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E ffective CBT requires you to evaluate clients thoroughly, so you can accurately formulate the case, conceptualize the individual client, and plan treatment. While there is overlap among treatments for various disorders, there are important variations as well, based on the cognitive formulation—the key cognitions, behavioral strategies, and maintaining factors—of a particular disorder. Attention to the client's presenting problems, current functioning, symptoms, and history, along with their values, positive attributes, strengths, and skills, helps you develop an initial conceptualization and formulate a general therapy plan. You hold the evaluation session before the first treatment session. Assessment isn't limited to the initial evaluation session though. You continue to collect assessment data at each session to confirm, change, or add to your diagnosis and conceptualization and to make sure clients are making progress. It's possible to miss a diagnosis if • you get incomplete information, • clients deliberately withhold information (e.g., some clients with substance use problems or ego-syntonic eating disorders may do this), and/or • you erroneously attribute certain symptoms (e.g., social isolation) to a particular disorder (depression), when another disorder is also present (social phobia). When another clinician has performed the evaluation, you will undoubtedly need to collect additional information pertinent to the use of CBT as the treatment modality. THE EVALUATION SESSION

In this chapter, you'll learn the answers to these questions: What are the objectives and structure of the evaluation session? How do you conduct the evaluation session? What do you do in Part 1 (starting the session)? What do you do in Part 2 (conducting the assessment)? What do you do in Part 3 (relating your diagnostic impressions, setting broad goals, and relating your general treatment plan)? What do you do in Part 4 (setting an Action Plan)? What do you do in Part 5 (establishing expectations for treatment)? What do you do in Part 6 (summarizing the session and eliciting feedback)? What do you do between the evaluation and the first treatment session? It will likely take between 1 and 2 hours (or possibly more) to conduct the evaluation session. OBJECTIVES FOR THE EVALUATION SESSION Your objectives for the evaluation session are to • collect information (both positive and negative) to make an accurate diagnosis and create an initial cognitive conceptualization and treatment plan, • determine whether you will be an appropriate therapist and can provide the appropriate "dose" of therapy (level of care, frequency of sessions, and duration of treatment), • figure out whether adjunctive services or treatment (such as medication) may be indicated, • initiate a therapeutic alliance with the client (and with family members, if relevant), • educate the client about CBT, and • set up an easy Action Plan. Cognitive

It's desirable to collect as much information as possible before the evaluation session. Request that clients send, or arrange to have sent, relevant reports from current and previous clinicians, including both mental health and health professionals. The evaluation session itself will require less time if clients are able to fill out questionnaires and self-report forms beforehand. It's especially important that clients have had a recent medical checkup. Occasionally, clients suffer from organic problems, not psychological ones. For example, hypothyroidism can be mistaken for depression. It's good practice to inform the client during the initial phone call that it's often useful to have a family member, partner, or trusted friend accompany the client to the evaluation session to provide additional information and/or to learn how he or she can be helpful to the client. Make sure clients understand that the evaluation will help you determine whether they are good candidates for CBT and whether you believe you will be able to provide the needed treatment. STRUCTURE OF THE EVALUATION SESSION In this session, you • greet the client, • collaboratively decide whether a family member or friend should participate in the session, • set the agenda and convey appropriate expectations for the session, • conduct the psychosocial assessment, • set broad goals, • relate your tentative diagnosis and your broad treatment plan and educate the client about CBT, • collaboratively set an Action Plan, • set expectations for treatment, and • summarize the session and elicit feedback. At this session or the first treatment session, you'll also fulfill the ethical and legal requirements where you practice. If you work in an area that doesn't have such requirements, it's still a good idea to have clients read and sign a consent to treatment form that includes such items as risks and benefits of treatment, limits of confidentiality, mandatory reporting, and privacy of records.

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PART 1: STARTING THE EVALUATION SESSION Before clients enter your office, review whatever records they have brought and the forms they've completed. It's usually desirable to meet with clients alone at first. At the beginning of the session, you can discuss whether the client wants an accompanying family member or friend (if there is one) to attend none, part, or all of the session. It's often helpful to bring this person in at least toward the end of the session, as you convey your initial impressions (including tentative diagnosis) and review broad therapy goals. You can ask for the family member/friend's perspective on the client's problems and, if advisable, set the scene for this individual to return at some point to learn more about what he or she can do to be helpful to the client. Setting the Agenda Start the session by introducing yourself and setting the agenda. Judith: Abe, as I explained on the phone, this is our evaluation session. It's not a therapy session, so we won't work on any issues today. We'll start doing that next time. (pause) Today, I need to ask you a lot of questions [providing a rationale] so I can make a diagnosis. Some of the questions will be relevant. Some won't be, but I need to ask them so I can rule in the problems you have and rule out the problems you don't have. [being collaborative] Is that okay? Abe: Yes. Judith: I'll probably need to interrupt you a few times, so I can get the information I need. If it bothers you, would you let me know? Abe: Yes. Judith: Before we begin, I'd like to tell you what to expect. This is what we call "setting the agenda," and it's something we do at every session. Today, I need to find out why you're here, and I'll ask you about the symptoms you've been having, how you've been functioning lately, and about your history. (pause) All right? Abe: Yes. Judith: Second, I'm going to be asking you what's going right with your life and when the best period of your life was. Then I'll

ask you to tell me anything else you think I should know. Does that sound okay? Abe: (Nods.)

Judith: Third, I'll tell you what I think your diagnosis is, but I may need to look over your records and forms and my notes and talk to you more about it next week. Fourth, I'll tell you what I think we should focus on in treatment. (pause) And along the way, I'll be telling you more about CBT, and I'll ask you how it all sounds. (pause) At the end, we'll set some broad goals for how you'd like your life to be different. Then I'll ask you whether you have any questions or concerns. Okay? Abe: Yes. Judith: Anything else you want to cover today? Abe: Well, it would be good to know how long therapy will last. Judith: (making a note) Good question. We'll talk about that toward the end of the session. Abe: Okay. PART 2: CONDUCTING THE ASSESSMENT Areas of Assessment You need to know about many aspects of the client's current and past experience to develop a sound treatment plan across sessions, to plan treatment within sessions, to develop a good therapeutic relationship, and to carry out effective treatment. (See Appendix B for Abe's Case Write-Up, which includes many different areas you need to ask clients about; you can download an outline with specific questions at beckinstitute.org/CBTresources.) While a detailed account of assessment procedures and instruments are beyond the scope of this book, many sources can help, including Antony and Barlow (2010), Dobson and Dobson (2018), Kuyken and colleagues (2009), Lazarus and Lazarus (1991), Ledley and colleagues (2005), and Persons (2008). Note that it is critical to determine the degree to which clients might be homicidal or suicidal. Wenzel and colleagues (2009) provide assessment and practice guidelines for suicidal clients, as does an online course on suicidality (beckinstitute.org/CBTresources). Eliciting a Description of a Typical Day Another important part of the evaluation (or the first treatment session) is asking clients how they spend their time. This description gives you additional insight into their daily experience, facilitates goal setting, and helps pinpoint positive activities that you can encourage

them to engage in more frequently. It also helps you identify activities clients are spending too much or too little time doing. As clients describe a typical day, take notes and look for • variations in their mood; • the degree to which they are interacting with family, friends, and people at work; • their general level of functioning at home, work, and elsewhere; • how they're spending their free time; • activities that bring them a sense of pleasure, accomplishment, and/or connection; • self-care activities; and • activities they're avoiding. Judith: Abe, I'd like to get an idea of what your daily routine is like. Can you tell me what you do from the time you wake up in the morning until the time you go to sleep at night? Abe: Okay. (Sighs.) Well, I usually wake up around 7 o'clock. Judith: Then what do you do? Abe: Usually I toss and turn for a couple of hours, or I just doze. Judith: What time do you get out of bed for the day? Abe: It depends. Sometimes not until 10. Judith: What do you do when you first get out of bed? Abe: I usually have coffee and a little breakfast. Some days I get dressed. Some days I don't. Judith: What do you do after breakfast? Abe: I usually just stay home. Watch TV or waste time on the computer. Judith: What else do you do in the afternoon? Abe: Sometimes I just sit on the couch doing nothing. If I have enough energy, I might run an errand, get some food. But usually I don't. Judith: Do you have lunch? Abe: I just grab some snack food. Judith: Anything else you do in the afternoon? Abe: I might do one thing, like a load of laundry. Sometimes I try to read the newspaper. But I usually just fall asleep. Judith: Do you take a nap most days? Abe: Yeah. Maybe for an hour or two.

Judith: What do you do for dinner? Abe: I usually put a frozen dinner in the microwave. Judith: What do you do after that? Abe: Not much. Watch TV. Surf the web. Judith: And when do you get in bed? Abe: Around 11 or so. Judith: Do you fall asleep right away? Abe: Not usually. It sometimes takes a really long time. Judith: And then do you sleep through until 7 o'clock? Abe: Sometimes. But sometimes I'm up for a couple of hours around 3 o'clock. Next, I ask Abe if his weekends are different from his typical weekday. Fortunately, he's a bit more active. He sometimes attends his grandson's games or visits with one of his two children and their family. He told me there had been a change in his routine about a year before. Until then, even though he was moderately depressed, he routinely had breakfast with two buddies on Saturdays and attended church on Sundays. Collecting data in this way guides your thinking in developing an initial treatment plan. You'll also use the information in the first session when you set goals for treatment and do activity scheduling. Responding to Hopelessness and Skepticism Throughout the evaluation, you'll be alert for indications that the client is unsure about committing to treatment. As Abe describes his current symptoms, he expresses hopeless thinking. I use his automatic thoughts to subtly relate the cognitive model, indicate how thoughts like these would be a target of treatment, and ensure that our tentative alliance hadn't suffered. CLINICAL TIPS When clients offer you too much information, you can structure their responses so you'll have time to accomplish what you need to. Providing a guideline can help—for example: "For the next few questions, I just need you to answer 'yes,' 'no,' or 'I'm not sure' [or 'in one or two sentences']." When clients start to provide unneeded details or go off on a tangent, it's important to gently interrupt: "Sorry to interrupt, but I need to know. . . . "

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Abe: It feels like I've got so many problems. I'm not sure anything can help. Judith: Okay, it's good you told me. That's an interesting thought: "I don't think anything can help." How does that thought make you feel? Sad? Hopeless? Abe: Both. Judith: This is exactly the kind of depressed thought that we'll be talking about starting next week. We'll need to find out whether that thought is 100% true, 0% true, or someplace in the middle. Meanwhile, is there anything I said or did that leads you to think I can't help, or that this kind of treatment can't help? Abe: No . . . Judith: What makes you think it might not work? Abe: I don't know. My problems just feel overwhelming. Judith: Good to know. And given your depth of depression, I'm not surprised. We'll take your problems one at a time and do problem solving together. I want you to know, you're not alone anymore. You've got me on your team. Abe: (Sighs in relief.) Okay, good. Judith: Now I don't have a crystal ball, so I can't give you a 100% guarantee. But there's nothing you've told me that makes me think it won't work. (pause) And there are a lot of things that make me think it will work. Should I tell you some of them? Abe: Yeah. Judith: You're obviously intelligent and very capable. You accomplished a lot and functioned highly before you got depressed. For many, many years, you did really well at work. You got promoted. You prided yourself on doing a good job. You were productive and reliable. You were a good father and you tried to be a good husband. Also, you had good friends and you helped other people. All of these are good signs. Abe: Okay. Judith: So, what do you say? Are you willing to give it a try? Do you want to come back next week? Abe: Yeah, I do. CLINICAL TIPS When clients express concern because previous treatment hasn't worked, positively reinforce them ("It's good you told me that") for Cognitive Behavior Therapy: Basics and Beyond

expressing their skepticism or misgivings. Ask whether they felt they had a good relationship with their previous therapists and whether, at every session, their therapists • set agendas, • figured out with them what they could do to have a better week, • made sure the most important points of the session were recorded for them to review daily at home, • taught them how to evaluate and respond to their thinking themselves, • successfully motivated them to change their behavior, and • asked for feedback to make sure therapy was on the right track. Most clients have not experienced this kind of treatment, and you can say, “I’m glad to hear that your previous therapists didn’t do all these things. It sounds as if our treatment here will be different. If it were exactly the same as your past experiences, I’d be less hopeful.” Don’t take clients’ reports at face value if they say that a previous therapist engaged in all these activities at every session. Do spend more time finding out precisely what occurred, especially whether the therapist provided treatment individualized for the client and his/her specific disorder(s), based on the latest research and practice guidelines. In any case, you can encourage the client to give your treatment a try for four or five sessions and indicate that you and the client can then review how well treatment is working. Seeking Additional Information Toward the end of the assessment, it’s useful to ask clients two questions: “Is there anything else that’s important for me to know?” and “Is there anything you’re reluctant to tell me? You don’t have to tell me what it is. I just need to know whether there’s more to tell, maybe some time in the future.” Involving a Trusted Person If a family member/friend has accompanied the client to the office, you might now ask the client whether he or she would like to invite the individual into the session (unless, of course, this person has been there from the beginning). Make sure there is nothing the client wants you to refrain from saying. Elicit the client’s agreement for you to

• inquire what the family member/friend thinks is most important for you to know; • ask about the client’s positive qualities, strengths, and helpful coping strategies; • review your initial diagnostic impressions; and • present your tentative treatment plan and elicit feedback. If the client doesn’t want you to talk about all these topics or wants you to address something else, make a collaborative decision to do so, or provide a rationale for why you don’t think it’s a good idea. PART 3: RELATING YOUR DIAGNOSTIC IMPRESSIONS, SETTING BROAD GOALS, AND RELATING YOUR GENERAL TREATMENT PLAN Diagnostic Impressions When you aren’t confident of clients’ diagnoses, explain that you will need time to review your notes, their forms, and previous reports. For many clients though, it’s appropriate to give your initial impression of their diagnosis(es) and offer hope that you can help them. Judith: Abe, you certainly are depressed. Next week, we’ll talk about how I know that. Okay? Abe: Okay. Judith: The good news is that depression is treatable, and cognitive behavior therapy has been shown in dozens and dozens of studies to be effective for this condition. Setting Goals and Relating Your General Treatment Plan Setting goals often stimulates hope (Snyder et al., 1999), as does describing a treatment plan that makes sense to clients. It’s important for them to get a concrete idea of how it is that they will recover from their condition. When you relate the treatment plan, make sure to elicit feedback. Judith: Now I’d like to set some broad goals with you and tell you how I think you’re going to get better and then I want to hear how it sounds to you. Abe: Okay.

Judith: (Writes “Goals” at the top of a sheet of paper and gives a copy to Abe at the end of the session.) I know you told me you’d like to get over your depression and be less anxious, right? Abe:

Yes. Judith: Would another good goal be to help you have a sense of wellbeing? Abe: Yeah, that's really important. Judith: Based on what you told me, we'll also work on helping you function better at home and, when you're ready, start reconnecting with people and looking for a job. Abe: That sounds good. Judith: [to avoid Abe's becoming overwhelmed] We'll do all of this step by step, so it doesn't feel overwhelming. (pause) How does that sound? Abe: (Sighs in relief.) Good. Judith: Next week, I'm going to find out what's really important to you and what you want for your life. Then we'll set more specific goals for treatment. At every session, we'll be working toward your goals. For example, next week you might say that you want to reconnect with a friend or start doing more around your apartment. We'll figure out what obstacles could get in the way and we'll do some problem solving. (pause) Does that sound okay? Abe: Yes. Judith: In fact, about half of what we'll do in therapy is problem solving. The other half is teaching you skills to change your thinking and how you behave. We'll especially look for depressed thoughts that could get in your way. For example, earlier in today's session you said, "I can't do anything right" and you told me how depressed you feel when you have thoughts like that. Do you see how that idea can affect your motivation to get off the couch? How it can make you feel terrible? How you might then keep watching television instead of getting busy? Abe: Yeah, that's what happens. Judith: So one thing we'll do together is evaluate thoughts like that. What's the evidence you can't do anything right? Any evidence that's not true, or not 100% true? Could there be another way of looking at this situation? For example, maybe we'll discover that because you're so depressed, you need some help in problem solving or motivating yourself. But needing help doesn't necessarily mean you do everything wrong. Abe: Hmm.

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Judith: Here are three things we'll do. One, we'll work together to help you change your depressed and anxious thinking to make it more realistic. Two, we'll come up with things for you to try so you can move closer to improving your life and creating the life you want. Three, you'll learn skills you can use during the week and actually for the rest of your life. (pause) How does that sound? Abe: It makes sense. Judith: So that's going to be our general treatment plan: set goals, start working toward them one by one, and learn skills. In fact, that's how people get better, by making small changes in their thinking and behavior every day. [asking for feedback] Now, was there anything I just said that didn't sound good? Abe: No, it makes sense. PART 4: SETTING THE ACTION PLAN Creating an easy Action Plan with clients at the evaluation gets them accustomed to the idea that it's important for them to carry on the work of the session throughout the week. Make sure you keep a copy of Action Plans yourself. Here's how I transitioned from relating the treatment plan to setting Abe's Action Plan. Judith: Good. I'll write down some of what we just talked about so you can look at it during the week [Figure 5.1]. What should we call the things you're going to do between sessions? Your Action Plan? Self-help activities? Something else? ACTION PLAN May 6 Put this Action Plan next to the coffee maker and read it every morning and again later in the day. 1. Therapy Notes: When I start to feel more depressed, remind myself that the therapy plan makes sense. With Judy's help, I'll be working toward goals every week, step by step. I'll learn how to evaluate my thinking, which may be 100% true, or 0% true, or somewhere in the middle. The way I'll get better is by making small changes in my thinking and behavior every day. 2. Take grandchildren out for ice cream. 3. Give myself credit for doing all of the above and for doing anything that's even a little difficult—because I do it anyway. FIGURE 5.1. Abe's evaluation Action Plan. Cognitive Behavior Therapy: Basics and Beyond

Abe: Action Plan is good. Judith: Do you think you could read this Action Plan twice a day, once in the morning and once later on, especially if you start to feel more depressed? Abe: Yeah, I can do that. Judith: How will you remember to read it? Abe: I'll put it next to the coffee maker. I have coffee every morning, so I'll see it. Judith: And every time you read it, I'd like you to give yourself credit. Abe: Okay. Judith: You know, when people are depressed, it's like they're trying to walk through quicksand. Everything is harder. Have you found that? Abe: Yeah. Judith: So actually, I'd like you to give yourself credit whenever you do anything on your Action Plan and anything that's even a little bit hard but you do it anyway. You can just say something like "It's good I did that." (pause) Could you try giving yourself credit this week? Abe: Yeah. Judith: Okay, I'll write that down, and we'll talk more about credit next week. Now what do you want to remind yourself if you start to feel hopeless? Abe and I then jointly composed the following: "When I start to feel more depressed, remind myself that the therapy plan makes sense. With [my therapist's] help, I'll be working toward goals every week, step by step. I'll learn how to evaluate my thinking, which may be 100% true, or 0% true, or somewhere in the middle. The way I'll get better is by making small changes in my thinking and behavior every day." Judith: So, you'll do most of the work of therapy between sessions. (pause) I wonder if there's something meaningful you could do this week to demonstrate to yourself that you can make a change. (pause) Could you do something you haven't done for a while, maybe with a family member? Abe: (Thinks.) I could take my grandchildren out for ice cream. Judith: Excellent. And when you do, could you tell yourself that this is

an important first step in taking control of your depression? And give yourself credit? Abe: Yes. Judith: Should I write that down? Abe: Yeah. PART 5: ESTABLISHING EXPECTATIONS FOR TREATMENT It's important to give clients reasonable expectations for treatment (Goldstein, 1962). Doing so can help reduce the possibility of termination (Swift et al., 2012) and lead to better treatment outcomes (Constantino et al., 2012). You should give clients a general sense of how long they should expect treatment to take. Usually it is best to suggest a range, 2 to 4 months for many clients with straightforward major depression, although some might need fewer sessions (or be constrained by finances or insurance). Other clients, particularly those with chronic psychiatric disorders, or those who are comorbid with substance use or personality disorders, may require more treatment. Clients with severe or recurrent mental illness may need more intensive treatment when they are more highly symptomatic, and periodic booster sessions for a very long time. Many clients make progress with weekly sessions. But if their symptoms are severe or their functioning is at quite a low level, they may need to see you more frequently, especially initially. Toward the end of treatment, you will gradually space sessions farther apart to give clients more opportunities to function independently. Here's how I give Abe an idea of how I expected therapy would proceed. Judith: If it's okay with you, Abe, we'll plan to meet once a week until you're feeling significantly better, then we'll move to once every 2 weeks, then maybe once every 3 or 4 weeks. We'll decide how to space out therapy together. Even when we decide to end, I'll recommend that you come back for a "booster" session once every few months for a while. (pause) Okay? Abe: Yeah. Judith: It's hard to predict now how long you should be in therapy. My best guess, given how severe your depression is, is somewhere around 15 to 20 sessions. If we find that you have some long- standing issues that you want to work on, it could take longer. Again, we'll decide together what seems to be best. Okay?

PART 6: SUMMARIZING AND ELICITING FEEDBACK At the end of the evaluation, you'll summarize the session to give the client a clear picture of what was accomplished. First, remind the client that treatment will start next week. Then elicit the client's reaction to the session. Here's what I say to Abe: Judith: Okay, I'd like to summarize what we covered today, if that's all right. I told you that this is an evaluation session, not a therapy session, and that we'd really start to work on reaching your goals and solving your problems next week. Right? Abe: Yeah. Judith: I asked you lots of questions, and I gave you a tentative diagnosis. You told me how you spend your time on a typical day. I told you a little about how your thoughts can make you feel depressed and that when people are depressed, their thoughts may be true or they may be not true. Right? Abe: Yes. Judith: I also told you a little about this kind of therapy and what I thought your treatment plan should focus on, and we created an Action Plan for you for the coming week. Then we discussed the mechanics of treatment, for example, how often we'll meet and how long treatment will last. (pause) Any final questions? Or was there anything you thought I got wrong or didn't understand? Abe: No, I think you understand me pretty well. Judith: Good. Then I'll see you next week for our first therapy session. ACTIVITIES BETWEEN THE EVALUATION AND FIRST TREATMENT SESSION Before the first therapy session, you'll write up your evaluation report and initial treatment plan. If you haven't already done so, you'll obtain consent and contact the client's previous mental health and health professionals to request reports, ask questions, and obtain additional information. You'll also contact relevant current professionals to discuss your findings and coordinate care. Talking by phone to other professionals often reveals important information that had not been documented in writing. You'll also start to devise a tentative cognitive conceptualization and an initial treatment plan. (See also Chapters 3 and 9.)

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SUMMARY In your initial session with a client, you will conduct a thorough assessment to collect data so you can accurately conceptualize and diagnose your client and plan treatment. You seek to accomplish many objectives, including developing the therapeutic relationship, increasing the client's hope, educating the client about CBT and the cognitive model, addressing hopelessness and skepticism, setting broad treatment goals, relating your general treatment plan, setting an Action Plan, establishing expectations for treatment, and summarizing and eliciting feedback. Following this session, you confirm the diagnosis and, when relevant, contact former and current health and mental health care providers who have treated or are treating the client. You will continue to assess the client at every session, to ensure your diagnosis is correct, to refine your conceptualization of the client, and to monitor progress. REFLECTION QUES TION What's important to accomplish during the evaluation session in addition to collecting data to make a diagnosis? PRACTICE EXERCISE Create a partial Case Write-Up about a real or imaginary client (Parts One and Two in Appendix B). Cognitive Behavior Therapy: Basics and Beyond