 minutes or so?
Michael: We're thinking of ways to deal with my suicidal thoughts.
Therapist: That's right. And which of these strategies do you think will be most helpful to you?
Michael: Talking to my mom, definitely.
Therapist: Anything else?
Michael: I liked the idea of going for a walk in the park. Anything to get out of that cramped apartment.
Therapist: What have you learned from this discussion?
Michael: That, really, I'm not feeling suicidal all the time. I guess if I can get my mind on something else, it will pass.
Therapist: And why do you think these strategies will be helpful for you?
Michael: Um, I guess I don't feel so alone when I talk to my mom. And walking in the park lets me clear my head.
Therapist: That's great, Michael. You are taking an important step in your recovery. Should we move onto the next item on the agenda?

Homework Assignment

- **Homework assignment**

Homework is an essential component of CBT. We find that patients are often adept at "talking through" strategies for managing their symptoms and problems in session, but that it is much more difficult for them to implement these strategies in their daily lives. Homework provides an opportunity for patients to test out cognitive and behavioral skills in their own environment. Practicing cognitive strategies can help to make the process of gaining a balanced perspective just as automatic as the automatic thoughts patients experience. Moreover, approaches for modifying unhelpful thinking are strengthened by carrying out behavioral homework assignments that are consistent with a new way of thinking. For example, individuals who think that they *no longer enjoy anything* may find that engaging in pleasant activities helps them to recognize that they do enjoy some activities. Although we include this section on assigning homework near the end of the section on CBT session structure, in practice, homework assignments can be developed at any point in the session when it is logical to devise a homework assignment following the discussion of an agenda item.

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ Agenda Setting
- ✓ Review of Previous Session Homework
- ✓ Discussion of Agenda Items
- ✓ Periodic Summaries
- ✓ **Homework Assignment**
- ☐ Final Summary & Feedback

It is more likely that patients will actually do the homework assignment if they develop the assignment themselves rather than complying with an assignment that the therapist gives them. To foster collaboration, the therapist may say, "On the basis of what we have discussed today, what is something that you would like to work on this week?" The therapist then helps the patient to shape the homework assignment to best meet his or her needs or goals. It is vital that the therapist and patient *collaborate* in developing the homework assignment so that the patient takes ownership over it and invests in it. If therapists find themselves in a situation in which they are taking the lead in developing a homework assignment, then they can solicit patients' input in modifying the assignment so that it is as individualized as possible.

It is more likely that patients will actually do the homework assignment if they develop the assignment themselves rather than complying with an assignment that the therapist gives them.

There are several other strategies that cognitive behavioral therapists can use to ensure that homework is successful. As much as possible, the homework assignment should be a "win-win" proposition, so that patients are set up for success and that the possibility of falling short is minimal. In most instances, there should be no more than two components of the homework assignment so that patients do not become overwhelmed or discouraged by their magnitude. Homework assignments *should always be written down during the session*, and both the patient and the therapist should retain a copy of the assignment. When relevant and time-permitting, homework assignments should be started in session so that patients have a model when they attempt to complete it on their own. When development of the homework assignment is saved until the last few minutes of the session, it runs the risk that it will not be developed fully, patients will not fully understand the rationale for it, and patients will not fully understand how to carry it out.

Homework assignments should always be written down during the session.

In most instances, it is helpful to obtain a commitment to complete the homework assignment by asking the patient, "On a scale of 0 to 100, with 0 being 'very unlikely' and 100 being 'very likely,' how likely is it that you will do the homework?" If the patient indicates a rating less than 90, then more time is devoted to ensuring that the assignment will be successful. For example, it often is helpful to ensure that the patient can articulate the reason for doing the assignment. Obstacles to completing the assignment can be anticipated, and strategies for overcoming those obstacles can be identified.

The following is an illustration of an instance in which the development of the homework assignment runs smoothly. At this point in the session, Kate and her therapist were discussing Kate's financial concerns and her difficulty finding a job.

Therapist:	It sounds like there is one job possibility out there, the one at the clinic, even if it is not optimal. What might be a next step in resolving this issue?
Kate:	I guess I should put in an application.
Therapist:	Would you like to make that your homework assignment?
Kate:	Yes, I think that would be a good idea.
Therapist:	Let's do everything we can to make sure this is successful. What are the steps you will take in submitting a job application?
Kate:	I need to complete the application on the Internet, have my transcripts from the nursing school sent, make sure my references know that someone may contact them … Ugh, it seems like a lot of work.
Therapist:	Yes, there are several steps to making this happen. Let's talk about each of these steps. Maybe it would be a good idea for you to write down the steps so that you have a guide you can follow?
Kate:	OK. [pulls out a notebook and pen]
Therapist:	The first thing you had mentioned was that you need to complete the application on the Internet. How are you going to do that?
Kate:	I need to find the website for the clinic.
Therapist:	And how are you going to do that?
Kate:	I'll search for the name of the clinic. I should be able to find it.

Therapist: Sounds good. Do you need to do anything else in completing the application online?

Kate: Yeah, I need to look at my resume because it has information about my job history that I'll need to list on the application.

Therapist: So, to fill out the application, you are going to search the Internet for the clinic website and retrieve your resume. Do you know where it is?

Kate: Sure do. I keep a copy on my home computer. [writes down the steps]

Therapist: The next step you mentioned was to have your transcripts sent to the clinic. What does that involve?

Kate: I need to go to the school website and request that they send the transcripts to the clinic. [writes down next step]

Therapist: Have you done that before?

Kate: Yeah, it's easy when you can just place an order online to have your transcripts sent.

Therapist: Let's see, the final step was that you were going to contact your references. What does that involve?

Kate: My references are listed on my resume. I just need to let them know that a potential employer might be contacting them.

Therapist: How are you going to do that?

Kate: Well, I could give them a call and ask them. Hmm, maybe I could just send them an e-mail. That would be easier. [writes down to e-mail her references]

Therapist: So, what have you written down?

Kate: First, I'm going to search the Internet to find the website where I can apply online. Then, I'm going to find my resume on my computer to complete the application. Next, I'm going to the nursing school website and request that they forward my transcripts, and then I'll e-mail my references and let them know that they might be contacted.

Therapist: That's terrific. So, on a scale of 0 to 100, with 0 being extremely unlikely and 100 being extremely likely, how likely is it that you will complete all of these tasks?

Kate: Oh, it's very likely. I have to, or I'm going to get evicted.

Therapist: So you're 100% likely to do this?

Kate: Definitely.

Therapist: Do you think it would be helpful to plan out when you will do each of these steps, in order to make sure you get to all of them in between now and the next session?

Kate: Yeah, that's a good idea. I can start by filling out the application online when I leave here today.

Therapist: That sounds like a great start. What about getting your transcripts from the nursing school?

Kate: I can do that today as well.

Therapist: Sounds like a plan.

Kate: And then I'll send the e-mail messages to my references tomorrow.

Therapist: So, today you will complete the application online as well as get the transcripts sent and then tomorrow you will e-mail your references. I think you're all set.

Developing homework often does not run as smoothly as it did in this example with Kate. For example, Claire's therapist suspected that her anxiety and agitation would escalate if she continued to stay at home ruminating over the fact she had not heard back from the medical board about being reinstated to her position. Her therapist also anticipated that it would be helpful to begin developing adaptive coping skills in the event that the board determined that she would be unable to fly again. Thus, she presented this rationale to Claire and encouraged Claire to identify pleasurable, distracting activities in which she could engage while she was waiting for the board's response. Although Claire agreed, in theory, that these strategies would be helpful, she had trouble committing when they began to develop a concrete homework assignment.

Therapist:	It sounds like you agree that finding some activities that you enjoy to occupy your time in the next week would be helpful. Might this be a good homework assignment for the next week?
Claire:	Sure, I guess so.
Therapist:	OK, let's talk more specifically about what you might do and when. Any ideas?
Claire:	Well, I really need to read up so that I can take the test so that I can be promoted to the next level, so that I can fly a bigger plane.
Therapist:	[hypothesizing that focusing on a work-related activity would likely increase her rumination on the board's decision and would not contribute to increasing her repertoire of coping strategies] How much do you enjoy studying for a test like that?
Claire:	Oh, I enjoy it a lot. I would feel totally stressed out if I didn't prepare.
Therapist:	It sounds like you enjoy studying because it reduces stress. But what about an activity that you enjoy in its own right, not just because it makes you feel less stressed?
Claire:	You mean like going out to dinner or something?
Therapist:	Sure, if that's something you truly find enjoyable.
Claire:	Well, I wouldn't find it enjoyable. It's a waste of time. I have too much studying to do right now. Between studying and all of these medical appointments, I don't have much free time.
Therapist:	So over the past few weeks, you've pretty much been spending your time studying and going to appointments, right? [Claire nods] Anything else?
Claire:	Not really. Just those things and taking care of my apartment, which takes more effort now that I'm an amputee.
Therapist:	And how would you say your mood has been in the past few weeks?
Claire:	[reluctantly] Bad, I guess. I've been really preoccupied with the board's decision. And I've been so anxious that I haven't been sleeping well.
Therapist:	Is it preferable to keep things the way they are, or is it preferable to do something different?
Claire:	[becomes tearful] Of course, it's preferable to do something different. I hate feeling like this. And people hate being around me, too. But I just don't know *what* I can do.
Therapist:	That's what I'm here for—I can help you find ways to manage your anxiety and improve your life, no matter what the board says.

Claire:	OK.
Therapist:	Think back to a time when you were feeling much less anxious. [pauses so that Claire can generate a mental image] How were you spending your time?
Claire:	I guess that would be two years ago. I was working a lot—of course, you know how much I love flying. But I guess I was doing other things, too. I had just moved into my apartment, and I was having a lot of fun decorating it. And there were some other people that had also started the new job with me—we went out and socialized from time to time.
Therapist:	Good, Claire. You've identified two activities—decorating your apartment and socializing with friends. Is there any way to do either one of those activities in the next week, to take a break from studying?
Claire:	I can call one of the guys I work with, Thomas, and see if he wants to go out. Actually, he's called me a few times, but I haven't gotten back to him. I guess I don't want people to pity me just because I lost my leg.
Therapist:	[choosing to ignore Claire's prediction that people will pity her in the interest of focusing on a behavioral homework assignment] Before your injury, had you spent much time with Thomas?
Claire:	Yeah, we probably went out, like, every other week.
Therapist:	And did you enjoy going out with him?
Claire:	Oh, yes. He has a fabulous sense of humor.
Therapist:	Can you predict what effect spending time with Thomas would have on your anxiety?
Claire:	I'm sure it would be a positive effect. Maybe it would take my mind off of my problems.
Therapist:	[gently] What do you think, then, of a homework assignment in which you return Thomas' phone call and see if he wants to get together.
Claire:	[proudly] Yes, I can do that.
Therapist:	[goes on to identify any obstacles to completing this assignment and obtain likelihood ratings of its completion]

Several points about this dialogue deserve note. First, in actuality, Claire's therapist judged that it was premature and potentially harmful for Claire to be putting so much effort into studying for a pilot examination when it was unclear whether she would even be allowed to return to her post. However, because being a pilot and excelling professionally were so central to Claire's self-concept, the therapist reasoned that it would be unwise to directly challenge her need to study at this time. Second, Claire's therapist took care to ensure that she was not arguing with Claire or trying to bully her to "come around" to the therapist's point of view. Thus, the therapist used open-ended questions that helped Claire to critically evaluate her situation and ultimately draw her own conclusions. As therapists gain experience with CBT, they begin to see that cognitive and behavioral changes are much more powerful when they stem from the patient's insights and own conclusions, rather than being supplied with an insight or a conclusion by the therapist.

Final Summary and Feedback

- **Final summary and session feedback**

At the end of session, the therapist conducts a final summary or, alternatively, has the patient summarize the most important lessons gleaned from the session. In obtaining feedback about the session, you should avoid asking patients if the session was helpful. In our experience, patients will usually respond that the session was helpful. Although such responses may be reassuring to the therapist, they do not necessarily facilitate the treatment. Rather, we suggest that you ask, "What was the most helpful thing that we discussed in today's session?" or "What will you take away from this session?" Asking for feedback in this manner allows for the therapist to gain a better understanding of the specific points that resonated most with the patient. Therapists should also ask about how the patient felt about the session, especially if a particularly upsetting or sensitive topic was discussed. This is an important question to ask because patients may avoid future sessions if they leave sessions feeling distressed and do not have a plan for dealing with this distress. The therapist can also assess whether the patient thinks she was understood correctly and whether she wants to do anything differently in the next session. Items not discussed in this session could be identified at this point and established as agenda items for the following week. The therapist writes down this feedback and is sure to introduce the items identified by the patient in the next session. Many of the questions used to bridge from the previous session (see page 39) can be modified to obtain a final summary and feedback from patients.

- ✓ Mood Check
- ✓ Bridge from Previous Session
- ✓ Agenda Setting
- ✓ Discussion of Previous Session Homework
- ✓ Discussion of Agenda Items
- ✓ Periodic Summaries
- ✓ Homework Assignment
- ✓ **Final Summary & Feedback**

The following dialogue with Jack occurred at the end of his second session.

Therapist:	We're about at the end of our session, Jack. What was the most helpful thing that you got out of the session today?
Jack:	Well, I appreciate that you want to do things at my speed, you know, focus on what I think is important. It hasn't always been that way with other doctors.
Therapist:	Good. So how would you summarize today's session?
Jack:	Basically, that I need to stop avoiding being around other people all the time. And when I am around them, I need to try and be less irritable.
Therapist:	I agree. So it sounds like you're on board with the goals we set for treatment.
Jack:	Yeah, I'll give them a try.
Therapist:	Is there anything else that you learned from today's session?
Jack:	Well, put my money where my mouth is and actually do the things I say I'm going to do.
Therapist:	In that spirit, what are you going to do in between now and the next time I see you?
Jack:	I'll go over to my neighbor's when I see he's working on his truck. [smirks and waves his appointment card with his homework assignment written on the back] And I have this card to keep me in line if I forget.

Therapist: [responding to Jack's rare display of positive affect] That's great, Jack. You're getting into the swing of this already. I'm looking forward to hearing about it.

The therapist may also desire written feedback from the Veteran. On occasion, patients may be more comfortable providing written feedback to the therapist rather than providing face-to-face verbal feedback. Therapists can provide patients with simple forms that ask them to respond to open-ended questions such as, "What was the most helpful aspect of the session today?" Therapists can also obtain brief ratings to standardized questions such as, "On a scale of 0 to 10, with 0 being not at all helpful and 10 being very helpful, how helpful did you find today's session?"

- **Working Alliance Inventory**

Inquiring about the therapeutic alliance can also be beneficial for assessing the strength or degree of collaboration of the therapeutic relationship. One excellent measure of the therapeutic alliance is the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989). The WAI was derived from Bordin's (1979) theory of change-inducing relationships, which has as key components of the working alliance (a) agreement on the treatment goals, (b) agreement on how to achieve the goals (task agreement), and (c) development of a personal bond between patient and therapist. An abbreviated version of this measure that can be easily and effectively incorporated into CBT for depression, and which we use in training clinicians in CBT for depression, is the *Working Alliance Inventory–Short Revised* (WAI-SR; Hatcher & Gillaspy, 2006). Therapists can ask patients to complete this at the end of some therapy sessions. We recommend administering the 12-item WAI-SR at sessions 1, 4, 7, and 11. An effective way to use the WAI-SR in therapy is by reviewing individual items and discussing, in particular, any issues with respect to the therapeutic alliance suggested by the patient's responses.

Inquiring about the therapeutic alliance can also be beneficial for assessing the strength or degree of collaboration of the therapeutic relationship.

Implementing the Session Structure

When learning to structure CBT sessions, we recognize that it can be challenging for therapists who are learning the CBT protocol to remember to do all of the components described. In response to this concern, we have created a brief checklist to serve as a reminder to therapists of the various session components. This brief checklist may be displayed or consulted while the session is taking place.

Brief CBT Checklist

_____ 1. Mood Check
_____ a. Review BDI
_____ b. Medication Check
_____ c. Drug/Alcohol Check
_____ 2. Bridge from Previous Session
_____ 3. Set Agenda
_____ 4. Review of Previous Homework
_____ 5. Discussion of Agenda Items
_____ 6. Identify Key Thoughts/Behaviors
_____ 7. Implement a CBT Strategy
_____ 8. Periodic Summaries/Feedback
_____ 9. Homework Assignment
_____ 10. Final Summary
_____ 11. Session Feedback

- **Brief CBT Checklist**

We encourage therapists to keep in mind several benefits of implementing CBT session structure. Most fundamentally, it models to patients a systematic approach to organizing and addressing their life problems. When therapists exhibit a calm, reasoned approach to setting an agenda and discussing each of the agenda items, it communicates a sense of hope and optimism that patients can indeed manage their life problems and associated distress. In addition, implementation of CBT session structure has the potential to enhance the therapeutic relationship, in that it communicates to patients that their therapist wants to ensure that they thoroughly cover the issues that are important to them. Finally, maintenance of a session structure allows for a natural thread to run across sessions, in that the patient's mood is assessed each week on the same scale (thereby facilitating evaluation of the degree to which therapy is effective), topics or themes from the previous session are reviewed, and progress on homework completion can be monitored.

At times, therapists are hesitant to implement a session structure, wondering whether it will be somehow off-putting to patients or prevent patients from spontaneously expressing affect or cognitions that are inconsistent with agenda items. Some therapists have even wondered whether their patients will want to return if they adhere to an agenda and focus on the development of cognitive behavioral skills, rather than allowing the patient to "vent" what is on his or her mind. We encourage therapists to acknowledge their own automatic thoughts about the implementation of CBT session structure and check out the assumptions they are making with their patients. Oftentimes, therapists are surprised to find that patients are relieved to have a session structure because it contributes to a sense of productivity and efficiency. In instances in which therapists are correct in their hypothesis that a patient is having an adverse reaction to CBT session structure, they can work together with the patient to address this concern, thereby enhancing collaboration and the sense that they are working as a team. Ultimately, a collaborative therapeutic relationship is more important than the implementation of every piece of CBT session structure, but we

caution therapists to modify CBT session structure only after obtaining direct feedback from patients.

PART III: INITIAL PHASE OF TREATMENT

PART III: INITIAL PHASE OF TREATMENT

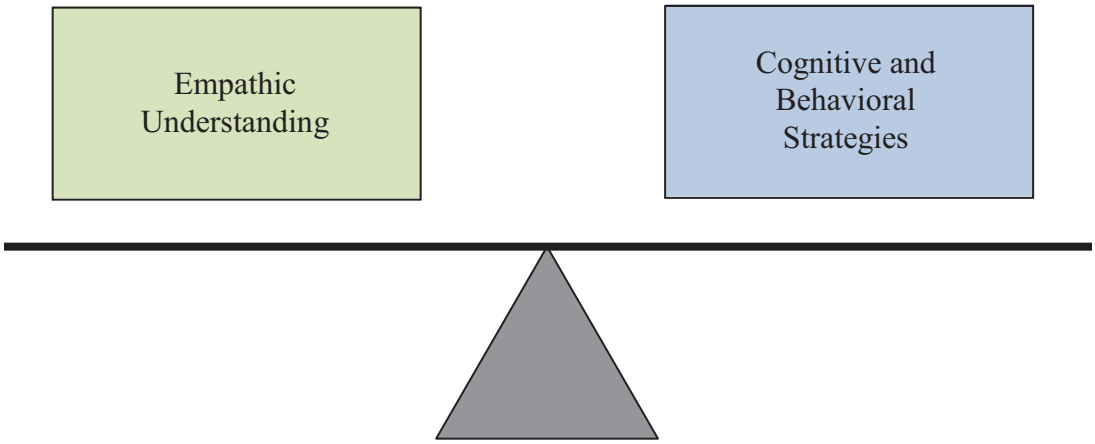
The initial phase of treatment can last as few as one session and as many as three sessions. The main goals of the initial phase of treatment are to (a) conduct an initial clinical assessment; (b) motivate patients for change; (c) socialize patients into treatment, including helping them to understand the structure and process of CBT; and (d) establish clear treatment goals. During the initial sessions, the therapist works to form a sound working alliance with patients that will serve as a basis to develop a case conceptualization and to implement the behavioral and cognitive interventions described in the next section. In other words, during the initial sessions, the therapist makes interventions that will set the stage for success in the middle phase of treatment. The patient, in turn, assents to treatment, communicating a commitment to working on his or her problems within the CBT framework.

- **Empathic understanding**

As previously mentioned, a strong, collaborative therapeutic relationship is central to the success of CBT with patients. Many therapists have the mistaken view that CBT comprises a set of strategies or skills, with little attention given to the therapeutic relationship in session. This could not be further from the truth. In our experience, patients make the most meaningful changes through psychotherapy when they are in an accepting environment in which they feel comfortable articulating sometimes-painful thoughts and beliefs and experimenting with different strategies to improve their lives. Thus, cognitive behavioral therapists strive to exhibit warmth, *empathic understanding*, validation, and genuineness with their patients. Moreover, empathic understanding is one of the essential therapeutic skills in CBT and is achieved by acknowledging the patient's suffering and communicating an understanding of their problems from a cognitive behavioral framework. In our experience, this stance facilitates a "connection" between the therapist and patient and instills hope. In fact, therapists continually evaluate whether their response to a patient will be one that primarily enhances the therapeutic relationship versus one that is focused primarily on change. We encourage cognitive behavioral therapists to achieve a balance between these two stances in session (see Figure 3.1), realizing that cognitive and behavioral change might be achieved rather slowly with some patients in the interest of building a sound therapeutic relationship. Many therapists ask us when it is best to adopt a stance primarily geared toward empathic understanding as compared to when it is best to adopt a stance primarily geared toward cognitive and behavioral change. We suggest that therapists select whatever strategies are necessary for moving the patient forward. The key issue during the course of treatment is for interventions, whether they target empathic understanding or whether they target cognitive and behavioral change, to be guided by the strategic consideration of the case conceptualization.

Many therapists have the mistaken view that CBT comprises a set of strategies or skills, with little attention given to the therapeutic relationship in session.

Figure 3.1. Balance Between Relationship-Enhancing and CBT Strategies



Initial Clinical Assessment

In the initial clinical assessment, cognitive behavioral therapists collect much of the same information gathered at the beginning of any type of psychotherapy—current mental health problems, personal and family history of mental health problems, current and past alcohol and substance use, medical history, and psychosocial history. All of this information contributes to the development of the CBT case conceptualization, described at the end of Part I of this manual. However, cognitive behavioral therapists also direct their questions in a manner such that they develop hints about patients' core beliefs, intermediate beliefs, and compensatory strategies. Examples of ways to assess for these constructs are presented in the case conceptualization section of Part I.

Although clinical assessment is an important part of the initial phase of CBT, in reality, assessment takes place across the entire course of psychotherapy. We encourage therapists to assume an inquisitive stance in each session, gathering information to test their hypotheses about their patients' beliefs and compensatory strategies. As more information is uncovered, you will modify your case conceptualization, which in turn helps to refine the interventions selected in treatment so that the most meaningful cognitive and behavioral changes are achieved in your patients' lives.

Motivational Enhancement

Many therapists who work in VA Medical Centers, as well as in other settings, have undoubtedly come across patients who are not motivated for treatment. Although these patients sometimes attend their first appointment, it is clear they are not ready to engage in the therapeutic process and make healthy changes in their lives. Some patients do not understand that the symptoms they are experiencing fall under the rubrics of depression or anxiety or do not have an understanding of what psychotherapy involves. Other patients agree to attend therapy sessions for external reasons, such as to appease their primary care physicians or family members. In all of these instances, starting a course of psychotherapy

Some patients do not understand that the symptoms they are experiencing fall under the rubrics of depression or anxiety or do not have an understanding of what psychotherapy involves.

before addressing the patient's motivation and readiness to change will diminish the likelihood that psychotherapy will be successful.

Motivational enhancement is a process that uses some aspects of motivational interviewing to help patients commit to the therapy process and to making change in their lives. According to Rollnick and Miller (1995), motivational interviewing is "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (p. 325). It is a style of interacting that helps patients elicit the motivation to change from within, rather than agreeing to change because they are responding to persuasion, coercion, or external contingencies. To achieve this aim, the therapist is directive in asking questions that will help patients identify areas of their lives that they would like to change, the benefits of participating in therapy to make those changes, and obstacles that might interfere with them committing to therapy. Below we list several motivational enhancement strategies (Zanjani, Miller, Turiano, Ross, & Oslin, 2008).

- **Motivational enhancement and interviewing**

Motivational Enhancement Strategies

- Identify patients' short-term goals in many areas of their lives, compare with their current functioning in these areas, and demonstrate the manner in which psychotherapy can help patients to meet these goals.
- Identify the consequences of their psychological symptoms.
- Identify the benefits of reducing their psychological symptoms.
- Assess patients' attitudes and expectations for treatment and, if necessary, use the cognitive strategies described in Part IV to modify unrealistic or negative attitudes and expectations for treatment.
- Discuss patients' previous therapy experiences and examine the manner in which they contribute to negative attitudes and expectations toward treatment.
- Identify potential obstacles to attending and participating in treatment and brainstorm ways to overcome those obstacles.

Short-Term Goals

To start the motivational enhancement process, therapists often ask patients to identify their short-term goals in a number of important areas of their lives, including their physical and emotional health, employment and career, activities and hobbies, relationship and social life, and financial well being. This activity orients patients to the positive changes that can be achieved in therapy in a relatively short time frame. Moreover, it starts the initial phase of treatment on a positive, optimistic note rather than a pessimistic note by not focusing exclusively on what is going wrong for the patient.

- **Short-term goals**

Throughout this section, we illustrate the motivational enhancement process with Jack, who expressed ambivalence about treatment from the outset, complaining that actions of others were the main problem in his life. This dialogue took place in Jack's second CBT session, when he and his therapist decided to address treatment goals as the first item on the agenda.

Therapist: It sounds like it has been a rough few months for you, Jack. [choosing to make an empathy statement rather than questioning his view that others are the cause of his problems]

Jack: It sure has. And I really don't see why I need to be here if *they* are the ones who are the problem. People these days! They don't make them like they used to!

Therapist: [makes an empathetic facial expression without verbally reinforcing Jack's rigid perceptions about the world] What I'm interested in hearing more about, Jack, is *your* life—where you hope to be in the near future. It can often be helpful to identify where you'd like to be in major areas of your life in the next few months and to see if there's a discrepancy between those estimations and where you are now. Does that make sense?

Jack: Yeah, well, I've already told you that I have lots of problems.

Therapist: Yes, and I am sorry to hear that things have been difficult. [taking the opportunity to communicate another expression of empathy] Why don't we start with your job? [strategically choosing a concrete problem area, rather than one that is more abstract (e.g., emotional health) in order to help Jack focus] In the next three to six months, what would you like to see changed regarding your employment status?

Jack: I need another job. I can't live without one.

Therapist: That makes a lot of sense. So, one short-term goal you have for yourself is to get a new job. Any idea of what kind of job you'd like? Part-time or full-time?

Jack: Definitely full-time. I'm not ready to sit around the house doing nothing all day.

Therapist: Do you want to stay in the same line of work you were in?

Jack: Yeah, that's really all I know. Cars, trucks, SUVs, you name it.

Therapist: It sounds like you're really onto something, Jack. [restates goal in concrete terms] So it sounds to me that one goal you have is to get a new full-time job in the same line of work as your last job.

Jack: Yeah, exactly. [frowns] Easier said than done, though, with the economy like it is.

Therapist: Yes, I realize that. Finding a new full-time job is not easy these days. [brightens] But this is a perfect example of something the two of us can work on together in treatment. We can develop strategies to improve your mood and increase motivation, which might help you to find a job. How does that sound?

Jack: [sarcastically chuckling] If you can get me a new job where people stay off my back and let me do my thing, I'm all for it.

Therapist: [choosing to move onto another area of his life rather than correcting Jack's misperception that she can get him a new job] Let's move onto other areas of your life—finances, for example. What are your financial goals for the next three to six months?

Jack: Just to make sure I don't go bankrupt.

Therapist: [gently] Are you having some financial troubles right now?

Jack: Sort of, now that I lost my job. We're living paycheck to paycheck right now, not really doing anything for retirement. [snorts] That will definitely have to change, since we can't count on our kids for anything.

Therapist:	[reframing Jack's goal] Let me make sure I understand what you're saying. Your financial goals for the next three to six months are not only to prevent bankruptcy, but also to begin contributing to your retirement funds?
Jack:	Yeah, that's it.
Therapist:	[summarizing their progress so far] You're doing great, Jack. You've come up with two concrete goals to strive for in the next several months—to get a new job and to improve your financial situation by making sure the bills are paid and contributing to your retirement account. Do you have any short-term goals for any other areas of your life?
Jack:	Uh, not really. I just live one day at a time.
Therapist:	[having read Jack's chart and knowing that he suffers from pancreatitis and diabetes] Well, how about for your physical health? …

Jack's therapist went on to assess his goals for his physical health, emotional health, activities and hobbies, and relationships and social life. When relevant, she encouraged him to compare his current functioning with the goals that he verbalized so the discrepancy was clear to him. She also helped him to frame his goals as ones that he, personally, could achieve (e.g., *I hope to have better control over my anger*), rather than ones that were about others' behavior (e.g., *I wish my wife would take care of the house better*). Throughout the discussion, she linked his goals back to the process of therapy, explicitly stating that the goals were relevant for their work in treatment and could be readily attained through CBT. Later, in the initial phase of treatment, Jack's therapist reminded him of this discussion as they explicitly formulated goals for treatment (see page 74).

Consequences of Psychological Symptoms

A second motivational enhancement strategy is to work with patients to identify the consequences of their psychological symptoms. Patients often are not cognizant of the effects that depression and anxiety have on their close relationships, work functioning, parenting, and enjoyment of recreational activities and hobbies, in part because they are struggling just to make it through each day. Although identifying the consequences of depression and anxiety can be painful for some patients, it often motivates them to continue with treatment to prevent further life interference. Jack was diagnosed with major depressive disorder, but he was convinced that he was not depressed and that others were the problem. However, he admitted that his anger and irritability have caused problems for him. Thus, Jack's therapist focused on the consequences of his anger and irritability rather than his depression per se, in order to facilitate a collaborative relationship rather than one that is adversarial.

Patients often are not cognizant of the effects that depression and anxiety have on their close relationships, work functioning, parenting, and enjoyment of recreational activities and hobbies, in part because they are struggling just to make it through each day.

Therapist:	You mentioned earlier that you could stand to learn how to manage your anger and irritability. I'm wondering if you can tell me a little more about that, Jack. How have your anger and irritability caused problems for you?
Jack:	I'm just really angry all the time. People have really gotten on my nerves lately.

Therapist:	Yes, it certainly seems like you've had quite a few conflicts with others recently. [reframes question] I'm wondering if your anger and irritability somehow make these conflicts even worse than they already are.
Jack:	I don't know. I think people get what they have coming.
Therapist:	[offers a menu of choices] When you have a problem with others and get very angry and irritable, do you usually achieve the end result that you were hoping for, or is the end result not particularly satisfying for you?
Jack:	[sighs] I guess most of the time the conflicts just go unresolved. I don't give in, and they don't give in.
Therapist:	And how does that affect you?
Jack:	It does wear you down, I'll say that much.
Therapist:	What would life be like without the anger and irritability?
Jack:	[demonstrating ambivalence] Sometimes, I think it would be nice just to say, "Screw it. Who cares?" and just kick back, relax, and be done with it. But it's not that easy. I've always had to fight for everything I have coming to me—promotions, raises—hell, even respect from my own family.
Therapist:	What I'm hearing you say is that the anger wears you down, that you wish you could let some of it go and just relax. Is that right?
Jack:	Yeah, but like I said, then I'll be letting others get the best of me.
Therapist:	[linking the consequences of Jack's symptoms to treatment] I wonder if we could put our heads together to figure out a way in which you wouldn't feel quite so angry and irritable all the time while ensuring that you are getting what you feel is coming to you.
Jack:	That would be nice, I guess—if it were possible.

Notice that Jack still seems ambivalent about giving up his anger and irritable style of interacting with others because he is concerned that it would leave him vulnerable to being taken advantage of by others. The therapist made several attempts to illustrate the adverse consequences of his anger and irritability while, at the same time, validating his concern about getting what is coming to him. Below we list several questions therapists can ask to assess the consequences of patients' psychological symptoms (Zanjiani et al., 2008).

Strategic Questions for Assessing Consequences of Psychological Symptoms

- What problems have [symptoms] caused you recently?
- What effects do [symptoms] have on your life?
- Do [symptoms] get in the way of doing things you normally do? Like what?
- Do you avoid doing certain things because of your [symptoms]? Like what?
- How do [symptoms] affect your work? Your relationships?
- Do [symptoms] reduce your life satisfaction?
- Have other people noticed [symptoms]? Have they expressed concern that [symptoms] are problematic?
- What would life be like for you without [symptoms]?

Benefits of Reducing Psychological Symptoms

It is logical to encourage patients to identify the benefits of reducing their psychological symptoms after considering their deleterious consequences. This will help them to see that there is a "light at the end of the tunnel" and that there is hope that their lives will improve. Patients who are depressed and anxious often feel overwhelmed when presented with the option of psychotherapy, perceiving that it will require more energy and effort than they have to give. By identifying the benefits of reducing psychological symptoms, many patients begin to view the long-term benefits as outweighing the short-term costs. Because patients in the midst of a depressive episode often think in general terms and have difficulty generating specific pieces of information to solve problems (Williams, Barnhoffer, Crane, & Duggan, 2006), it often is helpful for therapists to provide a menu of choices (below) so that patients can select from a wider range of benefits than they might identify on their own.

Benefits of Reducing Psychological Symptoms

- Happiness
- Increased confidence
- Lowered stress
- Ease in speaking one's mind
- Sleep better
- Safer
- Better memory and concentration
- Better able to achieve my goals
- Relaxation
- Take better care of self
- Physically feel better
- Mentally feel better
- Exercise and eat better
- Feel in control
- More energy
- Able to enjoy pleasurable activities
- Better able to deal with problems
- Increased productivity
- Enjoy life more
- Easier to deal with people
- Avoid legal problems
- Enhanced sexual performance
- Better relationships with family and friends
- Have more hope for the future

Note: From Zanjani et al. (2008).

Like many depressed patients, Jack had difficulty identifying specific benefits for attending treatment and reducing his psychological symptoms. Jack's therapist knew it was important for Jack to clearly articulate some benefits because he expressed resentment that he was the one in treatment when so many others were causing problems for him—a belief that surely would decrease his motivation for treatment. When Jack reviewed a list of potential benefits of getting treatment and reducing his psychological symptoms, he indicated that being better able to achieve his goals, having an easier time dealing with people, and sleeping better were the three most relevant benefits to him.

Attitudes and Expectations Toward Treatment

- **Attitudes and expectations toward treatment**

Attitudes and expectations toward treatment can have a powerful influence on the degree to which patients are actively engaged in the therapy process. Research shows that patients with higher expectations for treatment are more likely to recover from their mental health problems and report fewer psychological symptoms (Shapiro & Shapiro, 1997), in part because the therapeutic relationship is stronger in patients with higher expectations for treatment (Meyer et al., 2002). Furthermore, patients who report a neutral or negative attitude about talking with a therapist about their

problems report more depression and suicide ideation than patients who report a positive attitude 12 months after beginning treatment (Wenzel, Jeglic, Levy-Mack, Beck, & Brown, 2008). On the basis of this body of research, we encourage you to assess attitudes and expectations for treatment in the first session. If patients report low or negative attitudes and expectations, we encourage you to take time to understand the rationale behind these beliefs, provide psychoeducation to correct incorrect assumptions about treatment, and use the motivational enhancement strategies described in this section to overcome these beliefs and create a context in which patients decide to commit to treatment.

Assessing Negative Attitudes Toward Treatment

Understanding the rationale behind patients' negative attitudes toward treatment achieves several aims:

- It communicates to patients that you are taking their views seriously and reinforces the collaborative relationship between you and the patient, rather than a relationship in which your opinions as a therapist are more important than those of the patient.
- It provides additional insight into the patient's cognitive processes, thoughts, and beliefs, which can be incorporated into the case conceptualization.
- It provides information about aspects of treatment that the patient perceives to be unhelpful, which can be considered in developing a treatment plan and tailoring specific interventions to the patient's clinical presentation and personal preferences.

In our experience, negative attitudes toward treatment come from two main sources—preconceived notions about what therapy is and is not, and negative experiences with one or more previous courses of therapy. In both instances, it is helpful to educate the patient about the goals, structure, and process of CBT in order to ensure that he has an accurate understanding of what *this* trial of therapy will be like. For example, therapists will encounter some patients who have never been in therapy and who base their opinion about the usefulness of psychotherapy on stereotypes (e.g., the idea that they will be asked to attend several sessions a week for several years). In other instances, patients will have had a course of therapy that they did not perceive to be particularly helpful, and they expect that CBT will be the same. In fact, Wenzel at al. (2008) found that negative attitudes toward talking with a therapist about one's problems were associated with more previous experiences with therapy and higher levels of hopelessness before treatment started.

The following excerpt is an example of the manner in which Jack's therapist handled his negative attitudes toward treatment.

Therapist: [making a periodic summary] So, let's summarize where we are so far: It sounds like you would like several aspects of your life to be different than they are right now. Your anger and irritability are wearing you down, and you identified three important benefits of reducing your anger and irritability—reaching some of your goals, dealing with people more effectively, and being able to sleep better. Am I on target here?

Jack: Yeah … I guess so …

Therapist: I'm sensing that you're not convinced that this will be helpful to you.

Jack: Yeah. I mean, I've done this before, and things are still the same. The problem is more with other people than with me, but yet I'm the one who is stuck going to see a counselor.

Therapist: So you've been in therapy before. What was that like?

Jack: To be honest, I didn't really get anything out of it. All I did was show up, tell my counselor what happened that week, and leave.

Therapist: Were you having the same sorts of problems then as you have now?

Jack: Some yes, some no. Things with my wife have been bad for at least 15 years. But at least back then, I had a job.

Therapist: So your relationship with your wife was the major issue that brought you into treatment before?

Jack: Yeah, that and the problems with my kids. And, I guess, problems with my boss at work as well.

Therapist: Did you develop any concrete strategies for dealing with these relationship problems from your previous experience in therapy?

Jack: No, not at all! All I did was talk about the relationships, over and over and over. It probably made my anger worse, not better.

Therapist: It occurs to me that your previous therapist might have been providing a different type of treatment than the type of therapy that I do. Would you be willing to hear more about the cognitive behavioral approach that I take with the people I work with?

Jack: Cognitive what?

Therapist: Cognitive Behavioral Therapy—or CBT, for short. It is an active approach to therapy that focuses on helping you to develop strategies to address your current problems. In each session, we'll figure out the most important topics to cover in order to meet your treatment goals, and then you and I will work actively as a team so that you can start to develop some concrete skills for handling problems differently. In many instances, you'll try to use these skills in your real life, and you'll come back to the next session and let me know how it went. What do you think of this so far?

Jack: It's a lot different than I thought it would be.

Therapist: In what way?

Jack: It sounds a lot more direct than I expected.

Therapist: And do you view that in a positive way or in a negative way?

Jack: Well, I guess positive because it sounds like we might get a lot done. But I won't lie to you—it also sounds like a lot of work. I have so much on my mind right now that I really don't need more work piled on me.

Therapist: I understand. Another aspect of this treatment that I should make you aware of is that it is tailored to each person, so that we figure out ways to solve problems that work best for your needs. How does that sound?

Jack: It sounds good in theory. But you know how things go—everything is always different than you were led to believe once you get into it.

Therapist: I have an idea. What if you were to agree to come in for just four sessions? That should give you enough time to judge whether this type of therapy is helpful for you and whether it requires more effort than

	you are willing to give. At the end of the fourth session, we can re-evaluate.
Jack:	Four sessions…that's it? I don't have to commit to anything more than that?
Therapist:	And in the fourth session, we'll look at everything we've done together and decide together whether it has made a difference in your life.
Jack:	OK. Four sessions it is.

Notice that when Jack's therapist attempted to describe CBT, she stayed away from technical terms and jargon as much as possible. Once patients commit to treatment, it is important that they understand what is meant by *cognition* and *behavior*, as these constructs lie at the heart of CBT. However, when patients are ambivalent about treatment, they will likely tune out information that seems foreign to them or difficult to understand. Thus, when therapists use motivational enhancement to increase patients' *commitment to treatment*, they focus on concrete aspects of treatment and the manner in which they will affect patients' lives.

- **Commitment to treatment**

At the end of this dialogue, Jack still was not convinced that he was willing to participate in CBT. It is not uncommon for patients with negative attitudes toward treatment to be hesitant to commit to an entire course of psychotherapy. In this case, Jack's therapist made use of a strategy called the *behavioral experiment*. Briefly, a behavioral experiment requires that a patient try out something (e.g., four sessions of treatment) and evaluate the outcome based on the "data" he collected experientially. This is one of the most powerful approaches to modifying maladaptive thoughts and beliefs, as patients experience the costs and benefits in their lives rather than evaluating them hypothetically. This behavioral experiment, as applied with patients like Jack, is an effective tool for getting patients' "feet in the door" without creating a context in which they resent having committed to more than they had anticipated.

- **Behavioral experiment**

Obstacles to Participating in Treatment

In addition to negative attitudes toward treatment, there are several other barriers that prevent patients from attending their sessions on a regular basis or otherwise actively engaging in treatment. Some of these obstacles are logistical in nature, such as living far away and having trouble arranging for transportation, not having resources for childcare, having other medical problems that interfere with attending sessions, and working during business hours. Other patients have few logistical obstacles but, instead, have difficulty attending sessions and/or engaging in treatment because of decreased energy and motivation, concurrent substance use, other crises that demand their attention, and generally chaotic lifestyles. Many of these barriers can be identified in advance during the initial sessions before they disrupt the course of treatment.

- **Obstacles to participating in treatment**

When these obstacles are identified, cognitive behavioral therapists use problem-solving strategies to help patients develop a plan for overcoming them. Not only does this approach increase the likelihood that patients will attend and engage in treatment, but it also models an adaptive problem-solving approach that can be generalized to other problems in patients' lives. In many instances, it is important to write down the plan to overcome obstacles on a piece of paper so that patients can take these

problem-solving plans with them and consult them outside of session. In the following dialogue between Jack and his therapist, they identified obstacles that would prevent him from attending treatment and problem solved ways to overcome these obstacles.

Therapist:	I'm glad that you have committed to attending four sessions, Jack. I'm wondering, though, if there is anything that might prevent you from attending these sessions or from getting the most you can out of them?
Jack:	I don't think there's anything. Once I set my mind to something, I do it.
Therapist:	OK. So that means that you have all of the basics in place, like transportation to get you here and time each week to attend sessions?
Jack:	Yeah, it shouldn't be a problem. My car's running good, and I only live a half hour away. No big deal.
Therapist:	[realizing there are no overt logistical barriers to attending sessions but that there might be other barriers] Sometimes, when people are depressed or angry or irritable, people have the best intentions to go to their session, only to find that when it's time for them to get ready, they just don't feel like it. Do you think this will happen to you?
Jack:	I think our appointments will be at 9:30 in the morning, right? As long as I had a good night's sleep, everything should be fine.
Therapist:	[sensing a "red flag" when Jack mentioned his sleep] Jack, I recall that you told me that sleep is a pretty big problem for you. That sometimes you don't fall asleep until 2:00 or 3:00 in the morning, and then you have trouble getting up in the morning. How often do you have those kinds of nights?
Jack:	A lot, unfortunately. Four or five times a week.
Therapist:	So do you think there is a high probability that something like that might happen the night before we have a session?
Jack:	Now that I think of it, yeah probably. It's worse whenever I know I have to get up in the morning.
Therapist:	How should we handle this, to ensure that our sessions run smoothly?
Jack:	Do you have any appointments in the afternoon instead of the morning?
Therapist:	Sometimes I do, and sometimes I don't. When I do, you're more than welcome to grab one of those appointment times. But what will happen when I don't have an afternoon available and you have a morning appointment?
Jack:	I guess I should think about that, huh?
Therapist:	Yes, I guess you should. But that's what I'm here for. I can help you figure out possible solutions to these sorts of problems and decide on the best one. So, what would you say are possible ways to ensure that you wake up and can get to a morning appointment?
Jack:	Well, maybe I should go to bed earlier. I have this thing where I sit on the couch and watch TV until I nod off. Maybe I should just try to get in bed at a decent time.
Therapist:	That sounds reasonable. Any other ways to address this problem?

Jack: I guess I could set the alarm clock the night before. I haven't been using the alarm lately because I don't have to get up and go to work. But I can try to remember to do that.

Therapist: Sounds great. So to recap, on the days you have a morning appointment with me, you'll prepare for that in advance by getting in bed at a reasonable hour the night before and setting your alarm to ensure you wake up.

Jack: Yeah.

Socialization into CBT

- **Socialization into CBT**

Earlier, Jack's therapist provided him with some information about CBT to show him how this course of therapy has the potential to be different than other courses of therapy in which he participated in the past. His therapist did this for two reasons: (a) to increase his motivation to commit to treatment, and (b) to begin orienting him to CBT structure and process. It is important for therapists to spend time educating patients about CBT so that they have accurate expectations of their role and responsibilities in treatment, the therapist's role and responsibilities in treatment, and the types of things that will transpire over the course of treatment. Below we list the topics that therapists often cover when they socialize their patients into CBT.

Topics for Socialization to CBT

- Structure, length, and frequency of sessions
- Rationale for regular attendance, homework, and full participation
- Goals of CBT and their relation to the patient's goals and problems
- CBT model and the manner in which it relates to their problems and subsequent intervention
- Roles and responsibilities of the patient and therapist
- Research on the effectiveness of CBT
- Personal experiences of the effectiveness of CBT with past patients

Jack's therapist provided additional orientation to CBT at the beginning of his third session, after he had made a commitment to treatment at the end of the second session. The following is a dialogue that demonstrates the manner in which Jack's therapist socialized him into CBT.

Therapist: Let's talk a little bit more about what CBT is all about.

Jack: Yeah, that's good. I forget what CBT even means.

Therapist: That's OK, I realize this is all new to you. CBT stands for Cognitive Behavioral Therapy. Last time, I talked with you about the fact that CBT is an active treatment that is aimed to help you develop strategies for solving problems in your life.

Jack: Well, I've got a lot of them.

Therapist: We'll be sure to address them in the upcoming weeks. [pause] Did you notice anything about the last session that was different from when you were in therapy previously?

Jack: Yeah, you had me fill out that form [referring to the *Beck Depression Inventory]*.

Therapist: You're very observant. This is something I am going to have you do every week. It will give me an idea of how your mood and other symptoms are changing from week to week.

Jack: OK.

Therapist: Did you also notice that we set a game plan for today's session?

Jack: Yeah.

Therapist: That's another thing that we'll do every week. You and I, together, will set an agenda for the session to be sure that we are covering important topics that are relevant to the goals that you'll set for treatment. Then, we'll make sure we pace the session so that we cover all of those topics.

Jack: OK.

Therapist: Another important component of CBT is homework.

Jack: [snarls] I always hated homework in school.

Therapist: [smiles] Maybe we can call it something different, like "practice."

Jack: That's a little better.

Therapist: I realize that practicing what we have discussed in between sessions is not real attractive to you. However, in my experience, practicing what we have covered in session is more likely to lead to lasting changes in people's lives. For example, let's say that we're talking about getting another job. Your assignment might be to actually submit an application. So, in addition to talking in here about a problem, like needing a job, the assignment helps you to take action. Does that make sense?

Jack: Yeah, if all of the assignments are like that, then I guess it wouldn't be so bad.

Therapist: [pause] Another thing about these practice assignments is that I'm not just going to "assign" you something on my own. In fact, the two of us will work together to develop an assignment that both of us think has promise in improving your life situation.

Jack: [seems a bit relieved] OK, I like that a lot better than you giving me something that feels like school, like a book to read or something.

Therapist: Now, as we said last time, at this point you've made the commitment to attend four sessions, after which time we'll evaluate whether CBT is a helpful approach for you. If you choose to continue, then I would anticipate the entire course of treatment would be around 16 sessions.

Jack: There's actually an end to therapy?

Therapist: Yes, we typically find that in approximately 16 sessions, people have learned to address problems in their lives and manage mood problems, like depression, anger, and irritability. However, some patients may stay in therapy for longer periods of time, if needed, or they may also benefit from booster sessions. These are follow-up sessions that are scheduled one to three months after therapy is over.

Jack: This is a lot different than other times I was in therapy. Before, it just seemed endless.

Therapist: That's why we describe this type of therapy as one that is active and problem-focused. We'll be getting a lot of work done in each of those sessions.

Jack: And this really works?

Therapist: In fact, research studies have repeatedly shown that CBT is a very effective treatment for depression.

Jack: I guess I didn't realize this would be so different.

Therapist: One thing that makes this approach so effective is that you and I both have distinct roles and responsibilities that we bring to the table. My job is to make sure I'm prepared at each session, that we stick to the agenda, and that I really listen to what you are saying about your problems so that we can be sure the treatment is tailored to your individual needs. You have a few jobs, too, though. Your jobs are to make sure you get to your sessions on time, to participate actively when you are here, and to try out whatever assignments we come up with. Does this sound reasonable to you?

Jack: That sounds fine.

Therapist: I have a suggestion. I have a short article, *Coping with Depression*, that I can give to you to read. It provides a brief description of what depression is as well as some strategies that might be useful for treating depression. The article would give you more information about CBT. Would this be something that you would be interested in reading between now and the next session?

Jack: Sure. I usually don't like to read a lot, but this is short, so I'm willing to give it a shot.

Therapist: I appreciate your flexibility, Jack.

- **Bibliotherapy**

Notice that Jack's therapist assures him that, together, they will develop homework assignments that fit Jack's strengths and inclinations. One type of homework assignment that is often very useful and effective, especially in the initial phase of therapy, is bibliotherapy. *Bibliotherapy* consists of recommendations by the therapist for the patient to read published information such as therapy workbooks or Web-based materials. Bibliotherapy resources, which are often based on CBT principles, can help to expand on concepts and reinforce cognitive and behavioral strategies discussed in session. In an effort to promote the use of bibliotherapy, particularly as an adjunct to professional treatment, VA has developed a *VA Bibliotherapy Resource Guide* (Karlin et al., 2009), which identifies and describes a wide range of print and Web-based materials that therapists may recommend to their patients. Some patients, like Jack, may find extensive reading undesirable, so it is important to tailor homework assignments to their personal preferences. For example, providing Jack with very brief reading assignments and encouraging him to record sessions and listen to the recordings between sessions may be better suited for reinforcing key concepts discussed during sessions than having him read extensive chapters or record a great deal of information. Whether it is through bibliotherapy or listening to audio recordings, clinical experience has shown the value of repeated exposure to expedite learning and increase compliance with prescribed cognitive and behavioral homework assignments.

Bibliotherapy resources, which are often based on CBT principles, can help to expand on concepts and reinforce cognitive and behavioral strategies discussed in session.

In many instances, it is relevant to inform patients of the potential for negative reactions to treatment. Although it is anticipated that patients will benefit in general from a course of treatment, at times, they leave individual sessions with unpleasant emotions because they had discussed difficult topics or because they had difficulty

arriving upon a resolution to the problem being discussed. In these instances, it can be helpful to draw an analogy between therapy and exercise. With consistent exercise, patients receive the long-term benefits of being healthier and increasing strength and stamina despite feeling sore after individual workouts. The same is often true of therapy. If patients know this in advance, a negative reaction to a session will not be as alarming as it might otherwise have been perceived.

Setting Treatment Goals

- **Setting treatment goals**

During the initial phase of treatment, the patient and therapist collaboratively agree upon the overarching problem areas to be addressed over the course of therapy. It is essential for patients to play an active role in the process (and also that they *perceive* that they play an active role in this process) so that they assume ownership over the course of treatment. Once the general problem areas have been identified, therapy can focus on more specific examples of these problems.

To develop treatment goals, the therapist works with the patient to generate a list of *target complaints* that reflect the challenges that the patient is experiencing as well as things the patient hopes to accomplish in therapy. Next, the patient ranks the importance of each of these complaints, which, in turn, is used to identify short-term and long-term goals. Short-term goals are those that can be attained in a period of a few weeks; in our experience, patients' motivation for and commitment to treatment increases when they see relatively immediate and tangible changes in their lives. It is important to set realistic short-term goals, as inappropriate or overly ambitious goals may set patients up for perceived failure. Examples of short-term goals include "Develop relaxation skills" or "Run two miles twice a week." Long-term goals, in contrast, are those that the patient hopes to achieve by the end of treatment and even beyond. These goals are typically broader in scope and apply to many problematic areas in the patient's life.

A key feature of treatment goals is that they are specific, well-defined, and described in observable and measurable terms. For example, if a patient indicates that she would like to feel happier by the end of treatment, the therapist might ask, "How could someone tell if you were happier?" and then formulate the goal in these more specific terms (e.g., "To be spending more time with friends and family, to be exercising at least three times a week, and to resume participation in art classes"). In some instances, it is helpful to reframe goals using positive, change-oriented language rather than language that focuses on the patient's deficits. For example, many patients indicate that they would like to feel "less depressed," which can be restated as "improve depressed mood and learn skills for controlling my mood." This places a positive spin on the problem and helps patients to begin to think in terms of change rather than focusing exclusively on areas in which they may be deficient. The use of small behavioral steps affords patients the opportunity to achieve success early on, which serves as mastery experiences on which they can draw later.

A key feature of treatment goals is that they are specific, well-defined, and described in observable and measurable terms.

Exhibit 3.1 summarizes the treatment goals identified by each of the four patients described in this manual. In Jack's case, you will see that many of his treatment goals follow logically from the issues that arose when his therapist engaged in motivational

enhancement strategies. Thus, although the initial phase of treatment usually ends with setting treatment goals, in reality, the patient and therapist form treatment goals throughout the entire initial phase of treatment.

Exhibit 3.1. Treatment Goals for Sample Cases

Jack's Treatment Goals

- Reduce anger and irritability by decreasing conflicts with family members and co-workers and sleeping at least seven hours per night.
- Improve relationships with wife and children by increasing the frequency of spending time with wife, engaging wife in family problem-solving, and speaking with children on the telephone every week.
- Improve quality of life by getting a new job, contributing to a retirement fund, adhering to medical advice, and participating more frequently in recreational activities.

Kate's Treatment Goals

- Improve depressed mood by engaging in at least one pleasurable activity each day and sleeping no more than eight hours per day.
- Re-negotiate a satisfying relationship with children, including daily telephone and biweekly in-person contacts.
- Improve adaptive functioning by getting a new job, paying bills on time, and maintaining frequent contact with family members and friends.

Michael's Treatment Goals

- Decrease suicide ideation by developing reasons for living and decreasing self-reported hopelessness.
- Improve depressed mood by increasing engagement in pleasurable and mastery-oriented activities every day.
- Improve coping with cognitive limitations from IED explosion by tolerating frustration and identifying a new career path.

Claire's Treatment Goals

- Decrease anxious and irritable mood by decreasing conflict with others.
- Diversify engagement in pleasurable activities by initiating social interaction and engaging in recreational activities at least once a week.
- Improve coping with physical limitations from airplane crash by tolerating frustration and, if necessary, identifying a new career path.

Suicide Risk Assessment and Safety Planning

- **Suicide risk assessment**

Veterans who are seeking mental health treatment, including CBT, in the community or VA health care facility may be at risk for suicide, and it is typically recommended that a *suicide risk assessment* be conducted during the initial phase of treatment. We have already suggested that a suicide risk assessment may be conducted if patients endorse a 1 or higher on the suicide item of the BDI. There may be other reasons for conducting a suicide risk assessment, such as the patient's report of suicide intent or plan, a recent suicide attempt, new or increased severity or frequency of suicide ideation, threat or other behavior indicating imminent risk, uncertainty that the patient can control his impulse to harm self or others, an abrupt positive or negative change in clinical presentation, lack of improvement or worsening despite treatment, significant loss, or other negative life event. Thus, although we recommend that the risk assessment be completed during the initial phase of therapy, it may be completed during any phase of treatment as indicated by warning signs or other risk factors as

reported by the patient, as indicated by assessments measures or the medical record, or as indicated by direct observation of the patient's behavior.

Below is a list of risk and protective factors for suicidal behavior that is often considered in the context of a suicide risk assessment. The therapist may assess for these risk factors by the Veteran's verbal self-report as well as by other sources, such as completed measures, medical record, other therapists, or family members. The therapist should note whether each risk factor is present or absent. Although a detailed description of specific strategies for conducting a comprehensive suicide risk assessment is beyond the scope of this manual, additional information can be found in *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003).

Potential Risk Factors	
• History of single or multiple suicide attempts (lifetime and especially in the past 30 days) • History of non-suicidal self-injury behavior • History of aggressive or violent behavior toward others • Preparations to kill self (purchased a gun, wrote a suicide note) • Current wish to die, or wish to die outweighs wish to live • Current suicide ideation with intent to kill oneself • Current specific plan to kill oneself, lethal method currently or easily available • Reluctant to reveal suicide ideation • Regrets surviving a previous attempt • Any recent stressful life event such as a job loss, break-up of a relationship, interpersonal conflict • Any abrupt negative or positive change in clinical presentation	• Current severe hopelessness • Current major depressive disorder • Current psychosis (especially command hallucinations to kill oneself) • Traumatic images • Current mania or other highly impulsive behavior • Relapse or current substance abuse (illicit drugs, alcohol, and/or medication) • Exacerbation of physical pain or other serious medical problem (e.g., Chronic Obstructive Pulmonary Disease) • Current agitation or acute anxiety • Current perceived burden to the family • Current homicidal or aggressive ideation • A problematic treatment history, including hopelessness, indifference, or dissatisfaction about current treatment, history of treatment noncompliance, current unstable or poor provider relationship, or other problem interfering with treatment
Potential Protective Factors	
• Current hopefulness • Current reasons for living • Current wish to live outweighs wish to die • Current perceived self-efficacy in the problem area • Current responsibility to children, family, others, or pets • Current living situation with dependents	• Current engagement in treatment and/or emotionally connected to the provider • Current supportive social network • Current fear of death, dying, or suicide • Current belief that suicide is immoral • Current lethal method of suicide unavailable • Current participation in religious or spiritual activities

After the risk and protective factors have been assessed, the therapist determines whether or not the patient is imminently or highly dangerous to himself. The reasons for this determination should be noted on the medical record.

Next, the therapist chooses an appropriate *action plan* given the Veteran's level of suicide risk. Although this is not intended as an exhaustive list of possibilities, one or more of the following action plans may be implemented by the therapist:

(a) If the Veteran is determined to be at high risk for suicide, the Suicide Prevention Coordinator is consulted. (b) The Veteran should be placed on the High Risk List and the Enhanced Level of Care process started. This includes the development of a safety plan, frequent visits, and/or hospitalization and treatment plan modifications. (c) Veterans may be hospitalized if the therapist or another clinician determines that they are at a high or an imminent risk for homicide or suicide or are otherwise a danger to themselves and cannot be safely treated on an outpatient basis.

The therapist may complete a safety plan with the Veteran for any level of risk. A safety plan is a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that Veterans can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides patients with something more than just a referral at the completion of suicide risk assessment. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, patients can determine and employ those strategies that are most effective in managing acute distress. It is strongly recommended that therapists consult the following VA manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version* (Stanley & Brown, 2008) for a full description of the safety plan protocol.

- **Safety plan**

The Veteran may also be referred to another provider or agency, or the therapist may assist with the coordination of care, including referral to a VA clinic or agency, to a physician for a medication evaluation, to a Suicide Prevention Coordinator, or to the emergency department or urgent care service. The Veteran's agreement to go for additional consultation should be noted, and the method of transporting the patient to this evaluation should also be disclosed. Regardless of the referral options provided, therapists should be familiar with and follow specific guidelines established at their local facility.

Finally, the therapist identifies *follow-up procedures*. These may include ensured continuation of care in the days or weeks following the suicidal crisis or plans to conduct a follow-up risk assessment (interview time and date are noted), examining the medical record (especially from any recent hospital admissions), contacting a provider or agency also responsible for the patients care, or contacting family members or other responsible individuals (especially to alert them of increased suicide risk).

PART IV: MIDDLE PHASE OF TREATMENT

PART IV: MIDDLE PHASE OF TREATMENT

During the middle phase of treatment, the patient and therapist work together to address the treatment goals established in the initial sessions in a systematic, strategic manner. The therapist uses a combination of cognitive and behavioral strategies as indicated by the case conceptualization. However, the therapist also continues to remain cognizant about the strength of the therapeutic relationship and balances relationship-building strategies with cognitive- and behavioral-change strategies, as necessary. In this part, we describe a number of standard cognitive and behavioral strategies that therapists can apply in their work with individual patients. We describe behavioral strategies first and cognitive strategies second because, in our experience, many Veterans achieve the greatest amount of success when they first make tangible behavioral changes in their lives, which puts them in a better place to examine and evaluate their thoughts and beliefs using cognitive strategies. Although these strategies primarily occur in the middle phase of treatment, we encourage therapists to use them when relevant in the initial phase of treatment so that patients notice symptom change as immediately as possible.

Many Veterans achieve the greatest amount of success when they first make tangible behavioral changes in their lives, which puts them in a better place to examine and evaluate their thoughts and beliefs using cognitive

Behavioral Strategies

As you have undoubtedly seen in your previous clinical experience, many depressed patients claim that they lack the motivation and energy to engage in activities that were once pleasurable and meaningful to them. Some depressed patients spend most of their time doing things that give them little sense of pleasure or accomplishment. Not only does engaging in few positive activities provide little enjoyment or reward, it also serves to reinforce pessimistic and self-defeating cognitions that contribute to depression. Other depressed patients actually are engaging in activities that give them a sense of pleasure and accomplishment, but they view these activities through a negative lens and focus more on failures than on successes. Behavioral strategies can be used to help patients re-engage in their environment, become more active, and attend to the fact that they are engaging in pleasurable activities, all of which can be associated with a significant improvement in mood.

Behavioral strategies can be used to help patients re-engage in their environment, become more active, and attend to the fact that they are engaging in pleasurable activities, all of which can be associated with a significant improvement in mood.

Activity Monitoring

One of the core components of CBT involves working with the patient, in a structured way, to identify, plan, and carry out pleasant activities and activities that provide her with a sense of mastery or accomplishment. This behavioral component of CBT often begins early in the treatment, particularly with patients with moderate to severe depression, to activate the patient and engage her in treatment. This process involves two related strategies: Activity Monitoring and Activity Scheduling. Activity Monitoring is typically done before Activity Scheduling in order to collect accurate data about the manner in which patients are spending their time. This exercise gives patients and their therapists a baseline assessment of their engagement in pleasurable and meaningful activities. It requires that, in the time between sessions, patients write down the activities in which they engage, no matter how trivial or mundane. In

- **Activity Monitoring**

addition, patients are asked to provide three ratings: (a) the amount of pleasure [p] that they obtain from each activity (0 = no pleasure; 10 = a great deal of pleasure); (b) the amount of mastery/accomplishment [m] that they obtain from each activity (0 = no mastery/accomplishment; 10 = a great deal of mastery/accomplishment); and (c) their overall mood for the day (0 = depressed; 10 = happy). This process is demonstrated in the following dialogue with Kate.

Therapist:	From what you have told me, it sounds like you haven't been enjoying yourself much recently and getting much done. Is that correct?
Kate:	Yes, I would say that's correct.
Therapist:	I'm wondering if we may be able to monitor your activities, say, over the next week to see how you are spending your time. You can also rate how much pleasure and sense of accomplishment you get from the activities in which you engage.
Kate:	Alright. What kind of activities?
Therapist:	Well, right now, I'm interested in how you're spending your time, no matter how that may be. I think this will be helpful information for us.
Kate:	Actually, I never really looked that closely at what I do. How do I do that?
Therapist:	This sheet is called the *Activity Monitoring Form*. It's kind of like a weekly calendar. Right now, it's blank. Throughout the next week, I'd like for you to write down what you do each hour of the day, however big or small it may be.
Kate:	OK. You know, I'm not working or doing much these days. So, do you want me to include things like watching TV, eating, taking naps?
Therapist:	Yes, whatever it is.
Kate:	OK, I can do that.
Therapist:	It would be good if you could also rate how much pleasure or enjoyment you received from the activity on a scale of 0 to 10, with 0 being absolutely no pleasure and 10 being the most pleasure you could imagine.
Kate:	OK.
Therapist:	So what might be an activity you would rate a 0?
Kate: Hmm.	Probably going grocery shopping.
Therapist:	So, you get no enjoyment whatsoever out of going grocery shopping?
Kate:	Well, I kinda like walking down the aisles, mainly in the frozen section because of the ice cream, and reading the magazines. But it's standing in line and unloading groceries that I hate.
Therapist:	So, it sounds like maybe there is some small enjoyment you get from that activity.
Kate:	Yes, I would say more like a 3 or 4.
Therapist:	That's good to know. What do you think would be a 0, then?
Kate:	Going to the Unemployment Office. That would definitely be a 0.
Therapist:	Now, what might be something you would rate a 10?
Kate:	A 10? It's been a long time since I have done anything like that. Let me think for a minute.
Therapist:	Take your time.
Kate:	When I used to go to the park with my kids. That would be a 10.

Therapist: I think you've got down the pleasure rating. There is another rating that I'd like you to make—the mastery rating. The mastery rating refers to the degree of mastery or accomplishment you received from the activity. We'll use a similar 0 to 10 scale for mastery, with 0 being no sense of mastery or accomplishment at all, and 10 being the highest level of mastery or accomplishment you can imagine.

Kate: Like, if I did something that required effort or some achievement I felt proud of?

Therapist: Exactly. It could even be something small, even a household chore.

Kate: OK.

Therapist: What do you think would be a 10?

Kate: Cooking a full course meal. Or, when I was working, I would feel great when I really helped a patient.

Therapist: Those sound like good examples from your life. What do you think would be a 0?

Kate: Umm, lying on the couch in the middle of the day. It seems pretty useless and unproductive.

Therapist: So, lying on the couch provides you with no sense of mastery or accomplishment?

Kate: Yeah.

Therapist: Good, so that would be a good example of a 0. You seem to be getting the pleasure and mastery scales. For each activity, I'm going to ask you to record your pleasure and mastery ratings next to or under the activity. You may use P as an abbreviation for pleasure and M as an abbreviation for mastery. Let's see how we would do this for today, as an example.

Kate: Where should I start?

Therapist: So, today is Tuesday. Let's start with this morning before you came in today. What did you do this morning?

Kate: Well, my alarm clock rang at 7:00 am, but I didn't want to get up, so I stayed in bed for about two hours and watched TV.

Therapist: Go ahead, write stayed in bed and watched TV between 7 and 9. How would you rate your pleasure from that activity?

Kate: I would say that was a 2.

Therapist: It sounds like it wasn't very pleasurable.

Kate: No.

Therapist: OK, then go ahead and write down P = 2.

Kate: OK [writes down "P = 2"]

Therapist: How about mastery?

Kate: Mastery? That was very low; in fact, I would rate that a 0. I was just lying there.

Therapist: So you can go ahead and record M = 0.

Kate: OK, M = 0. Got it. [writes down "M = 0"]

Therapist: What happened after that?

Kate: I ate some cereal. I don't have much in the house today.

Therapist: Was that at 9:00 am?

Kate: Yes, because it was right after the Today Show.

Therapist: Go ahead and write that down.

Kate: OK [writes]. I would say that pleasure was a 3 and mastery was a 2. [writes]

Therapist: Was that right before you came here, then?

Kate: Yes.

Therapist: So, would you like to continue with recording the therapy session?

Kate: OK.

Therapist: How would you rate the session in terms of both pleasure and mastery?

Kate: This has been pretty good. I wasn't sure what to expect today, but I think I would rate my pleasure a 5 and mastery a 4.

Therapist: Let's go ahead and record the numbers.

Kate: Should I finish this for the rest of the day?

Therapist: Yes, it would be helpful to complete this today and continue for the rest of the week until we meet again next week. How does that sound to you?

Kate: I can do that.

Therapist: At the bottom of the column for each day, you can also rate your overall mood for the day, just as you've been keeping track of your mood until now, on the 0 to 10 scale, with 0 being depressed and 10 being happy.

Kate: Just do it on this same form?

Therapist: You got it. Are there any things you can think of that might get in the way of doing this?

Kate: Umm [pause], I might forget to record the activities, or I might forget later what the activity was.

Therapist: Good point. What might help you with this?

Kate: [pause] I guess I could keep this monitoring sheet in my purse and do it right away.

Therapist: Sounds like that could be very helpful. In fact, it is best to record the activity on the chart as soon as possible after it happens. This also will allow you to most accurately rate the degree of pleasure or mastery because you aren't having to think back your experience after the fact.

Kate: I'm not exactly clear on how all of this will be helpful to making me feel better.

Therapist: I'm glad you brought that up. It's important to me that you understand why we do the things we do in here. Knowing how your activities affect your mood—both in a positive and a negative way—will help us come up with some activities that you might enjoy and feel a sense of accomplishment. It's very effective in treating depression. Are you willing to give it a try?

Kate: OK. I'm willing to give it a try.

Therapist: One final thing—shortly before we meet again next week—say in the morning or the evening before, do you think you would be able to review the Activity Monitoring Form and see if you notice any patterns in terms of the activities you engaged in and in the ratings?

Kate: Yeah, I can do that.

Therapist: Terrific. Do you want to summarize what we discussed doing, then, over the course of the week?

Kate: OK. [pause] I'll complete the Activity Monitoring Form for the week and review it for patterns.

Therapist: This is a big assignment because it requires that you write down many things each day. What's the likelihood that you'll do it?

Kate: I'd say 90%. You're right, it seems like a lot of work. But I need to do something to start feeling better.

Therapist: Tell me in your own words why you think this will be a useful assignment.

Kate: I think this will show me how little I'm really doing to take care of myself.

Therapist: [asking a question that will instill hope] And how will that information be important?

Kate: Maybe I can figure out things to do that will make me happier.

Therapist: Yes, Kate, that's exactly it.

When reviewing the pleasure and mastery scales, it can be useful to ask the Veteran for specific examples of activities that she would rate at different points on the scales to assess understanding of the scales and the rating process, as the therapist did with Kate. Also, it is useful to note that when the therapist initially asked Kate for an example of an activity that she would rate a 0 on pleasure, she responded "going to the grocery store." However, when they looked more closely at this activity, she noted that there were things about this activity that she liked and revised her pleasure rating. This is fairly common with depressed patients. Failing to recognize positive aspects of activities or situations is often part of the negative bias of depression, which can lead to inactivity. Finally, as described previously when discussing homework assignments, the therapist assessed the likelihood that Kate would engage in Activity Monitoring and tried to identify and problem solve any barriers to engaging in this activity.

Exhibit 4.1 displays the *Activity Monitoring Form* that Kate completed between her third and fourth CBT sessions. Note that her mood was very low (i.e., ratings of 0 or 1) early in the week, on days in which she did little more than sleep, watch TV in bed, and eat light meals. Although she attempted to get out of the house and go for a walk on Saturday, her mood improved very little. Kate's therapist speculated that sitting on a park bench and watching children play had an adverse effect on her mood because this activity activated negative thoughts and beliefs about the implications of her husband taking her children away. However, Kate's mood improved on Sunday and Monday, when she woke up at a reasonable hour, showered, and left the house for activities such as church, a haircut, and lunch with a friend. On the basis of this exercise, Kate's therapist hypothesized that a lack of engagement in pleasurable and meaningful activities was contributing to Kate's depression and that there was the potential for her mood to improve if she scheduled more of these sorts of activities into her daily routine.

- **Activity Monitoring Form**

Exhibit 4.1. Kate's Activity Monitoring Form

	Wed	Thurs	Fri	Sat	Sun	Mon	Tues
7–8 am	Sleep M = 0 P = 5	Sleep M = 0 P = 5	Sleep M = 0 P = 3	Sleep M = 0 P = 3	Sleep M = 0 P = 2	Sleep M = 0 P = 3	Sleep M = 0 P = 2
8–9 am	↓	↓	Woke up; lay in bed M = 0 P = 0	↓	Showered M = 0 P = 0	↓	↓
9–10 am	↓	↓	↓	↓	Went to church M = 2 P = 5	Showered M = 1 P = 1	Showered M = 1 P = 1
10–11 am	↓	Ate cereal M = 0 P = 0	Ate cereal M = 0 P = 0	Went for a walk M = 2 P = 4	↓	Got hair cut M = 2 P = 3	Therapy appointment
11am–noon	↓	Tried to pay bills M = 0 P = 0	Looked online for jobs M = 1 P = 0	Sat on park bench watching kids play M = 0 P = 0	Went to Mom's house for lunch M = 0 P = 4	↓	
noon–1 pm	Ate cereal M = 0 P = 0	Mom visited M = 0 P = 2	Watched movie on TV M = 0 P = 3	Made lunch M = 0 P = 0	↓	Met friend for lunch M = 2 P = 7	
1–2 pm	Watched TV in bed M = 0 P = 0	↓	↓	Nap M = 0 P = 2	Looked online for jobs M = 2 P = 0	↓	

	Wed	Thurs	Fri	Sat	Sun	Mon	Tues
2–3 pm	↓	Nap M = 0 P = 2	Ate sandwich M = 0 P = 2	↓	Revised resume M = 4 P = 2	Looked online for divorce attorney M = 3 P = 0	
3–4 pm	Nap M = 0 P = 2	↓	Nap M = 0 P = 2	↓	Watched TV in living room M = 1 P = 4	Watched TV in living room M = 1 P = 4	
4–5 pm	↓	↓	↓	↓	↓	↓	
5–6 pm	Called kids M = 1 P = 5	↓	Light Cleaning M = 2 P = 0	Called kids M = 1 P = 3	Called kids M = 2 P = 5	Dozed off on couch M = 0 P = 0	
6–7 pm	Made frozen dinner M= 0 P = 0	Made frozen dinner M= 0 P = 0	Watched TV in living room M = 0 P = 2	Watched TV in bed M = 0 P = 1	Cooked light dinner M = 3 P = 4	Tried to call kids – no luck M = 0 P = 0	
7–8 pm	Showered M = 0 P = 0	Tried to call kids – no luck M = 0 P = 0	↓	↓	Called friend M = 2 P = 6	Cooked light dinner M = 2 P = 2	
8–9 pm	Watched TV in bed M = 0 P = 1	Watched TV in bed M = 0 P = 1	Made frozen dinner M = 0 P = 0	Ate a piece of fruit M = 0 P = 0	Watched TV in bed M = 1 P = 4	Watched TV in bed M = 1 P = 2	

	Wed	Thurs	Fri	Sat	Sun	Mon	Tues
9–10 pm	*Sleep* *M* = 0 *P* = 5	↓	*Sleep* *M* = 0 *P* = 3	*Sleep* *M* = 0 *P* = 2	↓	↓	
10–11 pm	↓	*Sleep* *M* = 0 *P* = 3	↓	↓	*Sleep* *M* = 0 *P* = 3	*Sleep* *M* = 0 *P* = 3	
11 pm–midnight	↓	↓	↓	↓	↓	↓	
midnight–1 am	↓	↓	↓	↓	↓	↓	
1–2 am	↓	↓	↓	↓	↓	↓	
2–3am	↓	↓	↓	↓	↓	↓	
3–4am	↓	↓	↓	↓	↓	↓	
4–5am	↓	↓	↓	↓	↓	↓	
5–6am	↓	↓	↓	↓	↓	↓	
6–7am	↓	↓	↓	↓	↓	↓	
Overall Mood (0-10)	*0*	*0*	*1*	*0*	*4*	*3*	

After patients complete their Activity Monitoring Form, it is important for therapists to review the results at the following session. We encourage therapists to approach this review from a collaborative stance, sitting alongside the patient while reviewing the form and actively asking questions to supplement the information on the form. The goals of reviewing the Activity Monitoring Form are to (a) help patients recognize the link between mood and the activities in which they engaged, and (b) begin to identify activities associated with a sense of pleasure or accomplishment that can be scheduled more frequently in upcoming weeks. Special attention should be given to the identification of specific types of activities associated with increased ratings of pleasure, a sense of mastery, or the patient's mood rating. Observations about the degree to which the patient is engaging in pleasurable and meaningful activities should be linked explicitly to the behavioral model. The information gathered on an Activity Monitoring Form often facilitates subsequent behavioral change because patients are faced with "hard data" indicating that the activities in which they are currently engaging are not particularly helpful for them.

The goals of reviewing the Activity Monitoring Form are to (a) help patients recognize the link between mood and the activities in which they engaged, and (b) begin to identify activities associated with a sense of pleasure or accomplishment that can be scheduled more frequently in upcoming weeks.

CASE EXAMPLE: KATE

Before completing the Activity Monitoring Form, Kate believed that sleeping was helpful for her, claiming that she had always enjoyed sleeping and that it helped to refresh her. However, her ratings suggested that she did not derive as much pleasure from sleeping that she would have predicted, and in fact, she discovered that she derived less and less pleasure from sleep as the week went on. Without the information recorded on the Activity Monitoring Form, Kate might not have altered her view that sleeping improves her mood, rather than maintains her depression.

Activity Scheduling

- **Activity Scheduling**

After patients complete the *Activity Monitoring Form*, they often collaborate with their therapist in the process of *Activity Scheduling*. Once patients have an understanding of the manner in which the activities they engage in relate to their mood, they can work with their therapists to identify activities that gave them a sense of pleasure and/or accomplishment and brainstorm ways to work them into their daily and weekly schedules. Veterans may have difficulty identifying activities that they find enjoyable. It may have been a long time since they have engaged in such activities. If this is the case, it can be helpful to ask patients what they previously enjoyed when they were happier. In addition, it can be useful to provide patients with a checklist of pleasant activities, such as the Pleasant Events Schedule described in the subsequent section, to help patients recognize activities that provide them with pleasure and mastery. After patients have identified themes or activities of interest, their therapist works with them to plan activities that they commit to engage in during the week at specific times.

Once patients have an understanding of the manner in which the activities they engage in relate to their mood, they can work with their therapists to identify activities that gave them a sense of pleasure and/or accomplishment.

It is important to be as specific as possible when planning activities. It is also recommended that therapists begin with activities that can be easily achieved, especially with severely depressed patients, in order to increase the likelihood that they will actually engage in the activities. In addition, achievable activities can make a substantial impact on depressed patients and on their level of confidence in

treatment. As they implement the activity schedule, they continue to monitor their activities and mood. Within a short time, patients can typically see, through their own empirical data, a close relation between the nature and frequency of activities they engage in and their mood. Patients can recognize this relation through the process of indirect questioning, known as *Socratic questioning*. Socratic questioning is a key skill used by cognitive behavioral therapists that can be employed in the implementation of all of the strategies described in this manual. The purpose of Socratic questioning is to help patients make important realizations on their own. When patients make discoveries or realizations on their own, they are much more likely to remember them and this discovery will have greater impact than when information is told or suggested to them. Socratic questioning is discussed further in relation to cognitive strategies in CBT on page 109. The following dialogue demonstrates the process of Activity Scheduling with Kate.

- **Socratic questioning**

When patients make discoveries or realizations on their own, they are much more likely to remember them and have greater impact than when information is told or suggested to them.

Therapist:	So, Kate, were you able to complete the Activity Monitoring Form we discussed last week?
Kate:	Yes, I think I pretty much got it all. I kept a note by my bed to remind me to do it. I also kept it with me when I went out.
Therapist:	That's good, Kate. Did you have a chance to look it over before session today?
Kate:	Yes, I looked over it yesterday.
Therapist:	Did anything stand out for you, or did you notice any patterns?
Kate:	Actually, I did notice that I spend a lot of time on the couch watching TV.
Therapist:	How much pleasure and sense of mastery did that provide?
Kate:	I rated it quite low, usually 2 to 3 for pleasure and 0 for mastery.
Therapist:	That's good information. This is a fairly common activity of depressed individuals that is usually rated quite low and often contributes to their depression. Did you notice anything else?
Kate:	[looking at form] Yeah, I don't go out much. Although, on Wednesday I went to the grocery store and on Friday I went to the Women's Clinic at the VA.
Therapist:	How did you find those activities?
Kate:	The grocery store I rated as a 4 on pleasure and 4 on mastery. It was actually my highest rated activity for both pleasure and mastery that day. For the visit to the Women's Clinic, I rated a 6 on pleasure and 5 on mastery.
Therapist:	It sounds like these were fairly positive activities. Tell me more about them.
Kate:	At the grocery store, it kinda felt good to be out of the house. I also kinda like looking at the different foods and magazines. I got a lot of stuff I had been putting off for weeks, so it felt good to get that done.
Therapist:	How about the visit to the clinic?
Kate:	Well, I saw Wendy, a friend of mine who goes to the same clinic. I haven't seen her in a while. We're about the same age.
Therapist:	How was it talking to her?
Kate.	It was pretty good. She said she has had some health stuff going on. it was nice to focus on someone else's problems, rather than my own.

Therapist: Any other observations about the week?

Kate: I noticed that my mood ratings were better on Wednesday and Friday, but I'm still feeling pretty depressed most of the week.

Therapist: Do you mind if I take a look at the form with you? You've done a really nice job with Activity Monitoring, Kate. I noticed, just like you did, that on most days, you do activities that don't provide you with a lot of pleasure or sense of accomplishment. This doesn't seem to help you to feel well. And, in fact, over time the lack of activities may make you feel worse.

Kate: Yeah, I feel just "blah" when I'm always on the couch. Then, later, I feel worse because I didn't do anything I wanted to do. I usually then just bum around because I have little energy to do anything else.

Therapist: Sounds like you get caught in a pretty vicious cycle.

Kate: Yeah, that's how I feel.

Therapist: What I also have learned from your Activity Monitoring Form is that when you went out, your sense of pleasure and mastery, and your mood, increased. You feel somewhat better when you break this cycle.

Kate: Yeah, but I can't seem to do anything consistently.

Therapist: We'll get there, but now we are recognizing some important patterns. As I mentioned last week, we are going to start working on increasing the number of activities you engage in that provide you with pleasure and a sense of accomplishment.

Kate: How are we gonna do that?

Therapist: Well, first, it's important to identify activities that you enjoy. What are some activities that you like doing?

Kate: I don't know.

Therapist: What about from this past week?

Kate: Umm, well, I kind of liked talking with Wendy.

Therapist: Yeah, and in fact, from what you've said previously and today, it seems like you enjoy socializing with others even though you can be shy. Would you say that's accurate?

Kate: I guess so. But I don't do much of that anymore.

Therapist: Are there other activities, either with other people or on your own, that you enjoy doing or enjoyed doing in the past?

Kate: Umm, nothing specific really comes to mind.

Therapist: I know this can be difficult, especially when it's been awhile since you've engaged in these activities. I have an idea of an exercise that may help. It involves closing your eyes and thinking back to a time when you were happy. Would you be willing to try this?

Kate: OK.

Therapist: Go ahead and take a couple of deep breaths. Now close your eyes. Now think back to a time when you can see yourself feeling happy and doing things that you enjoyed…

Kate: I can't think of anything.

Therapist: It's OK. It doesn't always come right away. Just relax and try to focus on a time in your life when you were particularly happy. What do you see?

Kate: Umm. Actually, I used to like gardening. It's been a long time since I did that. I used to grow these really large zucchinis, which I would use to make zucchini bread.

Therapist: You mentioned previously that you used to enjoy cooking. Is there anything else, whether recent or a long time ago, that you enjoyed doing?

Kate: I used to really like going to the park with my kids.

Therapist: Those were very happy times for you.

Kate: Yeah. [tearing up]

Therapist: What did you do at the park?

Kate: Play Frisbee, have a picnic, and just be with my kids. I felt more connected to the outdoors and my life.

Therapist: How did that feel?

Kate: Much better than my life now.

Therapist: OK, feel free to open your eyes. It sounds like these activities brought you great joy and a sense of meaning.

Kate: Yes.

Therapist: It also sounds like relationships were very important to you.

Kate: Yeah, I kinda lost that in my life.

Therapist: Well, you and I can work on rebuilding that together, if you would like.

Kate: OK.

Therapist: Thank you for engaging in that exercise with me. I think some important work we can do together that can make a big difference in your life and help you feel better is to work on increasing pleasant activities in your life. As we identify activities you enjoy and that are associated with a sense of accomplishment, we're going to schedule some of these activities to create what we call an activity schedule using this Activity Schedule Form. [gives Kate the form]

Kate: It looks like the Activity Monitoring Form I completed this past week.

Therapist: Yes, it looks very similar. But we'll use this form to schedule pleasurable and meaningful activities over the course of the next week. I'm wondering if we can maybe start today with scheduling two pleasant activities for this next week. How does that seem to you?

Kate: OK. How?

Therapist: Well, let's think of a couple of pleasant activities. You mentioned earlier that you saw your friend Wendy this past week. And you liked talking with her?

Kate: Yeah, I did.

Therapist: Would you have any interest in calling her to continue the conversation over coffee or something?

Kate: Yeah, I could do that.

Therapist: When do you think would be a good time to do that?

Kate: Maybe on Sunday. She's most likely to be home. If I plan to do it at noon, it may get me out of bed before my normal 3:00 pm on Sunday.

Therapist: Scheduling activities can help get you going. Is there anything else you would like to schedule, perhaps something pretty straightforward?

Kate: Umm, let me think… Well, you asked me to complete this checklist of pleasant activities. Maybe I could go sit in the park and do this. Would that count?

Therapist: Nice idea. Do you have any thoughts on when you might do this?

Kate: Well, I could do this on Tuesday at 2:00, to spread things out a bit.

Therapist: Tuesday at 2:00 pm, it is.

Kate: Should I write it down on the Activity Schedule Form?

Therapist: Yes. So, Sunday you are going to call Wendy and on Tuesday you are going to go to the park?

Kate: Yes, that's it.

Therapist: Are there any things that you think might get in the way of you doing these things?

Kate: The only thing I can think of is if it rains on Tuesday, I won't want to go to the park.

Therapist: Maybe we can think of a contingency plan if that happens.

Kate: OK. Maybe I could go to the coffee shop. I used to do homework there when I was in nursing school.

Therapist: So, coffee shop is the contingency plan. Kate, do you have any questions?

Kate: Uh, no, I don't think so.

Therapist: Do you think you could also continue monitoring your activities each day over the next week, as you did the last week?

Kate: You mean using the Activity Monitoring Form you gave me?

Therapist: Yes. Here are a few more copies if you in need them.

Kate: Yes, I can do that. Would I include these activities on there when I do them?

Therapist: Yes.

Kate: OK.

Therapist: To recap on our work today, we started by reviewing your Activity Monitoring Form from the past week and learned that you're engaging in few pleasant or meaningful activities, and that a good amount of your time is spent in bed or lying around the house. We then talked about Activity Scheduling and identified activities you enjoy even if it's been a while since you've engaged in these activities. You identified a couple of activities you used to enjoy and we went ahead and scheduled some over the next week. Does that sound right?

Kate: Yeah, you got it.

Therapist: How do you feel about how this exercise went?

Kate: This makes sense. I'm beginning to understand how things I do, or don't do, impact how I'm feeling. I've never talked about this kinda stuff before or made a plan from week to week.

Therapist: Is there anything you did not like about this exercise?

Kate: Umm, I was unsure at first about closing my eyes, but when you explained to me what we'd be doing, that helped. That exercise helped me connect with the side of me who used to enjoy more pleasant activities, um, that's gotten lost.

Therapist: I think this process will help you get that side back, Kate.

In the preceding dialogue, the therapist and Kate began the session by reviewing Kate's Activity Monitoring Form from the previous week. In reviewing the form, the therapist used Socratic questioning to help Kate recognize her baseline activity functioning (or lack thereof) and make connections between her behaviors and mood. Guiding patients to make discoveries on their own (often referred to as *guided discovery*) is usually much more effective than directly lecturing patients.

- **Guided discovery**

In this example, Kate made two key discoveries: (a) she spends a great deal of time in bed or on the couch, which provides her with little pleasure or sense of mastery; and (b) when she goes out of the house, she tends to feel better. After reviewing Kate's Activity Monitoring Form, she and her therapist began the process of Activity Scheduling by identifying a few activities that provided Kate with pleasure and a sense of accomplishment. Kate initially had some difficulty identifying such activities, so the therapist used an imagery exercise in which she asked Kate to imagine a time in her past when she was happy and activities she enjoyed. This helped Kate to identify pleasurable activities as well as connect with a side of herself she had not seen in some time and to recognize that there are things she can do to feel happier.

When introducing the *Activity Schedule Form*, it can be helpful to begin completing a few of the items in session to get the process started and pique interest in the patient, which seemed to occur with Kate. The exercise concluded by scheduling a couple of very simple pleasant activities Kate could engage in for homework.

- **Activity Schedule Form**

Exhibit 4.2 displays an excerpt from the *Activity Schedule Form* that Kate and her therapist created during a subsequent session, with the intention that it would help Kate increase the frequency of pleasurable and meaningful activities in which she engaged. On the basis of the *Activity Monitoring Form* she completed during previous weeks, Kate realized that her mood improves when she has interactions with others, such as with her best friend. Thus, she took care to include these interactions in the activity schedule for the following week. In addition, she noticed that her mood was quite low on days she took naps and watched television, particularly those days in which she watched television in bed. Kate's therapist helped her to brainstorm inexpensive activities Kate had previously enjoyed, such as going on walks, reading, and watching particularly pleasurable television shows (versus those she watched to numb her mind).

Exhibit 4.2. Excerpt from Kate's Activity Schedule Form

	Tues	Wed	Thurs
7–8 am		*Get up and have breakfast*	*Get up and have breakfast*
8–9 am		*Shower*	*Shower*
9–10 am		*Request transcripts*	*Contact references*
10–11 am	*Therapy appointment*	*Go for a walk*	*Go for a walk*
11am–noon	*Grocery shopping*	*Sort through mail*	*Pay bills*
noon–1 pm	*Lunch*	*Have lunch with friend*	*Lunch*
1–2 pm	*Pay bills*	*Window shopping*	*Read*
2–3 pm	*Work on finances*	*Get car washed*	*Read*
3–4 pm	*Go for a walk*	*Come back home & read*	*Write a letter to Grandma*
4–5 pm	*Submit online application*	*Read*	*Look for more jobs online*
5–6 pm	*Call Mom*	*Call Mom*	*Call kids*
6–7 pm	*Cook and eat dinner*	*Cook and eat dinner*	*Meet Mom for dinner*
7–8 pm	*Call kids*	*Call kids*	*Dinner with Mom*
8–9 pm	*Watch favorite show on TV*	*Watch movie*	*Watch TV*

Pleasant Events Schedule

- **Pleasant Events Schedule (PES)**

In some instances, depressed patients have difficulty identifying pleasurable and/or meaningful activities, even when they are prompted to identify the activities they had enjoyed doing in the past. As stated previously, depressed patients sometimes have difficulty remembering details from their past (Williams et al., 2006), and this can interfere with the ability to remember the activities they pursued during happier times in their lives. In these cases, it can be helpful to provide a menu of choices for patients to consider, such as MacPhillamy and Lewinsohn's (1982) *Pleasant Events Schedule* (PES). The PES has been slightly revised for Veterans. To complete the PES, patients are instructed to rate how often each event happened in the past month. Thus, each item is rated on the Frequency Scale (Column F):

0: Event has not happened in the past 30 days
1: Event happened a few times (1 to 6) in the past 30 days
2: Event happened often (7 times or more) in the past 30 days

Next, the patient rates how pleasant, enjoyable, or rewarding each event was during the past month. To do this, each item is rated on the Pleasantness Scale (Column P):

0: This was not pleasant—use this rating for those events that were either neutral or unpleasant.
1: This was somewhat pleasant—use this rating for events that were mildly or moderately pleasant.

2: This was very pleasant—use this rating for events that were strongly or extremely pleasant.

There are three PES scores: Mean Frequency Score, Mean Pleasantness Score, and Mean Cross-Product Score. To compute the Mean Frequency Score, add the frequency ratings in Column F and divide by the total number of items (i.e., 320). To compute the Mean Pleasantness Score, add the pleasantness ratings in Column P and divide by the total number of items (i.e., 320). To compute the Cross-Product Score, multiple the score in Column F by the score in Column P and enter the score in Column F x P. Then add the F x P scores of all items, and divide this total by the number of items.

There are three distinct patterns that may be observed when using the PES:

Pattern 1: Low frequency/low pleasantness: The patient is not engaging in many of the activities on the list and is not enjoying the activities in which she is engaging.

Pattern 2: Low frequency/average or above-average pleasantness: The patient is not engaging in the kinds of activities that have the potential to be enjoyable for her.

Pattern 3: Average or above-average frequency/low pleasantness: The patient is engaging in activities but is not deriving much enjoyment from them.

Recognition of these patterns helps to determine whether a behavioral intervention would help the patient increase the number of pleasurable activities in which he engages or would help the patient change the types of activities in which he engages in order to increase the amount of pleasure derived from them. MacPhillamy and Lewinsohn (1982) provide additional information on the administration, scoring, and interpretation of the Pleasant Events Schedule.

Consider the following dialogue that Kate's therapist had with her when she had difficulty identifying pleasurable activities:

Therapist:	Do you think you could try to identify activities that you find enjoyable or meaningful for homework over the next week?
Kate:	I guess so, but I'm not sure if I'll be able to come up with anything.
Therapist:	Well, I have a checklist of activities that may help you. Would you be willing to learn more about it?
Kate:	OK.
Therapist:	[gives Kate a Pleasant Events Schedule] This form includes a long list of activities that some people find enjoyable. Not everybody finds all of these enjoyable, but usually people can find several that resonate with them. This list includes activities both small and large. Next to each activity, it asks to indicate how frequently you engage in the activity: 2 if it happens often (about 7 times or more in the past 30 days); 1 if it has happened a few times in the past 30 days; and 0 if the activity has not happened at all in the past 30 days. You can record your frequency rating under the column labeled "F".
Kate:	OK.

Therapist: It also asks you to rate how pleasant or enjoyable you found the activity or would find the activity: 2 if very pleasant; 1 if somewhat pleasant; and 0 if not at all pleasant. You can record your pleasure rating under the column labeled "P." If an event has not happened to you during the past month, then rate it according to how much fun you think it would have been. Does this sound like something you would be willing to do as homework over the next week?

Kate: Yeah.

Therapist: Would you like to record it in your homework sheet?

Kate: OK. [writes it down]

Therapist: How about we do the first few together?

Kate: Alright.

Therapist: The first item is "Being in the country." How frequently have you been in the country in the past 30 days, using the ratings we went over at the top?

Kate: I haven't been in the country for some time, so not at all.

Therapist: What would we write down in the Frequency column?

Kate: 0?

Therapist: Yes. Now, how pleasant or enjoyable do you think you would you find that activity?

Kate: I used to love the country; that's where I grew up. I would say 2, very pleasant.

Therapist: Good. So, let's go ahead and write that down in the Pleasure column. [Kate writes down 2] The next activity is "Wearing expensive or formal clothes." What would be your frequency rating for that?

Kate: I haven't dressed up in the last month, so I would say 0.

Therapist: OK. How pleasant would this be for you?

Kate: I hadn't really thought about this. But in doing so, I would say somewhat pleasant. When I get dressed up, it's kinda nice, though I rarely do it. Right now, I just lay around the house in sweats and a sweatshirt.

Therapist: OK. How about one more? "Making contributions to religious, charitable, or other groups"?

Kate: I didn't do this at all.

Therapist: If you were to do it, how pleasant would it be?

Kate: In theory, a 2, but right now I can't imagine doing it. It would be way too overwhelming for me. I just really need to take care of myself right now.

Therapist: So does that mean that you'd rate it a 0 right now?

Kate: Yes, I probably would. It would just stress me out.

Therapist: Good, you seem to get the gist of this. Do you have any questions?

Kate: No, I don't think so. I think I can do it over the week.

Alternative Activity Scheduling Strategies

At times, patients find it aversive to schedule every hour of their day with pleasurable activities or activities that will give them a sense of accomplishment. For these patients, there are viable alternatives that achieve the same aim.

CASE EXAMPLE: CLAIRE

Claire was hesitant to schedule pleasurable activities into concrete time slots, indicating that she wanted to reward herself with these activities after she accomplished a set amount of studying and practice exercises. She was unable to estimate the precise number of hours she would devote to studying each day, claiming that it varied as a function of the particular module on which she was focusing that day. Thus, her therapist suggested an alternative approach to Activity Scheduling, such that they would create a list of activities that Claire finds pleasurable. To do this, Claire and her therapist reviewed each item of the Pleasant Events Schedule, and Claire rated whether she thought the event would be not at all pleasurable, somewhat pleasurable, or definitely pleasurable. Then, Claire and the therapist discussed which of the pleasurable items could be worked into the activity schedule. To do this, Claire made a list of the pleasurable events and made a check mark whenever she participated in one of these activities in the days between her therapy sessions.

Exhibit 4.3 is an example of Claire's modified activity schedule, which she had completed and brought back to her third CBT session.

Exhibit 4.3 Claire's Modified Activity Schedule

	Days						
Pleasurable Activities	Wed	Thurs	Fri	Sat	Sun	Mon	Tues
1. *Call Thomas*	✓			✓		✓	
2. *Visit with Thomas in person*	✓			✓			
3. *Read a book for pleasure*		✓	✓		✓	✓	
4. *Watch a movie*						✓	
5. *Listen to music*	✓	✓		✓	✓	✓	✓
6. *Sew curtains for apartment*			✓				✓
TOTAL # EVENTS	*3*	*2*	*2*	*3*	*2*	*4*	*2*
OVERALL MOOD (0–10)	*6*	*4*	*3*	*5*	*4*	*7*	*3*

There are many instances in which Activity Scheduling does not go as smoothly as it did with Kate and Claire. Some patients have negative beliefs about their ability to attain a sense of pleasure or accomplishment from daily activities; others have inaccurate predictions about the degree to which Activity Scheduling will improve their mood. These are instances in which therapists can use some of the cognitive strategies described in the next section ("Cognitive Strategies," pp. 101–139) to enhance patients' commitment and motivation to implement behavioral strategies.

Consider this dialogue between Michael and his therapist, in which he expressed the belief that he could no longer pursue activities that used to give him a sense of pleasure and accomplishment because of his brain injury. This conversation occurred in Michael's third CBT session after he half-heartedly completed an Activity Monitoring Form.

Therapist: [examining Activity Monitoring Form with Michael] What does the information on this form tell you, Michael?

Michael: I don't know.

Therapist: [trying a different approach] In general, does it look like you are doing things that help you to feel better, or instead, does it look like you are doing things that contribute to your depression?

Michael: [exasperated] There's nothing else I *can* do.

Therapist: What do you mean by that?

Michael: Everything is lost. Everything I used to do to make me who I am is gone. And it's never coming back.

Therapist: [gently] So, you're saying that all of the activities that used to give you a sense of pleasure or accomplishment are no longer available to you?

Michael: Pretty much. Look at me. I'm not finishing school. I can't work in the law firm. Everything that I spent my whole life working toward…it's gone.

Therapist: I understand that going to school, working in the law firm, and doing other things that gave you a sense of accomplishment are not options available to you at the moment. In fact, my hope is that down the line, we'll be able to examine how you define accomplishment and see if there are other ways for you to attain a sense of accomplishment and mastery. But for now, it might be useful for us to figure out some activities that might give you a sense of pleasure, with the hope that it will improve your mood a bit so that we can work on these larger issues. Does that make sense to you?

Michael: [dejected] I guess so.

Therapist: What sorts of things did you do for fun in the past…that you did for the sheer enjoyment of them, regardless of whether they helped you with your schoolwork or get into law school?

Michael: Nothing, really. School and work were my life.

Therapist: [recognizing an all-or-nothing thinking pattern] So, is what you're saying that other than eating and sleeping, that you spent *all* of your time with schoolwork or working at the law firm?

Michael: [irritable] Well, of course not. I had a girlfriend, you know.

Therapist: [brightens] Yes, your girlfriend! And I recall you telling me that your relationship is very strong, despite the fact that there's been some tension lately. What kinds of things did you and your girlfriend enjoy doing?

Michael: We went out to eat a lot, I guess. And we're both pretty athletic, so we'd do things like playing tennis, going for runs, even shooting baskets.

Therapist: Is there anything that would get in the way of you going out to eat, exercising, or shooting baskets with your girlfriend?

Michael: No, I guess not.

Therapist: If you were to choose a couple of these to do in the next week, which ones would you select?
Michael: Going out to eat, I guess.
Therapist: Great. Where would you like to go?
Michael: My girlfriend's been wanting to go to a Mexican restaurant that we used to go to all the time before I left.
Therapist: That sounds reasonable. When might you go?
Michael: I guess I can suggest to her that we go tonight or tomorrow.
Therapist: OK. And what about another activity to do between now and the next time I see you?
Michael: I don't know if I'm up for exercising. My coordination's still a little off.
Therapist: Fair enough. Is there something the two of you used to do together that isn't quite as athletic?
Michael: We can probably go for a walk in a park that's not too far away. She just likes to get out of the house and stay active.
Therapist: And when would you do that?
Michael: She's usually over during the day when she doesn't have to work. I think her next day off is Friday.
Therapist: So, eating at the Mexican restaurant tonight or tomorrow night, and going for a walk during the day on Friday?
Michael: Yeah. OK.
Therapist: Earlier, you expressed the belief that there are no activities that you can do that will give you a sense of pleasure. After this conversation, do you still believe this?
Michael: Kind of. But I guess that there are some little things that I can do.
Therapist: In my experience, Michael, life is rarely all or nothing, 100% or 0%. I realize that you and I have some work to do to help you redefine your sense of identity and direction in life. But all is not 100% lost. We just need to continue working to find those parts of you that are not lost and make sure they're working *for* you, not *against* you.
Michael: Yeah, I see what you mean.

In this excerpt, Michael's therapist accomplished two important clinical goals. First, she helped Michael schedule two activities that were once pleasurable to him. Although this was not as elaborate as Kate's daily Activity Schedule Form or Claire's list of activities from which she could choose on a daily basis, it achieved the same aim—to help Michael to attain a sense of pleasure from his life. It is important to keep in mind the spirit of the exercises that are described in this manual and to modify them accordingly so they are tolerable to patients but can still achieve cognitive and behavioral change. Second, after working with Michael to schedule two pleasurable activities, his therapist revisited the belief that Michael had articulated earlier—there were no longer any activities that would bring him a sense of pleasure or accomplishment. The therapist took care to reassess Michael's belief in that idea after the Activity Scheduling exercise, with the hope that it would model an approach for evaluating rigid thoughts and beliefs that prevent him from doing things that would help him overcome his depression.

As we have stated previously in this manual, it is important to assess patients' commitment and motivation to follow through with Activity Scheduling, identify obstacles that might interfere with engagement in the activities, and problem-solve ways to overcome those obstacles. A common obstacle that many depressed patients identify is that they "might not feel like doing anything" on the day an activity is scheduled due to fatigue and lack of motivation. One strategy for overcoming this obstacle is for patients to write a list of benefits of engaging in scheduled activities. Then, they keep the card nearby and consult it in times that they consider not engaging in the activities they had scheduled.

It is important to assess patients' commitment and motivation to follow through with Activity Scheduling, identify obstacles that might interfere with engagement in the activities, and problem-solve ways to overcome those obstacles.

Behavioral Activation

Behavioral activation is an approach to treating depression that is based on Lewinsohn's behavioral model of depression (Lewinsohn et al., 1980). However, even the experts have differing opinions about exactly what it involves. Some therapists, such as Wright et al. (2006), regard behavioral activation as a single procedure in which the therapist encourages patients to identify and implement one or two specific actions that can make a difference in how they feel. Other therapists regard behavioral activation as an entire treatment in and of itself that incorporates the strategies described in this section, such as Activity Monitoring, Activity Scheduling, and graded task assignment (Addis & Martell, 2004). In this manual, we refer to behavioral activation as a single procedure.

- **Behavioral activation**

When behavioral activation is regarded as a single procedure, its goal is to produce change in the immediate future, which can build momentum in treatment and instill hope. It is often helpful to implement behavioral activation early in treatment so patients can be socialized into the process of completing homework assignments and so they can achieve some change as soon as possible. We recommend that this strategy be used both in the initial phase of treatment to facilitate tangible behavioral changes and at later times when patients may be behaviorally "stuck." Additional specific tips for implementing a successful behavioral activation intervention are offered by Wright et al. (2006, pp. 124–127).

It is often helpful to implement behavioral activation early in treatment so patients can be socialized into the process of completing homework assignments and so they can achieve some change as soon as possible.

It is easy to confuse behavioral activation with Activity Scheduling, as the goal of both is to provide a forum for patients to commit to engaging in pleasurable and meaningful activities. Behavioral activation is often simpler and more easily implemented than the other behavioral strategies described in this section. Similar to Wright et al. (2006), we do not recommend suggesting activities or behaviors that are too challenging in order to increase the likelihood that the patient has success. For example, a patient who implements behavioral activation might commit to walking the dog once in between sessions. In contrast, a patient who uses Activity Scheduling might determine precise times of the day to walk the dog on several occasions throughout the time in between sessions. Activities done in the spirit of behavioral activation are usually simple, straightforward, able to be implemented whenever the patient is able to do so, and immediately reinforcing. Other examples include cooking a favorite meal, arranging an album of cherished photos, or going out to a movie.

However, what is ultimately chosen for behavioral activation depends on the patient's perception of what would be enjoyable, simple, and easy to implement.

CASE EXAMPLE: JACK

Jack was unwilling to complete an Activity Monitoring Form, stating that he "hates to write things down." Because she suspected that Jack would benefit from an increase in the frequency with which he engages in pleasurable activities, Jack's therapist presented him with the behavioral theory of depression and asked whether he viewed himself as being caught in the vicious cycle of depression. Jack agreed that he was bored most of the time, spending most of the day watching television. On the one hand, Jack expressed a reluctance to schedule activities at certain times of the day, stating that he did not want to be controlled and that he wanted to come and go as he pleased. On the other hand, he indicated that he is tired of television and that it might do him some good to participate in a more engaging and meaningful activity. By the end of the discussion, Jack decided to work on a project that he had tabled a few months ago—building a computer from scratch. Playing "devil's advocate," Jack's therapist wondered whether such an undertaking might be a bit much, given the severity of depression. Jack assured her that he truly enjoys working with electronics and that he cares more about having fun with the process than having to finish the task within a certain time period. In other words, he viewed this as a simple, straightforward activity that was already set up for him in his garage and that would provide a great deal of pleasure. Thus, Jack's behavioral activation exercise was to work on his homemade computer at one time of his choice in between sessions and to notice its effect on his mood.

Graded Task Assignment

- **Graded task assignment**

Graded task assignment is a technique for simplifying behavioral tasks into smaller parts, or what one of us (BK) often refers to in therapy as "baby steps." It is often used in conjunction with the activity schedule, such that various tasks associated with a larger goal can be scheduled throughout the week. Graded task assignment is particularly helpful when patients are faced with complicated tasks, tasks that have multiple or sequential parts, or tasks that have looming deadlines and important implications for patients' lives. For example, in Part II, you saw that Kate agreed to apply for a job as part of her homework assignment. Her therapist encouraged her to identify the necessary steps to apply for a job. Kate identified three components: (a) completing an online application, (b) requesting her transcripts from nursing school, and (c) notifying references that they may be contacted by the potential employer. In the previous section on Activity Scheduling, you saw that Kate included each of these components in her activity schedule (Exhibit 4.2, page 91).

A common obstacle preventing graded task assignment from being successful is the presence of negative thoughts or problematic styles of information processing that interfere with the identification and/or execution of one or more steps that are necessary for completing the task. In particular, patients with an all-or-nothing thinking style often dismiss the progress they are making toward completing a task and, instead, view partial progress as a failure. We encourage therapists to be alert to cognitions that interfere with graded task assignment and use cognitive strategies as necessary to address them.

Graded task assignment is particularly helpful when patients are faced with complicated tasks, tasks that have multiple or sequential parts, or tasks that have looming deadlines and important implications for patients' lives.

Relaxation Training and Controlled Breathing

- **Relaxation training and controlled breathing**

In addition to the other behavioral strategies used in CBT, therapists may also implement relaxation training and controlled breathing. Relaxation and breathing strategies may be especially useful for patients who present with agitated depression, anger and impulsivity, and/or anxiety. These strategies work via several mechanisms of action. First, they decrease the physiological arousal that accompanies agitation, anger, and anxiety. Second, they serve as a coping strategy to help patients with these clinical presentations tolerate their distress, rather than immediately engaging in reactive behavior that has the potential to be self-defeating. Third, they provide evidence to patients that they *can* indeed tolerate distress, which can counteract negative perceptions of their ability to cope.

Below is a script that therapists can use with their patients. It includes the rationale for using relaxation techniques followed by specific instructions on how to get started.

One of the things that is often seen together with depression is tension. It is possible that tension contributes to people getting depressed. It is also possible that when people start to get depressed, they become more tense. In either case, the tension adds to the burden of being depressed.

Tension usually involves both a subjective feeling of being tense as well as actual muscular tension. When the muscles are tense, they are using up energy. This can lead to feeling very tired at the end of the day. In addition, continual muscular tension can produce physical problems, such as pain, headaches, neck aches, and so on. And, tension in general can cause other problems, such as problems with the digestion, ulcers, and so on.

By learning to relax, you can stop wasting your energy in useless muscle tension, and this energy can then be used to deal with everyday tasks. Many people who go in for treatment of depression find relaxation training very helpful. I will teach you this technique now and practice it in future classes so that you can use it preventively.

- **Progressive muscle relaxation**

Sit in your chair, with feet flat on the floor, and your body in a comfortable position. We are going to practice a technique called progressive muscle relaxation. This technique involves tensing and relaxing most of the muscle groups in your body.

First, see how I tense and relax my left hand. Now you try doing it. Place your hand on your lap, make a fist with it, and tighten up the fist as hard as you can without causing discomfort or pain. Then, hold the tension, hold it, feel what it is like to be tense, and then relax the hand all at once. Pay attention to what it is like to relax. What you want to learn is what it is like to be tense and what it is like to be relaxed, so that later you can just remind yourself to relax and you will be able to do so instantly.

Now, I want you to close your eyes so that you can reduce the distractions around you and pay attention only to my instructions for relaxing. You should know that this is not hypnosis. You will be in total control of how much you relax. The purpose of teaching you this is to allow you to develop greater control over yourself, your actions, your

thoughts, and your mood. Deep muscle relaxation is a skill that you learn. The more you practice it, the better and faster you will be at relaxing.

It is also helpful to use your breathing to help you relax more deeply, by combining your breathing with the tension-relaxation exercises. First, allow your breathing to become slow and easy, very smooth, very rhythmic. [pause] Pay attention to how that feels. <Pause> Allow yourself to imagine that each time you exhale you go deeper and deeper into a state of complete relaxation. Let your breath take you down farther and farther into a very calm, very relaxed state. Some people like to imagine that each time they breathe out, they are going one more step down a long stairway, and the lower they go, the more relaxed they get. Let your breath relax you as much as you can, and then we will add the tension-relaxation exercise. [pause] OK, now, let's begin with your right hand.

Therapists can apply this procedure to all of the major muscle groups, such as the hands, arms, shoulders, upper back, neck, forehead, jaw, feet, and legs. They continually remind patients to use their breathing between muscle groups. It is sometimes helpful to have them breathe in when they tense up, and breathe out when they relax. At times, patients wonder why their therapist is asking them to tense up if the purpose of the exercise is relaxation. In such instances, therapists can explain that tensing allows people to see clearly the contrasting effect of relaxation when they let go, and that it is more difficult to identify what it feels like to be relaxed without that contrast.

It is important to emphasize to patients that these strategies will not work optimally if used on only one or a few occasions. Much like riding a bicycle, relaxation and breathing strategies are skills that are acquired over time. If patients attempt to use them only in times of distress, then these strategies will probably be of only limited effectiveness because they have not been practiced. Relaxation and breathing strategies often work best when patients first practice them on a regular basis when they are not in distress so that the procedures are readily available in the future when they are in distress.

In addition, it can be useful to incorporate imagery exercises with meditative breathing techniques. In these exercises, therapists verbally present a picture of a calming environment after the patient closes her eyes and begins to block out thoughts and distractions and begins rhythmic breathing. Providing a specific focus on colors, textures, and temperatures can help patients connect with the scenes. It can be helpful to offer options of different scenes (e.g., beach, tropical island, mountainside) to patients before commencing with the exercise to maximize the likelihood that they will be able to visualize the scene and find it to be particularly calming. It is worth noting that therapists should take some caution before engaging in imagery exercises with Veterans with PTSD or military sexual trauma, as certain images or visual cues may trigger trauma-related memories or symptoms.

Cognitive Strategies

- **Cognitive restructuring**

Cognitive strategies help patients to (a) identify unhelpful thoughts, beliefs, and images; (b) distance themselves from unhelpful cognitions before they act upon them; (c) evaluate the veracity of those cognitions; and (d) if necessary, develop alternative cognitions that more realistically characterize the situation at hand. This process is called *cognitive restructuring*. At first, patients evaluate these cognitions retrospectively in the therapist's office and in homework assignments. However, the ultimate goal of implementing cognitive strategies is for patients to be able to engage in the cognitive restructuring process in the moment, as they are faced with situations that elicit strong affect. Through this process, patients learn how to be their own therapist by applying the skills they learn to situations that arise in their daily lives. Teaching patients to become their own therapists is an important goal of CBT and greatly helps to extend treatment gains and prevent relapses following the termination of regular treatment sessions.

The ultimate goal of implementing cognitive strategies is for patients to be able to engage in the cognitive restructuring process in the moment, as they are faced with situations that elicit strong affect.

We introduce cognitive strategies after behavioral strategies in this manual because, in our experience, we have found that many Veterans respond best to behavioral strategies at the beginning of treatment, and as they experience an improvement in mood, they are in a better place to acquire cognitive strategies. However, there is no firm rule saying therapists must implement behavioral strategies first. As was seen in Part III, in many instances it is difficult to completely avoid the use of cognitive strategies, as many patients have negative thoughts and beliefs that prevent them from implementing the behavioral strategies, or more generally, from fully engaging in treatment. Furthermore, some patients clearly indicate that they are struggling with negative thinking and that they believe it contributes to their mood disturbance. Such patients already grasp the link between thoughts, emotions, and behaviors and are ready to acquire cognitive mood management strategies.

Before implementing specific cognitive strategies, it is important to educate patients about the cognitive piece of the CBT model. The goal is for patients to understand that thoughts and beliefs can often have a significant influence on emotions, behaviors, and physiological responses, and that evaluating these thoughts and beliefs using *all* available evidence usually results in the identification of alternative, more balanced thoughts and beliefs, which in turn may improve mood and overall functioning.

Before implementing specific cognitive strategies, it is important to educate patients about the cognitive piece of the CBT model.

A common way to present this to Veterans is to use basic airborne operations as an example. For some, the notion of standing in the doorway of a C-130 Hercules—the common plane used in modern Airborne Operations and also used at jump school—evokes thoughts such as "I'm going to die" or "My parachute won't open," which are, in turn, associated with anxiety and fear. Others, in contrast, have ideas such as "This is going to be an incredible experience," which, in turn, is associated with exhilaration and excitement. The external stimulus is the same for both, yet the automatic thoughts and associated emotions provoked by the situation are quite different. Not surprisingly, the people who experience automatic thoughts associated

with anxiety and fear are likely to show hesitation before jumping out of the plane, whereas the people who experience automatic thoughts associated with exhilaration and excitement are likely to dive out with no problems. What this is intended to underscore to patients is that it is often our interpretation of events rather than the events themselves that influences how we feel.

This section describes several strategies for identifying and modifying problematic cognitions. It is divided into three main sub-sections: (a) working with automatic thoughts, (b) working with core beliefs, and (c) developing problem-solving skills.

Working with Automatic Thoughts

As stated previously, automatic thoughts are evaluative thoughts and images that arise very quickly when people experience a shift in their mood. The purpose of working with this level of cognition is to (a) demonstrate to patients the links between cognition, mood, and behavior, and (b) help patients develop a sense of mastery in modifying these cognitions when necessary. This sense of mastery will be used strategically to modify unhelpful core beliefs that are identified as treatment progresses.

Identifying Automatic Thoughts

- **Identifying automatic thoughts**

The first step in working with automatic thoughts is to help patients develop skills in identifying instances in which they arise in specific situations. In session, cognitive behavioral therapists ask patients to describe situations associated with a noticeable shift in mood. As patients provide details about the situation, the therapist uses questioning to identify the cognitions that were activated during that situation—a process called *guided discovery*. When the therapist notices a shift in affect, the most fundamental question a therapist can ask to initiate this process is, "What was running through your mind just then?" The following is an excerpt from Claire's fourth therapy session. This session occurred two days after she had received notification from the medical board that they would delay their decision about reinstating her for another six months and that she was expected to resume work in a different capacity in the meantime.

When the therapist notices a shift in affect, the most fundamental question a therapist can ask to initiate this process is, "What was running through your mind just then?"

Claire:	[visibly agitated] I just can't believe this! Who do they think they are to put my life on hold like this? And a desk job? Please!
Therapist:	I'm sorry to hear that you did not receive the news you had hoped for.
Claire:	[becomes tearful] This is awful! I think there is a real possibility that I won't be able to fly again.
Therapist:	Let's stay with this notion of not flying again for a moment. When you think about not flying again, what's the first thing that runs through your mind?
Claire:	[sniffs] That my life will be meaningless.
Therapist:	And when you have that idea, that your life will be meaningless, how does that make you feel?
Claire:	Horrible! Sad and depressed.
Therapist:	On a scale of 0 to 100, with 0 being no depression and 100 being the most depressed you've ever been, how intense is the depression?

Claire: This is the worst I've ever felt. So it's 100.

Therapist: Claire, it strikes me that anyone who has the idea that their life will be meaningless would experience a high level of depression. [draws the situation → thought → emotion model on a piece of paper] My guess is that this thought—*my life will be meaningless*—is closely related to the high level of sadness that you're experiencing.

Claire: Yeah, that makes sense. But what can I do about it? This is the way it is right now.

Therapist: I understand, so we'll have to put our heads together and see what we can do about it … [goes on to explain the rationale behind cognitive strategies]

Not every patient is as adept as Claire at identifying automatic thoughts. In some cases, patients simply do not know what ran through their minds, focusing exclusively on the resulting painful affect. In these instances, it can be helpful to use imagery techniques for patients to first develop a vivid image of the problematic situation, and then to identify the thoughts that were running through their minds at that time. Other patients confuse thoughts and emotions, stating "I was sad" or "I was scared," without recognizing the underlying cognition. Still other patients provide an elaborate description of the situation that prompted the shift in affect but do not touch on the meaning that the situation had for them. Below we list a variety of questions therapists can ask to assist clients in identifying key automatic thoughts (J. S. Beck, 1995).

It can be helpful to use imagery techniques for patients to first develop a vivid image of the problematic situation, and then to identify the thoughts that were running through their minds at that time.

Questions to Elicit Patients' Automatic Thoughts

- What do you guess was running through your mind at that time?
- Might you have been thinking _____ or _____?
- Were you imagining something that might happen or remembering something that did?
- What did this situation mean to you (or about you)?
- Might you have been thinking _____? [Therapist chooses thought that is opposite of the expected thought]

Consider this dialogue with Jack, who had difficulty understanding the rationale and procedure for identifying automatic thoughts.

Jack: And just like always, my son Christian calls, doesn't even ask how I'm doing, and just asks to speak with his mother.

Therapist: When that happened, what ran through your mind?

Jack: Ran through my mind? Nothing, I just handed the phone to my wife without saying anything else.

Therapist: OK, that's what you did. How did you feel in that situation? [deciding first to identify the affect, then to link the affect to the thoughts]

Jack: Oh, you know, it's just the same ol', same ol'.

Therapist: Actually, I'm not sure what you mean by "same ol', same ol'." Did this bother you?

Jack: Yeah, I guess it does bother me.

Therapist:	So when your son calls, you answer the phone, and he immediately asks for your wife. How does that make you feel? What emotion do you experience?
Jack:	Hurt, I guess.
Therapist:	You felt hurt in that situation. [pause] Can you tell me how you felt hurt?
Jack:	[describing the situation instead of identifying the automatic thought and also becoming more agitated] He does this a lot. No "Hi Dad, how are you"—no nothing!
Therapist:	[gently] It certainly seems like this prompts a lot of emotion in you, Jack. So as you talk about it, what is going through your mind right now?
Jack:	It's all of that. He has no respect for me! He doesn't appreciate anything I've done for him! I'm going to die an old man, all alone, because my son's off doing whatever kids these days do!
Therapist:	[reflects for a moment] These are powerful thoughts, Jack. No wonder you were feeling hurt that day when Christian called.
Jack:	Yeah, I guess I didn't realize that all of this was in my head.
Therapist:	So, the first step in helping you to improve your mood is to identify the thoughts you are having.
Jack:	I guess so. I mean, it's pretty depressing to think about it all. So I just try to block it all out…just go about my business.
Therapist:	And does that help your life to be more satisfying?
Jack:	Not really. My life is not satisfying at all.
	[Therapist went on to link the situation with his thoughts, emotions, and subsequent behaviors (e.g., numbing) to illustrate the links among these construct]

Notice, in this case, that once Jack's therapist supplied examples of possible automatic thoughts Jack might have experienced, he then responded with a barrage of his own examples. This is not uncommon with some patients, particularly when they initially have difficulty identifying automatic thoughts. This process is much different than many people are used to, so it takes time and creativity for it to resonate with some patients. Once patients supply their own examples, however, it is important to use their words, rather than the hypothetical automatic thoughts that you supplied.

The *Thought Record* is a tool for patients to systematically record descriptions of situations associated with a shift in affect, their emotions, and their automatic thoughts. It is a means for patients to collect "data" on their automatic thoughts and further examine the notion of the interrelatedness between thoughts and emotions. Therapists can suggest to their patients that the Thought Record is a "test" to see if their thoughts and emotions are truly linked. Some patients like to think of themselves as "detectives" or "scientists" as they work to identify their thoughts and examine their associated emotions. The most basic Thought Record consists of three columns: (a) situation, (b) emotion, and (c) thought. A Thought Record can be completed using a whiteboard, blackboard, pad of paper on an easel, or a sheet of paper. Figure 4.1 displays a *Three-Column Thought Record*.

- **Thought Record**

Figure 4.1. Three-Column Thought Record

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0–100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?

- **Three-Column Thought Record**

Entries on the Thought Record can be completed in session, and if the patient agrees that the identification of automatic thoughts is valuable, the Thought Record can be assigned as homework. Completion of the Thought Record as a homework assignment allows patients to begin to understand the effects of automatic thoughts on their mood in their daily lives.

The following is a dialogue that illustrates the manner in which Jack's therapist taught him how to complete a Thought Record. Jack's Thought Records are shown in Exhibits 4.4, 4.5, and 4.6.

Therapist: Can you tell me in your own words how emotions are related to thoughts and behaviors?

Jack: What you're saying is that when I think something bad, it ends up making me feel bad. And then I act on it without thinking about it.

Therapist: Yes, that's what I'm saying. Do you buy that?

Jack: Yeah, I guess I do. I never really thought of it before.

Therapist: We have a real simple tool for being able to figure out what you're thinking in these situations, with the idea that once we identify what's running through your mind in these situations, we can eventually begin to evaluate those and see if there are times when you're making yourself feel worse than you need to. Would you be up for learning more about that tool?

Jack: OK, shoot.

Therapist: [shows Jack a Three-Column Thought Record] We call this a *Thought Record*. It is a way for you to jot down situations that are tough for you, in which you experience a shift in your emotion, and the subsequent thoughts that run through your mind. Maybe we can do an entry together so that you can see how it works?

Jack: OK.

Therapist: [Therapist moves the chair so she is sitting next to Jack] We've already identified how you were feeling and what you were thinking when Christian called and immediately asked for his mother. Let's turn our attention to another situation that occurred in the last week. Were there any other times when you experienced an increase in negative emotion, whether it was anger, frustration, or even depression?

Jack: I got down once when I couldn't have a slice of pizza when the guys from poker night ordered it. Man, I wanted that.

Therapist: [gently] Does the strict diet that you're on prevent you from having pizza?

Jack: [glumly] Yeah, cheese and grease make my pancreatitis act up. I can't eat anything that's worth tasting. Everything is bland. I don't even care if I eat anymore.

Therapist: You've identified a good situation to consider in the Thought Record. [gives Jack the Thought Record and a pen] So, it sounds like the situation that caused the upset was not being able to eat pizza at poker night, right?

Jack: Yeah.

Therapist: OK, go ahead and put that in the situation column.

Exhibit 4.4. Jack's Three-Column Thought Record: Step #1

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0–100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?
8/18	*Guys ordered pizza. Couldn't have any.*		

Therapist: Great, you've got the first step down. Now let's turn to the second column. How did that make you feel?

Jack: I felt like I never get to eat anything that's good.

Therapist: [differentiating between emotions and thoughts] It sounds like that's something that actually ran through your mind, that you *thought*. What I'm wondering is how you *felt*. What emotion did you experience?

Jack: Unfair. It's just not fair.

Therapist: [continuing to help Jack differentiate between emotions and thoughts in a sensitive manner] OK. You viewed this as unfair. And how did you feel inside? Angry? Frustrated? Self-Pity?

Jack: Mostly down.

Therapist: You were feeling down. Go ahead and jot that in the second column under emotion. [Jack writes "down"] On a scale of 0 to 100, with 0 being not down at all, and 100 the most down you've ever felt, how down did you feel?

Jack: Oh, I'd say about a 75.

Therapist: A 75. Go ahead and write that in parentheses after "down."

Exhibit 4.5. Jack's Three-Column Thought Record: Step #2

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0–100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?
8/18	*Guys ordered pizza. Couldn't have any.*	*Down (75)*	

Therapist: You're doing a great job, Jack. Now let's turn to the final column, the one in which we identify your thoughts. When the pizza was delivered

and you realized that you could not have any, what ran through your mind?

Jack: Shit, I can't have any.

Therapist: [realizing that this was a description of the situation, rather than an automatic thought that facilitated his negative emotion reaction] OK, so you can't have any pizza. What does that mean?

Jack: I can't eat, I can't even have a beer anymore. There's no enjoyment in life anymore.

Therapist: [repeating the key automatic thought] There's no enjoyment in life anymore. It makes sense that you would feel down. Go ahead and jot down that statement in the "thought" column.

Exhibit 4.6. Jack's Three-Column Thought Record: Step #3

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0–100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?
8/18	*Guys ordered pizza. Couldn't have any.*	*Down (75)*	*There's no enjoyment in life anymore.*

Notice on the Thought Record that, in the Emotions column, Jack was instructed to rate the intensity of his emotion on a scale of 0 to 100 (0 = no [emotion]; 100 = most [emotion] I have ever experienced). This rating accomplishes two purposes. First, it demonstrates to patients that there is variability in the intensity of negative affect that they experience. Patients often realize that the degree of emotional intensity is associated with the nature of automatic thoughts they identify, such that more intense emotional experiences are often associated with more negative, or maladaptive, automatic thoughts. Second, as will be described in the next sub-section (i.e., Evaluating Automatic Thoughts), the goal of cognitive restructuring is to help patients develop different, more balanced cognitions to counteract negative or maladaptive automatic thoughts. Cognitive behavioral therapists often have patients provide another rating of the intensity of the emotion after developing an alternative response, which provides evidence to support the notion that cognitive restructuring helps to reduce negative affect.

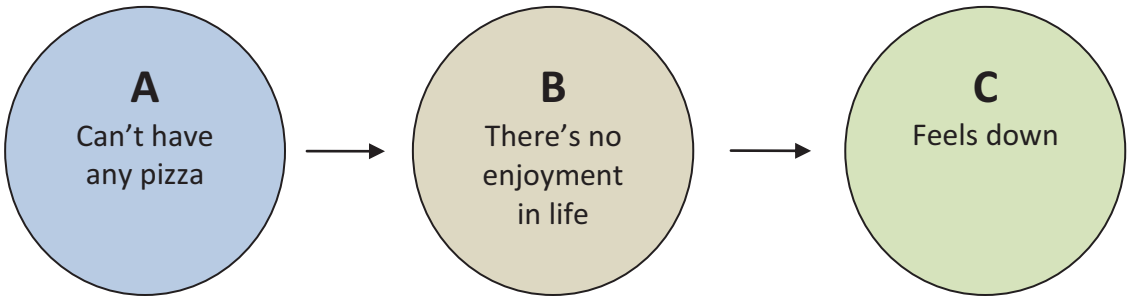
- **Alternative response**

We find that many patients respond favorably to Thought Records after some time has been spent with them in session because they provide a concrete means for evaluating thoughts and ideas that have been unhelpful to them. Such re-evaluation, in turn, often instills in patients a sense that they are making meaningful changes in treatment. Moreover, Thought Records provide the opportunity for patients to slow down their thought processes and identify the link between their thoughts and emotions more systematically than they might have otherwise. In fact, many depressed and anxious patients report that one thought prompts another thought, which prompts another thought, which prompts yet another thought, etc., with each thought being more negative and distorted than the previous one. We call this phenomenon the *runaway train effect*. Use of the Thought Record will stop the "runaway train" by interrupting the cascade of thoughts.

Thought Records provide the opportunity for patients to slow down their thought processes and identify the link between their thoughts and emotions more systematically than they might have otherwise.

Not all patients may necessarily respond favorably to completing Thought Records. For example, some patients have limited educational, language, or English-speaking skills and find the completion of Thought Records to be a burdensome task. In these instances, therapists can take the lead in completing the Thought Record for them in session, such that they sit with their patients in a side-by-side position; list the situation, emotions, and thoughts; and visually demonstrate the link between them. Sometimes, using the letters ABC to represent the cognitive model can be helpful with this type of patient.

Figure 4.2. The Link Between Situations, Emotions, and Thoughts



- **ABC model**

In Figure 4.2, the letter "A" stands for activating event, "B" for beliefs or automatic thoughts, and "C" for emotional and behavioral consequences. Drawing a diagram using these letters can help the patient visualize the flow of how activating events give rise to automatic thoughts, which in turn give rise to unpleasant emotions and self-defeating behaviors. For other patients, Thought Records invoke painful memories of school struggles and remind them of a school assignment. Cognitive behavioral therapists are creative in working with patients to develop exercises and assignments that fit their patients' individual personalities that at the same time achieve CBT's basic goals. For example, therapists might create straightforward checklists of patients' automatic thoughts identified in each session and ask patients to make a check mark each time they catch themselves thinking the automatic thought in the time between sessions.

Drawing a diagram using these letters can help the patient visualize the flow of how activating events give rise to automatic thoughts, which in turn give rise to unpleasant emotions and self-defeating behaviors.

Evaluating Automatic Thoughts

There are a number of strategies that can be easily implemented when automatic thoughts are identified so that more balanced, adaptive interpretations can be constructed. The strategies are, for the most part, relatively simple; yet, they require consistent practice. We often remind patients that they have had a substantial amount of time to practice responding to the world in a way that elicits automatic thoughts. Therefore, it stands to reason that it will take a commitment along with some work and practice to develop a new way of responding to the world, which will then become a habit. In other words, patients' previous cognitive style has been over-learned, and most of the time they do not put a great deal of effort into addressing the logic of their thoughts—they just trust them to be sound and reliable. With practice, they will learn a new way of evaluating information from their environment, and eventually it will become as automatic as the automatic thoughts. For military personnel, this can be likened to learning to march at Basic Training. At first, the

- **Evaluating automatic thoughts**

commands sounded foreign, and they had to think about how and where they stepped. However, after practicing it enough times, they knew exactly what to do when they heard, "Column Left, March!" In fact, they eventually did it instinctively.

As previously stated, a common method to help patients evaluate their automatic thoughts is to ask questions that stimulate critical thinking and accurate examination of these cognitions—a process called *Socratic questioning*. We encourage therapists to refrain from directly challenging the accuracy of their patients' automatic thoughts. In fact, there is often a "grain of truth" in these thoughts, and it would damage the therapeutic relationship to overlook that. The goal of Socratic questioning is for the patient and therapist to work collaboratively to evaluate the automatic thought's validity or usefulness and to develop an alternative, balanced response that follows logically from the evaluation. Below we list common questions that you can ask your patients after they identify problematic automatic thoughts.

- **Socratic questioning**

Questioning Automatic Thoughts

- What evidence supports that thought? What evidence does not support that thought?
- Could there be any other explanations?
- What is the worst that could happen? The best? The most realistic?
- If the worst thing were to happen, how bad would that be? How would you cope with it?
- Do you know for certain that _____ will happen?
- Are you 100% sure about this?
- Does _____ have to lead to or equal _____?
- Is _____ really so important or consequential?
- Does _____'s opinion really reflect that of everyone else?
- What is the effect of believing my automatic thought? What is the effect of taking a different perspective on this situation?
- How useful is it for you to be focusing on this thought?
- What should you do about this?
- What would you tell a friend if he or she were in the same situation?
- If you must be in this situation, how can you survive it?
- What wisdom can you gain from this situation to deal with similar circumstances in the future?

Note: Many of these questions can be found in J. S. Beck (1995) and Heimberg and Becker (2002).

When therapists first introduce the process of Socratic questioning, they usually take the lead in asking these questions to facilitate patients in viewing their thoughts from a different perspective. Cognitive behavioral therapists take care not to argue with patients or pressure them to change their thoughts; rather, they approach this process with a collaborative, inquisitive, and curious spirit. The ultimate goal is for patients to be able to engage in this process, particularly in the moment when they notice automatic thoughts that have the potential to lower their mood or prompt an effective behavioral response. The following dialogue illustrates the manner in which Michael's therapist helped him evaluate the idea that his life was not worth living, which was associated with substantial depressive affect and often prompted subsequent suicidal thoughts.

This transcript is from Michael's fifth session of CBT, and it occurs during discussion of the first agenda item—review of Michael's Three-Column Thought Record.

Therapist: Should we turn to the first item on the agenda? Review of your Thought Record?

Michael: Sure.

Therapist: [scanning assignment] It looks like a number of the automatic thoughts you experienced in the past week revolved around a certain theme—that life is not worth living now that you've suffered an injury that may prevent you from attaining the academic and professional success you had hoped.

Michael: [looks dejected] Yeah.

Therapist: I know this has been a concern of yours since we started treatment. I'm curious, Michael—you did some things early on to improve your relationships and to generally become more active. When you were doing these things, how was your view that life isn't worth living affected? [attempting to identify evidence that contradicts the idea that life is not worth living]

Michael: I guess it took my mind off of being suicidal, if that's what you mean.

Therapist: So, one outcome of engaging in those behaviors was to distract you from potentially harmful thoughts. That's great. I'm also wondering if they provided a different perspective on life for you, perhaps, that life *is* worth living.

Michael: I don't know. I guess doing those things gave me some short-term gain. But, what kind of life is worth living if the only time I get enjoyment is from occasionally going out to eat or watching a movie with my girlfriend or my mother?

Therapist: You're right, we still have some work to do to reach one of your treatment goals—to develop reasons for living. I'm wondering, though, if you still believe that life is 100% not worth living. Or, are there times, even if they are fleeting, when you can see some purpose?

Michael: I don't know. Maybe there's some purpose. My girlfriend told me that she's staying by me no matter what. I was kind of surprised about that. But, in other ways, it all just seems so pointless. My ambitions, my career plans…all down the toilet!

Therapist: [gently] Does not going to law school and not pursuing a career in politics have to equal a life worth living?

Michael: It seems like it for me.

Therapist: Do you know of other people who have not gone to law school or had a career in politics who have lives worth living?

Michael: [pause] I see what you mean. My mom, I guess. She doesn't have anything other than a high school degree, but people really look up to her. She really tries to make a difference. And she really makes a difference for me.

Therapist: So, might it be helpful for us to work together to redefine, specifically for *you*, what it means to make a difference and to have a life worth living, given your new life circumstances?

Michael: Yeah, I think so.

Therapist: So, we started with your idea that life is not worth living. After this discussion, what might be an alternative way of looking at your life?

Michael: I guess that life doesn't have to be meaningless just because I can't do what I expected to do. That it's up to me to find different kinds of opportunities to make a difference.

Therapist: Well put, Michael. Now, I'd like to explore what effect this different perspective has on your mood. In looking at your Thought Record, it seems that when you had the idea that life was not worth living, your depression was at a very high level, 95 to 100. Now that you have an alternative way of viewing things, how would you rate your depression?

Michael: I guess lower, like a 60 or so. This is all still really overwhelming for me.

Therapist: In my experience, it's a lot easier for people to work on their problems when their depression is at a 60, rather than when it is at a 95 or 100. Would you say this is the case for you?

Michael: Yeah, definitely.

- **Five-Column Thought Record**

A useful tool for helping patients evaluate their automatic thoughts is an expansion of the Three-Column Thought Record described previously—the *Five-Column Thought Record*. The first three columns of this Thought Record are the same as the Thought Record described previously—patients record the situation or event that elicited a shift in affect, the intensity of the associated emotion, and the automatic thought. However, the Five-Column Thought Record requires that patients supply two additional pieces of information. In the fourth column, patients record alternative responses to the automatic thoughts listed in the third column. They arrive upon the alternative response through the process of Socratic questioning, illustrated in the previous dialogue. In the fifth column, they record the outcome associated with the alternative response. The outcome might be a reduction in the negative affect listed in the second column (e.g., depression decreases from a level of 100 to a level of 60). However, the outcome could be an entirely different emotion (e.g., "content" instead of "depressed"). The outcome could also be an adaptive behavioral response that the patient initiates as a result of the more balanced alternative response. It is critical for patients to complete the outcome column in order to provide evidence that the cognitive restructuring process is facilitating positive changes in their lives. Figure 4.3 is an example of a Five-Column Thought Record.

It is critical for patients to complete the outcome column in order to provide evidence that the cognitive restructuring process is facilitating positive changes in their lives.

Figure 4.3. Five-Column Thought Record

Date	Situation What event led to a shift in emotion?	Emotion What emotion(s) did you experience? (Rate on a 0–100 scale)	Thought What thoughts or images ran through your mind? What did the situation mean to you?	Alternative Response Use the questions to evaluate the automatic thought and construct a more balanced thought.	Outcome Re-rate the intensity of the emotion you listed in Column 2 or list a new emotion you are experiencing. Describe what you will do differently as a result of the alternative response.

The following transcript illustrates the manner in which Kate's therapist introduced her to the Five-Column Thought Record. This dialogue occurred in the sixth session of CBT; the third and fourth sessions had been devoted to behavioral strategies such as Activity Monitoring and Activity Scheduling, and Kate's therapist introduced the Three-Column Thought Record in the fifth session. Exhibits 4.7 and 4.8 show the manner in which Kate filled in her Five-Column Thought Record.

Therapist: [reviewing the Three-Column Thought Record Kate completed for homework] It looks like you've identified several thoughts associated with sadness, such as *I'll never see my children again*, as well as several thoughts associated with anxiety, such as *I'm going to be evicted*.

Kate: Yes. I really had a lot of negative thoughts in the past week.

Therapist: Did you find this exercise helpful?

Kate: A little. I guess it helps to know what I am thinking. But I'm still the same—still depressed and anxious.

Therapist: I'm glad you brought that up. The purpose of the Three-Column Thought Record is twofold—one, to give you practice in identifying automatic thoughts that come up during the week, and two, to provide evidence for the link between emotions and thoughts. Now that you've spent some time recording situations, emotions, and thoughts, do you believe that there is a link between your thoughts and emotions?

Kate: Yes, it makes sense. If I constantly focus on the loss of my children, then it's no wonder that I am so down.

Therapist: You're right. And I also want to acknowledge the comment that you made a minute ago—that your depression and anxiety did not change as a result of doing this exercise. That also makes sense because there is more to this process. You've *identified* the thoughts, but you have not yet *evaluated* them to see whether or not they're accurate.

Kate: How do I do that?

Therapist: Let me show you a tool that is similar to the Three-Column Thought Record. [pulls out a sheet of paper] This is called the Five-Column Thought Record. You'll notice that the first three columns are the same as they were before—situation, emotion, and thought. But there are two additional columns. One is for you to write down an alternative response. I will work with you today to develop ways to evaluate your automatic thoughts to come up with more balanced, adaptive thoughts. And the other column is for you to write down what happens once you have constructed an alternative response. For example, are you less depressed? Are you feeling something entirely different? Or will you do something differently as a result of viewing the situation with the alternative response, rather than the original automatic thought?

Kate: So the goal is for me to come up with an alternative way to look at the situation?

Therapist: You got it. Why don't you choose the entry from the Three-Column Thought Record you completed for homework that was most distressing for you?

Kate: Definitely the time when I tried to reach my children on the telephone for three days in a row, and they did not return my calls.

Therapist: [handing Kate the Five-Column Thought Record] OK, we'll focus on that situation. Can you record on this new sheet the same information you had on your Three-Column Thought Record—the situation, emotion, and thought?

Kate: OK. [records information]

Therapist: Your thought was *I'll never see my children again.* It's not surprising that that was associated with a very high level of despair—95 to 100. Now that you have some distance from the situation, do you still believe that you'll never see your children again?

Kate: [sighs] No, I guess not. I finally was able to talk to them. My husband is still being difficult, but he reluctantly agreed to meet me halfway so that I can pick them up in a couple of weekends.

Therapist: I'm glad to hear that, Kate. I know this issue has been weighing on you. So, in the moment you had the idea that you were never going to see them again. What would have been a more balanced way of viewing the situation at that time?

Kate: Gee, I don't know. I was completely consumed with emotion.

Therapist: If you were to think about it in as systematic a way as possible, what evidence did you have to support the idea that you were never going to see your children again?

Kate: They hadn't returned my calls in three days. I didn't know what to do.

Therapist: [Here, the therapist decided not to discuss Kate's assumption that not talking to her children for three days was equivalent to not ever seeing them again] And what evidence refutes the idea that you would never see them again?

Kate: Well … it's not like my parental rights are terminated. Legally, I have to at least be able to visit them.

Therapist: That's one piece of evidence that goes against the idea that you'll never see your children again. Is there any other evidence against that idea?

Kate: My mother's really angry at Kevin as well for all of this. She's also been in contact with him and is trying to figure out a visitation schedule.

Therapist: Good. So when you keep all of those things in mind, what might be an alternative way of viewing the situation?

Kate: [pauses] That it's unrealistic to think that I'll *never* see them again?

Therapist: Yes, that works. How would you formulate that into an alternative response?

Kate: Um … how about "This is just short term. I have to be able to see them again, even if it will take going to court to arrange visitations."

Therapist: That sounds great. Go ahead and jot that down in the fourth column.

Exhibit 4.7. Kate's Five-Column Thought Record: Step #4

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0-100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?	**Alternative Response** Use the questions to evaluate the automatic thought and construct a more balanced thought.	**Outcome** Re-rate the intensity of the emotion you listed in Column 2 or list a new emotion you are experiencing. Describe what you will do differently as a result of the alternative response.
9/12	*Kids did not return phone calls 3 days in a row.*	*Despair (95-100)*	*I'll never see my kids again.*	*This is just short term. I have to be able to see them again, even if it will take going to court to arrange visitations.*	

Therapist: When you had the idea that you would never see your children again, you experienced a lot of despair, at a level of 95 to 100. When you have the idea that this is just short term, that you'll see them again even if you have to go to court, do you still feel despair?

Kate: No, not despair. Scared, though. And maybe frustrated that Kevin is putting me through this process.

Therapist: On a scale of 0 to 100, how scared and how frustrated?

Kate: Um … scared maybe a 50. And frustrated at a 60.

Therapist: Are you better able to handle problems when your despair is at a 95 or 100, or when your fear is at 50 and your frustration is at 60?

Kate: Definitely when my fear and frustration are in the middle of the scale. I was so upset about my kids not calling back that I didn't eat for a day and a half, I quit trying to call them, and I missed an appointment with my psychiatrist.

Therapist: So, what might you do differently if you had the idea that you *would* be able to see your children, even if it involved going to court?

Kate: I probably would have looked into getting a lawyer.

Therapist: Ah, so it sounds like two things would have happened had you had the alternative response handy at the time you experienced despair. One, you would have been feeling something different. Although fear and frustration aren't pleasant, they would have been at a manageable level. And two, you would have taken the beginning steps to arrange for visitations with your children.

Kate: Yeah, I guess that's right.

Therapist: Go ahead and jot down those outcomes, both the new emotions and the action you might take as a result of the alternative response.

Exhibit 4.8. Kate's Five-Column Thought Record: Step #5

Date	**Situation** What event led to a shift in emotion?	**Emotion** What emotion(s) did you experience? (Rate on a 0-100 scale)	**Thought** What thoughts or images ran through your mind? What did the situation mean to you?	**Alternative Response** Use the questions to evaluate the automatic thought and construct a more balanced thought.	**Outcome** Re-rate the intensity of the emotion you listed in Column 2 or list a new emotion you are experiencing. Describe what you will do differently as a result of the alternative response.
9/12	*Kids did not return phone calls 3 days in a row.*	*Despair (95-100)*	*I'll never see my kids again.*	*This is just short term. I have to be able to see them again, even if it will take going to court to arrange visitations.*	*No more despair. Scared (50) Frustrated (60) Call lawyer.*

As patients begin to identify their unhelpful thoughts, they may begin to notice specific patterns in both the types of thoughts and the situations that are difficult for them. Patients may even begin to notice that they have a particular style of interpreting events and situations. These styles are referred to as types of *cognitive distortions*. For example, in the transcript presented previously, Michael was demonstrating *overgeneralization*, one type of cognitive distortion, when he was equating the inability to pursue his expected academic and career path with a lack of meaning in his life in general. In Kate's case, the idea that she would never be able to see her children again was an example of all-or-nothing thinking, another type of cognitive distortion, because she failed to recognize the "shades of gray" indicating that, in the long term, some sort of arrangement would be made so she could have scheduled visits with them.

- **Cognitive distortions**

It can sometimes be helpful to introduce patients to a list of cognitive distortions so they have labels with which to identify their cognitive patterns. However, we do not believe that this is needed with all patients. In some instances, patients become overwhelmed when they attempt to evaluate numerous automatic thoughts they have identified. On the other hand, some patients can find it helpful to see that they are prone to making a small subset of the cognitive distortions. Once patients recognize specific cognitive distortions, they may begin to conceive of ways to correct certain cognitive patterns rather than having to address numerous negative thoughts. We encourage you to become familiar with the definitions of these cognitive distortions, as it will help you ask your patients relevant questions to stimulate critical thinking as they evaluate their automatic thoughts. You can find such a list on pages 11–12 of the Wright et al. (2006) book or on page 119 of the J. S. Beck (1995) book.

Once patients recognize specific cognitive distortions, they may begin to conceive of ways to correct certain cognitive patterns rather than having to address numerous negative thoughts.

Even the most seasoned cognitive behavioral therapists occasionally find instances in which patients complete the cognitive restructuring process and construct viable alternative responses, but they do not experience the expected decrease in negative affect. Usually this occurs when the automatic thought that was "restructured" was not the key thought precipitating the negative emotional response, or when the patient did not fully "buy into" the cognitive restructuring process or the alternative thought. Below we list additional possible explanations (J. S. Beck, 1995).

Explanations for Unsuccessful Cognitive Restructuring

- There are more important or central automatic thoughts that were not identified or evaluated.
- The evaluation was implausible, superficial, or inadequate.
- The patient did not fully articulate the evidence that supported the automatic thought.
- The patient understood at an intellectual level that the thought was distorted but did not believe it at an emotional level.
- The patient discounted the evaluation.

Claire, for example, went through the cognitive restructuring process to evaluate her belief that her life will be meaningless if she is not able to resume her position as a pilot. In collaboration with her therapist, she constructed the alternative response, *Although I will be disappointed if I cannot pursue a career as a pilot, I am an*

intelligent and successful person and can use those qualities to pursue a related career that has worth and prestige. When she first identified the automatic thought, *Life will be meaningless*, she assigned a rating of 100 to the associated emotions of sadness and depression. After cognitive restructuring, she rated her level of sadness and depression at an 85. In the following transcript, Claire's therapist works with her to identify the reason why cognitive restructuring did not result in a significant reduction in negative affect.

Therapist:	You constructed a very balanced alternative response, accounting for the fact that you'd be disappointed if you couldn't pursue a career as a pilot, but that you have faith in your abilities to be successful at a related career. Yet, you're still very sad and depressed. Why do you think that is?
Claire:	[sniffs] It's just that I've spent my whole life preparing for this. I know I could do something else that is meaningful if I really had to, but it's going to take so much work. [speaks softly] I just don't know if I have it in me to invest the same amount of energy and commitment into another career.
Therapist:	Ah, so the issue is that there are some other automatic thoughts at work here—the idea that another career will require the same amount of work as you had put into being a pilot, and the idea that you won't be able to put in that same amount of work.
Claire:	Yes, that's it.
Therapist:	Well, let's take a look at these ideas systematically, in the same way as we did with the idea that life will be meaningless if you cannot be a pilot.
Claire:	OK.
Therapist:	Let's start with the idea that pursuing another career will require the same amount of work. I'd like to get a sense of exactly how much work you put into being a pilot.
Claire:	I've been focused on it my entire life. When I was a little girl, I would read about planes. I worked non-stop in high school to get into a top university. I did ROTC in college, and as soon as I graduated six years ago I began intensive training in the Air Force. I've been doing that ever since.
Therapist:	Let me make sure I understand. Did every course and every activity in which you participated in high school and college focus exclusively on flying planes?
Claire:	Well, no, I had to take the typical classes, too. You know, math, science, English, etc.
Therapist:	And did you major in aviation at your university?
Claire:	No, my university didn't offer that major.
Therapist:	What did you study?
Claire:	Mechanical engineering.
Therapist:	Did you enjoy that?
Claire:	Yeah, actually I did. I think it gave me a good sense of the mechanics of the machines I'd be working with.
Therapist:	So, if the worst case scenario were to happen—that the medical board rules that you cannot fly in the Air Force—does your mechanical

	engineering background prepare you are an alternative career? Or the other general classes you took in college?
Claire:	[looks stunned] That's true. I've been consumed with flying and spending a lot of my mental energy and spare time on preparing to be a pilot. And, of course, all of my training after college centered on flying. But you're right, my actual major was something different.
Therapist:	Would a career as a mechanical engineer be fulfilling to you?
Claire:	I won't lie to you, it would be disappointing relative to being a pilot. But I guess I have some background in that area.
Therapist:	Could you even focus a career in mechanical engineering on designing parts of airplanes?
Claire:	[brightens] Yeah, I guess I could. When you think about it, I might even be pretty good at it, since I have the practical experience of flying.
Therapist:	Let's revise our alternative response. Before we had come up with, "Although I will be disappointed if I cannot pursue a career as a pilot, I am an intelligent and successful person and can use those qualities to pursue a related career that has worth and prestige." Can we make that more specific to incorporate mechanical engineering?
Claire:	Um … how about, "Although I will be disappointed if I cannot pursue a career as a pilot, I have a bachelor's in mechanical engineering, and I can look for a job in which I can design parts for airplanes."
Therapist:	Great! Now what level of sadness and depression are you experiencing?
Claire:	[smiles weakly] It's lower. Maybe a 40 or 50.

In this example, Claire's therapist suspected that she was discounting the more general training that she had completed, such as her college education, which did not focus specifically on flying. Moreover, he realized that there might be a way for Claire to continue to pursue her interest in airplanes even if she were unable to be a pilot. Nevertheless, it would have been counterproductive for Claire's therapist to point this out directly, as it would have invalidated Claire's strongly held belief that being a pilot was the sole source of meaning in her life.

Coping Cards

- **Coping cards**

A coping card is a valuable tool to use once patients have been introduced to, and have exhibited some proficiency in, earlier methods for evaluating and modifying automatic thoughts, or for those who may have difficulty learning or using other ways of working with their thoughts, such as a Five-Column Thought Record. Coping cards can help patients quickly recognize re-occurring automatic thoughts and then "over-learn" adaptive responses to these thoughts. Over-learning is useful because it increases the likelihood that the adaptive responses will be recalled during stressful situations. In addition, coping cards have the potential to be used more frequently than longer or larger documents because the patient may be more likely to place the card in a more easily accessible location. To construct a coping card, the automatic thought (or core belief) is usually placed at the top of the card, and the

Coping cards can help patients quickly recognize re-occurring automatic thoughts and then "over-learn" adaptive responses to these thoughts.

alternative response is written at the bottom. Alternatively, the automatic thought may be written on one side of the card, and the coping strategy or alternative thought on the reverse side.

There are several benefits to using coping cards. First, coping cards are simple to create during or following the therapy session as homework. Second, they are highly transportable because of their size. Third, we have found that coping cards are particularly useful for Veterans who benefit from visual cues and who prefer to use simple approaches. Finally, patients may be more likely to remember to follow simple instructions or recall helpful coping statements if such information is readily available in an easy-to-use format.

To illustrate the manner in which one might use coping cards, consider how these strategies were applied with Claire. Over the course of their work together, her therapist recognized that Claire experiences interpersonal difficulties due to the assumptions she makes about others. The therapist attempted to use coping cards to preemptively deal with future problems that may arise in this area.

Therapist:	Claire, in the last few weeks, we have talked a great deal about the automatic thoughts you have regarding what people might be thinking about your injury. I would like you to take out your homework (last week's Thought Record) so that we can go over one of the automatic thoughts you have been having.
Claire:	I seem to continually assume that whenever someone is being nice to me regarding my injury, that they automatically assume that I am incapable of performing my job or even daily life.
Therapist:	How has that made you feel?
Claire:	Well, it makes me feel badly about myself, but it also makes me feel angry.
Therapist:	Does this automatic thought link up with an underlying belief that you may have about your situation? Is that why you get angry?
Claire:	Yeah, we discussed that last week. It makes me think I am never going to be able to do the things I did before, like flying. I believe the doctors on the medical board are going to assume the same thing that everyone else does—that I am incapable.
Therapist:	So, whenever you experience someone trying to help you, you instinctively think that they assume certain things about you, like you are not capable.
Claire:	Yeah, that's it.
Therapist:	What I would like to do today is to develop some strategies to help you be prepared to combat these automatic thoughts when they happen in the future.
Claire:	OK.
Therapist:	Let's take a moment and think of a situation in which you might experience the automatic thoughts that we just discussed.
Claire:	When I walk into restaurants, people always rush to hold the door for me. They may just be nice people, but I assume they pity me. That triggers all of the thoughts
Therapist:	Good. What do you imagine that would make you feel like?

Claire:	Angry, sad, and bitter.
Therapist:	How would you know if the person was pitying you or being nice?
Claire:	Well, I wouldn't necessarily know that.
Therapist:	So, it would be somewhat inaccurate to always think that you are being pitied when, in fact, some people are genuine. Do you know of or have you experienced any situations in which someone is genuinely nice and not pitying you?
Claire:	My friend Aaron always used to hold the door for me when we would eat out, and he still does, so I just assume he is doing what he would do naturally.
Therapist:	Is there a way that you can use this evidence in the future to help you deal with new situations? How might you do that?
Claire:	I could remind myself that most people are genuinely nice and that I know many situations in which people do not pity me but are being genuine and chivalrous.
Therapist:	What else?
Claire:	Well, I could also say to myself that just because I assume people are thinking a certain way does not really mean they are. I mean, I really don't know what they are thinking. I am just mind reading and assuming the worst.
Therapist:	How would that relate to what you assume about the medical board in these situations? What might you tell yourself to avoid spiraling into a negative thought process about your being allowed to fly again?
Claire:	Well, the people at the restaurant are not the doctors, so it would be illogical for me to infer what the doctors might think from how a person at the restaurant behaves.
Therapist:	Great. What I would like to do now is put all of that information on a card so that when you are in a situation like this, you can simply take out the card and remind yourself of the strategies that we have developed. Here is the format for the card.

The therapist then goes on to explain to Claire the manner in which the completion of the coping card is similar to the completion of a Thought Record. For Claire, she listed the automatic thoughts at the top of the coping card (see Exhibit 4.9). On the bottom of the card, she listed specific coping strategies that included some alternative responses to this thought.

Exhibit 4.9. Claire's Coping Card

Thought:
When people do nice things for me, they think that I'm not able to do things for myself. I hate when people pity me.

Coping Strategies:
- Remind myself that people are genuinely nice and that I have experienced many situations in which people do not pity me but are being genuine and chivalrous.
- Remember, just because I assume people are thinking a certain way does not really mean they are.

Although the most common usage of coping cards is to summarize the automatic thought and either the alternative response or ways to cope with the automatic thought, it is important to note that coping cards serve many uses and can be used creatively by therapists to remind patients of *any* of the cognitive behavioral strategies described in this manual. For example, a patient could have had success with a number of activities intended to promote behavioral activation, and he could list those activities on a coping card so that, in times of especially pronounced depression, he can consult the card and be reminded of the activities that have helped him to break out of the "vicious cycle" in the past. If a patient found a particular relaxation or controlled breathing protocol especially helpful, she could summarize the main components of that protocol on a coping card to consult in times of distress when she might not remember the specific steps of these strategies. Later in the manual, we discuss the cognitive behavioral approach to problem-solving; coping cards can be used in conjunction with this intervention, such that a patient records the sequential steps that he will take in order to address the problem that is discussed in session.

In all, the fundamental idea underlying coping cards is that they are a quick, easy-access method for patients to remember and apply the strategies developed in session into their daily lives. Coping cards are easy to make in session so that patients have something tangible to take home with them. Therapists who use coping cards are encouraged to spend time with patients identifying where the cards will be kept and the specific circumstances under which they will be consulted. Moreover, we have found that patients are more likely to use these cards if they are made of colored paper and/or laminated. Additional information on coping cards can be found in Wright et al. (2006, pp. 118–119).

Patients are more likely to use these cards if they are made of colored paper or laminated.

The 3Cs Approach: Catch It, Check It, Change It

A simple mnemonic acronym that has been developed to help patients understand and use cognitive restructuring is the *3Cs Approach*: Catch It, Check It, Change It (McQuaid et al., 2000). This three-step approach (shown in Figure 4.4) is useful for helping patients manage their mood. We have found this approach to be particularly useful with Veterans who have difficulty organizing and structuring more complex information.

- **3Cs Approach**

Figure 4.4. Catch It, Check It, Change It.

(1) **Catch It.** This first step involves catching the automatic thought associated with a change in mood. Sometimes it is easier to identify a shift in mood first and then to ask yourself what was going through your mind just then. For example, patients may be coached to think about a time in the recent past when they noticed a negative shift in their mood. For some patients, it may be helpful to imagine or describe the situation

that led to the negative mood state. Then, patients can be asked to identify the automatic thought associated with the mood change.

(2) **Check It.** In the next step, patients are instructed to check or evaluate whether the thought is true, complete, or balanced. Patients may ask themselves, "What is the evidence indicating that the thought is true?" Similarly, patients may be instructed to ask themselves whether the thought is complete or balanced. A complete thought is based on all of the important and relevant information related to the situation that was associated with the initial automatic thought. A balanced thought includes information that is not extreme and is more fair and reasonable than the initial automatic thought.

(3) **Change It.** The third step involves changing the automatic thought into a more accurate thought. In this step, patients are instructed to think of a replacement thought that is true, complete, or more balanced than the initial automatic thought. The 3Cs Approach aims to help patients learn ways to talk back to their thoughts and replace an automatic thought with an alternative, more balanced or helpful thought.

Working with Core Beliefs

You will recall that core beliefs represent the most central, fundamental beliefs about ourselves, others, and our world. Our experience is that therapists do not usually focus on core belief modification early in treatment. Rather, working with core beliefs is done after the therapist has developed the case conceptualization and established a strong alliance with the patient. Usually, these beliefs often develop early in childhood and remain dormant until they are triggered by periods of acute stress. In some Veterans, core beliefs develop in young adulthood after particularly difficult or traumatic experiences in the military.

Core Belief Identification

In a similar manner as working with automatic thoughts, the first step in working with core beliefs is to identify and clearly articulate them. Most often, core beliefs are identified by the therapist using guided discovery, which is often applied when the patient describes crises that emerge during treatment or recalls critical negative experiences from her past. As the patient describes these negative experiences, the therapist develops hypotheses about specific core beliefs by speculating about particular beliefs that might lead the patient to react in a specific way. Once the therapist begins to formulate hypotheses about the patient's beliefs, she looks for opportunities to share them with the patient in order to obtain feedback. The best opportunities to solicit feedback occur either when an emotional topic is being discussed or when an emotional reaction occurs during the session. At this time, the patient may actually articulate a belief as an automatic thought. For example, the patient may express the belief on a Thought Record or articulate the belief when the therapist asks what was running through her mind in a particular situation. The therapist recognizes the patient's response as a core belief when (a) it is associated with significant affect, (b) it summarizes a theme that has been evident across the patient's previous Thought Records or other cognitive restructuring work done in session, and/or (c) it is consistent with typical core beliefs observed by cognitive

- **Core belief identification**

behavioral scientist-practitioners, such as J. S. Beck (1995; see Chapter 11 on core beliefs).

CBT Strategies for Identifying Beliefs

1. Looking for the expression of a belief as an automatic thought
2. Recognizing a common theme across automatic thoughts or situations
3. Directly asking the patient what he thinks the belief is
4. Reviewing a belief questionnaire
5. Using the downward arrow technique (Burns, 1980)
6. Completing a Cognitive Conceptualization Diagram

- **Downward arrow technique**

One specific strategy for identifying core beliefs is the *downward arrow technique* (Burns, 1980), in which the therapist asks the patient a series of questions such as "What does this mean to you?" or "What does this mean about other people?" The idea is to identify the meaning or the fundamental idea that underlies the cognitions that patients express. The downward arrow technique begins with the identification of a key automatic thought. The therapist hypothesizes that the content of the automatic thought is not consistent with the severity of the emotional reaction experienced by the patient and wonders if the patient has a core belief that has not been previously expressed. The therapist then asks the patient, "What does that mean to you when you thought…?" The therapist may use an "If–Then" question to identify the belief; for example, "If your thought was true, then what does that say about how you view yourself?" While carefully listening to and summarizing the patient's responses to the questions, the therapist may continue to ask the patient about what any given response means to her until the core belief is expressed.

For example, consider the following dialogue with Michael, who discloses his core belief after he had a strong reaction to his mother:

Michael: …and then my Mom asked me about getting a job.
Therapist: What went through your mind when she said that?
Michael: Oh, that'll never happen
Therapist: So what does that mean to you?
Michael: Like I said before, it means I'll be unemployed forever.
Therapist: So if you are unemployed forever, what would that mean to you?
Michael: [pause] That my family will keep looking down on me.
Therapist: And what would that mean?
Michael: [pause] Obviously, it means that I'm no good to anybody. I'm just a burden to my family. [starts crying]
Therapist: [pause] That's a powerful belief, Michael. Can we talk about this a bit more?
Michael: I guess so.
Therapist: What I understand is the thought that you will be unemployed forever is associated with a belief that you are a burden to others, especially to your family.
Michael: Yes.
Therapist: Is this one of the reasons why you sometimes think that life is not worth living?
Michael: Yes, my life is pretty worthless.

Therapist: You had not told me about the belief that you are a burden to your family in previous sessions. This is new information to me and sounds pretty important. Perhaps these beliefs are something that we can work on together.

The therapist then went on to discuss when Michael might have developed this belief and under what other circumstances he views himself as a burden.

Core Belief Modification

Oftentimes, more than one core belief emerges during the course of treatment. In this instance, the therapist and patient collaboratively decide which belief should be the focus of treatment. In choosing the particular belief to address, the therapist identifies the core belief that is most strongly endorsed by the patient, is relatively enduring, and/or is most clearly associated with the patient's presenting problems. Patient-therapist collaboration in identifying and modifying specific beliefs is of critical importance, and there are several strategies to facilitate this collaboration (see strategies below).

In choosing the particular belief to address, the therapist identifies the core belief that is most strongly endorsed by the patient, is relatively enduring, and/or is most clearly associated with the patient's presenting problems.

Strategies for Modifying Core Beliefs

1. Completing a Core Belief Worksheet in which evidence that contradicts the core belief and supports a more adaptive one is noted (J. S. Beck, 1995)
2. Writing down the beliefs and rating fluctuations in the degree of certainty of these beliefs over the course of a session, day, or week (J. S. Beck, 1995)
3. Simply writing down the modified core belief
4. Completing a Thought Record
5. Developing a "Reasons Why" coping card
6. Using the cognitive continuum
7. Restructuring perceptions of early experiences that contributed to development of the core belief
8. Making behavioral changes that support a new, more adaptive core belief

- **Modifying core beliefs**

The Core Belief Worksheet (J. S. Beck, 1995) is a tool that allows patients to (a) articulate the "old," unhelpful core belief and a "new," more adaptive core belief, and (b) accumulate evidence over time that supports each of these beliefs. It is hoped that the longitudinal evaluation of the old and new belief allows patients to see that the old core belief was overly rigid and negative. The procedure for using the Core Belief Worksheet is as follows. First, the patient writes down the "old" core belief and, using a scale of 0–100, indicates the percentage that she believes the old belief at that moment, the most that she believed the old belief in the past week, and the least that she believed the old belief in the past week. In addition, the patient writes down the "new" belief and, using the same scale, rates the degree to which she believes the new belief at that moment. Not only does the Core Belief Worksheet help patients to clearly articulate their beliefs, but it also allows them to observe fluctuations in their degree of certainty about these beliefs over the course of a week, which provides evidence that these beliefs are not necessarily 100% "true" or "fixed." To facilitate belief change, patients are encouraged to document evidence that contradicts the old core belief and supports a more adaptive one. This approach of strengthening the new

belief and weakening the old one produces a stronger therapeutic effect than either method used alone (Layden, Newman, Freeman, & Morse, 1993).

Patients can also observe fluctuations in the degree of endorsement of a particular belief and evaluate the meaning of those fluctuations without using the Core Belief Worksheet. If changes in the degree of belief are observed only in given situations, the therapist and patient may agree to modify the belief so that it more accurately reflects reality. Sometimes, when patients write down their beliefs, they notice that their written belief does not accurately capture the underlying belief. In this case, patients are encouraged to modify the written belief so that it is more accurate. This strategy often leads to shaping highly dysfunctional beliefs into more adaptive ones, because they are revised to be less extreme or less pervasive.

In the following dialogue, Michael and his therapist continued to evaluate his core belief that he is a burden to his family by noting fluctuations in the degree to which he believed that belief, depending on the particular aspect of the belief he was considering, and modifying it to reflect his reality as accurately as possible.

Therapist:	Would it be OK if we talk about your belief of a burden a bit more?
Michael:	OK.
Therapist:	I'm going to write down this belief on a sheet of paper so that we can focus on this more objectively. [writes "I am a burden to my family"] Is that correct?
Michael:	Yes.
Therapist:	How much do you believe this on a scale of 0 to 100, with 0 meaning that you do not believe this at all and 100 meaning that you believe this 100%?
Michael:	I completely believe that this is true, so 100.
Therapist:	[writes down 100] Have you always believed this to be the case?
Michael:	No. I started feeling this way when I realized that I couldn't concentrate while I was working and decided to quit. Because I'm not able to work, I think I'm a burden on them.
Therapist:	So you only have believed you are a burden since being unemployed. Do you believe you are a burden because of financial concerns?
Michael:	Well, not completely. As you know, I receive support from the government for my head injury. It's more that I feel like an emotional burden, I guess.
Therapist:	What do you mean by that?
Michael:	I have these periods of ups and downs. Sometimes, everything is fine and then at other times, I become irritable, frustrated, and depressed. At those times, I'm not the easiest person for my family to be around.
Therapist:	I see. Maybe, we should change this statement that we wrote down because it is not exactly right. What if we were to write down, "I am an emotional burden to my family." Would that be more accurate?
Michael:	Yes, it would.
Therapist:	[writes down the revised belief] There. So I understand that you have periods when you are very upset, irritable, and frustrated. Is it only during those times that you believe you are a burden, or do you believe that all the time?

Michael: Hmm…it's only really during those times that I feel that way. Actually, I really only believe that after I get upset.

Therapist: So, you are saying that you do not believe you are an emotional burden all the time, just during the time after you get upset.

Michael: Uh-huh.

Therapist: How would you change this statement, then, so that it better reflects what you just said?

Michael: I guess I would say that sometimes after I get upset, I believe I am an emotional burden to my family, and at other times, I don't.

Therapist: Let's write that down, OK?

Michael: [writes down modified belief] So every once in a while I believe I am an emotional burden to my family after I get upset, and at other times, I don't.

Therapist: How often do you really get frustrated and upset that you end up believing you are a burden? Every day? Once a week?

Michael: Let's see….The last time I lost my cool was last Monday, but before that it had been a couple of weeks.

Therapist: So every once in a while. Maybe we should re-write this sentence again to read, "Every once a while, I believe I am an emotional burden to my family after I get upset, and at other times I don't."

Michael: OK. [writes modified belief]

Therapist: After you get upset and believe you are a burden, what happens?

Michael: I usually go somewhere by myself.

Therapist: And then what happens?

Michael: Then, I think about what I did and go back and tell 'em that I'm sorry for being that way and that I feel really stupid.

Therapist: And how do they respond?

Michael: They say that they understand that I have my good days and bad ones, and that it's OK.

Therapist: I see. So it sounds like you have a very supportive family who is quite understanding.

Michael: Yes, I do. Thank God for that. They really care about me.

Therapist: So, is it that you really believe you are a burden, or is it that you feel badly about getting upset with your family?

Michael: I guess it's mostly that I feel badly about getting upset with my family.

Therapist: If we come back to our original belief that we wrote down [points to the "I am a burden to my family" statement], how much do you believe that now?

Michael: I guess it's too extreme. There are only specific times when I'm an emotional burden. And my family really doesn't even see it that way.

This example illustrates the manner in which talking about a strongly held belief can change over time. Notice that the therapist did not directly challenge the belief. Rather, he worked with Michael in trying to understand the circumstances that led to his endorsement of the belief. In our experience, the gradual shaping of a core belief is less threatening and often more effective in helping patients address their maladaptive or unhelpful beliefs than direct challenging.

In our experience, the gradual shaping of a core belief is less threatening and often more effective in helping patients address their maladaptive or unhelpful beliefs than direct challenging.

The core belief work done in session provides an important platform for patients to develop and articulate new, more adaptive core beliefs. However, it is equally as important for patients to gain practice with accessing the new core beliefs outside of session in their daily lives. Some of the strategies already discussed in this section of the manual can achieve this purpose. For example, patients can keep Thought Records in which they catch themselves reverting to their old, unhelpful core beliefs and use the cognitive restructuring skills they have gained earlier in the course of therapy to arrive upon the new, more adaptive beliefs. Completion of the Thought Record in this manner shows patients the frequency with which old, unhelpful core beliefs are activated and the situations in which they are manifest. It provides an opportunity to restructure those old core beliefs in the moment.

Coping cards can also reinforce new, adaptive core beliefs and remind patients of the evidence that supports them. One of us (AW) has developed the "Reasons Why…" coping card for this purpose. The therapist and patient collaboratively develop a title for the coping card that reflects the new, more adaptive core belief, such as "Reasons Why I am Successful" (to counteract the core belief, "I am a failure") or "Reasons Why I am Lovable (to counteract the core belief, "I am unlovable."). In session, they develop a bulleted list of evidence that supports the new core belief. The patient can consult the list in between sessions at times in which he notices that the old core belief has been activated, and he can add to the list when new evidence that supports the more adaptive core belief is identified.

Some patients have a particularly difficult time modifying unhelpful core beliefs when they compare themselves to others whom they perceive (usually inaccurately!) as being more successful or adaptive than they are. The cognitive continuum is a strategy that helps patients to perceive as accurately as possible where they stand on a particular dimension associated with a core belief. Using this strategy, patients often realize that their belief is much less "all or nothing" than they had originally stated and that there are many aspects of their lives in which they are doing quite well.

Consider Kate, who has the belief that she is a failure. In using the cognitive continuum strategy, her therapist drew a horizontal line on a piece of paper, in which the right end was labeled as "100% failure," and the left end was labeled "0% failure." The following dialogue illustrates the manner in which Kate evaluated the degree to which this belief is truly characteristic of her.

Therapist:	Where would you place yourself on this continuum?
Kate:	[tearful] 100%. I really have failed at everything I've cared about in life. My children. My marriage. My career. The list goes on and on.
Therapist:	[writes "Kate" under 100%] So there's not one person in this world who you would judge as more of a failure than you?
Kate:	[shrugs her shoulders]
Therapist:	Let's start with the first area you mentioned—children. Are there any behaviors in which a parent could engage that would lead you to say, "That person is a failure as a parent?"
Kate:	[pauses] Well, I guess parents who abuse or neglect their children are really bad.
Therapist:	Would you consider them failures as parents?

Kate:	Yes, I guess I would.
Therapist:	Here's an important question Kate. Have you ever abused or neglected your children?
Kate:	Gosh, no.
Therapist:	What does this tell you, then, about your failure as a parent?
Kate:	[hesitating] I don't know. Right now my children don't even live with me. That's pretty bad.
Therapist:	Does that make you as bad of a parent as if you had abused and neglected them?
Kate:	I guess not.
Therapist:	[pointing to the cognitive continuum] Should we erase this mark at 100? Does this mean that you are not a 100% failure because there are people out there who have abused and neglected their kids, thereby making them more of a failure than you?
Kate:	Fine, put me at 99% then.
Therapist:	[erases her name under 100% and makes a tick mark labeled 99%] So right now you're saying that you're only 1% more successful than parents who abuse and neglect their children. Is that right?
Kate:	[tearful again] Yes.
Therapist:	Kate, is it your fault that your children are not living with you right now? That you did something so horrible—that you would consider failed parenting—that they no longer want to be around you?
Kate:	Well, no, I guess. All of this is just a big game that Kevin is playing.
Therapist:	Do your children seem happy to talk to you on the phone?
Kate:	[whispers] Yes.
Therapist:	Would children whose parent did something horrible to them be happy to talk to that parent on the phone?
Kate:	No. I can actually tell they look forward to talking to me. I didn't see that in the past, but now I do. Yesterday, they even asked when they were coming home.
Therapist:	Would children whose parent is a 99% failure spontaneously say those things?
Kate:	[brightens] No, they wouldn't. And you know what? I think Kevin is more of a failure as a parent than I am because he's the one who is keeping them from seeing their mother. I would never do that to the children, no matter how bad my marriage was. I would always keep their best interest in mind.
Therapist:	Hmmm. Do we need to revise where you fall on this continuum?
Kate:	I guess we do. I would put Kevin at 90% failure. I guess I can't call him 99% or 100% failure because he doesn't abuse and neglect the kids, and there are times he can be a good dad.
Therapist:	But you'd judge yourself as more successful than he is, given how he is behaving right now?
Kate:	Yes, I really would.
Therapist:	Where are you now on the failure continuum?
Kate:	Like an 80 or 85%.

Kate's therapist went on to use Socratic questioning to facilitate the same sort of evaluation about her success/failure with her career and her marriage. Kate decided

that she needs to give herself credit for becoming a nurse, especially when she did not go to college right away after high school. She also realized that she performed her duties just as well as the other nurses and that her inability to get a job could be attributed more to the job market than to her abilities or credentials. Regarding her marriage, she concluded that she and Kevin were never a good match and that they both contributed equally to their marital problems. She also acknowledged that many people get married to someone with whom they are not a good match and that she would not necessarily regard them as failures. The conclusion of the cognitive continuum exercise was as follows:

Therapist:	What do you conclude about the degree to which you've had success vs. failure as a parent, as a wife, and with your career?
Kate:	[sighs] I guess I'm not a failure. Some things aren't my fault. I always go there, thinking everything is my fault when it's not.
Therapist:	Where would you put yourself on this continuum? Are you still at 80–85% failure?
Kate:	No. Honestly, looking at it like this, I'd say I'm a lot like everyone else.
Therapist:	What do you mean by that?
Kate:	I guess everyone has successes and challenges in their lives. It's all part of being human. My problems don't make me more of a failure than anyone else. Not that I'd say I'm truly successful either. I have a long way to go.
Therapist:	So what percent failure would you indicate in this continuum?
Kate:	I guess what I'm saying is that I'm at 50%. Neither success nor failure, just average like most people.
Therapist:	Back when you put yourself at 100%, how did that make you feel?
Kate:	Lower than low. Totally depressed, where I would just throw my hands up in the air and say, "What's the point?"
Therapist:	When you view yourself as 50%, as just like most people who experience some successes and some challenges, how does that make you feel?
Kate:	Much better. I'm not doomed to fail at everything in my life.

In some instances, therapists and patients work collaboratively to track the development of unhelpful core beliefs. When core beliefs are linked with specific experiences or interactions with others from the past, it can be helpful to apply cognitive restructuring strategies to the memories of these experiences. This process allows patients to evaluate the degree to which the messages they received or the expectations others had for them might have been unrealistic or inaccurate, leading to the development of a rigid, inaccurate, or unrealistic core belief. For example, Claire remembers her father saying that she must outperform the other children in all of her activities—academic performance, sports, theater—in order to be a "winner." Through the course of CBT, she realized that she held rigid, and often unrealistic, expectations of herself, fueled by the belief that anything less than the best was unacceptable. In the following example, Claire and her therapist critically evaluated her memory of the message that she took from her father in order to reshape this core belief.

Therapist: What do you think is the origin of the belief that it is unacceptable to be less than the best?

Claire: I've always been a person who strives for perfection, just like my father.

Therapist: Do you recall your father pushing you to be the best?

Claire: I don't know if he pushed. We all just knew than anything less than #1 was unacceptable to him.

Therapist: Can you remember a specific example when you took this message from him?

Claire: [pauses] I remember a time when I was six years old and on a beginning soccer team. You know, one of those teams when the kids don't know what they are doing, and they all run around in swarms chasing the ball?

Therapist: What happened?

Claire: I was the goalie, but I didn't really understand fully what a goalie did. So when I saw all of the kids on my team chasing the ball, I went after it, too.

Therapist: And then what happened?

Claire: I wasn't tending the goal, so the other team scored. When the half ended, I went to my parents to get a drink of water from the cooler they bought. And my father ripped into me.

Therapist: [gently] What did he say?

Claire: [with disdain] I remember him saying that I have no business being the goalie if I can't do my job right. That what's the point of being on my team if I don't help the team to win?

Therapist: How did that make you feel?

Claire: I was totally embarrassed. My father yelled at me in front of the other kids and their parents. I was humiliated.

Therapist: That sounds like a painful experience.

Claire: Yeah, I guess it was, except that was how my father was a lot, so I got used to it.

Therapist: Did you believe what he was saying to you?

Claire: I did. I remember that it was at that point that I stopped enjoying soccer and started dreading it. I would get stomach aches before games, even before practice. I worried that I would let the team down if I didn't do what I was supposed to do. [snorts] The problem is, at six years old, I wasn't always sure what I was supposed to do.

Therapist: How much did you believe that you had to perform at a high level, or else you were letting the team down?

Claire: Oh, 100%. That was the only thing that went in my household.

Therapist: Now, as an adult, how could you use the cognitive strategies we've developed in this treatment to evaluate that idea?

Claire: [thinking] You know what, I was only six years old, for God's sake! Aren't I allowed to have fun?

Therapist: It sounds like you're starting to view the message you received from your father in a different light. Can you put that into words for me?

Claire: Kids are allowed to have fun. They don't have to win all the time. Sometimes, it's OK not to compete, to just go out and enjoy yourself

	rather than striving to be the best and carry the weight of the team on your shoulders.
Therapist:	That's a powerful revelation, Claire. How much do you believe that?
Claire:	If we're talking about me as a child, I believe it at a high level, like 80 or 90%. But it's different now. I'm an adult, and the stakes are higher.
Therapist:	Would you be willing to continue to examine this belief that it is unacceptable to be anything other than the best, to see if it needs to be maintained in *all* of your adult endeavors, or whether it can be relaxed in some of your adult endeavors that are meant to be fun and enjoyable?
Claire:	I'd be willing to keep looking at it. To be honest with you, it's exhausting to think like this all the time.

The best way to solidify a new, more adaptive core belief is to behave in a manner that reinforces it. Making small but steady behavioral changes advances a patient's adaptive behavioral repertoire so that maladaptive or unhelpful beliefs gradually erode (Layden et al., 1993). Many cognitive behavioral therapists have described behavioral strategies that facilitate the translation of adaptive beliefs into behavioral changes (e.g., J. S. Beck, 1995; Layden et al., 1993). Some of these strategies are as follows.

- Instruct patients to self-monitor any adaptive behaviors that occur in response to adopting more adaptive beliefs and to keep a log of these behaviors for future reference. Not only does this exercise promote awareness of behaviors that support the new core belief, but it also provides evidence that a new core belief can be activated and maintained and that it results in tangible behavioral changes that make a difference in patients' lives.

- Role-play various scenarios with patients in session to improve interpersonal skills and to develop more adaptive ways of viewing themselves and others. When therapists use this strategy, they spend time helping patients to identify ways that the skills they gained from the role-play can generalize to their daily lives. When patients observe success as they implement these new skills, they are collecting "data" that refute the old core belief and support the new core belief.

- Encourage patients to "act as if" they are characterized by the new core belief. When patients adopt this strategy, they often find that behaviors consistent with their old core belief are self-defeating, and they teach themselves that they indeed have the skill and fortitude to carry themselves according to a different set of beliefs. They also see that their behavior has resulted in improvements in their mood and relationships with others. After completing this exercise, many patients who "act as if" they had a more adaptive core belief wonder why they clung so tightly to the old core belief. Although some patients worry that this exercise makes them "fake," we find that most patients take home a valuable message and that, very quickly, the behaviors associated with the new core belief feel more natural to them.

In summary, when therapist and patients collaboratively focus on core beliefs, they are working at the most fundamental level of cognition that has pervasive effects on the patients' subjective experiences of stressful situations in their daily lives. Cognitive behavioral therapists who use strategies other than those pertaining to core beliefs can make significant progress with their patients; however, it is often the case that the most lasting change arises from the modification of maladaptive or unhelpful core beliefs. It is often difficult for patients to acknowledge painful core beliefs, so attention to the therapeutic relationship is paramount during this phase of treatment. Once a core belief is identified in therapy, therapists and patients will usually orient their work toward that cognitive theme, rather than toward more superfluous or peripheral cognitions associated with everyday stressors.

Problem-Solving Strategies

- **ITCH problem-solving strategy**

Assisting patients in acquiring problem-solving skills is one of the hallmarks of CBT. Some patients have difficulty solving problems because they do not possess the skills to do so. When a therapist determines that a patient is characterized by such a skills deficit, she can apply systematic steps to help the patient work through problem. This strategy involves a series of four steps, called *ITCH*, that the therapist and patient can follow during the session.

ITCH Problem-Solving Strategy

1. **I**dentify the problem
2. **T**hink about possible solutions
3. **C**hoose a solution to implement
4. **H**ow well does it work?

Step 1. Identify the Problem. This first step in teaching any problem-solving strategy involves recognizing that a problem exists and that attempting to solve the problem is a worthwhile endeavor. It is crucial that the patient perceive that the therapist understands his problem(s) before assisting the patient in trying to generate possible solutions (Step 2). The therapist should clearly understand the difficulty and the manner in which this difficulty is leading the patient to feel unhappy, sad, or anxious. Listening carefully to the patient and providing periodic summaries of the problem are critical to establishing a good collaborative relationship.

On occasion, patients may describe more than one problem with which they would like help. If there are several problems listed, the therapist should write down the problems and briefly review them. The therapist then asks the patient for feedback in order to determine which problem has the highest priority. This process is similar to the agenda setting process that was used during the beginning of the session.

It is important that the therapist approach this process with a positive attitude and view the situation as an opportunity or challenge. The therapist models the problem-solving strategy by approaching the situation with confidence and with a willingness to devote some time and effort to finding an appropriate solution to the patient's problem.

The following dialogue illustrates the manner in which Jack's therapist (a) concluded that he lacked the skills to solve problems that required interaction or negotiation with others, and (b) identified the specific problem that was of highest priority for him to solve. This dialogue demonstrates that two problems were identified—the skills that Jack lacked and the most important problem in his life that he wanted to address.

Jack: Boy, this week has taken the cake. Just when I thought things couldn't get any worse. [frustration escalates] I'm behind on my truck payments, and it might get repossessed. My refrigerator is crapping out even though it's still under warranty. My wife just announced that her nagging sister is going to be staying with us for a week. And…

Therapist: [gently intervening] It sounds like you are facing a number of problems that require your immediate attention, Jack.

Jack: I sure am. And no matter what I do, it's not going to work out. It never does.

Therapist: What do you mean that it never works out?

Jack: Just like I said. I really can't think of a time when I've had a problem like these and it actually works out in my favor.

Therapist: Let's take the example of, say, something like the refrigerator crapping out. Have you ever had an appliance break down in the past?

Jack: [thinking] Yeah, about five years ago, our washer broke, and there was water all over the basement.

Therapist: What did you do about it?

Jack: I cleaned up the water before it did any more damage!

Therapist: Fair enough. And what did you do to solve the problem of the broken washer?

Jack: [frowns] I got screwed as usual. I called the store where I bought it, and they said they couldn't help me, that I needed to call the 1-800 number for the manufacturer. And, just as I had expected, when I did that, I got the run-around. Nobody was willing to give me a straight answer.

Therapist: So did you actually get the washer fixed?

Jack: Nope, never did. My wife was taking clothes to the Laundromat for six months until we finally got a new one. [Therapist takes time to examine the precise steps that Jack took to try to resolve the issue with the manufacturer and concludes that his limited communication skills and inappropriate expression of anger likely interfered with working effectively with the manufacturer of the washing machine]

Therapist: What I'm hearing you say, Jack, is that you handled the immediate problem—the water on the floor. And you came up with a solid solution to address the broken washing machine—to call the store where you bought it, and then follow up with calling the manufacturer. But where the process broke down was in your interaction with the customer service representative and then the manager with whom you asked to speak. It became so frustrating for you that you gave up, and you ultimately weren't able to get the washing machine repaired.

Jack: They were impossible to deal with! They call themselves customer service. Yeah right! They should be thrown in jail, those crooks!

Therapist:	[using an even, soothing voice in response to Jack's anger] Would it be worth it for the two of us to figure out a way to solve problems that involve interacting or negotiating with other people, like customer service representatives?
Jack:	You're saying the whole problem is *me*? *They're* the ones who have the problem.
Therapist:	[gently] Did you hear me say that you are the *entire* problem?
Jack:	[reluctantly] No, I guess not.
Therapist:	There's a lot of truth in what you say about many customer service people being difficult to deal with. I know what it's like to perceive that I'm getting the "run-around." But what is preferable—going without a washing machine or a refrigerator for six months, or figuring out a different approach to dealing with these people so that you can solve your problem or get what you want?
Jack:	I'm tired of not getting what I want.
Therapist:	Would you like to, then, work on developing some skills for solving these kinds of problems?
Jack:	OK.
Therapist:	You mentioned three problems—being behind on truck payments, the refrigerator crapping out, and your sister-in-law coming for a long visit. I have a feeling that, to be solved, each of these problems will require some interaction with others. Which of these would be most important for us to address today?
Jack:	You've actually already made me think about some things for when I deal with customer service jerks. So maybe we can talk about what to do about my sister-in-law. I tell you, you will have to lock me up in the loony bin if I have to entertain her for three weeks.
Therapist:	OK, we'll focus on that. Let's make this problem even more specific. Is your goal to not have her visit or stay with you at all, or might the goal be to set some clear boundaries regarding her visit, so that you are sure to have some space and not be expected to spend time with her 24/7?
Jack:	She's coming. I can't stop that. So I guess it's how to set those boundaries so that we don't kill each other.

Step 2: Thinking About Possible Solutions. After the patient and therapist agree on a problem worthy of further consideration, the therapist helps the patient generate possible alternatives by encouraging her to brainstorm possible solutions. This process often involves educating the patient about the purpose of brainstorming—that it is the creative generation of all possible solutions, even those that seem unrealistic, without evaluating or judging them at this point. Many patients have difficulty with this step, as they simultaneously dismiss potential solutions, often because they might involve some sort of discomfort experienced as they implement them. Thus, it is important to foster an open environment in which the patient can explore all possible solutions, patiently remind patients that they will have an opportunity to evaluate them later in the session, and identify and evaluate any cognitive errors (e.g., all-or-nothing thinking) that are interfering with the fruitful generation of possible solutions. It is our experience that, in many instances, the solution ultimately decided upon is a combination of two or more of the potential solutions generated, and that at least one

aspect of the solution is one that the patient would have omitted or dismissed had she not engaged in this brainstorming process.

A common mistake made by cognitive behavioral therapists is taking a much more active lead than patients in generating possible solutions, which essentially leads to the therapist solving the problem for the patient. Some therapists have the urge to take the lead in generating solutions when they perceive that they do not have much time for a problem-solving exercise, or if they only see the patient infrequently and believe that they have to be as efficient as possible with the time in session. However, it is important to remember that solving the problem for the patient may give him a tangible plan of action for the problem under consideration, but it does little to ensure that the patient will be able to solve problems more effectively in the future. Thus, we strongly encourage therapists to give the patient space to grapple with the generation of potential solutions and allow them to articulate their experience in doing so, so that they have consolidated their learning about ways to generate possible solutions to problems they encounter outside the therapist's office. If a situation arises in which a therapist decides that it would be beneficial to supply some potential solutions, then it is important to follow up with questions such as, "How do you think I came up with that solution?" or "Tell me what I just did there. How can you do something similar the next time you are faced with a problem?"

CASE EXAMPLE: JACK

Jack and his therapist worked together to solve the problem of maintaining reasonable boundaries with his sister-in-law during her visit. At first, Jack was at a loss in generating any possible solutions. His therapist asked questions such as "What might you like to communicate to your wife before her sister's visit to ensure that the two of you are on the same page?" and "What can you communicate to your sister-in-law to ensure that the two of you have your own space?" Jack immediately dismissed conversations with either woman about boundaries, stating that they don't listen to him and do what they want anyway. Jack's therapist gently reminded him of the purpose of brainstorming, asked him whether he was falling into a cognitive error (i.e., fortune telling), and reassured him that, together, they can practice ways to implement solutions that seem difficult. Jack visibly relaxed at this point in the session, and he generated three more possible solutions: (a) ensuring that he had somewhere to go for part of every day, (b) continuing to work on building his homemade computer in the garage (which simultaneously extended the behavioral activation intervention), and (c) avoiding "hot topics" of conversation that have caused conflict in the past, such as politics.

Step 3. Choose a Solution to Implement. After a list of potential solutions has been generated, the therapist asks the patient to evaluate each one and choose the one solution that seems to be most likely to work and least likely to cause additional problems. Issues to consider in the evaluation of potential solutions are (a) the specific steps that would be involved in their implementation, (b) patients' ability to implement those specific steps, (c) the likelihood that patients will follow through with the implementation of those specific steps, (d) barriers to implementing the specific steps, and (e) short- and long-term implications for the implementation of each solution. Because this is a substantial amount of information to organize and track, it is often helpful to evaluate each of these domains in writing, such as on a sheet of paper or on a whiteboard. After each of these domains is considered for each

possible solution, the factors that carry the greatest weight to the patient can be circled or highlighted. Then, together, the therapist and patient consider the results of this evaluation and begin to eliminate potential solutions on the basis of this analysis. Some patients find that this approach to problem-solving is overwhelming; in these cases, the therapist can facilitate a straightforward pro-con analysis, which is described in the subsequent section.

At times, patients find the problem-solving process discouraging when they arrive upon a solution that does not seem optimal to them. It is often helpful to assess patients' expectations for the result of problem-solving and to use the cognitive restructuring strategies described earlier in the manual to ensure that their expectations are realistic (e.g., that most solutions are not ideal and have some potential drawbacks; that they cannot guarantee that their solution will result in the desired outcome). What is most important about a systematic approach to identifying a solution to a problem is that the patient acquires skills to be able to do it on her own, outside of therapy.

CASE EXAMPLE: JACK

Jack continued to dismiss the potential solutions of communicating his desire for boundaries during his sister-in-law's visit, stating that the facts that he is not a good communicator and that there is already a great deal of tension with his wife would be barriers to implementing that solution and would decrease the likelihood that he would follow through. However, he admitted that the long-term implications of that solution would be substantial, in that he would develop a way to reestablish his relationship with his wife, which could contribute to repairing their relationship in the future. Although he indicated that he would not adopt that solution for this particular problem, he was open to revisiting his treatment goals and working on developing effective communication skills to enhance his relationship with his wife and other family members. In contrast, Jack was enthusiastic about implementing the other three solutions they had identified—having a place to go once a day, working on his computer in the garage, and avoiding hot topics. He estimated that there was a high likelihood that he would implement these solutions and that there were important short- and long-term implications, as they had the potential to minimize the likelihood that his sister-in-law would "get on his nerves." Two of the solutions were straightforward to implement, as his workshop in the garage was already set up to work on his computer, and he could easily avoid hot topics. Jack and his therapist, then, began to work on the steps to implement the solution of having somewhere outside the house to go each day.

Step 4. How Well Does It Work? After deciding on one or more solutions to the problem, a logical homework assignment is for patients to follow through with the implementation of that solution. As with any homework assignment, it is crucial to review it in detail in the subsequent session, evaluating the degree to which the solution was helpful. Factors to consider in the evaluation of the solution include: (a) Did it achieve the desired goal? (b) To what degree did the patient exhibit skill in implementing the solution? (c) To what degree can the patient generalize the problem-solving skills obtained to other problems in his or her life? and (d) What barriers did the patient encounter in implementing the solution, and how might those barriers be overcome in the future?

If the solution indeed achieved the desired goal, it is helpful to relate that to the patient's overall treatment goals and reinforce a sense of hopefulness that treatment will be effective. In contrast, if the solution did not achieve the desired goal, then the therapist and patient can revisit Steps 2 and 3, refining the brainstorming and selection processes. We encourage therapists to normalize this experience for patients, reminding them that solutions are not always guaranteed to work and that they nevertheless made significant progress in the acquisition of problem-solving skills. Patients are often able to articulate important "lessons learned" even if the solution did not work well. In the event that the solution does not achieve its desired goal, and the therapist determines that it is due to a skills deficit in the patient's ability to implement the chosen solution, then reasonable courses of action would be to (a) revisit the criteria for selecting an appropriate solution, given that the patient lacks particular skills, and/or (b) address the acquisition of those skills in treatment.

CASE EXAMPLE: JACK

Jack's sister-in-law arrived the weekend in between his sessions, and at the time of his subsequent session, she had been staying at the house for four days. Jack was successful in implementing two of his solutions. Each day, he left the house mid-morning to have coffee at a local diner, and later in the afternoon he retreated to the garage to work on his homemade computer. Jack's therapist took care to assess the degree to which these strategies (a) were perceived as successful solutions to the problem, (b) resulted in a positive impact on his mood, and (c) would be likely to be used in the future. Jack expressed relief that he did not have to be "trapped" in the house with his sister-in-law all day. Although he was reluctant to say that these strategies were associated with an improvement in mood, he admitted that he was much less irritable during this visit than during previous visits. Jack was partially successful at implementing his third solution, which was to avoid discussion of hot topics with his sister-in-law. Two nights ago, he "blew up" at her when he perceived her as "preaching that liberal baloney." Jack and his therapist put this incident on the agenda, and together they identified the cognitions that contributed to his frustration and subsequent behavioral response and ways to respond more adaptively, both cognitively and behaviorally. Jack agreed to practice these new skills over the following week, as his sister-in-law's visit would still be ongoing, and he agreed that it would still be a worthy goal to stay away from hot topics of discussion.

Thus far, we have discussed the application of a problem-solving approach for patients who lack the skills to do so on their own. However, it would be an erroneous assumption to conclude that all patients lack problem-solving skills. In some instances, patients have the requisite skills, but depression, anxiety, or other symptoms interfere with their implementation. This is regarded as a performance deficit rather than a skills deficit. As was illustrated earlier in the dialogue with Jack, therapists first determine whether a patient is characterized by a skills deficit or a performance deficit. If the therapist determines that a performance deficit more accurately characterizes the patient's difficulties with solving her current life problems, then strategies that can be considered include (a) evaluation of the manner in which strategies that the patient had used for previous problems in her life can be applied to the current problem, (b) cognitive restructuring of unhelpful attitudes or beliefs that interfere with problem-solving, and/or (c) behavioral strategies for increasing motivation and energy to solve the problem, such as graded task assignment.

In summary, it is more important for therapists to use a guided discovery approach to improve a patient's problem-solving skills rather than for therapists to solve the problem for the patient. Patients should be reminded that problem-solving is an acquired skilled. This four-step ITCH process will become easier to do the more often patients attempt to use it to address personal problems. A depressed patient may be inclined to view his therapist as an expert problem solver and assume that the therapist was born that way, which is likely to be an erroneous assumption. It may be helpful to point out that, like any skill, practice makes perfect. Initially, this four-step problem-solving process may be unfamiliar and awkward for the patient and may require some effort, but in time and with practice, it can become a more automatic way in which the patient comes to address his most difficult problems.

In summary, it is more important for therapists to use a guided discovery approach to improve a patient's problem-solving skills rather than for therapists to solve the problem for the patient.

Evaluating Pros and Cons

- **Evaluating pros and cons**

When patients are confronted with problems, it can be very difficult to decide on the best option, and they may be plagued by indecision. At times, the patient is forced to choose between two equally good options; at other times, she is forced to decide between two choices that both have drawbacks. Patients may waver back and forth between different alternatives and may feel paralyzed in settling on a specific course of action. A problem-solving strategy to assist patients in deciding between two options is to evaluate the pros and cons of each option.

There are two approaches that the therapist can adopt to evaluate the pros and cons. In the most straightforward approach, the therapist and patient draw two columns and list all of the pros and cons for any one decision. Alternatively, the therapist and patient draw four cells, in which they list the pros and cons of both decisions in a manner that facilitates easy comparison. After all of the pros and cons have been listed, the patient evaluates the strength of each point raised and makes a decision based on all of the available information listed. Exhibit 4.10 on the next page shows the manner in which Claire evaluated the pros and cons regarding her decision of whether to look for a new job.

Exhibit 4.10. Claire's Pros and Cons

Looking for a new job	
Pros	**Cons**
• *I might get a higher salary.* • *I can use skills that I don't use in my current job.* • *I would experience fewer hassles because of my medical condition.* • *I would have certainty regarding my employment situation.* • *It would be a new challenge, and I like challenges.*	• *Finding a new job takes a lot of time and effort.* • *I won't be doing what I truly love.* • *I might have to go back to school in order to advance, and that would seem like starting over.*
Staying at current job	
Pros	**Cons**
• *Being a pilot has been my dream as long as I can remember.* • *I'm on a "fast track" to being captain.* • *I'm good at being a pilot.* • *I like my co-workers.* • *I will overcome adversity by piloting even though I'm an amputee.*	• *The hours are irregular.* • *I might continually have to fight the "system" to show that I can fly.* • *I experience some gender bias because there are few female pilots.* • *The work I need to put in to advance seems all-consuming.*

After completing the comprehensive pro-con analysis of continuing her fight to remain serving as a pilot versus getting another job, Claire weighed the strength of each of the items that she listed. Although she was able to recognize some sound reasons for looking for another job, the items that carried the most weight in her decision were that she has strived to be a pilot for her entire life and that she truly enjoyed flying. Thus, Claire ultimately decided to continue to await the decision of the medical board regarding her reinstatement as a pilot. However, she acknowledged that this exercise relieved anxiety because she identified many advantages to working in a different position in the event that she is not cleared to fly. This realization had the effect of modifying Claire's view that it would be terrible if she could not resume work as a pilot. From this example, we hope therapists will see that effective problem-solving not only helps patients to settle on a specific solution to their problems, but it also has the potential to create cognitive change by dispelling all-or-nothing thinking surrounding less desired solutions.

PART V: LATER PHASE OF TREATMENT

PART V: LATER PHASE OF TREATMENT

The main focus during the later phase of this treatment is to evaluate patients' progress toward their treatment goals and whether they have learned and can apply specific skills that may help to reduce or prevent a relapse of depression. Usually, the later phase of treatment occurs following an adequate dose of treatment (usually 12 to 16 sessions). However, given the flexible nature of this protocol, the later phase of treatment may occur after patients have attended a fewer number of sessions, or it may occur after the patient has attended more than 16 sessions. In this part of the manual, we present some guidelines for assisting therapists in determining whether patients are clinically ready for the later phase of treatment. As with other aspects of CBT, it is recommended that the termination or tapering of CBT sessions is collaboratively decided between the therapist and patient. There are three main tasks that the therapist undertakes in the later phase of CBT for depressed patients: (a) reviewing progress toward treatment goals, (b) summarizing and consolidating skills learned during the middle phase of treatment, including the preventing future lapses of depression, and (c) additional treatment planning.

As with other aspects of CBT, it is recommended that the termination or tapering of CBT sessions is collaboratively decided between the therapist and patient.

Reviewing Progress Toward Treatment Goals

- **Reviewing progress toward treatment goals**

The initial step for determining if patients are ready for the final phase of CBT involves the consideration of a patient's *progress toward the treatment goals*. Thus, the therapist and patient review the treatment goals established during the initial phase of treatment as well as any additional treatment goals agreed upon during the middle phase of treatment. Because these goals were operationally defined in observable and measurable terms, the therapist and patient can use objective "data" to facilitate their assessment.

CASE EXAMPLE: KATE

Kate's goals for treatment included (1) improving her depressed mood by increasing engagement in at least one pleasurable activity per day and sleeping no more than eight hours per day; (2) re-negotiating a satisfying relationship with her children, including regular telephone and in-person contacts; and (3) improving adaptive functioning by getting a new job, paying bills on time, and maintaining frequent contact with family members and friends. Thus, Kate and her therapist should review the progress that was made with respect to each of these specific goals.

One fundamental issue to consider in evaluating a patient's response to CBT is whether the patient is less depressed. The therapist and patient review the changes in scores on the BDI since the beginning of treatment. Sometimes, the therapist plots the scores on a graph for each session to measure the patient's progress. Generally, a patient is considered to have successfully responded to treatment if his BDI total score has been reduced by at least 50% or if the BDI total score is in a minimal range of severity (10 points or fewer). Although the BDI has been shown to be a sensitive measure of treatment response, therapists may also evaluate the degree to which depression has remitted in other ways. For example, the therapist may consider the following questions: (a) Does the patient spontaneously report that he is feeling less depressed? (b) Is the patient engaging in more activities during the week? (c) Does

the patient report that other people in his social network notice a change in her mood or in her behavior? (d) Are the key symptoms less severe than were initially recognized as a problem by the patient? Thus, the therapist may choose to focus on a variety of indices and sources of information, including standardized measures like the BDI, in determining the degree to which her patient's depression has remitted.

Regardless of overall improvement in the level of severity in depression, the therapist should specifically consider two additional symptoms: hopelessness and suicide ideation. As discussed earlier in this manual, hopelessness and suicide ideation are Items 2 and 9, respectively, on the BDI. If the patient continues to report hopelessness or suicide ideation on the BDI, or spontaneously expresses hopelessness or suicide ideation during the therapy session, the ending or tapering of treatment is likely not to be clinically appropriate even if the patient has made progress in other areas of her life. Treatment should be continued and/or other treatment (e.g., medication) added until the hopelessness and suicide ideation have resolved.

Review and Consolidation of Skills

- **Review and consolidation of skills**

Once the therapist and patient have determined that adequate progress toward the treatment goals has occurred, the next step in the final phase of CBT is to review all of the skills that were learned and practiced during treatment. This comprehensive review is appropriate when (a) the severity of patients' acute symptoms of depression have diminished; (b) patients perceive that most, if not all, of the issues that brought them into treatment have been addressed; and (c) patients have demonstrated that they have acquired skills for coping with future distress or a potential relapse in depression.

To facilitate the review and consolidation of skills, the therapist asks the patient which skills were most helpful in reducing his depression as these skills were applied during the course of treatment. Reviewing the learned skills may be a useful homework assignment because it allows time for the patient to reflect upon the skills or aspects of treatment that he found most beneficial. If it becomes evident the patient is having difficulty generating a list of specific cognitive and behavioral coping strategies, it is likely that he is not ready to move out of the middle phase of treatment.

To facilitate the review and consolidation of skills, the therapist asks the patient which skills were most helpful in reducing his depression as these skills were applied during the course of treatment.

For patients who have made progress toward their treatment goals and who are less depressed, it is helpful to discuss the potential for relapse of depression. This discussion might include the identification of specific issues or circumstances that are likely to trigger an increase in depression. Typically, when patients experience a setback, such as a relapse in depression, they will often experience hopelessness. This pessimism is often associated with an all-or-nothing thinking pattern that leads patients to conclude that treatment was ineffective. This belief is especially dangerous because patients may generalize this setback to indicate that any treatment will not be helpful which, in turn, could prompt patients not to seek future treatment.

To prepare patients for possible setbacks or lapses, unrealistic expectations should be addressed, along with potential strategies for dealing with setbacks. The therapist and

patient should review the skills that would be most helpful in dealing with such setbacks or future crises. Patients should be encouraged to work on a "survival kit" that includes many of the skills or other tools that have been helpful to them in the past. Items for the survival kit may include coping cards, Thought Records, or activity schedules that were completed during treatment, as well as blank forms and other sources of information (e.g., self-help books) that are likely to be helpful in preventing relapse. The survival kit usually includes only those items or tools that patients have found to be helpful in the past.

To prepare patients for possible setbacks or lapses, unrealistic expectations should be addressed, along with potential strategies for dealing with setbacks.

Additional Treatment Planning

After the successful completion of the review of treatment goals, the consolidation of treatment skills, and relapse prevention, the therapist and patient discuss four treatment options: (a) continuation of treatment, (b) tapering treatment sessions, (c) referral for additional treatment, and (d) termination of treatment.

Continuation of Treatment

- **Continuation of treatment**

Occasionally, patients may make substantial gains in improving their depression. However, despite these treatment gains, there may be other issues or problems that are not associated with depression but that could be addressed using CBT. If there are other issues to be addressed, the therapist and patient may revisit the treatment goals for the continuation phase of treatment and negotiate the number and/or frequency of sessions. Once new specific treatment goals have been collaboratively established, the therapist and patient continue to work toward these goals using a similar session structure that was described in Part II. Because patients may no longer be depressed, the therapist and patient may decide that the weekly completion of the BDI is no longer necessary, and they may decide to complete the BDI less often. In addition, it might be helpful to use other standardized measures or mood rating scales on a regular basis that measure the symptoms or problems that have become the focus of the continued treatment. The administration of such measures or ratings is important because they provide for an objective measurement of treatment progress.

Tapering Treatment Sessions

- **Tapering treatment sessions**

If the therapist and patient agree that the specific treatment goals that were established during the initial phase of CBT have been reached, then they may also agree that meeting on a weekly or biweekly basis is no longer necessary. Instead of terminating treatment at this point, however, the therapist should consider whether it would be advantageous to continue with occasional treatment sessions for several reasons: (a) to monitor the patient's clinical status, (b) to discuss CBT strategies for maintaining treatment gains or preventing relapse, or (c) to focus on other specific issues associated with ending treatment. For example, the therapist and patient may decide to taper the frequency of the sessions by scheduling biweekly or monthly meetings instead of weekly visits. On occasion, the therapist may find that he is one of the few supportive persons in the Veteran's social network. When this occurs, the therapist should be keenly aware of and assess the patient's reactions following any discussion about ending or even tapering the frequency of therapy sessions. Working toward expanding the patient's network may help to ease the Veteran's sense of

dependency on the therapist. In addition, when changes in the frequency of visits are being considered, it may be helpful to consult with other providers who are providing care for the patient or with the patient's family members. Other providers and family members may assist the therapist in determining if changing the frequency of visits is clinically appropriate as well as in helping the therapist to choose the best approach for handling this issue with the patient.

Referring for Additional Treatment

- **Referring for additional treatment**

On other occasions, a patient may need further treatment that is beyond the expertise of the treating therapist. In such instances, the therapist would consider the specific diagnoses or problems requiring further treatment and seek out providers with the appropriate area of expertise. When referring a patient to other providers, it is important to ensure that there is a continuity of care. This may be accomplished by discussing the patient's expectations for additional care, assisting with scheduling an appointment with the new provider, determining if the patient attended the appointment, and evaluating the patient's reactions to the additional treatment.

Termination of Treatment

- **Termination of treatment**

The *termination of treatment* may be considered when the treatment goals have been met, the patient is no longer clinically depressed, the specific CBT skills learned during treatment have been reviewed, and strategies for dealing with relapses or setbacks have been discussed. Even though patients may be doing relatively well at the end of treatment, some patients may continue to have concerns about the possibility of a relapse of a depressive episode and may want the option of "checking in" with the therapist without having to initiate another course of CBT treatment. One treatment option for use after therapy has terminated involves the use of booster sessions. These sessions provide the opportunity for a mood check and the assessment of depressive symptoms (such as the administration of the BDI), an assessment of any ongoing treatment of other mental health or substance use disorders, an assessment of any specific circumstances or stressful life events that may be associated with relapse, a review of the patient's implementation of the skills learned during therapy, and the assessment and general reinforcement of the sustained gains that have been accomplished since the termination of treatment. Booster sessions may be scheduled many weeks or even months after the final session or they may be provided on an as-needed basis. If the booster sessions have not been scheduled, it is important for the therapist and patient to agree upon the specific circumstances or indicators for scheduling such sessions. Listing some of these indicators is important so that the patient may recognize them and return for an appointment before a relapse of a full depressive episode. These indicators might include the emergence of a few key symptoms that may signal impending relapse such as feeling depressed or a lack of interest in activities that are usually pleasurable, a sense of hopelessness or isolation, or other depressive symptoms. It is helpful for the therapist to keep in mind the advantages of scheduling a booster session as opposed to waiting until a full relapse of depression has occurred. Patients who have scheduled a booster session may see it as a prompt for continuing to practice and implement the acquired

Even though patients may be doing relatively well at the end of treatment, some patients may continue to have concerns about the possibility of a relapse of a depressive episode and may want the option of "checking in" with the therapist without having to initiate another course of CBT treatment.

skills. Scheduled booster sessions spaced over time may help to prevent relapse for some patients.

CONCLUSION

The aim of this user-friendly treatment manual is to describe and illustrate the application of CBT for depression with Veterans and Military Servicemembers using a short-term approach (i.e., approximately 12 to 16 sessions). This manual represents one of the first therapist manuals focusing on the use of CBT with Veterans and Military Servicemembers that utilizes illustrative case examples.

CBT is a structured, time-limited, present-focused approach to psychotherapy that helps patients develop strategies to modify unhelpful cognitions and behaviors in order to assist them in resolving current problems and managing mood. The treatment is based on clinical observation and substantial research that reveals that patients with depression exhibit negative thoughts and beliefs about themselves, their world, and their future. Helping patients to acquire cognitive strategies to identify and evaluate such negative thinking styles will lead to improved mood and a decrease in the severity of depression. CBT is also based on extensive clinical observation and research that patients with depression often disengage with their environments. Depressed patients may not have sufficient pleasant activities or mastery experiences, and this behavioral pattern often leads to low motivation and other depressive symptoms. Assisting Veterans and Servicemembers in recognizing and changing such behavioral patterns in their lives is important for treating depression.

The protocol presented in this manual emphasizes the use of a case conceptualization approach to implementing CBT for depression with Veterans and Military Servicemembers. [For additional information on adapting CBT for depression in older patients, see Karlin (2011)]. In this protocol, cognitive behavioral therapists use the CBT theoretical framework to develop an understanding of the patient's clinical presentation and to identify stressful situations, automatic thoughts, and maladaptive behaviors that contribute to the patient's depression. The case formulation approach allows for the treatment to be implemented in a flexible manner so that the specific cognitive and behavioral strategies employed are tailored to the patient's individual needs and goals for treatment. In the case conceptualization process, therapists apply an empirical approach to each case, meaning they generate hypotheses about the cognitive, emotional, behavioral, and situational factors that contribute to, maintain, and exacerbate a patient's mental health problems. Chronic and recurrent unhelpful thoughts and behaviors are also conceptualized by identifying core beliefs and intermediate beliefs that become apparent during stressful periods and that are maintained or reinforced by long-standing compensatory strategies.

This protocol also emphasizes the importance of the therapeutic relationship, recognizing that the therapeutic relationship is a key contextual variable in CBT. A strong therapeutic alliance is an important component of CBT and is enhanced by a warm, empathic understanding of the patient's problems in light of the CBT model. Moreover, a solid therapeutic alliance is critical to success of CBT and to realizing substantive patient gains.

Other key features of the present protocol include the use of a structured session format that facilitates the delivery of the therapy. This includes a brief mood check, the use of standardized measures of depression to measure progress, conducting a

summary of the previous session, reviewing the homework that was assigned during the previous session, setting a prioritized agenda of topics to be discussed during the session, assigning homework, conducting periodic summaries, and obtaining feedback during and at the end of each session. The treatment uses a collaborative approach to identifying treatment goals, agendas, specific cognitive and behavioral strategies, and homework assignments.

The application of CBT also includes an initial phase, a middle phase, and an ending phase. During the initial phase, the therapist identifies the patient's motivation and expectations for treatment. Educating Veterans about the structure and general approach used in CBT and addressing any negative expectations for treatment helps increase the likelihood that treatment will be successful. Identifying specific treatment goals in behavioral terms and obtaining feedback on the helpfulness of treatment also helps the patient succeed in therapy.

On the basis of the CBT case conceptualization, the therapist and patient collaboratively choose specific behavioral and cognitive strategies that are most likely to be successful in addressing the patient's key automatic thoughts, beliefs, or behaviors. Behavioral strategies include Activity Monitoring, Activity Scheduling, behavioral activation, graded task assignments, and relaxation and breathing strategies. Cognitive strategies include identifying and evaluating key automatic thoughts using Socratic questioning, Thought Records, and/or coping cards. Core beliefs are addressed using the downward arrow technique, understanding the benefits and costs associated with such beliefs, and using reframing strategies to adopt more helpful beliefs. CBT focuses on resolving a patient's current problems and aims to teach effective problems-solving skills.

During the later phase of treatment, the CBT therapist and her patient review progress toward the treatment goals established during the initial phase of treatment, summarize and consolidate the skills learned during the middle phase of treatment, and plan for the continuation or termination of treatment.

We hope this manual will be helpful to clinicians new to CBT, as well as to those who are interested in enhancing their CBT skills. Although the primary aim of this manual has focused on the treatment of depression, it is our expectation that the core CBT competencies described in this manual can be adapted and applied to treat other mental health and behavioral health conditions.

Although CBT has been used for decades with mental health patients, it is now being implemented more systematically (along with other evidence-based treatments) in VA facilities as well as other clinics, hospitals, and practices across the country. Countless patients have expressed the gratitude for the opportunity to receive CBT, many observing that, for the first time in their lives, they have developed strategies and tools for managing their mood, solving their life problems, and enhancing quality of life. Use of an active, structured treatment approach such as CBT allows for the efficient treatment of patients, which not only helps patients to see change in their lives rather quickly, but also allows therapists to see more patients because the course of treatment is time-limited. As a result, therapists and patients, alike, develop a renewed sense of hope and optimism for treatment success.

REFERENCES

REFERENCES

Addis, M. E., & Martell, C. R. (2004). *Overcoming depression one step at a time: The new behavioral activation approach to getting your life back.* Oakland, CA: New Harbinger.

American Psychiatric Association. (2003). *Practice guideline for the assessment and treatment of patients with suicidal behaviors.* Arlington, VA: Author.

Basco, M. R., & Rush, A. J. (1996). *Cognitive-behavioral therapy for bipolar disorder.* New York, NY: Guilford Press.

Beck, A. T. (1967). *Depression: Causes and treatment.* Philadelphia, PA: University of Pennsylvania Press.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York, NY: Basic Books.

Beck, A. T., Freeman, A., Davis, D. D., & Associates. (2004). *Cognitive therapy for personality disorders (2nd Ed.)*. New York, NY: Guilford Press.

Beck, A. T., Rector, N. A., Stolar, N., & Grant, P. (2009). Schizophrenia: Cognitive theory, research, and therapy. New York, NY: Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York, NY: Guilford Press.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. Dallas, TX: The Psychological Corporation.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York, NY: Guilford Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond.* New York, NY: Guilford Press.

Beck, J. S. (2005). *Cognitive therapy for challenging problems: What to do when the basics don't work.* New York, NY: Guilford Press.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16*, 252–260.

Bouton, M., Mineka, S., & Barlow, D. H. (2001). A contemporary learning theory perspective on the etiology of panic disorder. *Psychological Review, 108,* 4–42.

Burns, D. D. (1980). *Feeling good: The new mood therapy.* New York, NY: Nal Penguin.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17–31.

Clark, D. A., & Beck, A. T. (1999). *Scientific foundations of cognitive theory and therapy of depression.* New York, NY: Wiley.

Craigie, M. A., & Nathan, P. (2009). A nonrandomized effectiveness comparison of broad-spectrum group CBT to individual CBT for depressed outpatients in a community mental health setting. *Behavior Therapy, 40*, 302–314.

DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., Shelton, R. C., Young, P. R., Salomon, R. M., …Gallop, R. (2005). Cognitive therapy vs. medications in the treatment of moderate to severe depression. *Archives of General Psychiatry, 62,* 409–416.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., …Parloff, M. B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry, 46,* 971–982.

Fairburn, C. (2000). Cognitive-behavioral therapy for bulimia nervosa. In F. Flach (Ed.), *The Hatherleigh guide to psychiatric disorders, Part II. The Hatherleigh guide series* (pp. 69–88). Long Island City, NY: The Hatherleigh Company.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25.

Heimberg, R. G., & Becker, R. E. (2002). *Cognitive-behavioral group therapy for social phobia: Basic mechanisms and clinical strategies.* New York, NY: Guilford Press.

Hirsch, C., Jolley, S., & Williams, R. (2000). A study of outcome in a clinical psychology service and preliminary evaluation of cognitive-behavioral therapy in real practice. *Journal of Mental Health, 9,* 537–549.

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology, 57,* 285–315.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223–233.

Karlin, B. E. (2009). *Dissemination of evidence-based psychotherapy in a health care system: National strategy and initial evaluation outcomes.* Plenary presentation at the Department of Veterans Affairs National Mental Health Conference. Baltimore, MD.

Karlin, B. E. (2011). Cognitive behavioral therapy with older adults. In K. H. Sorocco & S. Lauderdale, (Eds.), *Cognitive behavioral therapy with older adults: Innovations across care settings* (pp. 1-28). New York: Springer Publishing Company.

Karlin, B. E., Meuller, L., Adler, L., Beaudreau, S., Kauth, M. R., Kuhn, E., …Walser, R. D. (2009). *Department of Veterans Affairs: Bibliotherapy resource guide.* Washington, DC: Department of Veterans Affairs.

Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., Resick, P. A., & Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of Traumatic Stress, 23*, 663-73.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization: Working efficiently with clients in cognitive-behavioral therapy.* New York, NY: Guilford Press.

Layden, M. A., Newman, C. F., Freeman, A., & Morse, S. B. (1993). *Cognitive therapy of borderline personality disorder*. Boston, MA: Allyn and Bacon.

Lewinsohn, P. M., Sullivan, J. M., & Grosscup, S. J. (1980). Changing reinforcing events: An approach to the treatment of depression. *Psychotherapy: Theory, Research, and Practice, 17,* 322–334.

MacPhillamy, D. J., & Lewinsohn, P. M. (1982). The Pleasant Events Schedule: Studies on reliability, validity, and scale intercorrelations. *Journal of Consulting and Clinical Psychology, 50,* 363–380.

McQuaid, J. R., Granholm, E., McClure, F. S., Roepke, S., Pedrelli, P., Patterson, T. L., & Jeste, D. V. (2000). Development of an integrated cognitive-behavioral and social skills training intervention for older patients with schizophrenia. *Journal of Psychotherapy Practice and Research, 9*, 149–156.

Meyer, B., Pilkonis, P. A., Krupnick, J. L., Egan, M. K., Simmens, S. M., & Sotsky, S. M. (2002). Treatment expectancies, patient alliance, and outcome: Further analyses from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 70,* 1051–1055.

Mineka, S., & Zinbarg, R. (2006). A contemporary learning theory perspective on the etiology of anxiety disorders: It's not what you thought it was. *American Psychologist, 61,* 10–26.

Persons, J. B. (2006). Case formulation-driven psychotherapy. *Clinical Psychology: Science and Practice, 13,* 167–170.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*, 325–334.

Shapiro, A. K., & Shapiro, E. (1997). *The powerful placebo: From ancient priest to modern physician*. Baltimore, MD: Johns Hopkins University Press.

Stanley, B. & Brown, G. K. (with Karlin, B., Kemp, J. E., & VonBergen, H. A.) (2008). *Safety plan treatment manual to reduce suicide risk: Veteran version.* Washington, DC: U.S. Department of Veterans Affairs. Retrieved from http://www.mentalhealth.va.gov/College/docs/VA_Safety_planning_manual.doc.

U. S. Department of Veterans Affairs (2010). *Cognitive behavioral therapy with depressed Veterans: Therapist training video* [DVD]. St. Louis, MO: Employee Education Service.

Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications.* Washington, DC: APA Books.

Wenzel, A., Jeglic, E. L., Levy-Mack, H., Beck, A. T., & Brown, G. K. (2008). Treatment attitude and therapy outcome in patients with borderline personality disorder. *Journal of Cognitive Psychotherapy, 22*(3), 250–257.

Williams, J. M. G., Barnhoffer, T., Crane, C., & Duggan, D. S. (2006). The role of overgeneral memory in suicidality. In T. E. Ellis (Ed.), *Cognition and suicide: Theory, research, and therapy* (pp. 173–192). Washington, DC: APA Books.

Wright, J. H., Basco, M. R., & Thase, M. E. (2006). *Learning cognitive behavioral therapy: An illustrated guide*. Washington, DC: American Psychiatric Publishing, Inc.

Zanjani, F., Miller, B., Turiano, N., Ross, J., & Oslin, D. (2008). Effectiveness of telephone-based referral care management: A brief intervention to improve psychiatric treatment engagement. *Psychiatric Services, 59,* 776–781.

GLOSSARY

GLOSSARY

3Cs Approach: A simple mnemonic acronym—Catch It, Check It, Change It—developed to help patients understand and use cognitive restructuring.

Activity Monitoring: The recording of behaviors by the patient that include ratings of mastery, pleasure, and mood.

Activity Scheduling: Identifying activities that provide a sense of pleasure and/or accomplishment and choosing a specific point in time to do the activity.

Agenda setting: A collaborative process between the therapist and patient in which they identify and prioritize the topics or issues to be addressed during the therapy session.

Alternative response: An adaptive response developed to counter or modify an automatic thought after evaluation of the thought indicates that it is maladaptive or unhelpful.

Automatic thoughts: Evaluative thoughts that arise in response to particular situations or events.

Basic cognitive model: A model in which Activating events ("A") influence automatic thoughts or Beliefs ("B"), which influence an emotional, physiological, or behavioral Consequence ("C").

Beck Depression Inventory-II (BDI): A 21-item self-report instrument developed to measure severity of depression in adults and older adults in the preceding two weeks and is used to gauge progress and assist in treatment planning.

Behavioral activation: An approach to treating depression based on Lewinsohn's behavioral model of depression, whereby the therapist encourages patients to identify and implement one or two actions that can make a difference in how they feel.

Behavioral experiment: An agreed-upon protocol whereby a patient tests a prediction by trying out something and evaluating the outcome based on the "data" she has collected.

Behavioral theory: A theory that postulates that a lack of positive reinforcement or aversive experiences influences depressive symptoms.

Bibliotherapy: A homework assignment that usually consists of recommendations by the therapist for the patient to read published information such as self-help therapy workbooks or Web-based materials.

Booster sessions: Therapy sessions scheduled as needed by the patient during the final phase of treatment and scheduled in response to the emergence of suicide ideation, an exacerbation of life stress, or a worsening of factors that initially brought the patient into treatment.

Bridge from the previous session: A brief summary provided by the therapist or patient to ensure that the patient recalls the work completed in the previous session and to follow up on relevant issues as well as to identify any negative reactions that the patient might have had to the previous session.

Brief mood check: An assessment of the patient's mood since the previous session for the purpose of tracking progress.

Case conceptualization: Individualized formulation of the patient's presenting problems in order to guide treatment planning and intervention.

CBT session structure: The format of therapy sessions that often includes a mood check, bridge from the previous session, prioritized agenda, review of previous session homework, discussion of agenda items, periodic summaries, homework assignment, final summary, and session feedback.

Cognitions: Thoughts or images including both automatic thoughts and goal-directed thoughts.

Cognitive behavioral theory: A theory that postulates that emotional experiences are influenced by our thoughts and behaviors; extreme patterns of thinking and behavior are associated with mental health problems.

Cognitive Behavioral Therapy: A structured, time-limited, present-focused approach to psychotherapy that helps patients develop strategies to modify dysfunctional thinking patterns or cognitions and maladaptive emotions and behaviors in order to assist them in resolving current problems.

Cognitive distortion: A particular style of interpreting events and situations; also called a *cognitive error*. Mind reading, all-or-nothing thinking, and overgeneralization are types of cognitive distortions.

Cognitive restructuring: A process whereby patients (a) identify unhelpful thoughts, beliefs, and images; (b) distance themselves from unhelpful cognitions before they act upon them; (c) evaluate the veracity of those cognitions; and, if necessary, (d) develop alternative cognitions that more realistically characterize the situation at hand.

Cognitive theory: A theory that postulates that thought content and styles of information processing are associated with our mood, physiological responses, and behaviors.

Compensatory strategies: Behavioral strategies that support or maintain core beliefs.

Conditional assumptions: Rules or intermediate beliefs that are related to core beliefs.

Coping cards: Small cards that include brief cognitive or behavioral strategies that are easily accessible. Coping cards may include automatic thoughts that are often experienced by the patient as well as adaptive responses.

Core beliefs: Rigid and persistent beliefs that people have about themselves, the world, and/or the future.

Dysfunctional thinking patterns: Unhelpful or maladaptive cognitions.

Empirical approach: An approach whereby hypotheses are generated about the cognitive, emotional, behavioral, and situational factors that contribute to, maintain, and exacerbate a patient's mental health problems.

Feedback: The process of asking patients whether a specific intervention or session was helpful or how it was helpful; asking patients questions to ensure that they understand the therapist's line of reasoning.

Final summary: A review or recap of the most important issues addressed during the session by the therapist or patient; typically occurs at the end of the session.

Graded task assignment: A technique for simplifying complicated behavioral tasks into smaller parts or steps.

Guided discovery: The process of using Socratic questioning to guide patients to make discoveries on their own; usually more effective than directly lecturing or educating patients.

Homework assignment: An agreed-upon assignment serving as an opportunity for patients to practice their cognitive and behavioral skills in their own environment.

Intermediate beliefs: Inflexible and absolute rules and assumptions about the way the world operates.

ITCH: A simple mnemonic acronym developed to help patients learn problem-solving skills. ITCH stands for (1) Identify the problem; (2) Think about possible solutions; (3) Choose a solution to implement; (4) How well does it work?

Mastery rating: The degree of mastery or sense of accomplishment a patient received from an activity rated on a scale from 0 to 10.

Mastery: A sense of accomplishment.

Motivational enhancement: A process that uses some aspects of motivational interviewing to help patients commit to the therapy process and to making changes in their lives.

Motivational interviewing: A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve their ambivalence about treatment.

Negative cognitive triad: Negative or pessimistic thoughts and beliefs that depressed patients have about themselves, the world, and/or the future.

Periodic summaries: Brief recaps of the issues discussed in session that typically occur at the close of discussion of an agenda item. Summaries aim to ensure that the therapist and patient have a mutual understanding of the nature of the problem being discussed as well as the identified solutions.

Pleasant Events Schedule: A checklist of potential activities that involves ratings of the frequency and pleasantness of the activities.

Pleasure rating: The degree of pleasure or enjoyment a patient experiences during an activity rated on a scale from 0 to 10.

Progressive muscle relaxation: A relaxation technique involving the systematic tensing and relaxing of the muscle groups in the body.

Punishment: Person–environment interactions associated with negative outcomes and/or emotional distress.

Response-contingent positive reinforcement: Person–environment interactions associated with positive outcomes or that make a person feel good.

Runaway train effect: A cascade of thoughts where depressed and anxious patients report that one thought prompts another thought, which prompts another thought, which prompts yet another thought, etc., with each thought being more negative and distorted than the previous one.

Safety plan: A prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises.

Schemas: "Relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way, thereby determining how phenomena are perceived and conceptualized" (Clark & Beck, 1999, p. 79).

Self-concept: A belief about oneself.

Socratic questioning: A therapeutic method to help patients evaluate their automatic thoughts whereby the therapist asks questions that stimulate critical thinking and accurate examination of the patient's cognitions.

Suicide risk assessment: An evaluation of the risk and protective factors for suicide that involves the determination of whether or not a patient is imminently or likely to be dangerous to himself.

Target complaints: Primary problems that led the patient to seek treatment.

Thought Record: A form for patients to record descriptions of situations, their emotions, and their automatic thoughts associated with a shift in affect (three-column) or a form for patients to record descriptions of situations, their emotions, their automatic thoughts, adaptive responses, and outcomes (five-column).

Vivid images: Nonverbal thoughts and pictorial images in response to particular situations or events.

Working Alliance Inventory (WAI): A brief measure for inquiring about the therapeutic alliance derived from Bordin's (1979) theory of change-inducing relationships, which has as key components of the working alliance (a) agreement on the treatment goals, (b) agreement on how to achieve the goals (task agreement), and (c) development of a personal bond between patient and the therapist.

APPENDIX

APPENDIX

ACTIVITY MONITORING FORM

ACTIVITY MONITORING FORM

Instructions: Please list the activities you did on each day of the week, whatever it may have been. Below each activity, rate the degree of pleasure (P) and mastery/accomplishment (M) on a 0 - 10 scale for each, where 0 is no pleasure or mastery/accomplishment and 10 is the greatest degree of pleasure or mastery/accomplishment. Please also rate your **overall** mood for the entire day on a scale of 0 - 10, where 0 is feeling the **worst** you could imagine feeling and 10 is feeling the **best** you could imagine feeling.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 A.M.							
9:00 A.M.							
10:00 A.M.							
11:00 A.M.							
12:00 P.M.							
1:00 P.M.							
2:00 P.M.							
3:00 P.M.							
4:00 P.M.							
5:00 P.M.							
6:00 P.M.							
7:00 P.M.							
8:00 P.M.							
9:00 P.M.							
Overall Mood (0 - 10)							

ACTIVITY SCHEDULE FORM

ACTIVITY SCHEDULE

Instructions: This is your personalized activity schedule. For each day, circle those activities **that you actually did** (or write in whatever else you did if you did something else). Please also rate your **overall** mood for the entire day on a scale of 0 -10, where 0 is feeling the **worst** you could imagine feeling and 10 is feeling the **best** you could imagine feeling.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00 A.M.							
9:00 A.M.							
10:00 A.M.							
11:00 A.M.							
12:00 P.M.							
1:00 P.M.							
2:00 P.M.							
3:00 P.M.							
4:00 P.M.							
5:00 P.M.							
6:00 P.M.							
7:00 P.M.							
8:00 P.M.							
9:00 P.M.							
Overall Mood (0 - 10)							

CALIFORNIA OLDER PERSON'S PLEASANT EVENTS SCHEDULE

CALIFORNIA OLDER PERSON'S PLEASANT EVENTS SCHEDULE

Dolores Gallagher-Thompson, Larry W. Thompson, Kenneth L. Rider

Name_____
Date_____

This is a list of 66 events that people tend to find pleasant. For each event, make 2 ratings:

How often did this event happen to you in the past month?

0 = Not at all
1 = 1-6 times
2 = 7 or more times

How pleasant, enjoyable, or rewarding was this event? If the event did *not* occur, then please rate how pleasant you think it *would have been* if it *had* occured.

0 = Was not or would not have been pleasant
1 = Was or would have been somewhat pleasant
2 = Was or would have been very pleasant

Here are two sample events with the answers properly filled in. Please remember to circle an answer for both HOW OFTEN and HOW PLEASANT for each event.

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
A. Winning the lottery	[0] 1 2	0 1 [2]
B. Writing a letter	0 [1] 2	0 [1] 2

California Older Person's Pleasant Events Schedule

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
1. Looking at clouds	0 1 2	0 1 2
2. Being with friends	0 1 2	0 1 2
3. Having people show an interest in what I say	0 1 2	0 1 2
4. Thinking about pleasant memories	0 1 2	0 1 2
5. Shopping	0 1 2	0 1 2
6. Seeing beautiful scenery	0 1 2	0 1 2
7. Having a frank and open conversation	0 1 2	0 1 2
8. Doing a job well	0 1 2	0 1 2
9. Listening to sounds of nature	0 1 2	0 1 2
10. Having coffee, tea, etc., with friends	0 1 2	0 1 2
11. Thinking about myself	0 1 2	0 1 2
12. Being complemented or told I have done something well	0 1 2	0 1 2

California Older Person's Pleasant Events Schedule

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
13. Doing volunteer work	0 1 2	0 1 2
14. Planning trips or vacations	0 1 2	0 1 2
15. Kissing, touching, showing affection	0 1 2	0 1 2
16. Being praised by people I admire	0 1 2	0 1 2
17. Meditating	0 1 2	0 1 2
18. Listening to music	0 1 2	0 1 2
19. Seeing good things happen to family or friends	0 1 2	0 1 2
20. Collecting recipes	0 1 2	0 1 2
21. Doing a project my own way	0 1 2	0 1 2
22. Seeing or smelling a flower or plant	0 1 2	0 1 2
23. Saying something clearly	0 1 2	0 1 2
24. Thinking about something good in the future	0 1 2	0 1 2
25. Looking at the stars or moon	0 1 2	0 1 2

California Older Person's Pleasant Events Schedule

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
26. Being told I am needed	0 1 2	0 1 2
27. Working on a community project	0 1 2	0 1 2
28. Complimenting or praising someone	0 1 2	0 1 2
29. Watching a sunset	0 1 2	0 1 2
30. Thinking about people I like	0 1 2	0 1 2
31. Completing a difficult task	0 1 2	0 1 2
32. Amusing people	0 1 2	0 1 2
33. Baking because I feel creative	0 1 2	0 1 2
34. Reading literature	0 1 2	0 1 2
35. Being with someone I love	0 1 2	0 1 2
36. Having an original idea	0 1 2	0 1 2
37. Having peace and quiet	0 1 2	0 1 2
38. Listening to the birds sing	0 1 2	0 1 2
39. Making a new friend	0 1 2	0 1 2

California Older Person's Pleasant Events Schedule

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
40. Being asked for help or advice	0 1 2	0 1 2
41. Bargain hunting	0 1 2	0 1 2
42. Reading magazines	0 1 2	0 1 2
43. Feeling a divine presence	0 1 2	0 1 2
44. Expressing my love to someone	0 1 2	0 1 2
45. Giving advice to others based on past experience	0 1 2	0 1 2
46. Solving a problem, puzzle, crossword	0 1 2	0 1 2
47. Arranging flowers	0 1 2	0 1 2
48. Helping someone	0 1 2	0 1 2
49. Getting out of the city (to the mountains, seashore, desert)	0 1 2	0 1 2
50. Having spare time	0 1 2	0 1 2
51. Being needed	0 1 2	0 1 2
52. Meeting someone new of the same sex	0 1 2	0 1 2

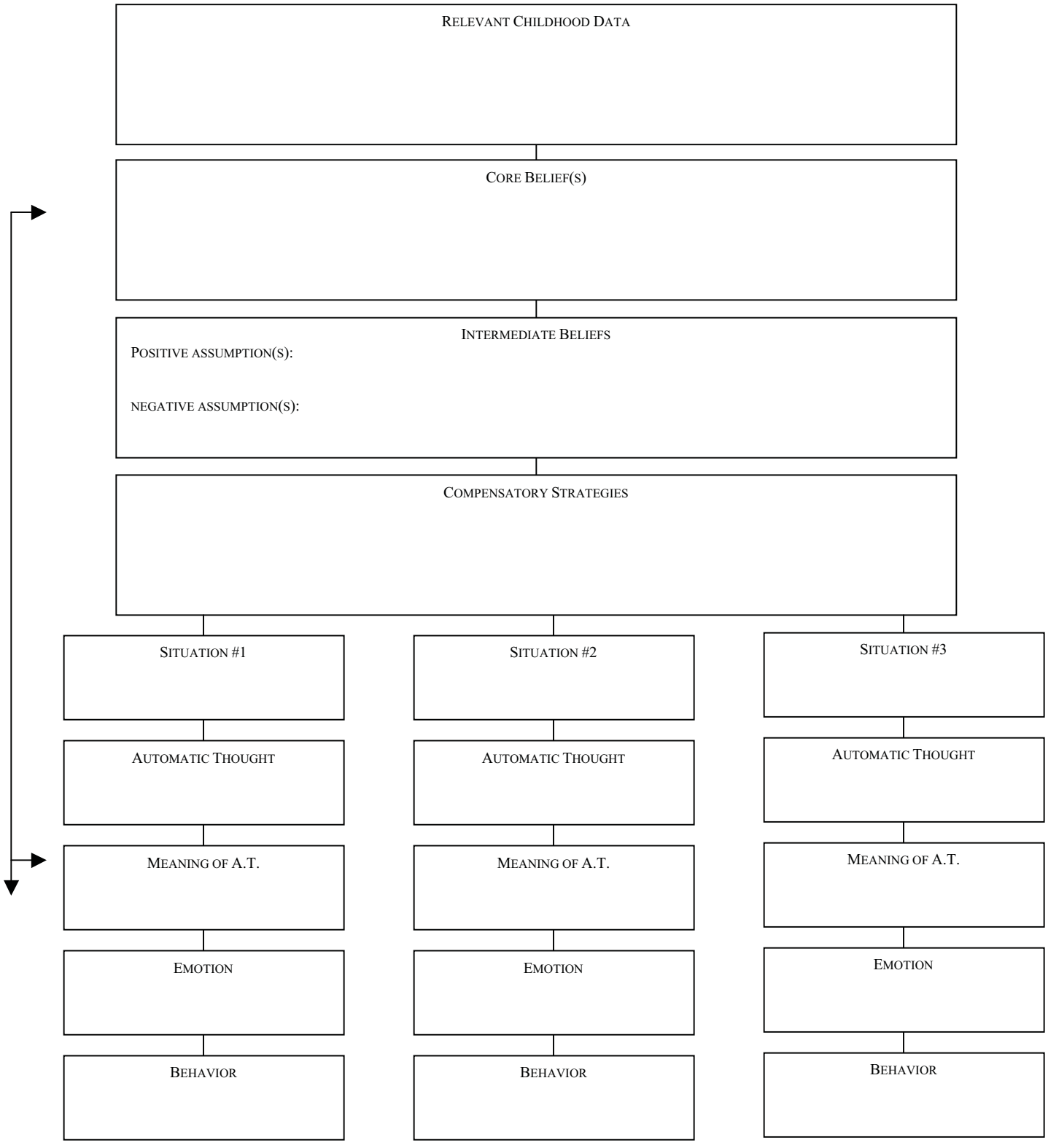
California Older Person's Pleasant Events Schedule

Please circle ONE number in EACH column for each item	HOW OFTEN in the past month? 0 = Not at all 1 = 1-6 times 2 = 7 or more times Circle ONE number	HOW PLEASANT was it or would it have been? 0 = Not pleasant 1 = Somewhat pleasant 2 = Very pleasant Circle ONE number
53. Exploring new areas	0 1 2	0 1 2
54. Having a clean house	0 1 2	0 1 2
55. Doing creative crafts	0 1 2	0 1 2
56. Going to church	0 1 2	0 1 2
57. Being loved	0 1 2	0 1 2
58. Visiting a museum	0 1 2	0 1 2
59. Having a daily plan	0 1 2	0 1 2
60. Being with happy people	0 1 2	0 1 2
61. Listening to classical music	0 1 2	0 1 2
62. Shopping for a new outfit	0 1 2	0 1 2
63. Taking inventory of my life	0 1 2	0 1 2
64. Planning or organizing something	0 1 2	0 1 2
65. Smiling at people	0 1 2	0 1 2
66. Being near sand, grass, a stream	0 1 2	0 1 2

COGNITIVE CONCEPTUALIZATION DIAGRAM

Pts Name: _____ Diagnosis:_____ Date: _____

COGNITIVE CONCEPTUALIZATION DIAGRAM



FEELINGS HANDOUT

Feelings

Sometimes when we have trouble identifying or naming our feelings, it is helpful to look at them in terms of basic and general categories such as mad, sad, glad, etc. and then begin to define them more specifically such as annoyed, defeated, eager…

MAD	GLAD	SAD	SCARED	ASHAMED	HURT
	Affectionate	Abandoned	Anxious	Crazy	
Angry	Blissful	Burdened	Fearful	Different	
Annoyed	Calm	Defeated	Frantic	Embarrassed	
Attacked	Capable	Despair	Frightened	Flustered	
Betrayed	Cheerful	Grief	Helpless	Foolish	
Bitter	Clever	Homesick	Nervous	Guilty	Deceived
Challenged	Confident	Inadequate	Obsessed	Odd	Disturbed
Cheated	Contented	Isolated	Overwhelmed	Rejected	Ignored
Combative	Delighted	Lonely		Screwed up	Inadequate
Competitive	Eager	Longing		Stupid	Intimidated
Frustrate	Ecstatic	Low		Confused	Left out
Furious	Enchanted	Maudlin			Powerless
Hateful	Excited	Melancholy	Panicked		Vulnerable
Infuriated	Happy	Miserable	Petrified		
Mean	Honored	Sympathetic	Powerless		
Outraged	Needed	Weepy	Queasy		
Quarrelsome	Pleasant		Tense		
	Pleased		Terrified		
	Proud		Threatened		
	Refreshed		Trapped		
	Relieved		Unsettled		
	Satisfied		Worried		
	Wonderful				

HOMEWORK ASSIGNMENT FORM

Homework Assignment

Date:

Goal:

Specific homework assignment to do before the next session:

PLEASANT EVENTS SCHEDULE (REVISED)

Pleasant Events Schedule

Author: Douglas J. MacPhillamy, & Peter M. Lewinshon.

Scoring: In order to score the Pleasant Events Schedule, follow the points listed below:

Average Ranges			
Age Group	Mean Frequency Score (F)	Mean Pleasantness Score (P)	Mean Cross-Product Score (F * P)
20-39 0.63-1.03		0.86-1.26	0.99-1.19
40-59 0.57-0.97		0.82-1.22	0.92-1.12
60 or older	0.50-0.90	0.78-1.18	0.86-1.06

1. Add the frequency ratings (in column F) and divide the total by 320. This is your *mean frequency score*. For example, suppose adding all your frequency ratings gives you a total of 176. Dividing this total by 320 equals 0.55. Your mean frequency score tells you something about how much (or how little) you engage in the activities on the list. It reflects you overall activity level. By comparing your score with the average range for persons your age, shown in Table 2, you can evaluate yourself. If your score is equal to or lower than the low end of the average range, you are not engaging in the activities to the extent that people your age do.

2. Add the pleasantness ratings (in column P) and divide the total by 320. For example, if your rating total was 256, you would obtain 0.80 for you *mean pleasantness rating*. The mean pleasantness rating tells you something about your current *potential* for pleasurable experiences. If this number is low (equal to or lower than the low end of the average range shown in Table 2), it means that, at present, there are few activities that are sources of satisfaction and pleasure for you. If the score is high, it means that you have a good potential to enjoy a large number of activities and events.

3. Compute a cross-product score for each item and enter it in the column marked F x P. For example, if you did not go to the movies during the past 30 days (mark 0) but going to the movies is a very pleasant activity for you (mark 2), then the product score would be 0 x 2 = 0, and you would enter 0. If you have been watching television (Item 33) a great deal and you have therefore assigned it a frequency rating of 2, but you don't enjoy watching television and have, therefore, assigned it a pleasantness rating of 0, the product score would be 2 x 0 = 0. You are now ready to compute your *mean cross-product score* by adding the F x P scores of all 320 items and dividing this total by 320. he cross-product score is probably the most important score of this test because it is a measure of how much satisfaction and pleasure you derived from your activities during the past month. If the score is high, it mans that you are deriving considerable pleasure and satisfaction from your activities.

My mean frequency score is _____.
My mean pleasantness score is _____.
My mean cross-product score is _____.

If your cross-product score is low, you can obtain one more useful bit of information by examining your score pattern. There are three possible patterns that can produce a low cross-product score.

> Pattern 1—Low frequency/low pleasantness: You are not doing many of the activities on the list *and* you are not enjoying the activities that you do engage in.
>
> Pattern 2—Low frequency/average or above-average pleasantness: You are not engaging in the kinds of activities that are potentially enjoyable for you.
>
> Pattern 3—Average or above-average frequency/low pleasantness: You are doing many things but are not deriving much enjoyment from your activities.

Reliability: The Pleasant Events Schedule demonstrates adequate test-retest correlations ranging from .50 to .72 over a 3 month period.

Validity: Demonstrates good concurrent, construct and predictive validity (correlations of .57 and .62 for predictive validity).

References:

MacPhillamy, D. J. & Lewinshon, P. M. (1982). The Pleasant Events Schedule: Studies on reliability, validity, and scale inter-correlation. *Journal of Consulting and Clinical Psychology, 50(3)*, 363-380.

Pleasant Events Schedule

Instructions:
This assessment will take you about two hours to take and score. You should plan to complete it in a quiet place and at a time when you will not be interrupted.

HOW OFTEN HAVE THESE EVENTS HAPPENED IN YOUR LIFE IN THE PAST MONTH?

Please answer this question by rating each item on the frequency scale (Column F):

0—This has *not* happened in the past 30 days.
1—This has happened a *few times* (1-6) in the past 30 days.
2—This has happened *often* (7 times or more) in the past 30 days.

Place your rating for each item in Column F. Here is an example: Item 1 is *Being in the country*. Suppose you have been in the country 3 times during the past 30 days. Then you would mark a 1 in Column F next to Item 1.

Some items will list *more than one event*; for these items, mark how often you have done any of the listed events. For example, Item 12 is *Doing artwork (painting, sculpture, drawing, movie-making, and so on)*. You should rate Item 12 on how often you have done any form of artwork in the past month.

Because this list contains events that might happen to a wide variety of people, you may find that many events have not happened to you in the past 30 days. It is not expected that anyone will have done all of these activities in a single month.

Begin now by putting your frequency rating for each of the 320 items in Column F. After you have gone through the list for the first time and have assigned a frequency rating to each of the 320 items, review the list once again. This time ask yourself the following question:

HOW PLEASANT, ENJOYABLE, OR REWARDING WAS EACH EVENT DURING THE PAST MONTH?

Please answer this question by rating each event on the Pleasantness Scale (Column P).

0—This was *not* pleasant (use this rating for those events that were either neutral or unpleasant).
1—This was *somewhat* pleasant (use this rating for events that were mildly or moderately pleasant).
2—This was *very* pleasant (use this rating for events that were strongly or extremely pleasant).

If a particular event has happened to you *more than once* in the past month, try to rate roughly how pleasant it was *on the average*. If an event *has not happened* to you during the past month, then rate it according to how much fun you think it would have been.

When an item lists more than one event, rate it on the events *you have actually done*. (If you haven't done any of the events in such an item, give it the average rating of the events in that item that you would have liked to have done.) Place your rating for each event in Column P (pleasantness).

Example: Item 1 is *Being in the country*. Suppose that each time you were in the country in the past 30 days you enjoyed it a great deal. You would then rate this event 2 because it was very pleasant.

The list of items may contain some events that you would not enjoy. Keep in mind that the list was made for a wide variety of people, and it is not expected that one person would enjoy all of the activities listed. Go through the entire list rating each event on *roughly how pleasant it was* (or would have been) *during the past 30 days*. Please be sure that you rate each item.

Blank spaces are provided at the end of the list. Here you may add activities that you find yourself doing often, or that you think you would find pleasant which are not on the list. Place your ratings in Column F and Column P just like you have for the other items.

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
1.	Being in the country				
2.	Wearing expensive or formal clothes				
3.	Making contributions to religious, charitable, or other groups				
4.	Talking about sports				
5.	Meeting someone new of the same sex				
6.	Taking tests when well-prepared				
7.	Going to a rock concert				
8.	Playing baseball or softball				
9.	Planning trips or vacations				
10	Buying things for myself				
11.	Being at the beach				
12.	Doing artwork (painting, sculpture, drawing, movie-making, etc.)				
13.	Rock-climbing or mountaineering				
14.	Reading the scriptures or other sacred works				
15.	Playing golf				
16.	Taking part in military activities				
17.	Rearranging or decorating my room or house				
18	Going to a sports event				
19.	Reading a "how-to-do-it" book or article				
20.	Going to the races (horse, car, boat, etc.)				
21.	Reading stories, novels, non-fiction poems, or plays				
22.	Going to lectures or hearing speakers				
23.	Driving skillfully				
24.	Breathing clean air				
25.	Thinking up or arranging a song or music				
26.	Saying something clearly				
27.	Boating (canoeing, kayaking, motor-boating, sailing, etc.)				
28.	Pleasing my parents				
29.	Restoring antiques, refinishing furniture, etc.				
30.	Watching TV				
31.	Talking to myself				
32.	Camping				
33.	Working in politics				
34.	Working on machines (cars, bikes, motorcycles, tractors, etc.)				
35.	Thinking about something good in the future				
36.	Playing cards				
37.	Completing a difficult task				
38.	Laughing				
39.	Solving a problem, puzzle, crossword, etc				
40.	Being at weddings, baptisms, confirmations, etc.				
41.	Criticizing someone				
42.	Shaving				
43.	Having lunch with friends or associates				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
44.	Playing tennis				
45.	Taking a shower				
46.	Driving long distances				
47.	Woodworking or carpentry				
48.	Writing stories, novels, plays, or poetry				
49.	Being with animals				
50.	Riding in an airplane				
51.	Exploring (hiking away from known routes, spelunking, etc)				
52.	Having a frank and open conversation				
53.	Singing in a group				
54.	Thinking about myself or my problems				
55.	Working on my job				
56.	Going to a party				
57.	Going to church functions (socials, classes, bazaars, etc.)				
58.	Speaking a foreign language				
59.	Going to service, civic, or social club meetings				
60.	Going to a business meeting or a convention				
61.	Being in a sporty or expensive car				
62.	Playing a musical instrument				
63.	Making snacks				
64.	Snow-skiing				
65.	Being helped				
66.	Wearing informal clothes				
67.	Combing or brushing my hair				
68.	Acting				
69.	Taking a nap				
70	Being with friends				
71.	Canning, freezing, making preserves, etc.				
72.	Solving a personal problem				
73.	Being in a city				
74.	Taking a bath				
75.	Singing to myself				
76.	Making food or crafts to sell or give away				
77.	Playing pool or billiards				
78.	Being with my grandchildren				
79.	Playing chess or checkers				
80.	Doing craftwork (pottery, jewelery, leather, beads, weaving, etc.)				
81.	Weighing myself				
82.	Scratching myself				
83.	Putting on makeup, fixing my hair, etc.				
84.	Designing or drafting				
85.	Visiting people who are sick, shut in, or in trouble				
86.	Cheering, rooting				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
87.	Bowling				
88.	Being popular at a gathering				
89.	Watching wild animals				
90.	Having an original idea				
91.	Gardening, landscaping, or doing yardwork				
92.	Reading essays or technical, academic, or professional literature				
93.	Wearing new clothes				
94.	Dancing				
95.	Sitting in the sun				
96.	Riding a motorcycle				
97.	Just sitting and thinking				
98.	Seeing good things happening to my family or friends				
99.	Going to a fair, carnival, circus, zoo, or amusement park				
100.	Talking about philosophy or religion				
101.	Planning or organizing something				
102.	Drinking water, soda, juice, coffee, or tea				
103.	Listening to the sounds of nature				
104.	Dating, courting, etc.				
105.	Having a lively talk				
106.	Racing in a car, motorcycle, boat, etc.				
107.	Listening to the radio				
108.	Having friends come to visit				
109.	Playing in a sporting competition				
110.	Introducing people I think would like each other				
111.	Giving gifts				
112.	Going to school or government meetings, court sessions, etc.				
113.	Getting massages or backrubs				
114.	Getting letters, cards, or notes				
115.	Watching the sky, clouds, or a storm				
116.	Going on outings (to the park, a picnic, a barbecue, etc.)				
117.	Playing basketball				
118.	Buying something for my family				
119.	Photography				
120.	Giving a speech or lecture				
121.	Reading maps				
122.	Gathering natural objects (wild foods or fruit, rocks, driftwood, etc.)				
123.	Working on my finances				
124.	Wearing clean clothes				
125.	Making a major purchase or investment (car, appliance, house, stocks, etc.)				
126.	Helping someone				
127.	Being in the mountains				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
128.	Getting a job advancement (being promoted, given a raise, or offered a better job; getting accepted at a school, etc.)				
129.	Hearing jokes				
130.	Winning a bet				
131.	Talking about my children or grandchildren				
132.	Meeting someone new of the opposite sex				
133.	Going to a revival or crusade				
134.	Talking about my health				
135.	Seeing beautiful scenery				
136.	Eating good meals				
137.	Improving my health (having my teeth fixed, getting new glasses, changing my diet, etc.)				
138.	Being downtown				
139.	Wrestling or boxing				
140.	Hunting or shooting				
141.	Playing in a musical group				
142.	Hiking				
143.	Going to a museum or exhibit				
144.	Writing papers, essays, articles, reports, memos, etc.				
145.	Doing a job well				
146.	Having spare time				
147.	Fishing				
148.	Loaning something				
149.	Being noticed as sexually attractive				
150.	Pleasing employers, teachers, etc.				
151.	Counseling someone				
152.	Going to a health club, sauna bath, etc.				
153.	Having someone criticize me				
154.	Learning to do something new				
155.	Going to a "drive-in" (Dairy Queen, McDonald's, etc.)				
156.	Complimenting or praising someone				
157.	Thinking about people I like				
158.	Being at a fraternity or sorority				
159.	Being assertive				
160.	Being with my parents				
161.	Horseback riding				
162.	Protesting social, political, or environmental conditions				
163.	Talking on the telephone				
164.	Having daydreams				
165.	Kicking leaves, sand, pebbles, etc.				
166.	Playing lawn sports (badminton, croquet, shuffleboard, horseshoes, etc.)				
167.	Going to school reunions, alumni meetings, etc.				
168.	Seeing famous people				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
169.	Going to the movies				
170.	Kissing				
171.	Being alone				
172.	Budgeting my time				
173.	Cooking meals				
174.	Being praised by people I admire				
175.	Outwitting a "superior"				
176.	Feeling the presence of the Lord in my life				
177.	Doing a project in my own way				
178.	Doing "odd jobs" around the house				
179.	Crying				
180.	Being told I'm needed				
181.	Being at a family reunion or get-together				
182.	Giving a party or get-together				
183.	Washing my hair				
184.	Coaching someone				
185.	Going to a restaurant				
186.	Seeing or smelling a flower or plant				
187.	Being invited out				
188.	Receiving honors (civic, military, etc.)				
189.	Using cologne, perfume, or aftershave				
190.	Having someone agree with me				
191.	Reminiscing, talking about old times				
192.	Getting up early in the morning				
193.	Having peace and quiet				
194.	Doing experiments or other scientific work				
195.	Visiting friends				
196.	Writing in a diary				
197.	Playing football				
198.	Being counseled				
199.	Saying prayers				
200.	Giving massages or backrubs				
201.	Hitchhiking				
202	Meditating or doing yoga				
203.	Seeing a fight				
204.	Doing favors for people				
205.	Talking with people on the job or in class				
206.	Being relaxed				
207.	Being asked for my help or advice				
208.	Thinking about other people's problems				
219.	Playing board games (Monopoly, Scrabble, etc.)				
210.	Sleeping soundly at night				
211.	Doing heavy outdoor work (cutting or chopping wood, clearing land, farm work, etc.)				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
212.	Reading the newspaper				
213.	Snowmobiling or dune-buggy riding				
214.	Being in a body-awareness, sensitivity, encounter, therapy, or "rap" group				
215.	Dreaming at night				
216.	Playing ping-pong				
217.	Brushing my teeth				
218.	Swimming				
219.	Running, jogging, or doing gymnastics, fitness, or field exercises				
220.	Walking barefoot				
221.	Playing Frisbee or catch				
222.	Doing housework or laundry; cleaning things				
223.	Being with my roommate				
224,	Listening to music				
225.	Arguing				
226.	Knitting, crocheting, embroidery, or fancy needle work				
227.	Petting, necking				
228.	Amusing people				
229.	Talking about sex				
230.	Going to a barber or beautician				
231.	Having houseguests				
232.	Being with someone I love				
233.	Reading magazines				
234.	Sleeping late				
235.	Starting a new project				
236.	Being stubborn				
237.	Having sexual relations				
238.	Having other sexual satisfactions				
239.	Going to the library				
240.	Playing soccer, rugby, hockey, lacrosse, etc.				
241.	Preparing a new or special food				
242.	Birdwatching				
243.	Shopping				
244.	Watching people				
245.	Building or watching a fire				
246.	Winning an argument				
247.	Selling or trading something				
248.	Finishing a project or task				
240	Confessing or apologizing				
250.	Repairing things				
251.	Working with others as a team				
252.	Bicycling				
253.	Telling people what to do				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
254.	Being with happy people				
255.	Playing party games				
256.	Writing letters, cards, or notes				
257.	Talking about politics or public affairs				
258.	Asking for help or advice				
259.	Going to banquets, luncheons, potlucks, etc.				
260.	Talking about my hobby or special interest				
261.	Watching attractive women or men				
262.	Smiling at people				
263.	Playing in sand, a stream, the grass, etc.				
264.	Talking about other people				
265.	Being with my husband or wife				
266.	Having people show interest in what I have said				
267.	Going on field trips, nature walks, etc.				
268.	Expressing my love to someone				
269.	Caring for houseplants				
270.	Having coffee, tea, a coke, etc., with friends				
271.	Taking a walk				
272.	Collecting things				
273.	Playing handball, paddleball, squash, etc.				
274.	Sewing				
275.	Suffering for a good cause				
276.	Remembering a departed friend or loved one, visiting the cemetery				
277.	Doing things with children				
278.	Beachcombing				
279.	Being complimented or told I have done well				
280.	Being told I am loved				
281.	Eating snacks				
282.	Staying up late				
283.	Having family members or friends do something that makes me proud of them				
284.	Being with my children				
285.	Going to auctions, garage sales, etc.				
286.	Thinking about an interesting question				
287.	Doing volunteer work, working on community service projects				
288.	Water skiing, surfing, scuba diving				
289.	Receiving money				
290.	Defending or protecting someone; stopping fraud or abuse				
291.	Hearing a good sermon				
292.	Winning a competition				
293.	Making a new friend				
294.	Talking about my job or school				

PLEASANT EVENTS SCHEDULE

		F	P	F x P	√
295.	Reading cartoons, comic strips, or comic books				
296.	Borrowing something				
297.	Traveling with a group				
298.	Seeing old friends				
299.	Teaching someone				
300.	Using my strength				
301.	Traveling				
302.	Going to office parties or departmental get-togethers				
303.	Attending concert, opera, or ballet				
304.	Playing with pets				
305.	Going to a play				
306.	Looking at the stars or moon				
307.	Being coached				

RELAXATION LOG

RELAXATION PRACTICE LOG

Directions: Rate your level of tension from "1," least tense to "10," most tense before and after the relaxation exercise. Record the time of day that you did the exercise and some comments regarding the prior stressful situation and whether the relaxation helped you. Do this each day.

DATE	TIME	RELAXATION SCORE	COMMENTS
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	
		Before: 1 2 3 4 5 6 7 8 9 10 **After: 1 2 3 4 5 6 7 8 9 10**	

REVIEWING CBT SESSIONS FORM

	Reviewing CBT Sessions	
	This form may be used by the clinician either during or following a therapy session in order to determine if the essential elements of CBT are covered in the session. Specific cognitive and behavioral strategies are listed on the back of the form that correspond to Item 13.	
1.	Did a brief **mood check** occur?	
2.	Was the **BDI** scored and reviewed? Was the patient suicidal or hopeless? If so, was a suicide risk assessment conducted? Was there a significant change in the depression score? If so, was this put on the agenda?	
3.	Was a **medication check** conducted (if taking medication)? If so, were the changes in medication noted? If so, were the last and next appointments with provider noted?	
4.	Was an **alcohol and substance abuse check** conducted (if indicated)? If so, were any changes in amount of alcohol or substance abuse noted? If so, were the last and next appointment with substance abuse counselor noted?	
5.	Was a **brief summary of the last session** conducted? Did a brief review of treatment goals occur? Was the patient asked about the most important issue that was discussed during the last session?	
6.	Did the therapist **review the homework** assignment from the last session?	
7.	Was a **collaborative agenda** established? Was the agenda prioritized?	
8.	Did the therapist **listen and empathize** with the patient's concerns? Did the therapist summarize the patient's concerns throughout the session?	
9.	Did the therapist have good **interpersonal skills** (such as warmth, concern, confidence, genuineness, and professionalism)?	
10.	Was the session **reasonably paced** by limiting peripheral and unproductive discussion?	
11.	Did the therapist use **guided discovery** to help the patient draw his/her own conclusions? Did the therapist limit the use of debate, persuasion, or lecturing?	
12.	Did the therapist **focus on key thoughts, beliefs, or behaviors** that were most relevant to the problem?	
13.	Did the therapist **select a CBT strategy** that offered some promise in helping the patient? Could the CBT strategy be clearly identified? (See next page) Did the therapist ask for feedback to determine if the strategy was successful?	
14.	Did the therapist skillfully **implement the CBT** strategy?	
15	Did the therapist develop a **homework assignment** that was custom tailored to the patient's concerns? Was the homework written down? Did the therapist ask the patient if he/she understood the rationale for the homework? Did the therapist ask the patient how likely he/she would complete the homework assignment?	
16.	Was a **final summary** of the therapy session conducted?	
17.	Did the therapist ask the patient for **feedback about the session**? Was the patient asked about the most helpful issue that was discussed?	

LIST OF CBT TECHNIQUES

BEHAVIORAL STRATEGIES:	
□ Guided Discovery for Mood/Behavior	Beck 96-97; Wright 91-95
□ Identified Key Behaviors	Beck 26-33
□ Activity Monitoring	Beck 200-211; Wright 131
□ Activity Scheduling	Beck 200-211; Wright 127-135
□ Identified Pleasant or Meaningful Activities	Beck 201; Wright 129
□ Behavioral Activation	Beck 249; Wright 124-127
□ Graded Task Assignment	Beck 216-218; Wright 135-138
□ Cognitive Rehearsal	Wright 118
□ Distraction Technique	Beck 211-213; Wright 161
□ Relaxation Exercise, Imagery, Controlled Breathing	Beck 213-214, 229-247; Wright 160
□ Role Play/Modeling	Beck 218-221; Wright 96-99
□ Safety Planning	
COGNITIVE STRATEGIES:	
□ Identified Key Automatic Thoughts	Beck 80-86; Wright 90-100
□ Inductive Questioning	Wright 91-95
□ Noted In-Session Mood Shift	Beck 80; Wright 90-91
□ Used Guided Discovery/ for Mood/Thoughts	Beck 145-146; Wright 91-95
□ 3-Column Thought Record	Wright 95-96
□ Monitored Automatic Thoughts and Mood	Beck 125-136; Wright 102-105
□ Developed an Adaptive Response	
□ Identified Cognitive Errors	Beck 118-120; Wright 109-111
□ Examined the Evidence	Beck 108-116; Wright 111-112
□ 5-Column Thought Record	Beck 125-136; Wright 102-111
□ Coping Card	Beck 214-216; Wright 118-121
□ Used Guided Discovery	Beck 145-146; Wright 91-95
□ Used Behavioral Experiment to Test Thoughts or Beliefs	Beck 197-200; Wright 167-170
□ Weighed Pros/Cons or Advantages/Disadvantages	Beck 194-197; Wright 190-193
□ Used Problem Solving Strategy	Beck 193-197; Wright 141-149
□ Identified Core or Intermediate Beliefs, or Compensatory Strategies	Beck 138-147; Wright 179
□ Used Guided Discovery	Beck 145-146
□ Downward Arrow	Beck 137-143; Wright 178-179
□ Completed Conceptualization Diagram	Beck 138-147
□ Revised and Rated Core Belief	Beck 170-182

Note: Pages numbers are provided for each strategy from the following books:

Beck, J. (1995). Cognitive Therapy: Basics and Beyond. New York, NY: Guilford.

Wright, J, Basco, M., & Thase, M. (2006). Learning Cognitive Behavioral Therapy: An Illustrated Guide. Arlington, VA: American Psychiatric Publishing.

THREE-COLUMN THOUGHT RECORD

3-COLUMN THOUGHT RECORD

DIRECTIONS: When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** and as soon as possible jot down the thought or mental image in the Automatic Thoughts column.

DATE/TIME	SITUATION	EMOTION(S)	AUTOMATIC THOUGHTS
	1. Describe what happened. What were you doing at the time? 2. What (if any) distressing physical sensations did you have?	1. What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	1. What thoughts(s) and/or image(s) went through your mind?

FIVE-COLUMN THOUGHT RECORD

5-COLUMN THOUGHT RECORD

Directions: When you notice your mood getting worse, ask yourself, **"What's going through my mind right now?"** and as soon as possible jot down the thought or mental image in the Automatic Thoughts column.

DATE/ TIME	SITUATION	AUTOMATIC THOUGHT(S)	EMOTION(S)	ALTERNATIVE RESPONSE	OUTCOME
	1. What event, daydream, or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	1. (optional) What cognitive distortion did you make? (e.g., all-or-nothing thinking, mind-reading, catastrophizing) 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0-100%) is the emotion? 3. What will or did you do?

Questions to help compose an alternative response:

(1) What is the evidence that the automatic thought is true? Not true?
(2) Is there an alternative explanation?
(3) What's the worst that could happen? Could I live through it?
What's the best that could happen? What's the most realistic outcome?
(4) What's the effect of my believing the automatic thought?
What could be the effect of changing my thinking?
(5) What should I do about it?
(6) If _____ (friend's name) was in the situation and had this thought, what would I tell him/her?

WORKING ALLIANCE INVENTORY

Date_____ Session__ ID # _ _ _ _ - _

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Think about your experience in therapy, and decide which category best describes your own experience. Please circle your choice.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe my therapist likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. My therapist and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. My therapist and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. My therapist and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that my therapist appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. My therapist and I agree on what is important for me to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I feel my therapist cares about me even when I do things that he/she does not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

11. My therapist and I have established a good understanding of the kind of changes that would be good for me.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always