A THERAPIST'S GUIDE TO

BRIEF COGNITIVE BEHAVIORAL THERAPY

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THE BRIEF CBT MANUAL

This manual is designed for mental health practitioners who want to establish a solid foundation of cognitive behavioral therapy (CBT) skills. Concepts contained in the manual detail the basic steps needed to provide CBT ("Practicing CBT 101") with the intent that users will feel increasingly comfortable conducting CBT. The manual is not designed for advanced CBT practitioners.

Instructional material in this program is designed to be used within the context of a psychotherapy supervisory relationship to ensure appropriate application of the training materials and timely feedback, which are viewed as critical to the development of CBT skills.

The content of this manual is a compilation of foundational works on CBT, such as Judith Beck's (1995) Cognitive Therapy: Basics and Beyond, with the addition of key skills needed for developing CBT therapists. The information is condensed and packaged to be highly applicable for use in a brief therapy model and to aid in rapid training.

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ESSENTIAL PSYCHOTHERAPY SKILLS

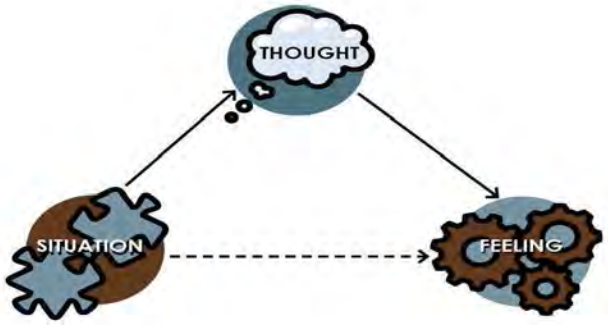
Module 1: Introduction to Brief Cognitive Behavioral Therapy (CBT)

Objectives

- To understand CBT and the process of Brief CBT
- To identify key treatment considerations and problems most suitable for Brief CBT
- To learn how to assess the patient's suitability for Brief CBT

What is Brief CBT, and why does it require specific treatment considerations?

CBT combines cognitive and behavioral therapies and has strong empirical support for treating mood and anxiety disorders (Chambless & Ollendick, 2001; DeRubeis & Crits-Christoph, 1998). The basic premise of CBT is that emotions are difficult to change directly, so CBT targets emotions by changing thoughts and behaviors that are contributing to the distressing emotions.



CBT builds a set of skills that enables an individual to be aware of thoughts and emotions; identify how situations, thoughts, and behaviors influence emotions; and improve feelings by changing dysfunctional thoughts and behaviors. The process of CBT skill acquisition is collaborative. Skill acquisition and homework assignments are what set CBT apart from "talk therapies." You should use session time to teach skills to address the presenting problem and not simply to discuss the issue with the patient or offer advice.

Brief CBT is the compression of CBT material and the reduction of the average 12-20 sessions into four to eight sessions. In Brief CBT the concentration is on specific treatments for a limited number of the patient's problems. Specificity of the treatment is required because of the limited number of sessions and because the patient is required to be diligent in using extra reading materials and homework to assist in his or her therapeutic growth.

Brief CBT can range in duration from patient to patient and provider to provider. Although variability exists, the following table shows an example session-by-session outline. You are encouraged to think flexibly in determining length of treatment. Time-limited therapy may offer additional incentive for patients and therapists to work efficiently and effectively. However, the exact length of treatment will likely be determined by a host of factors involving the therapist, patient, and treatment setting. As indicated in the following table, you are not expected to rigidly adhere to a "set schedule" of progress or topics but rather should be flexible and adaptive in approaching all brief CBT applications. For example, it is often helpful to work within a "session-limited framework" where the patient receives four to six sessions of "active" treatment, followed by one or more follow-up sessions that occur at increasing intervals after the active-treatment phase (e.g., 2 weeks post treatment with an additional booster 4 weeks after that).

Potential Brief CBT Session Structure

	Session Content	Possible Modules
Session 1	Orient the Patient to CBT. Assess Patient Concerns. Set Initial Treatment Plan/Goals.	Module 5: Orienting the Patient Module 4: Case Conceptualization Module 6: Goal Setting
Session 2	Assess Patient Concerns (cont'd). Set Initial Goals (cont'd) Or Begin Intervention Techniques.	Module 4: Case Conceptualization Module 6: Goal Setting Technique Modules 9-13: Maladaptive Thoughts, Behavioral Activation, Problem Solving, Relaxation
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Session 4	Continue Intervention Techniques. Re-assess Goals/Treatment Plan.	Technique Modules 9-13 Module 4: Case Conceptualization Module 6: Goal Setting
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Session 6	Continue Intervention Techniques.	Technique Modules 9-13
Session 7	Continue Intervention Techniques. Discuss Ending Treatment and Prepare for Maintaining Changes.	Technique Modules 9-13 Module 14: Ending Treatment and Maintaining Changes
Session 8	End Treatment and Help Patient to Maintain Changes.	Module 14: Ending Treatment and Maintaining Changes

When? (Indications/Contraindications)

Certain problems are more appropriate for Brief CBT than others. The following table summarizes problems that may and may not be conducive to Brief CBT. Problems amenable to Brief CBT include, but are not limited to, adjustment, anxiety, and depressive disorders. Therapy also may be useful for problems that target specific symptoms (e.g., depressive thinking) or lifestyle changes (e.g., problem solving, relaxation), whether or not these issues are part of a formal psychiatric diagnosis.

Brief CBT is particularly useful in a primary care setting for patients with anxiety and depression associated with a medical condition. Because these individuals often face acute rather than chronic mental health issues and have many coping strategies already in place, Brief CBT can be used to enhance adjustment. Issues that may be addressed in primary care with Brief CBT include, but are not limited to, diet, exercise, medication compliance, mental health issues associated with a medical condition, and coping with a chronic illness or new diagnosis.

Other problems may not be suitable for the use of Brief CBT or may complicate a straightforward application of Brief CBT. Axis II disorders such as Borderline Personality Disorder or Antisocial Personality Disorder typically are not appropriate for a shortened therapeutic experience because of the pervasive social, psychological, and relational problems individuals with these disorders experience. Patients exhibiting comorbid conditions or problems also may not be appropriate because the presence of a second issue may impede progress in therapy. For example, an individual with substance dependence comorbid with major depression may not be appropriate because the

substance use requires a higher level of care and more comprehensive treatment than is available in a brief format. However, Brief CBT could be used with Axis II and comorbid patients in dealing with specific negative behaviors or in conjunction with more intensive treatment.

Examples of Suitable and Unsuitable Problems for Brief CBT

Problem	Brief CBT?	
Anxiety	Yes	✓
Depression	Yes	✓
Assertiveness	Yes	✓
Diet	Yes	✓
Exercise	Yes	✓
Social Isolation	Yes	✓
Specific Phobia	Maybe	?
Grief/Bereavement	Yes	✓
New Diagnosis of COPD	Yes	✓
Coping with Chemotherapy	Yes	✓
Caregiver Burden	Yes	✓
Alcohol Dependence	No	×
Paranoid Personality Disorder	No	×
Crisis Intervention	Maybe	?
Chronic PTSD	No	×
Divorce	Maybe	?
Somatoform Disorder	No	×

How? (Instructions/Handouts)

Therapist Considerations

It is important to be adequately skilled to evoke change in a patient's life in a short amount of time. You should periodically assess and seek supervision/consultation regarding your capabilities in the process and content of Brief CBT.

The following are general therapist skills and abilities required for Brief CBT:

- Capability to establish a strong working relationship quickly
- Thorough knowledge of the treatments used
- Skill in structuring sessions and homework material to address all problems
- Skill in presenting material clearly and concisely with specific examples for each of the patient's issues
- Therapist interpersonal/personality variables: ability to be assertive, directive, nonjudgmental and collaborative

Assessing the Patient

It is necessary to choose patients who are appropriate for Brief CBT versus traditional CBT or other types of therapy. Below are important points to consider in selecting patients for Brief CBT. This assessment should precede the treatment phase and may be based on the intake assessment, input from the referral source, or a review of the medical chart.

Things to Consider in Evaluating Patients for Brief CBT

1. **Strong Motivation to Change**
    a. Increased distress is often associated with increased motivation to change.
    b. Positive treatment expectancies (e.g., knowledge of CBT and perceived benefits of treatment is associated with improved outcomes). Alternatively, the patient does not have negative self-thoughts that might impede progress or change (e.g., "Seeking care means I am crazy"; "Nothing I will do can change things").
    c. Patients who have clear goals for treatment are good candidates.

2. **Time Commitment**
    a. Patient is willing to devote the time needed for weekly sessions.
    b. Patient is willing to devote energy to out-of-session work (e.g., homework).

3. **Life Stressors**
    a. Too many life stressors may lead to unfocused work and/or frequent "crisis-management" interventions.
    b. Patients who are supported by family and friends are more likely to benefit.

4. **Cognitive Functioning and Educational Level**
    a. Not being able to handle the extra independent reading material and/or homework expectations may be a poor prognostic indicator.
    b. Patients able to work independently are more likely to carry out between-session work.
    c. Patients who are psychologically minded are more likely to benefit from short-term therapy.

5. **Severity of Psychopathology**
    a. Patients with comorbid psychopathology may be more difficult to treat in short-term therapy. In addition, some conditions such as substance abuse or serious mental illness require focused and more intensive interventions.
    b. Patients with an Axis II diagnosis are also less likely to benefit from short-term CBT. Long-standing interpersonal issues often require longer treatment durations.

Supplemental Materials

Bond, F.W. & Dryden, W. (2002). *Handbook of Brief Cognitive Behavioral Therapy*. San Francisco: Wiley.

Module 2: Using Supervision

Objectives

- To discuss the importance of supervision / consultation in CBT training
- To provide information on how to use clinical supervision and consultation in CBT training
- To outline various models of supervision / consultation in CBT training
- To provide tips on selecting a supervisor / consultant

Introduction

Knowledge about psychotherapy can be broken down into two broad domains – 1) knowledge of concepts and 2) knowledge of how to apply concepts. Information contained in this manual will provide you with a basic knowledge of CBT concepts and will attempt to provide you with practical tips on how to use these concepts. However, because the provision of CBT is highly variable, depending on the therapist, patient, and treatment setting, applications of CBT will need to be customized and practiced in real-world settings. This manual is therefore only the first step toward obtaining information and knowledge about how best to apply CBT principles to actual clinical patients. Supervision and consultation are two methods to advance CBT practice skills through routine feedback and interaction with a CBT trainer.

What is Supervision, and why Is It Important to CBT?

Supervision is designed to a) foster the supervisee's development and b) ensure patient welfare and safety by monitoring patient care – see following table:

Goals and Focus of Supervision

For the Supervisee	□ Provides therapist performance feedback □ Provides guidance and acquisition of alternative viewpoints □ Contributes to the process of forming a therapist's identity □ Serves as a secure base to explore applications and therapeutic principles
For the Patient	□ To ensure that patients receive acceptable care - Therapists do no harm - Therapists possesses sufficient skills - Those who lack skills are provided with remediation
Supervision is <u>NOT</u>	Therapy … although supervision may involve an exploration of a therapist's personal experiences, such a focus is restricted to issues that influence the therapist's professional work.

Supervision versus Consultation

There is a difference between supervision and consultation. Whereas supervision involves the direct oversight of clinical cases over a period of time (often involving evaluation of the clinician), consultation refers to a relationship that is designed to assist in professional development but does not involve formal oversight of clinical cases and may or may not continue over time. In essence, consultation involves a growth-oriented discussion of cases or issues without oversight or evaluation.

When? (Indications/Contraindications)

Ideally, supervision or consultation occurs on a regular basis. Typically, for therapists learning CBT, supervision/consultation should occur every week or every other week. Monthly consultation meetings may be appropriate for licensed practitioners in a more advanced stage of psychotherapy training.

How? (Instructions/Handouts)

The following table outlines the most common formats for supervision. The usefulness of each procedure will be determined by the goals of supervision and the supervisee's level of training and developmental needs. Exposure to multiple training modalities is seen as most effective.

Format	Description	Advantages	Disadvantages
Verbal Report	Therapists verbally report to the supervisor the details of a given therapy session or case.	- Less threatening to therapists - Allows for free-flowing discussion between therapist and supervisor	- Subject to therapist recollection (errors and omissions) - Limited ability for supervisors to monitor and provide feedback on the "process" of therapy
Process Notes	Therapists write down and recount issues identified in session along with their own personal reactions and feelings encountered in the session.	- Less threatening to clinicians - Provides a more detailed recount of the session (compared with verbal report alone) - Begins to identify therapist issues during session (process)	- Subject to therapist focus and recollection - Limited ability to monitor and provide feedback on the process of therapy
Audio/Video Taping	Actual sessions are audio or video taped and reviewed in supervision.	- Provides access to objective and process content of sessions - Serves as an excellent learning tool	- Can be threatening to therapists (and sometimes to patients) - Logistical issues – specific informed consent for patients, availability of equipment
Group Supervision	Multiple therapists interact with supervisor in group format.	- Provides therapist-to-therapist learning - Uses all the above techniques in addition to group format	- Less individual emphasis, not as much time for each therapist

Selecting a Supervisor/Consultant

The following are characteristics to seek out in selecting a CBT supervisor or consultant:

1) CBT knowledge and practice experience
    - Ideally, CBT supervisors and consultants have received formal training in CBT and use CBT in their daily practice settings.
2) Availability
    - For those first learning how to apply CBT, it is highly recommended that you identify supervisors/consultants who are available for weekly or bi-weekly meetings that involve anywhere from 30 to 60 minutes per meeting. The actual length of meetings can be determined by the number of cases being reviewed.
    - Consider logistical issues in scheduling. Would the supervisor/consultant be available for in-person or telephone sessions (in-person is more effective)? Consider proximity, travel, and availability of resources (e.g., audio/video taping).
3) Experience with a patient population similar to those you will be serving.

<u>Supplemental Readings</u>

Bernard, J. M. & Goodyear, R.K. (2004). *Fundamentals of Clinical Supervision – 3rd Edition.* New York: Pearson.

Liese, B.S. & Beck, J.S. (1997). *Cognitive Therapy Supervision*. In Watkins, C.E. (Ed). *In Handbook of Psychotherapy Supervision*. New York: Wiley; pp114-133.

Module 3: Nonspecific Factors in Brief CBT

Objectives

- To better understand the need for a strong therapeutic relationship in Brief CBT
- To understand the factors associated with a strong therapeutic relationship
- To learn strategies for developing rapport and maximizing non-specific factors

What are Nonspecific Factors, and why are they important to CBT?

CBT is structured and goal-directed. The context is supportive, and the techniques are paired with a collaborative therapeutic stance. Nonspecific factors refer to the relationship components of therapy (e.g., rapport, installation of hope, trust, collaboration) and can be compared with specific factors that refer to the technical aspects of psychotherapy (e.g., the actual techniques such as guided imagery, thought challenging, etc.) Nonspecific factors are common within all psychotherapies and serve as the foundation for patient improvement. Specific factors refer to intervention techniques unique to the type of therapy being provided (e.g., CBT, psychodynamic, interpersonal). Studies show that nonspecific factors are responsible for a large percentage of the change associated with psychotherapy treatments.

When? (Indications/Contraindications)

Nonspecific factors are critical during the early stages, but important at all phases, of treatment. Strong nonspecific factors aid in engaging and retaining patients in psychotherapy and also strengthen the technical components of treatment. Patients who perceive the therapeutic relationship to be collaborative, safe, and trusting are in a better position to obtain benefit from the treatment, will likely be less resistant and will be more open to exploration and change. As treatment progresses, the therapeutic relationship should become stronger, allowing the therapist and patient to gradually move into more complex and meaningful therapeutic issues.

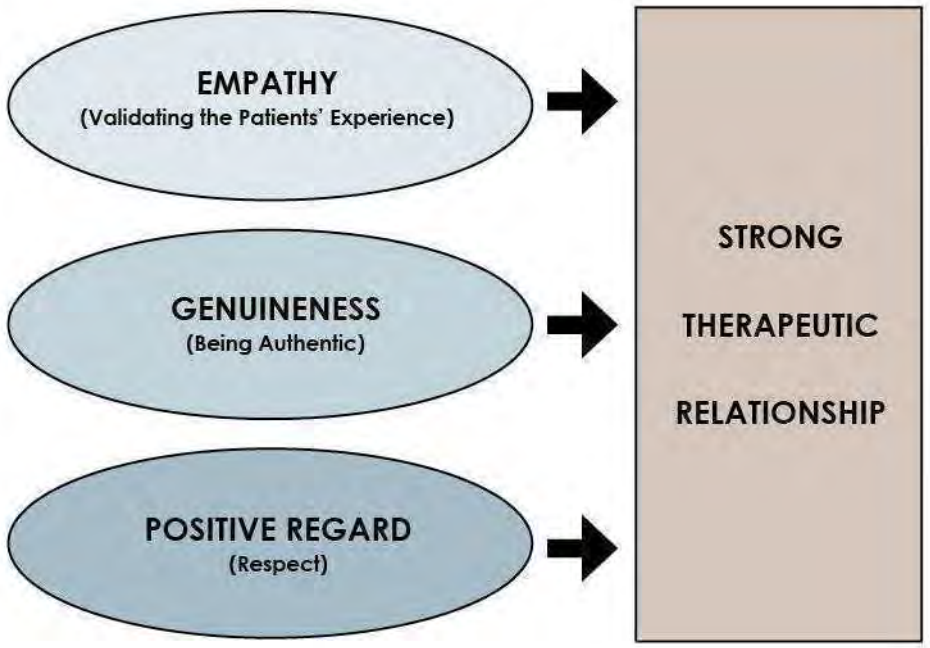
How? (Instructions/Handouts)

Borrowing from person-centered therapy, this module focuses on three factors important to the development of a strong therapeutic relationship. These factors are empathy, genuineness, and positive regard. These concepts are defined and discussed but represent general characteristics that all therapists should seek to attain in working with patients. Following a discussion of these principles, the concept of active listening is introduced as a technique to better attain a solid therapeutic relationship.

Empathy (Validating the Patient's Experience)
Empathy is the ability to understand experiences from another person's point of view. Empathy is an important part of building rapport and facilitates feelings of trust and mutual respect between the patient and therapist. It is necessary for the therapist to consider the concept of "multicultural empathy," which relates to understanding persons from other life backgrounds (ethnicity, socioeconomic status, age cohort, gender, etc.). It is impossible for a therapist to be knowledgeable about every patient's unique background. Empathy, which at its core consists of asking questions in a respectfully curious manner and expressing emotional understanding of the answers received, is a solid first step towards understanding patients' unique life background. Additional reading about cultural differences may

facilitate more informed questions and better prepare the therapist for additional questions and/or rapport development. Ultimately, the therapist has an added task of learning about the culture of patients and appreciating life from their perspective.

Showing empathy to a patient helps to validate his or her experiences. Being critical, even subtly, of what a patient is sharing in therapy often makes him or her feel judged and unwilling to disclose additional information. Use validating responses to show empathy towards a patient. Validating responses are simply statements of understanding of your patient's viewpoint. Validating responses usually entail the therapist's describing what he or she heard the patient say.



Genuineness

Genuineness is the ability to be authentic and free of dishonesty or hypocrisy. You can be professional and express who you are at the same time. Genuineness helps build rapport and solidify a therapeutic relationship by allowing the patient to view the therapist as a human being. It also allows patients to access the genuineness of the therapist for credible critical feedback about progress in their functioning.

Genuineness consists of wide variety of concepts ranging from nonverbal behaviors to overt statements. Examples of factors related to genuineness include:

> Supporting nonverbal behavior includes behaviors like keeping eye contact, giving a patient your full attention, and nodding in agreement or understanding. It's important that these nonverbal behaviors match what is going on in the conversation, so as not to seem unnatural or fake.
>
> Role behavior: CBT therapists encourage patients to be active and empowered and subsequently attempt to facilitate this development through their behaviors in therapy. Therapists that stress their authority in and between sessions with patients

can cause a patient to feel inferior or intimidated. It is important to remember that the therapeutic relationship is one of partnership and that the therapist and patient work together to alleviate concerns, fears, and problems in the patient's life.

Congruence: Making sure that your words, nonverbal behavior, and feelings match each other is referred to as congruence. Not demonstrating congruence of your feelings and thoughts can become confusing or misleading to a patient.

Spontaneity: This concept deals with the way the therapist speaks and the timeliness of responses. Responses and feedback provided "in the moment" are more valuable than feedback provided at a later time. Patients are more likely to receive spontaneous messages as genuine.

Positive Regard

Positive regard simply means showing all patients the respect they deserve. It's essential to show the patient that he/she is valued and that what he/she has to say is important. Patients who feel that their thoughts and feelings are acknowledged and understood often share more and feel more connected to the therapist and the therapeutic process.

Communicating positive regard may be harder than it seems, especially if you hold some negative beliefs about the person you are trying to help, which can be a common experience for therapists. Sharing any negative feelings or beliefs about your patients with your supervisor or consultant can be an excellent method to ensure that you develop and demonstrate genuine positive regard toward your patients.

Commitment to the patient means that you are dedicated to working with the patient on whatever issues he or she is bringing to therapy. This includes being on time, avoiding cancelling the patient's appointments, and using all efforts to help the patient work through those issues.

Having a nonjudgmental attitude towards the thoughts, feelings, and actions of the patient is essential. It is possible to accept and understand a perspective without necessarily agreeing with it.

Displaying warmth towards patients is a vital part of building rapport. Warmth can be displayed through tone of voice, facial expressions and body postures, or the thoughtfulness of your responses.

The following section addresses the concept of active listening. Active listening is a useful technique to communicate the nonspecific factors of empathy, genuineness, and positive regard.

Active Listening

Listening to your patients is the foundation of all therapeutic approaches. Listening is made up of three steps: receiving a message, processing it, and sending it back. Therapists should attempt to remain open to all messages from their patients (both verbal and nonverbal), and attempt to process as many messages as possible.

Clarification: Since we all speak from our own frame of reference, messages we send to others may not be received in the way we intended. Clarification is a useful and

necessary tool for all therapists. Clarification can be used to help simplify a message that is being sent by the patient or to help confirm the accuracy of what the therapist thinks he or she understood.

Patient:	I just do not feel like trying any more.
Therapist:	**Tell me more about what you mean.**
Patient:	I just feel like giving up.
Therapist:	**Do you mean giving up on your goal to complete college; or are you referring to something different, like giving up on life and possibly harming yourself?**
Patient:	I am not referring to suicide, if that is what you mean, but I am feeling really depressed. Each day seems like such a struggle, and I often just feel like staying in bed. When I said "give up," I guess I was referring to not wanting to face all the struggles I face in life … my school work, financial problems, relationship problems, etc.

Notice that the clarifying statement and question helped the therapist and patient to more fully explore her feelings and thoughts. Given this new information, the therapist is in a better position to explore in more detail the patient's concerns and to set up targeted efforts and strategies for treatment.

Paraphrasing and Reflection: These techniques involve restating the patient's main thoughts in a different way or reflecting back the emotions the patient is currently experiencing to gain depth or clarification.

Patient:	Since my fiancé's death, I feel like every day is a struggle, and I often question whether my life will ever get better. I just miss him so much that I think about him constantly. I don't know what to do, but the pain is getting to be too much.
Therapist:	**You are really struggling to feel better, and much of your pain comes from the grief and loss you feel from losing your fiancé. You may even be questioning whether or not this pain will subside because it is getting unmanageable.**
Patient:	Yes, that is correct. I do not want you to think that I think only about the pain of losing him. The pain I feel comes from my intense feelings of loss, but this pain is also because I miss all the things he meant to me, and the joy he brought to my life. I am really struggling because I do not want to let go of him, but holding on hurts so much.

In this example of paraphrasing, the therapist gives back to the patient what he or she heard, which allows the patient to hear her own words and react with a more detailed response. The use of paraphrasing in this example facilitated a deeper understanding of the issue but also conveyed to the patient a feeling of being heard and understood.

Listening for Themes and Summary Statements: Often, patients express thoughts, feelings, and behaviors that become thematic across situations. Although novice therapists may initially have difficulties identifying this thematic content, repetition

over time (e.g., across sessions) usually helps to create a clearer picture of the salient therapeutic issues that require attention or focus. With experience, therapists become more effective and efficient at identifying thematic content.

Once identified, thematic content can be a very powerful mechanism to influence treatment outcomes. Summarization is the technique that brings thematic content into the purview of the patient. Summarization is a condensed phrasing of the patient's responses over a specific period of time (e.g., across the session, since the outset of treatment, since the onset of his/her current difficulties). You should rephrase the themes, and repeat them back to the patient for clarification.

Barriers and Challenges to Building an Effective Therapeutic Relationship

Setting limits in an empathetic manner is an essential tool for new therapists. Many new therapists desire to "make it all better," in that they may coddle and console the patient and are distracted from working on deeper issues. A therapist can create a holding environment through empathetic words and active listening. A holding environment is a setting in which the patient feels like he or she is being heard and that he or she is in a safe and secure place to voice thoughts and feelings without judgment.

Moving from rapport and relationship building to assessment and goal setting can be challenging. When therapist and patient are "on the same page," this transition appears seamless. Often, however, patients and therapists are not speaking the same language. For example, a therapist may feel most comfortable when tackling a certain issue first; whereas a patient may wish to focus on a different problem first. When the therapist and patient are not in congruence regarding goals, the move between rapport building and goal setting is strained. To overcome this issue, therapists are encouraged to use motivational interviewing strategies (see Rollnick, Mason, Butler – Chapters 3, 4, and 5). Primary techniques involve listening to the patient, following the patient's lead and/or motivation, and setting collaborative and mutually agreed-upon goals. A vital aspect to transitioning from rapport to goal setting involves assessing the importance, confidence, and readiness of the patient about specific treatment goals (see Goal Setting, Module 6).

Supplemental Readings

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. Chapter 3. New York: Guilford Press.

Cormier, W.H. & Cormier, L.S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions, 3rd edition. Chapters 2, 3, 4, 5. Pacific Grove, CA: Brooks/Cole Publishing Company.

Rollnick S., Mason, P., & Butler, C. (1999). *Health behavior change. A guide for practitioners*. Chapters 3, 4, 5. New York: Churchill Livingstone.

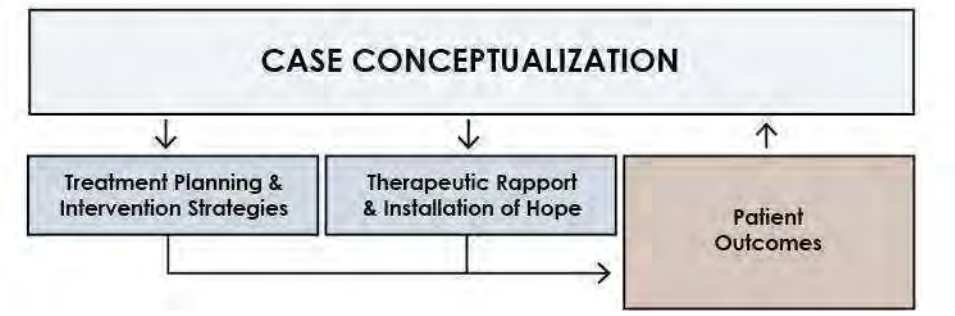
Module 4: Case Conceptualization and Treatment Planning

Objectives

- To better understand the role of case conceptualization in cognitive-behavioral therapy.
- To develop specific case conceptualization skills, including:
    a) Assessing patient concerns/difficulties
    b) Establishing a treatment plan (goal setting)
    c) Identifying treatment obstacles

What are case conceptualization and treatment planning, and why are they important in Brief CBT?

Case conceptualization is a framework used to 1) understand the patient and his/her current problems, 2) inform treatment and intervention techniques and 3) serve as a foundation to assess patient change/progress. Case conceptualization also aids in establishing rapport and a sense of hope for patients.



Case conceptualization is vital to effective treatment and represents a defining characteristic of expert clinicians. Using these skills, clinicians are better able to define a treatment plan using intervention techniques that provide the best opportunities for change. This focused and informed approach provides the roadmap for both patients and therapists and should include a foundation for assessing change/progress. Case conceptualization is particularly important for short-term therapy, as it serves to focus both the patient and clinician on the salient issues so as to avoid ancillary problems that often serve as distractions to core goals.

When? (Indications/Contraindications)

- Conceptualization should begin during the first session and become increasingly refined as treatment progresses.
- An assessment of current difficulties and the creation of a problem list should occur during the first session.
- A treatment plan (including treatment goals) should be addressed early in treatment (sessions 1, 2). Early conceptualization and treatment planning may require modification as additional information becomes available.
- Treatment plans and goals should be routinely revisited to ensure that the patient is improving and agrees with the flow of the therapeutic work.

How? (Instructions/Handouts)

Case Conceptualization Step 1: Assessing Patient Concerns/Difficulties

The patient's presenting concerns and current functioning can be assessed in a number of different ways. The following section outlines several possible avenues for identification of problems/concerns.

A) Using established self-report symptom inventories. A common practice in CBT involves the use of self-report symptom measures to assess baseline functioning as well as therapeutic progress. Frequently used measures for depression and anxiety include Beck Depression Inventory – Second Edition, Patient Health Questionnaire (depression), Geriatric Depression Scale, Beck Anxiety Inventory, and the State-Trait Anxiety Inventory.

Self-report measures are often completed by patients while in the waiting room and evaluated by the clinician during the session. Often self-report measures can serve as a routine agenda item during CBT sessions and can highlight important improvements and/or continuing symptoms. Information obtained from these self-report inventories can also provide insight into the way the patient thinks and behaves and factors that might be important areas of need.

B) Problem lists. These are a common and useful strategy for identifying the psychological, social, occupational, and financial difficulties faced by patients. Therapists who used problem lists typically elicit a list of five to 10 difficulties from the patient during the first part of session 1. Problems are best identified using open-ended questions (e.g., "What brings you to this clinic?" "What issues would you like to focus on in our work together?"). Problems are best described in terms of symptom frequency (How often does the symptom occur?), intensity (How mild or severe is it?) and functional impact (What influence does the symptom have on daily functioning or general distress?).

Some patients may describe their difficulties or goals in vague or abstract ways, such as, "I want to improve my life, or I want to be happy again." Problems and subsequent goals are best described in specific terms to maintain clinical focus. For example, specific problems are listed in the following table.

Problem	Frequency	Severity	Impact
Socially Isolated	Stay at home 6 out of 7 days	Limited social contacts; moderate-to-severe isolation	Highly distressing; socially debilitating; estranged family/friends
Pain	Experience pain each hour	Pain intensity is high, 7 of 10, when present	Pain leading to decreased activity level, inability to work
Feelings of Worthlessness	Occur 3 out of 7 days	Very intense when present; sometimes involves suicidal thoughts	Highly distressing; influences work, social, and intimate relationships
Fatigue	Occurs almost constantly	Fatigue not intense but troublesome	Decreased activity level, frequent naps, inability to complete daily tasks

C) Assessing cognitions. Within the CBT model, it is often helpful to examine the patient's thoughts especially as they are perceived by the patient. A commonly used, structured way to examine these factors is to assess (ask questions related to) how the patient perceives him-/herself, others, and the future. For example, a patient might describe him- or herself as incapable, not useful, or a burden. He or she may generally perceive others to be critical or hard to please. And his/her view of the future might be largely pessimistic and contain beliefs that the future will include only more losses and disappointments (see also Thought Records in Modules 9 and 10).

D) Assessing behaviors and precipitating situations. Precipitating situations are events, behaviors, thoughts, or emotions that activate, trigger, or compound patient difficulties.

The Antecedents, Behavior, Consequences (ABC) Model is a formalized model for examining behavior (symptoms) in a larger context. It postulates that behaviors are largely determined by antecedents (events that precede behavior/thoughts/mood) and consequences (events that follow the behavior/thoughts/mood).

The ABC model (see worksheet) is used in a functional assessment. It follows the premise that behavior (B) is shaped by antecedents (A) and consequences (C). The antecedent occurs before a behavior and may be a trigger for a particular reaction in the patient. Behavior is any activity (even a thought or feeling) that the patient exhibits in response to an antecedent. Consequences are events that occur after the behavior and direct the patient to either continue or discontinue the behavior. Two kinds of consequences are examined in a functional assessment: short-term and long-term consequences.

Antecedents: Antecedents, or events that occur before a behavior, typically elicit emotional and physiological responses. Antecedents may be affective (an emotion), somatic (a physiological response), behavioral (an act), or cognitive (a thought). They are also subject to contextual (situational) and relational (interpersonal) factors. For example, a patient who reports depression (behavior) may feel bad when he or she is alone at home late at night (contextual antecedent) or better when he or she is around family (relational antecedent). Alternatively, he or she may feel depressed by thinking, "I will always be alone" (cognitive antecedent). It's important to remember that antecedents can both increase and decrease a particular behavior.

To help your patient identify antecedents, teach him or her to pinpoint conditions that affect his or her behavior.

> "What were you feeling right before you did that?" (Affective)
> "What happens to you physically before this happens? Do you feel sick?" (Somatic)
> "How do you normally act right before this happens?" (Behavioral)
> "What thoughts go through your mind before this happens?" (Cognitive)
> "Where and when does this usually happen?" (Contextual)
> "Do you do this with everyone, or just when you are around certain people?" (Relational)

Behaviors: A behavior is anything the patient does, feels, or thinks immediately following the antecedent. Each behavior that your patient displays could potentially include an affective component (feelings or moods), a somatic component (bodily sensations such as rapid

heartbeat or stomachache), a behavioral component (what a patient does or doesn't do), and a cognitive component (thoughts or beliefs).

Consequences: Consequences are categorized as being either positive or negative. Positive consequences increase the chances that a behavior will be repeated through the experience of something pleasant or the removal of something negative (e.g., do not have to do a chore). Negative consequences decrease the occurrence of a behavior, either by the presence of something noxious (e.g., being yelled at) or the absence of something desired (e.g., a child being grounded from watching TV). Patients tend to repeat behaviors that result in something positive or the removal of something negative.

Identifying Consequences. Similarly to identifying antecedents, when you and a patient are attempting to identify the consequences of a certain behavior, it is important to explore all components of each consequence.

> "How do you feel immediately after this occurs?" (Affective)
> "Do you have any bodily sensations after this happens, like trembling?" (Somatic)
> "How do you react after this behavior occurs? (Behavioral)
> "What do you think about after this happens?" (Cognitive)
> "Are you in a different place when this behavior ends?" (Contextual)
> "Are there any people who make this behavior worse? Make it better?" (Relational)

When completing a functional assessment, both short- and long-term consequences are examined. Short-term consequences tend to be behavioral reinforcers, while long-term consequences tend to be negative outcomes. In the case of addiction, the short-term consequence of using a substance is intoxication, or escape from a negative mood; the long-term consequence may be legal trouble, family problems, or a hangover. Understanding the positive and negative consequences of a behavior for a patient helps design the timing and nature of intervention. For example, in the case above, an intervention would need to follow a noxious antecedent to offset the negative mood it causes. Treating the negative mood would then decrease the need for escape through substance use. A variety of questions may be used to elucidate a short-term consequence:

> "Does this behavior get you attention in some way?"
> "What good things happen as a result of this behavior?"
> "Does this help you in some way?"
> "Do you feel a certain 'rush' from doing this?"
> "Does this behavior help you avoid something you don't want to do?"

Case Conceptualization Step 2: Clinical Hypotheses and Treatment Plan

Establishing focused clinical hypotheses based upon the information obtained in Case Conceptualization Step #1 serves to direct intervention options and possible treatment techniques. These hypotheses may require adaptation as new information becomes available during treatment. Clinical hypotheses can either be used exclusively by the therapist or can be shared with patients. Generally, sharing this information only improves trust and communication between patient and therapist.

A focused clinical hypothesis for a person with depression might be as follows:
"Since your retirement, you have experienced many life transitions and numerous losses (e.g., financial, social, functional). Your thoughts, which used to be largely positive and ambitious, are now negative and pessimistic; and you appear to be fearful of the future. In reaction to your mood and negative thoughts, you have reduced the number of your activities; and you have begun to withdraw from your family."

The end result of case conceptualization is formation of a treatment plan, an agreed-upon strategy between patient and therapist that gives direction to the therapeutic process. A treatment plan should include a presentation of the causes of the patient's current difficulties (e.g., cognitive and behavioral factors creating symptoms or difficulties) and a specific plan. When presenting the plan, actively involve the patient and incorporate his or her feedback.

Example: "In the brief amount of time we have spent together, it appears that we have identified some thoughts and behaviors that are likely contributing to your current difficulties. In particular, your view of yourself and your future are quite negative, and you have stopped doing many things that used to bring you pleasure. My recommendation would be to further explore your thoughts and see if we can find a more balanced view of your current difficulties. I would also like to talk with you more about re-engaging in activities you used to find pleasurable. What do you think about these targets for therapy?"

Case Conceptualization Step 3: Identifying Possible Treatment Obstacles

It is not uncommon for patients to simply agree with recommendations from their therapist. However, it is important to identify potential obstacles to treatment early on to avoid setbacks or treatment failures. Asking for frequent feedback from the patient helps to reduce over-compliance and serves to include the patient in a collaborative and active treatment approach. As part of this collaborative venture, it is important to ask the patient whether he or she sees any potential obstacles to treatment. Barriers might include logistic difficulties (financial, travel), personal beliefs (concerns about stigma, effectiveness of treatment) or interpersonal issues (family not supportive of therapy).

Tips for Using Case Conceptualization in Brief Therapy

- Case conceptualization in Brief CBT is much the same as with longer forms of treatment with the following exceptions:
  - Brief therapy leaves little room for delays in case formulation.
  - The time constraints of brief therapy must be considered in all treatment/goal-setting endeavors. Treatment goals should be reasonable, measurable and as simple as possible.
  - Because of limited time, the focus of treatment in Brief CBT also generally limits the depth of cognitive interventions. For example, it is quite frequent to address automatic thoughts and intermediate beliefs as foci of treatment, while addressing core beliefs is often difficult. If core beliefs are addressed, this usually occurs indirectly through more surface-level intervention techniques or at a time when the patient is particularly ready for such work.

Homework Assignment Examples

1. Think about our agreed-upon treatment plan, and consider any adjustments it might need.
2. Make a list of any obstacles to therapy that may arise.

Supplemental Readings

Cormier, W.H. & Cormier, L.S. (1991). *Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions, 3rd ed*. Pacific Grove, CA: Brooks/Cole Publishing Company. Chapter 8.

Persons, J.B. & Tompkins, M.A. Cognitive-behavioral case formulation. In Ells T. (Ed.). H*andbook of psychotherapy and case formulation*. New York: Guilford Press, pp. 314-339.

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press; Chapters 2 and 3.

Functional Assessment: ABC's

Antecedents (What happened before?)	Behaviors (What did you do?)	Short-Term Consequences (What was the result 1 second and 1 hour following behavior?)	Long-Term Consequences (What were the lasting results?)

ESSENTIAL BRIEF CBT SKILLS

Module 5: Orienting the Patient to Brief CBT

Objectives

- To learn how to convey information about the structure and content of CBT
  - To introduce the cognitive model
  - To introduce the collaborative nature of the therapeutic relationship

What is orienting a patient to therapy, and why is this process important?

Orienting the patient to therapy involves:

- ☑ A discussion of the theory underlying Brief CBT
- ☑ A description of how the presenting problems can be conceptualized and treated with this approach
- ☑ Education about the structure, format, and expectations of therapy

Orientation for Brief CBT also involves a discussion of the focused and time-limited nature of the therapy, plus the therapist's rationale for selecting Brief CBT to treat a particular problem. As noted in Module 1, this rationale includes the strong research basis of Brief CBT and the fact that it is an empirically supported treatment.

Many patients have little, if any, exposure to psychotherapy other than examples in the popular press. Providing patients with an understanding of the therapeutic process allows patients to be more active and aware of their role in the progression of therapy. Knowledge of the process of Brief CBT enhances the collaborative nature of therapy.

When? (Indications/Contraindications)

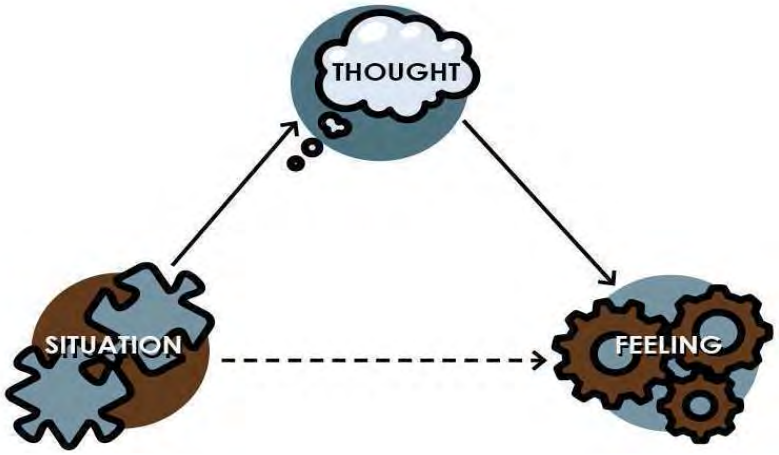
Discussing the rationale for CBT and describing the process of therapy should occur in the first session. However, it is useful to revisit the model throughout treatment to expand upon the rationale for particular skills. The explanation of the model can be tailored to the patient's presenting problem, and the examples that are used to explain each component can be drawn from those generated in discussion of problems. (e.g., "I can't seem to get out of bed, and then I feel worthless"). For patients who think in concrete terms, it might be necessary to provide many examples and focus initially on behaviors rather than on cognitions.

How? (Instructions/Handouts)

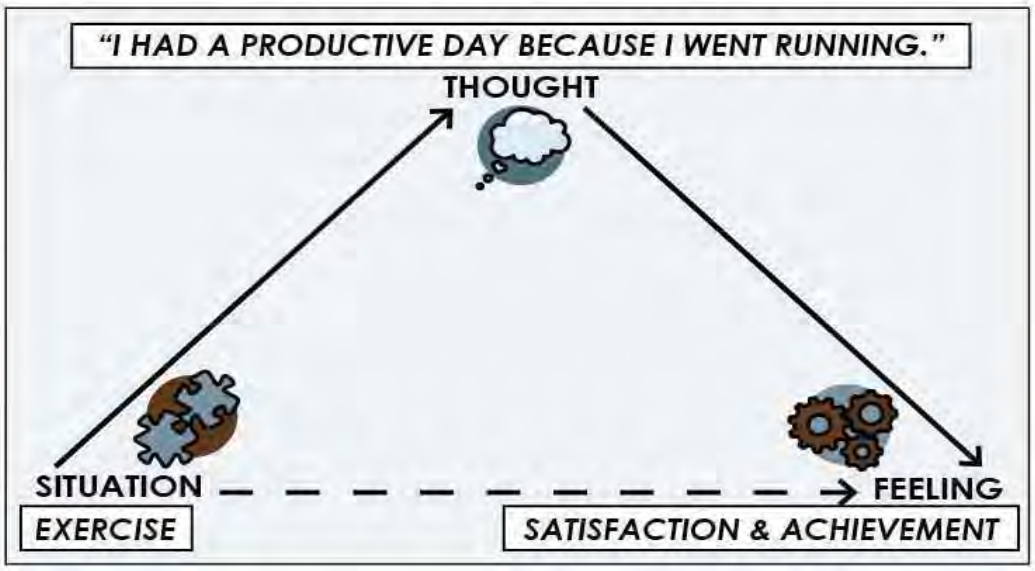
Introducing the Cognitive Model

The cognitive model is a theoretical paradigm for explaining how thoughts, feelings, and behaviors are associated. Most individuals believe that situations give rise to their emotions:

The cognitive model challenges this subjective experience and suggests, instead, that it is the thoughts we have about situations that give rise to emotions. Individuals who are depressed or anxious tend to display patterns of dysfunctional or "inaccurate" thinking. In the cognitive elements of CBT, the therapist trains the patient in specific skills that help the patient learn to improve his/her mood and change behavior by modifying the way hr or she thinks about situations. A key tool in identifying and examining the associations between thoughts, feelings, and situations is the thought record, which we will discuss in detail in Module 10: Challenging Automatic Thoughts.



The behavioral aspect of CBT addresses how behaviors influence mood. The therapist works with the patient to increase behaviors to improve mood and reduce behaviors associated with negative mood. As depicted in the figure below, changing behaviors can change feelings as well as thoughts. The associations among behaviors, thoughts, and feeling in CBT are captured by social learning theory, which suggests that the likelihood of a behavior is determined by its consequences. For example, social learning theory implies that a positive behavior, such as exercise, will occur more frequently if a patient experiences pleasure and a sense of satisfaction after completing physical activity. This is the premise of behavioral activation (see Module 11).



Avoidance and escape are particular learned behavioral patterns targeted in CBT. For example, not going to class because someone fears large crowds is an avoidance behavior. If someone leaves class because of anxiety over a large crowd, it is an escape behavior.

Initial Session

To prepare for the initial session, you are encouraged to thoroughly review all intake information. You need the intake information to form an initial conceptualization and formulation of a therapeutic plan. Using the patient's presenting problems, symptoms, current level of functioning, and history helps in developing the therapeutic plan. From the intake information, it is also imperative that you assess the patient's suicidality. This can be done by asking about the patient's suicidal ideation, intent, or plan and determining his or her level of hopelessness, as well as the reasons for hopelessness. If the patient's suicidality seems high, then crisis intervention is above all other therapeutic considerations. In the case of an acutely suicidal patient, you are encouraged to seek supervision or consultation and follow approved clinic procedures for managing a suicidal patient (e.g., contact on-call psychiatrist for evaluation).

Patient Expectations for Treatment
You should inquire about what the patient knows about how therapy is conducted. Orienting your patient to therapy includes describing the cognitive-behavioral model and answering any questions he/she might have about the progression of therapy. Using the patient's examples to help explain the cognitive-behavioral model will assist him/her in being able to see how the model can work and how it has worked for other patients with problems similar to his or hers. Often patients think therapy is a place where they will come and be lectured and told what to do or a place to vent without a focus on behavior change. It is essential in Brief CBT that the patient understands that therapy is a partnership between the therapist and the patient, in which they work together so that the patient can better understand feelings and solve problems.

Negotiating the amount of time the patient will need to be in therapy is also important. For Brief CBT, patients typically attend weekly individual sessions for 4-8 weeks. However, the amount of time in therapy and the number of days a week can be reassessed periodically and adjusted to meet the needs of the patient.

Discussing Symptoms and Diagnostic Issues with the Patient
Most patients want to know how they have been diagnosed. Explain the disorder in terms of cognitive and behavioral symptoms, to clarify how CBT will directly address their problems. Giving patients descriptions of common symptoms of their disorder can also be helpful.

> **Example:** There are cognitive and behavioral aspects of feeling depressed. Cognitive characteristics of depression include having negative thoughts about yourself, such as "I am no good," or "Things are not going to get better." Behavioral characteristics are ways your body tells you you're depressed, such as changes in your appetite or sleep patterns.

Feedback

The collaborative piece of CBT involves asking a patient for feedback on the session (e.g., "What did you think about our session today? Did we leave out anything you think is important to discuss?") and on how he/she feels about the cognitive-behavioral model ("Do you feel you have at least a basic understanding of the model, or should we be sure to review it in detail again next week?") at the end of the first and subsequent sessions.

Encouraging the patient to offer feedback strengthens the rapport and trust within the therapeutic relationship and indicates to the patient that they are an active member of the therapeutic process. It shows that the therapist cares about what the patient thinks and feels and values his/her input. This is also a time to resolve misunderstandings about the cognitive model or things that occurred in the session ("Was there anything that bothered you about the session, or anything that you'd like to change?"). Getting feedback from the patient shows how important it is to work as a team and also helps you work on sharpening your abilities in therapy. It also allows you to attend to and repair any real or perceived therapeutic fissures or needed treatment modifications in a timely way.

Important Introductory Elements

- ☑ Introduce Processes of Psychotherapy
  - Transparent
  - Collaborative
  - Time-Limited
- ☑ Introduce Cognitive-Behavioral Model
  - Research Basis
  - Association between behaviors, thoughts, feelings, and situations
  - Use of examples from patient's past week to clarify associations
- ☑ Educate the patient about his/her disorder
  - Describe patient's problems in cognitive and behavioral terms
- ☑ Instill hope and empowerment
  - Request for feedback
  - Creation of a warm, collaborative therapeutic environment

<u>Homework Assignment Examples</u>

1. Keep a running list of questions you may have about the therapeutic process, and bring it with you to the next session.
2. Use the cognitive-behavioral model diagram for at least three situations you experience this week.
1. Create a short list of the things you liked about the previous session and a short list of the things you wish we could have changed about the previous session and/or concerns you might have.

<u>Supplemental Readings</u>

Greenberg, D. & Padesky, C.A. (1995). *Mind over mood*: *Change the way you feel by changing the way you think*. New York: Guilford Press; Chapters. 1, 2, & 4.

Module 6: Goal Setting

Objectives

- To understand the concept of goal setting in Brief CBT
- To acquire skills to set feasible and appropriate goals in Brief CBT

What is goal setting, and why is it important to set goals in therapy?

Goal setting is the process of collaboratively identifying specific therapeutic outcomes for treatment. Goals must be observable, measurable and achievable and relate to cognitive or behavioral changes relevant to the patient's presenting problem. Goals are tied to specific skills to be addressed in treatment. Goals increase the continuity of sessions, allow for directed, focused treatment, and enable the patient and therapist to assess the progress of therapy and identify change in an objective manner.

When? (Indications/Contraindications)

In addition to identifying the problem and building rapport, goal setting is one of the first therapeutic activities to be completed in Brief CBT. Although goals can be changed/modified at any point during therapy, to maximize applicability and benefit to the patient, a preliminary set of goals should be established and agreed upon by the end of the first or second session.

How? (Instructions/Handouts)

Goal setting begins with the identification of broad goals. These are global and refer to areas of functioning (e.g., family, work, social relationships, financial concerns, health, etc). Broad goals are closely tied to the therapist's case conceptualization and the patient's presenting problem.

Once broad goals are identified collaboratively, the patient and therapist prioritize goals. This process involves determining the most central issues that cause concern and arranging them from most important to least important. Starting with the problem that has the best chance of being solved can help increase the patient's commitment to therapy. If one skill is prerequisite to a subsequent goal, that goal can also be prioritized in treatment (e.g., relaxation before exposure, awareness of thoughts before thought challenging).

Use a graded approach to goals, in which you take small steps in service of the larger goal each week through session content or homework assignments. Identifying and sequencing action steps involves breaking each goal into smaller steps to help the patient know what to do at every stage of accomplishing the goal without feeling overwhelmed by a huge task.

Once goals have been identified and prioritized, they are operationalized, which involves defining the goal and all the steps that it will take to achieve it in concrete, observable/measurable cognitive or behavioral terms.

Example
Goal: Learn two cognitive and two behavioral strategies for coping with stress.

- ☑ Operational Cognitive Goals
  - Learn and use thought testing and problem solving to manage anxious thoughts/situations
- ☑ Operational Behavioral Goals
  - Plan and complete one pleasant or social activity per week

Assessing Facilitators, Barriers, Importance and Confidence

Once a goal or multiple goals have been established, it is critical to assess the patient's situation and attitudes about the goals. For example, ask whether there are aspects of the patient's life that may facilitate or inhibit the goal. A strong family and social-support system may help a patient to reach his or her goal, but a functional limitation may create an obstacle. Explore facilitators and barriers and discuss strategies to maximize the chance of goal attainment.

Assessments of importance and confidence are also important. Ask the patient to rate the importance of the goal on a scale of 0 to 100 (where 0 is not important and 100 is very important). Discuss ratings lower than 60 or so, and refine goals to increase meaning. Similarly, ask the patient to rate his/her confidence in obtaining the goal. Here, confidence ratings could be a little lower but would hopefully increase as treatment progresses.

Troubleshooting Goal Setting

Some clues that goals may need modification are worsening symptoms, no change in symptoms, patient failure to complete homework (see Module 8: Homework), and patient/collateral report that the patient is not benefitting from treatment. In these cases, it is important to revisit initial goals with the patient and elicit his/her feedback about the progress of therapy ("What do you find helpful?"). Often, too-ambitious goals need to be modified. In these cases, it is important to frame the revision in terms of taking small steps towards lasting change, normalize the difficulty of making changes when depressed or anxious, and join the patient ("I think I may have gotten a little ahead of myself; let's modify these a little, so that they can be the most help for you"; "I may have missed the mark on this one; what do you think about adding/changing/removing a goal?"). Goal revision should not imply to the patient that he/she has failed in therapy. It is an opportunity to model functional change in response to changing situations.

If the patient is worsening, discuss any changes in context (e.g., relationship, work, sleep, medication compliance, physical health) the patient is experiencing. Create a new goal pertinent to what the patient believes is worsening and what might help. At this point, you should also consult a supervisor/colleague or other professional (e.g., patient's treating physician).

If the patient is not improving, elicit his/her feedback about changes he or she is experiencing and his/her perceptions about why these changes have occurred. If a patient

seems to have trouble understanding the assignments, focus on more concrete and behavioral skills.

Tips for Goal Setting

- **Provide Rationale for Setting Goals.**
  - This helps the patient understand the direction of treatment and how he/she will be involved in the process.
    - **Example:"** If you can identify what you want to change about your situation, we can then take steps to correct the problem."

- **Elicit Desired Outcomes.**
  - This involves the therapist's assisting the patient in defining goals and specifying reasons for coming to treatment.
    - **Example:** "List a few things you would like to get out of therapy."

- **Be Specific About What the Goal Is.**
  - Determine each goal, what the goal is attempting to target, and what the patient's role is in reference to the goal.
  - Guide the patient towards goals that require change from him/her (vs. others).
    - **Example: "**You said that you want your wife to listen to you. Since we can't really make someone do what we want, what could you do to help you feel heard or cope with a situation when you don't feel heard?"

- **State Goals in a Positive Light.**
  - This clarifies what the patient wants to do instead of highlighting what he or she doesn't want to do.
    - **Example: "**List some things that you want, instead of things that you don't want. For example, instead of 'I don't want to be depressed anymore,' you could list, 'I want to enjoy my favorite hobbies again.'"

- **Weigh Advantages and Disadvantages of a Goal.**
  - This aids in understanding the costs and benefits of the patient's achieving the goal.
  - It may be used to motivate an ambivalent patient or identify salient goals for a passive patient or a patient seeking to please the therapist.
    - **Example: "**What would be the benefits if you accomplished this goal? What might be some of the costs to you?"

- **Define Behaviors Related to Goal.**
  - This instructs the patient what actions to perform in relation to the goals that have been set.
    - **Example: "**What would it look like if you were less depressed? If I saw you and you were feeling happy, what would I see? What do other people do when they are happy? What things do you think have changed in your life since you have been depressed? What did you used to do that you enjoyed that you don't do anymore?"

Tips for Goal Setting (Continued)

- **Define a Level of Change.**
  - This determines how much a patient should do a particular behavior.
  - To increase the patient's chance of success, set achievable goals. In other words, it is usually not reasonable to try to do something every day, and setting a goal like this will result in failure if the patient misses just 1 day. Alternatively, discuss the goal with the patient; and start small. If the patient succeeds, he/she is more likely to remain actively engaged.
    - **Example:** How often do you think it is reasonable to do something pleasant? Once a week?

- **Regularly Evaluate Symptoms.**
  - Track how effective the goals are in decreasing mental health symptoms and increasing functioning and quality of life.
  - For example, assess the following areas during the intake process, during the actual intervention strategy, and a month to a year after termination of therapy:
    - Patient's level of satisfaction with your assistance and the results of therapy
    - Amount of growth the patient experienced from the beginning of therapy to the end
    - Benefits obtained by the change made by the patient and which treatment was effective in helping to accomplish the goal
  - Self-report tools, such as the Beck Depression Inventory or mood-tracking charts, and clinician-administered assessments, such as the Hamilton Depression Rating Scale, may be used as objective measures of change over the course of treatment.

Example Homework Assignments

1. Make a short list of broad goals. What areas of your life do you wish to improve (e.g. work, family, social, recreational, financial, health, etc.)? Think about which goal would be most important.
2. List three issues, in order of importance, that you want to discuss in the next session.
3. Weigh the pros and cons of each goal that we have agreed upon in treatment.

Supplemental Readings

Beck, J.A. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press, Chapter 6.

Cormier, W.H. & Cormier, L.S. (1991). *Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions, 3rd ed*. Pacific Grove, CA: Brooks/Cole Publishing Company; Chapter 10.

Module 7: Agenda Setting

Objectives

- To understand the rationale for setting an agenda
- To understand process of collaboratively setting an agenda
- To identify and address problems with setting an agenda

What is agenda setting, and why is important?

Agenda setting is a collaborative process through which the therapist and patient decide how session time will be spent. The patient and therapist offer items they would like to discuss and then decide the order of items and the amount of time they will spend on each. Each item should be in service of treatment goals (see Module 6: Goal Setting and Module 4: Cognitive Behavioral Case Conceptualization and Treatment Planning). Agenda setting ensures session that time is well spent and that both therapist and patient have input into session content.

When? (Indications/Contraindications)

An agenda should be set within the first 10 minutes of every session. Without setting an agenda, it is very easy for vocal patients to "run away" with the session by recounting the events of the past week or describing the history of a problem. It is also easy for more passive patients to never indicate which items are most important to them. By collaboratively setting an agenda, both the therapist and patient's needs are met. Setting a time limit for each item, increases the chance all items can be covered.

Patients should be encouraged to think between sessions about what they would like to discuss in session. If a patient does not offer an agenda item, you can introduce an item and check with the patient to see if he or she feels it would be valuable to discuss.

How? (Instructions/Handouts)

It is your responsibility to model how to set agendas for the patient. In the first few sessions, you will be setting the agenda because often the patient is unsure of what is being asked or what to discuss in therapy. You can help the patient become more comfortable with setting his or her own agenda by asking questions like, "What is the main reason you came to therapy?" or "What is causing you the most trouble right now?" or "What are your most pressing issues today?" or "What are your thoughts about the focus of today's session?" It is also important to assist the patient in prioritizing issues on the agenda to give an acceptable amount of attention to each issue. After listing and prioritizing items, allot an approximate time to each item for discussion.

Pay close attention to time management of issues on the agenda, and steer the patient away from superficial issues. As time passes, the responsibility of setting an agenda for the session should shift to the patient. This will eventually help him/her to set agendas, prioritize problems, and suggest interventions for issues encountered after completing therapy. This level of increasing patient responsibility also translates into his/her overall functioning by increasing autonomy of functioning as the patient works toward ending treatment.

Typical Session Outline

1. Briefly review patient's mood and/or physical functioning (5 minutes).
Elicit responses concerning the patient's mood, and consider any and all discrepancies (e.g., change in strength or nature of usual mood, change from last week or beginning of treatment). Medically ill patients may benefit from regular assessments and updates on their physical health symptoms and functioning. Also ask the patient to offer explanations for mood improvement or decline. This brief update allows you to gauge how the patient is progressing and identify positive and negative change. If medication management or physician collaboration is part of the patient's treatment, this is also a good time to check on any side-effects the patient might be having from medication and make adjustments as needed.

2. Bridge discussion from previous session with the current session (5 minutes).
In bridging sessions, you are checking the patient's understanding of what was discussed in the previous session. Reinforcing what the patient learned in past sessions is essential to the improvement that the patient makes outside the therapeutic relationship. Having the patient complete a Bridging Worksheet can assist in this stage of the agenda. Some issues discussed during this phase could become items on the agenda for the current session.

3. Set the agenda for the current session, and prioritize the items (5 minutes).
First ask the patient what he/she would like to discus, and then offer an item. If a patient brings several agenda items, he or she might need to indicate which is the most important to discuss first. When a situation (e.g., fight with boyfriend followed by food binge) is offered by the patient as an item, you can use the situation as part of his/her agenda item, that is, as part of the skill being taught. For example, you can use the above scenario to teach/review a thought record.

4. Review any homework given in the previous session (5-10 minutes).
Patients who do between-session homework show greater improvements than those who do not. To reinforce and troubleshoot between-session learning, it is important to review homework. In-session review serves two purposes: it reinforces the importance of homework and allows you to assess skill acquisition. If you identify errors in homework, you can use additional session time to review the skill. Reviewing homework can take a small amount of time; or it can take the entire session, depending on what the patient has learned from doing it and what difficulties he or she has encountered in completing it.

5. Discuss agenda items and set up homework (20-25 minutes).
Discuss agenda items, starting with the first and most important. If you are running short on time, inform the patient that you will discuss the other items at your next appointment. Set up homework that is directly connected to what has been discussed in the session.

6. Summarize the current session and exchange feedback (5 minutes).
Two types of summarizing are recommended. The first is a brief summary that should be done after the conclusion of each section of the agenda to reinforce what has been discussed. The second type is used to clarify and remind the patient of the thoughts he/she has presented and how those thoughts changed as a result of the exercise. It is important to use the patient's specific words in summarizing his or her thoughts. At the end of the session, summarize the main points of the entire session. As the sessions progress, ask patients to do the summaries. Finally, exchange feedback about the session, skill, or progress of therapy. This is a time for you to encourage and motivate patients to continue working towards change.

Troubleshooting Agenda Setting

In discussing agenda items, there are many pitfalls for a new CBT therapist. It is your responsibility to keep the discussion on track and focused. To prevent unfocused discussions, gently guide the patient back to the topic when he or she drifts, emphasize key emotions, beliefs, and automatic thoughts, and often summarize and rephrase what the patient says. You can also discuss at the start of therapy that one of your roles is to keep sessions on track; so you may, at times, need to shift the focus of conversation. Getting the patient's agreement on this point at the beginning helps him/her feel more comfortable if you need to redirect or interrupt later in therapy. Pacing is also a concern for therapists, but prioritizing and collaboratively agreeing on agenda items and times can help you and the patient stay within the allotted time.

Patients and therapists sometimes have difficulty setting the agenda together. Sometimes patients do not want to contribute to the agenda because of feeling hopeless or negative toward therapy. Occasionally, the patient may also be unfocused when setting the agenda (e.g., recount events of past week). It is often necessary to educate the patient about therapy by clarifying what kinds of issues constitute agenda issues and how session time may be optimally spent.

CBT suggests that change involves skill acquisition and not simply identifying distorted thinking. Therefore, recognizing a distorted thought can be enlightening, but you should also use session time to teach skills to address the problem (e.g., thought records, behavioral activation) and not simply discuss the issue with the patient or offer advice. The process of skill acquisition is what sets CBT apart from "talk therapies" (supportive therapy).

Example Homework Assignments

1. Create an agenda for next session, using the given outline.
2. Think about adjustments you would like to make to our current agenda and reasons why.
3. Crate a list of concerns/discomfort in the agenda-setting process.

Supplemental Readings

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press; Chapters 4 & 5.

[This worksheet is to be completed by the patient prior to beginning the session (e.g., in the waiting room) to prepare for therapy and assist in collaboratively selecting agenda items.]

BRIDGING SESSIONS

1. What main points did we reach in our last session? What did you learn from last session? Did anything come to mind in the past week about our last session that you'd like me to know or that you'd like to discuss?

2. Were you uncomfortable about anything we talked about in our last session? Is there anything you wish we had discussed that we didn't?

3. How is your mood? (How is your physical health?) Compared with last week, is it better or worse?

4. What treatment goals would you like to work on today? What problems would you like to put on the agenda?

5. What homework did you attempt or complete for last session? What did you learn from doing it?

Module 8: Homework

Objectives

- To understand how homework is introduced and used in Brief CBT
- To understand techniques for increasing homework utility and compliance

What is homework, and why is it a central part of CBT?

Homework is an essential and effective component of Brief CBT. Because of the condensed number of sessions in Brief CBT, assignments such as readings, behavior monitoring, and practicing new skills should be given to the patient to practice and use outside sessions. Homework assignments facilitate patient skill acquisition, treatment compliance, and symptom reduction by integrating the concepts learned in sessions into daily life. Homework is a key mechanism for facilitating between-session work and progress.

When? (Indications/Contraindications)

Give homework assignments throughout treatment. The nature and frequency of assignments is left to your discretion. Consider patient characteristics when assigning homework, specifically reading ability, cognitive functioning, level of distress, and motivation. During the beginning stage of therapy, suggest homework; but, as therapy progresses, encourage the patient to generate between-session activities. This helps the patient to continue to use skills outside therapy and after the end of treatment. Some patients may be hesitant to participate in homework assignments, so it is your responsibility to be open to patient feedback about assignments, give reasons for each task, and personalize homework assignments for each patient.

How? (Instructions/Handouts)

Seven Tips for Setting Homework

1. One Size Does Not Fit All.
Always tailor assignments to patients. Their reading level, desire to change, cognitive functioning, and, even, stage of life determine how much and what type of homework assignment fits them best. For example, a single, working mother who is also a full-time student may not have time to read a complete book as a bibliotherapy assignment. Assigning her a small part of the book or an article may be more reasonable. Breaking assignments down into smaller parts is also useful. Always consider the patient's diagnosis and presenting problem when assigning homework and ask yourself

> "Can the patient handle this homework, and will it be beneficial to his/her growth?"
> "Could there be a negative result from this assignment; and, if so, is the patient prepared to handle it outside session?"

2. Explain In Detail.
Knowing the reason for an assignment and how it relates to overall treatment goals helps the patient understand why he/she is doing the assignment and also may encourage him/her to complete it. Most patients are interested in how certain activities may improve their situation or relieve their symptoms. Explain assignments in the context of treatment goals and the cognitive model to enhance patient buy-in to the tasks.

3. Set Homework as a Team.
Involving the patient in designing and scheduling homework increases the chances he/she will complete it. It is also important to get the patient's agreement to complete the homework. Suggest homework assignments, and then ask the patient if you can help make adjustments to it. Ask, for example, the following:

> "Do you think this is reasonable?"
> "What would you change about the assignment?"
> "Let's do an example together first. Then we can make changes if we need to."

4. Create a Win-Win Situation.
Do not scold a patient for not completing homework assignments, but also do not dismiss their value. If a patient does not finish homework, which is common, you may learn about the patient's level of motivation, ability to follow-through, or level of distress (e.g., too depressed to complete it). Failure to complete homework is an opportunity for you to evaluate the patient's reason for noncompliance. The patient may have been anxious about completing an assignment incorrectly or may question the utility of the assignment. These thoughts are helpful to discuss in session.

5. Start Homework In-Session.
In the first few sessions after assigning homework, do a few examples with the patient in session, when possible. This gives the patient a clearer picture of what is expected and allows questions that he/she might have about the homework. It also gives the patient an idea how long the homework will take. In subsequent sessions, the patient may start the assignment with your assistance to troubleshoot questions about it.

6. Ask About and Review Homework.
To emphasize the importance of homework, always ask about and review homework the session after you assign it. If the patient did not complete homework, use session time, if possible, to complete the assignment, which may also help identify the aspects of the skill that need to be reviewed. If you do not review homework in session, patients may stop completing it.

7. Anticipate and Prepare for Problems.
With the first few homework assignments, help problem solve the assignment by eliciting feedback about it and planning when and how it will be completed. Assignments can be scheduled for a particular day and time to overcome barriers, and foreseeable problems for completing the assignment at that time can be discussed. For example, if the patient's behavioral activation is to walk for 15 minutes on Wednesday at 4pm, discuss what to do if it rains or other factors prevent him/her from completing it. Agree upon and schedule a second option (e.g., using treadmill for 15 minutes).

Using Bibliotherapy as Homework

Bibliotherapy, or assigning the patient reading materials relevant to Brief CBT or his/her presenting problems, is a useful tool for Brief CBT because it allows the patient to read about his/her disorder or CBT between sessions. Bibliotherapy emphasizes the self-management focus of CBT and can accelerate therapeutic progress and maintenance of changes. Reading materials may be websites, book chapters, or sections of CBT patient manuals. Some common examples of CBT bibliotherapy are *Mind Over Mood* (Greenberger & Padesky, 1995) and *Feeling Good Handbook* (Burns, 1999).

Homework Troubleshooting

Practical Problems
Occasionally, therapists may encounter a patient who waits until the day before a session to do the homework. This is problematic because certain assignments, such as monitoring automatic thoughts, are most effective and most accurate when completed in the moment. There are many reasons patients may put off doing homework, and your role is to explore these reasons in a proactive, nonjudgmental, nonpunitive way.

Sometimes a patient may simply forget to do homework. He/she may have a busy schedule or have trouble remembering to complete homework. Using a calendar and scheduling time to do homework are useful in this situation and provides the opportunity for time-management skill building.

A few assignments described in this text might be difficult for some patients. If a patient is having trouble completing an assignment because of the level of difficulty, it is your job to explain how to complete it and gauge the patient's understanding. Some assignments may need to be broken down into smaller steps until the patient can fully grasp how it is to be completed.

Psychological Problems
Patients who don't complete homework might have maladaptive thoughts about themselves, the homework assignment, or therapy that need to be addressed. In these cases encouragement, thought testing and listing the advantages and disadvantages of doing homework may be useful. Though outside the scope of this manual, techniques, such as motivational interviewing (Rollnick, et al 1999), may also be used to address the ambivalence a patient may feel about homework. Patient perceptions of importance and confidence are very important for non-compliance issues.

Many patients have negative reactions to the word *homework*. They may feel overwhelmed by the perceived time or energy it will take to complete, or concerned that therapy is like schoolwork. In giving homework, address any concerns the patient may have about time constraints, and explain how long each assignment should take, while working with the patient to generate reasonable tasks. If the patient dislikes the term *homework*, work with him/her collaboratively to select another label, such as *practice, between-session progress, task*, or *experimen*t.

Homework may be problematic for patients who are perfectionists or desire to please the therapist because they may spend too much time on an assignment or be overly concerned about getting the "right answer." Clarify that the exercise is not about getting

the "right answer," and that they should concentrate on recording real feelings and thoughts and not concern themselves with spelling, grammar, or appearance of the assignment.

Therapist Cognition Problems

Although completion of homework is primarily the patient's responsibility, sometimes your thoughts about an assignment or approach to homework plays a role in noncompliance. Check your own thoughts about assigning homework, and determine whether there is anything you can adjust in your approach that could better encourage the patient. Ask yourself, "Is the assignment too difficult?", "Did I explain the assignment thoroughly?", or "Have I led the patient to believe that homework is unimportant to therapy?"

Sample Homework Assignments

Examples of homework that could be assigned for each cognitive and behavioral skill are included in each module. Examples of tailoring a homework assignment to a specific case are included in Appendix B.

Supplemental Readings

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press; Chapter 14.

Burns, D.D. (1999). Feeling good handbook. New York: Plume Books (Penguin USA).

Cormier, W.H. & Cormier, L.S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions, 3rd ed. Pacific Grove, CA: Brooks/Cole Publishing Company; Chapters 12, 16, & 19.

Greenberg, D. & Padesky, C.A. (1995). Mind over mood: Change the way you feel by changing the way you think. New York: Guilford Press; Chapters 3, 6, 7, 8.

Rollnick S., Mason, P., & Butler, C. (1999). *Health behavior change. A guide for practitioners*. Chapters 3, 4, 5. New York: Churchill Livingstone.

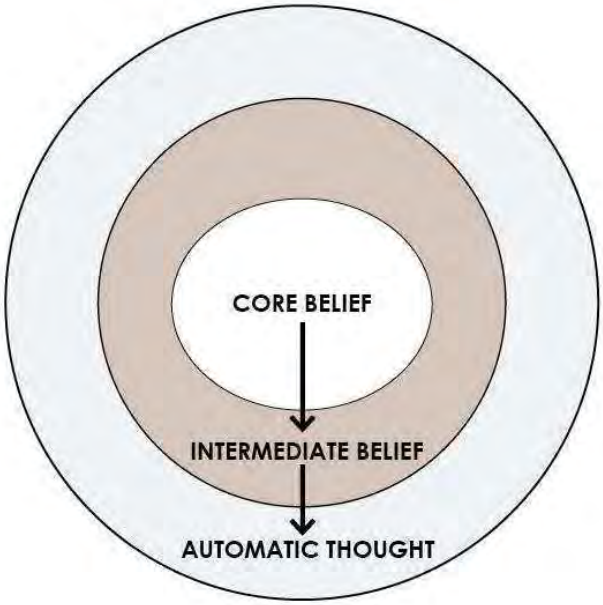
Module 9: Identifying Maladaptive Thoughts and Beliefs

Objectives:

- To understand the role of maladaptive thoughts and beliefs in Brief CBT
- To learn methods for educating the patient about maladaptive thoughts and beliefs

What are maladaptive thoughts, and beliefs and why they are important in Brief CBT?

The cognitive-behavioral model (as depicted below) suggests that three layers of cognitive dysfunction exist in individuals struggling with social and/or psychological problems: Automatic thoughts, intermediate beliefs, and core beliefs.



An automatic thought is a brief stream of thought about ourselves and others. Automatic thoughts largely apply to specific situations and/or events and occur quickly throughout the day as we appraise ourselves, our environment, and our future. We are often unaware of these thoughts, but are very familiar with the emotions that they create within us. Maladaptive automatic thoughts are distorted reflections of a situation, which are often accepted as true. Automatic thoughts are the real-time manifestations of dysfunctional beliefs about oneself, the world, and the future that are triggered by situations or exaggerated by psychiatric states, such as anxiety or depression.

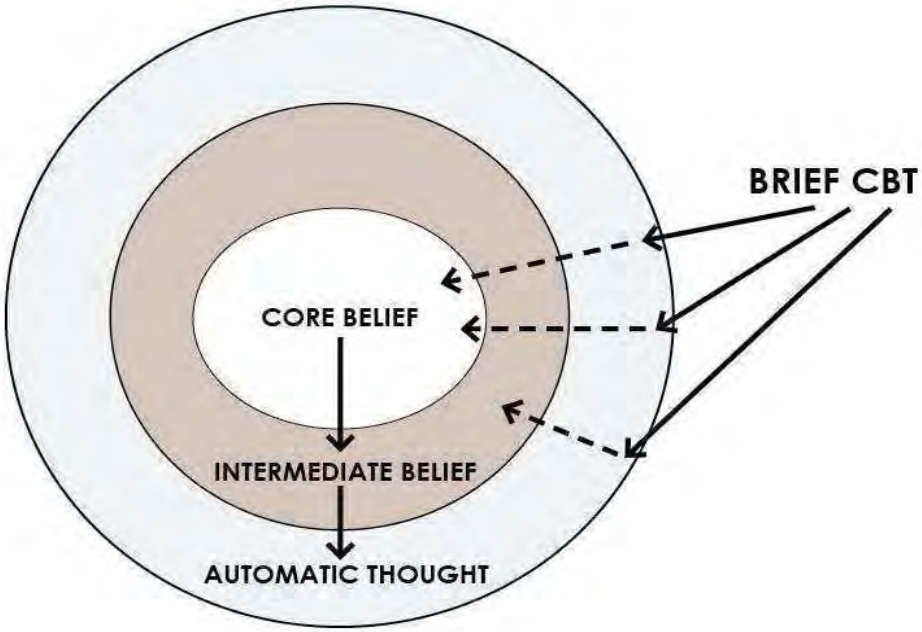
Intermediate beliefs are attitudes or rules that a person follows in his/her life that typically apply across situations (not situation specific as with automatic thoughts). Intermediate beliefs can often be stated as conditional rules: "It x , then y." For example, "*If I am thin, then I will be loved by others.*" Individuals create these assumptions by categorizing the information they receive from the world around them. These rules guide thoughts and subsequently influence behaviors.

Dysfunctional core beliefs drive dysfunctional rules and automatic thoughts. For example, the belief, *I am unlovable,* may be driving the conditional rule, *If I am thin, then I will be loved by others,* which may drive obsessive thinking about one's appearance, excessive exercise, or disordered eating habits. Core beliefs are often formed in childhood and

solidified over time as a result of one's perceptions of experiences. Because individuals with psychological disorders tend to store information consistent with negative beliefs but ignore evidence that contradicts them, core beliefs tend to be rigid and pervasive. Although automatic thoughts are often tied to a specific situational trigger, intermediate and core beliefs are more global and cut across domains. Beck suggests that individuals tend to have core beliefs that involve either interpersonal ("I'm unlovable") or achievement issues ("I'm incompetent").

When? (Indications/Contraindications)

Identifying maladaptive automatic thoughts is the first step in the cognitive component of therapy. The focus of intervention in Brief CBT is the dysfunctional automatic thought. Patients must master identifying and challenging thoughts to be able to grasp the concept and techniques of challenging beliefs. Because of the interrelated nature of thoughts and beliefs, an intervention targeting automatic thoughts may also change underlying beliefs (depicted below). Therefore, Brief CBT can result in belief modification, even if the target of treatment was automatic thoughts.



Because patients progress through treatment at different rates, you may be able to identify and challenge some beliefs late in brief therapy (sessions 5-8) for some patients. For other patients, work will be limited to automatic thoughts.

Because skill building to alleviate symptoms and prevent relapse is a central focus of CBT, mastery of skills is paramount. Focus on building a skill set with the patient that he or she can generalize to different situations, thoughts, or beliefs. It is less important to identify and modify deep-seated childhood beliefs. For most patients in Brief CBT, this will not be necessary for symptom reduction. However, some patients may benefit from this work.

Although you may not discuss beliefs directly with the patient, as part of the case conceptualization, he/she should constantly be forming hypotheses about what beliefs may be driving the thoughts (see Module 4: Case Conceptualization and Treatment Planning).

In identifying thoughts and beliefs, ask yourself several questions.

- Is the thought/belief secondary to another thought/belief?
- How much does the patient believe it?
- Does it affect the patient's life negatively?
- Is the patient prepared to work on it now, or should he/she tackle the belief at a later date?

After an automatic thought or belief is identified, it is challenged using the skills in Module 9.

How? (Instructions/Handouts)

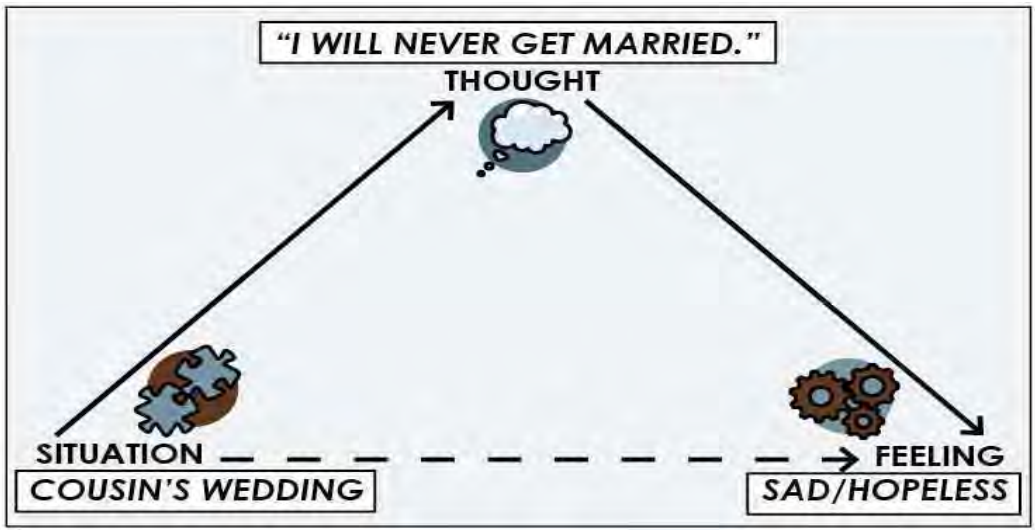
Explaining Automatic Thoughts to Your Patient

It is important for the patient to understand the rationale for identifying automatic thoughts before acquiring the skill of addressing his/her own thoughts. Using the situation→thought→ feeling triangle introduced in Module 5 (Orienting the Patient to Brief CBT) can be helpful in explaining automatic thoughts. Completing the triangle with the patient's recent or current automatic thoughts can facilitate his/her understanding.

Therapist:	**"So, Pamela, how have you been feeling this week?"**
Pamela:	"Just really sad…as usual. It seems like I'm always feeling that way."
Therapist:	**"Did anything in particular trigger this sad feeling this weekend?"**
Pamela:	"Yes, I had to go to my cousin's wedding, and it was really difficult because I started thinking about how I will never get married."
Therapist:	**"Pamela, that's what we call an automatic thought. It's something that just pops into our heads over and over again without our really thinking about it or examining the truth of the thought. It affects the way we feel and act in a negative way. Maybe we should look at some of your automatic thoughts a little closer."**

Using the patient's example, describe the association between thoughts and feelings to build awareness of the connection. This is a good time for the patient to write down the thought and begin using the cognitive-behavioral model.

Therapist:	**" So, let's write down this automatic thought that you are having. *I will never get married.* Your going to your cousin's wedding was the situation that triggered the thought, 'I will never get married'.**
Pamela:	"Yes, that's true."
Therapist:	**"When you were at the wedding and that thought came to you, how did you feel?"**
Pamela:	"I felt really sad and hopeless."
Therapist:	**So, can you see how our thoughts can affect our mood and change the way we are feeling?"**
Pamela:	"Yeah, I guess if I hadn't had that thought, I wouldn't have felt so bad."



Eliciting Automatic Thoughts

It is important for therapists to teach patients how to identify automatic thoughts during and outside of session.

Automatic Thoughts in Session
Be aware of patient's hot thoughts during sessions. Hot thoughts are automatic thoughts that occur in combination with a change in emotion or mood. Hot thoughts are particularly poignant or strong thoughts that are often associated with dysfunctional core beliefs, and should be targeted in therapy. Hot thoughts and the accompanying situation and emotion are tracked on the first three columns of the thought record (see p. 47).

To identify which automatic thoughts are "hot", the therapist listens for verbal cues, such as the language used in the thought (see Cognitive Distortion worksheet, p. 49), and watches nonverbal cues, such as increased volume of speech or fidgeting. Changes in facial expression, shifts in position, or hand movements can be helpful in determining whether a patient is experiencing an automatic hot thought. Listening to tone, pitch, volume, and the pace of a patient's speech is also beneficial. When you notice these actions, this is an opportune time to bring it to the patient's attention and assist him/her in identifying an automatic thought associated with the shift in emotions. In these instances, you are simply an observer of the behavior and make a note of your observation to the patient ("You are speaking more loudly; what is going through your mind right now?"). The patient then provides an explanation of the behavior.

Patient:	"My boss reprimanded me again yesterday" *(sighs heavily.)*
Therapist:	**"Tell me more."**
Patient:	"Well, we were at a meeting; and I had just made my presentation, and he said he had expected a better product for the client. (*voice gets softer, begins wringing hands)*.
Therapist:	**"Your voice changed a little when you said that; tell me what is going through your mind right now?"**
Patient:	"I just feel like a failure at everything. My work has always been the one thing I was good at, and now I am failing at that, too."

Example continued:

Therapist:	**"Let's take a look at that line of thinking and the feelings it creates. It seems that when that thought entered your mind, your mood changed very quickly. Did you notice that?"**
Patient:	"Yeah, I guess it did upset me pretty fast."

You usually will also need to use specific questions to elicit an automatic hot thought. These questions are found on p. 48-49 and in Module 10.

Automatic Thoughts Between Sessions

In Brief CBT, a principal characteristic is the work the patient does outside of session. Because identifying automatic thoughts is a novel concept to many, practicing outside of session will facilitate movement and change in therapy. In fact, Burns and Nolen-Hoeksema (1992) found that patients who completed homework had significantly better treatment outcomes than those who did not. Practicing key skills between sessions allows session time to be used for new skill acquisition and troubleshooting. Initially, when a specific situation is brought up in session, always ask, "What was going through your mind at that moment?" This helps the patient build awareness of his/her automatic thought, both within and outside of session.

Because automatic thoughts may occur outside awareness, asking for a more detailed description of the situation is also helpful in pinpointing maladaptive thoughts. For example, you could "take the patient back" to when it happened, using imagery (e.g., Where were you when this happened? What time of day was it?). If the patient reverts to past tense, remind him/her to tell the story in present tense to help bring back the thoughts and feelings that occurred in this situation.

With continued questioning, it is possible that there may be more than one automatic thought associated with a problematic situation. Elicit and record all automatic thoughts given for a particular situation.

Therapist:	**"Craig, what else were you thinking during this phone call with your wife?"**
Craig:	"I was thinking that she knows how bad I feel for not coming to the party and she wants me to feel even worse."
Therapist:	**"So you weren't thinking only that they were using you. You were also thinking that they knew you felt bad, and they wanted you to feel worse?"**
Craig:	"Yes."
Therapist:	**"So, that is really three different thoughts that you were having that were creating feelings of anger?"**
Craig:	"I guess so."

Remember that a patient's automatic thoughts should be the actual words or images that go through his or her mind. Patients (or therapists) may often interpret or rephrase thoughts; however, the goal is to get unprocessed thoughts verbatim.

Deciding Which Automatic Thoughts to Focus On

Once a patient becomes aware of how many automatic thoughts he/she has, he/she may feel overwhelmed by their sheer number. Uncovering one thought may lead to another and so on. Therefore, it is important to focus on the most important automatic thoughts and the hot thoughts that are likely to bring about the greatest change. There are several things a patient can do once he or she has identified an automatic thought. The patient can decide to focus on that thought, choose another thought associated with the situation, or move on to another topic if he/she feels that there is a more powerful thought that he/she would like to tackle.

You can help the patient choose automatic thoughts to focus on by frequently checking:

- Goals for this session
- Patient's agenda items and addressing those problems
- The importance of the thought chosen in reaching therapeutic goals

Another technique is to identify a few automatic thoughts and then rate them on a scale of 0-100, based on how intense the associated feeling is (rate the feeling from 0-100), and how much he/she believes the thought (rate believability from 0-100). This helps to quantify which automatic thoughts are most important. The thoughts with the strongest ratings should be considered first.

Dysfunctional automatic thoughts often fall into certain categories. These are common "cognitive distortions" or thinking errors. Identifying patterns of cognitive distortions in the patient's thought records or speech is instrumental for choosing a hot thought, case conceptualization, and treatment planning. A patient often has one or two common patterns of maladaptive thinking. Identifying these patterns helps him/her identify them when they come up and provides you an opportunity to intervene on a thought triggered in multiple situations. Therefore, changing a particular thought that is part of a dysfunctional thinking pattern (e.g., tendency to ignore the positive) may have multiple benefits for the patient. For list of common thinking errors, see the Cognitive Distortion worksheet (page 49).

Intermediate Beliefs

To identify an intermediate belief, you must first know how to recognize a patient's automatic thoughts. You can do this by identifying an automatic thought and then attempting to identify an attitude or assumption the patient feels about him-/herself, the future, others, or the world. These assumptions can be identified by listening for themes in the patient's thoughts and behavior. You can use several techniques to identify an intermediate belief:

- Look for an intermediate belief that comes in the form of a patient's automatic thought.
- Provide the first part of an assumption ("If x…"), and enlist the help of the patient to complete it.
- Elicit a rule or an attitude from the patient, and change it into an assumption.
- Look for themes in the patient's automatic thoughts. Either come up with a hypothesis, or ask the patient to identify a theme.
- Ask the patient directly about his or her beliefs.
- Have the patient complete a questionnaire or inventory that will help identify his/her beliefs (e.g., Dysfunctional Attitudes Scale).

Core Beliefs

Throughout therapy, hypothesize core beliefs that may be underlying dysfunctional behaviors and thoughts. These hypotheses aid development of the case conceptualization and treatment plan (see Module 5). A belief that is likely to be core will appear in several different areas of the patient's life (i.e., relationships, work, parenting).

If time permits in Brief CBT, after you have collected enough evidence to support the alleged core belief, present and discuss it with the patient.

> "I've heard you say several times that you either didn't do a good job, or that someone else put in more time and energy. It seems to me that you feel inadequate a lot of the time. Is that right?"

At this point, you can also elicit childhood experiences consistent with the belief. This helps identify the possible origin of the belief and helps you explain it to the patient.

In educating the patient about core beliefs, make several things clear:

- Core beliefs are only ideas. Feeling them strongly does not make them true.
- These beliefs started developing during childhood. The patient believes them today because he/she has stored evidence to support them and rejected evidence to contradict them.
- These beliefs can be tested and changed through use of the techniques that will be taught in therapy.

Example Homework Assignments

1. Keep a notepad with you and attempt to list automatic thoughts you have during the day.
2. Use the triangle diagram to dissect three to five situations when you experienced a strong emotion.
3. Create a list of assumptions and evidence for and against those assumptions.
4. Complete the first three sections of the Thought Record for one to two situations.

Supplemental Readings

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press; Chapters 6, 7, 8, 10, and 11.

Safran, J.D. & Greenberg, L.S. (1982). Elicitiing "hot cognitions" in cognitive behavioral therapy: Rationale and procedural guidelines. Canadian Psychology, 23, 83-86.

Greenberg, D. & Padesky, C. A. (1995). *Mind over mood: Changing the way you feel by changing the way you think.* New York: Guilford Press; Chapters 5, 6, 7, and 9.

THOUGHT RECORD

(1) Situation	**(2) Automatic Thought(s)**	**(3) Emotion(s) & Mood**	**(4) Evidence to Support Thought**	**(5) Evidence That Doesn't Support Thought**	**(6) Alternative Thought**	**(7) Rate Mood Now**
Out of breath when I played in the park with my granddaughter	I'm too old to play with her. I can't do what I used to do. I can't be her caregiver. I have nothing to offer my family any more. I am a burden to my family. I am no good to my family.	Defeated Sad Sad Disappointed Hopeless Hopeless Worthless Hopeless (80) Worthless (90)				
What actually happened? Where? What? How? When?	***What thought(s) went through your mind? How much did you believe it? (1-100)***	***What emotion(s) did you feel at the time? Rate how intense they were (1-100).***	***What has happened to make you believe the thought is true?***	***What has happened to prove the thought is not true?***	***What is another way to think of this situation?***	***0-100***

Helpful Questions

Situational Questions	Feeling Questions	Thought Questions
▪ What happened? What were you doing? ▪ Who was there? ▪ Who were you speaking to? ▪ When did this happen? ▪ What time of day was it? ▪ Where did this incident occur?	▪ How were you feeling before this happened? ▪ How did you feel while it was happening? ▪ What mood were you in after this happened? ▪ Can you rate your mood on a scale of 1-100?	▪ What was going through your mind before you started to feel that way? ▪ What made you feel that way? ▪ Do you have any other thoughts? ▪ Which thought bothered you the most? ▪ What images did you have with these thoughts? ▪ What are you afraid might happen? ▪ What if this is true? What does this say about you? ▪ What could happen if this were true? ▪ What other ways could we think of this?

Cognitive Distortions

1. **All-or-nothing thinking:** Viewing situations on one extreme or another instead of on a continuum.
   Ex. "If my child does bad things, it's because I am a bad parent."

2. **Catastrophizing:** Predicting only negative outcomes for the future.
   Ex. "If I fail my final, my life will be over."

3. **Disqualifying or discounting the positive:** Telling yourself that the good things that happen to you don't count.
   Ex. "My daughter told her friend that I was the best Dad in the world, but I'm sure she was just being nice."

4. **Emotional reasoning:** Letting one's feeling about something overrule facts to the contrary.
   Ex. "Even though Steve is here at work late every day, I know I work harder than anyone else at my job."

5. **Labeling:** Giving someone or something a label without finding out more about it/them.
   Ex. "My daughter would never do anything I disapproved of."

6. **Magnification/minimization:** Emphasizing the negative or playing down the positive of a situation.
   Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."

7. **Mental filter/tunnel vision:** Placing all one's attention o, or seeing only, the negatives of a situation.
   Ex. "My husband says he wishes I was better at housekeeping, so I must be a lousy wife."

8. **Mind reading:** Believing you know what others are thinking.
   Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."
   Ex. "My daughter's boyfriend got suspended from school. He's a loser and won't ever amount to anything."

9. **Overgeneralization:** Making an overall negative conclusion beyond the current situation.
   Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."

10. **Personalization:** Thinking the negative behavior of others has something to do with you.
    Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."

11. **"Should" and "must" statements:** Having a concrete idea of how people should behave.
    Ex "I should get all A's to be a good student."

Module 10: Challenging Maladaptive Thoughts and Beliefs

Objectives

- To learn techniques for addressing dysfunctional thoughts and beliefs
- To understand and manage potential difficulties using thought records

What are the techniques for challenging maladaptive thought, and why are these techniques important for Brief CBT?

Several techniques can be used to challenge dysfunctional thoughts or beliefs. Most are used in conjunction with a thought record. Challenging thoughts and beliefs in a collaborative, Socratic way allows patients to use their own statements to counter dysfunctional thinking. Generating counter-statements based on the data patients bring to session increases the believability of the thoughts/beliefs and, thus, the effectiveness of the counter thoughts/beliefs.

When? (Indications/Contraindications)

Typically dysfunctional automatic thoughts are the first targets in the cognitive component of CBT. Following the introduction of the cognitive model (see Module 5: Orienting patient to Brief CBT), and skills for identifying automatic hot thoughts and their accompanying emotions (see Module 9: Identifying Maladaptive Thoughts and Beliefs), techniques for challenging hot thoughts are introduced. These techniques should immediately follow the session on identifying hot thoughts, to build continuity and familiarity with the skill set and instill hope of change after identifying problematic thinking patterns. Although intermediate and core beliefs will be challenged in advanced stages of therapy, the techniques are similar for challenging thoughts. Many techniques below can be used interchangeably for challenging thoughts or beliefs. Brief CBT session time is best used for modifying thoughts or beliefs that are tightly held and strongly believed.

How? (Instructions/Handouts)

Socratic questioning is a therapist stance for questioning maladaptive thoughts and beliefs. This process involves asking a series of open-ended, brief questions that guide the patient to discover his/her idiosyncratic thoughts, feelings, or behaviors associated with a particular situation. Socratic questioning is nonjudgmental but is based on the therapist's insight that the original premise of a thought or belief may be untrue; therefore, the questions are designed to expose the dysfunctional thought or belief so that it may be challenged.

The Dysfunctional Thought Record (DTR) is the staple of cognitive work in Brief CBT. The first three columns (see Thought Record handout on p. 55) are used for identifying troubling situations and the accompanying emotions and dysfunctional thoughts. These three columns are used in conjunction with Module 8, in that when the situation→ thought → feeling triangle is unfolded, it forms the first three columns of a DTR (see figure).

A seven-column thought record is used to challenge dysfunctional thoughts and beliefs. Instructions for completing columns 4-7 are described in detail below.

Once a hot thought and its accompanying emotion have been identified and rated, the hot thought is questioned to generate evidence for and against it. Building evidence may be introduced in the following way:

> **Example:** We have identified a thought that is very powerful for you. You rated this thought as 90 out of 100 for sadness. Before spending a lot of time and energy on this thought, I want to know whether or not it is true. Often when people are depressed or anxious, they take thoughts like this at face value, without first asking whether it is true. Accepting thoughts like this as true would certainly lead to the symptoms you've been struggling with. If I thought, "I am worthless and can't do anything right," I wouldn't want to get out of bed in the morning either, and I would probably feel pretty hopeless and sad. When we test a thought like this, we are going to generate evidence for and against the thought. It is as though the thought were on trial, and you were a lawyer for the case. Remember, you have to be able to prove the evidence you are generating. So, now let's see how your thought stands up….

<u>Developing Balanced Thinking</u>

These instructions might be useful to help patients develop balanced thinking:
1. Help the patient question automatic thoughts by asking
   - What evidence is there that this thought is true?
   - What evidence is there that this thought is not true?
   - What would I tell someone I loved if they were in this situation and had these thoughts?
   - If my automatic thought is true, what is the worst that could happen?
   - If my automatic thought is true, what is the best thing that could happen?

2. Once evidence has been generated, combine it to form a more balanced thought. This thought will likely be much longer and more nuanced than the original hot thought.

> **Example:** Taking all this information (from columns 4-5) into consideration, what is a more balanced thought that more accurately reflects the facts?

You might want to ask the following questions:
- Taking the information into account, is there an alternative way of thinking about the situation?
- Can someone I trust understand this situation in a different way?

3. Rate the believability of the alternative thought between 0-100). If the thought is not more than 50 believable, more work is needed to identify an alternative thought. Go back to the evidence and keep working.

4. Once a believable alternative thought is generated, re-rate the mood associated with the hot thought (0-100) after reading the new thought. Reducing a thought/belief to a rating of 0 is not a realistic goal. Instead, a reduction of 30-50 often provides relief. Often

patients will generate new emotions from the alternative thought. However, it is most important first to re-rate the old mood before generating new emotions.

The same strategy of generating an alternative thought for a dysfunctional thought is used when challenging a core belief. Once the belief is identified, the evidence is weighed and a new more balanced belief is generated.

Summary: Completing DTRs

- ☑ Identify situation and corresponding thoughts and feelings.
- ☑ Identify cognitive distortions in thoughts (e.g., all or none thinking).
- ☑ Use Socratic questioning to identify hot thought.
- ☑ Elicit and rate emotions associated with hot thought.
- ☑ Rate believability of hot thought.
- ☑ Generate evidence for and against hot thought.
- ☑ Generate alternative thought from evidence.
- ☑ Rate believability of alternative thought.
- ☑ Re-rate emotion of hot thought that is elicited by alternative thought.

<u>Troubleshooting Thought/Belief Modification</u>

Some patients can see the benefits of doing a thought record immediately, but others might need to be motivated to be engaged. It is useful to use positive reinforcement to praise the effort of completing a DTR, point out the sections completed correctly, and review skills for the sections completed incompletely or inaccurately. If a DTR is assigned for homework, it must always be reviewed during the subsequent session. Taking session time to review the DTR emphasizes its importance to the patient.

Introducing the DTR as an "experiment" helps alleviate any performance anxiety the patient may have about completing it and may generate interest ("Give the DTR a try this week, and we'll see how it works for you. Let me know next session how the experience to complete it was. That will help us decide whether or not this is a useful tool for you.")

Occasionally, a patient will show disinterest in doing the DTR or get tired of it after a while. For instances like this, there are other ways you can suggest that the patient can continue to attempt the DTR:

- If a patient complains of never having time to do a DTR when certain situations occur, suggest that the patient carry a blank DTR in his/her wallet or purse.
- If a patient has done the DTR for awhile and is becoming disinterested, suggest doing a "mental" DTR, since he/she is familiar with the process.
- Suggest reading old DTRs that have similar situations and automatic thoughts of their own.
- The patient can verbally dictate a DTR to someone, and have that person write it down.

There will not always be an immediate change to a patient's mood after a thought record is completed. It might be necessary to assess why there is no change. It could be attributed to the patient's deeply rooted belief in the automatic thought, to an unchanged underlying core belief, or to additional automatic thoughts that have not been evaluated. It is necessary to ask: Why was there no mood change after completion of the Thought Record? These other questions will also be helpful.

- Have I described the situation in enough detail?
- Did I identify and rate the right moods?
- Is the thought I am testing an automatic thought?
- Do I believe a dysfunctional core belief is driving this thought?
- Did I list multiple thoughts? Do I need more information for each individual thought?
- Is there a stronger automatic thought that I have not put in my Thought Record?
- Do I believe the alternative thought? What other alternative thoughts are available?

If thought/belief testing is ineffective in reducing negative mood, you can also explore the advantages and disadvantages of maintaining a thought/belief. As we know, there are many disadvantages to negative beliefs we have, but there are also advantages. The patient's perceptions of the advantages may be obstructing the change process. Understanding the function of the thought/belief for the patient may be useful in clarifying why certain thoughts/beliefs are resistant to modification. The therapist should evaluate both the advantages and disadvantages of a patient's assumptions and beliefs, but in doing so work to diminish the advantages and highlight the disadvantages.

Often, when working to modify thoughts and beliefs, the patient may find evidence that supports the negative belief instead of evidence that contradicts it. If there is a good amount of evidence to support that negative core belief, then problem solving, rather then thought testing, is an appropriate strategy (see Module 12).

Seven Tips for Effective DTRs

1. You must have mastered the use of DTR before introducing it to patients.
2. Reinforce and make sure that the patient believes in the cognitive model being used.
3. Teach the DTR in two sections: (1) The first three columns; Situation, Automatic thought(s), and Emotion(s), and (2) the last four columns; Evidence for and against thought, Alternative response, and New rating of emotion.
4. Use the patient's exact words when recording thoughts and feelings. Working with thoughts verbatim preserves the emotions or personal meaning for each thought.
5. The patient should be able to adequately complete the first three columns of the DTR before learning about the last four columns.
6. Completing a DTR is a skill and, like other Brief CBT skills, requires practice. Success depends on the patient's understanding of the steps. Encourage the patient to take time with the skill and work through any frustration.
7. If the patient is not collaborative in completing the DTR in session or does not complete DTR homework, it is possible that he or she might have automatic thoughts about this type of exercise. Ask the patient to create a thought record of the DTR experience.

Example Homework Assignments

1. List the advantages and disadvantages of keeping a Thought Record.
2. Use an old Thought Record and analyze it using the Automatic Thought Questions we have discussed.
3. Complete the first three columns of a thought record for homework, and complete columns 4-7 with you in session.

Supplemental Readings

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press; Chapter 9.

Greenberg, D. & Padesky, C.A. (1995). *Mind over mood: Change the way you feel by changing the way you think.* New York: Guilford Press; Chapters 5, 6, & 7.

			THOUGHT RECORD			
(1) Situation	**(2) Automatic Thought(s)**	**(3) Emotion(s)**	**(4) Evidence to Support Thought**	**(5) Evidence That Doesn't Support Thought**	**(6) Alternative Thought**	**(7) Rate Mood Now**
Out of breath when I played in the park with my granddaughter	I'm too old to play with her. I can't do what I used to do. I can't be her caregiver. I have nothing to offer my family anymore. I am a burden to my family. I am no good to my family.	Defeated Sad Sad Disappointed Hopeless Hopeless Worthless Hopeless (80) Worthless (90)	My family has to look in on me more often than they used to.	I can still babysit my grandkids. I contribute to my family in new ways, such as offering advice and support. I still live independently. I am able to do many things physically, though I do have more limitations than I used to.	Because of my COPD and because I am getting older, I have more physical limitations than I used to, and I do need my family's help from time to time, but I am able to offer them many valuable things and contribute to my grandkids' lives.(80)	Hopeless (10) Worthless (5)
What actually happened? Where? What? How? When?	***What thought(s) went through your mind? How much did you believe it? (1-100)***	***What emotion(s) did you feel at the time? Rate how intense were they?(1-100)***	***What has happened to make you believe the thought is true?***	***What has happened to prove the thought is not true?***	***What is another way to think of this situation?***	***0-100***

Module 11: Behavioral Activation

Objectives

- To understand the important clinical components and applications of behavioral activation strategies in brief CBT.
- To learn skills and techniques to effectively use behavioral strategies for positive patient change (especially related to increasing pleasant events)

What is behavioral activation, and why is it important?

Behavioral activation includes a set of procedures and techniques aimed at increasing patient activity and access to reinforcing situations that improve mood and functioning. Behavioral activation amounts to the "B" in CBT interventions. From this behavioral standpoint, depression, for example, contains a host of characteristics that function to maintain depressive affect (e.g., passivity, fatigue, feelings of hopelessness) and decrease chances of adaptive coping by increasing avoidance. The key here is that difficulty with mood often serves to increase avoidance of adaptive coping, including pleasant events, which help to alleviate and avoid depression. Re-introducing pleasant events (one form of behavioral activation) can serve to improve mood in many different ways - 1) reversing avoidance, 2) increasing physical activity, 3) increasing self-confidence and 4) increasing feelings of usefulness and purpose. Recent empirical evidence suggests that behavioral interventions improve mood symptoms but also reduce maladaptive thought patterns (Jacobson et al., 1996).

An important point for therapists: Behavioral activation (alternatively referred to as increasing pleasant activities) consists of a host of possible behaviors including, but not limited to,

1) Re-introducing prior pleasant activities
2) Introducing new pleasant activities
3) Active coping (e.g., taking some form of behavioral action) to alleviate or reduce a life stressor; examples of active/behavioral coping that are not pleasant-event driven include
    - □ Filing or getting taxes done
    - □ Cleaning out a messy closet
    - □ Calling an estranged family member

The goal of active coping is to decrease stress through accomplishment or overcoming avoidance.

When? (Indications/Contraindications)

Because of its relatively simple and straightforward approach, behavioral activation is a good technique for initial stages of treatment and can be highly effective for patients with limited insight into their difficulties. Activation is also easily measured (e.g., number, frequency, or duration of activities) and therefore can be used to document and convey progress to patients (e.g., to increase treatment investment and improve patient self-confidence and control over symptoms).

Behavioral interventions are particularly powerful for depressed mood. Activation for depression generally serves to get the patient moving. Almost all behaviors that include physical activity, planning, or accomplishing tasks are appropriate here.

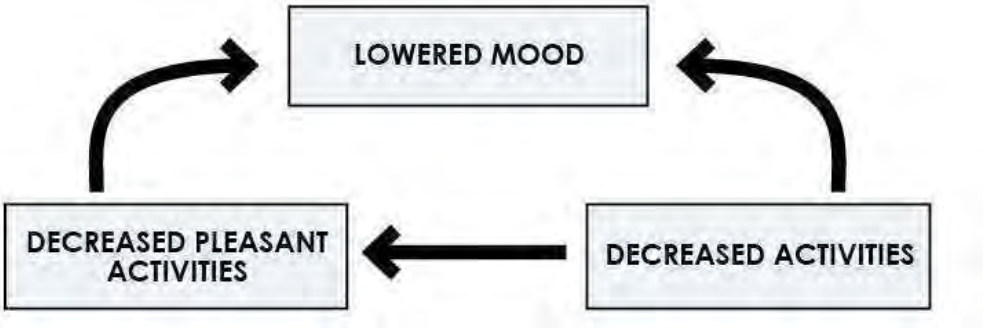
The use of behavioral activation for anxiety conditions requires a little more detail. Patients with anxiety symptoms often avoid situations out of fear of negative consequence occurring in response to engaging in a particular activity. Although behavioral activation can aid these patients, you must also understand that the activity itself is not reinforcing (pleasant) but rather feared. It is only the resulting completion of the task that may generate positive affect (e.g., I faced my fear, and nothing terrible happened). This response differs from depression in that depressed patients will often look at behavioral activation as a positive outcome in and of itself (e.g., "exercising is enjoyable" or "I love talking with my grand-daughter"). To effectively apply behavioral activation with anxious patients, it is important to monitor anxiety and combine behavioral activation with relaxation techniques to increase patient comfort and control. Similarly, be careful not to allow behavioral activation procedures to further aid in the patient's avoidance of fearful situations (e.g., presenting problem is avoiding interpersonal difficulties with spouse, and patient chooses to shop or be on the internet for pleasure but specifically when spouse is in the house to avoid confrontation/talking about issues).

How? (Instructions/Handouts)

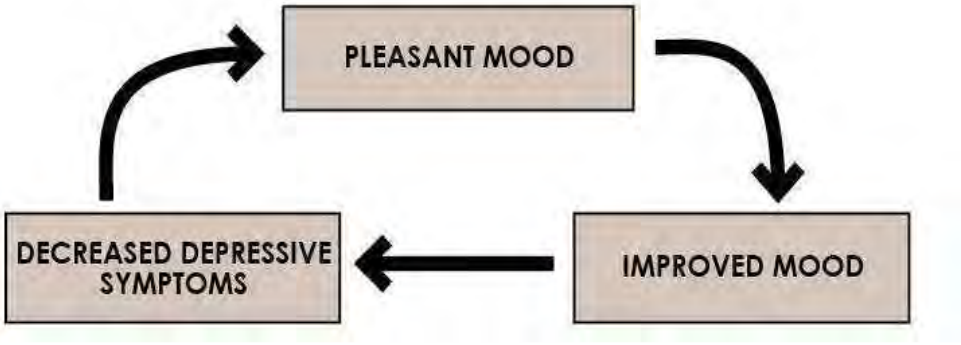
Step #1: Provide patient with rationale for behavioral activation.
It is important to educate the patient as to what behavioral activation is and how it can be useful for improving depression and anxiety. Let him/her know that when feeling a little down or having a bad day and not feeling well physically can make it more likely that he or she will stop doing many activities that used to be pleasurable. When this happens, the patient can get into the habit of avoiding pleasant activities that might actually help him/her feel better. It is also important for the patient to understand the connection between what he or she does and how he/she feels, both mentally and physically. You are encouraged to explain to the patient that increasing activity and/or taking action, even when we do not feel like it, help one to feel better physically, as well as decrease depression.

Therapist:	**I would like to talk a little about what your day looked like yesterday. Walk me through your day (e.g., what did you do in the morning, afternoon, evening)**
Patient:	Well, in the morning I woke up at 10 am and ate breakfast. I watched TV until noon. Then I ate lunch. Around 2:30 I took a shower. At 3:00 I went for a walk with my dog.
Therapist:	**Okay, thanks. How did you feel in the morning?**
Patient:	Tired. I just couldn't get motivated and did not want to do anything. I guess I was feeling sorry for myself – depressed, I guess.
Therapist:	**You say you were feeling depressed. If you had to rate that feeling on a scale of 0 to 100 (100 is worst depression) what would you say your depression was?**
Patient:	65.
Therapist:	**What about in the afternoon after your shower and walk? How would you rate your depression?**
Patient:	20.
Therapist:	**To what do you attribute this change in your depression?**
Patient:	I guess I just got off my couch and started moving which helped me feel better.
Therapist:	**That would be my guess as well. (subsequently, explain the connections between mood and behavior and encourage use of behavioral activation).**

The figure below visually describes the connection between mood and behavior and can be an effective aid in communicating with patients. To maximize the utility of the figure, you are encouraged to use the patient's own examples. For example, you and the patient can work together to complete a daily activity log (see handout). From this activity log, you might highlight activities that appeared to raise or lower the patient's mood.



If depressed persons increase their activities on a daily basis, it improves mood and decreases symptoms of depression.



Step #2: Identifying Behaviors - Discussing Activities.
Identification of potential activities begins by exploring with the patient activities that would be most meaningful. Have a general discussion of types of things he/she would like to do but have not been able to do and activities he/she already does but would like to do more often within the context of values or goals that are important to him/her. You might want to ask if there is something that he or she needs to do that he/she has been unable to do or has been avoiding. Some patients may want to accomplish something rather than focus on doing something pleasant.

Possible questions might include:

- "Can you think of any activities or hobbies that you used to enjoy doing but have now stopped doing?"
- "Can you think of any activities or hobbies that you would like to do but have never done?
- "Are there things in your life that you would like to change? If so, what would you like to do about these issues that you have previously not done?"

For patients who have difficulty identifying activities, you can introduce a behavioral activity checklist (see Appendix).

Before completing the next steps (e.g., setting a plan), it is important to discuss the potential importance of the behavior with the patient. If he/she reports low importance, encourage the patient to find another, more meaningful activity.

Step #3: Setting an Action Plan.
Once the patient has identified a meaningful activity to focus on, help shape this work into a meaningful therapeutic goal. Action plans are one mechanism of creating meaningful behavioral goals for therapy. Action plans in their most basic form stipulate the specific goal to be obtained, defined in terms of observable and measurable characteristics and a timeframe for monitoring progress.

> Example:
> **Goal**: To read at least three times per week (a minimum of 30 minutes per reading session).
> **Timeframe**: Patient will complete three reading sessions over the next week.

An expanded action plan might also include:

a) Additional details of the plan – e.g., how the goal will be obtained
b) Possible barriers to reaching the goal and ways to address barriers if they arise
c) Possible facilitators of obtaining the goal, e.g., important people or situations that might aid the patient
d) Patient's confidence in reaching the goal in the timeline established; if confidence is low, you might wish to alter the plan to increase chances of success.
e) Skills that the patient might want to enlist to help reach the goal (e.g., relaxation skills, problem-solving skills, etc.)

Step #4: Monitor progress in mood, mastery, and confidence
It is important to monitor the patient's mood and feelings of mastery and confidence. Outcomes such as improvement in mood, mastery, or confidence can be best identified through patient homework assignments that ask the patient to document the frequency and use of the behavioral activity and any corresponding emotions or feelings of mastery or confidence.

On the basis of this monitoring of outcomes, evaluate the action plan and the patient's ability to work towards achieving goals. If problems arise, make changes accordingly (e.g., breaking down goals into smaller steps, determining patient perceptions of importance and changing goals accordingly). Monitoring shows the patient that you continue to believe in the importance of the technique/exercise and also serves to further motivate many patients by increasing the effectiveness of the intervention.

Tips for Managing Barriers to Doing Activities
1) Help the patient break down more difficult activities into smaller steps. Look for alternative behaviors to accomplish a goal prohibited by a chronic illness or other physical limitations. For example, a structural/mechanical engineer who was forced to retire because of a physical limitation may feel that his/her life is no longer productive. Although the patient is physically unable to fulfill prior job duties, you can work with him/her to identify

meaningful activities related to the prior occupation. In this case, the patient might benefit from volunteering at a university, providing consultation (e.g., over email or telephone calls), or volunteering for a local school, youth or church organization (e.g., talking about engineering).

2) It is also helpful and supportive to look for ways that others can help. Family or other social networks that the patient has not yet fully engaged might exist, which might assist the patient in moving forward on goals.

3) Pleasant activities are the best first step. Pleasant activities are doubly beneficial to the patient, as they increase activity and feelings of pleasure. Activities designed to overcome avoidance or increase a sense of accomplishment should be entertained as the first goals only if highly important to the patient or apparently salient to the attainment of future goals.

Summary of Steps

Step 1. Introduce behavioral activation and its potential influence to the patient.
Step 2. Use patient examples to show relationship between mood and behavior.
Step 3. Identify pleasant activities/active-coping behaviors.
Step 4. Set an action plan.
Step 5. Monitor progress.

Examples of Homework Assignments

1. What activities did you previously use to enjoy that you would like to start participating in again?
2. List activities that you need to do to better your current situation (enroll in school, get your inspection sticker, etc.).
3. Create a schedule of the new activities you will perform. Which ones did you accomplish? Were there any barriers? Why? How did you handle them?

Supplemental Readings:

Hopko, Lejuez, Ruggiero, et al. Contemporary behavioral activation treatments for depression: procedures, principles, and prognosis. Clin Psychol Rev 2003; 23 (5): 699-717.

Mood Monitoring and Activity Chart

For each block of time, list the activity you did and rate (from 0-100) the level of Anxiety (A) and Depression (D) you experienced at that time.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6-7 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
9-10 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
10-11 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
11-12 Noon	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
12-1 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
1-2 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
2-3 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
3-4 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
4-5 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
5-6 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
6-7 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:

Module 12: Problem Solving

Objectives

- To introduce problem solving and its potential use in psychotherapy
- To learn how to apply problem-solving skills during Brief CBT

What is problem solving, and why is it important in therapy?

Problem-solving techniques generally involve a process by which an individual attempts to identify effective means of coping with problems of everyday living. This often involves a set of steps for analyzing a problem, identifying options for coping, evaluating the options, deciding upon a plan, and developing strategies for implementing the plan.

Problem-solving strategies can be used with a wide range of problems, including depression, anxiety, anger and aggression, stress management, coping with medical illness, addiction, and relationship/family difficulties. Problem-solving techniques teach skills that aid the patient in feeling increased control over life issues that previously felt overwhelming or unmanageable. In this manner, problem solving can help with practical problem resolution as well as emotion-focused coping (e.g., increasing control, decreasing stress, and increasing hopefulness).

When? (Indications/Contraindications)

Thoughts and beliefs are challenged when a thought or belief is not true or a situation is unchangeable. Alternatively, problem solving may be used when the root of an issue is a changeable situation; and the thoughts associated with the noxious situation might be accurate. Problem solving can be especially effective when a specific problem is able to be addressed and operationalized. A specific operationalized problem is one that is easily explained, identified, and/or measured. Problem solving works best when a practical solution is available. For example, a patient complaining of social isolation likely has potential solutions to this difficulty (e.g., calling a friend, joining a group, engaging in a socially driven hobby).

Examples of problems appropriate for problem solving include:

1) How to communicate with a partner about a difficult issue
2) How best to cope with the functional limitations of a medical condition
3) How to reduce financial distress

Note that you are not responsible for finding answers to these questions but rather should aid the patient in finding his or her own answers. In this manner you are a facilitator who possesses problem-solving skills.

Problem solving may be difficult for the following individuals:

1) Persons with serious mental illness (psychotic disorders, bipolar disorder)
2) Persons with severe depression, who might require more focused cognitive work or medications
3) Persons who have difficulty thinking about long-term effects (e.g., persons with cognitive impairment)
4) Persons with problems that are largely emotional; for example, a person who feels incompetent at work and often feels that others are overly critical may be

reacting to emotions (e.g., depression). This problem may be better served using another skill (e.g., maladaptive thoughts module).

How? (Instructions/Handouts)

Problem-Solving Therapy (PST)
In problem-solving therapy, it is important that you first educate the patient about the problem-solving strategies that will be used during sessions. To enable the patient to use the strategies after therapy ends, teach him/her to carefully examine a problem, create a list of solutions, and make decisions about which strategies are appropriate for a variety of problems.

General guidelines for using problem-solving strategies are as follows:

- Training should be tailored and specific to each patient.
- Obtain a thorough assessment of the problem before proceeding with problem-solving therapy.
- Encourage the patient to try as many solutions as possible.
- Decide whether the patient requires more problem-solving work or more emotional work to experience growth through the therapeutic process.

Strategies for Effective Problem Solving

The SOLVED technique helps guide you through the steps to most effectively identify and solve problems in your life.

S (Selecting a Problem) … the patient would like to solve.
Ask the patient to think about situations when he or she feels distress or difficulty problem solving. If planning does not seem to be possible, suggest a different therapeutic technique (e.g., changing maladaptive thoughts). The decision to remain with problem solving or move to a different skill is largely dependent on you to direct.

O (Opening Your Mind to All Solutions)
Here, it is important to be as broad as possible. You are encouraged to work with patients to "brainstorm" all possible solutions. Writing may be particularly helpful for some patients. Even ideas that seem ridiculous at first may generate realistic solutions.

For example, Bertha's family would often drop by several times a week without calling beforehand and expect her to care for their children. She enjoyed this, but felt tired many times and was beginning to get concerned about her ability to continue child sitting at such a frequent pace. Her first idea was to tell them she could no longer baby-sit. Although she did not like this idea, it led her to consider related ideas, such as telling them they had to call beforehand to make sure she felt up to the task.

Tips for generating possible solutions:
- Ask the patient to think about advice he or she would give someone else with this problem.
- Ask the patient to examine the ways he or she have handled similar situations.
- Instruct the patient to **consult with a close friend or relative** for additional solutions.

L (Listing the Potential Pros and Cons of Each Potential Solution)
Often, writing options, along with listing pros and cons, can be helpful in considering potential options. Writing allows additional thought, as well as a visual image of options. Recommend that patients consider solutions in a logical manner, thus reducing the time spent ruminating. It may also help to identify additional thoughts that might benefit from changes using the techniques, such as changing thoughts. In some cases, identification of pros/cons may require obtaining information from other people, such as lawyers or financial advisors.

V (Verifying the Best Solution)
Examine the pros and cons of the solutions listed. Patients may wish to "rank order" the solutions based on which solutions are most practical and/or desirable.

E (Enacting the Plan)
Identify the steps needed to carry out the solution selected. Patients may need to break actions down into steps small enough to facilitate achievement of goals. Once you and the patient finish formulating a specific plan, encourage the patient to carry it out.

D (Deciding if the Plan Worked)
Follow-up with the patient to see how well the chosen solution actually worked. If the solution was effective, give positive reinforcement. If the solution was not effective, return to the first step in the SOLVED technique to specify a new problem or move to "O" or "L" to identify other goals or potential solutions for the same problem. The decision to move back and to which step is largely up to you, who might now have additional information about pros and cons and possible solutions.

Problem-Solving Examples

To facilitate patient learning, you might wish to provide examples of the SOLVED program at work. The following section provides several examples of the SOLVED technique.

Examples of Specifying the Problem in SOLVED: Common Problems in Chronic Illness

Physical/Symptom Problems	Emotional/Social/Relationship Problems
Overcoming or Working With Physical Limitations	Managing Mood
Medication Adherence Issues	Difficulty Asking for Help
Transportation and Mobility Issues	Difficulty Communicating
Minimizing Influence of Symptoms	Marital Stress
Minimizing Influence of Medication Side-Effects	Family Stress

**To effectively use the SOLVED technique, problems may need to be more specific than those listed above.

Opening Your Mind Through Brainstorming to Solve Problems through SOLVED

SELECT A SPECIFIC PROBLEM: Minimizing Effect of Symptoms

OPEN your MIND to ALL possible SOLUTIONS
1. Talk to your doctor.
2. Change or modify medications.
3. Engage in healthy life choices, including proper diet and exercise.
4. Educate yourself by talking to others and by reading about your illness.
5. Explore alternative treatments.

SELECT A SPECIFIC PROBLEM: Forgetting to Take Medications

OPEN your MIND to ALL possible SOLUTIONS
1. Turn several alarm clocks on to remind you.
2. Put your medication in a place you will notice it at the time you are supposed to take it.
3. Have a friend or family member remind you.
4. Buy a medication dispenser to help you remember whether you have taken the medication.
5. Take it at the same time every day.

Other examples of problem-solving worksheets are listed at the end of this module. These worksheets expand the common pros and cons lists to help a patient consider multiple perspectives and outcomes before making a decision.

Homework Examples:

1. Create a list of possible solutions to your identified problem (brainstorm).
2. Implement your identified solution, assess it effectiveness, and modify as necessary.

Supplemental Readings

Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press; Chapter 6.

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SOLVED: Problem-Solving Exercise

Specific Problem:_____

_____

_____

Open Your Mind **L**ist

To Possible Solutions	PROS AND CONS
1.	
2.	
3.	
4.	

Verify the best solution by circling your choice.

Enact the Solution.

Steps and Time Frame of Solution:

1._____Time:_____

2._____Time:_____

3._____Time:_____

Decide if Your Solution Worked: **[ ] YES [ ] NO**

Pros and Cons

Behavior: _____

Positive Effects of Doing the Behavior	Positive Effects of Not Doing the Behavior
Negative Effects of Doing the Behavior	**Negative Effects of Not Doing the Behavior**

Short-Term Positive Consequences	Long-Term Positive Consequences
Short-Term Negative Consequences	**Long-Term Negative Consequences**

Module 13: Relaxation

Objectives

- To understand the concept and importance of relaxation in brief CBT
- To acquire specific relaxation skills (e.g., muscle relaxation, deep breathing, imagery)

What are relaxation techniques and why are they important?

Relaxation techniques consist of a collection of psychotherapeutic techniques designed to reduce tension, stress, worry, and/or anxiety. Relaxation techniques vary in their focus (e.g., physical sensations or changes in cognition/thoughts) and can be selected based on presenting difficulties, as well as patient preferences. Some patients respond to physical procedures (e.g., muscle relaxation and/or deep breathing, while others respond favorably to guided imagery.

Relaxation techniques are important for brief therapy for several reasons. First, they focus on skills that alleviate stress, anxiety, worry, and tension that are often debilitating and interfere with patient functioning. Second, stress, anxiety, worry, and tension are often very uncomfortable for patients, and providing help to alleviate their distress can go a long way towards increasing positive treatment expectations and rapport. Relaxation techniques are easily conveyed as a method of increasing control and often do not include a direct discussion of mental health difficulties, which can be important for some patients who are concerned about mental health stigma. Finally, relaxation techniques are generally easy to teach and learn. For these reasons, it is often advantageous to teach these techniques early in treatment to give patients an easy-to- learn, yet highly effective, skill set.

When? (Indications/Contraindications)

As indicated, relaxation techniques are quite effective early in treatment to reduce tension and increase early treatment successes. They generate increased self-efficacy, perceived control over stress, and improved coping.

Relaxation techniques are useful for broad application or for a specific patient situation. An example of broad applications might include daily relaxation exercises to reduce an overall sense of tension or stress not affiliated with any specific situation (e.g., general worry or apprehension). Relaxation can also be applied to specific situations such as a needle phobia, social anxiety, or stressors at work.

Relaxation procedures can also be appropriate for persons with depressive symptoms to increase their perceptions of control. However, it might not be appropriate for depressive symptoms occurring outside comorbid anxiety/worry. For example, teaching a severely depressed person, who is experiencing fatigue and lack of motivation, to relax would not be useful unless the patient has a specific need for relaxation.

How? (Instructions/Handouts)

Regardless of the actual relaxation technique, it is imperative that the physical environment be attended to so as to maximize results. Before beginning relaxation techniques, it is suggested that you create a safe, quiet, and comfortable environment. You are encouraged to work with patients to create such an environment. Patients may be

comfortable with certain recommendations (e.g., unfolding arms) but may be uncertain or uncomfortable with others (e.g., closing their eyes). The following list of options can be used to create an effective atmosphere for relaxation-based interventions.

Setting up the room:

- Comfortable chair (a high-backed chair to support the patient's neck, if possible)
- Safe and relaxing room (e.g., temperature, noise, and lighting)

Other tips to increase stress-management effectiveness include:

- Having the patient loosen tight clothing (collars, belts, shoes, etc) or remove glasses
- Having the patient sit in a comfortable fashion (e.g., uncrossing arms and legs, placing feet flat on the floor)
- Dimming the lights or removing bright sunshine from the room
- Having the patient close his or her eyes
- Asking the patient whether he or she needs a bathroom break before starting
- Asking the patient to clear the mind and focus on your voice and instructions

The following sections of this module addresses three specific techniques: progressive muscle relaxation, deep breathing, and imagery. You largely determine selection of a specific technique, but you should select it with the patient's expressed interests and learning preferences/abilities in mind. For example, patients who are largely somatically focused may prefer muscle relaxation or deep breathing. Other patients, especially those who appreciate the association between thoughts and mood, might be best served using guided imagery procedures. However, the ultimate decision of which procedure to use may relate to exposure to all three techniques and a trial-and-error approach.

Progressive Muscle Relaxation (PMR)

PMR consists of learning how to tense and then relax various groups of muscles all through the body in a sequential fashion, while paying close attention to the feelings associated with both tension and relaxation. Although muscle relaxation has been around for many years, it has become more popular recently for dealing with different anxiety and panic disorders. With this procedure, the patient learns how to relax and how to recognize and pinpoint tension and relaxation in the body to identify tension and reduce its influence before each reaches high levels/impairment.

In teaching patients muscle relaxation, you should first explain the reason for using muscle relaxation and how it will benefit the patient (rationale). You should also give a full explanation and demonstration of how it is done.

Step #1: PMR Increases Control.

Introduce PMR principles and procedures. PMR begins by letting the patient know that he/she can create sensations of relaxation and that this process of "inducing" relaxation begins by being able to identify and discriminate between sensations of tension and relaxation.

Step #2: Note the Incongruence of Tension and Relaxation.

Inform the patient that sensations of tension and relaxation cannot occur at the same time. No muscles in the body can be tensed and relaxed at the same time. This principle is

critical, and you should ensure that patients fully understand how this applies to their current difficulties.

Step #3: Identify States of Tension.
Explain to the patient that tension often builds gradually without conscious awareness. Learning to detect the initial signs of an increase is an important step towards avoiding a full- blown occurrence of tension. Inform the patient that, no matter the level of intensity, he or she can stop and reverse the tension using knowledge of PMR – in essence, it is never too late to reduce tension. Over time patients become increasingly skilled at identifying stress earlier and earlier (e.g., their awareness increases).

Step #4: Tense Muscle Groups.

A brief word of caution: If at any point during the technique a patient experiences pain, alter or completely discontinue the technique. If the patient experiences chronic pain in any part of the body, it is best to avoid the tensing component for muscles in that area; just do the relaxing component when the patient gets to those muscle groups.

PMR asks the patient to tense and release different muscle groups in sequence, moving from the arms to the face, neck, chest and shoulders, torso, and legs. For each specific muscle group, it's important to try to tense only that muscle group during the tensing part of the exercise. Throughout the procedure, it is important to concentrate on the sensations produced by the different exercises. Asking the patient to describe bodily sensations is very important for the learning process. Statements or phrases from you might include: "What are you noticing about your body right now?" These questions help the patient to focus on the way the body "feels" when tense and relaxed.

Tensing Instructions
Model each tension procedure. Ask the patient to practice, and provide feedback. Check to be sure that the patient can identify tension in each group before moving on to the next.

a. Dominant arm. Make a fist and tense biceps; pull wrist upward, while pushing elbow down against the arm of chair or bed.
b. Nondominant arm. Same as above.
c. Forehead, lower cheeks and jaw. Lift eyebrows as high as possible, bite teeth together, and pull corners of mouth tightly.
d. Neck and throat. Pull chin down toward chest; at the same time, try to prevent it from actually touching the chest. Counterpose muscles in front part of neck against those in the back part of neck.
e. Shoulders, chest, and upper back/abdomen. Take a deep breath and hold it. At the same time, pull the shoulder blades back and together, trying to make them touch. Try to keep your arms as relaxed as possible while tensing this muscle group. At the same time make the stomach hard by pressing it out, as if someone were going to hit you in the stomach.
f. Dominant leg. Lift foot off the floor and push down on the chair with thigh.
g. Nondominant leg. Same as above.

Step #5: Debrief After the Exercise.
After relaxation training, question the patient about his or her reaction to the muscle-relaxation exercise. It is also important to make any adjustments needed to the training. Monitor any pain the patient experienced to adapt and improve the technique for the individual patient's needs.

Step #6: Continue to Practice Outside Session.
It will be important for the patient to practice PMR at least once a day over the first week or two to build skills and confidence. As he or she becomes increasingly skilled at PMR, he/she might find it possible to relax without having to actively tense the muscles. The patient should use regularly scheduled homework to practice in a nondistracting environment. When he or she has learned to relax in a calm environment, it should be easier to relax in more distracting situations, whenever he or she notices tension developing.

Deep-Breathing Technique

Another physiological-based relaxation technique is deep breathing. Deep breathing focuses on reducing rapid and shallow (ineffective) breathing that often occurs during periods of stress, worry, or anxiety. Rapid and shallow breaths can lead the patient to have decreased oxygen in the system, which can cause hyperventilation, dizziness, lightheadedness, or decreased ability to concentrate. Alternatively, taking a deep, full breath can produce a feeling of calmness or slowing by increasing oxygen rich blood flow.

By asking the patient to attend to breathing and changing the rate and way he or she breathes, you enable him or her to be able to feel more relaxed and function more -rich blood,) as well as the mind (feelings of calmness). It can also strengthen muscles in the chest and stomach, which can make it easier to breathe on a daily basis.

Steps to Deep Breathing

Step #1: Introduce the patient to Deep Breathing. Indicate why Deep Breathing was chosen and provide an overview of the procedures and potential benefits.

Step #2: Ask the patient to put one hand on the abdomen, with the little finger about 1 inch above the navel, and to place one hand on the chest.

Step #3: Ask the patient to pay attention to his or her breathing (pause for several seconds to allow the patient the opportunity to assess breathing) and ask him/her to tell you which hand is doing more of the moving? Ideally, the hand on the abdomen should be moving; while the hand over the chest remains still. This ensures that the breaths are deep.

Step #4**:** Work with the patient to take deeper breaths by getting the hand over the stomach to move while having little movement of the hand over the chest. Inform the patient, "Your hand on your diaphragm should move out as you inhale and in as you exhale."

> **NOTE:** If the patient has a lung or heart condition, he/she might have difficulty with deep breathing. If he/she reports difficulty, slow the process down and help him/her to maximize the exercise comfortably.

Step #5: Ask the patient to continue slow, even, deep breaths. To pace the patient, you might suggest that he/she say the words *in* and *out* slowly, while taking breaths. Inhalations and exhalations should build to approximately 3 seconds in duration.

Step #6: Ask the patient if he or she notices any changes in breathing and feelings of relaxation. Ask for general feedback about the technique.

Step #7: Repeat the breathing exercise three or more times until the patient reports skill understanding and benefit.

Step #8: Ask the patient if he or she can identify situations when deep breathing might be appropriate.

Step #9: Continue practice outside of session. Work with the patient to set a homework assignment that encourages application of deep breathing to situations when the patient feels stress.

Other tips for deep breathing:

1) Inhale through nose and out of mouth.
2) Ask patient to purse lips (as if blowing on hot soup) while exhaling.
3) Do not pause between inhales and exhales.
4) Ask patient to close eyes during the exercise.
5) Patient may want to use mantra such as "relax" during each exhale.
6) Pair up deep breathing with imagery once the patient has begun to master breathing skills.
7) Point out that deep breathing is a portable skill that can be used in a variety of situations and relatively without notice of others (PMR is less portable).

Imagery

Imagery is a nonphysiological (cognitive) relaxation technique that can be used to ease stress and promote an overall sense of well-being. Imagery focuses on increasing cognitive, emotional, and physical control by changing the focus of an individual's thoughts. We all have daydreamed about pleasant things that have distracted us and made us feel better. Imagery uses much the same process but encourages positive adaptive "dreaming" that distracts and relaxes the individual. Imagery is highly effective for depression and anxiety, as well as specific situations that require clarity, focus, distraction, or feelings of mastery. The following are examples:

Topic	Focused Topic	Image	Outcome
Depression	Negative Self-worth	Images of success or past situations of success; images of a pleasant past experience	Increased self-confidence; reduced negative thoughts; distraction from negative mood
Anxiety/Worry	Public Speaking	Image of speech that goes well; image of something funny	Reduced negative focus, distraction, increased positive expectations
Medical Anxiety	Fear of Procedure (e.g., needles)	Relaxation; peacefulness; pain-free environment	Less tension, reduced anxiety, toleration of procedure with less distress
Sports Performance	Focused efforts during golf game	Envisioning the desired shot; positive words of advice	Increased focus, increased self-confidence, positive thinking

How Guided Imagery Works

Research has shown that the mind can actually affect how the body functions. It seems the body may not know the difference between an actual event and a thought. Guided imagery uses the power of the brain—images and the perception that you are either somewhere else or in a different state of mind—to increase pleasant experiences and performance to promote wellness and health. On the flip side, imagery helps to reduce stress tension and anxiety by changing thoughts and emotions or through distraction.

Imagery is commonly referred to as guided imagery. Guided imagery refers to a process whereby you facilitates or guide the initial images the patient uses. The following section describes how you can guide the patient into the effective use of imagery for relaxation or performance improvement.

Step #1: Introduce Imagery.

Introduce imagery to the patient, pointing out the power of the brain or thoughts and how images, when accessed correctly, can actually change physical and emotional states.

Step #2: Identify the Desired Outcomes, Such as Decreased Anxiety, Increased Focus, Distraction.

Step #3: Develop an Image or Scene.

Work with the patient on the third step to identify a situation, either in the past or a place he/she would like to be, that both you and the patient feel might benefit or produce the desired outcome. Sample imagery scripts are provided below and can be used if the patient has difficulty creating a personal situation. Selection of a powerful image is critical to the success of this technique. Selection of an image that the patient is able to fully embrace increases the odds of treatment success. Selection of a "weak" image (e.g., not viewed as important by the patient or unable to be fully visualized) will likely lead to treatment failure.

Step #4: Increase Vividness of the Image.

To ensure that patients find a "strong" image, ask them to explore as many senses as possible to increase vividness of the image. For example, when imagining a glass of lemonade, imagine holding a glass that feels icy and cold, visualize the color of the lemonade, think of the fresh citrus smell, and finally think of how the lemonade tastes. This is an example of imagery that uses multiple senses and increases vividness of the image.

Increasing vividness is largely a matter of increasing the details the patient experiences. The more details described by the patient, the more powerful the technique.

Step #5: Ask the Patient if He or She Notices Any Changes After the Imagery Exercise. Ask for general feedback about the technique.

Step #6: Repeat the Imagery Exercise Until the Patient Reports Skill Understanding and Benefit.

Step #7: Ask the Patient to Identify Situations When Imagery Might Be Appropriate. Expand upon the patient's responses by adding other situations (e.g., how the technique can be used).

Step #8: Continue Practice Outside Session. Work with the patient to set a homework assignment that encourages application of imagery to situations when the patient feels stress or feels that imagery might be beneficial.

Other tips for imagery:

1) Pair up imagery with deep-breathing exercises.
2) Ask patient to close eyes during the exercise to increase vividness.
3) Interject during the imagery experience aspects that you feel might benefit the patient. For example, a patient might use the beach image; and you might ask how the sun feels on the skin, whether he or she hears anything, or what else he or she sees.
4) Help the patient focus on aspects of the image that will guide him/her towards the goal. Help the patient to avoid too many unnecessary details that might distract from the goal.
5) Point out that imagery is a portable skill that the patient can use in a variety of situations and completely without notice of others (PMR is less portable).
6) Avoid imagery with psychotic patients, who might confuse reality with images.

Imagery: Example Scripts/Guides for Therapists

Script #1: Generic Example

Once your whole body feels relaxed, travel to your favorite place… it can be any time period or any place. This place is calm and safe… there are no worries here… Look around this place. What do you see? Do you hear the sounds around you? What are some of the sounds you hear in this place you are imagining? How does this special place smell? Walk around a little, and take in all the wonderful sights… Feel the air around you and relax…. The air is fresh, and it's easy to breathe here. Pay attention to how your body feels..…. Say to yourself, "I am totally relaxed… without worries… all the tension has drained away from my body." Take a moment to fully experience your favorite place…. Notice the sounds, the sights, smells, and how it feels to be in this very special place. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel at peace.

When you are done with your visit to this special place, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion. Take as long as you want to enjoy and relax. Feel at ease knowing your special place is always available to you, and find that you feel relaxed, even after you leave.

Script #2 – The Beach:

Imagine yourself walking down a sandy beach. The sand is white and warm between your toes. You are looking out over the calm, blue water. The waves are gently lapping at the shore. You feel the pleasant warmth of the sun on your skin… it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear sea gulls in the distance. You taste traces of salt on your lips. You are completely relaxed… there are no worries on this beach. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, sights, smells, and how it feels to be in this very special place.

Feel the sand under your feet… you decide to stretch out on the warm, fine, white sand… breathe deeply… feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up at the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Script #3 – The Meadows:

Imagine yourself walking through a lovely meadow. The breeze feels pleasant against your skin. You are looking out over the calm, beautiful green grass. The blades of grass are gently swaying in the breeze. You feel the pleasant warmth of the sun on your skin… it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear birds in the distance. You hear the wind blow gently through the trees. You taste the sweet summer air on your lips. You are completely relaxed… there are no worries in this meadow. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, the sights, the smells, and how it feels to be in this very special place.

Feel the cool grass under your feet… you decide to stretch out on the soft, cushiony grass… breathe deeply… feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up as the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Other Guided Imagery Scene Suggestions:

- A garden where you watch big, beautiful clouds in a blue sky, while you inhale the scent of flowers and feel a gentle breeze on your skin as the sunshine warms you.

- A mountain scene where you feel calm and relaxed as you look out over the valley. Just you and the vegetation and you dip your feet into a cool mountain stream; and let your foot rest on a big, slippery stone as the sunshine warms you and the wind blows through the trees.

- Advanced scenarios developed with assistance of patient (family, past experiences, etc).

Imagery: Troubleshooting and Tips

Do not use imagery with psychotic patients.

Supplemental Readings

Cormier, W.H. & Cormier, L.S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions, 3rd ed. Pacific Grove, CA: Brooks/Cole Publishing Company; Chapters 16 (pgs 514-529), 15 and 12.

Homework Assignment Examples

1. Practice PMR before you go to bed each night this week.
2. Attempt your deep-breathing exercise during a stressful time this week.
3. Create your own personal guided imagery script, and attempt to use it this week. Bring it to the next session.

Module 14: Ending Treatment and Maintaining Changes

Objectives

- To understand the process for preparing the patient for ending treatment
- To learn techniques for preventing relapse

What is ending treatment, and why is it important to plan for it?

End-of-treatment planning is the collaborative process of preparing the patient and assessing his/her readiness for ending treatment and moving beyond reliance on the therapist to apply skills. Planning allows the patient to prepare for the end of treatment, to review skills learned in treatment, and to vocalize and problem-solve concerns about functioning outside treatment. All these factors reduce anxiety and allay fears a patient might have about ending a therapeutic relationship.

When? (Indications/Contraindications)

End-of-treatment planning begins at the first session when you give the patient some indication of the frequency and duration of treatment. End-of-treatment planning is an ongoing process, culminating in the final sessions with a review of treatment and introduction of relapse-prevention skills.

Patients with personality disorders or disorders of attachment may be particularly sensitive to feeling abandoned or upset as a result of ending the therapeutic relationship. For these patients, it is important to discuss treatment termination in an empowering and thoughtful way—recognizing and normalizing their fears, assuring them safeguards are in place (e.g., emergency resources, booster sessions), and encouraging them via reminders that the purpose of CBT is self-management of symptoms.

How? (Instructions/Handouts)

Reviewing What Was Learned

The last session of Brief CBT should be spent reviewing and recording the different cognitive and behavioral skills the patient has learned. Use Socratic questioning to elicit this list ("What have you learned as a result of our time together? Is there anything that was particularly meaningful to you about your time in therapy?"), as patients may generate skills or benefits of therapy not known to you. Patients should have a list of these skills they can take with them. They should also be encouraged to keep the other handouts (e.g., thought records) completed during treatment as a reminder of their skills.

Relapse Prevention

Many patients are concerned that they will not be able to manage future psychological problems or psychosocial stressors without the aid of therapy. In planning for the end of treatment, you and the patient anticipate potential stressors and symptoms and plan: 1) What tools the patient has learned in therapy that he or she could use for particular stressors/symptoms, and 2) when he/she might need to contact a mental health professional for additional assistance (e.g., suicidal ideation). Preparing for inevitable difficulties is empowering and encouraging for patients. A functional assessment may be used to identify future problematic situations (see Module 4).

Relapse-Prevention Questions

1) When I feel (symptom), I will (tool learned in therapy).
2) If (stressor), I will (tool learned in therapy).

Example:
When I feel sad for 2 days, I will go for a walk and call a friend to have lunch.

When I feel depressed for a month, I will schedule an appointment with my primary care physician/mental health provider.

If my boyfriend breaks up with me, I will do a thought record to evaluate any dysfunctional thoughts.

Troubleshooting End of Treatment

Give Yourself Adequate Time to End Treatment.
Plan on an entire session devoted to ending treatment, wrapping up, and maintaining changes. It is highly recommended that you not introduce new concepts during the final session, as new issues may arise; and ending treatment during the session may become impossible.

Give the Patient Credit.
Depressed or anxious patients often attribute positive change to external entities and negative change to themselves. Therefore, at the end of treatment, discuss the patient's progress (using objective data, such as symptom-rating scales, when available), praise the patient, and emphasize his or her role in positive changes.

Respond to Concerns.
Checking in with the patient regularly about questions or concerns about ending treatment helps maintain the therapeutic relationship and offset negative emotions about treatment that could result in negative outcomes, such as feeling abandoned. If the patient seems particularly concerned about ending treatment, he or she could use a thought record to identify and challenge dysfunctional thoughts associated with leaving therapy.

Plan Self-Management Time.
Patients may be interested in planning self-management time when preparing for the end of treatment. Self-management times are a few minutes each week that the patient sets aside, once therapy is complete, to check mood and use of skills and problem solve situations or feelings that may be negatively affecting their mood. These times last approximately 10-15 minutes and follow a structure similar to therapy. Self-management time is beneficial because it is free, can be conducted at and when and where it is convenient for the patient, and helps prevent relapse. A self-management worksheet (see p. 82) may be used during these times.

Booster Sessions
Booster sessions can be scheduled approximately 1 month following the end of treatment and then as needed thereafter. During a booster session, you:

- Check in with the patient about his/her self-management of symptoms and stressors.
- Refresh skills learned in therapy.

- Discuss questions or concerns the patient might have about the transition.
- Review treatment goals and maintenance of treatment gains.

Supplemental Readings

Allsop, S. & Saunders, B. (1991). Reinforcing robust resolutions: Motivation in relapse prevention with severely dependent problem drinkers. In Miller, W.R. & Rollnick, S. (Eds.). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press, pp. 236-247.

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Self-Management Time Guide

I. Mood Check

a. List five emotions you are feeling right now, and rate their intensity from 0-100%.

b. List three emotions you have felt this past week, and rate their intensity from 0-100%.

II. Review the Previous Week

a. Did I use any tools I learned in therapy this week?
    i. If I did not, what problem did I have this week that could have been helped through the use of these skills?

b. What good things happened this week?
    i. How did I make those good things happen?

III. Current and Future Problematic Situations

a. What are my current problems?
    i. How can I think about these problems in a different way?
    ii. What can I do to change the feelings associated with these problems?

b. What problems can occur before my next self-management time?
    i. What skills can I use to deal with these problems?

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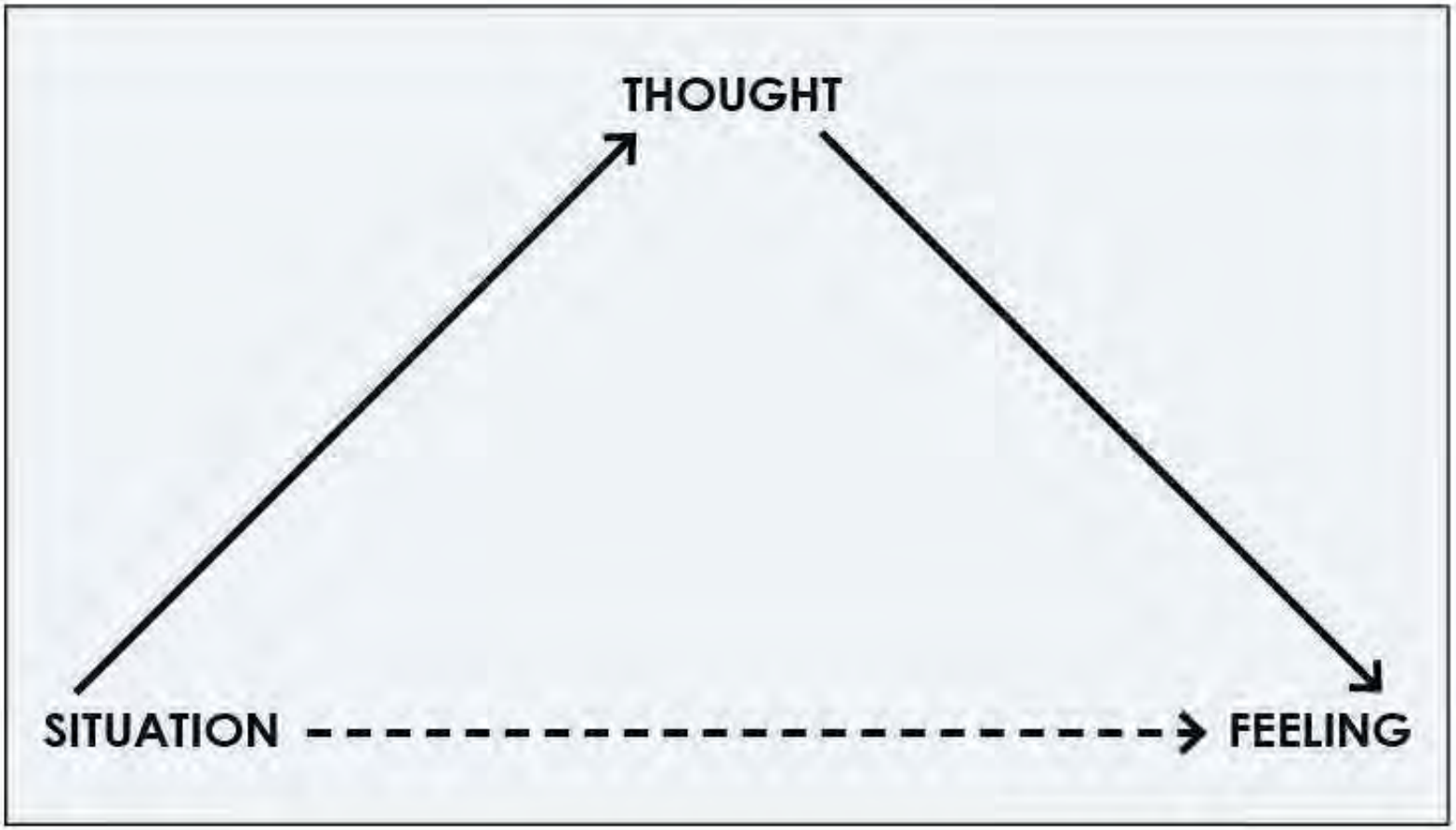
APPENDIX A:
PATIENT HANDOUTS


THOUGHT
SITUATION
FEELING

BRIDGING SESSIONS

1. What main points did we reach in our last session? What did you learn from last session? Did anything come to mind in the past week about our last session that you'd like me to know or that you'd like to discuss?

2. Were you uncomfortable about anything we talked about in our last session? Is there any thing you wish we had discussed that we didn't?

3. How is your mood? Compared with last week, is it better or worse?

4. What treatment goals would you like to work on today? What problems would you like to put on the agenda?

5. What homework did you attempt or complete for last session? What did you learn from doing it?

Cognitive Distortions

1. **All-or-Nothing Thinking:** Viewing situations on one extreme or another instead of on a continuum.
   Ex. "If my child does bad things, it's because I am a bad parent."

2. **Catastrophizing:** Predicting only negative outcomes for the future.
   Ex. "If I fail my final, my life will be over."

3. **Disqualifying or Discounting the Positive:** Telling yourself that the good things that happen to you don't count.
   Ex. "My daughter told her friend that I was the best Dad in the world, but I'm sure she was just being nice."

4. **Emotional Reasoning:** Feeling about something overrules facts to the contrary.
   Ex. "Even though Steve is here at work late everyday, I know I work harder than anyone else at my job."

5. **Labeling:** Giving someone or something a label without finding out more about it/them.
   Ex. "My daughter would never do anything I disapproved of."

6. **Magnification/Minimization:** Emphasizing the negative or downplaying the positive of a situation.
   Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."

7. **Mental Filter/Tunnel Vision:** Placing all your attention on the negatives of a situation or seeing only the negatives of a situation..
   Ex. "My husband says he wished I was better at housekeeping, so I must be a lousy wife."
   EX. "My daughter's boyfriend got suspended from school. He's a loser and won't ever amount to anything."

8. **Mind Reading:** Believing you know what others are thinking.
   Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."

9. **Overgeneralization:** Making an overall negative conclusion beyond the current situation.
   Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."

10. **Personalization:** Thinking the negative behavior of others has something to do with you.
    Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."

11. **"Should" and "Must" Statements:** Having a concrete idea of how people should behave.
    Ex. "I should get all *A*'s to be a good student."

THOUGHT RECORD

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence to Support Thought	(5) EvidenceThat Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
What actually happened? Where? What? How? When? (Date and time)	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? How intense were they?(1-100) Rate your mood.*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*Rate from 1 to-100 (worst to best)*

Helpful Questions

Situational Questions	Feeling Questions	Thought Questions
▪ What happened? What were you doing? ▪ Who was there? ▪ To whom were you speaking? ▪ When did this happen? ▪ What time of day was it? ▪ Where did this incident occur?	▪ How were you feeling before this happened? ▪ How did you feel while it was happening? ▪ What mood were you in after this happened? ▪ Can you rate your mood on a scale of 1-100?	▪ What was going through your mind before you started to feel that way? ▪ What made you feel that way? ▪ Any other thoughts? ▪ Which thought bothered you the most? ▪ What images did you have with these thoughts? ▪ What are you afraid might happen? ▪ What if this is true? What does this say about you? ▪ What could happen if this were true? ▪ What other ways could we think of this?

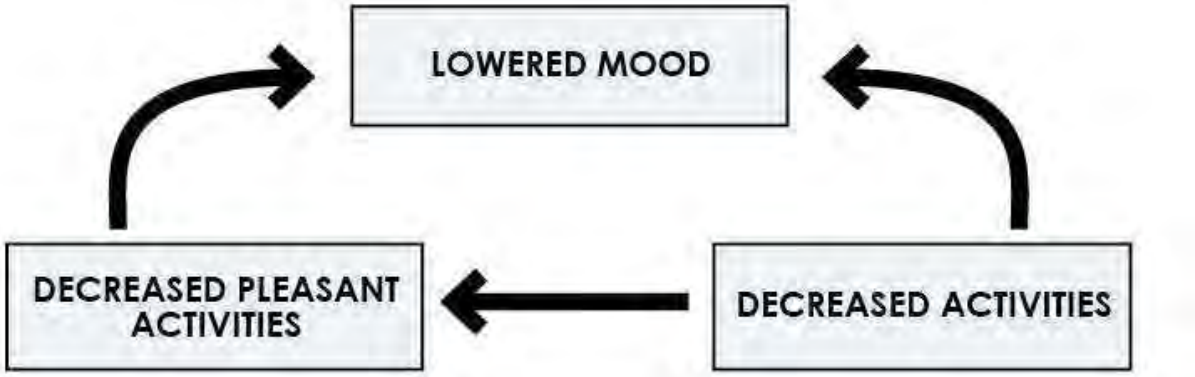
THOUGHT RECORD

(1) Situation	(2) Automatic Thought(s)	(3) Emotion(s) & Mood	(4) Evidence to Support Thought	(5) Evidence That Doesn't Support Thought	(6) Alternative Thought	(7) Rate Mood Now
What actually happened? Where? What? How? When? (Date and time)	*What thought(s) went through your mind? How much did you believe it? (1-100)*	*What emotion(s) did you feel at the time? How intense were they? (1-100) Rate your mood.*	*What has happened to make you believe the thought is true?*	*What has happened to prove the thought is not true?*	*What is another way to think of this situation?*	*Rate from 1 to100 (worst to best)*

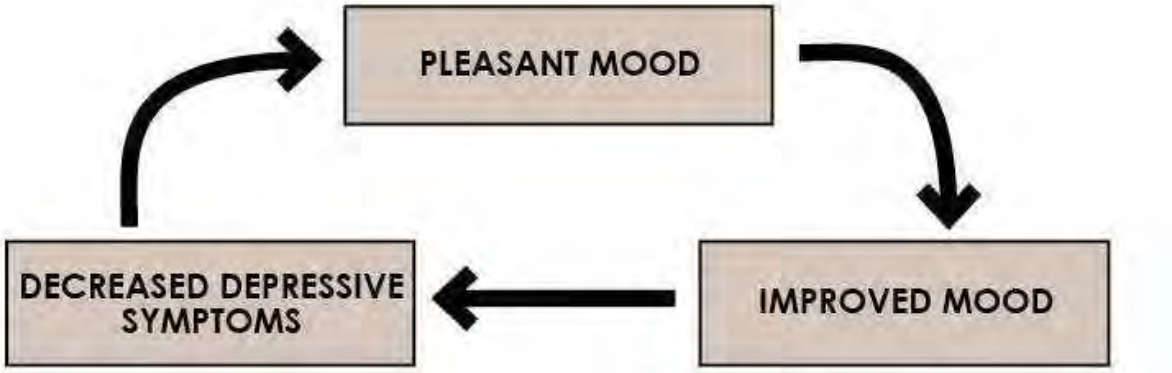
Functional Assessment: ABC's

Antecedents (What happened before?)	Behaviors (What did you do?)	Short-Term Consequences (What was the result 1 second, 1 hour following behavior?)	Long-Term Consequences (What were the lasting results?)

Mood and Behavior



For depressed persons, increasing their activities on a daily basis improves mood and decreases symptoms of depression.



Activities Checklist

EXCURSIONS/COMMUNITY	√	**SOCIAL ACTIVITIES AND INTERACTIONS WITH OTHERS**	√
1. Going to the park or beach		1. Getting together with friends	
2. Going out to dinner		2. Visiting a neighbor	
3. Going to the library or a book store		3. Having family visit or visiting family	
4. Going to the movies		4. Eating out with friends or associates	
5. Going shopping		5. Going to a local community center	
6. Going fishing		6. Playing bingo, cards, dominos with others	
HEALTH AND WELLNESS	√	**PHYSICAL ACTIVITY**	√
1. Putting on makeup or perfume		1. Walking for exercise or pleasure	
2. Eating healthier		2. Light housekeeping, such as sweeping	
3. Relaxing, meditating or doing yoga		3. Swimming or doing water exercise	
4. Improving one's health		4. Gardening or planting	
SPIRITUAL, RELIGIOUS, AND KIND ACTS	√	**RECREATIONAL AND OTHER LEISURE ACTIVITIES**	√
1. Going to a place of worship		1. Knitting, sewing or needlework	
2. Attending a wedding, baptism, bar mitzvah, religious ceremony or function		2. Writing in a journal or diary or keeping a scrapbook or photo album	
3. Reading the Bible		3. Playing with or having a pet	
4. Attending a Bible study group		4. Drawing, painting or crafts	
5. Doing favors for others or volunteering		5. Singing or listening to music	
6. Volunteering for a special cause		6. Reading the newspaper or magazines	
		7. Watching TV or listening to the radio	
		8. Doing word puzzles or playing cards	

Source: Adapted, with permission, from Lejuez, C.W., Hopko, D. R., & Hopko, S. D. (2001). A brief behavioral activation treatment for depression. *Behavior Modification 25:*255–286.Worksheet – Identifying pleasant events and meaningful activities

Mood Monitoring and Activity Chart

For each block of time, list the activity you did and rate (from 0-100) the level of Anxiety (A) and Depression (D) you experienced at that time.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
6-7 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
9-10 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
10-11 AM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
11-12 Noon	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
12-1 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
1-2 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
2-3 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
3-4 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
4-5 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
5-6 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
6-7 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
7-8 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:
8-9 PM	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:	A: D:

SOLVED: Problem-Solving Exercise

Specific Problem:_____

_____

_____

Open Your Mind **L**ist

To Possible Solutions	PROS AND CONS
1.	
2.	
3.	
4.	

Verify the best solution by circling your choice.

Enact the Solution.

Steps and Time Frame of Solution:

1._____Time:_____

2._____Time:_____

3._____Time:_____

Decide if Your Solution Worked: **[ ] YES [ ] NO**

Pros and Cons

Behavior: _____

Positive Effects of Doing the Behavior	Positive Effects of Not Doing the Behavior
Negative Effects of Doing the Behavior	**Negative Effects of Not Doing the Behavior**

Short-Term Positive Consequences	Long-Term Positive Consequences
Short-Term Negative Consequences	**Long-Term Negative Consequences**

Tensing Instructions

Model each tension procedure:

Dominant arm:
Make a fist and tense biceps; pull wrist upward while pushing elbow down against the arm of chair or bed.

Nondominant arm:
Same as above.

Forehead, lower cheeks and jaw:
Lift eyebrows as high as possible, bite teeth together and pull corners of mouth tightly.

Neck and throat:
Pull chin down toward chest; at the same time, try to prevent it from actually touching the chest. Counterpose muscles in front part of neck against those in the back part of neck.

Shoulders, chest, and upper back/abdomen:
Take a deep breath and hold it. At the same time, pull the shoulder blades back and together, trying to make them touch. Try to keep your arms as relaxed as possible while tensing this muscle group. At the same time make stomach hard by pressing it out, as if someone were going to hit you in the stomach.

Dominant leg:
Lift foot off the floor, and push down on the chair with thigh.

Nondominant leg:
Same as above.

Deep-Breathing Technique

Step #1: Put one hand on your abdomen, with the little finger about 1 inch above the navel, and place one hand on your chest.

Step #2: Pay attention to your breathing (pause for several seconds to assess your breathing). Ideally, the hand on the abdomen should be moving, while the hand over the chest remains still. This ensures that the breaths are deep.

Step #3: Take deeper breaths by getting the hand over the stomach to move, while having little movement of the hand over the chest.

NOTE: If you have a lung or heart condition and you are having difficulty with this exercise, slow the process down to your comfort level.

Step #4: Continue your slow, even, deep breaths. To pace yourself, you can say the words *in* and *out* slowly while taking breaths. Inhalations and exhalations should build to approximately 3 seconds in duration.

Step #5: Repeat the breathing exercise three or more times.

Other tips for deep breathing:

1) Inhale through your nose and out your mouth.
2) Purse your lips (as if blowing out hot soup) while exhaling.
3) Do not pause between inhales and exhales.
4) Close your eyes during the exercise.
5) Use mantra such as "relax" during each exhale
6) Pair up deep breathing with imagery once you have mastered the breathing skills.
7) REMEMBER: Deep breathing is a portable skill that can be used in a variety of situations and relatively without notice of others.

Imagery: Example Scripts

Script # 1: Generic Example

Once your whole body feels relaxed, travel to your favorite place… it can be any time period or any place. This place is calm and safe… there are no worries here… Look around this place. What do you see? Do you hear the sounds around you? What are some of the sounds you hear in this place you are imagining? How does this special place smell? Walk around a little and take in all the wonderful sights… Feel the air around you and relax…. The air is fresh, and it's easy to breathe here. Pay attention to how your body feels….. Say to yourself, "I am totally relaxed… without worries… all the tension has drained away from my body." Take a moment to fully experience your favorite place…. Notice the sounds, sights, smells, and how it feels to be in this very special place. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel at peace."

When you are done with your visit to this special place, open your eyes; and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion. Take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Script # 2 – The Beach:

Imagine yourself walking down a sandy beach. The sand is white and warm between your toes. You are looking out over the calm, blue water. The waves are gently lapping at the shore. You feel the pleasant warmth of the sun on your skin… it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear sea gulls in the distance. You taste traces of salt on your lips. You are completely relaxed… there are no worries on this beach. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, sights, smells, and how it feels to be in this very special place.

Feel the sand under your feet… you decide to stretch out on the warm, fine white sand… breathe deeply… feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up as the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Script #3 – The Meadows:

Imagine yourself walking through a lovely meadow. The breeze feels pleasant against your skin. You are looking out over the calm, beautiful green grass. The blades of grass are gently swaying in the breeze. You feel the pleasant warmth of the sun on your skin… it's a perfectly comfortable temperature outside. Breathe in deeply. There is a gentle breeze, and the sun is shining. Big, cotton-like clouds drift by as you hear birds in the distance. You hear the wind blow gently through the trees. You taste the sweet summer air on your lips. You are completely relaxed… there are no worries in this meadow. There is nothing to distract you from feeling tranquil. Worries drift away. Notice the sounds, sights, smells, and how it feels to be in this very special place.

Feel the cool grass under your feet… you decide to stretch out on the soft, cushiony grass… breathe deeply… feel the warm air. Your body is completely relaxed, and you have an overall feeling of warmth and comfort. You look up as the clouds pass by slowly across the beautiful blue sky. You are feeling rejuvenated and completely at peace. Remember that you can visit this place as often as you want and that it is wonderful. Say to yourself, "I am relaxed here… this place is special and makes me feel peaceful and content."

When you are done with your visit, open your eyes and stay in your comfortable position. Continue to breathe smoothly, in a relaxed and rhythmic fashion; take as long as you want to enjoy and relax. You feel at ease knowing your special place is always available to you, and you find that you feel relaxed even after you leave.

Other Guided Imagery Scene Suggestions:

- A garden where you watch big, beautiful clouds in a blue sky, while you inhale the scent of flowers and feel a gentle breeze on your skin as the sunshine warms you.
- A mountain scene where you feel calm and relaxed as you look out over the valley. Just you and the vegetation, and you dip your feet into a cool mountain stream, and let your foot rest on a big, slippery stone as the sunshine warms you and the wind blows through the trees.
- Advanced scenarios developed with assistance of patient (family, past experiences, etc).

Rating Moods

Describe a recent event. Rate the intensity of your mood at the time the event occurred on a scale of 0-100 (There is a list of different moods at the bottom if you need help).

1.

Event:_____

_____

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

2.

Event:_____

_____

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

3.

Event:_____

_____

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

4.

Event:_____

_____

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Mood:_____: 0 10 20 30 40 50 60 70 80 90 100

Angry Anxious Ashamed Confident Depressed Disgusted Embarrassed Enraged Excited Furious Frightened Frustrated Guilty Happy Hopeful Hopeless Hurt Humiliated Insecure Irritated Jealous Livid Mad Nervous Panicky Sad Scared Tense Warm

Self-Management Time Guide

I. Mood Check

a. List five emotions you are feeling right now, and rate their intensity from 0-100%.

b. List three emotions you have felt this past week, and rate their intensity from 0-100%.

II. Review the Previous Week

a. Did I use any tools I learned in therapy this week?
    i. If I did not, what problem did I have this week that could have been helped through the use of these skills?

b. What good things happened this week?
    i. How did I make those good things happen?

III. Current and Future Problematic Situations

a. What are my current problems?
    i. How can I think about these problems in a different way?
    ii. What can I do to change the feelings associated with these problems?

b. What problems can occur before my next self-management time?
    i. What skills can I use to deal with these problems?

APPENDIX B:
SAMPLE TREATMENT OUTLINES

Sample Brief CBT Outline #1

Patient Description
Maria is a 60-year-old airline pilot who is about to retire from 15 years of flying. Maria was diagnosed with Type II diabetes 5 years ago and has had difficulties maintaining her health since that time. She has suffered bouts of severe fatigue and dizziness. Maria says that flying is her "first love," but that it has become increasingly dangerous for her to fly. She states that she "feels like a failure" because she worked so hard to become a pilot and now "it is over." Maria says that she is usually a very active person but has lost interest in her hobbies and doesn't have the energy to do them, anyway. She says that her depression has been worsened by her deteriorating health.

Case Conceptualization: Maria is experiencing depression in response to a diagnosis of diabetes. She is unsure how to change her thoughts and behaviors to adjust to her new medical condition. Therapy will aid her adjustment by targeting dysfunctional thoughts about being a "failure" and exploring and increasing the things that she enjoys and feels a sense of achievement from, both for work and recreation.

Goals
Behavioral Activation
Identifying Maladaptive Thoughts/Beliefs
Challenging Maladaptive Thoughts/Beliefs

Session 1
Establish relationship.
Identify Maria's presenting problem.
Introduce Cognitive Behavioral Therapy.
Introduce the Cognitive-Behavioral Model.
Describe Problem in Context of Model.
Set Goals.
Receive Feedback from Maria.

Session 2
Check Mood.
Introduce Behavioral Activation, and Explore Potential Activities to Improve Mood.
Set Homework: Mood and Activity Tracking.
Receive Feedback From Maria.

Session 3
Check Mood.
Review Mood and Activity Tracking.
Use Tracking Sheet to Plan Where and What Behavioral Activation Will Be Employed.
Troubleshoot Completing Activity.
Assign Homework: 1 Behavioral-Activation Exercise.
Receive Feedback From Maria.

Session 4
Check Mood.
Review Behavioral Activation,
Introduce Three-Column Thought Record and Idea of "Hot Thought."
Practice Three Column With Event From Past Week.
Homework: 1 behavioral activation
1 three-column thought record
Receive Feedback From Maria.

Session 5
Check Mood.
Discuss Progress of Therapy and Termination.
Review Homework.
Introduce Cognitive Distortions.
Complete Three-Column in Session, and Have Maria Identify Hot Thought.
Introduce Concept of Challenging Hot Thought.
Homework: 1 behavioral activation
1 three-column thought record
Receive Feedback From Maria.

Session 6
Check Mood.
Review Homework.
Introduce Challenging Thoughts and Seven-Column Thought Record.
Complete Seven-Column in Session.
Introduce Concept of Challenging Hot Thought.
Homework: 1 behavioral activation
1 three-column thought record
Receive Feedback From Maria.

Session 7
Check Mood.
Review Homework.
Complete Seven-Column in Session (With Maria Writing and Talking Through asSshe Completes It)
Homework: 1 behavioral activation
1 seven-column thought record
Receive Feedback From Maria.

Session 8
Check Mood.
Review Homework.
Review Progress of Treatment.
Complete Relapse Prevention.
Introduce and Schedule Self-Management Sessions.
Homework: Self-Management Session

Sample Brief CBT Outline #2

Patient Description
James is a 24-year-old college student on a full academic scholarship. He called the therapist to discuss his feelings of anxiety and whether there is anything that can help him "calm his nerves." James said that he is used to getting anxious in certain situations, but that it is starting to affect all areas of his life. He says that he doesn't have a girlfriend because he gets "too freaked out" to ask anyone on a date. He also says that his anxiety is starting to affect his grades because he gets so nervous during exams that he breaks into a cold sweat and cannot concentrate. He wants to be able to control his anxiety but feels there is no hope.

Case Conceptualization: James is experiencing cognitive and physiological anxiety in response to evaluative situations. Therapy will focus on stress-management skills for his physiological symptoms and identifying dysfunctional thoughts or worries about his performance in academic and social situations. Specifically, therapy will identify catastrophic thoughts he has about failure.

Goals
Relaxation
Identifying Maladaptive Thoughts/Beliefs
Challenging Maladaptive Thoughts/Beliefs

Session 1
Establish relationship.
Identify James' presenting problem.
Introduce cognitive behavioral therapy.
Introduce the cognitive-behavioral model.
Describe problem in context of mode.
Set goals.
Receive feedback from James.

Session 2
Check mood.
Introduce and practice progressive muscle relaxation.
Set homework: Plan two times during week to practice progressive muscle relaxation.
Receive feedback from James.

Session 3
Check mood.
Review progressive muscle relaxation.
Introduce and practice imagery.
Homework: 1 progressive muscle relaxation
1 imagery exercise
Receive feedback from James.

Session 4
Check mood.
Review imagery.
Introduce three-column thought record and idea of "hot thought."
Practice three-column with event from past week.
Homework: 1 relaxation technique
1 three-column thought record
Receive feedback from James.

Session 5
Check mood.
Discuss progress of therapy and termination.
Review homework.
Introduce cognitive distortions.
Complete three-column in session, and have James identify hot thought.
Introduce concept of challenging hot thought.
Homework: 2 relaxation techniques
1 three-column thought record
Receive feedback from James.

Session 6
Check mood.
Review homework.
Introduce challenging thoughts and seven-column thought record.
Complete seven-column in session.
Introduce concept of challenging hot thought.
Homework: 2 relaxation techniques
1 three-column thought record
Receive feedback from James.

Session 7
Check mood.
Review homework.
Complete seven-column in session.
Homework: 2 relaxation techniques
1 seven-column thought record
Receive feedback from James.

Session 8
Check mood.
Review homework.
Review progress of treatment.
Complete relapse prevention.
Introduce and schedule self-management sessions.
Homework: self-management session