Do you ever find yourself in situations causing you stress/anxiety/fear, rationally knowing you shouldn’t be stressed/anxious/afraid? Have you stopped wishing you’d think self-defeating thoughts, mustering yourself to do the things you’ve wanted to do? You might find elements of cognitive behavioral therapy to be useful.

Cognitive behavioral therapy (CBT) is a standard first line of treatment for improving mental health disorders such as depression and anxiety. CBT has been found to be as effective as medication in treating many mental disorders.

Cognitive Behavior Therapy: Basics and Beyond, written by clinician Judith S. Beck (daughter of CBT’s inventor Aaron Beck), is the leading text for CBT practitioners. This CBT basics summary covers the principles of mental disorders and treatment.

Even if you aren’t formally diagnosed with a mental health disorder, you likely face situations that evoke more negative emotions than you’d like - nervousness talking to your boss, road rage, anxiety in social situations, stress that you won’t get everything done, or fear of failure in trying something new. This CBT summary will show tactics that are broadly applicable to your daily life, helping you overcome anxiety, sadness, anger, frustration, and stress.
In this CBT: Basics and Beyond summary, learn:

- Questions to ask yourself to get distance from stressful thoughts
- Types of cognitive distortions that are self-defeating
- How to address traumatic events earlier in your life, so that they have less hold on your thinking today
- Key ways to build rapport as a cognitive behavior therapist

1-Page Summary of CBT: Basics and Beyond

While Cognitive Behavior Therapy: Basics and Beyond is a text to train psychiatry practitioners, I’ve found many of the techniques applicable to daily life. Even if you aren’t formally diagnosed with a mental health disorder, you likely face situations that evoke more negative emotions than you’d like - nervousness talking to your boss, road rage, anxiety in social situations, stress that you won’t get everything done, or fear of failure in trying something new.

This summary focuses on the key CBT interventions to change your dysfunctional automatic thoughts and behaviors. These are generally applicable for all readers, not just those aiming to practice CBT for patients.

- When you feel dysphoria (negative emotion), think the cardinal question: “What was just going through my head?” Articulate the thought explicitly.
  - e.g. “I’m afraid that people will think my project proposal is stupid.”
- Evaluate the thought with these questions:
  - What is the evidence that your thought is true? What is the evidence on the other side?
  - What is an alternative way of viewing this situation? What else could explain the person’s behavior/the outcome?
  - Outcome analysis
    - What’s the worst that could happen? How would you cope with this situation?
    - What’s the best that could happen?
    - What’s the most realistic outcome of this situation? (especially if you tend to catastrophize)
  - What is the effect of believing your negative automatic thought? What could be the effect of changing your thinking to be more positive?
  - If your friend were in this situation and had the same automatic thought, what advice would you give him or her?
  - What should you do going forward? How likely are you to do this?
- Patterns of cognitive distortions: These put a label to common ways that people distort reality in self-defeating ways.
  - Catastrophizing - imagining the worst possible thing that could happen
  - Selective bias/tunnel vision/discounting the positive - focusing and emphasizing negative evidence for, ignoring or de-emphasizing positive evidence against
All-or-nothing - either you get an A or you’re a total failure
Mind reading - assuming negative intent or belief of other people, without considering other possibilities
Emotional reasoning - because you feel it so strongly, it must be true
  - I feel like a failure all the time, so it must be true
Exaggeration, or over-generalization
Should and must statements - a precise fixed idea of how people should behave.
  - Overestimate how bad it is if these expectations are failed

- **Conduct behavioral experiments** to push yourself to do what is uncomfortable. This will give you new data, to find a mismatch between your prediction and reality.
  - Realize that you can fall into a negative vicious cycle without intervention:
    - **Stressful situation arises**
      - Work asks you to work on a promising new project, but it risks failure. You get anxious.
    - **Automatic thoughts arise that cause a maladaptive, self-defeating reaction**
      - “I can’t succeed in this. If I fail, people will know and I’ll be ashamed.”
    - **A negative outcome results, further strengthening patient’s negative core beliefs and aggravating the automatic thoughts**
      - You don’t volunteer for the project. “I knew I wasn’t capable of signing up for this.”
    - **Patient also withdraws from situations that might lead to positive data**
      - You prevent yourself from volunteering for any future new projects, because the thought of doing so causes you too much anxiety.
  - Small bits of positive data will counteract the vicious cycle. When done repeatedly, it can build its own virtuous cycle.
- To uncover your deeper beliefs, keep asking yourself questions about the situation or the automatic thought. “What does it mean to me if X happens? What does it mean *about* me?”
  - Articulate your rules, assumptions, and attitudes.
  - Attitude: “It’s terrible to fail.”
  - Rule: “If a challenge seems to great, don’t even try it.”
  - Assumption: “If I try to do something difficult, I’ll fail. If I avoid doing it, I’ll be OK.”
- Generally, dysfunctional core beliefs fall into three categories:
  - Helplessness: “I want to achieve more, but I’m not capable of it.”
  - Unlovableness: “I’m not worthy of being loved by others. I’m undesirable.”
  - Worthlessness: “I’m bad. I’m fundamentally not worthy of good things.”
- For beliefs, consider the following interventions:
  - **Phrase the rulebelief as an assumption** - this makes it easier to spot the logical fallacy.
    - “If I ask for help, I’ll be seen as weak.” vs “Don’t ask for help.”
  - Present more functional beliefs, that are more qualified versions of the old belief
    - “If I don’t get an A, I’m a failure.” -> “If I don’t get an A, I’m just human, and I still tried hard. It’s better than 0%.”
    - “I can’t do anything right.” -> “I can do most things right, and there’s a good reason for when I get something wrong.” NOT “I can do everything right.”
- **Behavior experiment**
  - Act “as if” the belief weren’t true.
  - Act as if you assume the positive outcome will be true.
• Imagine counseling someone else with the same issue, or pretend your child has the same belief.
• Look back on major periods of patient’s life to find evidence that supports and contradicts the core belief.
• Role playing an early traumatic experience. Play an older version of yourself, counseling your younger self on why the situation should be interpreted more optimistically.
• Make a list of advantages and disadvantages of each option. Score each entry to help make the ultimate decision.
• Continue imagining beyond the near future - weeks, months, years after whatever is causing dysphoria. Likely will find (inferring from past experience) that things will resolve satisfactorily.

Caveats

Some studies are finding that CBT is declining in efficacy over time. Immediate possibilities are that the studies are getting more robust over time; the patient population is changing.

A more interesting and more disappointing possibility is that mental health responds to novelty. You need to believe the therapy will work for it to work. If a new method delivers you new insights about yourself, then you’re more likely to believe the tactics will work. There was a time when anxious people didn’t know their thoughts were irrational, and that mental health disorders meant they were more likely to think irrational thoughts.

Nowadays, CBT principles are seeping into popular media (eg Disney’s Inside Out). The ideas seem less novel (“no shit I know what I’m thinking isn’t rational, but that doesn’t help me in the moment.”) More CBT patients also means more patients for whom it doesn’t work, meaning less belief for new patients that the therapy will work.

In all, this suggests that mental health therapies necessarily come in generations - as CBT declines, a new form that better addresses the new population will arise.

Principles of Mental Disorders

• The cognitive model proposes that dysfunctional thinking is common to all psychological disturbances. Mental illness (depression, anxiety) may be considered thinking disorders. The patient has automatic dysfunctional self-talk that influences behavior negatively; the behavior is then interpreted in a negatively biased way, leading to worse thinking. This reinforces itself into a vicious cycle.
  ◦ Example: A patient wants to try something new. “You’re definitely going to fail, you’re not good at anything.” -> Patient demurs from trying the new activity -> “I told you, you can’t get anything right - you’re worthless.”
• The negative thinking extends to the core of a patient’s beliefs about herself, the world, and other people, as well as intermediate levels of attitudes, rules, and assumptions.
• It’s not just the situation itself that makes a person feel a certain way, but also how they construe it, what lens they use to view it.
Cyclical downfalls can be triggered by **precipitating factors**, such as a sudden provocation in stress.

Patient may have had key **developmental events** earlier in life that predispose her to the condition.

Patient may have developed **coping mechanisms** (adaptive and maladaptive) for the dysfunctional beliefs.

**Dysfunctional beliefs can be unlearned.**

### Cognitive Conceptualization

The patient’s cognitive conceptualization exists on 3 levels:

- **Core beliefs**
  - These are fundamental understandings regarded as absolute truths - just the way things are.
  - They are often not explicitly articulated by the patient consciously.
  - Early experiences may have developed these - by parents, early authority figures; by a traumatic event; by apparent negative treatment by others (accurate or not).
  - These generally fall into three categories: “I’m helpless.” “I’m unlovable.” “I’m worthless”

- **Intermediate attitudes, rules, and assumptions**
  - Attitude: “It’s terrible to fail.”
  - Rule: “If a challenge seems to great, don’t even try it.”
  - Assumption: “If I try to do something difficult, I’ll fail. If I avoid doing it, I’ll be OK.”
  - Generally, the logic is: “If I engage in [maladaptive coping strategy], then [my core belief] won’t come true and I’ll be OK.” And the inverse of this: “If I don’t engage in [maladaptive coping strategy], then [my core belief] will come true and I’ll be hurt.”
  - (Note the patient may also have positive inversions, which arise when the patient’s mood is better. Assumption: “If I work hard, I can overcome my shortcomings.”)

- **Automatic thoughts**
  - These arise unconsciously. Many people accept them uncritically, believing them to be true.

- **Typical coping strategies**
  - Generally, can be extreme implementation of behavior, or extreme absence of behavior.
  - Examples:
    - Try to be perfect, or appear purposely incompetent
    - Seek intimacy, or avoid intimacy
    - Try to control situations, or abdicate control

The beliefs shape the patient’s **reaction**, which is composed of **emotional**, **physiological**, and **behavioral** components.

- Reactions can become automatic coping mechanisms.
- Example: person afraid of failure doesn’t ask for help, for fear that others will think her
inadequate.

- The patient’s biased information-processing model can reinforce negative beliefs by:
  - Selectively paying attention to negative data
  - Discounting positive data, even turning positive into negative data
    - Getting an A on a test -> That test was too easy to mean anything
    - Getting praise -> I don’t deserve it, my boss is wrong
  - Ignoring positive or neutral data altogether
    - Eg not considering that other capable people have failed at the task, or that the task has poor instructions

- The negative vicious cycle works like this:
  - Stressful situation arises
  - Automatic thoughts arise that cause a maladaptive, self-defeating reaction
  - A negative outcome results, further strengthening patient’s negative core beliefs and aggravating the automatic thoughts
  - Patient also withdraws from situations that might lead to positive data
  - All this is interpreted by the patient not as a mental disorder, but rather that something is wrong with the patient. This worsens dysphoria.

- Important: the maladaptive response may offer some short-term relief but be long-term destructive
  - Example: patient feels anxious about taking a test. Staying in bed calms her heart rate, but causes poor performance and aggravates future anxieties.

- The conceptualization begins with first contact and is refined over more sessions and gathering more data.

Example patient:

- Sally was criticized as a child by her mother. She was often compared unfavorably to her more successful brother. This led to core beliefs about her inadequacy.
- She developed attitudes and rules about always doing the best, being great at everything she tried. In depressed states, she focused on her deficiencies and became afraid of never amounting to anything.
- Coping strategies including having high standards, overpreparing, looking for weaknesses and addressing them, not asking for help.
- Sally received new experiences leading to negative thoughts: her classmates had far more AP credits than she did; she didn’t make the school athletic team.
- Sally developed automatic thoughts: “I’m no good. I won’t be able to do this. I’ll probably fail and drop out of college.” She did not question her thoughts. These aggravated into meta-thoughts: “What’s wrong with me? Why am I so down? I’m just hopeless.”
- These thoughts led to self-defeating behaviors, like withdrawing from her friends, discontinuing activities that used to give her positive accomplishment, spending more time studying but not concentrating.
Example cognitive model sequence:

- **Situation:** Sally feels exhausted (physiological trigger) when she wakes.
  - **Automatic thought:** I’m too tired to get up. There’s no use getting out of bed.
  - **Reaction:** Emotionally feels sad, physiologically feels heavy, behaviorally stays in bed.
- **Automatic thoughts:** “What if my professor gives a pop quiz? What if this counts against my grade? What if I fail the class?”
  - **Reaction:** Emotionally feels anxious, physiologically feels heart rate rise.
- **Situation:** Notices rapid heartbeat.
  - **Automatic thought:** “What’s wrong with me? Why am I getting worked up over nothing?”
  - **Reaction:** Emotionally feels more anxious.
- **Automatic thought:** “I’d better just stay in bed, I can’t do anything right now.”
  - **Reaction:** Emotionally feels relief, physiologically feels heart rate slow, behaviorally stays in bed longer.

### Automatic Thoughts

- Patients misconstrue neutral or even positive situations as negative through automatic thoughts. Further, they tend to not examine their automatic thoughts and take them for granted. By examining their automatic thoughts and correcting errors, they often feel better.
- Patients are often more aware of the **emotion they feel than the thought itself**.
- Automatic thoughts may come in the form of verbal thoughts or images.
- Automatic thoughts can be examined on the basis of their validity and utility.
  - **Validity** - the thought is not supported by the evidence. Or, the conclusion drawn may be distorted: “I didn’t do what I promised -> I’m a bad person.”
  - **Utility** - the thought may be valid, but dysfunctional.
    - “It’ll take an all-nighter to finish this assignment.” -> Increased anxiety, decreased concentration -> Worse performance. Better thought: “I’ve done it before. Dwelling on how long it’ll take makes me feel bad, and I won’t concentrate. It’ll take me longer to finish. Better to concentrate on one part at a time, and give myself credit for finishing.”
- Situations that can evoke automatic thoughts
  - **External event**
    - Friend didn’t pick up my call.
  - **Stream of thoughts**
    - Thinking about the exam and how much is being tested.
  - **Cognition** (thought, image, memory, daydream)
    - Thinking of a violent image.
    - Flashback of a traumatic event.
  - **Emotion**
    - Anger. “I shouldn’t be angry at him. I’m such a bad person.”
  - **Behavior**
    - Binge eats. “I’m so weak. I can’t even get my eating under control.”
Physiological
- Heart beat. “There’s something seriously wrong with me.”

Mental experience
- Sense of unreality. “I’m going crazy.”

These automatic thoughts then lead to emotions. The two are distinct.
- Emotions are one word: sad, anxious, angry, jealous, ashamed, hurt, suspicious, disappointed.

Principles of Treatment

- CBT is directed toward solving current problems and modifying dysfunctional thinking and behavior. Changing the underlying belief system leads to enduring behavior change.
- CBT encourages the patient to:
  - Recognize the negative thoughts that are happening automatically.
  - Recognize the biased interpretations of their experiences.
  - Examine the evidence of a situation. View their experiences from a more realistic and objective perspective.
    - Example: Instead of thinking “I can’t do anything right,” patients are led to think, “I’m not good at this specific task. But I’m good at others.”
  - Experiment with exposure to situations they fear to test their negative predictions.
  - Reflect on their experiments to adjust their beliefs.
- The cardinal question of CBT: “What was just going through my mind?”
- CBT treatment is:
  - Collaborative
    - Therapist and patient work together on the session agenda and after-session homework. As the patient improves, the patient takes more initiative.
    - Therapist shares the conceptualization to ensure it “rings true.”
    - Therapist provides rationales for intervention and elicits approval.
    - Therapist asks for feedback at the end of each session.
    - Therapist constantly ends suggestions with “is that OK? Does that sound right?”
    - The pair uses guided discovery, Socratic questioning, and empiricism to explore the validity of automatic thought and test new situations.

  - Time-bound: Straightforward patients are empowered to be self-sufficient after 6-14 sessions, followed by periodic booster sessions.
    - The patient takes home therapy notes to review.
    - The patient carries coping cards with written statements that are important to remember.
    - The patient learns to conduct her own CBT sessions.

  - Customized: To the disorder and to the patient.
    - Different disorders require different approaches. Panic disorder involves testing catastrophic misinterpretations of bodily/mental sensations. Anorexia requires modification of beliefs about personal worth and control. Substance abuse focuses on beliefs about the self and permission-granting beliefs about substance abuse.
Each patient has different thinking patterns, beliefs, and developmental events.

- Present-focused: CBT is goal-oriented, current problem-focused.
  - [Contrast to Freudian psychoanalysis, which seems to focus on unconscious conflicts.]
  - Strategies are devised to overcome current problems. Often consists of evaluating the evidence of the situation, incremental solutions to experiment with the situation, changing beliefs.
  - Attention shifts to the past when patients get stuck in their thinking, and examining childhood roots can modify their rigid ideas. (“No wonder you feel that way. Can you see how almost any child who had the same experiences would grow up feeling the same way you do?”)
- Built on trust: warmth, empathy, genuine regard, competence.
  - Treat them the way you would like to be treated.
  - Accurately summarize the patient’s thoughts and feelings. Patient will feel understood.
  - Your previous successes will make the patient feel optimistic about chances of recovery. “I’ve helped other patients much like you.”
- Structured: Makes the session more understandable and empowers patient to do self-therapy.
  - Introduction: Mood check, reviewing the week, setting an agenda
  - Middle: Reviewing homework, discussing problems on the agenda, strategy setting, setting new homework, summarizing
  - Final: Eliciting feedback

The standard communication approach in a session is:

- Tell the patient what you are about to do, why, and say you will invite feedback.
- [Do what you said.]
- Does this ring true? How does that sound?

**Developing the Therapeutic Relationship**

- Share your conceptualization with the patient constantly, asking whether it “rings true.”
  - “OK, I want to make sure I understand. The situation was X, and your automatic thought was Y. This thought made you feel Z, so you acted in form A. Did I get that right?”
- When noticing dysphoria during the session (could be remembering something or the session itself), address it: “You look upset. What was going through your mind?”
- Positively reinforce patients for providing feedback. “It’s great that you recognized your thinking.”
- Positively reinforce patients for making strides in their therapy. For noticing automatic thoughts, suggesting new solutions, doing homework.
- **Evidence of improvement makes the patient more optimistic that the method is working.** Improve the patient’s mood during the session and create a plan to feel better during the week.
- **Emphasize the positive.**
Elicit patient strengths.
Elicit positive data from the preceding week. “What positive things happened since I saw you last?”
Elicit data contrary to their negative thoughts.
Ask what positive data means about them.
Give positive feedback on adaptive coping mechanisms: “What a good idea.”

- Don’t attack the core beliefs too early - this can endanger the alliance. Identify cognitions that are closest to conscious awareness.

Planning Treatment and Structuring Sessions

- Most patients feel more comfortable when they know what to expect from therapy and what they are expected to do.
- Session agenda at a high level:
  1: Reestablish the therapeutic alliance and collect data. Set and prioritize the agenda together.
  2: Discuss the problems on the agenda. Engage in problem-solving and thereby teach cognitive skills.
  3: Review the session and provide homework.
- Elicit the most important points of the session and make sure those are written down.
- Interrupt gently to guide the patient on the most helpful agenda items.

The Evaluation Session

- The goal is to start building a cognitive conceptualization of the patient. Treatment and problem-solving should NOT be done until the first therapy session.
- Prepare by gathering all the notes available, including previous psych work..
  - Check that the patient has had a recent medical check-up - an organic issue like hypothyroidism may be misdiagnosed as depression.
- Invite a family member or friend to attend, but start the meeting alone with the patient and discuss when to bring the other person in on the session.
- Set the agenda and convey expectations for the session.
  - This is an evaluation session. I’ll ask a lot of questions to determine the diagnose. A number of questions may not be relevant. Is that OK?
  - I’d like to find out about symptoms you’ve been experiencing and how you’ve been functioning lately. I’ll ask you to tell me anything else you think I should know. Then we’ll set broad goals, I’ll share initial impressions, and what we should focus on in treatment. At the end I’ll see whether you have other questions. Does that sound OK?
  - Anything else you want to cover today?
- Conduct the assessment.
  - Full medical and social history.
• **Ask patients to describe their typical day.** Look for variations in mood; how they interact with other people; how they function at home and work; how they spend free time.

• Pinpoint difficulties to address (e.g., difficulty sleeping, social isolation, limited opportunities for mastery, falling behind in schoolwork).

• Ask about positive experiences (“what are the better parts of the day?”) and coping strategies (“even though you were tired, how did you get yourself to go to class?”)

• Structure the questions to get what you need: “For these next questions, I just need a yes or no.”

• End with: “Is there anything you’re reluctant to tell me? You don’t have to tell me what it is. I just need to know if there’s more to tell.”

• **Discuss bringing the guest into the session, and make sure there’s nothing the patient wants to guard from the guest.**

• Ask the guest what is most important for you to know.

• If guest focuses on the negative, ask about the patients’ positive qualities and strengths.

• **Relate your impressions.**

• I’ll need time to review my notes to establish the diagnosis. But my impressions so far are X.

• **Set initial broad goals.**

• We’ll set more specific goals, but broadly should we say our goals are: reduce depression, do better at school, get back to socializing?

• In the future we’ll find problems to solve and engage in problem solving; examine your depressed thinking and the evidence; come up with solutions (elaborate).

• We’ll plan to meet every X weeks, then with less frequency later. My guess for how many sessions we need is between 8 to 14. We’ll decide together what’s best.

• **Elicit feedback from the patient.**

• How does that sound? Does this sound OK? Do you want to come back next week?

• **Look for indications the patient is unsure about committing to treatment.**

• Positively reinforce their expression of skepticism.

• “What makes you think I can’t help, or that this treatment won’t work?”

• “I can’t give you a 100% guarantee. But there’s nothing you’ve told me that makes me think it won’t work.”

• If it hasn’t worked in the past: **did your last therapist** set agendas; write down what to remember; ask for feedback; etc? If not, then **It sounds like our treatment here will be different.** If it were exactly the same as your past experiences, I’d be less hopeful.”

• If yes, then you will need to find out precisely what occurred in the past.

• **After the session, develop your hypothesis of the cognitive model and treatment plan.**

• Focus on fixing immediate short-term problems, then working more on core beliefs in the middle.

• May not be sure yet whether to focus on historic antecedents; or about other dysfunctional beliefs that were not mentioned.

• **Create goals other than what the patient has articulated.**

• Investigate dysfunctional beliefs about X

• Identify and respond to automatic thoughts
Initial Therapy Session

- As always, describe the agenda, ask if that sounds OK, and ask if patient would like to add anything.
  - **Rationale:** “We’ll do this at the beginning of every session so we make sure we have time to cover what’s most important to you.”
  - **Language:** “in a few minutes, we’ll discuss your diagnosis and how that affects your thoughts.” Signals that the agenda setting is not yet complete.
  - **Chronic problems (eg arguments with family) can usually be postponed to a future session.**
- **Do a mood check.**
  - “Tell me in a sentence or two how you felt for most of the week?”
  - Ideally patient fills out questionnaire beforehand.
  - If difficult for patient, simplify the question - mood from scale of 0 to 10.
- **Get an update**
  - Ask if anything significant has happened since the evaluation session.
  - For a reported problem, ask how upsetting or significant it was, too prioritize.
- **Discuss the patient’s diagnosis.**
  - **Use human language:** “The evaluation shows that you have a moderate depression. I want you to know that it’s a real illness. It’s not the same as people saying, ‘oh, I’m so depressed.’” Avoid label of a personality disorder diagnosis.
  - **Make it real:** “I know that because you have the symptoms in this diagnostic manual (DSM). The manual lists the symptoms for each mental health disorder, just like a neurology manual would list the symptoms of a migraine.”
  - **Normalize the situation:** “It’s very common for people with depression to feel this way.” “Most depressed people start criticizing themselves for not being the same.” “Sometimes it’s hard to figure out these thoughts.”
  - **Connect the patient’s reactions to the condition:** “The thoughts you’ve been having are a result of your depression. There isn’t anything wrong with you.”
  - **Give optimism** to avoid a crushing feeling of diagnosis: “Fortunately, cognitive behavior therapy is effective in helping people overcome depression. I’ve seen a lot of patients improve through the course of therapy.”
  - **Analogy:** “For everyone with depression, it’s as though they’re seeing themselves and the world through eyeglasses covered with black paint (pantomime this). These make everything look dark and hopeless. What we’ll do in therapy is to scrape off the black paint (pantomime) so you see things more realistically. Is that clear?”
- **Identify problems and set goals.**
  - “Let’s review the problems you’ve been having.” “It sounds like you have X major problems right now: [list]. Are there any others?”
  - “Would you like to write them down, or should I?”
  - **Invert the reported problems into goals, then into homework items.**
    - I don’t feel like I hang out with friends anymore -> Have an active social life -> Call Jessica this week to have lunch.
  - Elicit a response instead of dictating: “Would it help if you answered back the thought? What could you remind yourself?”
  - **Make broad goals more specific:** “I’d like to be happier.” “If you were happier, what would you be doing?”
• Make the goal something they have control over.
  ▪ Less “I’d like my boss to stop pressuring me.” More: “Learn new ways of talking to my boss.”
• For depressed patients, try to discuss the problem of inactivity. Overcoming passivity and experiencing pleasure and mastering is essential. [More generally, find the common problem that, if fixed, will yield short-term results.]

• Educate on cognitive model
  ▪ Can we talk about how your thinking affects your mood? Can you think of a time when you noticed your mood change? What were you thinking?
  ▪ So you had the thought “X.” How did those thoughts make you feel emotionally?
  ▪ You just gave a good example of how your thoughts influence your emotion. (Show diagram of Situation -> Automatic Thoughts -> Reaction.)
  ▪ [Making sure patient can verbalize understanding.] Can you tell me in your own words about the connection between thoughts and feelings?
  ▪ We’ll start evaluating your thoughts to see if they’re 100% true, 0% true, or somewhere in between. For example, you may find that instead of (automatic thought), the reality is (alternative explanation).
  ▪ (If patient balks that she has real problems, not just bad thoughts) I do believe you have real problems - I didn’t mean to imply you don’t. We’re going to solve those problems together. [Also possibly, show how the bad thoughts are causing the real life problems.]

• Start working on a problem (see next section for details).
• Set homework.
  ▪ Write homework tasks on a paper.
  ▪ Common tasks:
    ▪ Remind self of the disorder and positive thoughts. “If I start thinking I’m lazy and no good, remind myself that I have a real illness, called depression, that makes it harder for me to do things. As my treatment starts to work, my depression will lift, and things will get easier.”
    ▪ Identify automatic thoughts.
    ▪ Review the goals list.
  ▪ Patients in dysphoria overestimate the work it takes. Estimate the time needed for each item with the patient.
  ▪ Collaborate to find a way to review the homework regularly at multiple touchpoints per day. An alarm helps.
  ▪ If the patient balks at a task, suggest making it optional or crossing it off altogether, and ask patient what she’d like to do.

• End of session summary
  ▪ Can you tell me what you think is most important for you to remember this week?

• Elicit feedback.
  ▪ Give two chances - live in session, and after in a Therapy Report.
  ▪ What did you think of today’s session?
  ▪ Was there anything about this session that bothered you? Anything I got wrong?
  ▪ Anything you’d like us to do differently next session?
  ▪ Therapy Report questions:
    ▪ What did we cover today that’s important to you to remember?
    ▪ How much did you feel you could trust your therapist today?
- Was there anything that bothered you about therapy today? If so, what was it?
- How much homework had you done for therapy today? How likely are you to do the new homework?
- What do you want to make sure to cover at the next session?

Session 2 and Beyond

- Each session after the initial therapy session is similar in structure, save for these gradual changes:
  - Over time the problem solving will extend beyond automatic thoughts to underlying beliefs.
  - Start relapse prevention work, and **anticipate setbacks**, as patient feels better.
  - Over time the patient will play a more active role in setting the agenda.

- Prepare for the session yourself
  - What is your conceptualization of patient difficulties?
  - What progress have we made so far? In mood? Behavioral changes? Deepening of cognitive level?
  - How strong is our therapeutic alliance? What do I need to do today to strengthen it?
  - Have any dysfunctional ideas hindered therapy?

- Patient precedes session with Preparing for Therapy Worksheet.
  - What did we talk about last session that was important? What do my therapy notes say?
  - What has my mood been like, compared to other weeks?
  - What happened (positive and negative) this week that my therapist should know?
  - What problems do I want help in solving? What is a short name for each of these problems?
  - What homework did I do? What did I learn? If I didn’t do it, what got in the way?

- **Mood and medication check**
  - How are you feeling? Were you thinking about the whole week, or just today?
  - **Elicit attribution for the change.**
  - Why do you think you’re a little less depressed?
  - Can you see how your thinking and what you did affected how you felt, in a positive way?
  - If externally pointed (my medication started working), say, “I’m sure that helped, but did you also find yourself thinking differently or doing anything different?”
  - If patient does not identify anything to improve mood, **make a list of:**
    - Things that make me feel better
    - Things that make me feel worse
  - When asking about medication, ask not a binary question of whether they took medicine, but more, **“how many times this week** did you take your medication?”

- **Agenda setting**
  - Reduce patient suggestions to names of problems, like “applying for a job.” Interrupt if they get too long.
  - Ask for when in the past week they felt the worst.
  - Think about which problem is most important; most solvable; most likely to bring about symptom relief.

- **Update of week**
Did anything else happen this week?
For each mentioned problem, ask if it’s a problem we need to talk about today.
Ask when they felt the best this week, or what happened that was positive.
- This helps patients realize they didn’t feel distressed the entire week.

- **Homework review**
  - **Critical for patient to continue doing homework.**
  - Patient reads aloud the assignments.
  - Rate how much they believe the adaptive statements and beliefs.
  - Did you do the assignment? What did you learn from it?
  - Which are helpful to continue in the coming week?
  - How much did patient agree with each statement in the therapy notes from last week?

- **Prioritize the Agenda**
  - List the named problems. Is there any other problem that is even more important than those?
  - (If patient is unsure how to prioritize) Let’s say we can eliminate each of these problems one by one. Which one would make you feel better?
    - If this tactic is effective, teach patient to do this herself.
  - If we run out of time, are there things we can put off until next week?
  - Alternatively, ask what 1 or 2 problems are most important to talk about?
  - Avoid any problems the patient can resolve alone or at another session.

- **Problem solving**
  - List the important problems and ask which one to work on first. Gives them active responsibility.
  - The goals are:
    - Collect data to understand situation clearly
    - Investigate other situations the problem arose, and which one patient felt most upset in
    - Evaluate automatic thoughts (evidence for and against)
    - Solve the problem situation
    - “What would I do if I were in the patient’s position?”
    - Reduce patient distress and create symptom relief in the moment
    - Suggest behavioral changes
    - Teach patient new skills and reinforce cognitive model
    - Set new homework
    - Assess new patient mood after problem solving
  - If patient is fuzzy on details, paint a vivid picture of the scenario and ask patient to imagine it.
  - If you can’t solve a problem, ask patient to name a person who could have the same problem, and what advice she would give him.
  - Ask, “Do I need to do anything to reestablish rapport?”

- **Summarizing**
  - Summarize content of a problem. Use patients’ words as much as possible, or you will lessen the intensity of the automatic thought.
  - Summarize the session at the end. Do you think that about covers it?
  - With progress, ask the patient to summarize. “What do you think is most important for you to remember this week?”
Feedback
- What did you think about the session?
- Anything I got wrong?
- Is there anything we should talk about next time, or do differently?

Take notes
- Therapist objectives
- Problems discussed
- Dysfunctional thoughts and beliefs, written verbatim
- Interventions made in session
- Newly restructured thoughts and beliefs
- Assigned homework
- Agenda items for future sessions
- Refinements to conceptualization of patient

Identifying Dysfunctional Cognitions/Automatic Thoughts

- Key question: “What is going through your mind right now?”
- Patient should be led to describe the specific thought as it occurred. NOT speculating on its intent.
  - Not “I must be sabotaging myself.” Rather “I was thinking, “I’m going to fail the test.”
  - Not “I couldn’t get myself to start reading.” Rather “I can’t do this.”
  - Not “how will I get through it?” Rather “I can’t get through this.”

- To elicit the automatic thought:
  - Paint a vivid picture. Ask patient to imagine the situation, the time, what the patient was doing.
  - Ask for a description of the physical sensation of the emotion.
    - Where did you feel the anxiety?
  - Turn the reflection into present tense - past tense obscures the emotional response.
  - Ask the opposite of what you think the opposite was. “Did you think you were going to ace the test?”
  - Role play the situation.
  - If unresponsive, ask what the patient thought would have been the worst that could have happened.
  - Were you imagining something that might happen or remembering something that did?

- Probe if secondary automatic thoughts may have surfaced:
  - What else went through your mind? Which thought was most upsetting?
  - “I’m going to fail the test” -> anxiety -> “Why is my heart beating so fast, what’s wrong with me.”
  - Automatic thoughts about their reactions (emotion, behavior, or physiology) can cause a vicious cycle

- Frame the thought as an idea, not as a truth or fact. It will be evaluated later.
- Make clear the impact the thought has on emotion and behavior.
  - How did that thought make you feel?
  - What does that emotion make you want to do?
What would happen if you had the opposite thought? How would you feel?
• Patient should understand difference between thought and emotion. Emotions are one word.

• If the emotion doesn’t match the thought, then probe further - you may not be at the root of the situation.
  o “My mom didn’t pick up the phone and I thought ‘what if something happened to her?’ I felt sad.”
  o Probe further - “so the ring tone stops. What happened next?” “I get teary.” “What was going through your head?” “What if something happens to her? Then there’s no one left to care about me.” That’s the real underlying thought.

• Rate the intensity of the emotion to triage problems and gauge improvement in mood.
  o Let’s try to rate on a scale of 0 to 100%. 0 is no sadness at all, and 100% is the saddest you have ever felt.
  o Making a ruler: Let’s make a scale of when you felt sad in the past. When did you feel just a little bit sad? The saddest you’ve ever felt? And in between? Now how did you feel in this situation?
  o If a past event: How much did you feel [negative emotion]/believe [belief] then? How much do you feel it now?
  o Situations that are minor in sadness might not be worth exploring further.

Evaluating Automatic Thoughts

• Never challenge a belief. This violates the collaborative empiricism.

• Socratic Questions that help them gain distance:
  o What is the evidence that your thought is true? What is the evidence on the other side?
  o What is an alternative way of viewing this situation? What else could explain the person’s behavior/the outcome?
  o What’s the worst that could happen? How would you cope with this situation? (may give solutions to help) What’s the best that could happen? What’s the most realistic outcome of this situation? (especially if patient has a catastrophic response)
  o What is the effect of believing your automatic thought? What could be the effect of changing your thinking?
  o If your friend were in this situation and had the same automatic thought, what advice would you give him/her?
  o What should you do going forward? How likely are you to do this?

• Can vary the questions for more advanced patients:
  o Is it true that [extreme assumption, eg you need to make your mom happy at all times] always has to be true?
  o Is it reasonable to expect that sometimes [the situation] will happen?
  o Is it desirable to have [extreme goal]?

• Patterns of cognitive distortions
  o Catastrophizing - imagining the worst possible thing that could happen
  o Selective bias/tunnel vision/discounting the positive - focusing and emphasizing negative
evidence for, ignoring or de-emphasizing positive evidence against

- All-or-nothing - either you get an A or you’re a total failure
- Mind reading - assuming negative intent or belief of other people, without considering other possibilities
- Emotional reasoning - because you feel it so strongly, it must be true
  - I feel like a failure all the time, so it must be true
- Exaggeration, or over-generalization
- Should and must statements - a precise fixed idea of how people should behave. Overestimate how bad it is if these expectations are failed.

- When automatic thoughts are true
  - Focus on problem solving
  - Investigate whether patient has drawn an invalid conclusion
  - Work on acceptance

- Comforting lines
  - We’ll keep practicing this until it becomes easy.
  - (If difficult to get thoughts) Sometimes these thoughts are hard to catch. No big deal.

- Ask about patient’s current mood and how much they believe the automatic thought.
  - [This only works if the patient isn’t just telling you what she thinks you want to hear.]
- If after examination there is no mood improvement, a deeper root issue may be at hand.
  - The automatic thought may be too superficial. Other thoughts, images, or assumptions remain.
    - “I was thinking that I would fail the test.” -> “I was thinking I can’t do anything right. I saw my parents laughing at me.”
  - Evaluation of the automatic thought is implausible, superficial, or inadequate.
    - “I’ll get my work done for sure.”
  - Patient has not sufficiently expressed the evidence in support of the automatic thought.
    - Don’t skip after one response. Ask if there’s any other evidence in support of the thought, or against.
  - The person believes the new thought rationally, but doesn’t feel it emotionally. (often because of an underlying belief)
  - The automatic thought may be an inner belief. These need more intervention to change.

- Teach the patient to examine thoughts herself. Often 1-2 specific questions will work better than other questions.
  - Patients can keep a Thought Record or “Testing your Thoughts” worksheet, which goes through the whole Socratic questioning above.
    - Date/Time
    - Situation - What event or stream of thoughts led to the unpleasant emotion? What distressing physical sensations did you have?
    - Automatic thoughts - What thoughts or images went through your mind? How much did you believe each at the time?
    - Emotions - What emotion(s) did you feel at the time? How intense was the emotion?
    - Adaptive response - What cognitive distortion did you make? Use (Socratic) questions at bottom to compose a response to the automatic thought. How much do you believe each response?
    - Outcome - How much do you now believe each automatic thought? What emotion
do you feel now? How intense is the emotion? What will you do/what did you do?
  - Note to patient that this is a general tool, that it may not work all the time, and that relieving the emotion by 10% is worth it.
    - For some people, consider audio recordings of the main points, rather than written notes.
  - Not every thought needs to be examined. It might be more helpful to focus on a more distressing thought, teach other parts of the cognitive model, avoid distress.
  - With experience, patient can skip questions, going directly to examining alternatives and forming an adaptive response.

**Behavioral Experiments, Behavioral Activation**

- Cognitions are linked to patients’ negative predictions. **The goal of behavioral experiments is to show the mismatch between a patient’s negative prediction and the reality of the outcome.**
- Depressed people often have inactivity as a core problem. They deprive themselves of opportunities for pleasure or mastery, and they engage in dysphoric activities (sleeping, lying in bed) that may offer short-term relief from their negative automatic thoughts.
  - Even when they do pleasurable activities, their automatic thoughts may make it displeasurable. (“I’m doing a terrible job. I can’t do this as well as I used to.”)
- Use the patient’s daily schedule as an opportunity to spot positive things not done; negative things done too much; good balance between pleasure and mastery.
  - Ask how the activities make them feel. Probably bad. Then normalize: “Most depressed people think they’ll feel better in bed. But usually they find that doing anything else is better.”
- Anticipate barriers to executing the experiment.
  - If sensing hesitation from patient, ask what automatic thought crossed her mind.
    - If she doesn’t offer it, say the opposite: “were you thinking about what a good time you’d have?”
    - Confront the automatic thought by asking what evidence she has to support it, or contravene it.
  - Reduce the time delay - schedule an action today.
  - **Find the version of the behavior that is easiest** - finding the right friend to ask out, the easiest physical activity to resume.
  - If the behavior is too imposing, find an easier behavior to start with. Ask what takes less energy.
  - Preempt negative feelings if the experiment fails: “what would you feel if your friends said no to hanging out?”
  - If they have no ideas on what’s enjoyable, give a list of 5-10 activities and ask which are most enjoyable.
- Use an hourly activity chart to pan out the day. Plan in rest sessions.
  - Patient should write in the chart herself.
- Rate the sense of mastery and pleasure the person gets.
  - Create a scale of 0, 5, 10 for pleasure and mastery.
  - Rate activities done, and predictions of activities to come.
Ideally the real ratings contradict their predictions.

- Within the session, collaboratively design experiments that patients can conduct right in the session itself.
  - A depressed patient might have the automatic thought, “I won’t be able to concentrate on reading anything.” The experiment could be to read a passage from a book and summarize it for you, to see what degree the thought is valid.
- Teach patient to give herself credit when she does a good behavior or detects an automatic thought.
  - “Good. I did it.”
  - Even if these behaviors used to be easy in the past, being depressed makes it harder. So you deserve credit. When you’re over the depression, you don’t have to give yourself credit.

**Example discussion**

This discussion pieces together identifying automatic thoughts, evaluating them, and creating a behavioral experiment.

- Therapist: OK, Sally, you wanted to talk about finding a part-time job?
- Patient: Yeah, I need the money, but...I don’t know.
- Therapist: [noticing dysphoria] What’s going through your mind right now?
- Patient: [automatic thought] I don’t think I can handle a job.
- Therapist: [labeling the idea as a thought and linking to her mood] And how does that thought make you feel?
- Therapist: [beginning to evaluate the thought] What’s the evidence that you won’t be able to work?
- Patient: I’m having trouble getting through my classes.
- Therapist: What else?
- Patient: I’m so tired. It’s hard for me to even go and look for a job, much less go to work every day.
- Therapist: In a minute we’ll look at that. [suggesting an alternative view] It’s possible that it’s harder for you to look for a new job, rather than keeping up with a job that you already have. Is there any other evidence that you couldn’t handle a job, assuming you can get one?
- Patient: No, nothing comes to mind.
- Therapist: [evidence on other side] Is there any evidence on the other side, that you might be able to handle a job?
- Patient: I did work last year. That was on top of school too. But this year...I don’t know.
- Therapist: Is there any other evidence you could handle it?
- Patient: I don’t know...It’s possible I could do something that doesn’t take much time and isn’t too hard
- Therapist: What might that be?
- Patient: A sales job, maybe, like last year.
- Therapist: [helping build concrete solutions] Any ideas of where you could work?
Patient: Maybe the bookstore. I saw a job posting about it.
Therapist: OK. And what would be the worst that could happen if you could get a job there?
Patient: I’d get overwhelmed and fail.
Therapist: If that happened, how would you cope?
Patient: I guess I’d quit.
Therapist: What would be the best that could happen?
Patient: I guess it’d be that it’d be easy and I could do it.
Therapist: What’s the most realistic outcome?
Patient: It probably won’t be easy at first, but I might be able to do it.
Therapist: Sally, what’s the effect of believing your automatic thought, “I won’t be able to handle a job?”
Patient: Makes me feel sad and not even want to try.
Therapist: And what’s the effect of changing your thinking, of realizing that you realistically could work in the bookstore?
Patient: I’d feel better. I’d apply for the job.
Therapist: So what do you want to do about this?
Patient: Go to the bookstore and apply for the job.
Therapist: When will you go?
Patient: I guess this afternoon.
Therapist: How likely are you to go?
Patient: Pretty likely. I’ll go.
Therapist: How do you feel now?
Patient: A little better. A little more nervous. But hopeful.

Example coping card from the discussion: “If I avoid going to the bookstore, remind myself that I probably could handle a job there and I could always quit if it didn’t work out. It’s not a big deal.”

Identifying Intermediate Beliefs

- After the first session, you can begin building a cognitive conceptualization of the patient, linking formative experiences -> core beliefs -> intermediate rules, assumptions, and beliefs -> coping strategies -> automatic thoughts and reactions
  - Share conceptions as hypotheses. Avoid making the patient feel categorized or put in a box.
- Given the same core belief, people may have different intermediate beliefs.
  - “I’m not good enough to accomplish my goals.” -> “I should work as hard as I can at all times.” OR “I should lower my goals so I don’t get disappointed.”
    - This can be because of genetic predisposition or early environmental cues.
- Identifying intermediate beliefs
  - The patient may voice it, as an automatic thought or when directly asked.
  - Provide the first part of an assumption, and the patient fills it in.
    - “If I don’t get an A, then ___”
  - Spot patterns to automatic thoughts
Downward arrow technique

- **Ask what the automatic thought means to the person.** (Asking what the thought means about the person tends to show the core belief.)
  - “If that’s true, so what?” “What’s so bad about…” “What’s the worst part about…”
- Use questionnaires like the Dysfunctional Attitude Scale or Personality Belief Questionnaire

- Keep probing until you cause negative affect or patient repeats the words. This is about as deep as you can go.
- Educating the patient about beliefs
  - Show the patient how beliefs are learned and mutable.
  - Ask patient to think about someone who has different beliefs. Clearly the other person learned different beliefs, and so they’re not absolute rules. Also clearly the other person isn’t a failure (or whatever the extreme belief is).
- Examine advantages and disadvantages of beliefs
- Ask if this is an idea the patient would like to change

- In comparison to automatic thoughts, modifying intermediate beliefs may require more persuasion than just Socratic questioning. The key is to clarify the dissonance of the patient’s beliefs; deeper beliefs may require more visceral and narrative depictions.

  - **Phrase the rule/belief as an assumption** - this makes it easier to spot the logical fallacy.
    - “If I ask for help, I’ll be seen as weak.” vs “Don’t ask for help.”
  - Present more functional beliefs, that are more qualified versions of the old belief
    - “If I don’t get an A, I’m a failure.” -> “If I don’t get an A, I’m just human, and I still tried hard. It’s better than 0%.”
  - Socratic questioning
    - “Let’s say there are 2 people with the same problem. One does maladaptive behavior and feels worse. The other does functional behavior and feels better. Who’s more competent?”
  - Behavior experiment
    - **Act “as if” the belief weren’t true.**
  - Role play as the patient’s intellectual side and emotional side
    - Give rationale to patient that this will let you see what’s really maintaining the belief.
    - Be the intellectual side first to scaffold the reasoning for patient.
    - Switch sides. The patient will voice the more functional intellectual thoughts. Use the patient’s own words for the emotional side.
  - Cognitive continuum - establish that the situation isn’t binary, and the patient belongs somewhere better than absolute zero
    - Ask where she is on the scale. Then ask whether there is someone who is worse, and what that person would be doing. Keep drilling until it’s someone who’s at absolute zero (goes to zero classes).
    - Useful for “all or nothing” cognitive distortion
  - Ask the patient to imagine another person with a different belief. Then if that person is respected, model that belief for herself.
  - Ask the patient to counsel someone else:
    - Someone she knows who has the same issue
    - Their child who has the issue
○ Self-disclosure (you’ve gone through a situation before and came up with a solution.)
    ○ Assign homework to look for situations to practice the new belief and behavior.
    ○ It may be better to stop before modifying it to 0% belief level. Less than 30% is usually sufficient.

### Identifying Core Beliefs

- In mood disorders, negative core beliefs can be activated at all times, in contrast with “normally functioning” people, where they are activated only occasionally.
- **Core beliefs tend to be categorized into three types:**
  - Helplessness
    - “I want to achieve more, but I’m not capable of it.”
    - Other thoughts: “I’m vulnerable. I’m a victim. I’m a failure.”
  - Unlovableness
    - “I’m not worthy of being loved by others.”
    - Other thoughts: “I’m undesirable. I’m bound to be alone. I’m defective so others won’t love me.”
  - Worthlessness
    - “I’m bad. I’m fundamentally not worthy of good things.”
    - Other thoughts: “I’m evil. I don’t deserve to live.”
- Clarify a general statement to fit into the correct category.
  - “I’m not good enough.” can be “I’m not good enough to achieve more.” or “I’m not good enough to be loved.”
- Core beliefs are often formed through early childhood experiences. To elucidate them:
  - When patient recounts a recent situation causes negative affect, ask her to vividly imagine the present situation to intensify the affect. Ask where she feels the affect in her body.
  - Then ask when the earliest she can remember feeling this feeling in the past was.
- Techniques to correct core beliefs
  - All the above techniques to address automatic thoughts and intermediate beliefs.
  - Set positively adjusted core beliefs, rather than extreme core beliefs.
    - “I can’t do anything right.” -> “I can do most things right, and there’s a good reason for when I get something wrong.” NOT “I can do everything right.”
  - Keep a Core Belief Worksheet with two columns:
    - Evidence supporting new belief
      - If patient sees someone else doing something positive, ask whether she’s doing it herself and should give herself credit. Or visualize someone else doing what she’s doing.
      - If anything that, if it wasn’t done, would be negative data (eg going to class), it belongs in positive data.
    - Evidence supporting old core belief, with a reframe
      - “I got a B on the test, **BUT** this isn’t a total failure. If I were really incompetent, I wouldn’t be here.”
      - “I didn’t understand something in class, **BUT** the teacher may not have explained it well, and I didn’t read about it.”
Historical tests of the Core Belief
- Look back on major periods of patient’s life to find evidence that supports and contradicts the core belief
- Summarize each major period, often with reframings of the core belief to be more qualified
  - Eg “during high school, I was highly functioning. In college, I struggled more, but I still graduated and made it out.” etc.

Role playing an early childhood experience.
- Rationally discuss alternative explanations for the experience
  - Eg mom yelled at patient for poor grades because the mom was embarrassed among her peers
- Therapist role plays as the younger patient, but mounting a rational resistance against the traumatizer. Patient plays role of the traumatizer (eg the parent). The roles switch.
- Patient role plays as an older version of herself sitting beside her younger self.
  - “What does older Annie say to 7-year-old Annie?” “7-year-old Annie, do you believe her?”

Additional Techniques
- Making decisions - make a list of advantages and disadvantages of each option. Score each entry to help make the ultimate decision.
- Refocusing - when attention veers to distracting automatic thoughts, rather than evaluating their automatic thoughts, instead refocus attention on the task at hand
- Distraction - get mind off of automatic thoughts
  - Ask what has worked in the past
  - Watch TV, go for a walk, email a friend, clean desk, browse the web
- Exposure - keep engaging the object of concern until the negative affect dissipates
  - Patients often have safety behaviors - avoidances that ward off anxiety but perpetuate the fundamental problem
  - Make predictions and cross off ones that didn’t come true
- Graded task assignments - reaching an ultimate task (eg landing a job) may be intimidating. Break the task into its constituent stepwise tasks to make each step jump less problematic (prepare resume, look at job postings, etc.)
  - Represent it visually with a staircase
- Role playing
  - Assume a positive outcome: “If you knew for sure the teaching assistant would be willing to talk to you, what would you say?”
- Pie technique - visually represent something of distress
  - Time spend on different activities, actual vs ideal
  - Attribution of causes for a situation (the most feared one is unlikely)
  - The likelihood of outcomes (the catastrophic one is unlikely)
• Self-comparison - establish a more reasonable self-comparison by showing the analogous headwinds facing the patient
  ○ We know that depression is a physiological issue. Would you expect someone with pneumonia to do everything flawlessly?
• Credit lists
  ○ Keep track of things that were positive or difficult to do.
  ○ Good stepping stone to Core Belief Worksheet

Imagery

• Often specific vivid images are a primary source of patient distress. Elucidating the image is important for recovery.
• Synonyms include mental picture, daydream, fantasy, memory.
• Techniques to improve imagery
  ○ Continue imagining beyond the image.
    □ Often the patient stops at the most distressing part. Continuing past the image often shows how the patient will resolve the situation capably.
    □ Picture what happens in the far future - weeks, months, years after the anxious image. Shows that things will likely resolve satisfactorily.
  ○ Rework the image to include coping behaviors.
    □ Ask leading questions to guide adaptive behaviors the patient could do in the situation.
    □ Could include coping behaviors like reading coping cards during the stressful situation.
    □ Homework to remember the positive image.
  ○ Rework the image to imagine a different outcome.
    □ Could be realistic - possible outcomes. Then talk about behaviors that could push toward this outcome.
    □ Could be magical - a scary person becomes a crying baby.
    □ Imagine the image multiple times in succession. The severity of the image should decrease.
• Use imagery as a therapeutic tool.
  ○ Induce an image of a situation. The patient rehearses coping techniques.

Homework Assignments

• Homework gives opportunities to practice new behaviors and thinking. Patients who regularly complete homework show better progress.
• Sessions should typically begin with review of homework completion, outcomes, and appropriateness for future work.
  ○ If patient didn’t complete homework, take blame for assigning too difficult an assignment
or not explaining it well enough.

- Set homework collaboratively. Get patient buy-in for homework assignment.
- Lean toward making homework assignments easy and completable than too hard. Aim for 90-100% likelihood of completion.
  - Ask patient for their own estimation of how likely they are to complete, from 0-100%.
  - It’s better to remove an assignment than to set the habit of not completing an assignment.
- Explain rationale of homework, often in terms of improving patient affect or in proven efficacy.
- Make homework no-lose - even if patient doesn’t complete homework, she’ll discover thoughts that prevent her from progress.
- Common homework assignments
  - Behavior activation - often initially more useful to improve affect than more intellectual tasks.
    - Eg do light exercise, make a phone call to friends.
  - Notice automatic thoughts
  - Evaluate automatic thoughts
  - Review therapy notes, read coping cards
    - “If I start to think that I can’t apply for a job, remind myself that I’m only going to do it for 10 minutes, that it may be difficult but probably won’t be impossible, and that the first minute will be hardest and then it’ll get easier.”
  - Problem solving - implement solutions devised during sessions
  - Behavior experiments, and learning data against negative thoughts
  - Reading other source material
  - Preparing for next therapy session
  - Set reminders to read over homework multiple times per day

- As therapy progresses
  - Patient may start proposing homework and giving rationale.
  - Tasks become more complex, diving deeper into cognitive model.
  - Some regular tasks remain, like reviewing therapy notes or doing credit list daily.

- Tactics to improve homework completion rate
  - Commitment devices
    - Daily checklists of tasks
    - Scheduling items in calendars
    - Patient leaves voicemail with doctor whenever finishing a task
  - Find barriers for doing homework, and problem solve
    - Rehearse the situation leading up to doing homework to find issues.
    - Practical barriers in freeing up time or forgetting
    - Mental barriers in overestimating time or effort; overcoming activation energy; believing it won’t work.
      - Ask what the worst that can happen is, and the best.
      - Remind patient that they’re not aiming for perfection.
  - Anticipate negative results of homework and address subsequent automatic thoughts
  - Start homework in session, so that offline homework is merely continuation of the task rather than completion.
Troubleshooting Sessions

- In general, problems can be a result of socialization (training the patient on what to do) or reluctance to comply (knows what to do, doesn't want to do it).
  - Distinguish between the two by socializing patient to CBT model. If patient gives a neutral reaction, then it's a socialization problem.
  - If patient is frustrated follow standard procedure, 1) thank for expressing thought, 2) investigate automatic thoughts, 3) provide rationale for what you're doing. Directly tackling automatic thoughts can work but sometimes it causes too much friction.
  - Causes could be therapeutic alliance; structure or pace of session; unrealistic patient expectations; lack of patient understanding of cognitive model; biology or external environment.

- Interruptions
  - To get the session on track to cover the most helpful items, you will have to interrupt. An effective way is to 1) Ask if you can interrupt, 2) Ask for what you want, or summarize what you're hearing, 3) Ask if that sounds right.
  - If upset at interruption, follow standard procedure above. Also apologize for interrupting, and ask if they would like to continue and leave some topics behind, or talk uninterrupted.

- Overstructured
  - If automatic thoughts reveal feeling boxed in, ask if person would like to begin session without agenda setting but just talking at length.

- Pitfalls
  - Failing to set patient expectations for therapy, and of his responsibilities.
  - Failing to emphasize key automatic thoughts
  - Failing to summarize frequently
  - Failing to summarize using patient’s own words
  - Failing to ask the patient for depth of understanding
  - Failing to provide rationale for agenda items or your direction
  - Failing to make a therapeutic intervention - just talking about problems without solving them or assigning homework
  - Failing to record therapy notes for patient to review

- Suggest recording session to patient so you can review with a colleague to get feedback.

- Beware of your own negative automatic thoughts about the patient, therapy, or yourself.
  - Instead of catastrophizing the problem, see it as an opportunity to refine your skills.

Planning for Termination and Relapse Prevention

- CBT is intended to be fixed in duration, teaching the patient to be her own therapist.
  - Make this known to the patient at the beginning, to prepare for the expectation.

- To help ease the transition, help patient attribute positive changes to herself, not to the therapist or external causes.
  - Patient needs to develop confidence about ability to solve her own problems.
  - The patient is the one who puts in the work, so the therapist should get only a portion of
As sessions end, patients should anticipate setbacks and prepare their responses.
- Chart out the patient’s likely affect over time. This can look like the southern border of the US - Texas and Florida are troughs.
- Role play how they’ll feel during a setback. Ask how they predict they’d feel. In response, answer the thoughts and create coping cards.

Make a list of tools patient has employed to deal with stressful situations:
- Identifying, responding to automatic thoughts
- Using thought records
- Scheduling activities
- Relaxation, distraction, refocusing techniques

Guide the patient to conduct self-therapy sessions, consisting of a template similar to normal therapy sessions.
- Review past week, mood check
- Review homework
- Review current problems and engage in problem solving
- Set new homework
- Schedule next therapy session

Prepare for the taper like any other stressful situation.
- Elicit advantages and disadvantages of tapering therapy, with disadvantages reframed.
  - “I might relapse.” -> “If I’m going to relapse, it’s better for it to happen while I’m in therapy so I can learn how to handle it.”
- Help respond to any distortions (eg catastrophizing a relapse)

Schedule booster sessions
- Having these pre-scheduled may motivate doing homework in between
- Reduces anxiety about being on their own
- Assign questions to answer beforehand about work has done in between, how problems were handled, what CBT work was done