Chapter 3

STRUCTURE OF THE FIRST THERAPY SESSION

A major goal of the cognitive therapist is to make the process of therapy understandable to both therapist and patient. The therapist also seeks to do therapy as efficiently as possible. Adhering to a standard format (as well as teaching the tools of therapy to the patient) facilitates these objectives.

Most patients feel more comfortable when they know what to expect from therapy, when they clearly understand their responsibilities and the responsibilities of their therapist, and when they have a clear expectation of how therapy will proceed, both within a single session and across sessions over the course of treatment. The therapist maximizes the patient's understanding by explaining the structure of sessions and then adhering to that structure.

Experienced therapists who are unaccustomed to setting agendas and structuring sessions as described in this chapter often feel uncomfortable with this fundamental feature of cognitive therapy. Such discomfort is usually associated with negative predictions: The patient will not like it; the patient will feel controlled; it will make me miss important material; it is too rigid. Therapists are urged to test these ideas directly through implementing the structure as specified and noting the results. Therapists who initially feel awkward with a more tightly structured session often find that the process gradually becomes second nature, especially when they note the accompanying results.

The basic elements of a cognitive therapy session are a brief update (including rating of mood and a check on medication compliance, if applicable), a bridge from the previous session, setting the agenda, a review of homework, discussion of issue(s), setting new homework, and summary and feedback. Experienced cognitive therapists may deviate

from this format at times, but the novice therapist is usually more effective when he follows the specified structure.

This chapter outlines and illustrates the format of the initial therapy session, whereas the next chapter focuses on the common structure for subsequent sessions. Difficulties in adhering to the structure are described in Chapter 5.

GOALS AND STRUCTURE OF THE INITIAL SESSION

Preparatory to the first session, the therapist reviews the patient's intake evaluation. A thorough diagnostic examination is essential for planning treatment effectively because the type of Axis I and Axis II disorders (according to DSM) dictates how standard cognitive therapy should be varied for the patient (see Chapter 16). Attention to the patient's presenting problems, current functioning, symptoms, and history helps the therapist to make an initial conceptualization and formulate a general therapy plan. The therapist jots down the agenda items he wishes to cover during an initial session on a therapy notes sheet (see Chapter 4, Figure 4.3).

The following are the therapist's goals for the initial session:

1. Establishing trust and rapport.
2. Socializing the patient into cognitive therapy.
3. Educating the patient about her disorder, about the cognitive model, and about the process of therapy.
4. Normalizing the patient's difficulties and instilling hope.
5. Eliciting (and correcting, if necessary) the patient's expectations for therapy.
6. Gathering additional information about the patient's difficulties.
7. Using this information to develop a goal list.

A recommended structure for the initial session encompassing these goals includes:

1. Setting the agenda (and providing a rationale for doing so).
2. Doing a mood check, including objective scores.
3. Briefly reviewing the presenting problem and obtaining an update (since evaluation).
4. Identifying problems and setting goals.
5. Educating the patient about the cognitive model.
6. Eliciting the patient's expectations for therapy.

7. Educating the patient about her disorder.
8. Setting homework.
9. Providing a summary.
10. Eliciting feedback.

If the patient is taking medication for her psychological problems, if medication is indicated, or if she is currently abusing alcohol or drugs, the therapist also adds these relevant issues to the agenda.

Before describing each session element, a caveat is in order. If the patient is hopeless and suicidal, the goals and format of the first session (or any session) are modified. It is of paramount importance to assess the patient's degree of suicidality, to discover what the patient is so hopeless about, and to undermine her hopelessness (Beck et al., 1979; Fremouw, dePerczel, & Ellis, 1990; Freeman, Pretzer, Fleming, & Simon, 1990). Crisis intervention also takes precedence above all else when the patient is in danger from others or is a potential danger to others.

It is essential to start building trust and rapport with patients in the first session. This ongoing process is easily accomplished with most patients without personality disorders. The therapist whose patient has only a straightforward Axis I diagnosis does not usually need to express his empathy through a large number of direct statements. Instead, he continuously demonstrates his commitment to and understanding of the patient through his words, tone of voice, facial expressions, and body language. Patients feel valued and understood when the therapist demonstrates empathy and accurate comprehension of their problems and ideas through his thoughtful questions and statements.

The therapist's implicit and sometimes explicit messages are that he cares about and values the patient; that he is confident they can work together; that he believes he can help her and that she can learn to help herself; that he really wants to understand what she's experiencing and what it's like "to walk in her shoes"; that he's not overwhelmed by her problems, even though *she* might be; that he has seen and helped other patients much like her; and that he believes cognitive therapy is the appropriate treatment for her and that she will get better.

As a further way of demonstrating respect for and collaboration with the patient, the therapist checks on the patient's perception of the therapeutic process and of himself as a therapist at the end of each session. Asking for explicit feedback helps strengthen the therapeutic alliance. Eliciting the patient's feedback enables the therapist to assess whether he is coming across as empathic, competent, and caring and affords him the opportunity to correct *at an early stage* any misperceptions the patient has. Patients often appreciate the rare invitation to give feedback to a professional; they receive a positive message about their partnership in therapy

and ability to affect the therapeutic process. At times, a therapist and patient have a different perspective on what occurred in a therapy session; the likelihood of having the opportunity to explore these important moments is increased if the therapist consistently elicits the patient's feedback in a nonperfunctory, nondefensive manner.

SETTING THE AGENDA

As mentioned previously, an important objective in the first session is to begin to socialize the patient to cognitive therapy. As with other techniques, it is advisable first to provide the patient with a brief rationale.

THERAPIST: I'd like to start off our session by setting the agenda—deciding what we'll talk about today. We'll do this at the beginning of every session so we make sure we have time to cover the most important things. I have some items I'd like to suggest and then I'll ask you what you'd like to add. Is that okay?

PATIENT: Yeah.

T: Our first session will be a little different from future sessions, because we have a lot of ground to cover and we need to get to know each other better. First, I'd like to check on how you've been feeling. Then I'd like to hear more about what brought you to therapy, what you'd like to accomplish and what some of your problems are, and what you expect from therapy. Okay so far?

P: Uh huh.

T: I'd also like to find out what you already know about cognitive therapy, and I'll explain how our therapy will go. We'll talk about what you might try for homework, and at the end, I'll summarize what we've talked about and ask you for feedback—how you thought therapy went. . . . Is there anything you want to add to the agenda today?

P: Yes. I have some questions about my diagnosis and how long you expect I'll need to be in therapy.

T: Fine. Let me jot down your questions, and we'll make sure to get to them today. (*Jotting patient's items.*) You'll notice that I tend to write down a lot of things during our session. I want to make sure to remember what's important. . . . Okay, anything else for the agenda today?

P: No, that's all.

T: If you think of other things as we go along, just let me know.

Ideally, setting the agenda is quick and to the point. Explaining the rationale makes the process of therapy more understandable to the patient and elicits her active participation in a structured, productive way. Failure to set explicit agendas frequently results in at least some unproductive discourse as it hinders the therapist and patient from focusing on the issues that are of greatest importance to the patient. The therapist refers to agenda setting again toward the end of the session when he reviews the patient's homework. One homework assignment will be for the patient to think about (and perhaps jot down) the topic name (rather than a lengthy description) of a situation or problem she wants to put on the agenda for the next session. Most patients easily learn how to contribute to the agenda. Chapter 5 describes strategies to try when agenda setting is problematic.

MOOD CHECK

Having set the agenda in this initial session, the therapist does a brief mood check. In addition to her weekly subjective report, objective self-report questionnaires such as the Beck Depression Inventory, Beck Anxiety Inventory, and Beck Hopelessness Scale (see Appendix D) help the patient and therapist keep objective track of how the patient is doing. Careful examination of these tests can highlight for the therapist problems that the patient may not have reported verbally, for example, difficulties sleeping, decrease in sexual drive, feeling like a failure, and increased irritability.

If objective tests are unavailable, the therapist may choose to spend some time in the first session teaching the patient to provide a rating of her mood on a 0–100 scale. ("Thinking back over the past week, on the average, how has your depression [or anxiety or anger, if these are the presenting problems] been on a 0–100 scale, 0 meaning no depression at all and 100 meaning the most depressed you've ever felt?") In the transcript that follows, the therapist has finished setting the agenda and is in the process of assessing the patient's mood.

T: Okay, next. How about if we start with how you've been doing this week. Can I see the forms you filled out? (*Looks them over.*) It seems as if you're still pretty depressed and anxious; these scores haven't changed much since the evaluation. Does that seem right?

P: Yes, I guess I'm still feeling pretty much the same.

T: (*Giving rationale.*) If it's okay with you, I'd like you to come to every session a few minutes early so you can fill out these three forms. 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. Is that okay with you?

P: Sure.

The therapist notes the summed score of objective tests and also quickly scans individual items to determine whether the tests point out anything important for the agenda, especially noting items related to hopelessness and suicidality. He may also graph test scores or the 0–100 ratings to make the patient's progress evident to them both (see Figure 3.1).

If the patient resists filling out forms, the therapist adds this problem to the agenda so he can help her identify and evaluate her automatic thoughts about completing forms. If need be, he negotiates with the

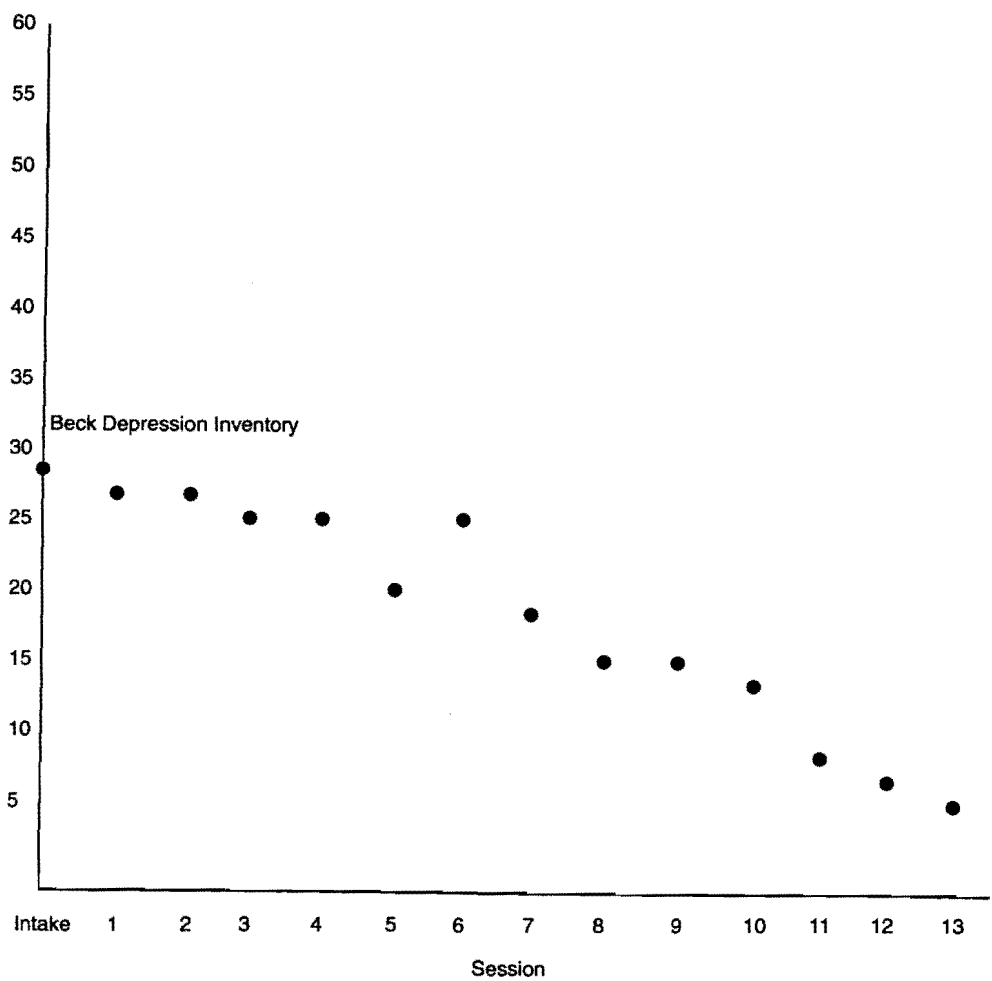

FIGURE 3.1. Graph of Sally's objective test scores.

patient, perhaps settling for 0–100 ratings or low/medium/high severity ratings in order to maintain their collaboration (see Chapter 5).

REVIEW OF PRESENTING PROBLEM, PROBLEM IDENTIFICATION, AND GOAL SETTING

In the next section, the therapist briefly reviews the patient's presenting problem. He asks the patient to bring him up-to-date, then turns their attention to identifying the patient's specific problems. As a logical extension, he then helps the patient turn these problems into goals to work on in therapy.

T: (*Summarizing first.*) Okay, we've set the agenda and checked on your mood. Now, if it's okay, I'd like to make sure I understand why you've come for therapy. I've read through the initial intake summary, and it looks as if you became pretty depressed about 4 months ago, shortly after you came to college. And you've also had a lot of anxiety, but that's not as bad as the depression. Is that right?

P: Yeah . . . I've been feeling pretty bad.

T: Anything important happen between when you were evaluated and now that I should know about?

P: No, not really. Things are pretty much the same.

T: Can you tell me specifically what problems you've been having? It helps me to hear it in your own words.

P: Oh, I don't know. Everything is such a mess. I'm doing terribly at school. I'm way behind. I feel so tired and down all the time. I feel sometimes like I should just give up.

T: Have you had any thoughts of harming yourself?

[The therapist gently probes for suicidal ideation because he will focus directly on the patient's hopelessness if the patient is actively suicidal.]

P: No, not really. I just wish all my problems would somehow go away.

T: It sounds like you're feeling overwhelmed?

P: Yes, I don't know what to do.

T: (*Helping the patient to focus and to break down the problems into a more manageable size.*) Okay, it sounds like you have two major problems right now. One is that you're not doing well at school. The other is that you feel so tired and down. Are there any others?

P: (*Shrugs her shoulders.*)

T: Well, what would you like to accomplish in therapy? How would you like your life to be different?

P: I'd like to be happier, feel better.

T: (*Getting the patient to specify in behavioral terms what "happier" and "feeling better" are for her.*) And if you were happier and feeling better, what would you be doing?

P: I'd like to be doing better in my courses and keeping up with the work . . . I'd be meeting more people, maybe getting involved in some activities, like I was in high school . . . I guess I wouldn't be worrying all the time. I'd have some fun and not feel so lonely.

T: (*Getting the patient to participate more actively in the goal-setting process.*) Okay, these are all good goals. How about if we have you write them on this no-carbon-required paper so we can each keep a copy.

P: All right. What should I write?

T: Here, date it at the top and write "Goal List." . . . Now what was one goal? (*Guiding the patient in writing the following list with items expressed in behavioral terms.*)

Goal List—February 1

1. Improve school work.
2. Decrease worrying about tests.
3. Meet more people.
4. Join school activities.

T: Okay, good. Now, how about for homework if you read through this list and see if you have any other goals to add. All right?

P: Yes.

T: Well, before we go on, let me just quickly summarize what we've done so far. We've set the agenda, reviewed your forms, talked about why you came for therapy and started a goal list.

The therapist efficiently reviews the patient's presenting problem, determines that the patient is not at risk for suicide and that there have been no significant developments since the initial intake evaluation, and helps the patient translate specific problems into goals for therapy. If the patient had been at risk for suicide, had important new information to impart, or had difficulty specifying her problems or goals, the therapist would have spent more time in this phase of the initial session (but would, of course, have had less time for other items).

Early in the session, the therapist gets the patient more actively

involved by writing. He suggests to her what to write, as it is not obvious to her. (In every session, he will ask her to take notes on no-carbon-required paper [available in office supply stores] or in a notebook [from which he can photocopy] so that both he and the patient can keep a copy.) The therapist himself does the writing for patients who cannot or strongly prefer not to write themselves. Patients, including children, who are not literate can draw pictures or listen to an audiotape of the therapy session as a way of reinforcing key therapy ideas.

The therapist also guides the patient to specify a global goal ("I'd like to be happier, feel better") in behavioral terms. Rather than allowing a discussion of goals to dominate the session, he asks the patient to refine the list for homework. Finally, he summarizes what they have discussed so far in the session before moving on.

EDUCATING THE PATIENT ABOUT THE COGNITIVE MODEL

An important overarching goal of cognitive therapy is to teach the patient to become her own cognitive therapist. Early on, the therapist elicits (and corrects, if necessary) what the patient already knows about this kind of therapy. He educates her about the cognitive model, using her own examples, and gives her a preview of therapy.

T: How about if we turn to finding out what you already know about cognitive therapy and how you expect therapy to proceed.

P: Well, I don't really know much about it, just what the counselor said.

T: What did you learn?

P: To tell you the truth, I don't really remember.

T: That's okay, we'll go over some of the ideas now. First I'd like to find out how your thinking affects how you feel. Can you think of any time in the past few days when you noticed your mood change? When you were aware that you had become particularly upset or distressed?

P: I think so.

T: Can you tell me a little about it?

P: I was having lunch with a couple of people I know and I started to feel a little nervous. They were talking about something the professor had said in our course that I didn't understand.

T: When they were talking about what the professor said, just before you began to feel nervous, do you remember what was going through your mind?

P: I was thinking that I didn't understand but I couldn't let them know it.

T: (*Using the patient's precise words.*) So you had the thoughts, "I don't understand" and "I can't let them know?"

P: Yeah.

T: And that made you feel nervous?

P: Yeah.

T: Okay, how about if we make a diagram. You just gave a good example of how your thoughts influence your emotion. (*Guides the patient in writing down the diagram in Figure 3.2 and reviews it with her.*) Is that clear to you? How you viewed this situation led to a thought which then influenced how you felt.

P: I think so.

T: Let's see if we can gather a couple more examples from the past few days. For example, how were you feeling when you were in the waiting room today, before our appointment?

P: Kind of sad.

T: And what was going through your mind at the time?

P: I don't remember exactly.

T: (*Trying to make the experience more vivid in the patient's mind.*) Can you imagine yourself back in the waiting room right now? Can you imagine sitting there? Describe the scene for me as if it's happening right now.

P: Well, I'm sitting in the chair near the door, away from the receptionist. A woman comes in, she's looking kind of smiley, and she talks to the receptionist. She's joking and looking happy and . . . normal.

T: And how are you feeling?

P: Sad.

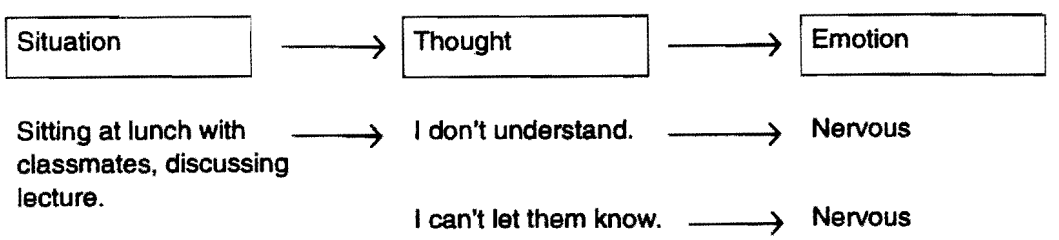

FIGURE 3.2. Sally's Session 1 notes: The cognitive model.

T: What's going through your mind?

P: She's happy. She's not depressed. I'll never be like that again.

T: (*Reinforcing the cognitive model.*) Okay. Again we have an example of how what you were thinking—"I'll never be like that again"—influenced how you felt; it made you sad. Is this clear to you?

P: Yeah. I think so.

T: Can you tell me in your own words about the connection between thoughts and feelings? (*Making sure the patient can verbalize her understanding of the cognitive model.*)

P: Well, it seems that my thoughts affect how I feel.

T: Yes, that's right. What I'd like you to do, if you agree, is to keep track this coming week of what's going through your mind when you notice your mood changing or getting worse. Okay? (*Facilitating the patient's carrying through the work of the therapy session throughout the week.*)

P: Uh huh.

T: In fact, how about if you write this assignment down [on no-carbon-required paper] so we both have a copy. "When I notice my mood changing or getting worse, ask: 'What's going through my mind?' and jot down the thoughts." Now, do you have an idea why I'd like you to jot them down?

P: I guess it's because you're saying that my thoughts make me feel bad.

T: Or they at least *contribute* to your feeling bad, yes. And to give you a preview of cognitive therapy—part of what we'll be doing together is identifying these thoughts which seem to be upsetting you. Then we'll examine those thoughts and see how *accurate* they are. Lots of times I think we'll find that these thoughts are *not* completely accurate. We should have you write down something about that, too.

P: (*Does so.*)

T: So we'll evaluate the thoughts and you'll learn to change your thinking.

P: That sounds hard.

T: Well, a lot of people think that at first, but pretty soon they find they get good at it. We'll just go step by step to teach you how to do it. But it was good that you identified your thought. Make sure if you do have any more thoughts like, "That sounds hard," to write them down so we can look at them next session. Okay?

P: Okay.

T: Do you think you'll have any trouble jotting down some thoughts?

(*Checking to see if the patient anticipates difficulties that they could problem-solve.*)

P: No. I think I'll be able to.

T: Good. But even if you can't, that's okay. You'll come back next week and we'll work on it together. All right?

P: Sure.

In this section, the therapist explains, illustrates, and records the cognitive model *with the patient's own examples*. He tries to limit his explanations to just a couple of sentences at a time and asks the patient to put into her own words what he has said so he can check on her understanding. (Had the patient's cognitive abilities been impaired or limited, the therapist might have used more concrete learning aids such as faces with various expressions to illustrate emotions.) He also makes sure that the patient writes down the most important points.

This particular patient easily grasps the cognitive model. Had she experienced difficulty in identifying her thoughts or emotions, her therapist would have weighed the benefits of using other techniques (see Chapter 6) to accomplish this objective with the possible consequence of pushing too hard (perhaps increasing the patient's dysphoria or interfering with rapport). Had he decided against further explication of the cognitive model, he would take care not to have the patient blame herself for failing to catch on. ("It's sometimes hard to figure out these thoughts. Usually they're so quick. It's no big deal. We'll come back to it another time.")

In the next section, the therapist probes for automatic thoughts in the form of visual images. Patients tend to have much more difficulty identifying these visual automatic thoughts and may not be able to provide examples. Nevertheless, they are much more likely to recognize and report images if they are alerted to them early in therapy.

T: Now, let me mention one more thing. Did you notice that I said you should ask yourself what is going through your mind when your mood changes, not "What am I thinking?" The reason I phrased it that way was because we often think in *images* or in picture form. For example, before you came in for the first time today, did you imagine what I might look like?

P: I think I had a vague picture of someone older and maybe more stern or more serious.

T: Okay, good. That picture or imagining is what we call an *image*. So when you ask yourself, "What's going through my mind?" check for both words and images. Do you want to write that down, too?

In this way, the therapist socializes the patient into recognizing that automatic thoughts may come in many different forms and even different sensory modalities, increasing the likelihood that she will be more readily aware of her automatic thoughts in *whatever* form they occur.

EXPECTATIONS FOR THERAPY

Patients often enter therapy with the notion that therapy is mystical or unfathomable and that they will not be able to comprehend the process by which they will get better. The cognitive therapist, in contrast, stresses that this kind of therapy is orderly and rational and that patients get better because they understand themselves better, solve problems, and learn tools they can apply themselves. The therapist continues to socialize the patient into therapy by imparting the message that the patient is to share responsibility for making progress in therapy. For most patients, a brief discussion, such as the one below, suffices.

T: Next I'd like to find out how you expect to get better.

P: I'm not sure what you mean.

T: Well, some patients have the idea that a therapist will cure them. Others think that they'll get better with the therapist's help but they have a sense that they are the ones who really will be doing the work.

P: I guess before I came in I thought you would somehow cure me. But from what you've said today, I guess you'll teach me things to do.

T: That's right. I'll help you learn the tools to get over the depression—and, in fact, you'll be able to use these tools for the rest of your life to help with other problems.

At the initial session, it is desirable for the therapist to give the patient a general sense of how long she should expect to remain in therapy. Usually it is best to suggest a range, 1½ to 4 months for many patients, though some might be able to terminate sooner (or might have to, due to financial constraints or insurance limitations). Other patients, particularly those with chronic psychological difficulties or those who want to work on problems related to a personality disorder, may remain in therapy for a year or more. Most patients progress satisfactorily with weekly sessions unless they are severely depressed or anxious, suicidal, or clearly in need of more support. Toward the end of therapy, sessions may be gradually spaced further apart to give the patient more opportunity to solve problems, make decisions, and use her therapy tools independently.

The next example presents one way in which the therapist might give the patient an idea of how therapy will proceed:

T: If it's okay with you, 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 make these decisions about how to space out therapy together. Even when we decide to terminate, I'll recommend that you come back for a "booster" once every few months for a while. How does that sound?

P: Fine.

T: It's hard to predict now how long you should be in therapy. My best guess is somewhere around 8 to 14 sessions. If we find that you have some real long-standing problems that you want to work on, it could take longer. Again, we'll decide *together* what seems to be best. Okay?

EDUCATING THE PATIENT ABOUT HER DISORDER

Most patients want to know their general diagnosis, that they are not crazy, and that their therapist has helped others like them before and does not think they are strange. Usually it is preferable to avoid the label of a personality disorder diagnosis. Instead it is better to say something more general and jargon free, such as, "It looks as if you've been pretty depressed for the last year and you've had some long-standing problems with relationships." It is also desirable to give the patient some initial information about her disorder so she can start attributing some of her problems to her disorder and thereby decrease self-criticism.

The following transcript illustrates how to educate patients who are depressed. (It requires alteration, of course, for patients with other disorders.)

T: Now the last thing on our agenda was your diagnosis. The evaluation shows that you are significantly depressed and anxious—as are many patients we see here. I'm quite hopeful that we'll be able to help you feel better. What do you think?

P: I was afraid you'd think I was crazy.

T: Not at all, you have a fairly common illness or problem called depression, and it sounds as though you have a lot of the same problems as most of our patients here. But again, that's a good automatic thought, "You'll think I'm crazy." How do you feel now that you've found out it isn't true?

P: Relieved.

T: So correcting your thinking *did* help. If you have any more thoughts like that, would you write them down for homework so we can evaluate them at our next session?

P: Sure.

T: This kind of very negative thinking is one symptom of your depression. Depression affects how you see yourself, your world, and your future. For most people who are depressed, it's as if they're seeing themselves and their worlds through eyeglasses covered with black paint. Everything looks black and hopeless. Part of what we'll do in therapy is to scrape off the black paint and help you see things more realistically. . . . Does that analogy make sense to you?

[Using an analogy often helps the patient to see her situation in a different way.]

P: Yeah. I understand.

T: Okay, let's go over some of the other symptoms of depression that you have, too. The depression interferes with your appetite, your sleep, your sexual desire and your energy. It also affects your motivation and drive, among other things. Now most depressed people start criticizing themselves for not being the same as they had been before. Do you remember any recent times you've criticized yourself? (*Eliciting specific incidents.*)

P: Sure. Lately I've been getting out of bed late and not getting my work done and I think I'm lazy and no good.

T: Now if you had pneumonia and had trouble getting out of bed and getting everything done, would you call yourself lazy and no good?

P: No, I guess not.

T: Would it help this week if you answered back the thought, "I'm lazy"?

P: Probably. I might not feel so bad.

T: What could you remind yourself?

[Eliciting a response rather than just providing one fosters active participation and a degree of autonomy.]

P: I guess that I *am* depressed and it's harder for me to do things, just like if I had pneumonia.

T: Good. And remind yourself that as you work in therapy and your depression lifts, things will get easier. Would you be willing to write something down about this so you'll remember it this week? (*Being collaborative, yet strongly giving the message that the patient is expected to participate actively in the session and to review session content between sessions.*)

P: Yeah.

T: And here's a booklet for you to read [*Coping with Depression*; see Appendix D] that tells you more about depression.

END-OF-SESSION SUMMARY AND SETTING OF HOMEWORK

Like the capsule summaries (see p. 58) the therapist makes throughout the session, the final summary ties together the threads of the session and reinforces important points. The summary also includes a review of what the patient agreed to do for homework. In the early sessions, the therapist summarizes; as therapy progresses, the therapist encourages the *patient* to summarize.

T: Well, let me summarize what we talked about today. We set the agenda, checked your mood, set some goals, and explained how your thoughts influence your feelings. We talked about how therapy will go. We're going to be doing two major things: working on your problems and goals and changing your thinking when you find it's not accurate. Now let's see what you've written down for homework. I want to make sure you think it's manageable and that it'll help.

Homework—February 1

1. Refine goal list.
2. When my mood changes, ask myself, "What's going through my mind right now?" and jot down thoughts (and images). Remind myself that these thoughts may or may not be true.
3. Remind myself that I'm *depressed* right now, not lazy, and that's why things are hard.
4. Think about what I want to put on the agenda next week (what problem or situation) and how to name it.
5. Read booklet and therapy notes.
6. Go swimming or running three times this week.

The therapist seeks to ensure that the patient experiences success in doing therapy homework (see Chapter 14). If he senses that the patient may not carry out any part of the assignment, he offers to withdraw it. ("Do you think you'll have trouble jotting down your thoughts? [If yes,] do you think we should cross it off the list for today? It's no big deal, one way or the other.")

Occasionally a patient bristles at the term "homework." The therapist then takes care to differentiate therapy homework, which is collaboratively set and especially designed to help the patient feel better, from previous experiences (usually school homework) which involved mandatory, unpersonalized, often unhelpful assignments. Therapist and patient can also brainstorm to find a more acceptable term such as "self-help activities." Having solved the practical problem of using the term "homework," the therapist might pursue (or mentally file away for future exploration) the meaning to the patient of the word "homework" to discover whether her objection to it fits into a larger pattern (e.g., Is she sensitive to control by others? Does she feel inadequate when asked to do a task?).

A common first-session (and later-session) homework assignment involves bibliotherapy. The therapist might ask the patient to read a chapter from a layman's book on cognitive therapy (e.g., Burns, 1980, 1989; Greenberger & Padesky, 1995; Morse, Morse, & Nackoul, 1992) or an educational brochure (see Appendix D). He tries to get the patient to become actively involved in the reading ("When you read this, mark it up so you can tell me what you agree with or disagree with, what seems to fit you and what doesn't").

A second common homework assignment in early sessions is activity monitoring and/or scheduling (see Chapter 12). The goal is to get patients to resume activities in which they had previously gained a sense of accomplishment and/or pleasure.

FEEDBACK

The final element of every therapy session is feedback. By the end of the first session, most patients feel positively about the therapist and the therapy. Asking for feedback further strengthens rapport, providing the message that the therapist cares about what the patient thinks. It also gives the patient a chance to express, and the therapist to resolve, any misunderstandings. Occasionally a patient makes an idiosyncratic interpretation of something the therapist said or did. Asking the patient whether there was anything that bothered her gives her the opportunity to state and then to test her conclusions. In addition to verbal feedback, the therapist may have the patient complete a written Therapy Report (see Figure 3.3).

T: Now at the end of each session, I'm going to ask for feedback about how you felt the session went. You actually get *two* chances—telling me directly and/or writing it on a Therapy Report which you can fill out

THERAPY REPORT

1. What did you cover today that's important to you to remember?

2. How much did you feel you could trust your therapist today?

3. Was there anything that bothered you about therapy today? If so, what was it?

4. How much homework had you done for therapy today? How likely are you to do the new homework?

5. What do you want to make sure to cover at the next session?

FIGURE 3.3. Therapy report. Copyright 1995 by Judith S. Beck, Ph.D.

in the waiting room after our session. I'll read it over, and if there are any problems, we can put them on the agenda at our next session. Now, was there anything about this session that bothered you?

P: No, it was good.

T: Anything important that stands out?

P: I guess that maybe I can feel better by looking at what I'm thinking.

T: Good. Anything else you'd like to say or anything you'd like to put on the agenda for next session?

P: No.

T: Okay then. It was a pleasure working with you today. Would you please fill out the Therapy Report in the waiting room now and the other three forms I gave you just before our session next week? And you'll

try to do the homework you wrote down on your homework sheet. Okay?

P: (*Nods.*) Okay. Thanks.

T: See you next week.

Occasionally, a patient does have a negative reaction to the first therapy session. The therapist tries to specify the problem and establish its meaning to the patient. Then he intervenes and/or marks the problem for intervention at the next session, as in the following example:

T: Now, was there anything about this session that bothered you?

P: I don't know . . . I'm not sure this therapy is for me.

T: You don't think it'll help?

P: No, not really. You see, I've got real-life problems. It's *not* just my thinking.

T: I'm glad you told me. This gives me the opportunity to say that I *do* believe that you have real-life problems. I didn't mean to imply that you don't. The problems with your boss and your neighbors and your feelings of loneliness. . . . Of course, those are all real problems; problems we'll work together to solve. I *don't* think that all we need to do is look at your thoughts. I'm sorry if I gave you that impression.

P: That's okay. . . . It's just, like . . . well, I feel so overwhelmed. I don't know what to do.

T: Are you willing to come back next week so we can work on the overwhelmed feelings together?

P: Yeah, I guess so.

T: Is the homework contributing to the overwhelmed feeling, too?

P: . . . Maybe.

T: How would you like to leave it? We could just decide now for you *not* to do homework this week and we'll do it together at our next session instead. Or you could take this sheet home and decide at home if you're feeling up to doing it.

P: I'd just feel guilty if I brought it home and didn't do it.

T: Okay, then let's plan for you not to do it. Anything else that bothered you about today's session?

Here the therapist recognizes the necessity for strengthening the therapeutic alliance. Either he missed signs of the patient's dissatisfaction during the session or the patient was adept at concealing it. Had the

therapist failed to ask for feedback about the session or been less adept at dealing with the negative feedback, it is possible that the patient would not have returned for another session. The therapist's flexibility about the homework assignment helps the patient reexamine her misgivings about the appropriateness of cognitive therapy. By responding to feedback and making reasonable adjustments, the therapist demonstrates his understanding of and empathy toward the patient, which facilitates collaboration and trust.

The therapist will make sure to express at the beginning of the next session how important it is to him that they work as a team to tailor the therapy and the homework so the patient finds them helpful. The therapist also uses this difficulty as an opportunity to refine his conceptualization of the patient. In the future, he does not abandon homework altogether but ensures that it is more collaboratively set and that the patient does not feel overwhelmed.

SUMMARY

The initial therapy session has several important goals: establishing rapport; refining the conceptualization; socializing the patient to the process and structure of cognitive therapy; educating the patient about the cognitive model and about her disorder; and providing hope and some symptom relief. Developing a solid therapeutic alliance and encouraging the patient to join with the therapist to accomplish therapeutic goals are of primary importance in this session. The next chapter describes the structure of later therapy sessions and Chapter 5 deals with difficulties in structuring sessions.

Chapter 4

SESSION TWO AND BEYOND: STRUCTURE AND FORMAT

Session two uses a format that is repeated in every subsequent session. This chapter presents the format and describes the general course of therapy from session two to near termination. The final phase of therapy is described in Chapter 15, and typical problems that arise in socializing the patient during early sessions are presented in Chapters 5 and 17.

The typical agenda for the second session and beyond is as follows:

1. Brief update and check on mood (and medication, alcohol and/or drug use, if applicable).
2. Bridge from previous session.
3. Setting the agenda.
4. Review of homework.
5. Discussion of issues on the agenda, setting new homework, and periodic summaries.
6. Final summary and feedback.

The experienced therapist may interweave the above elements to a certain extent. The beginning cognitive therapist, however, is advised to adhere to the above session structure as much as possible.

The therapist's goals during this second session are to help the patient select a problem or goal to focus on, to start solving problems, and to reinforce the cognitive model and the identification of automatic thoughts. He also aims to continue socializing the patient into cognitive therapy: following the session format, working collaboratively, providing feedback to the therapist, and starting to view her past and ongoing

experience in light of the cognitive model. If the patient is feeling at all better, the therapist also starts relapse prevention work (see Chapter 15). Above all, he is concerned with building the therapeutic alliance and providing symptom relief.

BRIEF UPDATE AND MOOD (AND MEDICATION) CHECK

The mood check is usually brief and may be combined with a brief update of the week. The therapist elicits a subjective description from the patient and matches it with objective test scores. If there is a discrepancy between the test scores and the self-report, he questions the patient (e.g., "You said you've been feeling better, but your depression inventory is actually higher than last week. What do you make of that?"). He also makes a quick comparison between the objective scores of the previous session and the present objective scores (e.g., "The anxiety score is lower this week than last. *Have* you been feeling less anxious this week?"). A typical second session begins as follows:

THERAPIST: Hi, Sally. How are you feeling today?

PATIENT: A little better, I think.

T: Can I take a look at your forms? While I'm looking at them, tell me how your week went.

P: Well, okay in some ways, not so great in others.

T: What happened?

P: Well, I've been feeling a little less depressed, I think. But a lot more anxious. I've been so worried about my economics exam that I couldn't concentrate.

T: Should we put the exam on the agenda? (*Socializing the patient into briefly specifying a problem to be discussed later in the session.*)

P: Yes. And I also had a problem with my roommate.

T: Okay, I'll write that down to talk about, too. Anything else I should know about your week?

P: I guess not.

T: Okay, back to the mood check. These tests also show a small drop in depression and an increase in anxiety. Why do you think you're feeling less depressed?

P: I've been feeling a little more hopeful. I guess I think therapy might help.

T: (*Subtly reinforcing the cognitive model.*) So you had thoughts like, "Ther-

apy might help," and those thoughts made you feel more hopeful, less depressed?

P: Yes . . . And I asked Lisa—she's in my chemistry class—to study with me. We spent a couple of hours yesterday going over some formulas. That made me feel better, too.

T: What went through your mind when you were studying with her yesterday?

P: That I liked her. That I was glad I asked her if she wanted to study together. . . . I understand it more now.

T: So we have two good examples of why you felt better this week. One, you had hopeful thoughts about therapy. And two, you *did* something different—studying with Lisa—and it sounds as if you gave yourself credit for it.

P: Yeah.

T: Can you see how in these two cases your thinking *positively* affected how you felt this week? . . . I'm glad you're feeling a little better. In a few minutes, I'll want to talk about the course of improvement, so we'll put that on the agenda, too.

Here Sally provided a brief statement about her mood. Had she started to elaborate at length, the therapist would have tried to socialize her to give a concise description (e.g., "Sally, let me interrupt you for a moment. Can you tell me in just a sentence how your depression and anxiety have been compared to the last time? . . . Or should we put 'mood check' on the agenda so we can spend more time discussing it?").

Sally also mentions two problems. Rather than initiating a discussion at this point, the therapist notes the problems for the agenda. Had he allowed her to launch into a lengthier description of the problems, he would have deprived Sally of the opportunity to reflect on what was *most* important to her to talk about during the session. He may also have had to forgo discussions of items he predicted would enable their therapy to proceed more efficiently.

Having noted a small change in her mood, the therapist asks for her explanation. If applicable, he suggests that the positive progress is a result of changes in the patient's behavior or thinking, rather than due merely to changed circumstances: "So you're feeling better but don't know why. Have you noticed any changes in your thinking this week? In the things you did?" Likewise, he seeks the patient's attribution if her mood has worsened: "Why do you think you're feeling worse this week? Could it have anything to do with your thinking or with the things you did or didn't do?" In this way, the therapist subtly reinforces the cognitive model

and implies that the patient has some control over (and therefore responsibility for) her progress.

The brief mood check and review of the week create several opportunities for the therapist. He can demonstrate his concern for how the patient has been feeling in the past week. He and the patient can monitor how the patient has been progressing over the course of therapy. He can identify (and can then reinforce or modify) the patient's explanation for her progress or lack of progress. He can also reinforce the cognitive model; namely, the way the patient has been viewing situations has influenced her mood.

When reviewing objective measures, the therapist makes sure to review individual items to look for important positive or negative changes (e.g., changes in suicidal ideation or hopelessness). He might also ask for additional information not specifically covered in the tests that may be relevant to her presenting problem (number of panic attacks for panic disorder patients, number of bingeing days for bulimic patients, 0–100 rating of anger for patients with hostility problems, and so forth).

If the patient is taking medication for her psychological difficulties, the therapist briefly checks for compliance, problems, side effects, or questions. If the therapist himself is not the prescribing physician, he first obtains the patient's permission and then periodically contacts the physician to exchange information and suggestions. Although the therapist does not directly recommend changes in medication to the patient, he might help her to respond to ideas that interfere with either taking medication or reducing medication (when applicable). He might also help the patient formulate and write down specific questions about side effects, dosage, alternative medications, and so on, in order to make it more likely that the patient will seek this information from her doctor. He also suggests that while medication may be responsible *in part* for her feeling better, the patient's own efforts have probably also contributed to her improvement. If the patient is not taking medication but the therapist believes a psychopharmacological intervention is indicated, he suggests a medical or psychiatric consultation.

BRIDGE FROM PREVIOUS SESSION

The purpose of this *brief* item is to check on the patient's perception and understanding of the previous session. Knowing that she will be asked about the previous session motivates the patient to prepare for the current session by thinking about therapy during the week. If the patient does not recall her reactions or the important points from the previous session, the therapist and patient problem-solve so she can better remember the content of the current session. The therapist may suggest, for

example, that the patient use the Session Bridging Worksheet (see Figure 4.1) to prepare for the next session, either mentally or in writing.

Asking for any further reactions to the past session may elicit important feedback that the patient had not previously offered. If either item appears to require more than a minute or two of discussion, the therapist may mark it down as an additional agenda item. This bridge from the last session helps to socialize the patient into the therapeutic process—giving her the message that she is responsible for reviewing the

SESSION BRIDGING WORKSHEET

1. What did we talk about last session that was important? What did you learn? (1–3 sentences)

2. Was there anything that bothered you about our last session? Anything you are reluctant to say?

3. What was your week like? What has your mood been like, compared to other weeks? (1–3 sentences)

4. Did anything happen this week that is important to discuss? (1–3 sentences)

5. What problems do you want to put on the agenda? (1–3 sentences)

6. What homework did you do/didn't you do? What did you learn?

FIGURE 4.1. Session bridging worksheet. Adapted with permission from Thomas Ellis, Ph.D.

content of each session and for telling the therapist whether she was bothered by anything about the therapist or the previous session.

T: Next, I'd like us to make a bridge between last session and this one, which is something we'll do at every session. First, what did you get out of the last session? What was important?

P: Well . . . a couple of things. I guess I was relieved to meet you and to hear about cognitive therapy and to know that I'm depressed and not crazy. The other thing was that how I think about something affects how I feel.

T: Good. Now a second question: Was there anything about last session that bothered you?

P: No. I thought it was good.

Had the patient brought up something that bothered her about the previous session, the therapist might have explored it with her right then or suggested that they put the problem on the agenda. Likewise, had the patient not remembered any content of significance, the therapist might have asked, "Do you remember that we talked about the connection between thoughts and feelings?" Or he might have said, "How about if we put a review of the cognitive model on the agenda?" As mentioned previously, he might also have indicated that the patient needs to take responsibility from now on for remembering important content by asking, "What could you do this coming week so you'll remember what we talked about today?" Note that a prime reason for patient's failure to recall session content is the *therapist's* failure to encourage the patient to write down the important points during the session itself.

SETTING THE AGENDA

Generally, the therapist takes more responsibility for agenda setting during early sessions and then gradually shifts responsibility to the patient. It is important for the patient to learn agenda-setting skills so she can continue with self-therapy after termination (Chapter 15).

T: Now we should set the agenda for today. We've already mentioned your exam, a problem with your roommate, and I wanted to talk about the course of improvement and some more about automatic thoughts. And, of course, I'd like to review your homework. Anything else?

P: No, I guess not.

T: This is a pretty ambitious agenda. If we run out of time, is there

something we can put off 'til next week? (*Helping the patient prioritize her problems.*)

P: Ummm . . . I guess the problem with my roommate. It'll probably just blow over.

T: Okay, we'll put it last on our list and we'll try to get to it, but if not, we'll talk about it next week, if it's still relevant.

Often patients need a little encouragement initially to suggest agenda items. They may not be clearly cognizant of what has been bothering them and/or they may be unsure of what is appropriate to bring up. The therapist socializes the patient to bring up *problems* that she needs help in solving. "What problem or problems do you want to focus on today?" "What do you want to put on the agenda to get help with today?" "What should we work on today?" If there are too many agenda items, therapist and patient collaboratively prioritize items, specify the amount of time to spend on each one, and put off one or more items to the following week if necessary.

It is important to note that the therapist need not always adhere to the agenda. Indeed, under some circumstances, the therapist *should not* follow the agenda. When deviating from the agenda, however, the therapist makes such a deviation *explicit* and elicits the patient's agreement.

T: Sally, I can see that you're still really worried about your exam, but we're running out of time. Would you like to spend the rest of the session on it and postpone our other agenda items to next week? Or we could try to spend just 5 more minutes on it so we'll still have time to talk about the problem with your roommate.

P: I guess the problem with my roommate could wait until next week.

T: Okay, let me mark that in my notes and let's go back to the exam.

The therapist might suggest a change in how they spend their time during a session for a number of reasons. For example, as in the previous transcript, the patient is quite upset about a particular issue and needs more time to discuss it. Or, a new topic arises which seems especially relevant. Or the patient's mood changes (for the worse) during the session. The therapist steers the patient away from peripheral issues which were not on the original agenda and which hold little promise for helping the patient progress during the session. A notable exception occurs when the therapist deliberately (though usually briefly) engages the patient in more casual conversation to achieve a specific goal. For example, the therapist might ask about a movie the patient has just seen,

or inquire about her family, or ask her opinion about current events in order to brighten her mood, facilitate their alliance, or assess her cognitive functioning or social skills.

REVIEW OF HOMEWORK

Studies suggest that patients who do homework regularly show greater improvement than do patients who do not (Persons et al., 1988; Niemeyer & Feixas, 1990). Reviewing homework at each session reinforces this behavior and communicates the value of between-session work. In our experience, if the homework is not reviewed, the patient begins to believe that it is *not* important and compliance with homework drops off dramatically. Sometimes the review of homework is relatively brief; at other times, however, it may occupy almost the entire session, especially when the issues the patient wants to discuss are contained within the homework assignment. (Homework is discussed in greater depth in Chapter 14.) Here is how a therapist might ideally review the homework:

T: Next on the agenda is the homework. What did you get done?

P: Well, I read the booklet you gave me.

T: Did you bring it with you? Could you pull it out and tell me what you learned that you think is important? (*The therapist and patient spend a few minutes discussing this.*) Anything else you have a question about? Anything else you're not clear on or you thought didn't apply to you?

P: No, that's about it. It *was* helpful.

T: Good. Now, another homework assignment was to try to catch your automatic thoughts when you noticed your mood changing.

P: I tried, but I don't think I always know what I'm thinking.

T: That's okay. We'll be talking about automatic thoughts each session 'til the end of therapy. For homework this week were you able to identify *any* automatic thoughts when your mood changed?

P: Yeah, I think so, but I didn't write them down.

T: What was the situation?

P: I was sitting in class and all of a sudden I got real anxious.

T: What was going through your mind?

P: I was thinking the exam was coming up and there's no way I'll be ready for it.

T: Good. Let me jot those down. Can we get back to these thoughts in a few minutes when we talk about the exam?

P: Yeah.

T: Any other automatic thoughts you were aware of this week?

P: Not really.

T: Okay, let's move on to your other homework assignments. Did you add anything to your goal list?

P: No. I looked at it, but I didn't think of anything else.

T: That's fine. Keep your copy, and if you do think of something else you'd like to add, let me know. And how did you do with reminding yourself that it's hard to do things because you're depressed, not lazy?

P: Pretty good. I did catch myself a few times.

The therapist intends to review all the homework assignments during the session, so he marks the automatic thoughts about the exam as a topic to pursue a little later in the session. The therapist does not have to review all the homework separately from the rest of the agenda items. Indeed, many experienced therapists integrate the homework review into a discussion of the issues on the agenda. The beginning therapist, however, needs a clear idea of where in the session he is and what is still left to be done. It is easier to adhere to the explicit structure and mark items to be discussed later. It would have been easy for this therapist, for example, to drift into a discussion of the exam and fail to review the rest of the patient's homework.

DISCUSSION OF ISSUES ON THE AGENDA, SETTING NEW HOMEWORK, AND PERIODIC SUMMARIES

Most of the time, the therapist asks the patient which agenda item she wants to start with. Doing so affords the patient the opportunity to be more active and assertive and allows her to take more responsibility. At times, the therapist takes the lead in suggesting an agenda item to start with, especially when he judges that the selection of a *particular* agenda item will result in greater progress during the session ("Is it okay with you if we start with the problem of finding a part-time job?").

The therapist interweaves his own goals as appropriate, whatever the topic under discussion. In this second session, the therapist seeks not only to help Sally do some problem-solving but also to (1) relate the topic to Sally's therapy goals, (2) reinforce the cognitive model, (3) continue teaching Sally to identify her automatic thoughts, (4) provide some symptom relief through helping Sally respond to her anxious thoughts, and (5) as always, maintain and build rapport through accurate understanding.

Agenda Item No. 1

T: Okay, let's take a look at the agenda. Where do you think we should start? We could pick a goal to work on, talk about your exam, or talk about the course of improvement.

P: My exam, I guess, I'm really worried about it.

T: Actually, that fits into two of your therapy goals, doesn't it—improving your grades and decreasing your anxiety about school.

P: Yeah.

T: Okay, can you give me an overview of what happened this week? How much did you study? What happened with your concentration?

P: Well, I meant to study all the time. But every time I sat down, I just got so nervous. Sometimes I didn't realize that my mind had wandered, and I had to keep rereading the same pages.

T: When is the exam, and how many chapters does it cover? (*Getting more data so he can help problem-solve and identify possible distortions in her thinking.*)

P: It's in 2 weeks, and I think it covers the first five chapters.

T: And how much have you read at least once?

P: About three chapters.

T: And there are still some things in the first three chapters that you don't understand?

P: A lot of things.

T: Okay. So, in a nutshell, you have an exam in 2 weeks, and you're worried that you won't understand the material well enough?

P: Right.

In this first part, the therapist just seeks a broad overview of the problem. He subtly models for the patient how to express this problem "in a nutshell." Next, he will get her to identify her automatic thoughts by having her remember a *specific* situation.

T: Can you remember a time this week when you thought about studying or tried to study and the anxiety got really bad?

P: Yes, sure. . . . Last night.

T: What time was it? Where were you?

P: It was about 7:30. I was walking to the library.

T: Can you picture it in your head now? It's 7:30, you're walking to the library. . . . What goes through your mind?

P: What if I flunk the exam? What if I flunk the course? How will I ever make it through the semester?

T: Okay, so you were able to identify your automatic thoughts. And how did these thoughts make you feel? Anxious?

P: Very.

T: Did you stop and say to yourself . . . What if I pass the exam? Maybe I'll pass the course. Maybe I'll get through the semester just fine? (*Using this problem to reinforce the cognitive model before doing problem-solving.*)

P: No.

T: What would have happened to your mood, do you suppose, if you had?

P: If I had believed it, I'd have felt better.

T: Let me tell you a little more about these automatic thoughts. We call them *automatic* because they seem just to pop into your mind. Most of the time, you're probably not even aware of them; you're probably much more aware of the anxiety or sadness they produce. Even if you *are* aware of them, you probably don't think to evaluate how correct they are. You just accept them as true. What you'll learn to do here in therapy is first to identify them and then to judge for yourself if they're completely correct or if there's some distortion in them. So, now, let's look at the first thought together. What evidence do you have that you'll flunk the exam? (*Starting the process of evaluating the automatic thought.*)

P: Well, I don't understand everything.

T: Anything else?

P: No. . . . Just that I'm running out of time.

T: Okay. Any evidence that you might *not* flunk?

P: Well, I did do okay on the first quiz.

T: Anything else?

P: I do understand the first two chapters better than the third one. The third one is the one I'm *really* having trouble with.

T: What could you do to learn the third chapter better? (*Starting problem-solving; having the patient take the lead.*)

P: I could read it again. I could look through my lecture notes.

T: Anything else?

P: (*Hesitates.*) I can't think of anything.

T: Anyone else you could ask for help?

P: Well, I suppose I could ask the teaching assistant. Or maybe the guy down the hall who took this course last year.

T: That sounds good. *Now* what do you think of your prediction that you might flunk?

P: I guess I do know some of the stuff. Maybe I *could* get help with the rest.

T: And how do you feel now?

P: A little less worried, I guess.

T: Okay, to summarize, you had a lot of automatic thoughts this week which made you feel anxious. But when you stop to evaluate these thoughts rationally, it seems likely that there are a number of things you *can* do to pass. When you really look at the evidence and answer back the thoughts, you feel better. . . . Is that right?

P: Yeah, that's true.

T: For homework this week, I'd like you to look for these automatic thoughts again when you notice your mood changing. These thoughts may have a grain of truth, but often they'll be distorted in some way. Next week we'll look for evidence together to figure out whether the thoughts you wrote down for homework are completely accurate or not. Okay?

P: Okay.

T: Now, identifying and evaluating thoughts is a skill for you to learn, like learning to drive or type. You may not be very good at it at first, but with practice you'll get better and better. And I'll be teaching you more about this in future sessions. See what you can do this week just to identify some thoughts but don't expect yourself to be good at it yet. Okay?

P: Yeah.

T: One more word about this. When you write down some thoughts this week, remind yourself again that the thoughts *may or may not be true.* Otherwise, writing them down before you've learned to evaluate them could make you feel a little worse.

P: Okay.

T: We'd better have you write some of this down now. (*The therapist repeats the assignment.*) And while we're at it, let's see if there's any homework from last week that you want to continue doing this

week. And you might want to add a plan for studying for your exam. [See Figure 4.2.]

In this section, the therapist accomplishes many things at once. He addresses an agenda issue that is of concern to the patient; he ties the issue to her therapy goals; he teaches her more about automatic thoughts; he helps her identify, evaluate, and respond to a specific distressing thought; he facilitates symptom relief by decreasing the patient's anxiety; and he sets up a homework assignment and cautions the patient to have realistic expectations about learning the new skill. Chapters 6 and 8 describe in greater detail the process of teaching patients to identify and evaluate their automatic thoughts.

Agenda Item No. 2

In the next section, the therapist gives the patient some information about the course of improvement. Having just finished a segment of the session, he briefly summarizes first:

T: Okay, we just finished talking about your midterm and how your automatic thoughts really made you feel anxious and interfered with problem-solving. Next, I'd like to talk about the course of getting better, if that's okay.

P: Sure.

T: I'm glad you're feeling a little less depressed today, and I hope you continue to feel better. But probably you won't just feel a little bit better every single week until you're back to your old self. You should expect to have your ups and downs. Now I'm telling you this for a reason. Can you imagine what you might think if you expected to keep feeling better and better and then one day you felt a lot worse?

P: I'd probably think I would never get better.

1. When I notice my mood changing, ask myself, "What's going through my mind right now?" and jot down my automatic thoughts (which may or may not be completely true). Try to do this at least once a day.
2. If I can't figure out my automatic thoughts, jot down just the situation. Remember, learning to identify my thinking is a skill I'll get better at, like typing.
3. Ask Ron for help with Chapter 5 of econ book.
4. Read over therapy notes.
5. Continue running/swimming. Plan 3 activities with Jane [roommate].

FIGURE 4.2. Sally's homework (Session 2).

T: That's right. So I want you to remember that we predicted a possible setback, that setbacks are a normal part of getting better. Do you want to get down something in writing about that?

See Chapter 15 for a more extensive discussion of relapse prevention and a pictoral representation of the normal course of therapy.

Periodic Summaries

The therapist does two kinds of summarizing throughout the session. The first kind is a brief summary when a section of a session has been completed so both he and the patient have a clear understanding of what they have just accomplished and what they will do next.

T: Okay, so we've finished talking about the problem with your finding the time and motivation to start running again and we agreed you'd try running twice this week as an experiment. Next, is it okay if we get back to the homework you did this past week, trying to catch your automatic thoughts?

A second kind of summarizing is of the content of what the patient has presented. Here the therapist briefly summarizes the gist of the patient's statements but tries to use her specific words. Often the patient has described a problem with many details. The therapist summarizes to ensure that he has correctly identified what is most troublesome to the patient and to present it in a way that is more concise and more clear to both of them, subtly demonstrating the cognitive model over and over again. He uses the patient's own words as much as possible both to convey accurate understanding and to keep the key difficulty activated in her mind.

T: Let me make sure I understand. You were considering getting a part-time job again but then you thought, "I'll never be able to handle it," and the thought made you so sad that you folded up the newspaper and went back to bed and cried for half an hour. Is that right?

Had the therapist paraphrased the patient's ideas and failed to use her own words ("Sounds like you weren't sure if you could do well if you got a part-time job"), he might have made the automatic thought and emotion less intense and the subsequent evaluation of the thought might then have been less effective. Summaries that substitute the *therapist's* words may also lead to the patient's believing that she has not been accurately understood:

P: No, it's not that I thought I might not do well; I'm afraid I might not be able to handle it *at all.*

FINAL SUMMARY AND FEEDBACK

In contrast to the above, the therapist *refrains* from activating negative thoughts distressing to the patient in the *final summary*. Here he aims to make clear to the patient the major points covered during the session in an upbeat way. Because this is an early session, the therapist himself does the summarizing. As the patient progresses in therapy, she may take over this task. Summarizing is much more easily accomplished if during the session the patient has taken good notes that cover the most important points. The following transcript is a straightforward example of making a final summary and eliciting the patient's feedback.

T: Well, we have just a few minutes left. Let me summarize what we covered today, and then I'll ask you for your reaction to the session.

P: Okay.

T: It sounds like you've had more hopeful thoughts this week and so you've felt less depressed. Your anxiety increased, though, because you made a number of negative predictions about your exam. When we looked at the evidence that you'll flunk, though, it seems unconvincing. And you came up with several good strategies to help your studying, some of which you'll try between now and our next session. We also discussed what you should remind yourself if you have a setback. Finally, we talked about identifying and evaluating your automatic thoughts, which is a skill we'll keep practicing in therapy. Does that about cover it?

P: Yeah.

T: Anything I said today that bothered you? Anything you think I got wrong?

P: I am a little bit worried that I could have a setback.

T: Well, a setback is possible and if you do find yourself feeling significantly worse before our next session, I'd like you to call me. On the other hand, you may very well have another better week.

P: I hope so.

T: Should we put the topic "setbacks" on the agenda again next week?

P: Yes, I think so.

T: Okay, does anything else bother you or stand out about today's session?

P: No, except that I hadn't clearly realized before what I could do to help my studying.

T: Maybe we'll talk about that more next week: What ideas got in the way of your being able to do good problem-solving on your own. Okay? See you next week.

If the therapist senses that the patient has not fully expressed her feedback about the session, or if he judges that the patient may leave the session without adequate reflection about what she learned, he may ask her to complete a therapy report (see Figure 3.3), either mentally or in writing.

SESSION THREE AND BEYOND

Therapy sessions subsequent to the second session maintain the same format. The content varies according to the patient's problems and goals and the therapist's goals. In this section, the flow of therapy across sessions will be outlined. A more detailed description of treatment planning can be found in Chapter 16.

As mentioned previously, the therapist initially takes the lead in suggesting agenda items, helping the patient to identify and modify automatic thoughts, devising homework assignments, and summarizing the session. As therapy progresses, there is a gradual shift in responsibility. Toward the end of therapy, the patient herself names most of the agenda topics, uses tools such as a Dysfunctional Thought Record (see Chapter 9) to evaluate her thinking, devises her own homework assignments, and summarizes the therapy session.

Another gradual shift is from an emphasis on automatic thoughts to a focus on both automatic thoughts and underlying beliefs (see Chapters 10 and 11). Shifts in the relative emphasis on behavior changes, too, though in a less predictable fashion. Depressed patients are encouraged from the beginning to schedule activities and become more active (see Chapter 12). (A severely depressed patient may be unable to concentrate on cognitive tasks and the therapist focuses on activating her behaviorally until her depression lifts sufficiently to allow her to do cognitive work.) The therapist returns to an emphasis on behavioral change in order to have the patient test certain thoughts or beliefs or practice new skills such as assertiveness (see Chapter 12). As therapy moves into the final phase, there is yet another shift: preparing the patient for termination and relapse prevention (see Chapter 15).

The therapist keeps in mind the stage of therapy when planning an individual session. As mentioned in Chapter 2, he continues to use his conceptualization of the patient to guide therapy. The therapist jots down agenda items on the therapy notes sheet (see Figure 4.3) before a session and is prepared to eliminate his items if necessary. As the patient reports on her mood, briefly reviews the week, and specifies agenda topics, the therapist formulates in his own mind a specific goal or goals

THERAPY NOTES

Patient's name: Sally **Date:** 3/15 **Session no.:** 7

Objective scores: Beck Depression Inventory = 18, Beck Anxiety Inventory = 7, Hopelessness Scale = 9

Patient's agenda:

Problem with English paper

Therapist's objectives:

Continue to modify perfectionist thinking.

Decrease anxiety and avoidance around participating in class.

Session highlights:

1. Feeling less depressed and anxious this week.
2. (Situation/problem) (Automatic thought) (Emotion)
   English paper due tomorrow → It's not good enough → Anxious

Intervention—Dysfunctional Thought Record—attached

Outcome—Anxiety ↓ (reduced)

3. Old belief: If I don't get an A, it means I don't have what it takes to be a success.
   90% **(strength of belief)**

   Intervention: Advice to Donna **(friend)**

   Outcome: 80% **(rerating strength of belief)**

   Intervention #2: Rational–emotional role–play

   Outcome: 60% **(rerating strength of belief)**

   New belief: I don't need all A's to succeed now or in the future. 80%
4. Coping card about asking questions after class (attached).

Homework: (If patient has written homework assignment on no-carbon-required paper, just attach it without rewriting here)

DTR and credit list.

Read therapy notes and think about old and new beliefs about success.

Read coping cards 3 times a day and as needed; then ask 1 or 2 questions after class.

Spend one more hour to polish English paper.

Next session or future sessions:

See how perfectionism affects other parts of life.

FIGURE 4.3. Therapy notes.

for the session. For example, in session three, the therapist's goals are to begin teaching Sally in a structured way to evaluate her automatic thoughts and to continue to schedule pleasurable activities. In session four, he aims to help her do some problem-solving about finding a part-time job and continue to respond to her dysfunctional thoughts. He continually seeks to integrate his goals with Sally's agenda items. Thus he teaches her problem-solving and cognitive restructuring skills in the context of situations she brings to therapy. This combination of solving problems and helping patients respond to their thoughts generally allows the therapist and patient sufficient time to discuss in depth only one or two problematic situations from the agenda during a given therapy session.

In order to refine his conceptualization, to keep track of what is being covered in a therapy session, and to plan future sessions, the therapist takes notes during the session (see Figure 4.3) and keeps a copy of notes the patient takes as well. It is useful for the therapist to note the problem(s) discussed, dysfunctional thoughts and beliefs (written verbatim) and the degree to which the patient initially believed them, the interventions made in session, the relative success of these interventions, the new restructured thoughts and beliefs and the degree of belief in them, the assigned homework, and topics for the agendas of subsequent sessions. Even experienced therapists have difficulty remembering all these important items without written notes.

This chapter outlined the structure and format of a typical early therapy session and briefly described therapy across sessions. The following chapter discusses problems in following the prescribed format, while Chapter 16 describes in detail how to plan treatment before individual sessions, within sessions, and across sessions.