01 - 6. The First Therapy Session

6. The First Therapy Session

T he most important objective in the first session is to inspire hope. You do this by providing psychoeducation (e.g., research shows that CBT is effective for the client's condition), reiterating the general treatment plan, directly expressing your confidence that you can help the client feel better, and identifying the client's values, aspirations, and goals. You'll also establish rapport and trust with clients, socialize them into treatment, do a mood check (so you can monitor progress and adjust treatment), collect additional data for the conceptualization, teach clients about the cognitive model, schedule activities or work on an issue, develop a new Action Plan, and elicit feedback. See Figure 6.1 for the structure of the first therapy session. You'll learn how to structure future sessions in Chapter 9. You'll find the answers to the questions below in this chapter. How do you do a mood/medication (or other treatments) check? How do you set an initial agenda? How do you ask for an update and review the Action Plan? How do you provide psychoeducation about depression, negative thinking, the treatment plan, and the cognitive model? How do you elicit values, aspirations, and goals? How do you set an Action Plan? How do you summarize the session and elicit feedback? THE FIRST THERAPY SESSION

Before the first session, review the client's intake evaluation and keep your initial conceptualization and treatment plan in mind as you conduct the session. Because it's important to tailor treatment to the individual, be prepared to change course if necessary. Most standard CBT outpatient sessions last for about 45 to 50 minutes, but the first one usually takes an hour. Try to identify one or more of the client's automatic thoughts sometime during the session. Then you can introduce or reintroduce the cognitive model. Or you can provide clients with an example. Also, look for opportunities during the session to generate positive emotions, for example, by having clients create a visual image in their minds of having achieved their aspirations, by having a brief conversation about their interests and values, and/or by using self-disclosure. CLINICAL TIPS • You may want to write key words of the structure on your Session Notes (Figure 10.1, pp. 176–177) prior to the session, so you can remember what to do. • You'll provide a significant amount of psychoeducation in the first session. A booklet such as Coping with Depression (J. S. Beck, 2020) reviews important concepts and can be suggested as an Action Plan item. In addition to the elements listed below, you may interweave psychoeducation, eliciting and responding to automatic thoughts, devising Action Plan items, and identifying goals throughout the session. Initial Part of Session 1   1. Do a mood (and, when relevant, a medication or other treatment) check.   2. Set the

agenda. 3. Ask for an update (since the evaluation) and review the Action Plan. 4. Discuss the client's diagnosis and provide psychoeducation. Middle Part of Session 1 5. Identify aspirations, values, and goals. 6. Do activity scheduling or work on an issue. 7. Collaboratively set a new Action Plan; check on likelihood of completion. End of Session 1 8. Provide a summary. 9. Check how likely it is that the client will complete the new Action Plan. 10. Elicit feedback. FIGURE 6.1. Structure of the first therapy session. Cognitive Behavior Therapy: Basics and Beyond

MOOD CHECK At the beginning of the session, greet the client and do a mood check. Research shows that when therapists and clients routinely track progress and therapists use feedback to improve their treatment, outcomes are enhanced (Miller et al., 2015). You can use published scales, such as the Beck Depression Inventory–II (Beck et al., 1996), the Beck Anxiety Inventory (Beck & Steer, 1993a), and the Beck Hopelessness Scale (Beck & Steer, 1993b). Or you can use scales in the public domain, such as the Patient Health Questionnaire (PHQ-9; www.integration. samhsa.gov/images/res/PHQ%20-%20Questions.pdf) or the Generalized Anxiety Disorder Scale (GAD-7; www.integration.samhsa.gov/clinical- practice/gad708.19.08cartwright.pdf). If clients are unable or unwilling to fill out forms, you can assess their mood by asking them to assign a number on a scale (0–10) that represents how they've been feeling. You might say, "If 10 means the most depressed you've ever felt and 0 means not depressed at all, how strong was the depression for most of the past week?" It's also good to ask clients to rate their sense of wellbeing on a 0–10 scale as illustrated in the dialogue below. It's especially critical to check on the level of clients' suicidality (and/or aggressive and homicidal impulses). Elevated scores on items of suicidality and hopelessness indicate the client may be at risk. If so, do a risk assessment (Wenzel et al., 2009) to determine whether you will need to spend the next part of the session (or the entire session) developing a plan to keep the client safe. It may also be important to check more specifically about other problems, such as sleep, anxiety symptoms, and impulsive behaviors. These issues may be important for the agenda. An advantage of having clients fill out symptom checklists is that you can quickly identify problems without having to ask additional questions. If you use symptom checklists, also elicit a subjective description ("How have you been feeling this week?") from clients and match it with their objective test scores. Regardless of how you measure their mood, make sure that clients are not reporting how they feel just that day but, instead, are providing an overview of their mood for the past week. Alert clients that you'd like to continue checking their mood every week. You might say: "I'd like you to come to every session a few minutes early so you can fill out these forms. [providing a rationale] They help give me a quick idea of how you've been feeling in the past week, although I'll always want you to describe how you've been doing in your own words too." As you'll see below, I start the session by checking on Abe's mood. As he's speaking, I quickly review the PHQ-9 and GAD-7 scales he

filled out just prior to the session. And I ask him to rate his sense of well-being. (I want to make sure we're not only decreasing his depression and anxiety but also helping him feel better more generally.) Judith: Hi, Abe. How are you doing today? Abe: Eh, not so good. Judith: Not so great? Abe: No. Judith: Is it all right if I take a look at the forms you filled out? Abe: Sure. Judith: Thanks for filling them out. [repeating the rationale] I think I mentioned last week that they help both of us make sure you're making progress over time. (looks at forms) Let's see. How do you think your mood is compared to what it was last week? Abe: Probably about the same. Judith: That's what the

forms look like too. This one, which measures depression (shows him the PHQ-9), was 18 last week and this week (pause), and this one, which measures anxiety (shows him the GAD7), is still 8. (pause) Could you also tell me how much of a sense of well-being you've had for most of the week? Zero means no sense of well-being, and 10 means the greatest sense of well-being you've ever experienced. Abe: About a 1, I guess. CLINICAL TIPS The mood check should be brief. When clients give you too many details, you might apologize for interrupting and then say one of two things: "Could you summarize how you've been feeling this week in just a sentence or two?" or "Could we put how you've been feeling [or the issue you've just been describing] on the agenda and get to it in a few minutes?" MEDICATION/OTHER TREATMENTS CHECK When clients take medication for their psychological difficulties, you'll briefly check on adherence, problems, and side effects. It's important to phrase the adherence question in terms of frequency—not "Did Cognitive Behavior Therapy: Basics and Beyond

you take your medicine this week" but rather "How many times this week were you able to take your medicine the way [the provider] prescribed?" (See J. S. Beck, 2001, and Sudak, 2011, for suggestions on how to increase medication adherence.) Whether your client is taking medication or receiving a different kind of treatment (e.g., electroconvulsive therapy, transcranial magnetic stimulation, or other brain stimulation therapies), you should obtain clients' permission and then periodically contact the provider to exchange information. You won't recommend changes in medication, but you might help clients respond to obstacles that are interfering with their being fully adherent. When clients have concerns about issues such as side effects, dosage, addiction to medications, or alternative medications or supplements, help them record specific questions to ask their provider and suggest that they write down the provider's answers. If clients aren't taking medication, but you believe a pharmacological or other intervention is indicated, you might propose that they have a medical or psychiatric consultation. CLINICAL TIPS If clients are hesitant to set up a consultation, they may be willing to look at the advantages and disadvantages of scheduling a consultation versus the advantages and disadvantages of not scheduling a consultation. It's helpful to suggest to them that they don't have to commit to taking medication or receiving an adjunct treatment; they can just get more information and then decide. INITIAL AGENDA SETTING Ideally, you set the agenda quickly. Most clients feel comfortable when you tell them how you'd like to structure the session. When you explain the rationale, you make the process of therapy more understandable to clients—which helps to elicit their active participation in a structured, productive way. Judith: [being collaborative] If it's all right with you, what I'd like to do now is to set the agenda. [providing a rationale] The reason we set an agenda is so I can find out what's most important to you and so we can figure out together how to spend our time. Since it's our first session, we have a lot to cover, and we'll have less time to talk about your agenda items. We'll have much more time, starting next week. (pause) Is that okay?" Abe: Yes.

Judith: You'll also notice that I take a lot of notes [providing a rationale] so I can remember what's important. Let me know if that bothers you. Abe: Okay. Next, you'll name your agenda items. Judith: The first thing I want to do is to get an update of what happened between last session and this session [providing a rationale] so I can see if there are other important things for us to cover today. I'd like to see what you were able to get done on your Action Plan and then talk a little bit about your diagnosis. Abe: Okay. Judith: Next, we'll set some goals, and if we have time, we'll talk

about some things you can do this week as part of your new Action Plan. Or we'll start working on one of your goals. (pause) And then at the end of the session, I'm going to ask you for some feedback. (pause) Does that sound all right? Abe: Yes. Judith: [eliciting Abe's agenda items] Anything else you want to make sure and talk about? Abe: No, that sounds like a lot. That'll be enough. Be alert for potentially important issues that arise during the session. You and the client may decide together that a new issue is more important than the ones on the original agenda. But be careful not to let clients drift into talking about a different issue without calling their attention to it. If this happens, make a collaborative decision about whether to continue talking about the new issue or to return to the original one. UPDATE AND REVIEW OF THE ACTION PLAN In traditional CBT, we would ask for an update in this way: "What happened between last session and this session that I should know?" This invariably led to a recounting of negative experiences, especially early in treatment. We'd then ask, "What happened that was positive?" As you'll see below, in CT-R (Beck et al., in press), we tend to start with positive experiences and help clients draw adaptive conclusions. The update is frequently intermingled with a review of the Action Plan.

Judith: You know, Abe, when people are depressed, they're usually preoccupied with all their problems. [providing a rationale] So it's important to focus on what's actually going okay. I wonder if you can think over the past week and tell me when you were at your best? Abe: (Thinks.) That would have been when I took my grandson Ethan out for ice cream. Judith: So you were able to do that? Abe: Yes. Judith: [giving positive reinforcement] That's great. That was part of your Action Plan. Abe: Yeah. It was good. Judith: [becoming conversational to try to lighten his mood] Did you get ice cream? Abe: Yeah. Judith: And how about Ethan? Did he have a good time? Abe: I think so. Next, I get Abe to focus on this experience and draw positive conclusions about it and about himself. Judith: So, what was good about taking him? Abe: Well, just getting out and doing something was good. We were outside for a while, but probably just being with him and hanging out was the best part. Judith: [asking more questions to help Abe to reexperience the positive event] What did you talk to him about? Abe: Mostly about soccer because he's on a team. So, we talked about how he's doing and how things are coming along for him. Judith: [being conversational, showing interest] How is he doing? Is he a good player? Abe: Well, according to him, he's doing pretty well. I haven't seen him lately, so I don't know. I think so. Judith: [trying to elicit a positive core belief] Abe, what does it say about you that you were able to take him out for ice cream? You told me last week that it's something you hadn't done in a long time. Abe: Seemed like something I should have done a long time ago.

Reinforcing the Cognitive Model Like many clients, Abe expressed a self-critical automatic thought. I take the opportunity to frame it according to the cognitive model. Judith: I see. And I bet you wish you had done it a long time ago. [discovering whether Abe has put a negative meaning on his avoidance] Why do you think you haven't done it for so long? Abe: I don't know. I keep thinking, "Everything is too hard." Judith: When you have the thought "Everything is too hard," how does that thought make you feel emotionally? [providing a multiple choice] Happy, sad, anxious? Abe: Sad. Really sad. Judith: And what do you usually end up doing? Abe: Just sitting on the couch. Judith: So, did I get this right? It sounds as if this kind of thing has been happening a lot. [summarizing in the form of the cognitive model] The situation is that you're deciding whether or

not to do something, like taking your grandson out, and you have the thought “Everything is too hard.” This thought makes you feel bad and you end up usually sitting on the couch. Abe: That sounds right. I could then have helped Abe respond to his automatic thought. Instead, to stay on track, I continue on with the update. Judith: Well, maybe we’ll come back to this thought in a little while. To get back to the update, did anything else happen between last session and this session that I should know? Abe: Nothing I can think of. I didn’t do much. Action Plan Review If you and the client agreed on an Action Plan during the evaluation, it’s important to find out what the client did and to what degree it was helpful. I start by reviewing the therapy notes we had composed the week before. Judith: Can we look at your Action Plan and see what else you were able to get done? Do you have it with you? Abe: Yeah. Cognitive Behavior Therapy: Basics and Beyond

Judith: Oh, good. Were you able to put it next to your coffee maker and read it every morning and again later in the day? Abe: I read it every morning, but I didn’t read it much later on. Judith: Okay. (Makes a mental note to discuss reading the new Action Plan twice later in the session.) Could you read the therapy notes right now and tell me what you think about them? Abe: “When I start to feel more depressed, remind myself that the therapy plan makes sense.” Judith: Okay, does it still make sense to you? Abe: Yes, it still makes sense. Judith: What else does the note say? Abe: “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.” Judith: What do you think about that? Because you’re depressed, your thinking might not always be completely true. Abe: Well, mostly up until now, my thinking seems 100% true. Judith: (making a note) Let’s get back to that in a little while. What’s next? Abe: (reading) “And the way I’ll get better is by making small changes in my thinking and behavior every day.” Judith: Exactly. Next, we review the activities on the past week’s Action Plan. Judith: Let’s see what’s next. You were able to take Ethan out for ice cream. And how about the third item? Do you want to read that? Abe: “Give myself credit for doing all of the above, for doing anything else that helps me get over the depression, and for doing anything that’s even a little difficult, but I do it anyway.” Judith: So, were you able to give yourself credit for taking Ethan to ice cream? Abe: Not very well, no. I should just do that stuff [automatic thought]. Judith: Well, in a few minutes, we’re going to talk about your depression and how that’s been getting in the way. Were you able to give yourself credit for reading your therapy notes every morning? Abe: I did, most of the time anyway. Judith: That’s good.

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Next, I summarize, to make the process of therapy more understandable and to keep us on track. “Okay, we checked your mood, we set the agenda, you gave me an update, and we reviewed the Action Plan. Next, I’d like to talk about your diagnosis.” DIAGNOSIS AND PSYCHOEDUCATION ABOUT DEPRESSION Most clients want to know their general diagnosis and to establish that you don’t think they’re crazy or strange or abnormal. It’s usually better to avoid the label of a personality disorder (and sometimes a serious mental health condition) at the first session and instead describe the difficulties the client has experienced, for example: “It looks as if you have major depressive disorder. It also seems that you’ve had some long-standing problems with relationships and with work. Is that right?” It’s desirable to let clients know how you made the diagnosis and to give them some initial psychoeducation about their condition. We want them to start attributing some of their problems to their disorder instead of to their character. Thoughts such as “There’s something wrong with me”; “I’m lazy”; or “I’m just no good” will negatively affect

their mood—and probably their behavior—and thus reduce their motivation. Judith: I'd like to talk about your diagnosis. Abe, you have a real illness. It's called depression. Now a lot of people go around saying "I'm depressed" from time to time. But that's very different. When people say, "I'm depressed," usually that's like having a common cold—but [offering an analogy] what you have is like a really bad case of pneumonia. You see how pneumonia and the common cold are very different? Abe: Yes. Judith: You have a real illness that's called depression. I know that because I have a book that helps me diagnose the problems people have when they come to see me. It's abbreviated as the DSM. It lists the symptoms of the real illness called depression. (pause) And I found from talking to you last week that you really do have this. Next, I list the symptoms he's been having that indicate he has the illness of depression.

"Tell me if I'm right. You're tired all of the time. You've felt very, very depressed for a long time. You've lost interest in almost everything. You rarely get a sense of pleasure. Your appetite has been off. You've been sleeping much, much more. You have trouble concentrating and making decisions, and sometimes you even think about death. (pause) These are all symptoms of what's called a major depressive disorder. It's a real illness." Having described his symptoms, I want to offer Abe hope. Judith: Fortunately, research shows that there's a really good treatment for it: cognitive behavior therapy. That's the kind of treatment that I do. (pause) So, what do you think of this idea—that you do have a real illness? Abe: I mean, what you said makes sense, and I do all that stuff. It describes me. I don't know about the idea of illness. A lot of this seems like I'm just not doing what I'm supposed to be doing. Analogizing Depression and Pneumonia Judith: If you had a terrible case of pneumonia, would you be able to do everything that you should be doing? Abe: No. Judith: No, because you'd be very tired all of the time, right? Abe: (Nods.) Judith: You might even have trouble concentrating if your symptoms were really severe. Your depression is every bit as real as pneu monia. And part of this real illness, Abe, is your depressed thinking. Psychoeducation about Depression and Negative Thinking Clients may start to blame themselves for their symptoms. Here's what I say to Abe to head that off. Judith: Now, it's not your fault that you have depressed thinking. These thoughts just pop up automatically. In fact, we call them "automatic thoughts." (pause) And depressed automatic thoughts are a symptom of depression, just like tiredness and sleeping too much and having a depressed mood are symptoms. (pause) Okay? Abe: Yes. Judith: Abe, when people are depressed, [offering a metaphor] it's as

if they're wearing the blackest glasses imaginable. And they see all of their experience as coming through these black glasses. So, everything looks very dark and very negative. (pause) What do you think about that? Abe: I guess that could be right. Additional Psychoeducation about the Treatment Plan and Depressed Thinking Next, to inspire hope, I preview how we're going to deal with his depressed thoughts. Judith: Because you're depressed, we know for sure that some of your automatic thoughts just aren't 100% true. Others may be true, but they're really unhelpful. I'm going to teach you how to evaluate your thoughts, so you can see for yourself how accurate or helpful they are. Okay? Abe: Okay. Judith: I also want to give you another analogy. When people are depressed . . . well, it's like horses in races that wear blinders. Why do they have them? Abe: So they don't get distracted. To keep them looking only straight ahead. Judith: Exactly. And when people are depressed, it's as if they have blinders too. All they can see is what's immediately

ahead of them. And all of those things, because they have black glasses on, seem really terrible and really negative. One of the things that we'll do, Abe, is to open up those blinders so you can see everything that's going on, not just the negative. Abe: Okay. Judith: Do you think it would be helpful to remember that this week? Abe: Yeah, probably. Next, we collaboratively create a therapy note for Abe to read daily between sessions. Judith: Do you want to write this down, or do you want me to write it down? Abe: You can. Judith: Okay. Maybe we should start this out, "When I criticize myself, remember . . . " And what do you think would be good to remember?

Asking Abe to summarize in his own words allows me to check on his level of understanding, makes him more active in the session, and reinforces the adaptive response in his mind. Abe: I'm only looking at part of the scene. Judith: Yes, "I'm only looking at part," and what part are you looking at? Abe: The part through my black glasses. Judith: Yes. "I'm only looking at part of the scene, and it's through black glasses." To make the response more robust, I offer two other ideas. Judith: And how about "It's not my fault I'm doing this"? Abe: (Sighs.) Judith: Doesn't sound like you really believe that? Abe: Not too much. I don't want to write down anything Abe disagrees with, so I modify the idea. Judith: How about "Judy says it's not my fault"? Abe: Okay. Judith: Is that all right? Abe: Yeah. Judith: "Judy says it's not my fault." And why do I say you're doing this? Abe: Because I have depression. Judith: Right. "It's happening because I have depression." (pause) Do you think that this is something that you could read to yourself this week? Abe: Yeah, yeah. I can do that. Psychoeducation about the Cognitive Model In the next part of the session, I explain, illustrate, and record the cognitive model with Abe's own examples. I also ask Abe to put what I had said in his own words so I could check on his understanding. Judith: The next thing I'd like to do is to talk just a little bit more about your depressed thinking. Here's the situation that just happened

a few minutes ago. We were talking about why you hadn't taken Ethan for ice cream for a long time. That was the situation, and do you remember what you were thinking? What your thought was? Abe: I'm not sure. Judith: You said, "Everything is too hard." Abe: Oh. Judith: Right? And so, when you had that thought, "Everything is too hard," how did it make you feel? Abe: Really depressed. Judith: And what did you usually end up doing? Abe: Just sitting on the couch. Judith: Let me draw a diagram that shows this. Situation: Think about doing something, like taking grandchildren out Automatic thought: "Everything is too hard." Emotion: Depressed Behavior: Stays sitting on couch Now if you'd had another thought, I wonder if you would have felt differently. For example, if you had thought "Well, everything seems too hard, but because I'm depressed that might not be true. Therapy makes sense. Judy says that she can help me, and I already did something good by taking Ethan out for ice cream." If you had had those thoughts, how do you think you would have felt? Abe: Better. Judith: Exactly. (Pointing to the cognitive model diagram.) It's not the situation directly that makes you feel tired or bad or depressed. It's what you're thinking in that situation. So, if you have the thought "Everything is too hard," of course you're going to feel depressed and sit on the couch. If you have a thought like "Well, therapy makes sense. Judy says she can help me," then you might feel a little bit better and you might be a little more likely to do something. Abe: I can see that. Judith: One of the things that's going to be really important in this treatment is to have you learn to identify your automatic thoughts. This is just a skill, like learning to ride a bike. I'm going to teach you how to do it. And then we're going to figure

a thought is 100% true or 0% true or someplace in the middle. (pause) So, I wonder, before you took Ethan out for ice cream, were you thinking that it would be a very hard thing to do? Abe: Yeah. Judith: And then how did it turn out? Abe: Pretty good. Judith: Was it as hard as you expected? Abe: No. Judith: So, that's a really good example of how you could have an automatic thought like "This is too hard" or "It's going to be very hard to take him out," but it might turn out not to be true, or not 100% true. Is that right? Abe: Yes. Judith: So, I wonder, could you tell me in your own words then what we've just been talking about here? Abe: Well, I guess you're saying that I have all these negative thoughts because I'm depressed. Judith: Right. And what effect do these thoughts have on you? Abe: They make me feel bad and then I might just sit on the couch. Judith: Oh, well, that's excellent. You're right. Your thinking affects how you feel and then what you do. In fact, if you had thought "It's too hard to take Ethan out" instead of just "It's very hard," what do you think would have happened? Abe: I don't know. I might not even have called him. See Chapter 12 (pp. 222–225) to find out what to do when clients have difficulty identifying automatic thoughts. But be careful to downplay the importance of identifying automatic thoughts when they struggle. You don't want clients to think they're incompetent. CLINICAL TIPS If you have difficulty identifying one of your client's automatic thoughts, you can provide an example: Therapist: I'd like to talk for a couple of minutes about how your thinking affects how you feel and what you do. Client: Okay. Therapist: What would you think if you texted your best friend 8 hours ago and he didn't text you back?

Client: That maybe there's something wrong. Therapist: How would that thought make you feel? Client: Worried, I guess. Therapist: And what would you do? Client: Probably text again, and if I still didn't hear anything, I'd probably call. Therapist: Okay, that's a good example of how your thinking influences how you feel and what you do. Then, if you want to reinforce the cognitive model, you can provide a different automatic thought, using the same situation. For example, ask what the client would feel and do if she had the thought "He's always doing this to me. He's so rude." Next, ask her to summarize what she's just learned. CLINICAL TIPS When clients' cognitive abilities are impaired or limited, you can use more concrete learning aids such as cartoon figures with various expressions to illustrate emotions with empty "thought bubbles" above their heads. Setting an Action Plan Item to Reinforce the Cognitive Model Next, I suggest that Abe look for depressed automatic thoughts during the week. I ask him to anticipate an automatic thought and remind himself that it might or might not be true. Judith: Here's something I'd like you to do this week. Notice when your mood is getting worse or when you're not being productive. Then ask yourself, "What was just going through my mind?" Abe: Okay. Judith: I wonder if you could predict what one of these thoughts might be? Abe: It could be almost anything. I could be sitting on the couch, and I could think about doing anything, cleaning the apartment . . . Judith: That's good. So, let's say you're thinking of cleaning the apartment. How do you think you'll be feeling ? Abe: Probably tired. I'll probably think, "I'm too tired to do anything." Judith: That's a good example. So, the situation is that you're sitting on the couch, thinking of cleaning, and you think, "I'm too tired

to do anything.” How does this thought make you feel emotionally? Abe: Depressed. Judith: And if you believe this thought, that you’re too tired to do anything, what do you think you’ll do? Abe: Probably just keep sitting. Judith: I think you’re probably right. (pause) Okay, this week, I’d like you to notice when you’re feeling really depressed or not being productive. Then I’d like you to ask yourself, “What was just going through my mind?” (pause) Then I’d like you to jot down your thoughts. But then remind yourself that they might not be true, or at least not completely true. Okay? Abe: I’ll try. Judith: You can write your automatic thoughts on this Identifying Automatic Thoughts Worksheet (pulls out worksheet in Figure 6.2) or you can use paper or a notebook or your phone. Which would be best? Abe: I’ll try the worksheet. Remember: Just because I think something doesn’t necessarily mean it’s true. When I change my unhelpful or inaccurate thoughts, I’ll likely feel better. Instructions: When my mood gets worse or I’m engaging in unhelpful behavior, ask myself, “What was just going through my mind?” Write down my thoughts below. FIGURE 6.2. Identifying Automatic Thoughts Worksheet. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania.

Judith: Good. (Hands Abe the worksheet.) You see it has the directions right at the top, the ones I just showed you. Abe: Okay. Judith: (Making sure Abe knows what to do.) Could you write your automatic thought on it—“I’m too tired to do anything”? Abe: Okay. (Writes this thought on the worksheet.) Judith: I wonder if you’ll need a reminder? Like a sticky note, or you could move your watch to your other hand or wear a rubber band around your wrist—to remind yourself to look for your automatic thoughts. Abe: I think I need to see something, some kind of reminder that I can see. A rubber band would be good. Judith: I have one here. Do you want to put it around your wrist now? Abe: Okay. Judith: (Hands Abe a rubber band; he puts it on his wrist.) So, every time you look at the rubber band, what are you going to ask yourself? Abe: What just went through my mind? Judith: That’s right, especially if your mood is getting worse, or you’re doing something that’s not productive. And you’ll remind yourself that the thoughts might not be true. Abe: Okay. IDENTIFYING VALUES AND ASPIRATIONS Eliciting Values Next, you focus on identifying clients’ values. Values are long-standing beliefs about what is most important in life. People’s values shape their choices and behavior. But when they perceive they’re not living up to their values, they often become distressed. In a conversational tone, you can ask clients, “What’s really important to you in life? Or what used to be really important to you?” CLINICAL TIPS If clients reply that nothing seems important or if they have difficulty formulating a response, you can offer suggestions: “How important is to you?” You can ask them to consider areas such as the following: • relationships (family, friends, intimate partner), • productivity (work outside the home, managing at home),

• health (might also include fitness, eating, sleep, use of alcohol or substances), • self--improvement (education, skills, culture, appearance, self- control), • community (locally or more broadly), • spirituality, • recreation (entertainment, hobbies, sports), • creativity, • nature, and • relaxation. Having clients reflect on what’s really important to them aids in identifying their aspirations and setting goals. These interventions can inspire hope, motivate clients to engage in treatment and complete Action Plans, and help them overcome obstacles and problems they face day to day. Judith: Abe, I wonder if we could turn to something else, and that is to talk about what’s really important to you in life. What are the most important things to you in life? Or maybe before

you got depressed, what was really, really important to you? Abe: My kids. Judith: Yes. Abe: Grandkids too. Judith: Your grandkids, okay. What else was really important? Abe: Well, it was always important to me to work and be productive, but I screwed that up. I had already reviewed the cognitive model with Abe, and I decide it would be better to let that automatic thought go unaddressed so we can continue identifying values. Judith: What else has been important to you? Abe: Friends. Sports, I guess. I've always liked sports. Judith: Oh, that's good. Playing or watching or both? Abe: Both. Judith: Anything else that's been really important to you? Abe: I don't know. I used to go to church, and I used to do things. I used to volunteer, help people. I liked helping people. Judith: Anything else? How about your health? Abe: Yeah. I used to eat healthy, exercise—-things like that.

Eliciting Aspirations To elicit clients' aspirations, ask one or more questions such as the following (Beck et al., in press): “What do you want for your life?” “What are your hopes for the future?” “What do you want your future to look like?” “When you were growing up, what did you want your life to be like? What did you hope for?” It's fairly easy to elicit Abe's aspirations. Judith: I know you've been very depressed for quite a while and you're unhappy with your life. (pause) What do you want for your life? Abe: I want it to be like it was before I got depressed. Judith: And what was that? Abe: I want to have a job. I want to have better relationships with my family. And with my friends. (Thinks.) I want to take care of myself better. And my apartment. Judith: Anything else? Abe: (Thinks.) I want to feel good about myself. I want to feel useful, helpful. Drawing Conclusions about Aspirations It's not clients' aspirations and experiences alone that are important. It's the meaning that clients put to them. Help clients draw conclusions about having achieved their goals and aspirations, especially in terms of improving their life, self-image, sense of purpose and control, and connectedness to others. Ask questions such as these (Beck et al., in press): “What would be especially good about [achieving your aspirations and goals]?” “How would you feel about yourself? What would it say about you? How might other people view you or how might they treat you differently?” “What would it suggest about your future?” “How would you feel [emotionally] if all this came true? Can you get that feeling right now?”

I use these questions with Abe. Judith: Abe, if you had a good job, good relationships with your family and your friends, if you were taking better care of yourself and your apartment, if you were helping other people, what would be good about that? Abe: I'd feel good about myself. I'd be productive. Judith: And what would that show about you as a person? Abe: I guess it would show I'm a good person, I'm responsible. Judith: Would it show that you were a good worker, a good father, a good grandfather, a good friend? Abe: Yes. Judith: And how would other people view you? Abe: I would hope the way they did before. That I'm reliable, I'm hardworking, friendly. Judith: And if all these things happen, what do you think your future would be like? Abe: Pretty good, I think. Judith: And how would you feel about yourself? Abe: Much better. Creating an Image of Having Achieved the Aspirations Using imagery can make aspirations more concrete and lead to clients' experiencing positive emotion in the session. Judith: Abe, I wonder if you could imagine a day in the future when you've completely recovered from depression, when all these good things have come true? Let's say it's a year from now. Where do you think you'll wake up? Abe: If I was working and had more money, maybe in a different apartment. Judith: Can you imagine opening your eyes?

What does the room look like? Abe: Umm, a year from now? My bedroom would be bigger. There would be a lot of light in the room. It'd be neat, well organized. Judith: And how are you feeling as you wake up? Abe: Pretty good. Judith: Looking forward to the day?

Abe: If I had a good job? Then yes. Judith: Can you see yourself getting out of bed? What are you thinking? Abe: Probably just about what I'm going to do that day. Judith: And how are you feeling? Abe: Pretty good. Judith: What do you think you'd do next? I continue to coach Abe in imagining this future day, in detail. As he speaks, I see his affect start to brighten a little. SETTING GOALS (PART 1) Having identified clients' values and aspirations, you collaboratively set goals and record them. These goals are more specific than the broad ones you discussed during the evaluation session. Clients with depression benefit from identifying goals in a variety of areas (Ritschel & Sheppard, 2018). You might suggest that they think about goals related to the same areas that were outlined on pages 104–105. Below, Abe and I set some goals. Then we address an automatic thought that gets in the way, before returning to goal setting. Judith: Abe, could we talk about some specific goals you might have? How would you like your life to be different? How would you like to be different? Abe: I'd like to be the way I used to be, doing all that stuff [we just talked about]. Judith: So, you'd like to spend more time your kids and your grandkids? Abe: Yes. Judith: (writing it down) That's a good goal. What else? Abe: Well, get a good job. But I don't know how I'm going to be able to do these things. I haven't been able to, up to this point. Addressing Automatic Thoughts That Interfere with Goal Setting I conceptualized that rather than continuing to set goals, it would be important to respond to Abe's automatic thoughts. I use our discussion to reinforce that

• his thinking may be biased and inaccurate, • we will work together as a team, • I have good reason to expect treatment to help, and • coming to treatment is a sign of strength. I also ask Abe to commit to making a change in the coming week, even if he has interfering thoughts. Judith: Yes, your depression has made it hard for you to do these things. So, what's different now? Abe: I don't know. Judith: Hey, Abe, I'm here. Do you have a sense that I can help? Abe: I think maybe you could. Judith: [trying to build hope] Abe, I have to tell you there's nothing about you that makes me think that you're not going to get over this depression. I really think you are. Should I tell you why I think that? Abe: Yes. Judith: Okay. So, the first thing is that you were willing to come for an evaluation last week, even though you were skeptical about treatment. But you did a good job on the evaluation. You were able to answer all my questions. We were able to make an Action Plan, especially taking your grandson for ice cream. You were able to do that, even though you thought it would be very hard. So I see that you're willing to try this treatment. And it's fine if you're still skeptical about treatment. (pause) You'll need to see for yourself that it's working. Okay? Abe: Yes. Judith: And you're not in this alone. We'll be working as a team to get you better. We'll work on the goals, step by step, so it won't feel overwhelming. And there are skills you need to learn, like answering back your automatic thoughts. You don't know how to do these things yet—I'll need to teach them to you. Abe: But I've always thought I should solve my problems myself. Judith: Okay. Back to the pneumonia analogy. If you had bacterial pneumonia, would you try to cure yourself? Abe: No. I'd have to go to the doctor. Judith: And the doctor would help you. (pause) I will too. But instead

of giving you medication, I'll be teaching you skills to get over your depression. Skills that research shows get people better. (pause) Okay? Abe: I guess so. Judith: You know, I think it's a sign of strength that you're willing to do something that goes against your grain. Abe: Maybe I am seeing everything through black glasses. Judith: Yes, I think you are. And what we have to do together—-note I said "together"—is to scratch off the black paint so you can get over your depression. (pause) Should we get back to setting goals? Abe: Okay. SETTING GOALS (PART 2) Having responded to Abe's dysfunctional thinking, we return to goal setting. I make sure to avoid overwhelming Abe with too many goals, and I limit our discussion so we'll have time to get to activity scheduling. Judith: Okay. Do you have other goals? Abe: I should see my friends more. But they might be annoyed with me, so I don't know if that'll work [automatic thought]. I haven't been in contact with them for a while. I conceptualize that it's more important to keep setting goals than to respond to this automatic thought. Judith: Should we put that down with a question mark? Abe: Yes. Judith: Anything else? Abe: Well, it would be good to clean the apartment. Judith: And how about your physical health? Abe: Yeah. It would be good to start eating better and exercising. Judith: I think this is a really good list. I've written your goals here on the bottom of your Action Plan. Would you be willing to take a look at this list during the week to see whether there are any goals that you want to cross off or add or change? I'm thinking you might want to have a goal of having more fun, doing more pleasurable things, but it's up to you. Cognitive Behavior Therapy: Basics and Beyond

Goal List May 13 · Get a good job · See friends more? · Clean the apartment · Eat better · Exercise Difficulties in Setting Goals There are three difficulties that sometimes arise when you're trying to set goals:

1. Clients have difficulty coming up with goals.
2. Clients set goals that are too broad.
3. Clients set goals for other people. When clients say, "I don't know" to your goal setting questions, you can try a "miracle" question instead. Solution-focused brief therapy (de Shazer, 1988) suggests you ask a question such as the following: "If a miracle happened and you weren't depressed when you woke up tomorrow, what would be different? How would someone know you weren't depressed?" Or you can find out whether clients believe there are disadvantages to setting goals. Sometimes clients express goals that are too broad (e.g., "I don't want to be depressed anymore" or "I want to be happier" or "I just want everything to be better"). To help them become more specific, you can ask, "If [you weren't depressed anymore/if you were happier/ if everything was better], what would you be doing differently?" Occasionally clients state a goal over which they don't have direct control: "I'd like my partner to be nicer to me"; "I want my boss to stop putting so much pressure on me"; "I want my kids to listen to me." In

this case, it's important to help them phrase the goal so it's something they do have control over. "I don't want to promise you that we can directly get your sister to be nicer to you. What do you think of phrasing it this way: 'Learn new ways of talking to Erica.' It's possible that if you take

control and change what you're doing, it will have some impact on her." For a broader discussion of what to do when clients set goals for others, see J. S. Beck (2005). CLINICAL TIPS Add new goals to the list as they come up in later sessions. Note that goals are the flip side of problems. For example, if the client says, "I don't know what to do about my teenager," you can say, "Do you want to have a goal to decide what to do?" If the client says, "It's so hard to get everything done," you can say, "Do you want to have a goal to figure out if you can do something to make it easier?" SCHEDULING ACTIVITIES If there's time in this first session, it's a good idea to help most depressed clients schedule activities for the coming week and give themselves credit for engaging in these activities. Alternatively, if there's a pressing problem that needs immediate attention, you can work on that. Because Abe has been so inactive, and because he hadn't brought up a more pressing problem, I bring up scheduling activities for the coming week. You'll read about what we did in the next chapter. END-OF-SESSION SUMMARY The final summary ties together the threads of the session and reinforces important points. Initially, you'll probably summarize. When you think clients are capable of providing a good summary, you'll ask them to do it. At the end of the first session, you might say something like this: "I'd like to summarize what we went over about today, so it's clear to both of us. We talked about your diagnosis and how your thoughts influence how you feel and what you do. We identified what's really important to you and what you want for your life. Then we set goals and figured out some activities for you to do this week."

The summary also includes a review of what clients have agreed to do for their Action Plan and an assessment of how likely they are to complete it. You'll read about this in Chapter 8 (pp. 135–159). Figure 6.3 presents Abe's first-session Action Plan. Make sure to give clients the written Action Plan and any other worksheets or notes that they'll need. FEEDBACK The final element of the first session is feedback. By the end of this session, most clients feel positive about the therapist and the therapy. Eliciting feedback further strengthens rapport, providing the message that you care about what the client thinks. It also gives clients a chance to express, and you to resolve, any misunderstandings. Clients may occasionally make an idiosyncratic (negative) interpretation of something you said or did. Asking them whether there was anything that bothered them gives them the opportunity to state and then test their conclusions. In addition to verbal feedback, it's a good idea to ask clients to complete a written Feedback Form (Figure 6.4). Judith: Abe, can you give me some feedback about this session, [providing rationale] so I can make changes for our next session if I need to? (pause) What did you think of it? Was there anything that bothered you or anything you thought I didn't understand? Abe: No, it was good. Judith: Is there anything you think we should do differently next time? Abe: No, I don't think so. Judith: If you did have any negative feedback, do you think you could tell me? Abe: I think so. Judith: If you do, the first thing I'll say is "It's good you told me that." If there's something I'm doing that's not right, I want to know, so I can fix it. In fact, you'll have another chance to tell me. Can I give you this Feedback Form to fill out in the reception area? You can give it to [the receptionist], and he'll give it to me. It will help you think about the session and whether there's anything I should know. Abe: Okay. Judith: That's good. Well, I'm so glad that you came in today. Is this time good for you next week? Abe: Yes. Judith: I'll see you then.

FIGURE 6.3. Abe's Session 1 Action Plan. Action Plan

May 13 Read this Action Plan and the one from last week twice a day. Continue to give myself credit. How my thoughts affect my reaction Situation: Thinking about doing something, like taking grandchildren out Automatic thoughts: “Everything is too hard.” Emotion: Depressed Behavior: Stay sitting on couch When I criticize myself, remember I’m only looking at part of the scene, and it’s through black glasses. Judy says it’s not my fault that I’m doing this. It’s happening because I have depression. When I notice my mood is getting worse or I’m doing something unproductive, ask myself, “What’s going through my mind right now?” and write down my thoughts on the Identifying Thoughts Worksheet. Wear a rubber band to remind me to do this. Remember, black glasses If I’m feeling really tired and feel like staying on the couch instead of going out—or doing something else—remind myself that I have to get back into the world. It’s important to go. Not going will probably keep me depressed. I want to get back into the world so I can be productive, be better to my family. I’ll feel more useful and competent and in control. Going out may or may not affect my mood right away. I may need to crank up the jack-in-thebox. To do:

1. Take Ethan out for ice cream.
2. Go out four times this week. For example, take a 5-minute walk, go to the grocery store, or go to the hardware store. Demonstrate to myself that I can take control and do things.
3. Look at the goal list. Do I want to add or cross off or change any? Cognitive Behavior Therapy: Basics and Beyond

FIGURE 6.4. Feedback Form. Copyright © 2018 CBT Worksheet Packet. Beck Institute for Cognitive Behavior Therapy, Philadelphia, Pennsylvania. Name

Date

What do you want to remember from the therapy session today?

Was there anything that bothered you about the therapist or about therapy? If so, what was it?

How likely are you to do the new Action Plan? How is it related to your aspirations and values? If you do it, what will that show you (especially about yourself)?

What do you want to make sure to cover next session?

The First Therapy Session

REFLECTION QUES TION Why is it important to help clients identify their values, aspirations, and goals? PRACTICE EXERCISE Ask yourself the relevant questions in this chapter to identify your own values and aspirations. Then identify at least one goal and write down one or two steps you can take this week toward achieving it. Cognitive Behavior Therapy: Basics and Beyond

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