CHAPTER 2

The problem list

The first step in implementing the case formulation model in clinica practice is specifying the patient's problem list. The problem list is an all inclusive list of the patient's difficulties. The problem list focuses the treatment; without it, therapy may be aimless and unproductive and i will be difficult or impossible to assess its effectiveness. In addition, a described in the next chapter, an exhaustive and detailed problem list i the first step in developing a case formulation.

The first section of the present chapter focuses on identifying the item that belong on the problem list. The second section outlines procedure for obtaining quantitative measures of mood, cognitive, and behaviora components of each problem on the list. The third section describes th use of the problem list to evaluate the results of treatment.

IDENTIFYING PROBLEMS

What problems belong on the problem list?

It is rare for a person seeking treatment to have only one problem; typical problem list has eight or ten items. Common problems includ depression, panic attacks, phobias, inability to drive on freeways, prc

crastination at work, overeating, drug or alcohol abuse, marital conflict, social isolation, unemployment, financial difficulties, unsatisfactory living arrangements, headaches, and medical problems.

Although many of these difficulties (e.g., unemployment) may not appear to belong on a list of problems to be worked on in psychotherapy, it is useful, for several reasons, to include all these items on the problem list.

The strategy of beginning with an all-inclusive problem list ensures that important problems are not missed; it can also be helpful in the process of proposing an underlying mechanism, as described in the next chapter. Although unemployment, for example, may not at first seem to be a psychological problem, careful investigation often reveals that the patient's psychological difficulties play a role in causing his joblessness and/or in preventing the patient from seeking and finding employment. The same is true for medical problems. Medical problems often have important psychological causes. A common way psychological difficulties contribute to medical problems is via the patient's failure to comply with treatment recommendations; for example, a patient with high blood pressure has been instructed to stop smoking, but feels unable to do so.

Patients are frequently reluctant to provide a comprehensive problem list. Often they seek treatment for the one or two primary problems that are most distressing, and prefer to ignore other issues. Problems may be avoided because they seem overwhelming and insoluble, because they are embarrassing, because tackling them is expected to be unacceptably painful and difficult, or because the patient does not consider the issue a problem and does not want to make a change in this area. Drug and alcohol abuse frequently fall in this last category. Sometimes patients avoid discussing problems because they are genuinely unaware that a problem exists. For example, a young woman seeking treatment for panic attacks and depression did not own a driver's license and did not drive. She did not consider this a problem, even though it inconvenienced many members of her family and caused her to be completely socially isolated. She was so accustomed to the constricted lifestyle she had adopted that she was not aware of a problem. In addition, of course, her constricted lifestyle allowed her to avoid the anxiety she experienced in social situations—in fact, it allowed her to avoid even the awareness that she *had* social anxiety.

Although patients often resist providing a comprehensive problem list, the therapist's failure to obtain one can jeopardize the treatment. Sometimes issues the patient is most reluctant to discuss are vital to the success of the treatment. A middle-aged boutique owner suffering from severe insomnia repeatedly refused to discuss business and financial problems.

When, after several weeks of unsuccessful treatment, she agreed to exam ine these issues, a clear relationship between sleeplessness and busines reverses was discovered; this made an important and effective differenc in her treatment.

Although the strategy recommended here involves drawing up a com prehensive problem list, this does not mean that all of the problems ar necessarily actively addressed in treatment. Months of therapeutic wor might pass before some of the problems on the list are addressed. Howev er, repeated monitoring of all the problems, even the ones that are no worked on actively, is a good idea. If the underlying mechanism is correc and all the problems are related, as predicted in the case formulatio model, work on some problems is expected to produce improvement i untreated problems.

The process of identifying problems

Obtaining an exhaustive problem list is a good focus for the initia therapy session. Often a new patient spontaneously begins with a recita tion of his difficulties. If this does not happen, the therapist can provid some structure for this process by saying, "I suggest that we work togeth er to develop a list of problems you want to work on in your therapy."

Often more than one session is required to complete the problem list As a homework assignment for the first session, the patient can be aske to spend a few minutes thinking about what other problems she migh like to work on and what other goals she'd like to accomplish in he therapy, or she can be asked to keep a log to collect baseline data on som particular aspects of a problem described in the first session.

Occasionally patients provide a clear statement of their difficulties i the same terms the therapist uses (e.g., "I'm afraid of contamination an I wash my hands constantly"). However, most don't use the model de scribed in Chapter 1 to conceptualize their problems. Instead, they de scribe difficulties in vague, general terms, saying, for example, "My life i a mess." The therapist's first task is to transform this kind of complain into one or more discrete problems of the sort that are treated by cogni tive-behavior therapists. In particular, the therapist looks for the mood behavioral, and cognitive components of problems patients report, as i the following example.

PATIENT My life is a mess!

THERAPIST What's going on? (The therapist looks for concrete behavioral, cognitive, and mood difficulties.)

PATIENT I'm not getting anything done at work. I hardly spend any time at my office. My mail just piles up and I don't even open it. (behavior)

THERAPIST What kind of work do you do?

PATIENT I'm a salesman—I sell medical equipment. But sometimes I think I want to change jobs—I'm not enjoying my work very much at all right now. (mood)

THERAPIST I see. Can you say more about what work is like for you?

PATIENT Well, I'm not returning phone calls. I have a pile of pink slips. Some of them are weeks old. (behavior)

THERAPIST So you're not returning phone calls. What about calling on your customers and making sure your orders are filled?

PATIENT I do OK at the things that *have* to get done, the ones that have a deadline. But things that can be put off, like developing more customers, don't get done. I put off everything that's not urgent until it turns into an emergency. (behavior)

THERAPIST So the vital stuff gets done, but there's a lot of procrastinating on non-emergency stuff.

PATIENT Right.

THERAPIST Any other problems?

PATIENT My social life is a disaster.

THERAPIST Tell me what you mean when you say that. (Again, looking for concrete thoughts, behaviors, and moods.)

PATIENT Well, I spend a lot of my free time in my apartment by myself, watching TV and feeling lousy. I guess I should try to get out of the house more. (behavior, mood)

THERAPIST Yes, that's probably a good idea. Any other problems in your social life?

PATIENT Well, I eat dinner three times a week with my grandmother. (behavior)

THERAPIST Tell me more about that.

PATIENT Well, she's old, and I'm her only relative here in town. I'd like to see her less, but I feel guilty about not spending time with her. Her husband is dead, and if I don't visit her, she'll be alone and unhappy. (mood, cognitions)

THERAPIST Anything else?

PATIENT Well, I'm not dating, and that's probably because I'm holding onto a relationship with an old girlfriend of mine who moved out of town a year ago. I spend holidays and vacations with her, and I sort of realize I need to quit doing that. (behavior, cognitions)

THERAPIST Why do you think you hold on to that relationship? When you think about letting her go, what thought do you get?

PATIENT I think, "I'll never find anyone else. No one would have me." (cognition)

Problems not reported by the patient

Frequently patients have important problems they do not report, eithe because they are not aware of them or because they are ashamed or afrai to mention them. Patients may be unaware of organic deficits or eve of serious interpersonal difficulties. They may be ashamed of havin financial difficulties or unable to admit that drugs or alcohol are inte fering with work or marriage. They may be frightened to own up to re peated suicide attempts for fear the therapist will refuse to continue trea ment.

The therapist can obtain information about these types of problems i several ways. Careful observation of the patient's behavior in the therap session may reveal interpersonal problems that the patient does not pe ceive or does not perceive as a problem. A person who is irritable an hostile in his interactions with the therapist is likely to act similarly wit others, although he may not volunteer this information.

The family and social history can also reveal unstated problems. personal history with a series of unsuccessful marriages points to inte personal problems, even if the patient does not report them. Alcohol an drug addictions in several family members suggests the possibility th the patient may be having similar difficulties.

The patient's family, previous therapists, or others may describe prol lems the patient is not aware of or wishes to hide. The therapist's hypot esis about the underlying mechanism can suggest the presence of prol lems the patient does not report. For example, a person whose chi problem is a need to gain the approval of others is likely to be unasserti and overly compliant to the wishes of others, be unclear about his ow needs, wishes and goals, and feel angry and resentful toward those I seeks approval from.

The mental status examination can be useful in picking up sympton of formal thought disorder, delusions, or organic deficits. All of the problems belong on the problem list but are rarely reported by the p tient.

When the therapist observes problems the patient does not report, it a good idea to try to point these out so they can be added to the proble list. However, patients may be reluctant to do this. Depending on t nature of the problems, the therapist may wish to make an agreeme with the patient to try treating the problems the patient presents a ignoring the ones the patient wants to ignore. However, if this treatme

strategy is ineffective, the unaddressed problems may need to be raised again.

At times the therapist may wish to add problems to the list that the patient is unwilling or unable to discuss at the time the problem list is made up. For example, at the beginning of treatment the therapist may not be able to point out to the patient that he has a tendency to manipulate and take advantage of others. When a problem cannot be placed on the mutual problem list, the therapist can keep in mind that a goal of treatment is to add this problem to the patient's list, so that the problem can be addressed in a collaborative way.

Sometimes a failure to agree on a problem list dooms the treatment. This happened to me recently when, after six months of unsuccessful treatment, a discussion of the lack of success of the treatment clearly revealed that the patient didn't really consider her difficulty leaving the house as a problem that needed work. Her view was that she was fragile and delicate and that she needed to stay home and rest. As soon as this difference in our problem lists (and treatment plans) was laid on the table, the patient came to the conclusion that she didn't want to work with me and left treatment. Although this was not a positive outcome, it was actually preferable to the unproductive and uncollaborative treatment we had been carrying out.

Changes in the problem list

The problem list is likely to change as treatment proceeds. When some difficulties are solved, others may appear. For example, a depressed, isolated, inactive patient who is successfully treated for depression may then reveal social anxiety that had been obscured by the social isolation and depression. Sometimes problems, particularly interpersonal ones, become apparent only as treatment proceeds and the relationship with the therapist develops. Thus, the process of arriving at a problem list is an ongoing one.

QUANTITATIVE MEASUREMENT OF PROBLEMS

When an exhaustive list of the patient's problems has been made, detailed, quantitative information about the mood, cognitive, and behavioral aspects of each problem is needed. Information about the multiple components of problems is necessary to understand the problems and formulate the case. Quantitative information about problems is neces-

sary in order to assess progress. Standardized scales and intervie proaches to obtaining this information are described here.

Depression

Often the depressed patient reports a difficulty in only one comp of the three components of overt difficulties described in Chapter 1: depressed mood. However, difficulties in one or both of the other co nents (cognitions, behavior) are likely to be present, and they need assessed as well. The Beck Depression Inventory (BDI) assesses n cognitive, and physiological aspects of depression. An activity log m helpful in assessing gross behavioral problems.

BECK DEPRESSION INVENTORY. The BDI is a 21-item self-report inve of the severity of symptoms of depression (the score on the weigh item is not tallied if the patient is trying to lose weight).[1] The BDI has frequently been found to show high correlations with clinical r of depression severity (Beck, 1972; reviewed by Carson, 1986). Bec set arbitrary cutoff scores for interpreting BDI scores, as follows: less than 10, not depressed; 10 to 15, mildly depressed; 16 to 20, m ately depressed; 25 or greater, severely depressed.

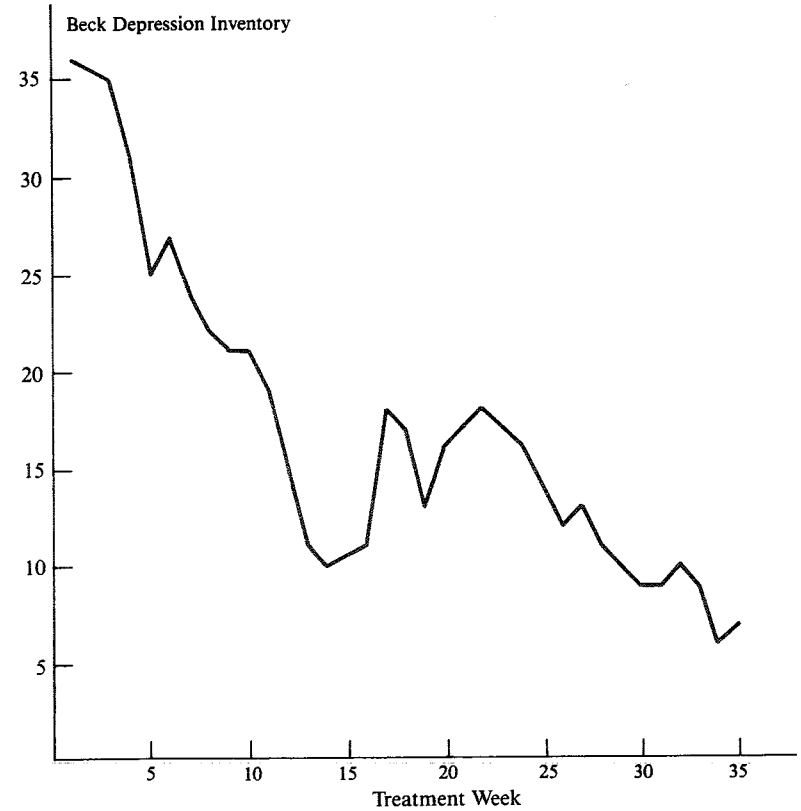
The BDI can be completed in two or three minutes, and I as depressed patients to complete one weekly before the therapy se Most—but not all—patients accept the BDI as a measure of depre and as a result it serves as a very useful measure of the progress c therapy. I plot the patient's score on a graph to monitor progre typical good treatment response is presented in Figure 2.1; it sho initial sharp drop in BDI, followed by slower improvements ther (Simons, et al., 1984).

In addition to monitoring progress in therapy, the BDI is also use guiding the therapy session. A look at the patient's BDI gives a index, before the session starts, of how the patient's week went.

ACTIVITY LOG. An activity log can be used to assess a variety of beha al aspects of problems. Depressed patients are commonly inactive withdrawn; to quantify this, the therapist can ask the patient to log activities or interactions, or time spent in bed. A written log is partic ly helpful in obtaining a quantitative assessment of problems. With

[1]The BDI is reprinted in Beck, Rush, Shaw, & Emery (1979, pp. 398–399) and in Co & Fischer (1987).

Figure 2.1 Changes in Beck Depression Inventory score over the course of a successful treatment.



written log, patients usually cannot give an accurate report, for example, of the number of times they wash their hands daily (for an obsessive-compulsive) or the number of hours they spend at home alone watching TV.

An activity log can be used to record any of a variety of problem behaviors or moods, panic attacks or episodes of suicidal thinking, angry outbursts, overeating, excessive drinking, unwanted sexual activity, shoplifting, and so on. A simple version of the log can involve simply a count of the frequency of the behavior in question – for example, a count of the number of panic attacks, colitis attacks, angry outbursts, or headaches per week. The log can also include ratings of severity or duration (e.g., for headaches). Ratings of severity can use a simple 0 to 100 scale or whatever type of scale is most appealing to the patient – perhaps she rates her headaches as mild, medium, or severe, for example.

More complex versions of the log can record, for each instance of a problematic behavior, the date, time, situation, mood, thoughts, or consequences. This type of information can provide clues about underlying mechanisms. Through the log, the patient and therapist can learn, for example, that panic attacks regularly occur after the morning cup of coffee or just before therapy sessions.

A log is also useful for keeping an ongoing record of homework exercises. For example, an agoraphobic can record what situations she entered and how anxious she felt. It can be altered to meet the needs of the situation at hand; for example, two anxiety ratings may be helpful, one rating of the *maximum* anxiety in the feared situation, and a second one of the anxiety at the end of the exposure session. In this way, the therapist can determine whether the patient stayed in the feared situation long enough for habituation to occur (see Exposure, Chapter 5).

Although log-keeping is offered here as a way of *assessing* problematic moods and behaviors, there is good evidence that the self-monitoring involved in keeping such a log also produces behavioral *changes*, usually in the desired direction, but these are usually short-lived (Bornstein, Hamilton, & Bornstein, 1986).

Suicidality

Assessment of suicidality is vital, as the failure to assess and treat a serious problem in this area may preclude treatment of any of the patient's other problems! The first interview with depressed patients should include at least one question about suicide. The obvious first question is, "Are you having any thoughts about suicide?"

If the answer to this question is a clear "no," then I often say, "It sounds like suicide is not a problem for you. Let's make an agreement that if it ever becomes a problem, you'll discuss it with me so we can work on it."

If the answer to the question about thoughts of suicide is "yes," additional assessment is needed. Strategies for doing this and for intervening with suicidality are presented in Chapter 10.

Assessment of suicidality is an ongoing process. When patients are completing the BDI weekly, the suicide item (#9) can be used as a quick way of keeping an eye on this issue.

Anxiety and phobic avoidance

The multiple-component view of anxiety (Lang, 1977, 1979) is more prominent than a multiple-component view of depression, and this is

reflected in the availability of more measures for assessing anxiety than depression. Several measures of anxiety are presented: the Burns Anxiety Inventory, the Fear Survey Schedule, the fear hierarchy, and the behavioral avoidance test.

BURNS ANXIETY INVENTORY. The Burns Anxiety Inventory, developed by David Burns, is a 32-item self-report scale listing feelings, thoughts and physical symptoms of anxiety. This inventory, reprinted here in Table 2.1, is extremely useful for monitoring the cognitive, mood and physiological (behavioral) symptoms of anxiety. Anxious patients can be asked to complete the BAI weekly.

FEAR SURVEY SCHEDULE. The Fear Survey Schedule (Wolpe & Lang, 1969) lists 108 commonly feared objects or events (e.g., journeys by airplane, looking down from high buildings, fainting). Each item is scored for the amount of "fear or other, related unpleasant feelings" on a scale from 0 (not at all) to 4 (very much). The Fear Survey Schedule is useful for alerting the therapist to fears the patient might not otherwise report. It is widely used in both research and clinical settings.

Internal consistency and test-retest reliabilities for the Fear Survey Schedule are high. However, the scale does not always correlate highly with behavioral and physiological measures of fear. This is not necessarily surprising, given the known desynchrony between the various aspects of fear (Lang, 1977, 1979). In addition, patients' fear ratings may be higher when in the feared situation than when far from it.

FEAR HIERARCHY. A fear hierarchy measures a person's verbal report of fear to a set of related objects and situations. Construction of a fear hierarchy requires the use of a subjective mood scale to obtain a quantitative measure of the patient's subjective experience of negative moods (e.g., anxiety, depression, hopelessness, anger). The ratings may also reflect negative physiological experiences (breathlessness, difficulty swallowing, palpitations, dizziness). Wolpe used such a scale to set up a hierarchy for systematic desensitization (see Wolpe, 1973); he called this the "suds" scale (subjective units of distress). To calibrate the scale he suggested the following instructions, "Think of the worst anxiety you have ever experienced, or can imagine experiencing, and assign to this the number 100. Now think of the state of being absolutely calm and call this zero. Now you have a scale of anxiety. On this scale how do you rate yourself at this moment?" (Wolpe, 1973, p. 120).

A fear hierarchy is extremely useful for guiding exposure homework (the patient can begin exposing herself to the items at the bottom of the

Table 2.1 Burns Anxiety Inventory

Symptom List

Instructions: The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you during the past week. If you would like a weekly record of your progress, record your answers on the separate "Answer Sheet" instead of filling in the spaces on the right.

Category I: Anxious Feelings	0 – NOT AT ALL	1 – SOMEWHAT	2 – MODERATELY	3 – A LOT
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange, unreal or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight" or on edge				
Category II: Anxious Thoughts				
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				

(continued)

Category II: Anxious Thoughts (continued)	0—NOT AT ALL	1—SOMEWHAT	2—MODERATELY	3—A LOT
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				

(continued)

Category III: Physical Symptoms (continued)	0—NOT AT ALL	1—SOMEWHAT	2—MODERATELY	3—A LOT
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

Add up your total score for each of the 33 symptoms and record it here: _____

Date: _____

Grateful acknowledgment is made to David Burns for permission to reprint this table.

list and then work up) and for assessing the effects of treatment. A hierarchy of feared situations for an agoraphobic young lady is presented in Figure 2.2. Pre-treatment ratings for all the items and post-treatment ratings (eight weeks later!) for a few of the items are supplied in the figure.

BEHAVIORAL AVOIDANCE TEST. The BAT provides a direct, objective, quantitative measure of the degree of avoidance of phobic objects and situations (Taylor & Agras, 1981). This is a direct measure of a key behavioral component of many anxiety problems. The BAT provides objective, quantitative, and clinically relevant data, and it is ideal for assessing changes due to treatment.

Figure 2.2 Pre- and post-treatment ratings of fear on a hierarchy for an agoraphobic young woman. Post-treatment scores are in parentheses.

100 (50) – holding down a job – being expected to be in one place all day without being able to leave.*
100 – crowded movie, alone
90 – crowded restaurant, alone
80 (0) – riding a crowded bus
80 – crowded movie, accompanied
80 (50) – crowded restaurant, accompanied
70 – elevator, alone
60–65 (50) – crowded, large department store
60 (30) – empty movie, alone
50 (30) – walking the crowded streets in the financial district
50 – shopping mall
40 (20) – elevator, with others
30–40 (15) – small elevator in the building where I live
30 (15) – empty restaurant, alone or accompanied
30 – empty movie, accompanied
30 (10) – spending the afternoon doing volunteer work
20 (10) – grocery store
10 – freeway driving

*At post-treatment the patient accepted a part-time job.

A test can be devised for almost any phobia. Acrophobics can be asked to report the maximum number of floors up a tall building they are able to climb. Cat phobics can be asked to approach a cat as closely as possible and report the number of feet between themselves and the cat when this has been done. Bridge phobics can be asked which bridges in the area they cannot drive over. Agoraphobics can be asked how many blocks from home they can go, or what places and situations they avoid – travel by public transportation, movie theaters, auditoriums, and so on. A related measure is duration of exposure to the feared object or situation. Claustrophobia, for example, can be assessed by measuring the length of time the patient can spend in a tiny room with the door closed.

Other measures

In addition to the scales described and reprinted here, many others a reprinted and described in Corcoran and Fischer (1987) and Hersen a Bellack (1988).

Interview strategies

The most commonly used method of collecting information is u doubtedly the clinical interview. Interview strategies for obtaining a qua titative description of the behavioral, mood, and cognitive aspects several common psychological problems are illustrated here.

"A PROBLEM AT WORK."

THERAPIST Tell me more about the problem at work.
PATIENT Well, I got demoted last year, and these days I am always afraid I'll be demoted again. I worry about it all the time, and it makes it hard to get any work done. (mood, cognitions, behavior)
THERAPIST So things aren't getting done?
PATIENT No, I tend to procrastinate on important projects.
THERAPIST I see. Like, for example, what projects are you procrastinat ing on right now?
PATIENT Well, I have a project for a big firm in Houston that I'm avoiding dealing with, and the end-of-the-quarter report is getting put off, too.
THERAPIST Is the end-of-the-quarter report usually a problem for you?
PATIENT Yes, I always put it off until the last minute, and then I have tc have my secretary put in a lot of overtime to finish it on time.
THERAPIST Does it ever get done late?
PATIENT Yes, last time it was late.
THERAPIST And do some of the other big projects run late too?
PATIENT Yes, I missed the deadline on the Cleveland project by a week!
THERAPIST What percent of the time would you say that your projects run late?
PATIENT Oh, maybe 30% to 40%.
THERAPIST So you'd like to work on that? You'd like to get these projects done on time?
PATIENT Yes, I would.
THERAPIST OK, that sounds good, let's make that a goal for you. Now, let's go back to the anxiety you're having. Let me ask you this: On

an average day at work, how strong, from 0 to 100, is your fear that you'll get demoted?

PATIENT Oh, it's hard to say. Maybe about 50.

THERAPIST Well, I'll tell you what I'd suggest. How about keeping a log. At the end of every workday, how about rating your fear of being demoted, on average during the day, and just writing the number on your appointment calendar—can you do that?

PATIENT Sure.

THERAPIST Good. Let's review it when you come in next week, and if you can keep that log on a regular basis, we can use it to evaluate how effective we're being at working on that problem. Does that make sense to you?

PATIENT Sure.

"A PROBLEM AT THE LAB." A depressed (mood) chemist felt incompetent in his laboratory work (mood) and avoided going to the lab (behavior). When he was in the lab, he experienced a barrage of self-critical thoughts (cognitions) assessing his performance as inadequate and inept.

To assess his lack of self-confidence, he rated, on a scale of 0 to 100, the feelings: "how confident I feel about the quality of my work" and "how confident I feel about the quality of my work when I talk with my supervisor." To assess the behavioral aspect of the problem, time spent at the lab, he kept a log of his hours at the lab. To get more information about the cognitive aspects of the problem, he recorded automatic thoughts when he was in the lab or imagined being in the lab, and rated his degree of belief in the thoughts. As therapy progressed, he spent more time in the lab, felt more confident about his work, and his automatic thoughts were less frequent and less believable.

"LONELINESS." A depressed young female computer programmer reported feeling intensely lonely and isolated. She estimated she felt this way 80% of the time. An assessment of her behavior indicated that, except for time at work, she spent most of her hours alone. Even at work and at home, where she had a roommate, she avoided social interactions whenever possible. Her typical week included one social event after work or on the weekend. When she was overwhelmed with loneliness, she had thoughts like, "I don't belong," "I'll always be alone," and "I'll never be happy unless I get married and have a family." Social interactions precipitated thoughts along the lines, "I'll get hurt," "I'll lose my autonomy and my life," and "This is dangerous." She believed these thoughts 100%. Treatment goals for this patient included reducing the frequency (and intensity, though that was not measured here) of negative moods of loneliness and depression, increasing the frequency of social interactions, and decreasing the frequency and degree of belief of the automatic thoughts.

EVALUATING THE EFFECTS OF TREATMENT

The problem list serves as a basis for evaluating the effects of treatment. Unless detailed, quantitative information about the patient's problems is collected at the beginning of therapy, the patient and therapist cannot know whether progress has occurred. The inability, at the end of many weeks or months of hard work, to clearly determine whether therapy has been helpful, can be extremely demoralizing to both patient and therapist.

Sometimes patient and therapist disagree in their assessment of the effects of the therapy. This type of disagreement may be due to the tendency of depressed patients to have a distorted, negative view of everything, including their progress in therapy. This type of patient may drop out of treatment, believing he has failed in therapy. A plot of weekly Beck Depression Inventory scores that shows steady improvement can remind patients who claim they have not benefitted from treatment that they have in fact improved. The opposite problem can occur as well. Some patients, particularly dependent, passive ones, wish to inflate the view of the progress made in therapy in order to maintain the status quo, particularly the therapeutic relationship. These patients wish to stay in therapy too long. In both these cases, objective, quantifiable data for assessing the effect of treatment are invaluable.

If treatment is unsuccessful, it is important to know this. Without frequent assessments of progress, the patient and therapist may waste valuable time pursuing an unproductive or misguided treatment. Although achievement of the goals of therapy may take years, some evidence of change in the desired direction is usually expected within a matter of weeks. For example, depressed patients who respond to cognitive therapy typically begin to show an improvement in Beck Depression Inventory scores within six weeks (Simons et al., 1984). If this does not happen, reevaluation is indicated.

In my own practice, I try to review progress every three months. I generally raise this issue by saying something like, "We've been working together for three months, so I'd like to review how we're doing. What I'd suggest is that you take some time to think about this during the week, and next time we meet we can spend a few minutes reviewing our progress. We can do this by going over the list of problems we made up when you started, and seeing how we're doing. How does that sound?"

Reviewing progress is often a very stressful event for patients, many of whom are frightened of failure or of being rejected by the therapist. The therapist's awareness of the patient's underlying belief and typical cognitions can be used to anticipate and prepare for negative reactions to the review process. For example, patients who believe, "Unless I please others, they will reject me" may be frightened that the therapist will feel angry at them for failing to improve fast enough; the therapist may wish to predict this fear and offer appropriate reassurance.

Sometimes it is difficult to determine whether progress is occurring. This is particularly true when some progress has taken place but the pace is slow. Is this a treatment failure or a slow treatment success? When faced with this question, I evaluate not only the accomplishment of the treatment goals, but also the process of the therapeutic work. Does change occur within the session? Do the patient and therapist work together in an effective, collaborative, productive way? If the answers to these questions are "yes," and the patient and I are willing to tolerate a slow rate of progress, we can decide to just keep plugging away.